Justice Studies 384 / Nonprofit Sector Leadership & Innovation 320:

Advocacy

Problem-Based Learning Case #5: Pharmacare

Submitted by students:
Ruth Easton and Julian Wotherspoon

Submitted to
Dr. Gloria DeSantis, Dept. of Justice Studies, University of Regina
and Ms. Holly Schick, Saskatchewan Seniors Mechanism (SSM)

Submitted March 2018

PBL Case #5 – Pharmacare: "Older adults are often on many medications prescribed by doctors. However, not all medications are covered by retirees' drug plans and some older adults don't have drug plans, thus many prescriptions go unfilled. Our board has talked about the fact our country has Medicare, but not Pharmacare, and wonders how we can go about changing this." (This assignment was co-created by Gloria, Holly and the SSM Issues Committee during the Fall of 2017.)

Introduction

We're to address the following statement provided by the Executive Director of the Saskatchewan Seniors Mechanism (SSM):

> Older adults are often on many medications prescribed by doctors. However, not all medications are covered by retirees' drug plans and some older adults don't have drug plans, thus many prescriptions go unfilled. Our board has talked about the fact our country has Medicare, but not Pharmacare, and wonders how we can go about changing this. (Schick, 2018).

In thinking about how to best go about responding to the statement from the Saskatchewan Seniors Mechanism, we immediately shifted to thinking about how SSM could be part of larger systemic—and thus (hopefully) more resilient—change. We will explain how our understanding of the history and the current context informed this shift.

We also chose to focus a considerable portion of our effort on providing the historical background for two reasons a) the SSM seems fairly experienced with advocacy work, and b) in conversation with board members, Julian discovered that relatively little research has already been completed by the SSM on the issue of pharmacare.

History of Medicare

Pharmacare has been called the "unfinished business of medicare" (Morgan et al., 2015, p. 3). Canada's public health system can be traced to Saskatchewan 1914 when the Municipal Doctors Plan, shortly followed by the Union Hospital Act of 1917, allowed rural municipalities to use revenue from property taxes to hire physicians and create 'districts' to build and run regional hospitals. At this early inception, pharmaceuticals had yet to become available on a large scale. Even after the advent of pharmaceutical drugs as we know them in the 1920s and 1930s, widespread use of pharmaceutical drugs did not become the norm until after World War II. However; by 1964, when the Royal Commission on Health Services was formed, Supreme Court Justice Emmett Hall recognized the importance of pharmaceutical drugs to the health care system and recommended that a universal prescription drug plan be implemented

immediately following the implementation of universal health insurance for physicians and hospitals (Morgan et al., 2015, p. 3).

While Hall's vision was never realized on a national scale, most provinces did introduce legislation which provided drug coverage for Canadians over the age of 65 (Morgan, Daw & Law, 2014). These programs remained virtually unchanged until the 1990s, when moves were made to make 'catastrophic drug coverage' available to all Canadians based on income instead of universal for those over 65. This is consistent with the trend in public health policy through the 1980s and 1990s where the interests of private insurance corporations shifted public policy to allow for greater control by the private sector in health care (Morgan et al., 2014).

In the 1970s, a drastic rise in the price of foreign oil sent Canada's economy into turmoil and resulted in "clawbacks" to public health care funding and creeping privatization which would continue for the next several decades. These cuts were introduced in 1977 in the form of Established Program Block Funding which cut federal contributions to health care by about half (Clarke, 2016, p. 261), and continued with the signing of the Fair Trade Agreement in 1987 which allowed private insurance companies to legally challenge public health spending and restrictions on private industry. Despite continued cuts and policy trends toward privatization, universal drug coverage was suggested again in the 1997 National Forum on Health led by Prime Minister Jean Chretien, and again in the 2002 Commission on the Future of Healthcare in Canada led by Roy Romanow (Morgan et al., 2015, p. 3).

Currently, Medicare covers only drugs administered in hospital. Most provinces provide some level of 'pharmacare', whether it is coverage for low income earners, for Canadians over 65, or regulations insuring employers provide a set standard of coverage (Morgan et al., 2015, p. 9). Despite these programs, cost remains a significant barrier to accessing prescription drugs outside of the hospital setting. According to a 2015 survey by Angus Reid, one in five Canadians report not taking a prescription as prescribed due to cost; one in seven report not filling a prescription at all, one in ten will not refill a prescription, and one in seven report skipping, splitting, or otherwise stretching their medication to last longer (Angus Reid, 2015). It is safe to say that a national universal pharmacare program is a long overdue, but natural extension of

Canada's public health care system, and yet if such a program were to be developed it would be a landmark move in the opposite direction of current policy trends.

Is there a window of opportunity?

Kingdon's model for understanding how items appear on the public policy agenda sets out three streams:

> (1) the *problem stream* refers essentially to policy problems in society that potentially require attention; (2) the *policy stream* pertains to the many potential policy solutions that originate with communities of policy makers, experts and lobby groups; and ([3]) the *politics stream* refers to factors such as changes in government, legislative turnover and fluctuations in public opinion (Howlett, McConnell & Perl, 2014, pp. 2-3)

We'll address each stream to try to understand how they might intersect to create a window of opportunity.

Problem

There are several problems with the current free market pharmaceutical drug system. First, and most obvious, is the inequitable access to pharmaceutical treatments created by economic inequality. Even though most provinces provide some level of drug coverage in cases of 'catastrophic drug cost', the cost of prescription drugs remains a barrier to access (Angus Reid, 2015). As described above, those who cannot afford their prescribed medications may try to stretch their medications by skipping or lowering dosages, or they may forgo their medications altogether leading to complications when symptoms or conditions are not properly controlled (Angus Reid, 2015).

Second, Canada's prescription drug regulation and prescribing practices are inconsistent and heavily influenced by the pharmaceutical industry itself (Clarke, 2016, p. 355). This inconsistency can lead to mis-prescribing, overprescribing, and unintended drug reactions which can lead to complications such as hospitalizations or even death (Morgan et al., 2015, p. 11)

Thirdly, though the cost of private pharmaceutical coverage presents a clear barrier to many Canadians, and despite the fact that the vast majority (91%) of Canadians support the idea of a national pharmacare plan, the economic cost of a national drug plan is still a large concern for many (Morgan, et al., 2015, p. 9).

As addressed in the introduction and history, the problem is visible, well-documented, and the solution of universal pharmacare has been oft-recommended since the 1960s. However, if the problem can be constructed as one only affecting seniors (or youth, or the unemployed), less desirable solutions may be brought forward by policy makers and politicians as sufficient.

Policy

The term 'pharmacare' describes a national prescription drug program alongside or within our current Medicare system. In short, it would mean federal regulation and funding for prescription drug programs. However, how the federal government chooses to implement a national pharmacare program could either improve access to prescription drugs or complicate it.

The Pharmacare 2020 report clearly states that a universal, comprehensive, evidence-based, and sustainable national drug program is not only ideal but attainable (Morgan et al., 2015, p. 14). Their proposal suggests that such a program would not only save our healthcare system $4-11 billion annually (Morgan et al., 2015, p. 14), but that it could also help standardize prescribing practices and minimize issues of mis-prescribing and overprescribing created by the patchwork of coverage which currently exists. Such a system would not only benefit Canadians accessing pharmaceutical drugs, but also employers, physicians, and pharmacists (Morgan et al., 2015, p. 9).

Short of universal coverage, a national prescription drug program could also be income-tested, meaning only those who meet certain income criteria would qualify; age-based, meaning only those in certain age brackets would qualify; or some combination of both as is currently offered at the provincial level. It is also possible that the federal government could simply legislate employers to provide a set standard of prescription drug coverage, as is

currently the case in Quebec (Morgan et al., 2015, p. 14). However, these approaches may only add to the inconsistencies which already exist in Canadian drug coverage and exacerbate health inequities.

One need only examine the move from universal drug coverage to income tested drug coverage at the provincial level to see that universality is a key factor in eliminating inequities in access to prescription drugs. Until the 1990s, Canadians over the age of 65 had universal access to prescription drug coverage in most provinces which ensured access to affordable prescriptions for every older Canadian regardless of income (Morgan et al., 2014). Now most of these programs have moved or are moving to income-tested programs which, when compared to universal programs based on access, equity, and efficiency, always perform poorly (Morgan et al., 2014). Not only do Canadians over the age of 65 have different drug needs than others accessing income-based programs, but the added administration and private co-pays mean more public and consumer cost for less access (Morgan et al., 2014).

In short, only a universal pharmacare program can equitably and efficiently provide access to prescription drugs for all Canadians. In advocating for a national pharmacare program, it is vital that the core values of our Medicare system, as listed in the Canada Health Act—universality, portability, accessibility, comprehensive coverage, administration on non-profit basis—are also applied to a national pharmacare program.

Politics

The Liberal government announced an advisory council on national pharmacare in their 2018 budget (Scotti, 2018). This announcement in particular provides a window of opportunity; however, this opportunity is not without its challenges.

The individual appointed chair of the new advisory council is the former Ontario Health Minister responsible for the roll out of pharmacare for those 25 and under in Ontario. In early 2017, when discussing the roll out of pharmacare in Ontario, he was quoted as saying "'I think if there is one message today it's that this is possible.' 'It's doable,' Hoskins said, and Ontario will prove it" (Harris, 2017). Hoskins may well be a strong advocate for national, universal pharmacare.

Speaking at an Economic Club of Canada breakfast, “Finance Minister Bill Morneau [said] a new national pharmacare program will be ‘fiscally responsible’ and designed to fill in gaps, not provide prescription drugs for Canadians already covered by existing plans” (Harris, 2018). Maintaining room for private insurance by only “filling in the gaps” is something that certainly benefits the private sector as “Canada’s inefficient system of private and public plans makes it easier for [private] managers to pass cost increases on to employers, patients, and taxpayers than it is for them to manage costs from a system perspective” (Morgan et al., 2015, p. 14). Morneau’s comments may indicate that the report generated by the advisory council will need to be supported by a strong advocacy effort if it is to be even *considered* by the Federal government. Some of this advocacy work has already begun. Morneau’s ties to a private insurance company were highlighted in a letter sent to Trudeau by “leaders of the Canadian Labour Congress, Canadian Federation of Nurses Unions and Canadian Doctors for Medicare” regarding Morneau’s remarks at the breakfast (Blatchford, 2018). Highlighting such perceived conflicts of interest could form part of an ongoing advocacy effort.

At the local level, the Saskatchewan NDP recently elected Ryan Meili to lead the party. Meili has been a long-time advocate of national pharmacare (CBC News, 2018), and regardless of the outcome of the upcoming provincial election, he is likely to continue that advocacy in his new role as leader of the NDP which will continue to force this issue onto the table in Saskatchewan.

In academia, the Pharmacare2020 report has received 281 endorsements at the time of this writing, from members of universities and healthcare practitioners all across Canada. However, the Pharmacare2020 report is more than 5 years old. Some of the momentum around the release of that report may have been lost.

Public momentum, on the other hand, seems to be building. In late 2017, the Canadian Labour Congress launched a petition and a series of townhall talks on Pharmacare (Canadian Labour Congress, 2018). At the beginning of March, Dr. Danielle Martin gave the CAH Distinguished Lecture at the University of Regina to a packed room, on her “six big ideas”—one of which is pharmacare—to improve healthcare in Canada (University of Regina, n.d.). Her 2018 speaking tour includes several other stops at universities and conferences across Canada and

the US (6bigideas.ca, n.d.). In contrast, Brett Skinner, an industry expert (and former employee of industry lobbyist group Innovative Medicines), felt the need to publish an opinion piece entitled “Canadians are being fooled into thinking we'll like pharmacare. We really, really won't” (Skinner, 2018a; Skinner, 2018b). The comments on this article indicate that some Canadians do believe private insurance will serve us better, but most are skeptical of the writings of a former pharmaceutical company employee.

Where does SSM start?

The Federal government has opened the conversation on pharmacare (Scotti, 2018), and advocacy should focus on pushing the government to “get it right”. We suggest that pushing for systemic change for all groups affected by pharmacare in Canada would best serve seniors, since it would create a system that would perhaps be less susceptible to dismantlement under changes in governments and/or shifts in government priorities; “getting it right” would look like a universal, comprehensive, evidence-based, and sustainable pharmacare plan (Morgan et al., 2015). Given the SSM’s current role as a hub for seniors’ organizations in Saskatchewan, in the upcoming advocacy effort for pharmacare, we suggest that SSM continue to serve as a hub—but not just for seniors’ organizations—by organizing a coalition of stakeholder groups and using their dispersed membership base across Saskatchewan to mobilize both urban and rural organizations of all ages.

First steps - *coalition building, participation in the advisory council consultations, and a community engagement campaign*

Drawing on the work of Poverty Free Ontario as they built a province wide coalition, we suggest that SSM could reach out to organizations such as the United Way and food banks (Freiler & Clutterbuck, 2017), as well as the Regina Anti-Poverty Ministry, ACORN Canada - Regina Chapter, End Poverty Regina, the Regina Community Clinic, Station 20 West (in Saskatoon), and student groups like Student Energy into Action on Regina Community Health (SEARCH, located in Regina), Student Wellness Toward Community Health (SWITCH, located in Saskatoon), and Students Mobilizing Against Cuts. Organized labour can also offer resources

and support in fighting for pharmacare; SSM should also reach out to the Canadian Labour Congress and local unions such as CUPE, SGEU, and URFA. Professional organizations such as the Pharmacy Association of Saskatchewan might also be helpful allies, or sources of information.

Once the advisory council begins its work, the SSM and organizations working in coalition should look for opportunities to participate. SSM should plan to go into these meetings with a well-defined set of requests, and rebuttals to common excuses for a scaled-down plan.

Engaging the public might work best if the "initiatives...are creative, practical, well-organized, and fun" (Hynd & Miller, 2011). Ruth suggests—for a fun campaign—a person in a pill bottle costume running away from folks who stop to talk (after giving them a bit of information about the campaign, of course). On a more serious note, Ruth found it personally powerful to frame Medicare as something which belongs to all Canadians; from that perspective, the absence of pharmacare feels more like a missing part than a looming additional cost. Julian suggests finding ways to clearly and visually illustrate how universal pharmacare differs from 'filling the gaps'.

It is imperative that SSM, in coalition with other organizations, take charge of the way national pharmacare is framed in the public consciousness. In particular, framing the question of cost by asking, what is the cost of *not* implementing universal pharmacare at the national level? Communicating the projected cost savings for the health system as outlined above, the current lack of consistency in prescribing practices, the quality of life issues faced by many due to the cost of prescription drugs, and Medicare as something which belongs to all Canadians may help build public acceptance of—or even demand for—a national universal pharmacare plan.

Aboriginal & newcomer populations

We fully recognize that in our review of national pharmacare and access to prescription drugs, that we did not address the unique and intricate barriers to health care, including pharmaceutical treatments, experienced by Aboriginal and Newcomer/refugee communities in

Canada. In part because we did not find critical analysis on how national pharmacare may affect these populations, and in part because both could be a paper in and of themselves. *Nevertheless, it is important that Aboriginal and Newcomer voices are represented in any advocacy that is carried out so that a universal plan can be truly universal.*

Notes

On March 17th, Erin Weir organized a town hall meeting which was used to launch the Federal NDP's campaign for #PharmacareForAll. An article summarizing the meeting was posted on March 18th in the Regina LeaderPost (Ackerman, 2018).

Works Cited

6bigideas.ca. (n.d.). 2018 Speaking Tour. Retrieved March 16, 2018 from http://6bigideas.ca/#section-tour

Ackerman, J. (2018, March 18). Federal NDP launches #PharmacareForAll tour in Regina. LeaderPost. Retrieved March 18, 2018 from http://leaderpost.com/news/politics/federal-ndp-launches-pharmacareforall-tour-in-regina

Angus Reid. (2015, July 15). Prescription drug access and affordability an issue for nearly a quarter of all Canadian households. Retrieved March 08, 2018, from http://angusreid.org/prescription-drugs-canada/

Blatchford, A. (2018, March 1). Critics call for Morneau's ouster from pharmacare file over remarks about study. Richmond News. Retrieved March 16, 2018, from http://www.richmond-news.com/cmlink/gmg-glacier-media-group/2.2062/critics-call-for-morneau-s-ouster-from-pharmacare-file-over-remarks-about-study-1.23189183

Canadian Labour Congress. (2018, February 6). Canada's unions unite with employers, doctors and retirees to call for pharmacare. Retrieved March 16, 2018, from http://canadianlabour.ca/news/news-archive/canadas-unions-unite-employers-doctors-and-retirees-call-pharmacare

CBC News. (2018, February 13). Sask. NDP leadership candidate Ryan Meili wants provinceto be renewable energy & pharmacare leader. CBC News. Retrieved March 14, 2018, from http://www.cbc.ca/news/canada/saskatchewan/sask-ndp-leadership-candidate-ryan-meili-wants-province-to-be-renewable-energy-pharmacare-leader-1.4533884

Clarke, J. N. (2016). Health, Illness, and Medicine Canada (Seventh ed.). Toronto, Ontario: Oxford University Press.

Fitzpatrick, M. (2017, April 29). Pharmacare advocates hope Ontario plan will push Trudeau to act. CBC News. Retrieved March 14, 2018, from http://www.cbc.ca/news/canada/pharmacare-advocates-hope-ontario-plan-will-push-trudeau-to-act-1.4090501

Freiler, C., & P. Clutterbuck (2017). Poverty Free Ontario: Cross-Community Advocacy for Social Justice. In N. J. Mule & G. C DeSantis (Eds.), The Shifting Terrain (172-199). Kingston: McGill-Queen's University Press.

Harris, K. (2018, February 28). Pharmacare won't be free for all Canadians, Bill Morneau says. CBC News. Retrieved March 14, 2018, from http://www.cbc.ca/news/politics/morneau-budget-2018-pharmacare-1.4555186

Howlett, M., A McConnell, & A Perl. (2014). Streams and stages: Reconciling Kingdon and policy process theory. European Journal of Political Research. Retrieved March 15, 2018, from https://www.sfu.ca/~howlett/documents/10.1111-1475-6765.12064.pdf

Miller, C. & B. Hynd (2011). Oxfam Canada: The "Fair Trade in Coffee" Campaign. In E. Whitmore, M. G. Wilson, & A. Calhoun (Eds.), Activism that Works (29-43). Canada: Fernwood Publishing.

Morgan, S. G. D., Jamie R. Daw, Michael R. Law (2014, December). Are Income-Based Public Drug Benefit Programs Fit for an Aging Population? Institute for research on public policy. Retrieved from http://irpp.org/research-studies/study-no50/

Morgan, S. G., D. Martin, M. Gagnon, B. Mintzes, J. R. Daw, & J. Lexchin. (2015, July 15). The Future of Drug Coverage in Canada - Pharmacare 2020. Retrieved March 08, 2018, from http://pharmacare2020.ca/

Schick, H. (2018, January). Saskatchewan Seniors Mechanism (for NSLI 320).

Scotti, M. (2018, February 27). Federal Budget 2018: Some (lesser-known) highlights, from Pharmacare to service dogs. Global News. Retrieved March 16, 2018 from https://globalnews.ca/news/4050606/budget-2018-tidbits/

Skinner, B. (2018a, February 15). Canadians are being fooled into thinking we'll like pharmacare. We really, really won't. Financial Post. Retrieved March 16, 2018, from http://business.financialpost.com/opinion/canadians-are-being-fooled-into-thinking-well-like-pharmacare-we-really-really-wont

Skinner, B. (2018b). User Profile. LinkedIn. Retrieved March 16, 2018 from https://www.linkedin.com/in/brett-skinner-70469555/

University of Regina. (n.d.). CAH Distinguished Lecture: Dr. Danielle Martin - Better Now: How we can Improve Healthcare for Seniors. Retrieved March 16, 2018 from https://www.uregina.ca/events/cah-distinguished-lecture-dr-danielle-martin-better-now-how-we-can-improve-healthcare-for-seniors