

Pan-Canadian Medical Student Perspectives on Pharmacare in Canada

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CFMS Position Paper



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Pan-Canadian Medical Student Perspectives on Pharmacare in Canada

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POSITION PAPER

In 2018, the *Advisory Council on the Implementation of National Pharmacare*, chaired by Dr. Eric Hoskins, released a report on three key elements of a national pharmacare program: who is covered, what drugs are covered, and who should pay. This position paper, created by the Canadian Federation of Medical Students (CFMS) Pharmacare Task Force, is a direct response to this report. We discuss: (1) the positions of major federal political parties on Pharmacare, (2) cross-country comparisons of various national pharmacare programs, (3) potential models for population coverage, drug coverage, and financing, and (4) current gaps in medical education. This paper integrates the results of our pan-Canadian survey on the perspectives of almost 800 medical students from coast-to-coast. Our recommendations are informed by these perspectives of the next generation of physicians.

BACKGROUND

Canada is the only country in the world that has universal healthcare without universal prescription drug coverage. The current system is inequitable and fiscally unsustainable. A repeatedly proposed solution is the implementation of Pharmacare: single-payer, public, universal prescription drug coverage. This has been endorsed by the CFMS through various initiatives. This is our stance, in this position paper, and beyond.

CONCERNS

1. The current state of prescription drug coverage is inequitable across various sociodemographic groups and does not serve every Canadian.
2. There is unjustifiable variation and incoordination of current public and private drug plans, leading to gaps in prescription drug coverage.
3. Current drug costs are increasingly unaffordable. As public drug expenditures continue to take up greater proportions of the healthcare budget, drug financing becomes progressively more fiscally unsustainable.
4. There is a lack of data systems and Information Technology (IT) infrastructure to support the integration, surveillance, and long-term sustainability of a national pharmacare program.
5. There is a need for increased undergraduate medical teaching on pharmacare, prescription drug stewardship, prevention of inappropriate drug plan management, and polypharmacy.

RECOMMENDATIONS

The CFMS recommends to the *Advisory Council on the Implementation of National Pharmacare*:

1. That a universal national pharmacare program be designed and implemented.
2. That the federal government work in partnership with the provinces and territories to replace Canada's current private and public patchwork coverage for prescription drugs with a single-payer, universal pharmacare program that designates prescription medications as medically necessary under an amended *Canada Health Act* (CHA).
3. That a national and evidence-based prescription drug formulary be developed. It should include safe and cost-effective medications, and drug coverage should be portable across all provinces and territories.
4. That Pharmacare be funded through the federal and all provincial and territorial governments, with no financial barriers to access for the individual patient (i.e., no co-pays, deductibles).
5. That confidential data and IT systems be implemented to promote stewardship in prescribing patterns, facilitate quality improvement practices in drug safety and effectiveness, and optimize appropriate drug plan management.

The CFMS recommends to the *Association of Faculties of Medicine of Canada* (AFMC) and medical school of Canada:

1. That Undergraduate Medical Education (UME) programs increase teaching on pharmacare.

Introduction

Canada is the only country in the world that has universal healthcare without universal prescription drug coverage. Instead of a single, national pharmacare program covering prescription drugs under uniform conditions, there is currently a patchwork system in Canada with over 100 public and 100,000 private insurance plans.¹⁻⁴ Rather than being based on medical need, coverage is highly variable, depending upon occupation, place of residence, sociodemographics, and disease status.^{1,4,5} This should not be the Canadian way.

Systematic Challenges

The current system faces health and economic challenges. The main health challenge is an existing coverage gap. Approximately 20% of Canadians are underinsured or uninsured, having to pay for prescription drugs out-of-pocket.⁶⁻⁸ Predictably, about 10% of Canadians forgo necessary prescriptions due to costs.^{1,9-11} This inequitable system has health consequences with missed prescriptions precipitating disease complications and adverse health outcomes.^{1,2}

The main economic challenge is system sustainability. In 2017, \$33.9 billion was spent on prescribed drugs dispensed outside of hospitals (i.e., outpatient drugs not covered under the Canada Health Act [CHA]), of which \$14.5 billion (42.7%) was financed publicly (through federal and provincial/territorial prescription drug plans), \$12.1 billion (35.5%) was financed through private health insurance (mostly through employment), and \$7.4 billion (21.8%) was paid for out-of-pocket.^{1,12} Drug spending accounted for 15.7% of total healthcare spending in 2017, surpassed only by hospital costs (28.3%) but ahead of physician services (15.1%). Moreover, drug expenditures were forecasted to increase by 3.2% in 2018, exceeding both hospitals and physician services.¹³ Without adequate cost-containment, the current system is arguably unsustainable,^{2,7} threatening to crowd out other services from the healthcare budget.

Pharmacare: The Way Forward

A proposed solution is the implementation of Pharmacare: single-payer, public, universal prescription drug coverage. Public and universal coverage would ensure that all Canadians receive equal access to prescription drugs at little to no direct costs. This would decrease out-of-pocket expenditures by an estimated 90%, nearly eliminating the coverage gap.^{1,14} A single-payer for the entire Canadian drug market would leverage increased purchasing power through bulk purchases of drugs at the lowest observable price. This would contribute to an estimated \$4.2 billion in savings, thus promoting system sustainability.^{14,15}

The Canadian Federation of Medical Students (CFMS) has endorsed Pharmacare through numerous position papers,¹⁶⁻¹⁹ reports,²⁰ press releases,^{21,22} and through the *Humans of Pharmacare* campaign.²³ We advocated Pharmacare to Members of Parliament in Ottawa during both the 2014 and 2016 Pharmacare Lobby Days,^{24,25} and recently during the 2019 Day of Action on Seniors Care and Aging.²⁶

We maintain that Pharmacare is the way forward. This paper includes updated literature and results of our pan-Canadian medical student survey, which provides direct responses to questions posed in the Government of Canada Advisory Council 2018 report on the Implementation of National Pharmacare—who will be covered, what drugs will be covered, and who will pay—prior to release of the Council’s final report.^{2,7} With over 760 responses across all 17 medical schools, it is clear that Canadian medical students strongly recommend Pharmacare. This is our position now and beyond.

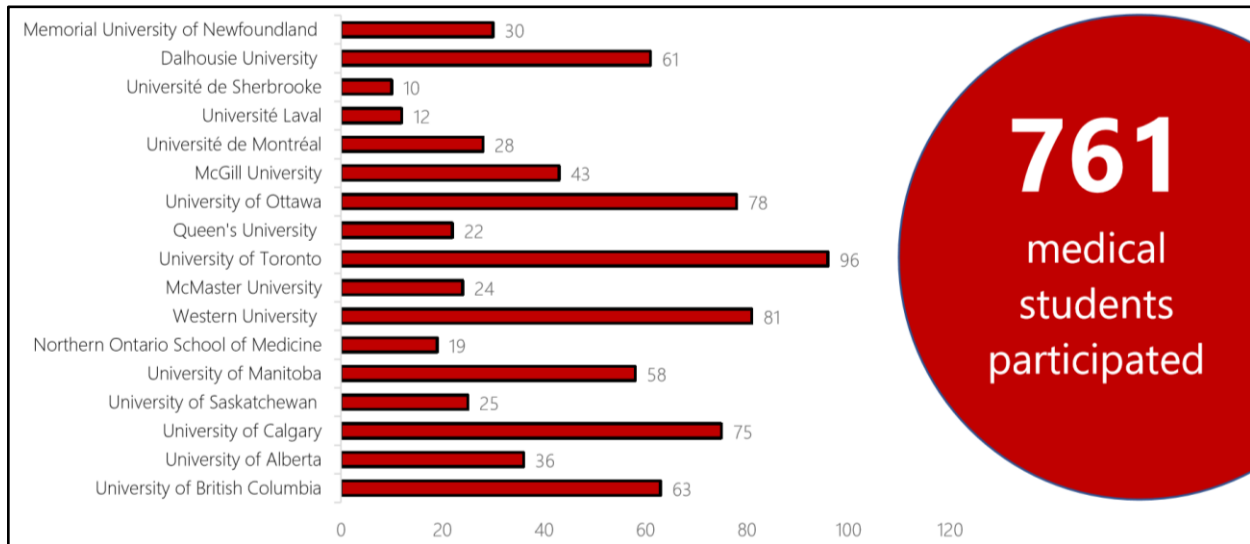


Figure 1. The number of participants categorized by each of the 17 Canadian medical schools. Students from coast-to-coast answered, with a total of 761 medical students who participated in the survey.

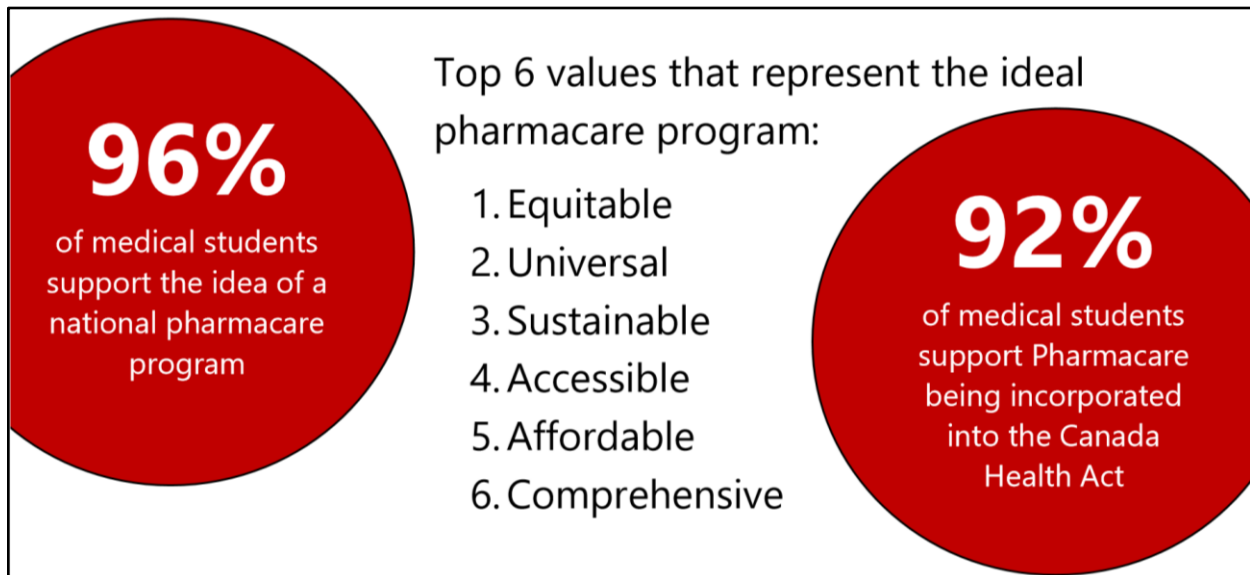


Figure 2. An overwhelming majority of medical students (96%) indicated support for a national pharmacare program, with a similarly large proportion (92%) who support Pharmacare being incorporated into the CHA. The top 6 values that medical students identified as being important to them when designing a national pharmacare program are also listed here. (N = 761)

Background

1) Positions of Major Federal Political Parties on Pharmacare

Party	Who is covered?	What drugs are covered?	Who will pay for it?
Bloc Québécois ²⁷	<p>No platform on a national pharmacare program is available.</p> <p>The party has committed to reducing the price of brand-name drugs.</p>		
Conservative Party of Canada ¹	<p>No platform on a national pharmacare program is available.</p> <p>The Party has submitted a “dissenting opinion” on the 2018 report of the House of Commons Standing Committee on Health (HESA) expressing concern for unanswered questions regarding the costs of a national pharmacare program, its impact on private insurance, and the jurisdiction of provinces.</p>		
Green Party of Canada ^{4,28,29}	All Canadians	Medically necessary prescription drugs.	<p>Single-payer funding model with a publicly accountable management agency.</p> <p>Does not support co-payments, deductibles, or other needs-based charges.</p>
Liberal Party of Canada ^{1,30,31}	All Canadians	National drug formulary through collaboration between federal, provincial, and territorial governments, including high-cost specialty drugs, oncology drugs, and drugs for rare diseases.	<p>Endorsement of a single-payer funding model.</p> <p>Recommends that the Government of Canada share the costs with provinces and territories through the Canada Health Transfer (CHT).</p> <p>The 2019 Federal Budget has pledged \$35 million over the next four years to establish the Canadian Drug Agency by working with provinces, territories, and industry stakeholders, and \$500 million a year (starting in 2022-23) on a strategy to lower drug costs for rare diseases.</p>

<p>New Democratic Party^{1,32}</p>	<p>All Canadians</p>	<p>Essential medications.</p>	<p>Endorsement of a single-payer funding model. Funding from “super-rich” taxpayers, through the recovery of \$15 billion/year from lost tax revenues and closure of tax loopholes.</p> <p>Does not endorse co-payments.</p> <p>Recommends that the federal government assume 50% of the overall costs of a national pharmacare program, with remaining costs shared between provinces and territories.</p>
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2) An International Comparison

At present, Canada’s combined public and private expenditure on pharmaceuticals is the highest per capita amongst countries in the Organization for Economic Co-Operation and Development (OECD), aside from the United States and Switzerland. When it comes to public spending (government or largely publicly funded health insurance schemes as opposed to private health insurance plans) on pharmaceuticals, Canada is among the lowest spending OECD countries, financing 36% of retail pharmaceutical spending compared to the OECD average of 57%.³³ Despite this, Canada spends more on drug coverage than other countries, spending 1.7% of GDP compared to 1.4% OECD average.³³

Given the variability in socio-demographics, geopolitical systems, and other factors amongst the 34 OECD member nations, publicly-funded drug insurance policies vary greatly. Different nations’ drug plans differ in who is covered and to what extent, strategies for cost-sharing, and policies to save on drug costs. Canada is one of the few OECD nations that does not provide universal prescription drug coverage to all of its citizens. Canada, like Israel, has a system composed of several drug insurance plans, but none are nationally available to all citizens.³⁴

In Canada and many other nations, copayment systems, where patients pay a certain amount or percentage for drugs out-of-pocket, are used. Unlike Canada however, some countries, such as England, Belgium, and New Zealand, have reduced or no payments on medications for certain medical conditions, most often chronic diseases. Some drug plans in Canada, the US, and Switzerland have implemented a monetary cap on the benefits a patient can receive during a given period.³⁴ After a cap is reached, the patient is responsible for subsequent payments. While this strategy is intended for cost-sharing, there is evidence to suggest that benefit caps are associated with an increased rate of discontinuation of medications amongst patients.³⁵

Countries such as Australia, with universal drug coverage systems, benefit from the ability to more efficiently and economically bulk purchase drugs. Compared to Canada, which spent C\$771 on drugs per capita in 2011, Australia spent almost \$200 less, at \$588. New Zealand, another country with a publicly funded universal drug coverage system, provides coverage for its residents with co-payments as low as NZ\$0 to NZ\$5 (C\$4.44) per drug per month. One of the benefits of New Zealand's universal drug coverage system is the existence of a single drug-purchasing body, which has the ability to negotiate lower prices.¹ In fact, list prices of drugs used in Canada were found to be 61% higher than the average of other high-income countries.³⁶

A key indicator for national drug coverage schemes is the reported drug underuse due to cost. According to one study, 8% of the Canadian population (2 million adults) reported that they were unable to afford one or more prescription drugs, in contrast to a rate of 23% in the United States.³⁷ When compared to 11 other OECD countries, Canada was found to have the second highest rate of drug underuse due to cost.³⁸ Collectively, Canada's current patchwork of drug coverage systems accumulates more costs than most OECD countries, yet continues to underperform compared to these other countries.

3) Who Should be Covered?

There are three main models for determining who should be covered by a national pharmacare program. Firstly, a pharmacare program can be "universal," meaning that it covers the entire population.¹ Alternatively, it can provide targeted coverage based on demographic information or situational expenses. This targeted demographic model involves covering medications for vulnerable populations (i.e., individuals with low or no income, children, seniors, etc.), which would "close the gaps" in our current system.¹ Finally, the catastrophic coverage model involves offering targeted coverage for individuals facing exceptionally high drug costs. This would result in a "safety net" for individuals facing catastrophic drug costs, irrespective of their other drug plans.³⁹ Each of these models can be further expanded and developed in different frameworks.

Universal Public Coverage

Universal coverage means that all Canadians, no matter their age, income, disease type, province/territory of residence, or other sociodemographic characteristics have access to the benefits of a national pharmacare program. A recent report by The Conference Board of Canada contains three frameworks for developing universal public coverage.⁴⁰ "Comprehensive public coverage" involves the creation of a public plan with a broad formulary, wherein the government pays for either all drug costs or a remainder of costs after co-payments. "Public coverage of essential medicines" consists of a more limited formulary with little to no cost to the patient. Similarly, "income-based deductible public coverage" includes coverage for a broad formulary and drug costs that exceed a certain threshold in proportion to income that would be financed by the government. HESA currently endorses the establishment of a universal, single-payer, public prescription drug coverage program, as this option reduces total pharmaceutical expenditures and maintains equitable access to prescription medications.¹

Targeted Demographic Coverage (“Closing the Gaps”)

The Conference Board has developed two frameworks for targeted public coverage, which allows for public and private sources of coverage while introducing publicly-funded plans to cover populations in need.⁴⁰ The first option consists of an “individual mandate,” in which all Canadians must be insured, either publicly or privately, by a provider who would be subjected to a minimum formulary and cost-sharing provisions. The second option is “optional public coverage,” where publicly funded plans with premiums would be made available to all Canadians. One major challenge for targeted demographic coverage is that it requires a huge administrative effort in order to identify those who are underinsured and require coverage. Additionally, this approach does not address the inefficiencies in the current patchwork of drug coverage.³⁹

Catastrophic Coverage (“Safety Net”)

Catastrophic coverage is designed to protect people from exceptionally high drug costs. Usually, this involves “capping” out-of-pocket expenses in proportion to the individual’s income, so that no more than a certain amount of their income will go towards prescription drug costs. As with other forms of targeted coverage, it is challenging to determine the threshold of coverage. Furthermore, this approach does not address the current problems with pricing, inaccessibility, and inequity in our current drug coverage landscape.³⁹

Summary

In conclusion, while the CHA currently ensures that all Canadians have access to medically necessary physician services and hospital care (including prescription drugs used within the hospital), it does not extend to pharmaceuticals used in the community. As a result, prescription drugs used outside of hospitals are financed by an incomplete patchwork of private and public drug plans, which leaves approximately 10% of Canadians with no coverage and an additional 11% with very limited coverage, requiring them to pay out-of-pocket for most of their prescription drug costs.^{8,41,42} Consequently, the pharmacare plan endorsed by HESA calls for the expansion of the CHA to include prescription drugs which are dispensed outside of hospitals.¹ This is particularly crucial for Canadians as 90% of pharmaceuticals are dispensed in a community setting.⁴³ A public pharmacare plan can be designed to cover all Canadians (universal public coverage) or specific groups (targeted public coverage, catastrophic coverage), with multiple frameworks available within each model.

What Do Medical Students Think?

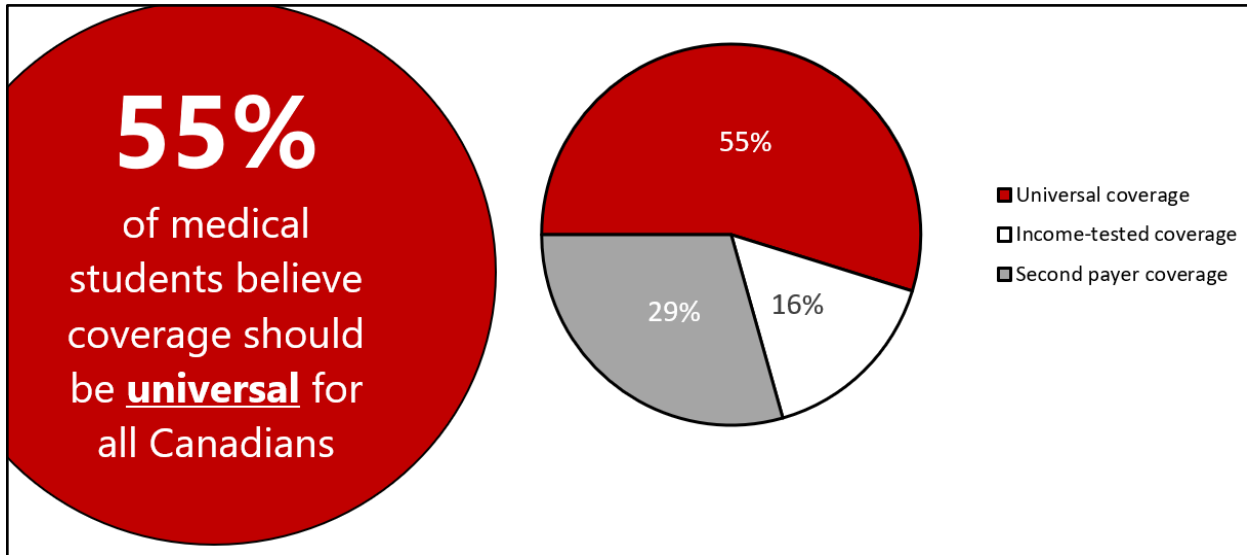


Figure 3. Who should be covered? Definitions: (1) Universal coverage: "All Canadians on uniform terms and conditions, irrespective of their ability to pay." (2) Income-tested coverage: "Only Canadians with drug expenses that exceed a certain percentage of their income." And (3) Second payer coverage: "All Canadians are covered under either private or public coverage." (N = 761)

4) What Drugs Should Get Covered?

The discussion around a comprehensive pharmacare program must consider the question of which drugs to cover. Current propositions revolve predominantly around the creation of a formulary, or a list of medications publicly-funded by Pharmacare. The contents of such a list are contentious, and permutations are wide-reaching in terms of scope of coverage. At present, all provinces cover the majority of medications and therapies in acute, or inpatient settings, but the extent of coverage in the outpatient setting is inconsistent and is particularly lacking for those outside of specific demographic categories (such as the elderly or those on social assistance). This results in inequities across provinces and demographics. As an example, patients may pay between \$74 and \$1332 out-of-pocket for their congestive heart failure medications, depending on their age and province of residence.⁴⁴ Three potential models of creating a national formulary are discussed below.

A) World Health Organization (WHO) List of Essential Medicines

The WHO list of essential medicines is a list of medications spanning the entire healthcare spectrum that the WHO has determined to be essential for the adequate provision of care to the general population.⁴⁵ This list comprises of medications from all medical specialties which are used to treat various conditions, both acute and chronic in nature. The most recent iteration, published in 2017, includes 433 different drugs.⁴⁵ Using this list of essential medicines as a basis for a national drug formulary is a potential option given that the list contains cost-effective medications that are designed to treat a wide range of medical conditions. Ideally, this list is

based on evidence, maximizing drug coverage while minimizing drug cost. However, it is important to recognize that the WHO list of essential medicines contains and omits medications not in keeping with a Canadian context. As such, it is important to customize the WHO list to best meet the needs of the general Canadian population.

A 2017 study from the University of Toronto and St. Michael's Hospital, known as the CLEAN Meds Project, proposed a refined adaptation of the WHO list of essential medications.^{46,47} The study aimed to provide a framework for the creation of a universal, essential formulary. Through a consultative approach, including a retrospective analysis of prescribing patterns of physicians in the Greater Toronto Area, an abbreviated list of 108 essential medications was derived—in comparison to the WHO's 448. The study determined that 93-96% of patients seen at these Toronto clinics would have all but one of their medications covered by this list of 108 medications. While this small study is limited to one geographic location and can only be imperfectly extrapolated to the entire country, it stands to reason that it is a more tailored fit than the WHO list given our country's unique needs, particularly in addressing the gaps in outpatient medication coverage.

A follow-up randomized controlled trial (RCT) is currently underway, assessing the economic and health outcomes of patients provided with these 108 medications free of charge as compared to the general population (i.e., the status quo). Further, a financial simulation study estimated that “adding universal public coverage of the CLEAN Meds model list of essential medicines to the existing complement of public drug plans in Canada could address most of Canadians' pharmaceutical needs and save billions of dollars annually.”^{15: p.E301} The specifics leading to this conclusion are multiple and complex, and include influential factors such as bulk purchasing power and downstream Medicare savings, among others.

B) Canadian Agency for Drugs and Technologies in Health (CADTH) Recommendation-based List

CADTH is an independent and not-for-profit pan-Canadian organization that, among other important functions, reviews Health-Canada approved medications and makes recommendations for drug coverage for federal, provincial, and territorial drug plan formularies.¹ The CADTH Common Drug Review (CDR) is an evidence-based evaluation of the safety, efficacy, and cost-effectiveness of new and existing drugs available in the Canadian market and their comparison to established gold-standard therapies.⁴⁸ Using the recommendations of the CDR would allow the federal government to develop a formulary based entirely on the most up-to-date evidence of each medication listed. Clinical efficacy and cost effectiveness analysis are determined typically through RCTs to optimize clinical impact and decrease costs. However, relatively few RCTs exist in the study of rare diseases. As such, CADTH has ongoing efforts to develop an evidence-based framework using alternative study designs to identify clinically efficacious and cost-effective medications for rare diseases.⁴⁹

CADTH currently operates on consensus between the federal government and 12 out of 13 provincial and territorial governments (Quebec is not a member of CADTH).^{1,50} It has no legislative power and can only make non-binding recommendations on the drugs to include on a

public formulary. It is the federal, provincial, and territorial governments' role to finalize their formularies,¹ and this process has the potential to be influenced by lobbying efforts from the pharmaceutical industry. In particular, confidential agreements, also referred to as Product Listing Agreements (PLAs), exist between pharmaceutical companies and provincial drug plans. The confidential nature of these PLAs result in dissimilar drug costs between provinces, and inflated prices for patients, private insurers, and less populated provinces with reduced negotiating power.⁵¹ A potential alternative to CADTH is an independent and intergovernmental drug agency with legislative power that facilitates bulk purchasing on a pan-Canadian scale and substantial discounting of safe, high quality, and cost-effective medications.

C) Provincial Formularies

Though recommendations have been made in the past to realign provincial formularies and improve consistency across the country for Canadians, studies demonstrate that these have not been widely accepted.⁵² Despite this, an assessment of which provincial formulary has been servicing its population with efficiency and good outcomes may be a mechanism for finding a common, national formulary system for Canada. The specifics need to be considered more closely, but an already existing system may prove more easily extrapolatable than creating a new formulary.

As an example, in British Columbia, the Drug Price Regulation established the Low Cost Alternative (LCA) Program and the Reference Drug Program (RDP) to regulate medication reimbursement under Pharmacare.⁵³ These programs intend to ensure the best value attainment for expenditures on multi-source drugs. This means that when the same drug is sold by two or more manufacturers, Pharmacare will cover the less costly drug version. Whereas drugs in the LCA Program include those with the same active ingredients, formulation and strength, drugs in RDP have different active ingredients but are used to treat the same medical condition. Ideally, RDP encourages cost-effective, first-line prescribing for common medical conditions by limiting reimbursement for certain drugs.⁵³

In considering the formulary options across provinces, the principle of equal access for all Canadians, regardless of province of origin or demographics, is paramount. Dr. Andreas Laupacis, the first chair of the Canadian Drug Expert Advisory Committee, once stated that; "Drug policy is a mix of scientific evidence, judgement, altruism, self-interest and politics superimposed on a complex, semi-rational, over-burdened, constantly changing healthcare system."^{54: p.1161} These multifaceted factors, both objective and subjective in nature, are what lead to the unjust inequities that a national pharmacare program addresses.

What Do Medical Students Think?

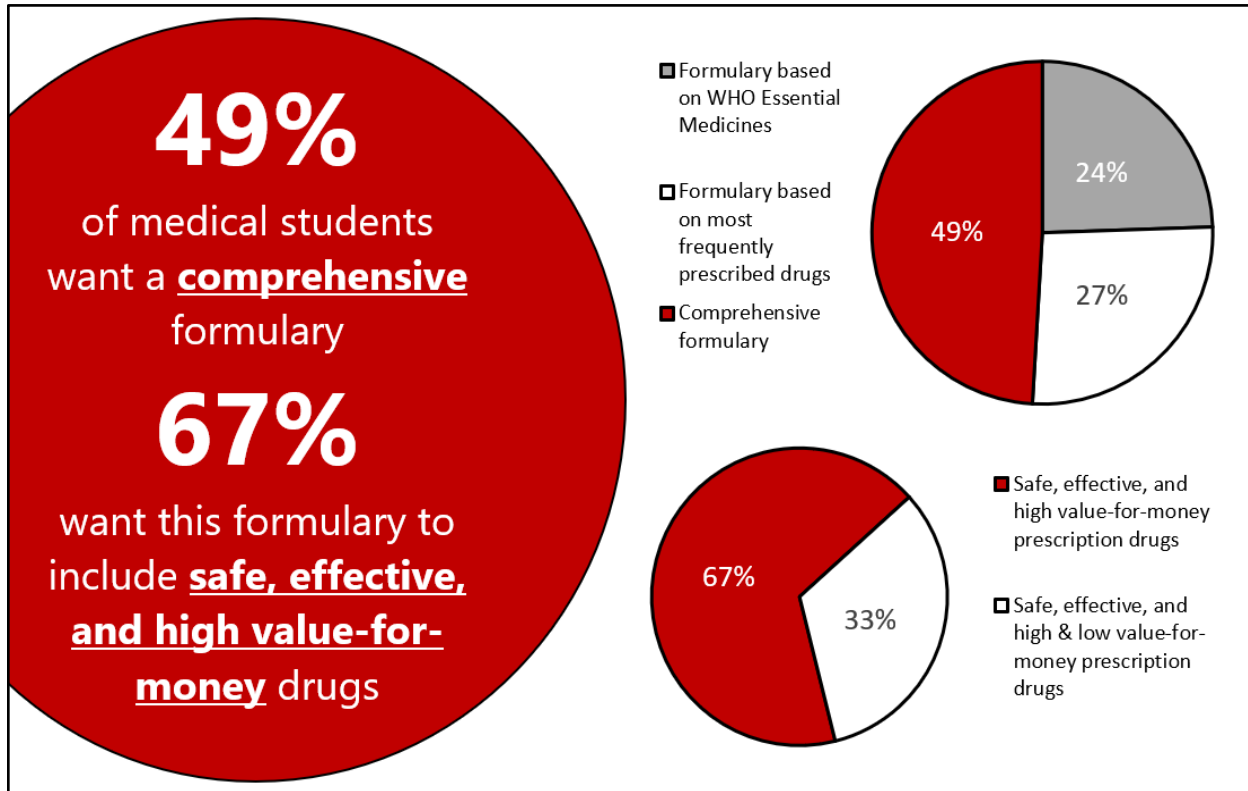


Figure 4. What drugs should be covered? Definitions: (1) Formulary based on WHO Essential Medicines: “A few hundred drugs defined by the WHO as meeting the priority health care needs of the population.” (2) Formulary based on most frequently prescribed drugs: “Drugs for a broad range of common medical conditions” and (3) A comprehensive formulary: “Drugs for the broad needs of a population, including new and high-cost drugs.” (N = 761)

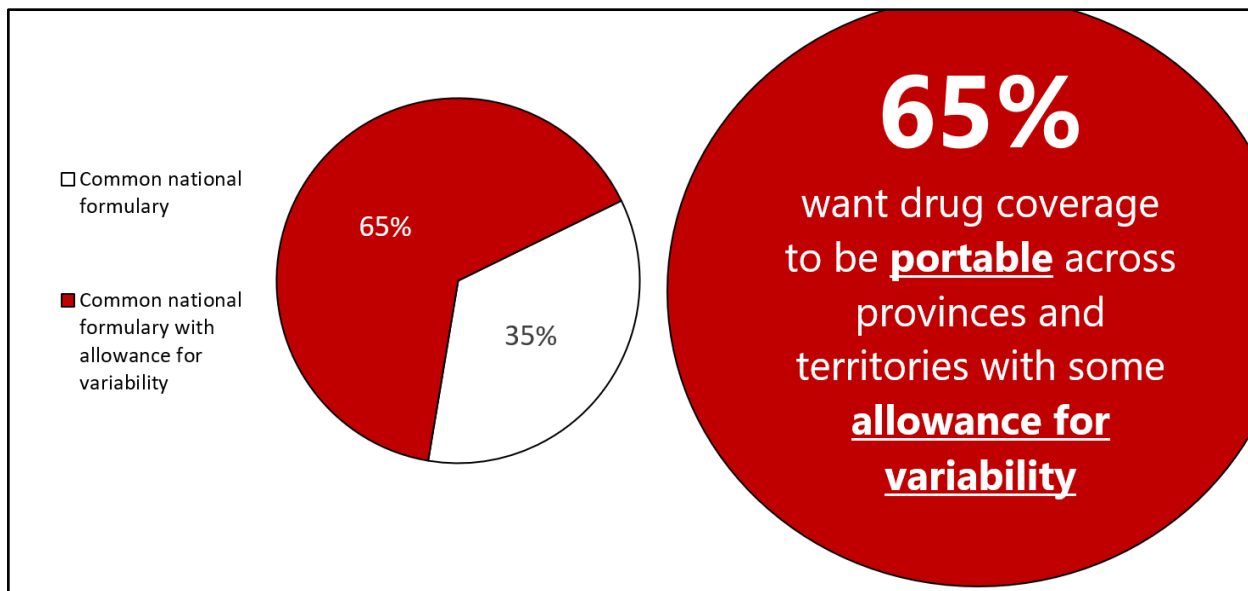


Figure 5. How much variability should there be across different drug plans or jurisdictions in the list of drugs covered by a national pharmacare plan? Perspectives on whether there should be a (1) common national formulary with no variation across drug plans or jurisdictions or (2) a common national formulary with allowance for jurisdictional differences depending on unique jurisdictional circumstances. (N = 761)

5) Who Should Pay?

A universal, first-dollar pharmacare program has been identified as the most cost-effective mode for the provision of national public drug coverage of prescription medicines.¹

The Institute of Fiscal Studies and Democracy (IFSD) issued a report in Summer 2018 on the implementation of Pharmacare where they examined some of the modes of financing of Pharmacare.³⁹ There are various funding models that have been contemplated. We have outlined the following two models:

1. Full federal funding (no cost-sharing with provinces and territories)
2. Partial federal funding (cost-sharing with provinces and territories)

A) Full Federal Funding Approach

The cost of Pharmacare was estimated in the Office of the Parliamentary Budget Officer (PBO) report in Fall 2017. It was estimated that the total cost of a national pharmacare program would be \$20.4 billion after factoring in drug pricing and consumption changes that would occur with this program.¹⁴ It was also estimated that the federal government already spends \$645 million on direct drug spending for certain populations. After accounting for an additional \$398 million in net revenues from co-payments, the net federal cost of Pharmacare was thus estimated to be \$19.3 billion.¹⁴ To fully cover this cost of a universal pharmacare program with a comprehensive formulary, the federal government could raise sufficient tax revenues by increasing the Goods and Services Tax (GST) by 2 percentage points (from the current 5% to 7%) while remaining fiscally sustainable.³⁹ Alternatively, the federal government can still be fiscally sustainable without cutting expenditures or raising incremental revenues by adopting a more limited formulary, such as the CLEAN Meds list.^{46,47}

B) Partial Federal Funding Approach

Provinces and territories are particularly wary of the financial burden of a universal pharmacare program, but they have agreed in principle at the Canadian First Ministers' Meeting in July 2018 that federal funding for Pharmacare must be long-term, adequate, secure, and flexible.³⁹ The federal government can also explore the partial funding approach, which would entail a cost-sharing mechanism with provinces and territories for the implementation of national pharmacare program through the CHT. In fact, provincial public plans already pay \$13.1 billion for prescription drugs.¹⁴ The PBO report noted that the additional gross cost of pharmacare to the public sector would be \$7.3 billion. In this partial federal funding model, we would see the \$7.3 billion to be financed from the federal government while provinces and territories continue to finance a similar amount into the new universal plan. The premiers also noted that such a program must be voluntary—that is, the provinces should have the right to opt out unconditionally, with full compensation, should the federal government finance a universal pharmacare plan.³⁹

Application of Deductibles, Co-Payments, or Co-Insurance

Many OECD countries have a system of deductibles, co-payments, co-insurance, or a hybrid thereof in the administration of a pharmacare program. The \$398 million in net revenues from co-payments arise from a modelled \$5 co-payment for all prescriptions of brand-name drugs (with categorical exemptions for certain subpopulations).¹⁴ However, studies have shown that even a small co-payment of \$5 may pose a barrier to access.^{1,55} Categorical exemptions built into the PBO's model addresses some of these disproportionate barriers to access.

Definitions:^{14: p.18}

- "Deductibles are the minimum amount of annual drug expenses paid that are not typically eligible for reimbursement under insurance plans.
- Co-payments are typically flat payments made per prescription filled and do not vary with the cost of the prescription.
- Co-insurance is usually determined as a fixed percentage of the prescription cost. Co-insurance is typical in private drug plan."

What Do Medical Students Think?

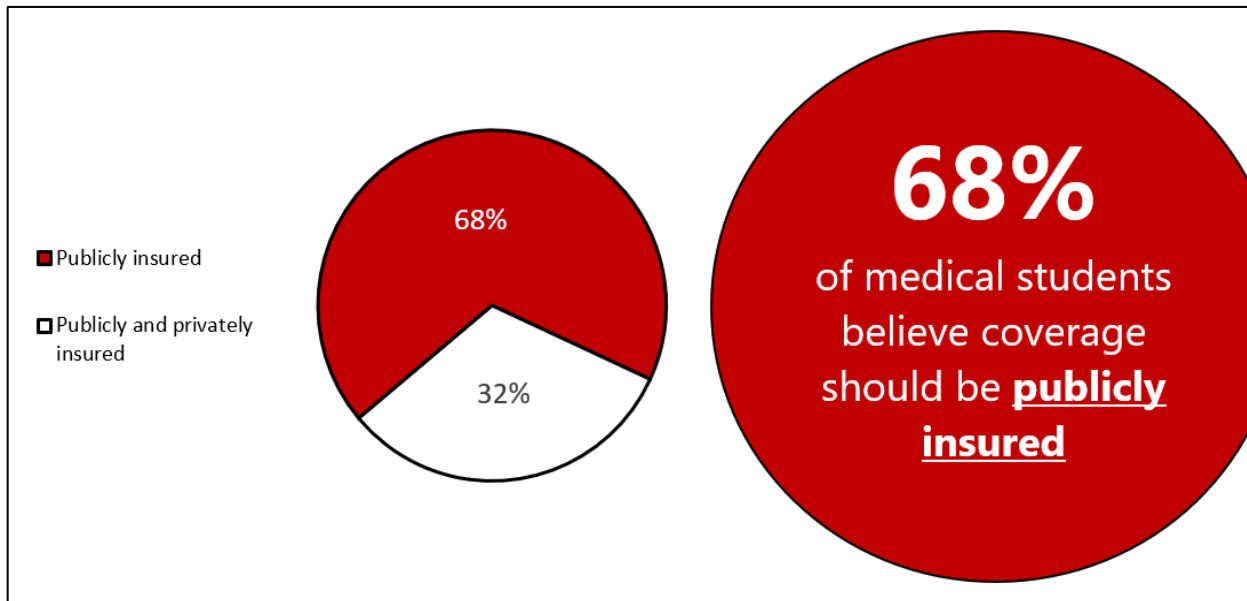


Figure 6. How should pharmacare be financed? 68% of medical students believe that a national pharmacare program should be publicly financed, decreasing financial barriers to access. (N = 761)

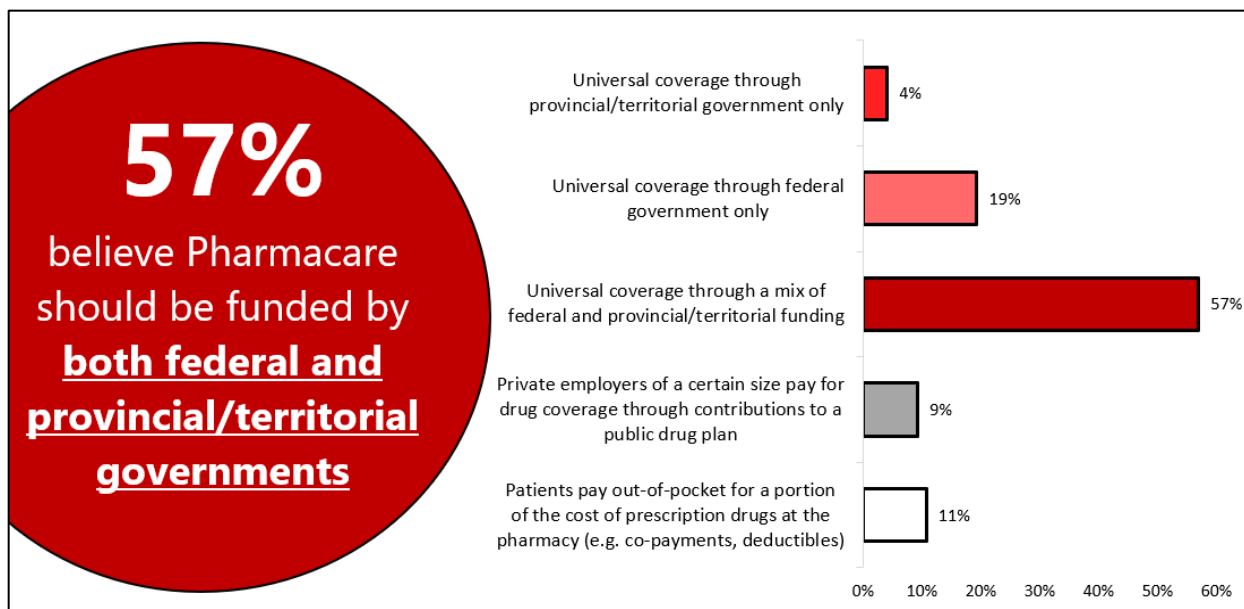


Figure 7. How should a national pharmacare program be funded? A majority of medical students agree that it should be funded by a partial, federal-provincial/territorial funding approach. (N = 761)

6) Medical Education and Pharmacare

The vision of the CFMS Pharmacare Task Force is divided into two pillars: advocacy and medical education. In our survey, we asked medical students how the teaching of a national pharmacare program is currently being delivered. From our survey, we discovered that Pharmacare is taught through various streams, the most common being formal Undergraduate Medical Education (UME) lectures (21%) and self-teaching (21%). However, almost one-quarter of students (23%) have not been taught about Pharmacare. Medical students recognize the urgency and importance of a national pharmacare program, with 87% of respondents indicating that they would like more education about this topic during medical school. This data can inform the ongoing education efforts of the CFMS in increasing exposure to new developments of a national pharmacare program.

What Do Medical Students Think?

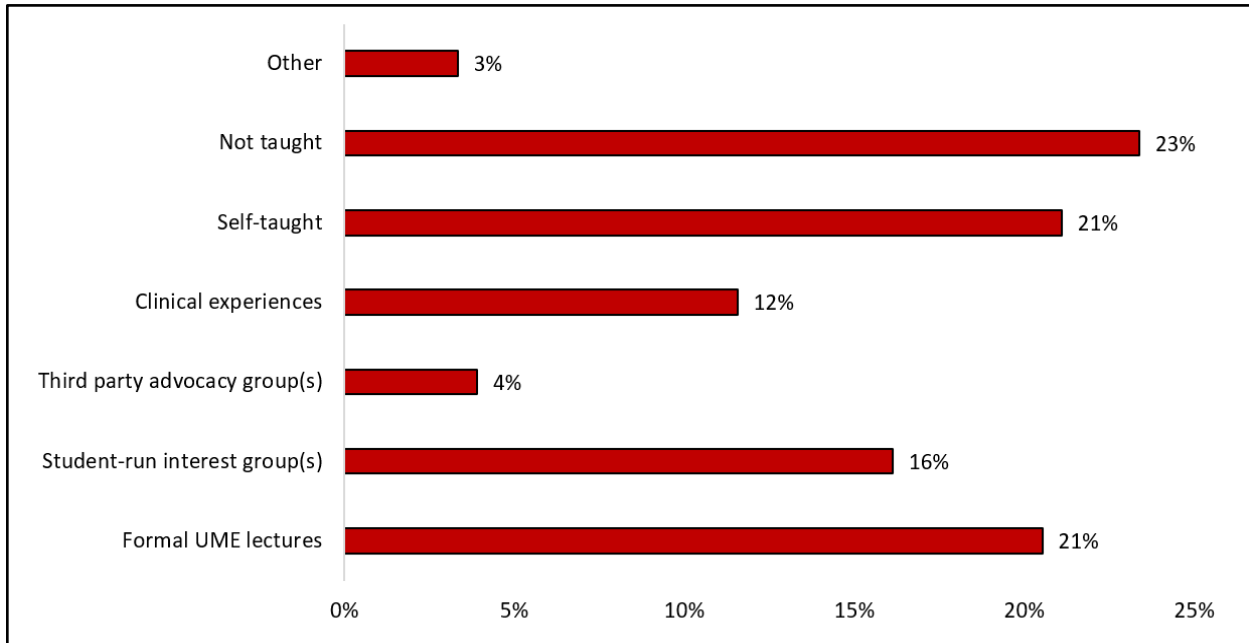


Figure 8. How has Pharmacare been taught in your medical school (check all that apply)? Many students have either not been taught about pharmacare during medical school, have taught themselves, or have been taught through formal UME lectures. “Other” responses included Pharmacare being taught in small group sessions, Case-Based Learning sessions, a ProComp session, tutorials, or as an informal teaching point during formal UME lectures. (N = 761)

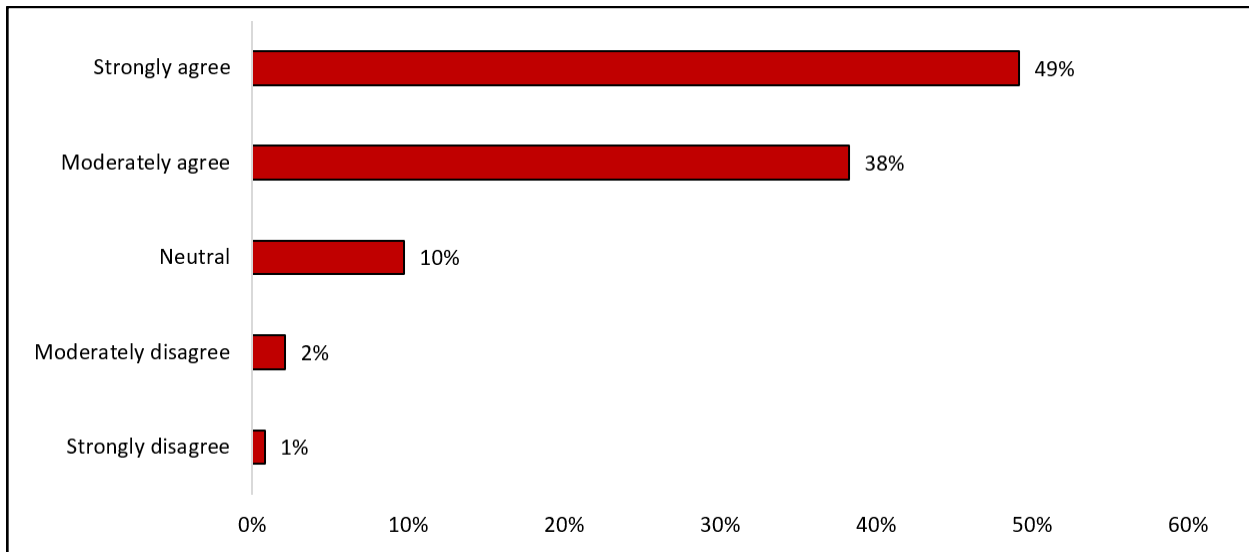


Figure 9. Would you like more teaching on Pharmacare during medical school? 87% of medical students responded that they would welcome more teaching, recognizing that a national pharmacare program is especially important in their future role as a healthcare provider. (N = 761)

Principles

The CFMS endorses the following principles in support of a successful implementation of a national pharmacare program:

1. Universal and uniform access to medically necessary prescription medications for all Canadians, with no financial, demographic, geographic, nor other barriers to access.
2. A comprehensive, evidence-based, and common national formulary that underpins access to safe, clinically beneficial, cost-effective, and emerging prescription medications.
3. A fiscally sustainable and single-payer program that is cost-shared between the federal and provincial/territorial governments.
4. A focus in undergraduate medical teaching on prescription drug stewardship.

Concerns

1. The current state of drug coverage is inequitable and does not serve every Canadian. Canadians of certain sociodemographics, particularly women, Indigenous people, and low-income patients, do not have adequate nor equal access to the medications they need, when they need them.
2. There is unjustifiable variation and incoordination of current public and private drug plans, leading to gaps in coverage for individual patients and various population groups.
3. Current drug costs are increasingly unaffordable. As public drug expenditures continue to take up greater proportions of the healthcare budget, drug financing becomes progressively more fiscally unsustainable.
4. There is a lack of data systems and Information Technology (IT) infrastructure to support the integration, surveillance, and long-term sustainability of a national pharmacare program.
5. There is a need for increased undergraduate medical teaching on pharmacare, prescription drug stewardship, prevention of inappropriate drug plan management, and polypharmacy.

Recommendations

The CFMS recommends to the *Advisory Council on the Implementation of National Pharmacare*:

1. That a universal national pharmacare program be designed and implemented.
 - a. 96% of medical students support the idea of a national pharmacare program.
 - b. 55% of medical students indicate coverage should be universal for all Canadians.
 - c. Participation of our Pharmacare Task Force in a Halifax town hall meeting with representatives from the Advisory Council indicated strong and urgent support by

the public for the development and implementation of a universal and national pharmacare program to address gaps in coverage.

2. That the federal government work in partnership with the provinces and territories to replace Canada's current private and public patchwork coverage for prescription drugs with a single-payer, universal pharmacare program that designates prescription medications as medically necessary under an amended Canada Health Act (CHA).
 - a. 92% of medical students agree with this recommendation.
3. That a national and evidence-based prescription drug formulary be developed. It should include safe and cost-effective medications, and drug coverage should be portable across all provinces and territories.
 - a. 49% of medical students want a comprehensive formulary, and 67% want this formulary to include safe, effective, and high value-for-money drugs to ensure that the program is fiscally sustainable.
 - b. 65% of medical students agree that a common national formulary should be established with allowance for variability across provinces and territories.
 - c. At a national roundtable meeting hosted by Dr. Eric Hoskins, the Pharmacare Task Force was represented alongside various community stakeholders, such as the Canadian Pharmacists Association. Many organizations agreed with Canadian medical students in that a common national formulary should be developed.
 - d. This formulary should be designed and managed by an independent and intergovernmental drug agency with legislative power, existing at an arm's length from the pharmaceutical industry. This agency should also serve to evaluate the clinical benefit, safety, and cost-effectiveness of new and existing drugs.
4. That Pharmacare be funded through the federal and all provincial and territorial governments, with no financial barriers to access for the individual patient (i.e., no co-pays, deductibles).
 - a. 68% of medical students state that a national pharmacare program should be publicly insured, rather than a mixture of public and private insurance.
 - b. 57% of medical students believe that funding for a national pharmacare program should be shared between the federal and provincial & territorial governments.
 - c. Studies by the Office of the Parliamentary Budget Officer (PBO) estimate savings of \$4 billion per year.¹⁴ Bulk purchasing of prescription drugs listed on a national formulary can lead to substantial discounting of drug prices. In addition, changes to the Patented Medicine Prices Review Board (PMPRB) in drug price regulations and reporting requirements of patented drugs are estimated to result in \$12.6 billion in savings to Canadian consumers over 10 years.⁵⁶ These savings can be progressively re-allocated towards funding costs associated with drug purchasing, administration, and information technology (IT).¹
5. That confidential data and IT systems be implemented to promote stewardship in prescribing patterns, facilitate quality improvement practices in drug safety and effectiveness, and optimize appropriate drug plan management.

The CFMS recommends to the *Association of Faculties of Medicine of Canada (AFMC)* and medical schools of Canada:

1. That Undergraduate Medical Education (UME) programs increase teaching on pharmacare.
 - a. 23% of medical students report that pharmacare has not been taught by their medical school and 21% of medical students have been self-taught about pharmacare.
 - b. 87% of medical students agree that pharmacare should be included as a key learning objective in their medical school curriculum.
 - c. This could be implemented in the form of increased education on prescription drug stewardship, monitoring of drug safety and effectiveness, and how prescription medications are financed and delivered across all provinces and territories for different patient demographic populations.
 - d. To facilitate this process, the CFMS has an integral role in advocating for the interests of medical students as its national representing body. The CFMS Pharmacare Task Force looks forward to facilitating the CFMS Advocacy Portfolio in increasing exposure to new developments on the implementation of Pharmacare. As an example, we aim to disseminate a one-pager report and infographic summarizing this position paper.

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Appendix

Survey Methods

In Winter 2019, all students enrolled in a Canadian medical school were invited to participate in our online, one-time, 10-15 minute survey “Pan-Canadian Medical Student Perspectives on a National Pharmacare Program.” Recruitment emails were sent to all representatives of the CFMS Government Affairs and Advocacy Committee (GAAC), who disseminated the survey to each of their respective medical schools using a templated introduction. Schools who did not have a GAAC representative were sent the survey by a CFMS student leader. Participation in the survey

was anonymous, confidential, and voluntary. Consent was obtained from all participants via electronic acknowledgement. As an incentive, participants were offered the chance to enter into a draw for 1 of five C\$20 gift certificates to a coffee retailer. The link for the draw was separated from the survey to preserve anonymity. The data was collected electronically and hosted on SimpleSurvey software.

Survey Measures

A five-section online survey was developed, incorporating questions from the Government of Canada Advisory Council 2018 report on the Implementation of National Pharmacare. Sections were: (1) Student Demographics, (2) Pharmacare in Medical Education, (3) Who Should Be Covered, (4) What Drugs Should be Covered, and (5) Who Should Pay. Question structure varied, and included multiple choice questions, Likert scale ratings, and free-text responses. A copy of the survey can be found in the appendix of this paper.

Statistical Analysis

Statistical analysis was conducted using Microsoft Excel.

Survey Limitations

Our survey captured responses from 761 medical students across Canada. This represents a response rate of 6.6% of the approximate 11,441 total number of currently enrolled Canadian medical students. We made numerous attempts to increase our response rate, including asking the GAAC members to distribute the survey through the CFMS Communiqué, email mailing lists, and Facebook medicine groups at their respective schools.

We acknowledge that the response rate is lower than we had hoped, and that there is also a potential for a response bias. Students who participated may have been more motivated to respond and/or are pro-Pharmacare than those who did not respond. Thus, our survey sample may be systematically different from our overall target population of all currently enrolled Canadian medical students. Despite this low response rate, we did get a large number of responses, and we believe there is still merit to the data—particularly when some of our questions produced overwhelming support for Pharmacare (e.g., 96% of medical students support the idea of national pharmacare program). Especially for these results, we are more confident that the data we collected sufficiently represents the Canadian medical student population.

Another limitation of our survey is the design of our questions and how we operationalized potentially vague concepts—deemed important to Pharmacare—into measurable variables. We were unable to conduct separate studies that would test alternative definitions of these concepts. However, our survey was designed to specifically address questions posed in the Advisory Council report. We thus based our survey questions in close alignment with the questions posed in the Council's report.

A third limitation is that medical students may have varying degrees of understanding and teaching on national pharmacare. We sought to resolve this limitation by providing a supplementary guide briefly explaining the current state of Pharmacare, the role of medical students in this issue, and the methodology of the survey. In addition, for questions that may have required some additional knowledge, such as the questions on population and drug coverage, we included information as part of the answer options for clarification.

The final limitation is that the number of medical student responses was not proportional to the total number of medical students enrolled in their respective medical school. However, students of all 17 Canadian medical schools participated and this is the only study to evaluate the perspectives of this unique voting population.

Survey Introduction

We are inviting you to complete a brief **10-minute survey** on your opinion on **Pharmacare** as a Canadian medical student. Pharmacare is a longstanding topic of debate in Canada in government, healthcare, and public discourse. Indeed, the idea of Pharmacare continues to garner significant attention, and it is suggested to be a potentially **significant topic of debate in the 2019 Canadian federal election**. <Please see this link for supplementary information>
content at the bottom of this document

Survey

Participant Demographics

1) Which medical school do you attend?

- University of British Columbia
- University of Alberta
- University of Calgary
- University of Saskatchewan
- University of Manitoba
- Northern Ontario School of Medicine
- Western University
- McMaster University
- University of Toronto
- Queen's University
- University of Ottawa
- McGill University
- Université de Montréal
- Université Laval
- Université de Sherbrooke
- Dalhousie University
- Memorial University of Newfoundland

2) How has the topic of Pharmacare been taught in your medical school? Check all that apply:

- Formal UME lectures
- Student-run interest group(s)
- Third party advocacy group(s)
- Clinical experiences
- Self-taught
- Not taught
- Other: _____

3) Pharmacare has been well-taught as part of my medical school curriculum:

- a. Strongly agree
- b. Moderately agree
- c. Neutral
- d. Moderately disagree
- e. Strongly disagree
- f. Pharmacare has not been taught during medical school.

Value-based Questions:

4) Do you support the idea of a pan-Canadian pharmacare program?

- a. Yes
- b. No

5) What values represent your idea of an ideal pharmacare program? Check all that apply.

- Equitable
- Equal
- Universal
- Comprehensive
- Portable
- Accessible
- Single payer
- Multi-payer (hybrid of single-payer/private insurance)
- Publicly-administered
- Privately-administered
- Hybrid of publicly- and privately-administered
- Affordable
- Sustainable
- Timely
- Effective
- Other(s): _____

Operational-based Questions:

6) The Canada Health Act (CHA) currently specifies the conditions and criteria for universal coverage of all medically necessary hospital and physician services. Should Pharmacare be incorporated into the CHA?

- a. Yes
- b. No

Who should be covered?

7) Who should be covered?

- a. Universal coverage: All Canadians on uniform terms and conditions, irrespective of their ability to pay.
 - Individuals with current private insurance drug plans would become covered by a public plan
 - Governments would absorb costs that are currently paid through private insurance and out-of-pocket spending.
- b. Income-tested coverage: Only Canadians with drug expenses that exceed a certain percentage of their income.
 - Provides increased flexibility for governments to adjust the threshold of coverage based on budgets
 - Lower equity and ability to reduce drug costs.
- c. Second payer coverage: All Canadians are covered under either private or public coverage.
 - Employers of a certain size provide private coverage to their employees.
 - Public subsidies cover those without access to private drug coverage.

8) How should a national pharmacare plan be delivered?

- a. Through public health insurance, similar to how existing hospital and physician services are delivered
- b. Through a mix of public and private insurance, similar to existing drug coverage

What drugs should be covered?

9) What drugs should be covered?

- a. Formulary based on WHO Essential Medicines
 - A few hundred drugs defined by the World Health Organization (WHO) as meeting the priority health care needs of the population. These drugs should be available at all times in adequate amounts and at a price the individual and the community can afford.
 - PROS: Ensures that all Canadians have access to a basic list of medicines.
 - CONS: this would not cover the full complement of drugs currently used in our healthcare system nor would it address the challenges of newer and higher cost drugs.

B. Formulary based on most frequently prescribed drugs

- Drugs for a broad range of common medical conditions (e.g. diabetes, hypertension, hyperlipidemia, etc.)
- PROS: Ensure that all Canadians have similar access to the most commonly prescribed drugs.
- CONS: Would not address the challenges of newer and/or higher cost drugs

c. A comprehensive formulary

- PROS: Ensures greater equity in coverage and augments bulk purchasing power across a wider range of drugs, including many of the newer and higher cost drugs as well as drugs for rare diseases.
- CONS: Higher cost for a comprehensive drug plan.

10) Which drugs should a national pharmacare plan cover?

- Only effective and safe prescription drugs that have good evidence of value for money (Less costly approach, but provides fewer options for some patients)
- The aforementioned drugs plus effective and safe prescription drugs that have less evidence of value for money (More costly approach, but provides more options for some patients)

11) How much variability should there be across different drug plans or jurisdictions in the list of drugs covered by a national pharmacare plan?

- There should be a common national list (no variation across drug plans or jurisdictions)
- There should be a common national list but with allowance for some variability depending on unique jurisdictional circumstances

Who should pay?

12) Who should pay? Check all that apply.

- The Canadian government & taxpayer
- Patients
- Private employers of a certain size

13) How should a national pharmacare plan be funded?

- Universal coverage through Federal government/taxpayers only
- Universal coverage through Provincial government/taxpayers only
- Universal coverage through a mix of federal and provincial (taxpayer) funding
- Patients pay out-of-pocket for a portion of the cost of prescription drugs at the pharmacy (e.g. co-payments, deductibles)
- Private employers of a certain size pay for drug coverage through contributions to a public drug plan

14) We welcome any questions or further comments that you'd like to share, especially if you did not answer or were unsure of how to answer a question.

<COMMENT BOX>

Thank you for your participation.

Supplementary Information on Pharmacare Survey

What is Pharmacare?

Pharmacare is national public health insurance program that provides all individuals in a country with access to prescription drugs under uniform terms and conditions. Canada does not currently have a national pharmacare plan, and although the majority of Canadians have some form of prescription drug coverage, widespread variability leaves many households facing cost barriers when filling their prescriptions. Thus, Canada continues to broadly consider the implementation of a national pharmacare program, but with many unresolved questions about the specific details. Although a number of options have been proposed and studied, no decisions on a specific model or approach have yet been made. A key to enabling the government to make an informed decision is to understand what works best for Canadians.

Why should you care?

As fellow medical students, we believe that we are no doubt **stakeholders** in this hot topic. However, our **collective voice has been missing** from the public discourse. Many of us have our own stories regarding issues with prescription drug coverage prior to medical school, and **these issues will undoubtedly touch us all as we become future frontline healthcare providers.**

Who is conducting this survey?

This survey is being conducted by a group of pan-Canadian medical students who are representatives of the Canadian Federation of Medical Students (CFMS) Pharmacare Task Force. Many of the questions in this survey are based on a discussion paper that was published by the Advisory Council on the Implementation of National Pharmacare. This council was established in Budget 2018 to consult relevant stakeholders, to ultimately provide options to the federal government on how to move forward. Their report is due by spring of 2019, meaning that the results of this survey are timely. These results will be incorporated into a position paper that the Task Force is currently working on and hopes to have tabulated and approved at the CFMS Spring General Meeting 2019. The results may also be used in future advocacy work.

The information that you provide will have NO impact on you as a student. There are no questions with personal identifiers so you will not be identified as a participant, and encrypted data will be aggregated at the school and national level. The completed surveys will be stored in an encrypted file on password-protected computer at Dalhousie University for five years after publication of the results. Thus, there are minimal risks associated with your participation.

By completing this survey, you are indicating that you have read and understood its scope and that you consent to participate. You may answer as many or as few questions as you feel

comfortable. Should you have any questions regarding the survey, please speak with the Pharmacare Task Force leads: Bartosz Orzel (br720600@dal.ca) or Hilary Pang (hilary.pang@mail.utoronto.ca).

References:

Advisory Council on the Implementation of National Pharmacare. (2018). *Towards Implementation of National Pharmacare*. Ottawa, ON: Health Canada.

Introduction du sondage

Un court sondage sur les perspectives des étudiants en médecine sur un régime d'assurance-médicaments au Canada

Nous vous invitons à compléter un court sondage d'une dizaine de minutes sur votre opinion concernant un régime d'assurance-médicaments en tant qu'étudiants en médecine au Canada. L'assurance-médicaments est depuis longtemps un sujet de débats au Canada au sein du gouvernement, du système de santé et du grand public. En effet, l'idée de l'assurance-médicaments continue de recueillir une attention considérable et ce sera potentiellement un **important sujet de débats aux élections fédérales canadiennes de 2019**. <Veillez visiter ce lien pour davantage d'informations> *joint à la fin de ce présent document*

Sondage

1) Dans quelle école de médecine étudiez-vous?

- University of British Columbia
- University of Alberta
- University of Calgary
- University of Saskatchewan
- University of Manitoba
- Northern Ontario School of Medicine
- Western University
- McMaster University
- University of Toronto
- Queen's University
- University of Ottawa
- McGill University
- Université de Montréal
- Université Laval
- Université de Sherbrooke
- Dalhousie University
- Memorial University of Newfoundland

2) Comment le sujet d'assurance-médicaments a-t-il été enseigné dans votre école de médecine?
Cochez toutes les cases:

- Cours magistraux formels
- Groupe(s) d'intérêts gérés par des étudiants
- Groupe(s) de pression tiers
- Expériences cliniques
- Auto-apprentissage
- Non enseigné
- Autres : _____

3) Le régime d'assurance-médicaments a bien été enseigné au travers le curriculum de mon école de médecine :

- a. Fortement d'accord
- b. Modérément d'accord
- c. Neutre
- d. Modérément en désaccord
- e. Fortement en désaccord
- f. Le régime d'assurance-médicaments n'est pas enseigné dans mon école de médecine.

Questions sur les valeurs:

4) Soutenez-vous l'idée d'un régime d'assurance-médicaments pancanadien?

- a. Oui
- b. Non

5) Quelles valeurs représentent votre idée d'un régime d'assurance-médicaments idéal? Cochez tout ce qui s'applique.

- Équitable
- Égal
- Universel
- Complet
- Transférable
- Accessible
- À payeur unique
- À payeurs multiples (un hybride de payeur unique/assurance privée)
- Géré publiquement
- Géré par le privé
- Hybride de gestion publique et gestion privée
- Abordable
- Durable
- Avec délais convenables
- Efficace
- Autre(s) _____

Questions sur les operations:

6) La Loi canadienne sur la santé (LCS) précise présentement les conditions et critères pour une couverture universelle de tous les services hospitaliers et de médecins médicalement essentiels. Le régime d'assurance-médicaments devrait-il être intégré à la LCS?

- a. Oui
- b. Non

Qui devrait être couvert?

7) Qui devrait être couvert?

- a. Couverture universelle : Tous les Canadiens selon des modalités uniformes, peu importe leur capacité à payer.
 - Les personnes qui ont présentement un régime d'assurance-médicaments privé seraient couvertes par un régime public.
 - Les gouvernements absorberaient les coûts qui sont présentement payés à travers une assurance privée et par les patients.
- b. Couverture fondée sur le revenu : Seulement les Canadiens avec des dépenses en médicaments qui dépassent un certain pourcentage de leur revenu.
 - Procure une flexibilité accrue aux gouvernements pour ajuster le seuil de couverture en fonction des budgets.
 - Moins d'équité et de possibilité de réduire les coûts des médicaments.
- c. Couverture par un deuxième payeur : Tous les Canadiens sont couverts par un régime soit privé soit public.
 - Les employeurs d'une certaine dimension procurent une couverture privée à leurs employés.
 - Des subventions publiques couvrent ceux qui n'ont pas accès à un régime d'assurance privé.

8) Comment un régime national d'assurance-médicaments devrait-il être octroyé?

- a. À travers le régime d'assurance maladie, semblable à la façon dont sont présentement offerts les services d'hôpitaux et de médecins
- b. À travers un mélange d'assurance publique et privée, semblable à la façon dont sont couverts les médicaments présentement

Quels médicaments devraient être couverts?

9) Quels médicaments devraient être couverts?

- A. Formule basée sur les médicaments essentiels tels que définis par l'OMS
 - Quelques centaines de médicaments qui, selon l'Organisation mondiale de la santé (OMS), satisfont aux besoins de santé prioritaires de la population. Ces médicaments devraient être accessibles en tout temps en quantités suffisantes et à un prix abordable pour l'individu et la communauté.

- POUR : Assure que tous les Canadiens aient accès à une liste de médicaments d'ordonnance de base.
- CONTRE : Ceci ne permettrait pas de couvrir la totalité des médicaments d'ordonnance actuellement utilisés dans notre système de santé, ni d'aborder les problèmes des médicaments plus nouveaux ou plus coûteux.

B. Formule basée sur les prescriptions les plus fréquentes:

Médicaments d'ordonnance pour une large gamme de conditions médicales courantes (diabète, hypertension, hyperlipidémie, etc.)

- POUR: Assure que tous les Canadiens aient un accès semblable aux médicaments d'ordonnance les plus fréquemment prescrits
- CONTRE: N'aborderait pas les problèmes associés avec les médicaments plus nouveaux et/ou plus coûteux

C. Une formule complète

- POUR: Assure une meilleure équité de couverture et augmente le pouvoir d'achat collectif pour une plus grande variété de médicaments, incluant plusieurs nouveaux médicaments à coûts plus élevés ainsi que des médicaments pour les maladies rares.
- CONTRE: Coûts plus élevés pour un plan d'assurance complet

10) Quels médicaments le plan devrait-il couvrir?

- a. Seulement les médicaments efficaces et sécuritaires, qui ont une base d'évidence solide pour leur rapport qualité-prix (approche moins coûteuse, mais offre des options plus limitées aux patients)
- b. Les médicaments ci-dessus ainsi que les médicaments sécuritaires et efficaces pour lesquels il existe moins de données qui prouvent leur bon rapport qualité-prix (approche plus coûteuse, mais qui offre plus d'options aux patients)

11) Quel degré de variabilité devrait-il y avoir à travers différents plans d'assurance ou juridictions par rapport à la liste de médicaments couverts par un régime national d'assurance-médicaments?

- a. Il devrait y avoir une liste nationale commune ne permettant aucune variation entre les différents régimes d'assurance-médicaments ou entre les juridictions.
- b. Il devrait y avoir une liste nationale commune, mais permettant un certain degré de variabilité dépendamment des circonstances uniques des juridictions.

Qui devrait payer?

12) Qui devrait payer? Sélectionner tous ceux qui s'appliquent.

- Le gouvernement canadien et les payeurs de taxes
- Les patients
- Les employeurs privés d'une certaine taille

13) Comment un plan national d'assurance-médicaments devrait-il être financé?

- a. Couverture universelle par le gouvernement fédéral/payeurs de taxes seulement
- b. Couverture universelle par le gouvernement provincial/payeurs de taxes seulement

- c. Couverture universelle par le gouvernement fédéral et provincial (payeur de taxes)
- d. Les patients paient de leur propre poche pour une portion des coûts des médicaments d'ordonnance à la pharmacie (ex : quotes-parts ou déductibles)
- e. Les employeurs privés d'une certaine taille paient pour la couverture de médicaments en contribuant à un régime public

14) Nous accueillons toutes questions ou commentaires que vous aimeriez partager, particulièrement si vous n'avez pas répondu à l'une des questions précédentes ou si vous étiez incertain(e) de comment y répondre.

< BOÎTE À COMMENTAIRES >

Merci pour votre participation.

Informations supplémentaires sur le sondage d'assurance-médicaments

Qu'est-ce que l'assurance-médicaments?

L'assurance-médicaments est un programme d'assurance de santé publique national qui offre à tous les individus dans un pays un accès aux médicaments d'ordonnance sous des termes et conditions uniformes. Le Canada n'a pas présentement de régime d'assurance-médicaments national, et bien que la majorité des Canadiens possède une forme d'assurance pour médicaments, une grande variabilité laisse plusieurs familles faire face à des coûts élevés lorsqu'ils remplissent une ordonnance. Ainsi, le Canada continue de considérer l'implémentation d'un régime national d'assurance-médicaments, mais avec plusieurs questions non résolues sur les détails spécifiques. Malgré le grand nombre d'options qui ont été proposées et étudiées, aucune décision sur un modèle ou une approche spécifique n'a été réalisée. Une clé pour permettre au gouvernement de prendre une décision éclairée est de comprendre ce qui fonctionne le mieux pour les Canadiens.

Pourquoi devriez-vous vous en soucier?

En tant qu'étudiantes et étudiants en médecine, nous croyons que nous sommes incontestablement **partie prenante** à ce sujet. Par contre, notre **voix collective a été absente** du discours public. Plusieurs d'entre nous avons nos propres histoires par rapport aux problèmes avec l'assurance des médicaments d'ordonnance avant d'entrer en médecine, et **ces questions vont sans doute tous nous toucher alors que nous devenons de futurs fournisseurs de soins de santé de première ligne.**

Qui mène ce sondage?

Cette enquête est menée par une équipe d'étudiants en médecine pancanadienne qui représente le Groupe de travail sur le régime d'assurance-médicaments de la FEMC. Plusieurs questions incluses dans ce sondage sont basées sur un document de réflexion publié par le Conseil consultatif sur la mise en œuvre d'un régime national d'assurance-médicaments. Ce conseil fut

établi par le Budget 2018 pour consulter les parties prenantes appropriées afin de suggérer des options au gouvernement fédéral pour pouvoir aller de l'avant. Leur rapport final est dû au printemps 2019, donc les résultats de ce sondage arriveront à un temps opportun. Ces résultats seront incorporés dans un exposé de position que le Groupe de travail est en train de rédiger, dans l'espoir de le compiler et de le faire approuver à l'Assemblée générale de la FEMC au printemps 2019. Les résultats du sondage pourront aussi être utilisés pour de futurs projets de plaidoyer.

L'information que vous partagez n'aura AUCUN impact sur vous en tant qu'étudiant. Il n'y a pas de questions avec des identificateurs personnels donc vous ne serez pas identifié comme participant, et les données chiffrées sont groupées par école et à l'échelle nationale. Les questionnaires complétés seront sauvegardés en format crypté sur un ordinateur protégé par mot de passe à l'Université de Dalhousie pendant 5 ans après la publication des résultats. Par conséquent, les risques de votre participation sont minimes.

En complétant ce sondage, vous indiquez que vous avez lu et compris son étendue et que vous consentez à y participer. Vous pouvez répondre à autant ou à aussi peu de questions que vous vous sentez en mesure de faire. Si vous avez des questions par rapport au sondage, s'il-vous-plaît vous adresser aux dirigeants du Groupe de travail sur le régime d'assurance-médicaments: Bartosz Orzel (br720600@dal.ca) ou Hilary Pang (hilary.pang@mail.utoronto.ca).

Références:

Conseil consultatif sur la mise en œuvre d'un régime national d'assurance-médicaments. (2018). *Vers la mise en œuvre d'un régime national d'assurance-médicaments*. Ottawa, ON: Santé Canada.