Presentation to the Standing Committee on Social Policy, Ontario Legislature, Queen's Park, Re: Bill 102

Armine Yalnizyan
Research Associate, Canadian Centre for Policy Alternatives

Today I am going to present you with three key messages:

- Why you should support this Bill
- Why you need to do this now, not later
- Why this Bill is potentially a model for the nation (and suggests the leadership role this province can play)

Why you should support this Bill

Everyone on this committee, from each party, should stand behind the proposed legislation because of the

- efficiencies gained (Principle: why spend a dollar when 99 cents will do?)
- potential for improving equity (Principle: together, we can make things better for *everyone*.)

As elected officials of three different political persuasions, your historic approaches are reflected in this initiative

- The Conservatives attempted to introduce price-volume agreements in the late 1990s, consistent with their "don't waste taxpayers' money" ethic.
- The NDP stand for preserving and enhancing access to basic services
- The measures in this bill meet both tests, true to the Liberal "brand" of balancing interests.

I don't need to go over the "curves" — the growth rate of drug spending, the growth rate of health care spending, comparing these rates of growth to that of the economy and provincial revenues. You are all familiar with these trends. Those mathematics simply make action unavoidable, forcing governments to once again

marshall and manage public resources, not just withdraw dollars from the public bank account. May I present another important set of contextual facts to consider, facts that lend credence for the approach taken by this bill.

1) Ontario is the biggest purchaser of drugs on the continent, just behind VHA (Veterans Health Administration). Why aren't we using our purchasing power "muscle" to better effect?

The VHA provides drug coverage for 5.5 million veterans (out of 7.5 M veterans enrolled for VA health care). They spend about $4 B on drugs covering 24,000 pharmaceutical products[1]

ODB (the Ontario Drug Benefits Plan) covers about 2.2 million people, spending $3.5 B on just over 3,000 products[2]

We could clearly be getting a better deal if the VHA numbers tell us anything. Why are we paying retail on every pill? 33% of all drug costs are going to pharmaceutical classes that deal with cardiovascular and cholesterol-related disease.[3] We can do better on bulk purchasing.

The major strokes in the bill address the real issues

- **We pay too much for generics.** The only price control legislation on generics is the 70% rule on their price vis a vis brand name products. That's being brought down to 50% — quite reasonable, given the price of brand name products
- **We pay too much for patent drugs.** The PMPRB (Patented Medicine Prices Review Board) regulates prices of patented medicines, but we do not take advantage of price-volume agreements like they do in US. VHA purchases are made at discounts ranging from 24 to 60 percent below drug manufacturers' most favored non-federal, non-retail customer pricing[4]

The Ministry estimates that savings made possible by the changes sought by Bill 102 are almost $300 million. That's almost 9% of the ODB bill. Who would not seek to offset rising costs in such a manner if possible? It is simply responsible governance.

Governments can accomplish things individuals and single insurance companies can't when it comes to rising prices, because of their scale and because of their ability to set the rules.

2) Sustainability of the system: the pressures are from the spending AND revenue sides of the equation

Public health care expenditures are rising at a faster rate of growth than public revenues. Growth rates in the prices of pharmaceuticals are one of the biggest cost drivers in the publicly (and privately) funded system, and the fastest growing single element of health care provision.

Every elected official wraps themselves in the values behind the CHA (Canada Health Act), The implicit message is support for universal accessibility, and leaving no one behind who is in need. The political and fiscal imperative is to control costs, while addressing these core values.

From an accounting point of view, the concerns are not just about trends in spending growth. The trends on the revenue side also place at risk the sustainability of health care (indeed all basic social services).

Between 1997 and 2004 fed and provincial governments together re-introduced $108 billion in new funds for health care. At the same time, these two levels of government withdrew $250 B from the public purse in tax cuts.[5] (The "Sustainability" booklet is attached to this presentation.)

If we are truly committed to principles of access for all citizens, we have to acknowledge that we will have to pay more over time.

Paying more over time is not optional. We *will* be paying more at the economy-wide level. But we *do* have options about how *much* more

we will have to pay, about the *ways* in which we pay, and the *distribution of benefits* from more spending.

While the elderly and an aging population is not a cost-driver for health-care overall, the growth of the over 65 age cohort, as well as the growth of the "near elderly" cohort, impacts the consumption of pharmaceuticals. The majority of those served by ODB is over 65.[6]

- The 65+ age cohort is a growing proportion of the population
- They are being aggressively courted by marketing strategies

Why you have to do this now:

A statement of claim was issued by the Ontario Superior Court on December 23, 2005 by CanWest Mediaworks Inc., who has challenged the constitutionality of the Food and Drugs Act and Regulations that prohibit direct-to-consumer ("DTC") advertising of prescription drugs, as well as advertising related to the treatment of various listed diseases.[7] As of March no date had yet been set.[8] The federal government was already in the process of reviewing this legislation to update it. The issue will move to the front-burner of health policy in the near future.

Most of the concerns around Bill 102 have focused on the supply/provider side. We need to wake up to the trends. The "consumption" of pharmaceuticals is increasingly demand-driven. An explicit objective of the pharmaceutical industry, judging from various presentations given at global producer-based meetings over the years, is to transform the utilization of prescription drugs into a consumer-driven, not physician-driven, market.

On the supplier side, more aggressive consumer marketing looms on the horizon.[9] The world leader in pharmaceutical sales statistics, IMS documents show 2005 was, globally, a "slow year" by their standards, with growth rates in expenditures at the lowest level since 1963.[10] They attribute this to the competition that patented drug companies are facing from generics, and from governments seeking greater cost controls. This requires "newthink" from the producers' side. The struggle is currently framed as getting more product onto the market with proven (or perceived) therapeutic "superiority" with as little regulatory impediments as possible.

Promotion now outstrips research and development in major pharmaceutical firms by a factor of 3 to 1.

- Breakouts for the 12 Fortune 500 drug companies show that, at the median in this group, profits accounted for about 18% of revenues, R&D 12% and marketing and administration 37%. The median revenue of these companies was about $13 billion (US).[11]
- Marcia Angell, the former editor in chief of The New England Journal of Medicine and now a senior lecturer in social medicine at Harvard Medical School, indicates that a surprisingly large share of employment in the pharmaceutical industries stems from marketing, not research and development. "By their own figures, over a third of their employees are in marketing. Not marketing administration, but marketing. So I think it's safe to conclude that somewhere on the order of 30 percent — over twice the R&D costs — are marketing"[12] Her information was based on conditions in the late 1990s and early years of the new millennium.
- IMS data show that, in the US, total expenditure on promotional spending was $15.7 billion (US) in 2000.[13] By 2003, the latest available public numbers, IMS reports that $31 billion (US) was spent in the US on promotional spending[14], almost double the amount spent only 4 years earlier. The category of direct-to-consumer advertising in the US quadrupled between

1996 and 2003. 2003, the most recent data available, is 3 years ago.

I'm sure I don't speak for just myself when I say how surprising, even alarming, I have found the increase in advertising for drugs in the past year or so, in print and electronic media. I am not just referring to American-sourced media, but right here in our midst, on billboards, bus shelters, and even washroom stalls in bars and restaurants.

Given demographics and the review of the federal Food and Drug legislation (for both safety purposes and for the federal prohibition on direct-to-consumer advertising), the government of Ontario should not wait to start to control the costs of pharmaceuticals.

Why this could be a model for the nation, a nation-building exercise

This legislation introduces changes that illuminate what governments can do for people that people — as individuals or even small groups — can't do for themselves:

- save money because of economies of scale/ bulk-purchasing possibilities
- set rules for safety, effectiveness of products in a way that private sector players can't
- countervail market forces by regulating prices in a market increasingly driven by demand-push due to intensified advertising and marketing
- make sure the benefits of economic and therapeutic gains are distributed to all citizens, not just some subset who have better insurance or a bigger wallet.

The provinces have been talking about uploading existing drug programs to the federal level since the July 2004 First Ministers' Meeting at Niagara on the Lake.

If this is a good set of reforms for Ontario, imagine the savings that could be possible at the pan-Canadian level through economies of scale and rule-setting.

Greater efficiencies could be used to buy greater equity, moving access to pharmaceutical products closer to a comparable norm across the country.

At the end of July 2006, at the Council of the Federation meeting of the provincial leaders in Newfoundland, there will undoubtedly be a reprise of attempts to further advance the idea of uploading provincial drug plans/move towards a system of Pharmacare.

By the fall the federal government will advance a new set of proposals about how to rebalance the nature of the federation, from a fiscal point of view.

This file feeds directly into the agenda of federal-provincial "fiscal imbalance".

- At the provincial level, Ontario's position is for more federal cash. Clearly the provincial Treasury would like more funds, without specific obligations attached. But in terms of optics, it is unclear what the government/the Premier wants to do with the money. This "show me the money" approach is not a satisfying or statesmanlike position to the average voter.
- Given the clear preference of the current federal minority government to reduce taxes; given the federal government's focus on Quebec for political purposes; and given the clear preference of Quebec to have the federal government disengage from arenas of provincial interest such as social policy, a possible outcome of the federal "solution" to the fiscal "imbalance" could involve providing more tax room (perhaps more tax than cash transfers) to the provinces.
- The current reality is that all jurisdictions are locked into a culture of tax competition. No government wants

to be seen as the party that raised the electorate's taxes. (This is a fool's paradise, and completely unsustainable if governments also attempt also to address voters' concerns and desires for services.) If provinces get increased federal transfers in the form of more tax room, that tax room will doubtless not be taken up to its full extent. Fiscal capacity to meet public needs will have been stripped by this modality of "fiscal rebalancing".

Uploading provincial drug programs is something truly useful and meaningful that could be achieved with existing federal surpluses, a federal-provincial fiscal reform that would actually end up saving the taxpayer money and/or improving levels of service at discounted prices. It doesn't involve spending more money, on balance. It simply involves learning how to spending it better, collectively.

Such an approach to the use of the federal fiscal surplus avoids the overly simplistic, "just give us more cash" line so frequently heard from the provinces. It reinforces that governments more than just elected balance sheets.

Governments can use our collective spending power to deliver savings and services in a way that we, as individual citizens cannot. That principle has even more force at the federal level than at the provincial level. (The piece in Canadian Healthcare Manager from September 2004, referenced here and attached to the presentation, has a telling example of how bulk-purchasing at the federal level shaved $3 dollars off the original $4.70 per pill cost of Cipro.[15])

Concluding Thoughts

Pharmacare is part of health care, for better or worse.

Regardless of political persuasion, any ruling party is going to have to learn to manage this part of the system better, not just spend more (or less) money on it.

Better governance practices — particularly, but not exclusively, in the public sphere — are being urged by a variety of factors all of which will become accentuated in the coming years as demographic pressures and growing economic risks accelerate.

The objective of good governance on this file is to find efficiencies that can help preserve and enhance equity. There is only true solution for making sure citizens — all the citizens you serve, the people who elect you — get the care they need. That solution is through the publicly-funded system

Bill 102 provides a unique opportunity to set a distinctive tone about the very role of government in concrete terms.

It is a message that is unapologetic about what governments can achieve for citizens.

It asserts governments can, on occasion, spend our money more wisely than any actor in the private sector.

It shows that, with the intervention of a third party, the benefits of market transactions can be distributed more evenly than any market exchange could.

It makes clear that the solutions to rising drug costs in the public health care system are not found by offloading the problem to the private sector, but by better managing the public sector itself.

Thank you for illuminating what is possible to achieve through the public sector. Please stay firm in your resolve to make public health care a winning proposition for ll.

Notes

1 The Independent Budget for the Department of Veterans Affairs, 2007, p.94 http://www.pva.org/independentbudget/pdf/IB_07_medcare.pdf

2 Ontario Ministry of Health and Long Term Care, 2004–05 Report Card for the Ontario Drug Benefit Program. Annual reports can be retrieved from http://www.health.gov.on.ca/english/public/pub/pub_menus/pub_drugs.html

3 *Ibid.*

4 VHA Budget 2007, *op cit.*

5 Armine Yalnizyan, Can We Afford to Sustain Medicare? Prepared for the Canadian Federation of Nurses Unions, July 2004, pp.8–9 http://www.nursesunions.ca/cms/updir/2004-07-29-Sustainability-Report-en.pdf

6 Ontario Ministry of Health and Long Term Care, *op cit.*

7 Pharmacapsules@Gowlings, January 16, 2006, Vol. 5, No.1 http://www.gowlings.com/resources/enewsletters/pharmacapsules/Htmfiles/V5No1_20060118.en.html

8 Jennifer Young, Drug Ad Regulations Under Fire, *Capital News on Line*, Ottawa, March 3, 2006, Vol.18, No.3 http://temagami.carleton.ca/jmc/cnews/03032006/n5.shtml

9 Key Trends in Pricing and Reimbursements 2004, http://www.imshealth.com/web/end/0,3150,64576068_63872702_71056299,00.html

10 Murray Aitken, senior vice president, corporate strategy for IMS, cited in *IMS Intelligence360*, an annual publication that provides global coverage of pharma issues. http://www.imshealth.com/vgn/images/portal/cit_40000873/24/0/78104378PE_KeepingPace_Harbingers_05-2006.pdf

11 *Fortune Magazine,* 1999 Company Annual Reports, Fortune 500, April 2000. www.fortune.com

12 NY Books, Vol. 51, No.12, July 15, 2004. Review of *The Truth About the Drug Companies* by Marcia Angell, http://www.nybooks.com/articles/17244

13 US Total Promotional Spend by Type, January - December 2000 (in US$), from *IMS HEALTH Integrated Promotional Services and CMR* http://www.imshealth.com/public/structure/dispcontent/1,2779,1343-1343-143223,00.html

14 IMS http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_44304752_44889690,00.html

15 Armine Yalnizyan, Accepting the Pharmacare Prescription, *Canadian Healthcare Manager,* September 1, 2004, http://www.chmonline.ca/images/Sept2004/healtheconomics.pdf

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
CENTRE CANADIEN
de POLITIQUES ALTERNATIVES

410-75 Albert Street, Ottawa, ON K1P 5E7

TEL 613-563-1341 FAX 613-233-1458
EMAIL ccpa@policyalternatives.ca
www.policyalternatives.ca

CAW 567 OTTAWA