DOWN THE DRAIN

How Canada Has WASTED $62 Billion Health Care Dollars without PHARMACARE

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CANADIAN FEDERATION OF NURSES UNIONS
LA FÉDÉRATION CANADIENNE DES SYNDICATS D'INFIRMIÈRES ET INFIRMIERS

THE CANADIAN FEDERATION OF NURSES UNIONS (CFNU)

The Canadian Federation of Nurses Unions represents close to 200,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

UNA
United Nurses of Alberta

Saskatchewan SUN
Union of Nurses

Manitoba nurses Union
A COMMITMENT TO CARING

ONA
Ontario Nurses' Association

New Brunswick Nurses Union
NBNU SIINB
Syndicat des infirmières et infirmiers du Nouveau-Brunswick

Nova Scotia Nurses' Union

pei nurses

Registered Nurses' Union
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WASTE

"to spend or use carelessly: squander *<waste valuable resources>*"

Definition by Merriam Webster

EXECUTIVE SUMMARY

A message from CFNU President, Linda Silas

Canada's nurses denounce unnecessarily wasted billions

We all know that the Canadian population is aging, health care costs are rising, and that governments are struggling to keep pace with these challenges. We also know that our federal, provincial and territorial governments are consumed by questions of health care funding, both regarding the level of federal transfers as well as dealing with the overall dollars spent on health care.

So why are governments allowing billions of dollars to be squandered without reason? In this paper, *Down the Drain: How Canada Has Wasted $62 Billion Health Care Dollars without Pharmacare*, noted economist Hugh Mackenzie calculates the disturbing amount Canada has wasted over the past 10 years by not implementing national pharmacare.

The report calculates the waste from 2006-2015. Mackenzie starts the clock two years after 2004, when Canada's premiers unanimously called for the federal government to implement national pharmacare. Today the rate of waste continues to grow, adding even more to the growing missed opportunity of pharmacare. This year, Canadians will waste an additional $7.3 billion, equaling $14,000 squandered health care dollars every minute of every day, due to Canadians paying among the world's highest prices for prescription drugs.

The calculation of what Canadians have wasted is made relative to the average of six comparator OECD countries (France, Germany, Italy, Sweden, Switzerland and the UK). The savings from pharmacare could well be larger if Canada were to adopt one of the lower-cost models of pharmacare, and if we consider the benefits of greater adherence to taking prescribed medications and the lower health care costs this engenders. Furthermore, pharmacare also allows for more appropriate prescribing practices and an evidence-based national formulary – both developments which would improve health care and contribute to lower costs.

The very substantial waste numbers outlined in this paper represent real resources which could assist with the increasing cost of acute care, support our aging population with more home care and community care, add more frontline workers, free resources for mental health, and contribute to a needed focus on Indigenous health – all of which means better overall health care outcomes for patients. Capturing these wasted dollars could greatly reduce wait times as well as increase equity and accessibility for all.

A great deal of the immense pressure that provincial and territorial governments bear every day due to rising health care costs could be alleviated if the federal government committed to implementing national pharmacare and mandated reinvesting the savings into health care.

In 2004, when the last health accord was being negotiated, Canada's premiers shocked many when they made their call for the federal government to implement national pharmacare. I attended these meetings and know that it was not easy to get all 13 provinces and territories to reach consensus agreement on just about anything, but they did agree on pharmacare.

Unfortunately, the Liberal federal government of the day only called for a more limited pharmaceutical strategy, which allowed the following Conservative government to sideline the initiative altogether. We must not miss this opportunity to move forward with a comprehensive national pharmacare program. As a result of this past lack of action, we have all been paying dearly ever since.

Unfortunately, the main focus on pharmacare has long been 'who will pay?' This is the wrong question, since we all pay by remaining the only country with public health care which does not have national pharmacare. We pay in higher prices but we also pay in more troubling ways. We pay by having a fragmented system where many people fall through the cracks and do not receive the medications they need. We pay because seniors are forced to split pills or delay medications in order to control costs. We pay because conditions get more acute when medications are not accessible. If the question is 'who will pay', the answer is that we are all already paying too high a price for government's inaction.

Canada's nurses fully supported the premiers' call for pharmacare in 2004 and continue to call for pharmacare today. We are truly saddened by the wasted billions that are being compounded every day, especially since we know what this needed investment in health care and increased accessibility to prescription medications mean for patients and the health care system. The CFNU represents close to 200,000 Canadian frontline nurses who know that this continued inaction is severely impacting our public health care system.

Fifty years ago we implemented public health care in Canada, and from the beginning it was clear that we must not stop at hospitals and doctors, we needed to expand the system into the community and also to cover prescription drugs. The sad reality is that we have done nothing to augment our public health care system over the past 50 years, and Canadians are paying a very high price for the current political stalemate.

The good news is that there is an opportunity. The federal government's agreement to negotiate a new Health Accord with the provinces and territories is very welcome and must lead to strengthening our health care system. To achieve this we need all governments working together, including implementing the long-sought national pharmacare program. Canada must join the rest of the developed world, where national pharmacare is part of national health care.

Canada's nurses call upon all governments to take the necessary steps to secure national pharmacare for Canadians.

These include:

1. **Creating an expert advisory group to establish an evidence-based national formulary**
2. **Consulting with health economists to propose a formula for financing national pharmacare**
3. **Appointing a pharmacare implementation committee to report on what framework and steps would be needed to implement pharmacare**

Canadians have to demand more from our governments, and pharmacare is a clear example where political pressure is needed to push politicians to do the right thing. The evidence has all been compiled - we now need action to be taken to move us forward. Canada is a large country with a small population. We are at our best when we work together and support good public programs which care for all Canadians. The promise of pharmacare must be fulfilled.

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equaling $14,000 squandered health care dollars every minute of every day, due to Canadians paying among the world's highest prices for prescription drugs.

“Canadians are currently wasting $7.3 billion a year in expenditures that could have been avoided under a universal pharmacare plan. Over the last ten years, this missed opportunity amounted to $62 billion wasted health care dollars (assuming the program was implemented in 2006) – waste at the rate of $17.1 million a day.”

DOWN THE DRAIN

How Canada Has Wasted $62 Billion Health Care Dollars without Pharmacare

By Hugh Mackenzie

In most areas of public policy a decision to proceed with a new initiative requires a careful assessment of opportunity costs, because the resources required to undertake the initiative must be diverted from an alternative valuable use.

That is not true, however, with respect to pharmacare. Detailed studies have reached the conclusion that replacement of the current fragmented system with that of a universal public pharmacare system, integrated with Canada's public health insurance system, would actually reduce overall costs and improve the management and financing of prescription medication. This would free up resources being used to support the current system to address other gaps in health care by investing in such priorities as expanded and coherent home care, improved mental health services, seniors care that responds adequately to the reality of our aging population, and better funding for indigenous people's health care.

That means that our collective failure to address the issues plaguing our prescription drug system imposes ongoing additional costs at no additional benefit – a 'careless use' that clearly meets the dictionary definition of 'waste'. It also means that in each year in which governments had the opportunity to create an efficient national pharmacare system but chose not to, Canadians collectively wasted resources that could have been directed to productive use.

The most recent such opportunity was in 2004, when the provincial and territorial premiers reached a consensus in favour of a national pharmacare program led by the federal government. Thanks to that missed opportunity, Canadians are currently wasting $7.3 billion a year in expenditures that could have been avoided under a universal pharmacare plan. Over the last ten years, this missed opportunity amounted to $62 billion wasted health care dollars (assuming the program was implemented in 2006) – waste at the rate of $17.1 million a day.

History

Over the years since medicare was created, there have been several clear opportunities to implement an efficient, universal, evidence-based pharmacare system. Right from the beginning, pharmacare was on the table for consideration as part of Canada's medicare system. In 1964, the Royal Commission on Health Services, whose work led to the establishment of medicare, recommended that the new social insurance system cover prescription drugs, following the implementation of universal coverage for medical services. Both the National Forum on Health in 1997 and the Royal Commission on the Future of Health Care in Canada in 2002 recommended that prescription drugs be added to the single-payer public insurance system.

The traditional excuse for inaction – the inability to achieve consensus for change in Canada's often fractious federal system of government – does not hold up. In 2004, remarkably, the provincial premiers and territorial leaders gave public unanimous support to a call on the federal government to take the lead in establishing a national pharmacare program.[1] In the years since then, provincial and territorial premiers and ministers of health have continued to call for national action to address this major gap in our public health care insurance system.

The federal government's failure to seize the initiative in pharmacare was not free. The waste continues to mount each and every year as the gap between what we are actually paying and what we could be paying through a national pharmacare plan continues to grow. Based on estimates of the difference in cost between current retail prescription drug costs and a national public pharmacare plan, our governments' failure of leadership on universal pharmacare wastes precious health care resources at a current rate of $7.3 billion a year.

1 Mackie, R. (2004). Premiers ask Ottawa for national drug plan. *Globe and Mail*, 31 July 2004. http://www.theglobeandmail.com/news/national/premiers-ask-ottawa-for-national-drug-plan/article18269473/

WE ARE WASTING $7.3 BILLION A YEAR. HOW CAN THAT BE HAPPENING?

The size of the gap between what we actually pay and what we could be paying can be measured either at a macro level, through a top-down analysis comparing drug costs in Canada with those in comparable jurisdictions that have national public drug insurance plans, or at a micro level, through a bottom-up analysis of the costs of a universal public system relative to the costs of the current mish-mash in Canada.

Canada's Patented Medicine Prices Review Board (PMPRB) has identified seven countries – France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States of America, described as PMPRB7 – as comparator jurisdictions against which to compare the drug system in Canada. All but one of those seven countries – the USA – have a public system covering prescription drugs, and the PMPRB system, minus the US, is therefore potentially useful as an indicator of what costs would be in Canada under a universal public drug insurance plan.[2]

The Organization for Economic Cooperation and Development (OECD) publishes a comprehensive set of statistics on health care spending in its member countries. Compared with the countries in the PMPRB7 group with universal insurance coverage, Canadians spent $202.93 per capita more in 2014.[3]

In 2014, a $202.93 per capita difference amounts to a total of $7.213 billion in annual expenditure, Canada-wide.[4]

Turning to the micro level, the most detailed analysis of the waste in our system, comparing drug costs in the current system with what we could be paying in a national pharmacare insurance plan currently available, is found in a study published in March 2015 in the *Canadian Medical Association Journal*.[5] That study analyzed drug costs in the ten provinces in Canada in 2012-2013 in comparison with a public universal system using a bottom-up detailed analysis down to the level of individual classes of drugs.

It found savings relative to the $22.3 billion cost of the drugs analyzed, ranging from $4.2 billion (19% savings) to $9.4 billion (42%) with a most likely base case value of $7.257 billion. Adding in estimates of wasted expenditure in the three territories results in an overall estimate of $7.274 billion.[6]

This estimate based on a bottom-up analysis of the retail prescription drug market is remarkably close to the top-down figure of $7.213 billion derived from a comparison of Canada's drug expenditures per capita with those of the comparator countries with public systems (PMPRB).

It is important to note that the *CMAJ* article-based figure of $7.27 billion – as high as it is – is a conservative estimate. The *CMAJ*-published study is restricted to the retail prescription drug market in Canada. It does not take into account the potential benefit from pharmacare to hospitals and long-term care facilities, for example, which are not part of the retail pharmaceutical market and whose purchases (amounting to approximately $5.8 billion annually)[7] are not covered by the analysis. It is likely that the consolidation and centralization of pharmaceutical financing that would take place with the introduction of national pharmacare would generate cost savings in the hospital and long-term care sectors as well.

In addition, the study does not take into account the differences in administrative overhead between private drug insurance plans and a public system. Recent estimates suggest that administrative overheads account for 23% of the costs in private extended health insurance plans, compared with 1.8% in public plans.[8] Based on recent estimates, adding administrative costs into the estimated waste in the current system would increase the total by a further $1.7 billion.

The more conservative of the two macro analyses based on OECD data results in an estimated differential of $7.2 billion, a figure that is very close to the base case results from the *CMAJ* study as modified to include estimated territorial expenditures.

2 A comparative analysis based on these countries will tend to produce a conservative estimate of cost differentials, since these comparators include some of countries with among the highest costs of medicines in the world. One could select many other universal systems that would have lower costs than, say, Germany, Switzerland, and France.

3 For 2014 – the most recent year for which complete data are currently available – Canada's expenditure on "pharmaceuticals and other medical non-durables" is reported as $722.20 per capita in US dollars.

The six PMPRB countries with universal prescription pharmaceutical insurance systems reported average spending of $607.60 per capita. Following the procedure used by the OECD, that differential of $164.60 US per capita is translated to Canadian dollars at the purchasing power parity (PPP) rate of 1.232879 Canadian dollars to the US dollar, for a Canadian dollar differential of $202.93 per capita.

4 The extent of Canada's disadvantage relative to other countries obviously depends on the list of countries selected for comparison. The PMPRB7 minus the US, used as the comparator above, will tend to produce a low estimate because the countries in the PMPRB7 group tend to be higher-cost countries. As an alternative to the PMPRB7 minus the USA as a standard of comparison, a group of countries with similar per-capita GDP levels and similar universal public health care systems was selected for comparison. The countries selected for this alternative comparison were: Australia; Denmark; Finland; New Zealand; Norway; and the UK. For these countries, the 2014 average per capita spend in the OECD database was $US 463.07. The differential relative to Canadian per capita spending of $US 722.20 is $US 309.13 per capita, or $381.11 per capita in Canadian dollars. That differential across Canada's 2014 population would be $13.547 billion in annual expenditure, Canada-wide.

5 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.

6 In the analysis by Morgan et al, the waste in the current system compared with national pharmacare is attributed to higher costs for generic drugs; higher costs for brand-name drugs; and prescribing patterns within drug families that result in increased cost for no therapeutic benefit. This measure of the difference between the two systems is offset in part by increases in costs arising from increased prescription drug use by individuals who had previously had no drug coverage.

7 Expenditures on prescription pharmaceuticals other than retail ($5.8 billion) are estimated as the difference between the figure for total prescribed drugs for 2012 ($28,237.3 million) and 2013 ($28,304.9 million) found in CIHI Series G-2015 and the figure for 2012-13 ($22,400 million) calculated from Morgan et al, CMAJ.

8 A 2003 study (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) found private plan administrative costs at 13% of plan costs, compared with 2% for public plans. A more recent study (Law, M.R., Kratzer, J., Dhalla, I. (2014). The Increasing Inefficiency of Private Health Insurance in Canada. *CMAJ*, 186(4)) found that private plan overheads had increased to 23%, while overheads in public plans remain at 1.8%. For a more complete discussion, see Gagnon, M.-A. (2014). *A Roadmap to a Rational Pharmacare Policy in Canada*. Canadian Federation of Nurses Unions. Pp. 29-30.

MISSED OPPORTUNITIES – OUR GOVERNMENTS' FAILURE TO MOVE ON PHARMACARE HAS WASTED BILLIONS

It's not as if we only recently figured out that it might make sense to replace the plethora of inefficient arrangements in Canada's current retail prescription drug system with universal pharmacare. In the past 20 years alone, there have been three clear occasions in which the issue has been put on the political agenda, and the issue has been ignored. And that represents a significant accumulation of wasted expenditures over time.

To estimate the waste attributable to our failure to implement universal pharmacare in prior years, the results of the detailed micro analysis reported in the *CMAJ* article were used as the starting point for the analysis of the evolving waste of resources over time. Those results showed expenditures of $22.344 billion on retail prescription drugs in 2012-2013 and a cost of $15.087 billion for the pharmacare alternative, for a waste gap of $7.3 billion as of 2012-2013.

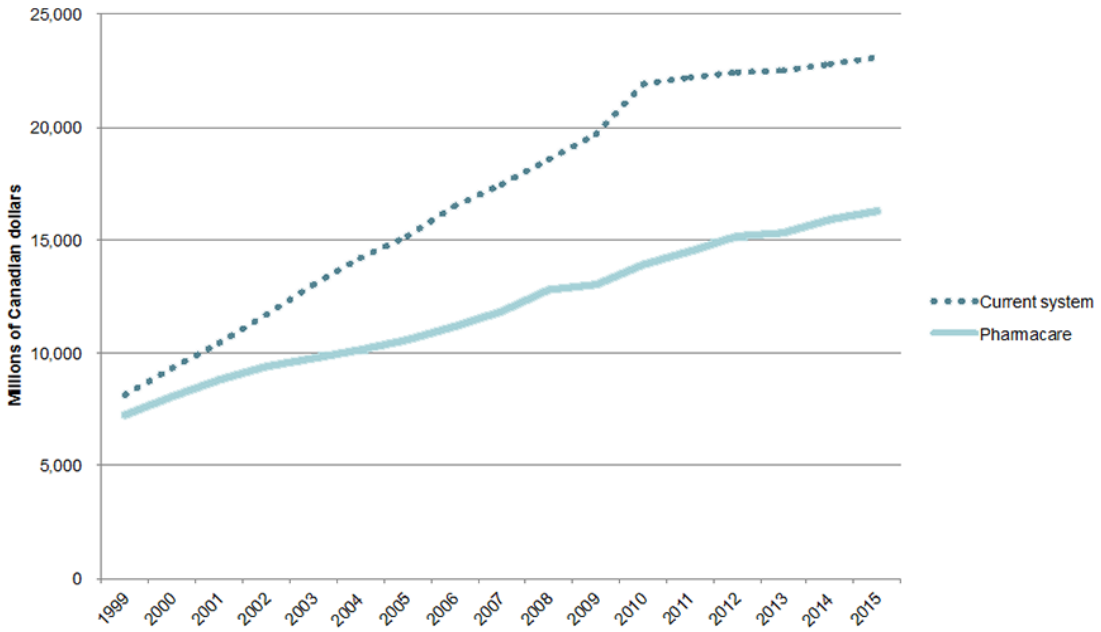
To estimate the evolution of this gap over time, data from the OECD and the Canadian Institute for Health Information (CIHI) were then used to estimate the value of the gap between the current system and a national pharmacare system. OECD data for per capita costs in the PMPRB7 countries, minus the US, between 1999 and 2015 serves as a proxy for the evolution of costs in a Canadian pharmacare system. CIHI data on per-capita spending on prescription pharmaceuticals were used to estimate the path of costs for retail prescription pharmaceuticals in the current system.[9]

As was noted above, Canada's leaders have walked away from many opportunities to build on the foundation of medicare by adding in prescription pharmaceutical coverage, going right back to the studies that led to the creation of medicare in the first place. The most recent and politically relevant missed opportunity – the failure of the federal government to take the provinces up on their July 2004 consensus in favour of a national pharmacare plan – represents a waste (assuming 2006 implementation) of $62 billion over that 10-year period.[10]

The build-up of waste over time is highlighted in the following chart.

Evolution of current system costs vs. pharmacare alternative (1999 to 2015)

2012-2013 reference year



9 To compare the evolution of costs over time, two cost indices were calculated: an index for the current system in Canada, using data on per-capita health expenditures published by CIHI; and an index for universal public insurance, using average per-capita costs in the PMPRB7 (minus one) countries as presented in OECD health expenditure data. The OECD average per-capita cost index was translated into Canadian dollars, using OECD annual PPP data. Data for the current system and the pharmacare alternative for 2012-2013 were adjusted using the calculated index values to produce estimates for each individual year. Those annual data were then adjusted for inflation to produce a current (2016) dollar estimate.

10 The wasted opportunity represented by Canada's failure to adopt the 1997 recommendation of the National Forum on Health (assuming implementation in 1999) represents a waste of $80.8 billion in 2016 dollars between 1999 and 2015.

On a sub-national level, the estimated current system and pharmacare costs and savings in the *CMAJ* base case are as follows.[11]

Canada's pharmacare missed opportunity 2012-2013
Estimated waste, retail prescription drug costs

Current system vs. pharmacare

Millions of Canadian dollars

Province	2012-2013 Status quo	2012-2013 Pharmacare	2012-2013 Estimated waste
Newfoundland and Labrador	400	279	121
Prince Edward Island	94	65	29
Nova Scotia	700	481	219
New Brunswick	597	414	183
Quebec	6,506	4,463	2,043
Ontario	8,371	5,470	2,901
Manitoba	662	480	182
Saskatchewan	577	397	180
Alberta	2,157	1,474	683
British Columbia	2,280	1,564	716
Yukon	18	13	5
Northwest Territories	22	15	7
Nunavut	16	11	5
Total	**22,400**	**15,126**	**7,274**

Source: Morgan et. al, *CMAJ*; data for territories estimated based on CIHI data

11 The *CMAJ* article estimated costs for the ten provinces only. Costs for the territories were estimated from CIHI total drug cost data.

12 Note again that these totals do not reflect either the additional administrative overhead costs associated with private insurance plans or the potential knock-on benefits of national pharmacare for wholesale pharmaceutical consumers (hospitals and long-term care facilities).

Amount wasted over time, province by province, based on two missed opportunities to adopt recommendations for national pharmacare: the National Forum on Health report of 1997, assuming 1999 implementation; and the provincial-territorial consensus of 2004, assuming 2006 implementation.[12]

Wasted expenditure over time, millions of Canadian dollars

Province	2004 provincial consensus (2006-2015)	1997 National Forum on Health (1999-2015)
Newfoundland and Labrador	945	1,059
Prince Edward Island	276	361
Nova Scotia	2,038	2,513
New Brunswick	1,756	2,215
Quebec	18,886	24,977
Ontario	23,633	31,765
Manitoba	1,641	2,008
Saskatchewan	1,616	1,958
Alberta	5,248	6,139
British Columbia	6,112	7,668
Yukon	56	70
Northwest Territories	59	49
Nunavut	45	52
CANADA	62,311	80,834

FROM FRAGMENTATION TO NATIONAL PHARMACARE

The remarkable reality is that Canadians – individually, through their employers and through their governments, both federal and provincial/territorial – are already paying substantially more ($7.3 billion more) for a fragmented and incomplete prescription drug financing system than it would cost to deliver a coherent and complete national pharmacare plan as a complement to medicare.

The extent of the fragmentation of the current system is evident in the data on prescription pharmaceutical finance reported in CIHI health expenditure statistics (CIHI Series G-2015).

Just over 43% of prescription drug expenditure in Canada was in the public sector in 2015. The federal share is quite small – 2.1% – made up of services for First Nations and indirect expenditures by the federal government as an employer. The provincial share includes 0.6% through workers' compensation systems and 3.9% through Quebec's prescription drug insurance.

The remaining 57% of total expenditure is private – 35% through private insurers and 21.8% through out-of-pocket expenditures by individual Canadians.

Shares of prescription drug expenditure, provinces and territories, 2015

	Public				Private		
	Provincial	Federal	WCB	Public funds	Private total	Insurers	Out-of-pocket
NL	33.7%	1.5%	1.3%	0.0%	63.5%	39.1%	24.4%
PE	34.0%	2.2%	0.7%	0.0%	63.1%	38.9%	24.2%
NS	31.0%	3.0%	1.0%	0.0%	65.1%	40.1%	25.0%
NB	29.3%	3.4%	0.5%	0.0%	66.8%	41.2%	25.7%
QC	30.1%	0.8%	0.6%	14.2%	54.2%	33.4%	20.8%
ON	40.8%	1.1%	0.6%	0.0%	57.5%	35.4%	22.1%
MB	35.9%	9.7%	0.3%	0.0%	54.0%	33.3%	20.7%
SK	38.1%	10.8%	0.5%	0.0%	50.6%	31.2%	19.4%
AB	43.6%	2.5%	0.4%	0.0%	53.6%	33.0%	20.6%
BC	33.3%	3.4%	0.5%	0.0%	62.9%	38.7%	24.1%
YT	39.2%	23.2%	0.4%	0.0%	37.3%	23.0%	14.3%
NT	22.9%	41.9%	0.3%	0.0%	34.9%	21.5%	13.4%
NU	24.6%	39.9%	0.4%	0.0%	35.2%	21.7%	13.5%
Canada	**36.5%**	**2.1%**	**0.6%**	**3.9%**	**56.9%**	**35.0%**	**21.8%**

NOTES:

1. Insurer/out-of-pocket split not available at subnational level; estimates are based on assumption that the split is the same across the country.
2. CIHI reports Quebec's prescription drug insurance, which is funded by mandatory contributions from employers, as a public expenditure. If those contributions were reclassified as private expenditures, Quebec's private share would be 68.4% and the estimated insurers share would be 47.6%. The national total for private expenditure would increase from 56.9% to 60.8%.

Even this summary understates the extent of the fragmentation. Provincial and territorial governments offer a wide variety of coverages for subgroups of the population defined by factors like age (seniors, for example) or economic circumstances (based on income or social assistance status). Quebec is alone in providing coverage for prescription drugs through public funds. And within the private insurance/out-of-pocket category, there are literally hundreds of different plans provided either to Canadians as individuals or through their employers.

The extent of the fragmentation of drug financing in Canada is a major contributor to the cost gap between the current so-called system and a national pharmacare plan, but it is not the only contributor.

The sources of direct cost advantage for a universal system can be broken down into several discrete areas:[13]

- Reduced prices for drugs, arising from a structural change that markedly increases the bargaining power of prescription medicine funders relative to drug suppliers – Canadians currently pay among the highest prices for drugs in the world;

- Elimination of wasteful, inefficient and inappropriate uses of prescription pharmaceutical products – in the current system, insurers have no incentive to manage costs in the long term, since increased costs are simply passed on to consumers in higher premiums;

- Establishing a coherent system for evaluating new drugs and screening out new drugs that offer no therapeutic improvement;

- Reducing administrative overhead by replacing private insurance (with its estimated 23% administrative overhead) with a public system (with expected overhead of 1.8%);

- Reducing system-wide overhead costs associated with the management of the relationships among the many different sources of funding within the current system.

In addition to these and related direct cost savings, the integration of a coherent pharmaceutical funding and management system into Canada's single-payer medicare system would result in significant indirect savings through the improvement of health outcomes and patient safety overall in Canada, as pharmacare increases the likelihood that Canadians will get the pharmaceuticals they need to manage their health.

13 For a detailed review of the key sources of waste in the current system and potential savings from a public pharmacare plan operated in conjunction with medicare, see Gagnon, M.-A., op cit. Another potential source of savings to governments is related to the tax position of compensation provided in the form of insured benefits. In the present system, insured benefits provided through employment are tax-exempt. Depending on how labour markets respond to the elimination of drug insurance from compensation packages and on how pharmacare is funded, governments could realize substantial savings if tax-free benefits are replaced by taxable forms of compensation. At an average income tax rate of 30%, potential savings in reduced tax expenditures could be as much as $2.5 billion, split about 1/3 to provincial governments and 2/3 to the federal government.

CONCLUSION

Canadians are already paying more – an estimated 32% more – for prescription pharmaceuticals than we would pay, collectively, in a national pharmacare plan.

The challenge in designing a new system is that Canadians currently pay for prescription drugs in a wide variety of different ways. The analysis by Morgan et al. identified the sources of funding for the $22.3 billion in existing system covered drug costs as follows.

Sources of funding for retail pharmaceuticals, 10 provinces, $ million

(2012-2013)

	Current	Share
Direct public spending on public drug plans	9,725	43.5%
Indirect public spending on private drug plans	2,425	10.9%
Private-sector spending on private drug plans	5,659	25.3%
Patient out-of-pocket spending	4,534	20.3%
TOTAL	**22,344**	

To put the numbers into perspective, out-of-pocket costs for retail prescription drugs in 2012 averaged $130.47 per capita, or $522 for an average family of four. Private sector spending on private drug plans averaged $162.85 per capita. As an employment benefit, basic drug coverage for a family is typically in the $100 per month range.[14]

The amount currently spent directly and indirectly by the public sector would account for roughly 80% of the cost of a new national pharmacare plan. We are already paying $12.15 billion from public funds for public drug plans or publicly funded private drug plans (largely for government employees).[15]

Every day, Canadians collectively – individually, through their employers and through their governments – waste over $17 million on prescription drugs. The longer we wait, the more the waste piles up. And that is only the direct cost being borne by Canadians for the failure of our governments to take the initiative on pharmacare. The indirect costs in increased hospitalizations and other health care system costs associated with inadequate access to prescription drugs and non-adherence to necessary prescription medicines are substantial, and they are primarily borne by provincial governments.

The case for national pharmacare has been made. It is one of those rare public policy initiatives in which there is no downside. With a pharmacare plan, we will have a significantly more effective system that will cost significantly less. Politically, it should be a no-brainer – eliminate waste and deliver a better service.

There is work to be done. And it is urgent. We literally cannot afford to waste time. We need to start now to develop the plan's initial drug formulary and a system for keeping it up to date. We need to start now to build consensus across Canada on the structure for a national pharmacare plan. We need to decide on a system for financing pharmacare that will determine how the savings from eliminating the waste in the current system will be shared among governments – federal and provincial/territorial, individual Canadians and employers.

14 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.
15 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.

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- Hugh Mackenzie

Hugh Mackenzie has worked as an economist for more than 40 years in a variety of different public policy capacities, at all three levels of government as well as in the non-profit sector. He has written extensively on the financing of health care capital and on the fiscal issues caused by rising health care costs in Canada.

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