Response to the Discussion Paper *Toward Implementation of National Pharmacare*

Diabetes Canada

Submitted to the Advisory Council on the Implementation of National Pharmacare

September 28, 2018

Executive Summary

As the registered national health charity representing almost 11 million people with diabetes or prediabetes, Diabetes Canada is well aware of how important the issue of access to medications is to people living with chronic illness. Many Canadians struggle to procure appropriate medications, devices and supplies in a fair and timely manner, to the detriment of their health. A better system is within reach.

To this end, Diabetes Canada makes the following recommendations for consideration to the Advisory Council on the Implementation of National Pharmacare:

1. All people in Canada should have access to the medicines they need. Most urgently, this includes patients who do not have coverage or have insufficient coverage through the public and private plans.
2. National pharmacare should value the health of all Canadians.
3. A national pharmacare approach, whether it is public, private, or a mix of both, should be equitable, affordable and sustainable. It should provide appropriate therapies in a timely manner. It should allow people with coverage to retain it, and ideally should enhance coverage. For those without, it must improve access. The approach should be person-centric, responsive to patient needs, improve health outcomes and add value to the system.
4. The Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada and other evidence-based guidelines should form the basis of a medication formulary (or formularies).
5. Insulin, as a life-sustaining medication, should be available at no cost to people of all ages living with type 1 diabetes, if they cannot afford it.
6. A national pharmacare approach must be created to support patient and provider choice and individualized disease management, while promoting cost-effective therapy.
7. Applications for treatments that fall outside regular reimbursement criteria should not be overly complicated or arduous for providers or patients to complete. They should be processed in a timely manner and the adjudication processes for formulary exceptions should be fair, consistent and transparent.
8. Drug review processes, and the organizations that conduct them, should put patients first.
9. A national pharmacare approach should provide access to medications, as well as necessary devices and supplies.
10. A national pharmacare approach should be comprised of the greatest components of the current systems and ensure something equal to, or better than, what they currently have. The system should be crafted to appeal to the provinces, whose jurisdiction over healthcare and pharmacare delivery should be respected.
11. The NIHB plan must be enhanced to improve access to medications, devices and supplies for people living with diabetes.
12. Co-pays, deductibles and premiums for medications should be applied to Canadians in a manner that is income-sensitive and does not place patients in the difficult position of having to choose between the necessities of life and their health.
13. Employers can help to promote general wellness, as well as prevent and manage diabetes, in a variety of ways.
14. The federal Ministers of Health and Finance should support Diabetes 360° (www.diabetes.ca/strategy).

Introduction

Every Canadian has experienced illness in one form or another over the life course. Access to the right therapies is critically important to people with disease. Among those living with a chronic condition, 90% take at least one prescription drug and 54% take four or more.[1] Appropriate treatment, including medications, is the gateway to good health, which is why Canadians have a large stake in how and when medications are procured, prescribed, dispensed and utilized in our country.

Diabetes Canada represents a large community of people who live with disease, many of whom rely on medications to manage their condition and achieve a better quality of life. Approximately 3.5 million Canadians in 2018 have been diagnosed with diabetes.[2] Someone new receives a diagnosis every three minutes. Another 1.5 million are living with the condition but do not know it. [2] And close to 6 million people across the country have prediabetes.[2] In total, about 28% percent of the entire population of Canada is directly impacted by diabetes or prediabetes[2], and countless family members, colleagues and friends are implicated by association.

About diabetes

Diabetes is a chronic, progressive disease in which the body has difficulty regulating the amount of glucose (sugar) in the blood. Elevated levels of blood glucose over time can lead to organ, blood vessel and nerve damage. Diabetes-related complications are potentially very serious and sometimes even life-threatening. The lifespan of someone with diabetes can be reduced by as much as five to 15 years.[3]

The disease manifests itself in different forms. Type 1 diabetes is an autoimmune condition that causes the body to destroy its insulin producing cells, resulting in a dangerous accumulation of glucose in the blood. Exogenous insulin delivered via multiple daily injections or infusion is required to normalize blood glucose levels and sustain life. People with type 1 diabetes must also carefully monitor lifestyle habits in order to manage their condition. Type 1 diabetes has no known cause or cure and makes up about five to 10 percent of diabetes cases.

About 90 percent of people with diabetes have type 2 diabetes. It is caused by a combination of genetic, lifestyle and environmental factors. Type 2 diabetes occurs when glucose increases to an abnormal level in the blood because the body does not make enough insulin or cannot properly use the insulin that is produced. There are several risk factors, such as age, ethnicity and medical history, that predispose certain groups of people to type 2 diabetes. It is treated with education, support and lifestyle modification, with one or more oral and/or injectable medications often acting as an important adjunct to therapy.

A third type of diabetes, gestational diabetes, is a temporary condition that occurs in pregnancy. When gestational diabetes is not well controlled, the risk to the mother and child of developing various health issues increases significantly. It is treated with lifestyle modification and medication, usually insulin. It affects approximately two to four percent of all pregnancies

(in the non-Indigenous population)[4] and involves an increased risk of developing diabetes for both mother and child in the post-partum years.

Prediabetes is a state in which blood glucose rises to levels that are higher than normal, but not sufficiently high to constitute a diagnosis of type 2 diabetes. If left untreated, more than half of people with prediabetes will go on to develop type 2 diabetes within eight to 10 years.[4]

The problem

Diabetes prevalence in Canada has doubled over the last decade.[2] This distressing trend is being attributed to the fact that Canada has an aging and ethnically diverse population, high levels of overweight and obesity, and environments that promote sedentary and unhealthy behaviours. Once a disease of adulthood, type 2 diabetes is now being observed and diagnosed in younger cohorts, impacting people in the prime of life. At age 20, Canadians today face a 50 percent chance of developing the disease in their lifetime.[5] For First Nations Peoples, that risk is up to 80 percent and in some subgroups within this population, it is even higher.[5]

Rates of diabetes are alarming, and ever rising. With about 1 in 3 people living with diabetes or prediabetes today, Canada is facing a disease epidemic. By 2028, it is estimated that over 13 million Canadians, or 32% of the population, will have diabetes or prediabetes.[2]

Diabetes, the healthcare system and pharmacare

Diabetes treatment and care in Canada comes at a staggering cost in terms of financials, but also to human life. Chronic disease, including diabetes, is the leading cause of disability and premature death in Canada.[6] Diabetes contributes to 30 percent of strokes, 40 percent of heart attacks, 50 percent of kidney failure requiring dialysis, 70 percent of non-traumatic leg and foot amputations, and the largest proportion of cases of blindness in people under the age of 50.[4] The full cost of diabetes to the healthcare system in 2018 is estimated to be around $27 billion.[4] If disease proliferation continues, by 2028, the price will exceed $39 billion[4] and could bankrupt our entire healthcare system.

Gaps in care and inaccessible treatments are contributing significantly to the escalating prevalence and systems cost of diabetes in Canada. Many Canadians struggle to pay not only for their medications, but also the devices and supplies they need to maintain their health. High cost limits access and can make diabetes self-management very difficult. Access through public coverage is highly dependent on a person’s age, income and health history. It also varies across jurisdictions. Private insurance helps offset the cost of medications for many Canadians, but some do not have insurance and illness can make it difficult to obtain.

All people living with type 1 diabetes and most living with type 2 diabetes require medication to live, with many relying on several different prescriptions medications for disease management. A 2011 Statistics Canada survey showed that 32% of people with diabetes take

three to four medications, 40% take five to nine medications, and 12% take 10 medications or more.[7]

Diabetes medications can be very expensive, which can affect a patient's ability to follow his/her prescribed regimen. In a Diabetes Canada survey from 2015, 25 percent of all people with diabetes indicated treatment adherence was affected by cost.[7] Forty percent of those earning less than $35,000 a year felt they were unable to follow through with their treatment because of cost.[7] Forty-five percent of those people reported that they had to choose between paying for food/rent/utilities and buying medication.[7] Eighteen percent said they did not fill their prescriptions or take medications because they were too costly.[7]

Some people deliberately do not take their medications as indicated, opting instead to decrease their daily dose or reduce their frequency (e.g. take their medications every second day) in order to make their prescriptions last longer so they are more affordable. Often doses can be reduced without any immediate impact on health and well-being, however, in doing so, people greatly increase the risk of long-term complications.

People living with type 1 diabetes can pay, on average, up to 17 percent of their annual income on diabetes. Public reimbursement accounts for about 19 percent to 78 percent of diabetes treatment costs, depending on age, income, and recommended management strategy.[7] People living with type 2 diabetes typically pay, on average, up to nine percent of their annual income on diabetes. Public reimbursement accounts for about five percent to 64 percent of diabetes treatment costs.[7] Those earning the lowest amount typically pay the greatest percentage of their salary to self-finance care. Out-of-pocket costs that exceed three percent, or $1,500 of a person's annual income, are defined as catastrophic drug costs by the Kirby and Romanow Commissions on healthcare. By this definition, the majority of people with diabetes in Canada face catastrophic drug costs.

A recent survey reported that 15 percent of Canadians with diabetes did not have private insurance to pay for their prescription medications, while 30 percent had no insurance coverage for the cost of equipment or supplies to monitor blood glucose.[7] About 18 percent of people with diabetes reported having difficulty getting insurance because of their disease.[7] People who earn a low income are the most affected when it comes to difficulty obtaining insurance, compared to those earning a higher income.[7] The largest percentage of the uninsured live in Atlantic Canada[7], where diabetes rates are among the highest in the country.

Diabetes Canada's response

Diabetes Canada applauds the federal government for creating the Advisory Council for the Implementation of National Pharmacare ('the Advisory Council') and for tasking it with the mandate of thoroughly studying national pharmacare with a view to providing recommendations to the Ministers of Health and Finance on its execution. We are pleased that a variety of consultations have been undertaken in various forms to date. The Advisory Council

has been active in soliciting the input of a broad range of stakeholders from coast to coast to coast, and Diabetes Canada commends it for these efforts.

In addition to preparing this written submission, Diabetes Canada, its members and constituents have been actively contributing to the national pharmacare dialogue in the following ways:

1. Diabetes Canada staff members and patient advocates participated in roundtable discussions and community fora in Toronto, Fredericton, Vancouver, Ottawa, Thunder Bay and Regina. The organization provided nominees for the Advisory Council secretariat's consideration to attend consultations in Winnipeg, Edmonton, Halifax, Charlottetown, St. John's and Whitehorse.
2. Through its social media channels, Diabetes Canada has encouraged members of the diabetes community to provide feedback on national pharmacare by responding to the Advisory Council's online questionnaire, preparing a written submission in response to the government's discussion paper and signing up to be part of the online forum.

Discussion questions from *Toward Implementation of National Pharmacare*

1. Who should be covered under national pharmacare?

The goal of a national pharmacare program, first and foremost, should be to 'fill the gaps', by providing treatments to those who have gone, or will go, without access. While Canadians have the right to universal and comprehensive care under the Canada Health Act, this is restricted to hospital and physician services, and the medications, devices and equipment required while in hospital. Drugs and supplies procured outside a hospital are not easily accessible to all Canadians when they need it.

Currently, access to drugs and drug coverage is not based only on medical need, but depends on factors such as age, income, employment status, workplace and province of residence, a situation that leaves many without coverage, or with limited coverage. The differences in coverage are particularly pronounced for newer and more expensive drugs. Many existing provincial plans offer drug coverage that is neither sufficient, nor equitable. Private insurance, such as employer insurance plans, provide much needed coverage but drug access still varies widely.

Insufficient drug coverage tends to impact people with low income jobs or part-time work more severely, as many would not qualify for public plans yet may not have good coverage, or any coverage, in some cases, through their workplace. It also significantly impacts Canadians who require extraordinarily expensive medicines by depleting their assets and leaving them facing the inevitable fact that their condition will not be treated, and their quality of life may not improve. Despite the 'theoretical' availability of medications, the ones they require are not available to them, nor are the better health outcomes.

Within the past two decades, rates of the major complications of diabetes such as heart attack, stroke and amputations have been reduced by half.[8] This improvement is attributed almost entirely to the use of evidence-based medicines. Unfortunately, not all Canadians stand to benefit from these advances. While disease etiology can be random and unfair, a national pharmacare approach should not be. No one should be denied access to medications on the basis of age, income or place of residence – everybody must have the chance to procure medications that allow them to achieve their health potential.

All people in Canada should have access to the medicines they need. Most urgently, this includes patients who do not have coverage or have insufficient coverage through the public and private plans.

In developing a pharmacare plan, it is unethical to give preference to one disease state over another. All Canadians living with disease, whether it is diabetes, a related condition, a rare illness or other, should have the ability to access the treatments they need. One patient group should not be 'advantaged' at the expense of another. Canadian society will thrive when all of its citizens have an equal ability to achieve good health. The government should be ever mindful of the fact that a system in which everyone stands to benefit, regardless of disease state, is the one worth pursuing.

National pharmacare should value the health of all Canadians.

2. How should national pharmacare be delivered?

A consistent, equitable, nation-wide approach to drug access in Canada is long overdue. At this point in the debate, Diabetes Canada does not endorse a particular pharmacare delivery mechanism or model. Rather, it advocates for the fulfillment of the following principles, which have been developed by the Health Charities Coalition of Canada (of which Diabetes Canada is a member), in collaboration with the Best Medicines Coalition and the Canadian Pharmacists Association, and are outlined in the report *Better Pharmacare for Patients: Evaluating Policy Options*:

- equity – every Canadian should have equitable and consistent access to necessary prescription medications
- timeliness of access – Canadians should be able to access the medications they need in a timely manner
- appropriateness of therapy – all Canadians should have access to high quality medications that are appropriate to their individual needs
- affordability – all Canadians should be able to afford their medications at the point of care
- sustainability – all Canadians should benefit from a pharmacare system that ensures ongoing health system sustainability

Throughout the history of this debate, various pharmacare models have been studied and proposed by different bodies. The one that the Advisory Council ultimately recommends must

see the aforementioned principles achieved. Ensuring these principles are respected and that no patients will experience reduced access to medicines because of the adoption of a national approach is essential.

A national pharmacare approach, whether it is public, private, or a mix of both, should be equitable, affordable and sustainable. It should provide appropriate therapies in a timely manner. It should allow people with coverage to retain it, and ideally should enhance coverage. For those without, it must improve access. The approach should be person-centric, responsive to patient needs, improve health outcomes and add value to the system.

3. Which drugs should be covered as part of a national pharmacare plan?

All drugs included as part of a national pharmacare approach should be selected on the basis of sound science, evidence, best practice and the most current clinical guidelines. Every five years, Diabetes Canada publishes clinical practice guidelines for diabetes care in Canada. These guidelines have been widely accepted across the country and around the world as the gold standard for prevention and treatment of diabetes. Many public formularies presently offer access consistent with the guidelines, while others are out-of-date and do not align with current evidence-based recommendations. Healthcare providers are encouraged to follow best practice guidelines for prescribing, but hit a roadblock when patients, who are covered through a public program, cannot fill their prescription due to lack of coverage. Formularies must be structured to support timely, evidence-based practice.

The Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada and other evidence-based guidelines should form the basis of a medication formulary (or formularies).

Any medication that is considered to be life-sustaining for people with diabetes should be universally covered. Canadians who live with type 1 diabetes must be able to obtain insulin regardless of age or circumstances. Under the current system, there are some people who cannot access this life-saving treatment. Those without private insurance who are not covered by any public plan, or who are eligible for a public plan that may only partially cover insulin, or only certain types of insulin, are forced to pay out-of-pocket for the very drug that keeps them alive. A humane national pharmacare approach is one that ensures people who require insulin are able to obtain it without experiencing any undue financial hardship.

Insulin, as a life-sustaining medication, should be available at no cost to people of all ages living with type 1 diabetes, if they cannot afford it.

Policy decisions are made for populations. Treatment decisions are made for individuals. Thus, a national pharmacare approach must endorse cost-effective treatments, but also be nimble to support the individualization of therapies. The current process-heavy approach is not patient-centred. It encourages rigid prescribing patterns, rather than supporting tailored

treatments. Diabetes that is entirely managed according to a standard or an algorithm, rather than patient preferences and needs, is likely to become, or to remain, suboptimally controlled. The trialing of a series of treatments in a particular order, to which patients may be limited because of their coverage but which may not be appropriate for all, can delay the achievement of optimal health outcomes and result in complications, which come at a high personal and systems cost.

Having access to treatment options is extremely important to patients and providers, so a national approach must include a broad range of evidence-based therapies. Prescribing decisions should be made using the best evidence available and informed by discussions between a patient and his/her healthcare team.

A national pharmacare approach must be created to support patient and provider choice and individualized disease management, while promoting cost-effective therapy.

Presently, most formularies adopt a process that requires healthcare providers who wish to apply for an exception to formulary criteria to complete and submit a form on behalf of their patients, which can be complicated and time-consuming. Approval processes tend to be subjective, non-transparent and vulnerable to budget constraints and adjudicator knowledge. Practitioners who have had applications for medication exceptions repeatedly refused become less inclined over time to even attempt accessing these out-of-reach medicines, even though they may have the potential to improve a patient's health. This must change. A better pharmacare approach will build on the strengths of different access models and not emphasize the failures of the current public system.

Applications for treatments that fall outside regular reimbursement criteria should not be overly complicated or arduous for providers or patients to complete. They should be processed in a timely manner and the adjudication processes for formulary exceptions should be fair, consistent and transparent.

The mechanism to determine which medications will be placed on public plans should be reviewed. Under the current system, new drugs to market are evaluated for listing based almost exclusively on economic analyses and select clinical data points. These, by nature, limit the decision-making to reflect cost-containment measures and certain clinical parameters, and sometimes fail to account for all the indicators that are important to patients.

For example, in its Common Drug Review process, the Canadian Agency for Drugs and Technologies in Health (CADTH) conducts cost-effectiveness studies which heavily influence the recommendations made to the public plans on drug reimbursement. CADTH's review mechanisms must allow for greater opportunity for patient engagement. More consideration should be given to a broader range of outcomes over a few primary endpoints. The benefits and the totality of the evidence should be evaluated, rather than focusing singularly on

individual measures (e.g. hemoglobin A1c reduction, decrease in incidence of severe hypoglycemia). Drug reviews must be focused on all issues that are important to patients.

Review organizations should ensure that patients are at the centre of their mandate and that processes are more transparent. The structure and governance of these organizations and boards of directors must support this. Canadians affected by health concerns should be given greater opportunity to provide their perspectives and offer constructive feedback to drug reviews, and other pharmacare and healthcare issues, based on their lived experience.

Drug review processes, and the organizations that conduct them, should put patients first.

Finally, any discussion about what should be included in a national pharmacare plan should not be restricted to medication coverage. It must also include the medical devices and supplies that allow for optimal disease management. For people living with diabetes, these may include, but not be limited to, glucometers, continuous glucose monitoring systems, insulin pumps, test strips, lancets and pen needles or syringes.

A common-sense approach would provide a patient with the medication and the means to administer and properly tracking how to dose it. Some equipment is essential to taking medication (e.g. pen needles for the administration of a GLP-1 receptor agonist; test strips and an appropriate glucometer for the proper titration of an insulin dose). How this is delivered administratively is less important than the principle that for many patients, the medicine is coupled with devices and supplies.

A national pharmacare approach should provide access to medications, as well as necessary devices and supplies.

4. **How much variability across different drug plans or jurisdictions should there be in the list of drugs covered by national pharmacare?**

People with diabetes should have timely access to treatments that can improve their immediate quality of life and that may decrease the likelihood of future interventions which are often more costly and less effective. Federal, provincial and territorial governments should commit to the development of an effective formulary system (or systems), which is (are) mindful of products providing the best outcomes based on best medical evidence, and which do not create additional barriers to access.

Healthcare administration and delivery is managed by the provinces, as per the *Constitution Act*, 1867. The difference in access to care and treatment by people living with diabetes from province-to-province is highly problematic. Greater consistency across Canada will make things more equitable for patients. This being said, the uniqueness of each province, its citizens and their needs is important to acknowledge and should be respected. This notion should underpin any attempts to make access more equal across Canada.

A national pharmacare approach should be comprised of the greatest components of the current systems and ensure something equal to, or better than, what they currently have. The system should be crafted to appeal to the provinces, whose jurisdiction over healthcare and pharmacare delivery should be respected.

The Non-Insured Health Benefits (NIHB) plan is in need of an overhaul. It too should be re-examined and updated to prevent Indigenous peoples from slipping through the cracks. The NIHB plan should permit greater access to medications that Indigenous people require to optimize their health outcomes. Efforts to revise the NIHB plan must be inclusive of the priorities of Indigenous groups and supported by governments at all levels.

The NIHB plan must be enhanced to improve access to medications, devices and supplies for people living with diabetes.

5. **Should patients pay a portion of the cost of prescription drugs at the pharmacy (e.g. co-payments or deductibles)?**

The costs of medications, devices and supplies to treat diabetes and associated conditions should never be a hardship on people or present a barrier to properly treating their disease. No Canadian should ever be put in the untenable position of having to choose between paying for the necessities of life and the medications that help them maintain their health. Efforts must be made to reduce the out-of-pocket payment burden for any needed medication. Co-pays, deductibles and premiums, even when set to be low, can be prohibitively expensive to people living with diabetes, particularly when they are on multiple medications, which is the reality for most. Any co-pays, deductibles or premiums for medications should be applied to Canadians in manner that is income-sensitive.

Co-pays, deductibles and premiums for medications should be applied to Canadians in a manner that is income-sensitive and does not place patients in the difficult position of having to choose between the necessities of life and their health.

6. **Should employers, which currently play a significant role in funding drug coverage for their employees, continue to do so (either through contributions to a private plan or through a public plan)?**

The impact of diabetes and other chronic conditions on workplaces is significant. Employers currently pay an estimated $1,500 annually per employee with type 2 diabetes due to reduced productivity and missed work.[9] Drug plan spending for employees treating type 2 diabetes is four times the amount for all other claimants, and for employees who must take disability leave because of their diabetes, the leaves are on average 15 percent longer in duration.[10] Many of these employees remain on disability for the maximum benefit period or until death.

Many small and medium-sized businesses (SMEs) are not able to offer the same level of group health benefits as Canada's larger employers. As a result, their ability to access the full spectrum of talent in the workforce is restricted. Employees with diabetes rely so heavily on group health benefits to manage their disease that they necessarily limit their employment prospects, and contributions, to those that can offer these benefits, thereby indirectly disadvantaging Canada's SMEs.

It is in everyone's best interest to have healthy, productive people in the workforce, including those with diabetes, contributing positively to Canada's economy. Whether they provide private insurance coverage to their employees or not, employers can contribute to employee wellness in many ways. They can offer a work environment that provides opportunities for healthy eating and physical activity, and discourages unhealthy habits. They can support work-life balance through organizational policies and practices. They can provide access to prevention programming, lifestyle supports, peer networks, counselling, and education as ways to maintain and improve employee health.

An example of the latter are the highly successful prevention programs in U.S. workplaces that have been modelled on the Center for Disease Control's Diabetes Prevention Program. In these programs, participants who received lifestyle interventions showed significant reductions in overall mean body weight, waist circumference and mean BMI; reductions in overall average mean arterial blood pressure; increases in overall mean physical activity level; improved glucose tolerance and blood lipids; reductions in overall mean diabetes risk score and averted progression from prediabetes to type 2 diabetes.[11,12,13,14] It is well within the purview of organizations to facilitate employees' access to such life-changing programs. Regardless of the pharmacare model that is adopted, employers have a role to play in maintaining and improving their employees' health.

Employers can help to promote general wellness, as well as prevent and manage diabetes, in a variety of ways.

Making the case for a national diabetes strategy

To make any notable progress in tackling the diabetes epidemic, a nation-wide approach is needed that helps all Canadians know their risk of diabetes, reduces individual risk factors for both diabetes and its complications, promotes healthier environments and creates measurable, attainable health outcomes. In 2018, Diabetes Canada is spearheading the development of such an approach, called Diabetes 360° (www.diabetes.ca/strategy). This flexible blueprint is set up to deliver results in a short timeframe by focusing on targets in the areas of primary prevention, screening, secondary prevention and treatment. If implementation is well underway by 2021, the anniversary of the discovery of insulin in Canada, Diabetes 360° is sure to improve the lives of people with diabetes and help prevent millions of cases of diabetes.

Equitable and consistent access to appropriate diabetes treatments is a key component of this

strategy. Diabetes 360° promotes improved coverage for diabetes drugs, devices, supplies, health providers and services. Medications that help people manage their diabetes and any complications should be made more consistently available across Canada, and the Diabetes 360° framework strongly supports this.

Pharmacare addresses the drug portion of the health system, but there are other health system costs that require efficient management. Diabetes 360° recommends some broad healthcare systems changes that, if adopted, could then help finance national pharmacare.

Investment in chronic disease prevention can go a long way to decreasing diabetes incidence. Initiatives that promote wellness and create healthier environments where Canadians live, work, learn and play help to decrease downstream medication and disease treatments costs. Greater government support in the area of prevention could lead to fewer cases of disease and less demand on the healthcare and pharmacare systems.

Some of the burden on pharmacare may also relieved if investments are made to non-pharmacological therapy areas. If more people were able to optimize other aspects of their treatment (e.g. had greater access to multidisciplinary healthcare teams, supportive counselling, self-management education, subsidized exercise programs, and nutritious food, as recommended in the Diabetes 360° approach), they would likely be less reliant on medication. The requirement of fewer medications/lower doses over time would represent a significant pharmacare cost-savings.

Through its support of Diabetes 360°, the government has the opportunity to address drug utilization, the continuum of health and disease management. Diabetes Canada urges the Advisory Council to promote measures that will concurrently improve the pharmacare system, the healthcare system and health outcomes.

The Advisory Council should recommend that the Ministers of Health and Finance support Diabetes 360°.

Conclusion

Canada's current pharmacare system has reached its breaking point. Too many people are unable to adequately manage their health conditions because their age, income or province of residence makes them unable to obtain the right treatment at the right time. Governments should be looking across silos in budgets to allow access to appropriate medications which benefit the patient, improve the healthcare system and support the economy. Everyone must work together to make Canadians healthier. All levels of government have a responsibility to collaborate.

Canadians deserve consistent access to medications. Reducing people to less-than-optimal therapies in order to provide access for all is not acceptable. It is the duty of the Advisory Council, through its recommendations to government, to ensure that this is not achieved

through a provision of a reduced formulary for all. A national pharmacare approach must benefit those who need it and not harm those Canadians who are satisfied with their current access to drug therapy. Ultimately, it should make access better for all Canadians.

Diabetes Canada commits to remain closely connected to the debate and will provide additional commentary to the government on a national pharmacare approach at the next opportunity. We strongly suggest that the government continue to meaningfully engage with, and involve, patient groups and patients themselves in scoping, implementing and evaluating national pharmacare. As the national organization representing almost 11 million people living daily with disease, we look forward to furthering the discussion in the hopes of seeing improvement in treatment access for those with diabetes, and all Canadians, in the near future.

About Diabetes Canada

Diabetes Canada aims to make the invisible epidemic of diabetes visible and urgent. The priorities of our mission are diabetes prevention, care and cure. Our focus on research and policy initiatives helps us to deliver impact at a population level. The partnerships Diabetes Canada has developed broaden our reach in communities across the country. For more information, please visit: www.diabetes.ca.

References

[1] Health Council of Canada. How Do Sicker Canadians with Chronic Disease Rate the Healthcare System? Toronto, ON: HCC; 2011. Retrieved from https://secure.cihi.ca/free_products/CMWF_Bulletin_6_EN.pdf.

[2] Diabetes statistics in Canada are estimates generated by the Canadian Diabetes Cost Model, a forecasting model that provides projections on prevalence, incidence and economic burden of diabetes in Canada based on national data from government sources. For more information about the Canadian Diabetes Cost Model, please refer to the 2015 Report on Diabetes – Driving Change (Canadian Diabetes Association. 2015 Report on Diabetes: Driving Change. Toronto, ON: CDA; 2015. Retrieved from https://www.diabetes.ca/getmedia/5a7070f0-77ad-41ad-9e95-ec1bc56ebf85/2015-report-on-diabetes-driving-change-english.pdf.aspx).

[3] Diabetes Canada. Diabetes in Canada. Toronto, ON: DC; 2018. Retrieved from https://www.diabetes.ca/getmedia/6960f8d5-0869-4233-8ac2-6c669dae7c59/2018-Backgrounder-Canada_KH_AB_KB-edited-13-March-2018_2.pdf.aspx.

[4] Diabetes Canada. Diabetes 360°: A Framework for a Diabetes Strategy for Canada. Toronto, ON: DC; 2018. Retrieved from https://www.diabetes.ca/getmedia/a4d52b4c-85fa-4cf2-aa4d-e15103f16ec3/Diabetes_360_Recommendations_1.pdf.aspx.

[5] Turin TC, Saad N, Jun M, et al. Lifetime risk of diabetes among First Nations and non–First Nations people. CMAJ. Nov 2016; 188 (16): 1147-1153. DOI: 10.1503/cmaj.150787

[6] Kaczorowski J, Campbell NRC, Duhaney T, et al. Reducing deaths by diet: Call to action for a public policy agenda for chronic disease prevention. Can Fam Physician. 2016; 62(6): 469-470.

[7] Canadian Diabetes Association. 2015 Report on Diabetes: Driving Change. Toronto, ON: CDA; 2015. Retrieved from https://www.diabetes.ca/getmedia/5a7070f0-77ad-41ad-9e95-ec1bc56ebf85/2015-report-on-diabetes-driving-change-english.pdf.aspx
[8] Gregg EW, Li Y, Wang J, et al. Changes in diabetes-related complications in the United States, 1990–2010. New Engl J Med. 2014; 370: 1514-1523.
[9] Managing Diabetes in the Workplace: Understanding the Motivated Patient. Survey conducted by Connex Health. Commissioned by Janssen Inc. 2012- 2013. (Note: data based upon an average annual salary of $50,000, working 48 weeks per year.)
[10] Benefits Canada. ROI of One Life: Diabetes. Toronto, ON: BC; 2014. Retrieved from https://www.benefitscanada.com/wp-content/uploads/2014/10/roi-one-life-diabetes-en-final-low.pdf
[11] Weinhold K, Miller C, Marrero D, et al. A randomized controlled trial translating the Diabetes Prevention Program to a university worksite, Ohio, 2012-2014. Prev Chronic Dis. 2015; 25(12). DOI: 10.5888/pcd12.150301.
[12] Giese K, Cook P. Reducing obesity among employees of a manufacturing plant: translating the Diabetes Prevention Program to the workplace. Workplace Health Saf. 2014; 62(4), 136-141.
[13] DeJoy D, Padilla H, Wilson M, et al. Worksite translation of the Diabetes Prevention Program: Formative research and pilot study results from FUEL Your Life. Health Promot Pract. 2013; 14(4), 506-513.
[14] Dallam G, Foust C. A comparative approach to using the Diabetes Prevention Program to reduce diabetes risk in a worksite setting. Health Promot Pract. 2013; 14(2), 199-204.