



Position Paper on National Pharmacare in Canada

Brain Tumour Foundation of Canada
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Background

Canada does not have a federal system of universal drug coverage.

The responsibility for health care falls to the thirteen (13) provinces and territories of Canada. Each provides basic hospital and physician services in exchange for federal funding support. The services they provide under this federal agreement do not include prescription or hospital drug coverage. Each province or territory makes independent decisions on WHAT pharmaceutical drugs they fund for the public, and HOW that drug funding is accessed.

This fragmented system is the result of a lack of political consensus on the importance, feasibility and affordability of national pharmacare within our public health care system¹.

The **Medical Care Act of 1966** was enacted to provide partial funding to the provinces for universal access to physician services outside of a hospital. Its purpose was to ensure residents of Canada could get basic medical care in each province/territory without a fee or undue hardship. By 1972 most provinces had signed agreements, and by 1977 the cost sharing agreement was replaced with block transfers¹ from the federal government. The block transfers allowed the provinces and territories more flexibility in how health care was provided. The intent was to eventually broaden the Act to include dental care, drugs, and home care, but due to shifts in federal economics and politics, this never occurred.

The **Canada Health Act of 1984** was enacted to ensure each province and territory abided by universal standards and regulations in return for federal block transfers. The Act mandates that each province and territory must provide their residents access to hospital, diagnostic, and physician services and that the access is universal (i.e. everyone has a basic level of access), publicly administered, portable across provinces (i.e. one province can claim \$ back from another if providing service), comprehensive, and affordable (i.e. patient is not charged in full or part). The Act was a positive step towards universality, but still limited funding to hospital and physician services. The expectation remained that Canadians would rely on their individual private insurance plans to cover the cost of secondary health services, including prescription drugs.

Over time, the provinces and territories developed their own programs to deal with growing needs of those in their populations who did not have access to insurance plans and could not afford the cost of prescription drugs on their own. This started with programs for seniors and those on provincial assistance programs, and over time extended to cover more people who lacked insurance coverage or had specific treatment needs. Each subsidized prescription drug program was developed in isolation under different

¹ A block transfer is a specific sum of money provided by one level of government to another for a specific purpose. How the sum is calculated and distributed is determined by the government providing the money (e.g. cash, tax points, etc.).

political mandates. Each program operates under its own provincial act or set of regulations. Eligibility to each program is typically restricted by age, income level, level of disability, or payment of a fee on a sliding scale. This means access to prescription drugs looks very different depending on age, income level, level of illness or disability, and location.

In parallel, the federal government developed a handful of programs that provided access to physician and hospital services AND secondary health needs like prescription drugs to specific groups under federal responsibility - registered First Nations and Inuit, eligible Veterans, active RCMP and military, eligible refugees, and those in federal correctional facilities. Each of these federal health programs continue to operate separately under their own set of policies and regulations.

In total, there are 105 provincial, territorial, and federal prescription drug programs in Canada.

Each publicly funded prescription drug program has a list of drugs that it covers, called a “formulary”. Drugs are added to this list after a rigorous and lengthy process that includes clinical evaluation, price negotiation and budget deliberation. Each province/territorial/federal plan is responsible for these processes, but there are two agencies in Canada that assist them: (1) the **Canadian Agency for Drugs and Technology in Health (CADTH)** provides extensive pharmacoeconomic assessments of new drug products with the input of clinician committees and patient groups; (2) the **pan-Canadian Pharmaceutical Alliance (pCPA)** conducts price negotiation with drug manufacturers on new drug products on behalf the public plans (unless a province opts out to conduct its own). While these agencies provide consistency in the drugs that are eventually recommended for listing on public prescription drug programs formularies, ultimately the final decision rests with each province/territory/federal committee. Final decisions are driven by budget capacity, provincial demand, and additional clinical input from advisory committeesⁱⁱ.

Context

Gaps in Drug Coverage

The absence of drug access from the Medical Care Act and Canada Health Act means drugs are **not a protected** benefit in Canada. As a result, Canada lacks any national guidelines, strategy or bill of rights to govern *how* or *when* drugs are accessed. Each province and territory takes their own approach to funding pharmaceutical drugs. This has resulted in gaps and inequities in access to drugs across the country^{iii, iv, vvi}.

The gaps in drug access mean some patients may have access to a drug treatment in certain parts of the country, while others may not. Some patients may have to pay part of the cost of a drug treatment, while others may not. Some may have to apply to get a drug covered and wait weeks for approval, while others can simply go to the hospital pharmacy and pick it up. These gaps pertain to a range of drugs - from basic antibiotics to primary cancer treatments.

The impacts of these gaps on people in Canada have been well documented. They include people going without essential medication^{vii}, rationing medications^{viii}, risking proper adherence^{ix}, going without other essential items^x, and even premature death^{xi}. There has been consensus across studies that a universal approach is required to close these gaps, and several papers have been published stating that a national universal pharmacare program makes social and economic sense.

Risk to Brain Tumour Community

Those living with or impacted by a brain tumour usually rely on pharmaceutical drugs to treat their tumour or to manage symptoms and side effects. This includes primary treatments for malignant tumours.

In 2020, **Brain Tumour Foundation of Canada** completed an environmental scan of public prescription drug programs across the country. The purpose was to determine how provinces and territories enabled patient access to the standard 1st line treatment for the most common type of brain cancer in adults - glioblastoma multiforme. The treatment is called temozolomide and has been the standard of care worldwide and in Canada for more than a decade.

The result was the production of a “road map”^{xii} that outlined the inconsistencies and gaps in access across the country. While several provinces had taken steps to ensure patients with brain cancer could access 100% funding for temozolomide, processes varied and many patients in different parts of the country were at risk of treatment delay. In Ontario and the Atlantic Provinces, patients were asked to rely on their personal insurance and were provided additional funding only after a time consuming application process, often with leftover costs remaining.

The project also found that many patients relied on the skills and ingenuity of various health professionals to figure out “stop gap” solutions and navigate potential delays from paperwork, loss of drug plan, etc. It was concluded that this fragmented and uncoordinated approach did little to ensure consistent delivery of care, adherence to treatment standards or the collection of reliable treatment data. It also did little to safeguard treatment continuity if a patient changed residency from one province to another.

Promise of National Pharmacare

In June 2018, the federal government of Canada launched the **Advisory Council on the Implementation of National Pharmacare**. The mandate of the 7-member Advisory Council was to determine the whether a national system of universal drug coverage was needed in Canada and how best to implement it. After a year of consultation, in June 2019 they produced a report^{xiii} that recommended a universal, single payer public pharmacare system for Canada. It was stated the system was needed to ensure equity, consistency and program sustainability. This system would work in a similar way to the medicare system, in that the federal government would provide specific federal funds to each province and territory, who in turn would administer the pharmacare program according to a single national formulary and a federal set of rules. For it to work, a province or territory would have to sign on and agree to the terms of the funding.

The Advisory Council recommended that the national pharmacare program be rolled out in stepwise fashion, starting with the creation of the Canadian Drug Agency. The role of this agency would be to create a national single formulary, establish a process for approving and adding new drugs in conjunction with CADTH, and oversee the implementation of the pharmacare program across Canada. The next step would be consult on the establishment of an initial national formulary by January 2022, with the goal of having a more comprehensive formulary by Jan 2027. In addition to these steps, the Advisory Council recommended that a specific national strategy for rare disease drugs be established.

The federal government committed the initial funding for the Canadian Drug Agency and the start of the rare disease strategy in the 2019 and 2020 budgets and work on the national drug formulary^{xiv} and rare disease decision pathway^{xv} have begun.

Principles

The vision of Brain Tumour Foundation of Canada is to find the cause and cure for brain tumours while improving the quality of life of those affected. Advocacy activities address the issues of the collective brain tumour community. The positions on national pharmacare in Canada are in keeping with this mission and the organization's value of providing hope and caring while acting with accountability, integrity, and collaboration.

Positions

- (1) **Brain Tumour Foundation of Canada acknowledges pharmaceutical drug products form a vital component of brain tumour treatment.** In addition to surgical and radiotherapy options, drugs treat disease and help manage symptoms. They are a necessary reality in the lives of many patients to reduce debilitating symptoms, improve quality of life, and extend survival.
- (2) **Brain Tumour Foundation of Canada acknowledges the gaps in drug coverage** associated with having over 100 different provincial and territorial public drug programs and the risks that these gaps present to the brain tumour community. Risks include delays in treatment, interrupted treatment, and suboptimal symptom management. Brain tumour patients rely on the knowledge of their health care professionals to navigate both public and internally driven measures to access certain brain tumour treatments. These measures are at times complex and not well documented.
- (3) **Brain Tumour Foundation of Canada supports the creation of the Canadian Drug Agency and the development of a national formulary that includes not only frequently used medicines but those critical to the treatment of certain diseases.** This includes temozolomide and other standard 1st line treatments for the treatment of brain tumours. The access to these treatments must be quick and seamless to ensure the best outcomes for each patient and this does not happen under the current patchwork system of drug coverage across the country.
- (4) **Brain Tumour Foundation of Canada supports a national system of drug coverage that follows the model of our Medicare system and standardizes access to pharmaceutical drug products for brain tumour patients.** The principles of universality, portability, and accessibility should be upheld to promote fairness and equity in treatment access. The recommendations of the Advisory Council on the Implementation of National Pharmacare should be adopted in each province to ensure automatic enrollment, adherence to a national formulary, and minimal to no cost barriers for each person.
- (5) **Brain Tumour Foundation of Canada encourages governments to allow for flexibility in a national pharmacare program.** Brain tumour patients have limited treatment options and unique needs. There should be allowances for exceptional circumstances, urgent requests, and supplemental insurance coverage in any new pharmacare system.
- (6) **Brain Tumour Foundations of Canada urges the federal and provincial/territorial governments to minimize delays in the implementation of a national pharmacare program** and to abide by recommended implementation targets. The rate of brain tumour incidence is growing in Canada^{xvi} and new drug technologies are in the future. There is a critical need to ensure there is a strong, consistent and affordable system of public drug coverage in place to ensure brain tumour patients can access innovative treatments as they come to market.

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