Speaker's Notes

for a

Presentation on Prescription Drugs

to the

House of Commons Standing Committee on Health

By

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Good morning.

My name is Stan Marshall and I am a Senior Research Officer with the Canadian Union of Public Employees (CUPE). I would like to thank the Standing Committee on Health for this opportunity to address important issues around prescription drugs.

CUPE represents approximately 525,000 workers in public sector employment across Canada. One in 60 Canadians is a member of CUPE and an even greater percentage of Canadians have a least one CUPE member within their family. It should go without saying that access to health care generally and affordable prescription drugs more specifically is of vital importance to CUPE members and their families.

This morning I wish to make the connection between the increasing costs of prescription drugs and the new reality faced by workers in their workplaces as they attempt to ensure coverage for themselves and their families.

Cost Pressures

It is well known that drug costs have increased astronomically over the last decade. In 1997, drug costs surpassed physician costs as a proportion of total health spending. It was the fastest growing health expenditure. By 2001 prescription drug spending had increased to 15.2% of total health expenditures or about $15.5 billion. Many industry experts predict that drug price increases will continue to gallop at 15% – 20 % over the next years.

Implications for Workers

What is less well known and understood is the impact that these increases have for ordinary workers – both those who are organized into trade unions and those who are not. Increased drug costs put a severe strain on the ability of workers to negotiate such benefits. Employers are squeezing workers in an effort to lower total compensation costs. While employers are undoubtedly paying more in drug costs, they are also downloading an increasing portion of the costs of prescription drugs to workers.

The implications of downloading are significant. The further you move away from the principle of comprehensive first dollar coverage for drugs, the more you are introducing forced, and often unpalatable, choices as to whether to purchase prescription drugs or not.

Many studies show that all too often, individuals and families cannot bear the entire burden of the downloading. A Kaiser Foundation study of seniors in the United States found that one quarter of seniors, irrespective of drug coverage, made choices to not fill prescriptions or to skip doses in order to make their prescriptions last longer. That proportion rose to over a third if they had no drug coverage at all.

These choices are driven by economic necessity. In this case the population was seniors but the situation would likely not be different if the study was of single parents or families with drug plans that require significant cost sharing. The Kaiser study found that those with better drug plans were less likely to engage in drug purchasing behaviour that is detrimental to their health.

The consequences of not filling prescriptions or skipping doses are significant of course, as heart disease, diabetes, and hypertension can worsen. In the end the savings realized by downloading to employees is transferred in even greater proportion to health expenditures borne by governments to deal with medical conditions that were poorly treated.

Further, at a societal level, all governments seek to curb health expenditures. Unfortunately, because they have not tackled the cost of drugs issue head on, they are looking to reduce overall health costs through privatization and contracting out of public sector work – work that is compensated with better pay and benefits when done in the public sector. Consequently, increasing drug costs has a dangerous indirect impact on the health and well - being of workers fostered by the shift to lower paid contracted and marginalized employment.

Bargaining for your health

Workers have always known that extended health benefits, including drug and dental plans are an essential part of the compensation package and have sought to bargain these benefits at bargaining tables around the world.

The landscape for drug coverage now includes a wide variety of options. I list some of them here in order of best to worst.

The best plans are 100 per cent employer-sponsored and paid with formularies that are jointly determined through negotiation. However, there are a variety of other inferior plans that do not benefit employees to the same degree. Some plans require employee co-payments or deductibles, or to share in the cost of paying the premiums. Some provide for flexible benefits where employees must choose which benefits they want to be covered. A recent trend is for employers to propose

health spending accounts where employees are provided with a certain amount of money to use for health benefits and when they have used it up they must shoulder the burden of additional costs themselves. This approach is tantamount to the employer divesting itself totally from any responsibility to provide meaningful coverage. It is done strictly as a cost-saving measure. Where there is no employer-sponsored plan, employees must purchase private insurance and make the premium payments themselves.

The worst-case scenario is that there is no employer-sponsored plan and the employee cannot make private insurance premium payments and is left without any insurance whatsoever. Interestingly, a number of commentators in the insurance field have made statements that the future may be no coverage at all – at least none provided by the employer.

These are not merely choices that employees make. They are the product of the employer-employee relationship and those in a stronger position are usually better off i.e., if they have a union they are more likely to have better coverage than if they don't. However, it is the employers who have disproportionate power in the employment relationship to effect negative changes which cost employees in economic terms, and which impact on system - wide health care expenditures. This is particularly true for the unorganized.

Increased drug costs put a severe strain on the ability of workers to negotiate such benefits. As drug costs increase and as employers seek to decrease its share of the costs we can expect greater labour relations conflict as bargaining tables deal with a significant tangible benefit for workers and their families.

WORKING TOWARDS SOLUTIONS

There are several areas where we need to look for solutions. Some of the recommendations of the Romanow Commission are relevant e.g., transfers to provinces for catastrophic drug coverage and the creation of a National Drug Agency to "evaluate and approve new drugs" and to "negotiate and contain drug prices." However, these changes will not be effective if we don't show the political will to make other changes first.

Patent Legislation

First and foremost patent legislation must be changed in order to allow generic drugs earlier access to markets. The current twenty year patent protection has driven overall health care expenditures up, and is threatening the health and well -being of Canadians. Brand name pharmaceutical companies and their share holders are benefiting disproportionately to the benefit they provide. Indeed, one could argue that the current patent protection is a net loss for Canadians.

It is time to re-introduce “compulsory licensing” to facilitate change that will reduce drug costs. Compulsory licensing provides for generic drugs to come to market earlier provided that a license is purchased such that the patent holder is compensated. Dr. Aidan Hollis makes the link between effective publicly funded health care and compulsory licensing in the *Canadian Medical Association Journal* (October 2002.) Dr. Hollis points out that compulsory licensing “shifts the power over price from patent holder to government” but preserves the patent holder’s right to make a profit.

By applying for a court injunction the twenty - year patent protection can be extended by at least two years and probably more depending on the length of the litigation. This dubious practice must end. It serves no other purpose than to protect profits and market share.

The practice of “evergreening” must also be stopped. Patent applications for slight variations of the same drug, with in many cases little measurable benefit to the patient, serves little purpose other than to protect the market from generic equivalents. The consequence is increased costs for Canadians.

These legal loopholes need to be closed.

Reference Based Pricing

In 1995 British Columbia began an important experiment to control the costs of drugs. They introduced the Reference Drug Program (RDP) to cut costs while still maintaining first dollar coverage for five classes of drugs. It works because it ensures that only the cost of the least expensive drug is covered in cases where more than one drug is proven effective for the condition.

By the end of 2003, the RDP will have saved the B.C. government over $352 million and several independent evaluations of the program indicate that there are no adverse health outcomes.

Why then, don’t we just adopt this program across the country? The answer is that brand name pharmaceutical companies are vociferous in their opposition to the RDP. Their profits tumble with the use of lower cost generics.

The lobbying of the brand name pharmaceutical companies aside, the example of the RDP in B.C. stands as a model for public policy on formulary management and should be considered in any serious reform or implementation of a pharmacare program.

Generic Drugs to Fight HIV/AIDS

Finally, I would like to say that we are encouraged that the government is considering changing legislation to allow for the domestic manufacture of low cost generic anti-retroviral drugs to fight HIV/AIDS in sub-Saharan Africa and other areas of the developing world. We feel strongly that this legislation should also permit Canadians with HIV/AIDS to access generic equivalents.

However, we are well aware that the government has not set specific timelines for the implementation of these patent changes and has not contemplated the specifics of the changes. We urge the government to make these changes expeditiously so that the more than 38 million people throughout the world who have HIV/AIDS can begin to receive cost-effective treatment. As importantly, this action is needed to ensure that economies devastated by the high death tolls are given an opportunity to recover.

The patent legislation should not be a shield behind which brand name pharmaceutical companies hide in order to make excessive profits at the expense of humanity.

Members of this Standing Committee on Health should be using one voice to stop the horrific death toll from HIV/AIDS.

We will be watching your actions as well as the actions of this government.

I thank you once again for this opportunity and CUPE will be submitting a more detailed brief in the next few weeks.

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