

Cost Savings Resulting from a National Pharmacare Program

Summary

On September 28th, 2017, the Parliamentary Budget Office (PBO) will release its estimates of the costs of “single-payer universal first-dollar prescription drug coverage” run by the federal government¹. While that report will provide Parliament, and Canadians, with an estimate of the **costs** associated with such a system, it is equally important to identify the **savings** that would result from its implementation.

Our analysis, outlined in this study, indicates **more than \$30 billion in public and private savings will result from the implementation of a universal pharmacare system** by eliminating the need for current government programs, and spending by employers and individuals on drug plans, as well as increasing overall system efficiency.

These savings include:

- **Approximately \$18.1–\$19.7 billion in public spending on prescription drugs**
 - \$12.74 billion from current provincial and territorial drug plans and insurance programs
 - \$649 million from current federal drug plans
 - \$3.34 billion from current drug plans for government employees
 - \$1.4 billion in tax subsidies currently provided to offset private sector drug insurance costs
 - Up to \$1.6 billion in health care savings from reducing non-adherence.
- **Approximately \$13.7 billion in private sector spending on prescription drugs**
 - \$7.3 billion in out-of-pocket spending of prescription medication by Canadians
 - \$6.4 billion in net savings on private drug insurance policies purchased by private sector employers and families.

The savings that would result from the implementation of universal pharmacare underline the high costs, administrative complexity and poor coverage of Canada's current patch-work of prescription drug plans. The evidence suggests that policy makers should seriously consider the cost of *not* implementing a comprehensive universal public plan.

Background: The significance of pharmacare

The issue of drug coverage has gained public prominence and public support over the last several years. Canada is the only OECD country with a universal healthcare system that does not include universal prescription drug coverage. In recent polls, 88% of Canadians supported the creation of a national pharmacare system,² and Canadian businesses also favoured investing in such a program³. This public support is driven by rising drug costs, declining accessibility, and resulting significant health consequences.

With as many as one in five Canadian families unable to afford medications they are prescribed⁴, and significant pressures on hospitals and emergency rooms for non-adherence⁵-related intakes and admissions⁶, the inaccessibility of prescription medications is an important health concern.

Recent studies that show Canadians are paying substantially more for medications than residents of other OECD nations are equally distressing, with drug costs at 30% above the OECD average⁷. These high costs are, in part, a function of a fragmented, multi-payer system.

Canadians access prescription medications through over 100 public sector programs administered by 14 governments⁸ as well as countless private insurance policies purchased by private-sector employers, Canadian families, and by governments at the federal, provincial and municipal levels for their employees. Universal drug coverage would have a substantial impact on this patchwork of programs and systems, resulting in savings in both the public and the private sectors. With multiple prescription drug payers (i.e. private drug plans, provincial and territorial drug plans) engaged in their own pricing negotiations, the Canadian health care system is unable to leverage the purchasing power of a single-payer system which would result in significantly lower drug prices.

As a result of these concerns, the Parliamentary Committee on Health (HESA), has been closely examining the prospects for a universal drug coverage program. On September 27th, 2016, it directed the Parliamentary Budget Office (PBO) to calculate the costs associated with the establishment and administration of a number of drug coverage models including “single-payer universal first-dollar prescription drug coverage”⁹ (often referred to as universal pharmacare).

Research suggests that the costs of a universal drug coverage program, while sizeable, would be offset by the considerable savings associated with eliminating the need for other drug coverage programs including existing public sector programs and private spending. Since Canadians spent \$31.8 billion through public and private means on prescription medications in 2016¹⁰, the potential for savings is significant.

Public Sector Savings

The Cost of Direct Public Spending on Drug Programs

A national pharmacare program would eliminate the need for the following federal, provincial and territorial drug programs and social insurance expenditures, replacing them with a unified, single-payer system.

Federal drug programs: The federal share of direct drug program spending, consisting of services for eligible Indigenous individuals, is a modest 2.1% of total drug spending in Canada. CIHI forecasts this federal government direct spending at \$648.9 million for 2016¹¹.

Provincial and Territorial drug programs: By far the largest share of public spending on prescription medication consists of the 13 provincial and territorial drug benefit programs, which in 2015 cost a collective \$10.67 billion and an estimated \$11.54 billion in 2016¹². Together, they provide 102 separate subsidy programs¹³ to ensure access to necessary medications mostly for vulnerable populations such as seniors, low income residents, and people who face exceptionally high medication costs.

Other Social Insurance Programs: The provincial share of prescription drug costs also includes workers' compensation systems (about 0.6% of total drug spending in Canada) and other social insurance spending.¹⁴ In 2015, these various programs added \$1.2 billion to public prescription drug costs.¹⁵

Indirect Spending

While most public sector prescription drug spending is directed to programs designed to directly provide medically necessary medications to Canadians, there are also billions of indirect public sector costs that accrue to governments through other obligations.

Employee Benefits: Federal, provincial and many municipal governments provide drug insurance for their employees for considerable public expenditure, to the tune of an estimated \$3.34 billion in 2016¹⁶.

Tax Subsidies: Federal and provincial governments encourage employers to provide insurance that covers prescription drugs for their employees. They do so through tax deductions for employer-sponsored health plans. These exemptions and incentives come in a variety of forms but estimates of public tax subsidies total \$1.4 billion¹⁷.

Reduced health care costs due medication adherence: Provinces and territories also incur considerable health care-related costs resulting from non-adherence — patients failing to take their medication. The PBO has been directed to calculate the avoided health system costs associated with reducing non-adherence, “to the extent possible”¹⁸ but it's a complex calculation.

Research indicates that between 5.4% and 6.5% of hospital admissions are the result of non-adherence, resulting in costs as high as \$1.63 billion¹⁹. However, only those admissions attributable to *cost-related* non-adherence would be offset by a pharmacare system. Consequently, though some savings are likely to result, current data does not allow for an accurate calculation of what proportion of the \$1.6 billion estimate might actually be reduced.

- **Total savings for public sector drug costs in 2016: \$18.1–\$19.7 billion**

- Federal government direct spending: \$0.649 billion²⁰
- Provincial government programs and social insurance: \$12.74 billion²¹
- All government spending on private insurance for public sector employees: \$3.34 billion²²
- Tax subsidies: approximately \$1.4 billion²³
- Medication adherence savings: some portion of \$1.6 billion²⁴

While these current direct and indirect public savings would considerably offset any new federal investment the PBO may calculate to achieve universal first dollar coverage for prescription medications, 85% of these savings would occur in provincial and territorial jurisdictions. This would require provinces to support the federal investment in a national pharmacare program, or that a cost-sharing model be developed.

Private costs

Almost 60% of all purchases of prescription medications are funded privately,²⁵ 22% through out-of-pocket expenditures by individual Canadians²⁶ and 35% through private insurance policies purchased by families and corporation.

Private out-of-pocket spending

Universal first dollar coverage would offset the \$7.3 billion Canadian families paid for prescription drugs in 2016²⁷.

Private insurance

\$11.1 billion was spent on prescription drugs through private insurance policies held by families, and by private companies and public sector employers to provide drug plans for their staff. Separating out the public sector insurance plans, totaling \$3.3 billion²⁸, the savings on insurance for private business and families alone would amount to \$7.8 billion. These savings would be partially offset by the loss of tax subsidies, noted above, amounting to \$1.4 billion. As a result, savings accruing to the private sector would amount to \$6.4 billion.

- **Total savings for private sector drug costs in 2016: \$13.7 billion**
 - \$7.3 billion in out-of-pocket costs for Canadian families²⁹
 - \$6.4 billion in savings on insurance for individuals, families and private corporations³⁰

It is worth noting that the PBO has also been tasked with exploring how a portion of private savings resulting from public investment in pharmacare could be directed to covering universal drug program costs, specifically through payroll taxes or sales taxes.

Savings are Supported by Efficiency

The opportunities to reduce costs and rationalize drug purchasing in Canada are attractive in and of themselves. However, these calculations gloss over one of the most significant fiscal benefits of a new universal single payer drug coverage program: efficiency. Canada pays more for accessing prescription medications than most industrialized countries, largely as a result of the inefficient administration and poor purchasing power caused by a fragmented, multi-payer system.

Costs of administration

Studies have repeatedly shown that private health care administration in the United States accounts for 13% or more of total health care costs, and public administration a much smaller 2% of total costs³¹. Recent studies show that the administration costs for Canada's private prescription drug plans are high and rising — at 23%, compared to 1.8% in public plans.³² Based on the most current data, private insurance administrative costs alone impose \$1.7 billion in avoidable costs on Canadian health care.³³

Drug Purchasing

The total cost of prescription medications in 2016 was \$31.8 billion. That, however, represents the costs associated with a wide variety of payers operating in a system that fragments purchasing power, resulting in prices far exceeding those paid by government purchasers in most OECD countries.

Detailed studies of drug purchasing in Canada show that considerable savings could be achieved through coordinated and savings-oriented purchasing policies.³⁴ The most prominent study, published in the *Canadian Medical Association Journal*,

estimated that universal drug coverage would have cost Canadians \$7.3 billion less than the \$22.3 billion they spent on prescription medication in fiscal 2012-13.

These estimates are based on an assumption that drug costs could be reduced by approximately 32%, through better use of purchasing power. However, in July 2017, the Province of Quebec negotiated a 40% reduction in costs for generic drugs as a result of aggressive new purchasing policies³⁵, suggesting the 32% estimate is likely at the low end of potential savings.

Conclusion

There is little doubt that the creation of a universal, first dollar prescription medication coverage program will result in considerable savings. While precise costs for some savings, most notably cost-related non-adherence, are difficult to calculate, it seems clear that public sector savings can be conservatively estimated at over \$18 billion. Additional private savings of \$13.7 billion would be realized by Canadian families and businesses.

Public and private savings on the scale of more than \$30 billion in total would justify considerable investment on the part of the federal government, directly or in partnership with provinces and territories.

There are, of course, additional benefits to investing in a universal pharmacare system. With one household in five unable to take medications as prescribed due to cost, and approximately 6% of hospital beds occupied by patients whose admissions were the result of non-adherence, the status quo is taking an unacceptable toll on Canadian lives.

Based on evidence from available studies, it's clear the cost that policy makers should consider first and foremost in discussions around pharmacare is that of *not* implementing a comprehensive universal public plan.

Notes

1 MINUTES OF PROCEEDINGS Standing Committee on Health (HESA) 42nd Parliament, 1st Session Meeting No. 20 Tuesday, September 27, 2016, 8:46 a.m. to 10:51 a.m.

2 "Prescription drug access and affordability an issue for nearly a quarter of all Canadian households" (2015) Angus Reid Institute, <http://angusreid.org/wp-content/uploads/2015/07/2015.07.09-Pharma.pdf>.

3 Ipsos Reid, "Two in ten (18% per cent) Canadians have no supplementary coverage," press release, <http://www.ipsos-na.com/news-polls/pressrelease.aspx?id=5714>.

4 "Prescription drug access and affordability an issue for nearly a quarter of all Canadian households" (2015) Angus Reid Institute, <http://angusreid.org/wp-content/uploads/2015/07/2015.07.09-Pharma.pdf>.

- 5** Patients failing to take their medication.
- 6** Iskedjian, M & Addis, Antonio & Einarson, Thomas. (2002). Estimating the economic burden of hospitalization due to patient nonadherence in Canada. *Value in Health — VALUE HEALTH*. 5. 470–471.
- 7** Gagnon, M.A., *The Roadmap to Rational Pharmacare*, (2104) CFNU, https://nursesunions.ca/wp-content/uploads/2017/05/Pharmacare_FINAL.pdf.
- 8** Clement, Fiona M. et al; *Canadian Publicly Funded Prescription Drug Plans, Expenditures and an Overview of Patient Impacts*, (2016) Health Economics Group and Health Technology Assessment Unit, O'Brien Institute for Public Health, Interdisciplinary Chronic Disease Collaboration, School of Public Policy, University of Calgary, (Prepared for Alberta Health).
- 9** MINUTES OF PROCEEDINGS Standing Committee on Health (HESA) 42nd Parliament, 1st Session Meeting No. 20 Tuesday, September 27, 2016, 8:46 a.m. to 10:51 a.m.
- 10** Calculations based on CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa, as Quebec data on public spending in 2015 and 2016 were missing, we therefore projected Quebec public spending from 2014 based on public spending growth in the rest of Canada during the period of 2014–2016.
- 11** CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa.
- 12** 2015 estimates from CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa. 2016 estimates from calculations based on CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa. Because Quebec data on public spending in 2015 and 2016 were missing, we projected Quebec public spending from 2014 based on public spending growth in the rest of Canada during the period 2014–2016.
- 13** Clement, Fiona M. et al; *Canadian Publicly Funded Prescription Drug Plans, Expenditures and an Overview of Patient Impacts*, (2016) Health Economics Group and Health Technology Assessment Unit, O'Brien Institute for Public Health, Interdisciplinary Chronic Disease Collaboration, School of Public Policy, University of Calgary, (Prepared for Alberta Health).
- 14** This includes the program cost for Quebec’s multi-payer prescription drug insurance program, which requires all residents to have drug insurance and funds programs for those who cannot afford, or are ineligible for coverage.
- 15** CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa.
- 16** The most recent estimate of public sector spending on private insurance for public employees was for 2013, at which time governments accounted for 30% of the total amount of private insurance spending at the time. We projected that fraction to 2016 private insurance spending levels from CIHI.
- 17** Gagnon, Marc-André, “Pharmacare and Federal Drug Expenditures: A Prescription for Change,” (2012) in *How Ottawa Spends 2012–2013: The Harper Majority, Budget Cuts, and the New Opposition*, edited by G Bruce Doern and Christopher Stoney, 161–172. Toronto: McGill-Queens University Press.
- 18** MINUTES OF PROCEEDINGS Standing Committee on Health (HESA) 42nd Parliament, 1st Session Meeting No. 20 Tuesday, September 27, 2016, 8:46 a.m. to 10:51 a.m.
- 19** Iskedjian, M & Addis, Antonio & Einarson, Thomas. (2002). Estimating the economic burden of hospitalization due to patient nonadherence in Canada. *Value in Health — VALUE HEALTH*. 5. 470–471.
- 20** CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa.
- 21** Calculations based on CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa, as Quebec data on public spending in 2015 and 2016 were missing, we therefore projected Quebec public spending from 2014 based on public spending growth in the rest of Canada during the period of 2014–2016.

22 See note 15.

23 Gagnon, Marc-André, “Pharmacare and Federal Drug Expenditures: A Prescription for Change,” (2012) in *How Ottawa Spends 2012–2013: The Harper Majority, Budget Cuts, and the New Opposition*, edited by G Bruce Doern and Christopher Stoney, 161–172. Toronto: McGill-Queens University Press.

24 Iskedjian, M & Addis, Antonio & Einarson, Thomas. (2002). Estimating the economic burden of hospitalization due to patient nonadherence in Canada. *Value in Health — VALUE HEALTH*. 5. 470–471.

25 CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa.

26 Mackenzie, H, *DOWN THE DRAIN: How Canada Has Wasted \$62 Billion Health Care Dollars without Pharmacare*, (2106) CFNU, https://nursesunions.ca/wp-content/uploads/2017/05/Down_The_Drain_Pharmacare_Report_December_2017.pdf.

27 CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa.

28 Ibid.

29 Ibid.

30 Calculations based on CIHI (2016) “National Health Expenditure Trends, 1975 to 2016: Data Tables.” CIHI: Ottawa.

31 e.g. (Woolhandler, S. et al. (2003). Costs of health care administration in the United States and Canada. *New England Journal of Medicine*, 349(8), 768–775).

32 Law MR, Kratzer J, Dhalla I., The increasing inefficiency of private health insurance in Canada. *Can Med Assoc J*. 2014;186(12):E470–E474.

33 Mackenzie, H, *DOWN THE DRAIN: How Canada Has Wasted \$62 Billion Health Care Dollars without Pharmacare*, (2106) CFNU, https://nursesunions.ca/wp-content/uploads/2017/05/Down_The_Drain_Pharmacare_Report_December_2017.pdf, Gagnon, M.A. (2014). *A Roadmap to a Rational Pharmacare Policy in Canada*. Canadian Federation of Nurses Unions. Pp. 29–30.

34 Morgan, S., Law, M., Daw, J.R., Abraham, L., and Martin, D. (2015). Estimated cost of universal public coverage of prescription drugs in Canada. *CMAJ*, March 13, 2015.

35 Fidelman, C, “Barrette says generic drug deal will save Quebec \$1.5 billion over five years”, *MONTREAL GAZETTE*, July 16, 2017.



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