LIFE BEFORE PHARMACARE

Report on the Canadian Health Coalition's Hearings into a Universal Public Drug Plan

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
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Canadian
Health
Coalition

LIFE BEFORE PHARMACARE: Report on the Canadian Health Coalition's Hearings into a Universal Public Drug Plan

November 2008

ISBN 978-1-897569-07-8

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ACKNOWLEDGMENTS

The Canadian Health Coalition thanks the many people and organizations who made these hearings possible, including the organizers, volunteers, resource people, moderators, presenters, and participants.

Thanks also to the following organizations whose financial assistance made the hearings and this publication possible:

- Canadian Auto Workers
- CAW Retired Workers
- Canadian Federation of Nurses Unions
- Canadian Labour Congress
- Canadian Union of Postal Workers
- Canadian Union of Public Employees
- Communications, Energy and Paperworkers Union of Canada
- Congress of Union Retirees of Canada
- Inter Pares
- National Union of Public and General Employees
- Public Service Alliance of Canada
- United Steelworkers of America

DEDICATION

To those who shared their stories, their suffering, and their hopes for the future.

To the memory of:

- René Quigley, organizer of the Halifax hearing
- Jim Connor, presenter at the Halifax hearing
- Marion Dewar, chairperson of the Ottawa hearing

SUMMARY

Life Before Pharmacare

IN THE FALL OF 2007, the Canadian Health Coalition (CHC) began a series of groundbreaking hearings in communities across the country. It was the first time that public hearings had been organized to deal specifically with Canadians' experiences and insights regarding the cost, effectiveness, appropriateness, and availability of prescription drugs.

This report features the stories told by people who appeared at the hearings. For example, Gretta Ross of Sarnia, Ontario, who said: "The burden of a loved one being sick in front of you and going down with dementia, is enough. Last year we were $6,000 in debt with drug bills. Now we are faced with losing our home. We both worked hard all our lives and I don't think that's right."

Over 250 people made presentations at the hearings. Many spoke of their personal experiences with injuries, illnesses, and chronic conditions that require prescription drugs. Doctors, nurses, pharmacists, and social workers spoke about the difficulties faced by their patients and clients because prescription drugs are not within reach.

The stories collected in this report will help explain to politicians, policy-makers and journalists why we urgently need a national drug plan and better management of pharmaceuticals in health care.

Canadians tend to believe that everyone is taken care of when it comes to prescription drugs. We think that elderly people are covered by provincial drug plans; that people in need are covered by social assistance; and that working people get drug coverage through employer benefit plans. But the hearings, and much research in the field, show this is not the case. Many Canadians do not

have drug coverage of any kind, and those who do are facing exorbitant and ever-increasing costs.

Medicare, our universal, public health care insurance plan, was introduced over 40 years ago. Since then, pharmaceuticals have fundamentally changed the nature of health care and yet they are still not included in Medicare.

Instead, we have a patchwork of private and public plans that are full of holes, leaving many Canadians without comprehensive drug coverage. Some people can afford to pay for drug insurance or the drugs themselves, but others cannot. This situation is reminiscent of the days before Medicare, so this report is called "Life Before Pharmacare."

At the end of this report, there is a list of recommended actions needed to rectify this inequity. At the top of the list is a call for a universal public drug plan that would be cost-shared by federal and provincial governments and employers, and administered by provinces and territories.

This is what many people at the hearings called for. In the words of Philip Lillies of Moncton, whose wife who suffers from multiple sclerosis: "Efficiency is one of the strongest arguments for implementing a comprehensive, universal pharmacare program. The hodge-podge of programs that attempt to substitute for it is not only unfair; they are also costly both in a financial sense and a social sense."

For information on the Canadian Health Coalition's Pharmacare Campaign, visit www.healthcoalition.ca/pharmacare-now.html.

1 Canadians Speak Up About the Suffering Caused by Inaction on Pharmacare

IN THE FALL OF 2007, the Canadian Health Coalition (CHC) began a series of groundbreaking hearings in communities across Canada. It was the first time that public hearings had been organized to deal specifically with Canadians' experiences and insights regarding the cost, effectiveness, appropriateness, and availability of prescription drugs. Hearings were open to everyone with an interest in a public drug insurance plan. The stories collected in this report will help explain to politicians, policy-makers and journalists why Canadians urgently need a national drug plan and better management of pharmaceuticals in health care.

As the hearings moved from British Columbia to the Northwest Territories to Newfoundland, Canadians from all walks of life spoke about the impact on their lives of the rising cost of pharmaceuticals. Many wondered why drugs are covered by provincial health care plans if a person is hospitalized, but it's pay-as-you-go as soon as a patient is discharged. Others asked if prescription drugs have become the answer for almost all medical ailments when in many cases other less expensive treatments would be more effective. Still others were frustrated by a confusing patchwork of provincial drug plans that meant a person's prescriptions were covered in one province but not in another.

In total, over 250 people made presentations during the hearings. Many spoke of their personal experiences with injuries, illnesses, and chronic conditions that require prescription drugs. Doctors, nurses, pharmacists, and social workers spoke about the difficulties faced by their patients and clients because prescription drugs are not within reach. Some presenters spoke as representatives of organizations such as social planning councils, political parties, unions, and advocacy groups.

As the hearings stretched from October 2007 through to the end of March, 2008, and moved from Victoria and Saskatoon to Sarnia and St. John's, it became clear that in all parts of Canada people are going without necessary prescription drugs because they cannot afford to pay for them. It also became clear that there were a number of reasons for this. Some people simply don't earn enough money to pay for the necessities of life *and* a hefty monthly payment for prescription drugs. Others found themselves out of work because of a serious illness and yet too young for pension benefits that would have included drug coverage. People with disabilities often had to choose either to stay on income assistance or go to work and lose their drug coverage. Even employees with health benefits at work found that their drug plan covered only part of their costs and then disappeared if they were laid off or retired.

Before Canada established a universal, public health care insurance plan in the 1960s, it was common to hear these sorts of stories about access to physicians, hospitals, and necessary medical treatment. In the intervening years, the role of pharmaceuticals in health care has expanded dramatically, and prescription drugs now play an essential role in maintaining our health.[1] But pharmaceuticals are not included in Medicare, our universal health care insurance plan.

So it's not surprising that we are hearing more and more stories about inequity when it comes to access to pharmaceuticals. Nor is it surprising that the answer to the inequity is a universal public Pharmacare program. Many people at the hearings called for one. And, like their predecessors who spoke up in the pre-Medicare days, they provided plenty of evidence that a universal public Pharmacare program is not only essential to our health, but would also cut back on drug costs for everyone – individuals, employers, and governments.

A special meeting was held in Quebec to discuss the particular pros and cons of that province's drug program. Everyone in Quebec is covered at some level for drugs, but it is a hybrid combination of private insurance plans at the workplace and a public program for everyone else. Quebeckers are experiencing the same problems as people elsewhere with rising costs and unequal access, and also call for a universal and public Pharmacare program to bring Medicare up to date.

2 The Reasons for Inequity

PRESCRIPTION DRUG COSTS have been skyrocketing over the last 10 years, rising on average by 11% a year, at least three times the rate of inflation. They have been rising quickly because pharmaceutical companies are very skilled at keeping prices, sales and profits high. They are among the most profitable companies in the world. The drug companies claim that research costs are high, but they spend three times more on advertising and promoting drugs than they do on research.

At the hearings, Reg Anstey from the Newfoundland and Labrador Federation of Labour described the "legal drug trade" as follows: "There's no reason in this country why anyone who needs life-saving drugs shouldn't have them. Our real problem is the legal drug trade, which probably produces more money for those who are in the legal trade than any of the illegal stuff we hear about on the news. Their profits are astronomical. And I think it's a system designed to cost a lot of money to the end consumer."

"The way business is conducted in the legal drug trade is really quite shocking. From the drug sales people – I should call them 'drug dealers' – who show up in a doctor's office. We all know there are all kinds of comps [free samples] left all over hell's half acre to get the doctors to write prescriptions. And it isn't just advertising… Everything from free dinners to free trips so that the 'scrips get written," he added.

According to Health Canada, only 15% of newly approved drugs are an improvement or a breakthrough over existing drugs. The other 85% are "me-too" drugs, just a different version of what already exists, but at a higher price and with monopoly price protection for 20 years. Massive advertising and promotion campaigns then create a demand for the "new" drug. For example, Lipitor is a drug used to reduce cholesterol. It is the top selling drug in Canada, at over 9 million prescriptions a year. Alan Cassels and Joel Lexchin showed that, if

"There's no reason in this country why anyone who needs life-saving drugs shouldn't have them. Our real problem is the legal drug trade, which probably produces more money for those who are in the legal trade than any of the illegal stuff we hear about on the news. Their profits are astronomical. And I think it's a system designed to cost a lot of money to the end consumer. The way business is conducted in the legal drug trade is really quite shocking. From the drug sales people (I should call them 'drug dealers') who show up in a doctor's office, we all know there are all kinds of comps [free samples] left all over hell's half acre to get the doctors to write prescriptions. And it isn't just advertising. Everything from free dinners to free trips so that the 'scrips get written. So it is a business where drugs are pushed.

"And so you combine that system with the patent laws, which really means that the drug companies can charge off their research and marketing costs forever and eternity. At the end of the day, it isn't any wonder that drug costs are escalating rapidly. Then there's the regulations that prohibit generic drugs that make it all the worse. A lot of the cost is because these companies, in my view, are well connected. There are very good lobbyists in Ottawa. It's not easy to change the system that these drug companies operate under in this country."

— Reg Anstey, St. John's, Newfoundland & Labrador Federation of Labour

Lipitor was replaced with a less expensive, but therapeutically equivalent drug, the savings would amount to almost $220 million a year.

And that's just for one drug. We are wasting enormous amounts of money by prescribing Lipitor and other high-priced drugs, instead of less expensive alternatives.

The issue is not just the cost of particular drugs, but also the wide prescribing of drugs to healthy people. Most Canadians taking drugs to reduce cholesterol do not have a heart condition, but are taking it as a preventative. Meanwhile, there is a major controversy about whether these drugs are effective in preventing heart conditions, particularly given the serious side-effects.

Governments, work-based benefit plans, and individuals are all struggling because of the inflated cost of drugs. Reg Anstey said: "I find it appalling that in this country the drug companies are taking more and more of the money spent on health care. At the end of the day, when you having a rising drug cost that is way beyond inflation, it really means that something else has to suffer, whether you are an individual or a workers' insurance plan, or a health authority, you have to make tough choices because too much money is going to the drug companies."

Rising costs are also punching holes in our inequitable patchwork of public and private drug plans. Obtaining coverage for drugs is not determined by need, but by where you live and work. In Manitoba, for example, only 9% of the population qualify for government reimbursement of drug costs, whereas in Quebec 43% qualify.[2] And although up to 75% of Canadians have private insurance coverage, usually through their employers,[3] many Canadians don't have access to workplace health care benefits or government subsidization of drugs. The rising cost of drugs also means higher premiums and deductibles for claimants of work-based plans. Drugs now account for 70 to 80% of the cost of those benefit packages, and premiums are rising by 15% each year.[4] Employers are pressing to contain costs, and health care benefits have become a major source of contention between unions and employers.

The situation is eerily similar to the years just before Medicare was established as a national insurance plan. In 1961, 53% of Canadians were enrolled in some kind of medical insurance plan. However, of that number only 9% had coverage for in-hospital professional services, which meant the remaining 44% did not have comprehensive coverage. Another 8 million Canadians had no coverage whatsoever.[5] If they had to consult a doctor, they paid out of their own pocket. If they couldn't afford the fees, they had to convince the doctor to treat them gratis. Or they simply went without necessary medical treatments and procedures.

As you will read in the pages that follow, it is clear that many people today are facing the same situation when it comes to prescription drugs.

3 Problems Caused by Excessive Drug Costs and the Patchwork Approach

SPEAKER AFTER SPEAKER at the hearings said that they could not afford their drugs, and they talked about the difficulties and confusion they encounter in the patchwork of public programs and private plans. It didn't seem to be a matter of people falling through the cracks. It's a costly patchwork full of holes that is designed to exclude rather than include people.

Retirees, young people, and the chronically ill are among those affected. But overall, the experiences of people across the country when it comes to buying and using pharmaceuticals fall into 10 categories.

- Low-income families and retirees who don't qualify for government support and must pay for their own medications.
- People with chronic illnesses, such as diabetes and asthma, that are not covered by provincial plans, and who must buy supplies and medications themselves.
- People caught in government regulations and red tape that discourage access to the programs that exist.
- Workers and their families who have partial coverage for drugs in their work-based plan, but must pay a significant proportion of the cost themselves.
- Laid-off workers who lose their drug plans along with their jobs.
- People who are prescribed expensive medications, when much cheaper equivalent drugs are available, or when treatments other than drugs would be appropriate and should be made available.

- People who cannot move from one part of Canada to another because provincial drug programs vary widely in what they provide.
- Older people under 65 who are not eligible for provincial drug programs that only start at 65 years, and workers who cannot take early retirement for that reason.
- Young people who have no drug coverage, because they have entry-level and part-time jobs that don't provide drug insurance at work.
- People in some provinces who need expensive, life-sustaining drugs that are not covered by their provincial government plans.

There is a prevailing myth that Canadians who do not have a drug coverage plan through their employment are covered by various provincial drug plans and income assistance programs that provide drug coverage. In this scenario, no one goes without the pharmaceuticals that they need. But evidence presented at the hearings showed there are many people who do indeed go without the drugs they need. Others pay sizeable sums out of their own pockets, even if it means going without something else that they or their families need.

"The burden of a loved one being sick in front of you and going down with dementia, is enough. Last year we were $6,000 in debt with drug bills. Now we are faced with losing our home. We both worked hard all our lives, and I don't think that's right."

— Gretta Ross,
Sarnia, Ontario

A recent study published in the Canadian Medical Association Journal (CMAJ) found that seniors pay 35% or less of their prescription costs in two provinces, but elsewhere they may pay as much as 100%. The study also found that, with few exceptions, non-seniors pay more than 35% of their prescription costs in every province. Most social assistance recipients pay 35% or less of their prescription costs in five provinces and pay no costs in the other five.[6]

The study compared costs for individuals with various illnesses in all the provinces. In an example of a patient with congestive heart failure, out-of-pocket costs for a prescription costing $1,283 varied between $74 and $1,332 across the provinces.[7]

People who came to the hearings spoke passionately about the need for Pharmacare because the prevailing myth of drug coverage for all is not a reality in their lives. What follows is the shape and sound of the problem as they see it, in all corners of Canada. People also came forward with solutions that would help them individually – and, they hope, all Canadians.

4 Stories from Across Canada

THE LOW INCOME TRAP

John Cox lives in Halifax. At one point in his life he had to choose between taking a job to support himself, and obtaining his medications; he couldn't have both. How did this happen? Cox has a disability that requires anti-psychotic medications. They were covered when he was receiving social assistance, but when he decided to go to work, he had to pay for the medications himself. Since he couldn't afford them, he stopped taking them and suffered severe consequences.

Cox is still working and manages to control his condition because his employer allows him to work flexible hours.

"…I know a lot of people on assistance in Nova Scotia, and across the country. Everyone will say to you they want to work. But many of these same people will say they can't work. They need their meds to stay well enough to work, but are denied them when they do," Cox told the hearings.

In Toronto, the Street Health Community Nursing Foundation conducted a study on homeless people, with particular emphasis on health issues. Among other things, the study found that, in the past year, 32% of the homeless people surveyed had not been able to obtain the prescribed medication they needed.

"The hard part is when they prescribe over-the-counter stuff or tell you that you have to get more diabetic test strips – the stuff you have to apply for. And no one will even give you two bus tickets to get to the doctor's. You spend all your money on diabetic supplies, the extra food, the over-the-counter stuff," said one respondent.

Brenda Young lives in PEI. She told the hearings that she and her husband work hard to support themselves and their two teenaged children. But they live

"I am a single mother. I work nights in a centre for delinquents. I earn $275 net per week...

Each month, my health issues force me to purchase a number of drugs. When you add the cost of my drugs to the various items I require, I have to spend a total of $5,031.25 per year. Consequently, I have $8,000 left to live on... Each day, I am stressed... If there was a program to pay our drugs, several people who live in a similar situation would not have to spend their life in the red, scared of tomorrow and afraid of the future. A Pharmacare program would enable me to stay healthy and continue to work, which would be good for me and for society."

— Réjeanne Roy, Petit-Rocher, New Brunswick

pay cheque to pay cheque, and for that reason cannot afford the $225 a month needed to pay for a drug coverage plan.

"I have neurofibromatosis. When I go for surgery, everything is covered. But as soon as I am out of the hospital, there is no money for ongoing drugs or physical therapy… If the children need prescriptions, I sometimes have to tell them to wait until pay-day," Young told the hearings.

In London, Ontario, Robert Buchanan of the Canadian Auto Workers (CAW) spoke out on behalf of health care workers who do not get any drug coverage through their employers. "Many of these people work in low-paying jobs only 20-24 hours a week. They do not have a benefits package, so they have to pay for any drugs themselves. A Pharmacare plan is essential for these people," Buchanan told the hearings.

In Edmonton, John Kolkman of the Edmonton Social Planning Council said Pharmacare would be most helpful for the working poor. "In Edmonton," Kolkman said," 60% of people with low incomes are not on government support. These people are also the least likely to have prescription drug coverage."

The Ontario government estimates that 19 per cent of the population of that province, or nearly 2.5 million people, lack adequate insurance. According to a published study out of Toronto's Hospital for Sick Children, a significant number of children lack timely access to necessary medications because of economic problems. Studies also show that the poorest fifth of the Canadian population spends more money out-of-pocket on prescription drugs than the richest fifth.[8]

CHRONICALLY HIGH COSTS

According to the World Health Organization (WHO), 60 per cent of all deaths world wide are due to chronic diseases – heart disease, stroke, cancer, diabetes and chronic respiratory diseases. In Canada, chronic diseases are projected to account for 89 per cent of all deaths. WHO also forecasts that over the next ten years deaths from chronic disease will increase by 15 per cent. Most markedly, deaths from diabetes will increase by 44 per cent.[9]

The Canadian Diabetes Association reports that more than two million Canadians have diabetes today, and more than three million will be diagnosed by 2010. By 2011, more than 50% of Canadians will be age 40 or over and therefore considered at risk of type-2 diabetes.[10]

According to the 2000-01 Canadian Community Health Survey, asthma affects 2.2 million people or 8.5% of Canadians 12 years of age and over. Asthma rates are increasing, especially among adult women. The Canadian Cancer Society estimates that 159,900 new cases of cancer and 72,700 deaths will occur in Canada in 2007. The Heart and Stroke Foundation reports that cardiovascular disease accounts for the death of more Canadians than any other disease. The Public Health Agency of Canada also includes mental illness and arthritis as categories of chronic diseases.

This means millions of people live with chronic diseases that require special supplies and medications to ease symptoms and pain. Some people have more than one chronic disease. Since these diseases can usually be managed without long periods of hospitalization, people with chronic diseases must find a way to cover the costs of the medications and supplies they need throughout their lives.

In its bi-annual survey of diabetes in Canada, the Canadian Diabetes Association states: "The greatest challenge for Canadians living with diabetes remains affordability and access to diabetes medications, devices and supplies. The out-of-pocket costs… required to manage diabetes in each province or territory varies dramatically across the country. It still matters where you live in Canada, if you have diabetes."[11]

Tracy Gilles, 33, lives in Charlottetown, PEI, and has had diabetes for 30 years. Last year she had one of her husband's kidneys implanted because hers were failing. She is spending $1,000 a month on treatment and is denied public coverage.

Tracy is not alone when it comes to financial problems associated with diabetes. Almost one in four (24%) of members of the Canadian Diabetes Association reported they could not afford to purchase and could not access through their insurance plan the diabetes drugs, supplies, or devices that their doctor recommended.[12]

Joan Barry, a nurse practitioner at the Saskatoon Community Clinic, has many diabetic patients. "The costs of the illness are overwhelming to many people who do not have insurance coverage or financial assistance," she was quoted as saying in a brief presented to the hearings. "Older insulins are available at reasonable costs, but the most effective new insulins are not covered by the provincial drug plan and are cost-prohibitive to many people."

Bill Swan of Halifax has suffered from severe asthma for most of his life. He told the hearings that he was spending $150 to $200 a month for medications over 20 years ago. When he went to an insurance company to see if he could purchase a plan that would help defray the costs, he was denied because he had a "pre-existing condition" – asthma. "I got so angry that I stopped taking the drugs and then I had to be admitted to hospital," he told the hearings.

"We need Pharmacare because people like me will never be able to get drug coverage through private insurance plans," Swan said.

Louise Dufour, an Aboriginal counselor at the Saskatoon Community Clinic, spoke for the grandmothers she works with: "Among our grandmothers' group participants there are individuals with heart disease, diabetes, high blood pressure, rheumatoid arthritis, vision loss, and limited mobility. Therefore, with some having multiple diseases, these Aboriginal grandmothers often cannot afford all their medications. At times they have to make decisions about which medications to get that month and also about what they need most – meds or their special diet food."

"I am 33 years old and I have been a diabetic for 30 years. Tomorrow I have to go for my very last laser surgery on my eyes before I eventually go blind. A year and a half ago my husband donated a kidney to me because my kidneys were failing....

"Right now there are several medications I should be taking, but I'm not. And I'm hoping we'll be able to afford them before I damage the new kidney...

"According to the government, we make too much money to qualify for drug coverage. But I don't know too many people who can take $1,000 a month off their net income and not have it have an effect. I think there's something wrong. And I also think I'm not unique. We need to start to look at the stories behind the numbers... Generally it's the sickest of the sick who have to deal with all this stuff. The people who need it the most are the people least able to fight for it. And it is a fight."

— Tracy Gilles, Charlottetown, PEI

CAUGHT IN GOVERNMENT RED TAPE

Since there are no federal guidelines or laws that currently cover outpatient drug reimbursement policies, provinces and territories establish and fund their own plans. This creates an inconsistent patchwork that requires people seeking coverage for drug costs to wrestle with complicated regulations and red tape. The regulations can be confusing and the red tape often means that people miss out on coverage for seemingly arbitrary reasons. In PEI, for example, the government runs 29 separate pharmaceutical programs targeted to specific groups.

Even though every senior 65 years and older is covered by a provincially funded drug plan, the extent of the coverage varies from province to province, with a complex mix of eligibility rules, deductibles, and co-payments. Coverage is especially limited in the Atlantic provinces.

Gerry and Lucette Goheen of Sudbury, Ontario, are both seniors with multiple health issues. They are enrolled in Ontario's drug plan for seniors, but find that ensuring they get the pharmaceuticals they need is almost a full-time job.

"We pay a set amount for each prescription that is accepted by the plan, plus we have to pay a deductible at the start of each year. But we have quite a few drugs that are not covered and there are others that have to be applied for separately, and even then they do not accept our doctor's word that we need the required drugs. Then there are some they finally agree to cover, but then they have an expiry date on them," the Goheens reported to the hearings.

There are also a variety of plans for non-seniors, aged 18 to 65 years. New Brunswick, Nova Scotia, and Newfoundland and Labrador do not offer public insurance for this age group. Prince Edward Island offers reimbursement to those whose annual household income is less than $22,000.

In most provinces, special plans for families with very low incomes are available. British Columbia, Alberta, Manitoba, Prince Edward Island, and Newfoundland and Labrador offer full reimbursement of drug costs to social assistance recipients. Ontario, New Brunswick, Nova Scotia, and Quebec have variable reimbursement policies.[13]

Rebekah Peters is the Clinical Director and Nurse Practitioner at the Saul Sair Health Centre in Winnipeg. She told the hearings about one of her patients, John, and the difficulty he has getting the medications he needs.

"He stays in our (homeless) shelter and gets a wake-up call at 6 a.m. so he can go to work… Because he is not on social assistance, does not have work with benefits, and his pharmacare deductible might as well be a million dollars, he has no way to pay for medications," Peters told the hearings.

When John developed glaucoma and needed medication so he could keep working, he discovered it would cost $80 a month, money he didn't have. Peters intervened and convinced a drug company to provide a year's supply; otherwise he would have gone without.

Christina Osmond from Newfoundland and Labrador told the story of her daughter, who has diabetes and in 2000 needed an insulin pump in order to control her blood sugar levels. The pump cost $5,000 and was not covered by the provincial government plan. In 2007, Osmond's daughter needed another pump

– the price had risen to $7,000 – and it still wasn't covered by the provincial plan.

"The new Low-Income Drug Program just brought in for low-income families does not cover the insulin pump supplies or the pump for her... so back to square one!" Osmond said.

A pharmacist in Saskatoon summed up the confusion that has become standard procedure for health professionals tangled in the red tape of provincial drug plans: "You have never experienced true frustration until you have had to meet all the requirements of entering an Alberta Blue Cross insurance on a Zadall computer system using a Saskatchewan formulary for the client who lives in B.C. Lack of standardization of computer systems, formularies, and increasing numbers of generic brands have made a morass of life in the pharmacy."

PONYING UP FOR A WORK-BASED PLAN

Work-based plans for drug coverage, often negotiated by unions, cover 58% of workers and their families.[14] These workers are insured in group plans, most commonly through private insurance companies. In total, 16 million people, half the population of Canada, have some kind of coverage through a work-based plan. The plans vary by how much workers contribute to the premiums, what percentage of drug costs are covered, and the deductibles charged. Drug coverage is lost if the worker leaves or is laid off, and only a minority of workers are covered by their drug plan once they retire.

Although work-based drug plans are of assistance to employees who require drug coverage, the cost to both employer and employee has been rising steadily. Even the professionals who administer these programs admit that the increasing cost of drugs is being borne by employees as employers seek ways to reduce their contributions. In an article in *Benefits Canada,* a magazine aimed at sponsors of employee benefit and pension plans, Shawn O'Brien, who works with AON Consulting, wrote:

> *Plan sponsors have traditionally been applying budget expense management principles to their corporate drug benefit programs. That's because, as sponsors struggle with the annual costs associated with their drug programs, they seek mechanisms that require minimal administrative effort and are easily understood by plan members, as well as yielding the highest direct cost savings. This often results in increases in co-insurance levels that penalize participants without focusing on the core causes of increased drug expenditure.*
>
> *Unfortunately, there is more focus on the bottom line than on the value of the drug program. And it has resulted in benefit levels being negotiated from one plan year to the next with little consideration of the influence on health outcomes.*[15]

Wendy Sol, Administrative Vice-President of the Communications, Energy and Paperworkers Union of Canada (CEP), told the hearings in Saskatoon that medical needs don't change from one workplace to another, and yet coverage is a patchwork affair. Sol then went on to cite the case of Gil Musso, a technician with Group Telecom, who lives in Manitoba.

At one point, Musso's employer paid all the premium costs for his benefit plan. This was important because Musso's wife needed expensive prescriptions in order to deal with her multiple sclerosis. But then things changed. Group Telecom was bought by Bell Canada and Musso's benefits were transferred to a "Flex Benefits Plan." Each employee was allowed $500 a year to purchase health and drug coverage. When the $500 worth of coverage was used up, workers had to pay any additional cost for coverage.

For Musso, this was devastating. He and his family now face drug costs of more than $1,600 a month.

Tom Graham, in a written submission from the Canadian Union of Public Employees Saskatchewan, pointed out that extended health benefit plans are not only more expensive than a single public plan, but they also create terrible inequities in the workforce. For example, many people working in some of the poorest-paid jobs in the public sector – child care centres, group homes, and activity centers – don't have any drug plan coverage in the workplace. The few who do have some coverage pay 50% of the premiums.

Many of the unionized workers who appeared at the hearings described how their employers were dealing with increasing drug costs by pressing hard in negotiations to pass on the costs to them. This means workers paying more of the premiums for their drug plans, or just having to pay more at the pharmacy counter. Unfortunately, those workers and family members with medical conditions that require expensive pharmaceuticals pay the highest price of all. And as drug costs continue to spiral upwards, employers will continue their pressure to reduce costs, and more workers will find their health plans and their drug coverage reduced.

"We need a plan for everyone – a plan based on your health needs, and not where you work," says Wendy Sol of CEP.

LAID OFF FROM THE DRUG PLAN

At age 57, Irene Ian's husband was "retired" from the company where he had worked for 30 years at a reduced pension and no benefits. Irene herself was laid off from her job in 2001 and, because of health problems, was not able to work on a regular basis. She is now 59 and estimates that her medications cost $25,000 to $30,000 a year. Her husband also needs drugs for high blood pressure, cholesterol, and acid reflux.

They could have paid $2,500 a year to buy into the basic benefit package offered by the company her husband used to work for. But the cost of their medications is so high they would have reached the drug coverage ceiling after

two months. So there was no advantage in taking out the coverage, as they would still have to pay for their prescriptions for the rest of the year.

Sandra Whirehead of the Bakery, Confectionary, Tobacco Workers and Grain Millers International Union told the hearings in Halifax what happened to workers when Hershey closed its Nova Scotia plant in 2007, laid off 600 workers, and left them with only a few months of drug coverage.

"A number of those people are on highly prescribed medications... They have no idea what is going to happen to them. One woman told me she was thinking of divorcing her husband so she could go on welfare and have her drugs covered. That's a pretty dramatic step," Whirehead said.

Ritchie Mihalick, a national representative with CEP who lives in Sudbury, pointed out that CEP, Steelworkers, and many other unions have had thousands of members laid off due to mill closures.

"These union brothers and sisters are told to go home. They have no job, with most of them losing their benefits shortly after. They are without a job and a financial burden put on them for the cost of any medication they may require. In one-industry towns and older work forces, these people have to make a choice between their medication and bread on the table. I don't have to tell you which one they pick," said Mihalick.

"Most people are too proud to say they can't afford it. So they go quietly away from the pharmacy counter."

— Don Mullins, Halifax, Nova Scotia, Community Advocates Network

PAYING THE PRICE FOR NEW AND EXPENSIVE DRUGS

Mary Lowther of Mesachie Lake, B.C., told the hearings about her son who at 4 years of age was still incontinent and misbehaving badly. When she took him to a doctor, he prescribed Ritalin, a medication often prescribed for children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). But when she took her son to see a doctor who used vitamins and diet in conjunction with other treatments, he suggested her son had a food allergy. Lowther put her son on a special diet and began vitamin therapy. Within four days, he was continent and his other symptoms had disappeared.

Since so many Canadians have to pay for medications, either directly out of their own pockets or through their taxes, it is essential that appropriate drugs are prescribed in order to keep costs down.

The 1985 World Health Organization Conference of Experts on the Rational Use of Drugs stated: "Rational use of drugs requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, and at the lowest cost to them and their community."

It is clear, however, that marketing by pharmaceutical companies often results in physicians prescribing the latest, most expensive medications when existing, less expensive brands would be just as effective. In some cases these "tried and true" drugs that have been widely prescribed for years are not only better value, but safer than the less-tested, most recent drug to come on the market. In some

cases physicians could prescribe other treatments than drugs, such as diets, food restrictions and exercise, but choose to prescribe expensive medications.

An analysis of drug prescriptions and drug costs conducted by Alan Cassels and Joel Lexchin found that, if physicians were to prescribe the less expensive tried-and-true drugs instead of the more recent 10 top-selling drugs, costs would be reduced by 45% without compromising clinical outcomes.[16]

"My husband – just this last month – took my daughter to our family doctor. But she wasn't there, so there was a locum covering off for her. And our concern was that she might have asthma. So this doctor prescribed her products well in excess of $100. We do have some drug coverage from my husband's employer. What shocked me was that he prescribed her the medication and then, three weeks later, arranged for the test as to whether or not she actually had asthma. So I looked at the side-effects and said she is not taking this until we actually have the test. This was an expensive new drug, which made me wonder how much they have actually tested it on children. As it turned out, she didn't have asthma. It bothers me significantly that my daughter was prescribed expensive medication, and as it turned out, there was no diagnosis and not even a test."

— Gillian Burles, Yellowknife, Northwest Territories

Why are doctors writing prescriptions for costly drugs when there are less expensive products that are equally safe and effective? According to the authors, most doctors are simply unaware of the costs. Another major factor is that doctors rely too much on information given to them by the pharmaceutical companies. Doctors are influenced by the extensive marketing and sales promotions conducted by the drug companies.[17]

The doctors may be unaware of the costs, but patients without drug coverage know them only too well.

Linda Segal told the hearings in Victoria that she was prescribed Fosamax because she has osteoporosis. Fosamax is not covered by B.C.'s drug benefits program, so she had to pay for it. And to make matters worse, the Fosamax contributed to the development of hiatal hernia because one of her doctors wasn't aware of its side-effects.

Marian in Saskatchewan (she didn't want her full name used) told the CHC about her experience with inappropriate prescription drugs. After taking one for eight weeks, she began to feel ill. "I was then given another drug to fix the problems the other drugs caused, and this cycling of drugs went on for many months, until I developed another condition for which I was given yet another drug to treat that which was creating more problems," Marian said. In the end, she stopped taking all the drugs, and found that her health started to improve.

"Older drugs that had been used seemed to be safer and more cost-effective than the newer, stronger drugs. However, they are no longer being prescribed by doctors. It is puzzling to me why they are no longer the drugs of choice," she added.

Cecelie Hewitt is with the NWT Council of People with Disabilities. She told the hearings that some of the people she works with find that the drugs for which they have coverage don't work for them. But they are stuck with the ineffective drugs because they can't afford to pay for better ones. She also provided the example of a man with chronic pain who requested coverage for a $110 machine that would have helped him. His request was denied, so he continues to use expensive pain medication which is covered by the provincial drug plan.

Both Hewitt and Gillian Burles, another NWT resident, spoke of the particular problems northerners have regarding visiting doctors known as "locums." One doctor will prescribe one medication, but when the patient goes back with concerns about it, he or she has to deal with a different doctor. As a result, patients often end up with medications they don't need, or that don't help them.

THE COST OF A MOVE TO A DIFFERENT PROVINCE

As discussed earlier in this paper, there is a patchwork of drug plans organized and subsidized by each provincial and territorial government. In the Northwest Territories, for example, the Non-Insured Health Benefits program funds prescription and over-the-counter medications that are not covered by other private or provincial /territorial health insurance plans. In Alberta, antiretroviral drugs are dispensed to patients diagnosed as HIV positive without deductible or complicated reimbursement programs. In Quebec, everyone who is not covered by a work based plan is covered automatically by the public drug program, which therefore covers 43% of the population. By comparison, in Manitoba, only 9% of the population qualifies for the provincial drug plan.[18]

But what if a person with drug coverage in one province moves to another part of the country to be with family or get a new job? Many people have found out the hard way that moving to another province means an increase in drug costs.

Nicholas Lane and his family moved from Quebec to New Brunswick and found that monthly drug costs escalated. "My wife was already on Nexium for a stomach ulcer, and the cost became about $85. She cut down and immediately suffered," Lane wrote in a submission to CHC. Eventually, she was prescribed 10 different prescriptions. "If my wife and two kids took all that was prescribed and dosage required, we'd be paying $450 a month, perhaps more…"

Albert Gelinas moved from Alberta to Ontario for a new job and realized that he would have to pay for the antiretroviral drugs that he had received for free in Alberta. He also found that the red tape made for lengthy applications and delayed payments.

"My own experience with the Trillium Drug Program has left me totally disgusted with the process, and now I do not even bother to send in receipts for reimbursement or acknowledge the program. It is not worth my time to send receipts back and forth and justify my expenses or argue over what drugs are covered or not. I made it through a second bankruptcy largely due to unexpected drug costs so now I just pay my monthly 'fine' (20% of drug costs) and avoid unnecessary stress of dealing with government programs which are supposed to help but in reality do not," Gelinas wrote in an email to the CHC.

Retirees often consider moving to another part of the country so they can be with family or enjoy warmer weather. But before they move, they must consider if they can afford the drugs they need in their new location. Or they have to consider moving to a province or territory where drug costs *are* covered.

Bonnie Thoen is 50 years old, lives in Saskatoon and has had type-1 diabetes since she was seven. She told the hearings she needs a minimum of $500 a month for diabetic supplies. But if she moved to the Northwest Territories, the infusion pump she needs would be covered by the NWT drug plan, whereas in Saskatchewan it is not.

"I will not be able to retire in this province. I have to look at where my costs for diabetes are covered," Thoen told the hearings. "… I live in Canada and I want to stay in Saskatchewan if that is my choice."

"I have been insulin dependent, a diabetic, for forty-four years. What came with that were the side-effects. I had a heart attack in 1999. My kidneys failed. In 2001 I had a kidney transplant. And there's a raft of drugs that I take. In fact, in 2006, the total cost between my wife and I was just over $11,000. I had a benefit plan at work which was quite good. Unfortunately my health didn't allow me to go back to work. I'm only 54 years old. So now I have a 10-year period without benefits.

"When we attempt to go to the other insurance companies – even expecting to pay outrageous premiums to have some sort of coverage – they won't cover me simply because of 'pre-existing' conditions. In a nutshell, it is a very grim view of retirement. I used to have this dream about when I retire I'll travel and I'll visit places I've never seen. Instead I have to think about whether I can afford to pay for my drugs. Another problem is that when I retire I'd like to move to Halifax to be close to my wife's family and the grandchildren. But I have to check on whether the Nova Scotia government will pay for my drugs before I can move.

"I mentioned earlier that being in the labour movement I have conversations with people who are retiring and losing benefits. That's widespread. You can go in any direction in this country and find the same circumstance. I'm not unusual. There's literally thousands of people like us."

— George Rozon, Edmonton, Alberta, Communications, Energy and Paperworkers Union of Canada, Local 1118

DRUG COVERAGE IN THE PRE-RETIREMENT YEARS

Gerry LeBlanc, Program Coordinator for the Steelworkers Toronto Area Council Injured Workers Program, told the hearings in Toronto that many workers find themselves stuck in a kind of "limbo" when it comes to drug coverage. He cited the example of one work site where it became obvious that many workers were suffering from the same occupational disease.

The Ontario Workplace Safety and Insurance Board agreed that the workers needed to be moved from that site and offered retraining for younger workers and compensation based on loss of wages for older workers. But, according to LeBlanc, many of the older workers opted to stay at work because, if they didn't, they would lose their drug coverage.

"People were willing to stay at work and further damage their health because leaving meant losing access to medications, or a new pair of glasses for one of their kids, or drugs for a spouse. These people earn too much money to be covered under Ontario's drug coverage plan, but not enough that they can forgo the drug coverage provided through an employee benefit plan. So they keep working," LeBlanc said. "It seems absurd."

In Moncton, New Brunswick, Connie Tanaka told the hearings that she struggles every month to pay for the drugs she needs to alleviate the symptoms of Crohn's disease. Connie is 59 and developed Crohn's about 15 years ago. Her income consists of a small disability pension and a widow's pension. She struggled to work part-time, but found she couldn't. She doesn't qualify for New Brunswick's drug coverage plan because she has more than $1,000 dollars in the bank. She knows that she will eventually have to take a means test if she wants coverage, and that will entail accounting for every penny of a small amount of money her husband left her when he died.

Len Carter of Kitchener, Ontario, told the hearings about a friend who was caught in limbo when she went blind at the age of 55. She was the manager of a set of retail outlets in southwestern Ontario. But she had to give up that work, and a good income, because of the blindness. Because she wasn't yet 65, she didn't qualify for Ontario's Seniors Drug Plan. "The Trillium plan is a complicated maze to get through, especially for a blind person," said Carter. And as we have seen with other presentations to the hearings, the Trillium plan requires that people pay up front for their drugs and then wait up to three or four months for reimbursement.

What happens when an employee over 50 years of age is forced into early retirement as an alternative to being laid off? Or when his/her health makes it impossible to continue working? As Gerry LeBlanc said, these people find themselves stuck in limbo: too old to obtain employment that offers drug coverage and too young to qualify for provincial seniors' drug coverage.

Fifty-four-year-old George Rozon of Edmonton, a member of the Communications, Energy and Paperworkers Union, is afraid he will find himself stuck in limbo when he has to take early retirement in less than a year. A diabetic for 44 years, Rozon has had heart bypass surgery and undergone a kidney transplant. The Alberta government covers the cost of his anti-rejection drugs, but other

drugs for him and his wife cost $11,000 last year. His drug plan at work covers 80% of this, while Rozon himself pays the other $180 a month. But what will happen when he retires?

"I won't be covered by my drug plan at work and will still need $900 a month for drugs," says Rozon. "Do I pay for the drugs, or put food on the table, fix-up the house? It's almost criminal when you think of the wealth in this country."

YOUNG ADULTS SHUT OUT OF DRUG COVERAGE

According to a 2007 Statistics Canada report, today's young people face a labour market that is quite different from that of their parents. Full-year full-time work, for young men in particular, has declined. Today's young people also face an increasing wage gap between newly hired employees and those with more experience; more temporary jobs for newly hired workers; and fewer employees covered by registered pension plans, meaning that new hires are entirely responsible for saving for their own retirement without the backup of an employer-sponsored pension plan.[19] Many young people are also involved in post-secondary education for a longer time than previous generations. They have to take part-time, temporary work rather than full-time work for several years so they can go to school. This kind of employment means they also go without employer-based drug coverage plans.

Wendy Renaud, a social worker in the trauma unit at Foothills Hospital in Calgary, told the hearings about a 25-year-old construction worker who required surgery after he was assaulted and stabbed. When he was sent home a few days later, he stopped taking antibiotics and painkillers because he couldn't afford them. Within days he was back in the hospital with a serious infection that required an even longer hospital stay.

Renaud said this case is not an isolated one. "This individual had a very low income. He worked day to day on a cash basis, so had nothing like a health benefits plan. He could have gone to Social Services and applied for drug coverage, but due to his weakness and the fact he didn't have transportation, he couldn't do that. So subsequently there was a cost to the health care system that very much outweighed the cost of a prescription," Renaud said.

In Saskatchewan, the story of a young man with a mental illness came to light. Peter is 25 and can work part-time if he is on medication. But his medication costs $1,000 a month and is paid for by his parents, although they do not have a drug insurance plan.

Lena Sutton spoke for the Steelworkers Organization of Active Retirees in Hamilton, Ontario. She told the hearings that many retirees with drug coverage are paying prescription costs for family members because no government plan will cover the cost.

"We also have members who subsidize family members' drug costs because the company drug plans will only cover a yearly cost of probably $5,000 and the medication might run as high as $2,500 a month," she said.

"I'd like to share with you the difficulties I have faced during the transition period of finishing my master's degree, when I was covered under a drug plan through the university, to being unemployed, job searching and student loan debt. And then being diagnosed with a mental illness. And needing to scrounge around for money to pay over $200 a month in prescription drugs. The last six months have been very hard for me in my personal life and became even worse financially. It was very difficult knowing I'd have to put more money on my credit card for prescription drugs and getting even further in debt. Even now, I have started a job that has drug benefits but I have to wait three months to access benefits."

— Nicole Wazir, Kitchener, Ontario

Part-time, temporary work for young people has become a norm for many of them. And yet, as hospital stays shorten and drug costs rise, they are often left to fend for themselves when it comes to the medications they need. Or their parents have to help pay.

LIFE-SUSTAINING DRUGS NOT COVERED BY PROVINCIAL PLANS

Dr. Decker Butzner is head of pediatric gastroenterology and nutrition at the Alberta Children's Hospital in Calgary. His responsibilities include a clinic which attends to 355 children from across southern Alberta who have inflammatory bowel disease. He told the hearings about his frustrating experiences obtaining coverage for his patients for a drug called infliximab (also known as Remicade) that is used to treat inflammatory bowel diseases such as Crohn's disease. About 5-10% of Dr. Butzner's patients require the medication. It costs $940 a vial, and most patients need three vials per treatment. Treatment usually costs about $23,000 the first year, and about $17,500 the second year.

Even though the drug was first reported to be effective in 1998 and pediatricians were prescribing it for their patients by 2002, in 2004 Dr. Butzner still had write to Alberta Health and Wellness and Blue Cross (the Alberta government's private insurance partner) every time he prescribed it for a patient. He also discovered that Alberta Blue Cross was willing to cover the cost of the drug if the applicant was already enrolled in a private group insurance plan, which meant there would be a co-payer. If the applicant only had the basic Alberta Blue Cross plan, coverage was denied.

According to Dr. Butzner, Blue Cross said coverage was denied because the drug hadn't yet been approved for use in children. And yet, if the applicant had a co-payer, coverage was approved regardless of the patient's age. It wasn't until 2005 that the drug was approved for use by children in Alberta. It took until 2007 before Health Canada approved it on a national basis.

New and experimental drugs for rare diseases are often extremely expensive. Darren Nesbit of Sarnia, Ontario, knows from experience just how expensive they can be. He has a rare and fatal genetic disorder known as Fabry's Disease. Thirty-one-year-old Nesbit found a life-saving treatment in the U.S and for 10 years was a human test subject.

In 2005, the drug was approved for use in Canada and the drug company withdrew its supply of experimental medication. Nesbit then discovered that it would cost $300,000 a year to keep him alive. At first the Ontario government wasn't willing to cover the cost, so Nesbit took his fight to the federal government. In the end, the federal and provincial governments agreed to sponsor an independent post-market study for the drug, thereby covering the cost of Nesbit's treatment.

"I can finally think about living healthy instead of how I will manage the huge cost of the treatment," Nesbit told the hearings.

Khaled Salam of the Aids Committee of Ottawa told the hearings that his agency deals with many people who require a cocktail of drugs because they are HIV positive. "This cocktail can cost up to $2,000 a month," he said. Under Ontario's Disability Support Program, the full cost of the drugs is covered. But if a person is working, they have to cover all or part of the cost themselves. Even the Trillium drug plan causes hardship, he said, because people with low incomes simply don't have the money to pay up front and reimbursement can take months.

In Vancouver, Ken Buchanan, secretary of B.C. Persons with AIDS Society, praised B.C.'s pharmacare program because it includes a plan that pays for the entire cost of purchase and distribution of all HIV/AIDS drugs prescribed to B.C. residents. There is a similar program in Alberta, which again highlights the discrepancies across the country when it comes to drug coverage – even for life-sustaining drugs.

But Buchanan also pointed out that, while B.C.'s pharmacare program covers the cost of antiretrovirals, it doesn't cover all drugs required by HIV patients. Drugs such as antibiotics, antifungals and chemotherapy agents, as well drugs to deal with pain and depression, are handled through community pharmacies. "The ease or difficulty of access depends on the particular drug, as well as the circumstances of the individual," Buchanan told the hearings.

5 Drug Insurance in Québec

THE QUEBEC DRUG PLAN is sometimes described as universal, because it does ensure some level of coverage for everyone in the province. However, it is not universal in the sense that everyone receives the same access to drugs. It is in fact a hybrid public-private plan that provides different levels of coverage to different people. Everyone who has access to a private plan, generally through work, is obliged to subscribe to that plan and to have his/her spouse and children covered under it. The rest of the population is covered by a public drug plan. At present, there are 4.3 million people covered under private plans and 3.2 million covered under the public system.

There are major differences between the public and private plans. For example:

- Under private plans, drugs are not provided free to children under the age of 18 or to students aged 18-21 as they are under the public system.
- Under private plans, people are required to pay cumulative taxes of 11.35% on their premiums, whereas this is not the case under the public system.
- Premiums are not the same under private plans as under the public system, for comparable incomes. They can cost twice as much with private insurers. This situation is a particular hardship for low-wage or part-time employees.

Even within the public system, there are major variations. Maximum contributions are calculated according to the source of income instead of the amount. For example, a person receiving social assistance pays a maximum of $16.67 per month, an elderly person receiving the partial guaranteed income supplement pays a maximum of $46.47 per month. However, a low-income employee whose

income comes from a job has to pay a monthly maximum of $71.42 – even if the real income is identical to that of the elderly person in terms of dollars.[20]

Apart from these inequalities for individuals, there are other problems with the mixed private and public system. The private system covers the so-called "good risks," those people who are working and most likely to be healthy. This leaves the public system covering the so-called "bad risks," including people on social assistance, people with disabilities who are not working, and the elderly – people who are more likely to need drugs. Instead of a single universal system that pools the risk across the whole population, the private insurance sector is advantaged, while the public sector carries the most costly part of the population. No financial cross-subsidization is permitted to rectify this imbalance.[21]

Across Canada, private plans have a disastrous track record in terms of controlling costs. The Mellon Group estimated that the average growth of insurance costs for Canadian companies would increase by 15.1% in 2005, while the increase in 2004 was estimated at 15.6%. The escalating cost of drugs is very real. Drugs are the most inflationary part of the overall health care system. Drug expenditures are exerting enormous pressure on our health care and social services systems and pose a direct threat to our access to these essential services.

Quebec's Coalition Solidarité Santé is comprised of 52 union, community, religious, and citizen organizations and was formed in 1991 to defend the right to health and health care for everyone. The Coalition calls for a drug policy in Quebec based upon the health of the public, rather than the commercial interests of the pharmaceutical industry. In the opinion of Coalition Solidarité Santé, "a universal and public drug plan, which must be accompanied by an effective drug policy, is the best way to ensure accessibility, equality, optimal use, and control of costs."[22]

"The situations we encounter most frequently are of a financial nature -- at least two requests for financial assistance per month. We give assistance and we receive great help from a pharmacy and doctors (the pharmacy helps by giving quantities of generic meds and doctors review their prescriptions). We also provide a quantity of meds and products like acetaminophen tablets, bandages, etc. Our social workers also have a good knowledge of income security and know how to obtain financial assistance. In short, from what I have seen elsewhere, the Clinic and its partners compensate pretty well for this problematic situation, although it remains that the access to medication is difficult. In the end, the users still have to come to the Clinic and ask clearly for what they need, etc...

— Luc, Montreal, Quebec, Pointe Saint-Charles Community Clinic

6 Conclusion

WHEN MEDICARE WAS FIRST introduced over 40 years ago, prescription drugs were not as important to the day-to-day lives of Canadians or the health care system in general as they are now. Today, prescription drugs provide relief from many of our regular aches and pains. They protect children from illnesses, cure diseases that once were a death sentence, and help manage the chronic health conditions of thousands of Canadians. Pharmaceuticals have also replaced the need for some intensive surgeries and have helped to reduce recovery times, often allowing people to recover at home rather than in hospitals. There's no question that pharmaceuticals have fundamentally changed the nature of health care in Canada.

But the many benefits of prescription drugs will only be fully realized if they are integrated into our health care system in a way that ensures they are appropriately prescribed and utilized, and are within reach of everyone who needs them.

People from across Canada presented evidence at the Canadian Health Coalition hearings that the rising cost of drugs prevents them from obtaining the treatments they need. Presenters also pointed to the disparities in coverage across the country, and they criticized their provincial government plan for being bureaucratic and confusing. They also questioned the cost and effectiveness of work-based drug plans.

In his wide-ranging 2002 report on Canada's health care system, former Saskatchewan premier Roy Romanow found that, in spite of considerable efforts by provinces and territories, drug costs are increasing and taking up a larger share of health care budgets across the country. Furthermore, prescription drugs continue to be on the sidelines of Canada's health care system rather than integrated, as they should be, with primary health care and with other aspects of the health care system.[23]

The situation regarding Canadians' access to necessary prescription drugs is eerily similar to the years just before Medicare was established as a national insurance plan. At that time, people who had to consult a doctor often paid out of their own pocket. If they couldn't afford the fees, they had to convince the doctor to treat them free of charge. Or they simply went without necessary medical treatments and procedures. This is exactly what is happening today when it comes to prescription drugs. Canadians often go without the drugs they need because they can't afford to pay for them, or they persuade a doctor or a pharmaceutical company to give them free samples or supplies.

Many Canadians who spoke at the hearings or submitted papers strongly suggested that we need a universal Pharmacare plan if we are to eliminate the inequities that people deal with on a daily basis when it comes to access to prescription drugs. Pharmacare would not only improve access to necessary drugs, but would reduce costs through a more efficient and controlled system.

Allan Blakeney, a former premier of Saskatchewan who also served in Premier Tommy Douglas's cabinet, reminded people at the hearings that coverage of prescription drugs was always part of the Douglas vision of a universal health care insurance plan.

In the words of Philip Lillies who lives in Moncton with his wife who suffers from multiple sclerosis: "Efficiency is one of the strongest arguments for implementing a comprehensive, universal Pharmacare program. The hodge-podge of programs that attempt to substitute for it are not only unfair, but are also costly both in a financial sense and a social sense."

Ken Buchanan, secretary of the B.C. Persons with AIDS Society, told the hearings: "Something must be done, and done now. If not, costs will continue to rise, access to essential pharmaceuticals will necessarily become ever more restricted, and with that will come an unnecessary worsening of our health care system generally… This is not what the Canada Health Act set out to do, but it's what is happening. Canada's federal government must create a national Pharmacare program now."

"I am the husband of a wonderful, well-educated woman, who unfortunately was afflicted with multiple sclerosis in the prime of her life, in her late thirties to be precise. Now in her early fifties, she is wheelchair bound and unable to walk. She does not qualify for benefits under Canada Pension, and New Brunswick, unlike most provinces, does not offer a disability pension… We have experienced arbitrary and inflexible rules that ignore real needs and lead to additional costs for everyone concerned. We Canadians have a strong sense of fairness, and that alone should motivate us to demand a comprehensive, universal Pharmacare program. But efficiency is also a strong argument for implementing a universal Pharmacare that replaces the hodge-podge of programs that are not only unfair but costlier, both in a financial and a social sense."

– Philip Lillies, Moncton, New Brunswick, Public Service Alliance of Canada, Local 60350

7 Recommendations

- A universal public drug plan to replace the more expensive patchwork of private and public plans. The public plan would be cost-shared (federal and provincial governments and employers) and administered by provinces and territories.
- A national formulary to cover the complete cost of all essential drugs. Decisions on which drugs are paid for are based on independent evaluation of safety, effectiveness, and value for money. Allowances will be made for special needs and circumstances.
- A national strategy to obtain reductions in drug prices through bulk purchasing.
- A national public drug information system, free of conflict of interest with the pharmaceutical industry, to provide unbiased drug information for all health care professionals and the public.
- Strengthen and strictly enforce legislation to ban all forms of direct-to-consumer advertising of prescription drugs in Canada.
- Improve prescribing behaviour of professionals so that drugs are used only when needed, and the right drug is used for the right problem.
- Accelerate access to more affordable non-patented drugs and repeal the regulations that extend monopoly patents beyond 20 years.

For further details, see the Canadian Health Coalition's policy paper More *For Less: Pharmacare – A National Drug Plan*, www.healthcoalition.ca/mfl2007.pdf

NOTES

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19 Clark, W. (2007). Delayed Transitions of Young Adults. *Canadian Social Trends*. Ottawa: Statistics Canada. www.statcan.ca/english/freepub/11-008-XIE/2007004/11-008-XIE200700410311.htm. Retrieved April 25/2008.

20 Coalition Solidarité Santé, "Pour une politique du medicaments qui fait passer la santé de la population avant l'interest des compagnies pharmaceutiques", avril 2005.

21 Marie-Claude Prémont, "A Pharmacare Program for Canada: the Quebec Model", Presentation to the Canadian Labour Congress Convention, May 28, 2008.

22 Coalition Solidarité Santé, avril 2005.

23 Commission on the Future of Health Care in Canada (2002). Prescription Drugs. p. 190. www.hc-sc.gc.ca/english/care/romanow/hcc0023.html. Retrieved April 28/2008.

PRESENTERS TO CHC HEARINGS

SASKATOON, OCTOBER 25, 2007

Kathy Storrie, Saskatchewan Health Coalition
Derwyn Crozier-Smith
Alan Blakeney, former Premier of Saskatchewan
Lorne Calvert, Premier of Saskatchewan
Sandra Finley, Saskatchewan Green Party
Roy Atkinson, National Framers Union
John Bury, MD
Don Fletcher
Jim Holmes, Saskatchewan Health Coalition
Ingrid Larson, Saskatoon Community Clinic
Blake McGrath, Saskatchewan Congress of Union Retirees
Wendy Sol, Communications, Energy & Paperworkers Union of Canada (CEP)
Bonnie Thoen
Howard Leeson, Department of Political Science, University of Regina
Marian (pseudonym)
"A pharmacist" (written submission)
Carla (written submission)
Stan Rice (written submission)
Tom Graham, Canadian Union of Public Employees (CUPE) Saskatchewan (written submission)
Dan Danacher (written submission)
Students from the Bachelor of Social Work program, University of Regina

EDMONTON, OCTOBER 29, 2007

Keith Wiley, United Nurses of Alberta
Wendy Armstrong, Consumers Association of Alberta
Brain Mason, MLA, Alberta NDP Leader
Thea Stobbe, Society for Diabetic Rights
John Kolkman, Edmonton Social Planning Council
Bill Chan, PAH Society
Susan Morrisey, Edmonton Social Planning Council
George Rozon, President, Local 1118, CEP
Noel Somerville, Public Interest Alberta
Aileen Taylor, Seniors' Action and Liaison Team
John Shaw, Alberta Society of Seniors United Now
Jack Goldberg, Friends of Medicare
Irene Slater, Seniors United
Verna Milligan
Terry O'Connor (written submission)

CALGARY, OCTOBER 30, 2007

Wendy Renaud, social worker
Carol Lawson, social worker
D'Arcy Lanovaz, President, CUPE Alberta
Decker Butzner, MD, Head, Division of Paediatric Gastroenterology, Faculty of Medicine, U. of Calgary
Rick Klimchuk, CEP
David Wood
Brenda May, RN
Gord Christie, Calgary & District Labour Council
Avalon Roberts, MD
Ted Woynillowicz, Friends of Medicare, Calgary
Pat Brownlee, President, Coalition of Seniors Advovcates
Donna Ingwersen
Heather Smith, RN, President, United Nurses of Alberta
Al Santos
Joan Teghtmeyer
Bev MacKay
Beryl Wood

YELLOWKNIFE, NOVEMBER 1, 2007

Ben McDonald, Alternatives North
Kerri King, Centre for Northern Families
Doug Ritchie, Ecology North
Gillian Burles
Suzette Montreuil, PSAC North
Lona Hegeman
Cecily Hewitt, NWT Council of Persons with Disabilities
Heather Clark, NWT Council of Persons with Disabilities
Eddie Kolosuk
Ernie Lennie, Center for Northern Families
Jean-Francois Des Lauriers, Regional Executive Vice-President, PSAC North
Dennis Bevington, MP, Western Arctic (written submission)

HALIFAX, NOVEMBER 6, 2007

Rene Quigley, President, Nova Scotia Federation of Union Retirees
Ian Johnson, Nova Scotia Citizens' Health Care Network
Alexa McDonough, MP, Halifax
John Cox, Community Advocates Network
Don Mullins, Community Advocates Network
Sandra Whitehead, retiree, Bakery Confectionery and Tobacco Workers International Union
Anne Smith, Nova Scotia Citizens' Health Care Network
Jim Connors
Maureen MacDonald, MLA, Halifax Needham
Bill Swan
Roch Longueépée, Community Advocates Network.
Kyle Buott, Nova Scotia Citizens' Health Care Network

CHARLOTTETOWN, NOVEMBER

Mary Boyd, PEI Health Coalition
Mary McNeil, PSAC
Linda Webber, Judge of Supreme Court of PEI (retired)
Pat Crawford, Pharmacist, Department of Health, Government of PEI
Sean Murphy, MP, Hillsborough

Herb Dickinson, MD
Dave Clow, PSAC
Barb Boudreau
Brenda Young
Jim Wicks
Bruce Garrity
Marilyn Yap Yu, MD
Carol Evans
Aquinas Ryan, Seniors United Network
Ann McNivan, Make Poverty History
Walace White
Ifo Ikede
Leo Garland
Tracy Gillis
Edith Perry
Noel Pauley, President, Local 401, CEP
Graham Gaudiest, Hospice Palliative Care Association
Mary Hagen, Catholic Women's League

MONCTON, NOVEMBER 8, 2007

Linda Silas, RN, President, Canadian Federation of Nurses Unions
Philip Lillies, President, Local 60350, PSAC
Agathe Lapointe, Dieppe (written submission)
Réjeanne Roy, Petit-Rocher (written submission)
Connie Tanaka
Greg Murphy, CN Pensioners Council No.1, Moncton
Art Richard, Association acadienne et francophone des ainées et ainés du Nouveau-Brunswick
Cécile Cassista, Coalition for Nursing Home Residents' Rights
Hector Cormier, président de la SERFNB
Rino Ouellet, CEP
Roger Duguay, NDP Leader, New Brunswick
Jean-Luc Bélanger, Président, Association acadienne et francophone des ainées et ainés du Nouveau-Brunswick
Jean-Claude Basque, Canadian Labour Congress, Atlantic Region
Paulette Sadoway, Canadian Labour Congress, Atlantic Region
Florian Levesque, New Brunswick Health Coalition

TORONTO, NOVEMBER 20, 2007

Julie Devaney, Toronto Health Coalition
Gerry LeBlanc, Steelworkers Injured Workers Program
Dave Parker, Steelworkers Job Action Centre
Doris Grinspun,RN, Registered Nurses Association of Ontario
Ruth MacNeil, Steelworkers Organization of Active Retirees, Chapter 1 (SOAR)
Jack Pinkus, retired pharmacist
Darrell Dular, Alliance of Seniors
Richard Kratz, CAW Retired Workers Council, Toronto Area
Laura Hanson, RN, written submission, Toronto
Carolyn Egan, United Steelworkers

ST. JOHN'S, NOVEMBER 26, 2007

Kathleen Connors, Health Coalition of Newfound and Labrador
Reg Anstey, President, Newfound and Labrador Federation of Labour
Shawn Strickland
Lorraine Michael, MHA, NDP Leader
Ralph Morris, President, Local 7022, NAPE Retirees
Mary Clark, Health Coalition of Newfoundland and Labrador
Mary Shortall, Canadian Labour Congress, Atlantic Region
Carol Furlong, President, Newfoundland Association of Public and Private Employees
Debbie Forward, RN, President, Newfoundland and Labrador Nurses Union
Sharon King, President, Association of Allied Health Professionals
Chris Rolton, MD

WINNIPEG, DECEMBER 6, 2007

Madeline Boscoe, Women's Health Clinic, Winnipeg
Sid Frankel, University of Winnipeg
Laurie Helgason, Disabled Women's Network, Manitoba
Robert Chernomas, Department of Economics, University of Manitoba
Wayne Helgason, Executive Director, Social Planning Council of Winnipeg
Judy Wasylycia-Leis, MP, Winnipeg North Centre, NDP Health Critic
Colleen Metge, Faculty of Pharmacy, University of Manitoba
Barbara Scheuneman, Pharmacist, Mount Carmel Community Health Centre
Marianne Cerilli, West Central Woman's Resource Centre
David Northcott, Winnipeg Harvest Food Bank
Vivian Studen, Federal Superannuates National Association
David Alper, Social Worker, St-Boniface General Hospital
Ron Guse, Manitoba Pharmaceutical Association
David Steen, Society of Manitobans with Disabilities
Tim Sale, former Manitoba Minister of Health
Diane Castonguay, written submission, Winnipeg

VANCOUVER, DECEMBER 10, 2007

Colleen Fuller, PharmaWatch
Monica Ghosh Malcolm, BC Federation of Retired Union Members
Joy Langan, BC Federation of Retired Union Members
Barbara Mintzes, UBC
Steve Morgan, UBC Centre for Health and Policy Research
Jim Sinclair, President, BC Federation of Labour
Adrian Dix, MLA Vancouver-Kingsway, NDP Health Critic
Terry Engler, ILWU, Local 400
Art Kube, Council of Senior Citizens Organizations of BC
Ken Buchanan, BC Persons With AIDS Society
Lorraine Logan, BC FORUM/COSCO
Russ St. Eloi, BC & Yukon Building and Construction Trades Council
Avelina Vasquez, Hospital Employees Union, Living Wage Campaign

VICTORIA, DECEMBER 11, 2007

Alan Cassels, University of Victoria
Phil Lyons, South Island Health Coalition
Sukhi Lalli, Pharmacist
Rob Fleming, MLA, Victoria
Carole Pickup, South Island Health Coalition
Denise Savoie, MP, Victoria, (written submission)
Max Halbert, Greater Victoria Seniors
Mary Lowther
Linda Segal, Council of Canadians
Linda Carter, RN, BC Nurses Union
Gail Nestel
Graeme McCreath
Lois Sampson

Jane Brett

Jim Hackler, retired professor of criminology

Judith Williamson

Vicki

Henry McCandless

SARNIA, FEBRUARY 4, 2008

Arlene Patterson, Sarnia Health Coalition

Natalie Mehra, Ontario Health Coalition

Tim Fugard

Roger Gallaway

Andy Bruziewicz

Gail Haukee

Darren Nesbit

Marsha Menard

Glenn Sonier, CEP

Gretta Ross

Kathy, VON

KITCHENER, FEBRUARY 6, 2008

Orville Thacker, Ontario Federation of Union Retirees

France Gélinas, MPP, Nickle Belt, NDP Health Critic

Keith Thompson

Frank Krenue

Len Carter

Joyce Cruchank

Nicole Wazir, Community Health Worker

Sandy Ellis, Canadian Labour Congress, Ontario Region

McGee McGuire, RN

LONDON, FEBRUARY 7, 2008

Jim Kennedy, London Health Coalition

Tim Kerry, President, CAW Local 27

David Leeson, Pharmacist

Mike Prudhomme, Abuse Rep, CAW Local 27

Erin Wilcox, RN

Tommy McSwigin, CAW Retiree

Robert Buchahan, CAW

Stan Korchuk

Josie Renesse

Brian Ginty, CAW Local 88

Hector McCallum

SUDBURY, FEBRUARY 8, 2008

Carol Hughes

John Filo

Ritchie Mihalick, CEP

Norm Shamas

Anne Marie MacInnis

OTTAWA, FEBRUARY 12, 2008

Pat Kerwin, Congress of Union Retirees

Marlene Rivier, Ottawa Health Coalition

Marion Dewar

Qais Ghanem, MD

Khaled Salam, AIDS Committee of Ottawa

Haoua Inoua

Una Ferguson, RN, Registered Nurses Association of Ontario

Richard Kitchen, CEP

Sheila Pepper, Council of Aging

Jo Ann Cook, Social Worker

Dave Batho, CEP (written submission)

HAMILTON, FEBRUARY 29, 2008

Malcolm Buchanan, CURC/Active Retired Member-OSSTF

Matthew Adams, Ontario Health Coalition

Chris Charlton, MP, Hamilton Mountain

Wayne Marston, MP, Hamilton East-Stoney Creek

Dave Christopherson, MP, Hamilton Center

Paul Miller, MPP, Hamilton East-Stoney Creek

Mahadeo Pandy, senior citizen

Lena Sutton, President, Chapter 10, Steelworkers Organization of Active Retirees [SOAR]

Karl Crevar, Ontario Network of Injured Workers

Bill Fuller, SOAR

George Sentak, United Seniors Citizens of Ontario

Lucy Morton, VON

Barry Cowles, CUPE Retirees

Betty-Ann Bushell, CURC/Active Retired Member-OSSTF

Jack Wilkinson, naval vet

Ed Falkenor, OPSEIU Retirees

Jane Noble

NEW GLASGOW, MARCH 12, 2008

Barbara Hodgins

June Cameron

Jim Cameron

Ross Tugreault

Bert Martin

Laura Fraser

Kattie Brennan

Stan Kivovich

Don Elleworth

Joe Van Buckerk

PORT HAWKESBURY, MARCH 13, 2008

Bob Crane, United Steelworkers

Clotilda Yakimchuk, Cape Breton Council of Seniors

Rita O'Keefe, Inverness/Victoria Council of Seniors

MONTREAL, APRIL 9, 2008

Claude Saint-Georges, Coalition Solidarité Santé

Claudelle Cyr, Coalition Solidarité Santé

Marie Pelchat, Clinique communautaire de Pointe Saint-Charles

René Charest, Confédération des syndicats nationaux – CSN

Karine Crepeau, Fédération Interprofessionnelle de la Santé du Québec – FIQ

Marie-Hélène Bolduc, Confédération des organismes de personnes handicapées du Québec

Mercedez Roberge, Table des regroupements provinciaux d'organismes communautaires et bénévoles

E-MAILED STORIES AND SUBMISSIONS

Nicholas Lane, New Brunswick

Albert Gélinas, Ottawa

Gerry Goheen, Sudbury

Erin Wilcox, London

Irene, London

Carol Romanow, British Columbia

Rebekah Peters, RN, Winnipeg

Christina Osmond, Mt. Pearl NL

Curtis Snow, Newfoundland

Elizabeth, Alberta

Lillian Edwards

A. Brown

Diane Middleton, Windsor

Gilbert Young, Toronto

Coalition says pharmacare argument simple it will cost less and help more people

Canadian Health Coalition co-ordinator tells Charlottetown meeting there is no economic or medical reaso

to prescription drugs to those who can afford to pay or who have a good drug plan

Poor often have to choose between food and filling prescriptions

A coalition advocating pharmacare is travelling across the country collecting

His EI sick benefits paid less than $1,500

ged much faster

patients can lead normal lives instead of being institutional-

Laid-off employees struggle to pay rising drug prices

By Anne Kelly
Record staff

WATERLOO REGION

workers in Waterloo

their

credit card for medication.

"The past six months

very hard," she said sobbi

she now has a job as a

health worker at the

Downtown Community P

benefits don't kick

Une coalition se penche sur les problèmes d'accès aux médicaments

L'organisme a pris le pouls de la population, hier, à Moncton

The StarPhoenix

Saskatoon, Saskatchewan

Friday, October 26, 2007

New Zealand example touted at hearing on universal drug plan

By Lana Haight
of The StarPhoenix

The campaign for a national drug plan arrived in Saskatoon smack in the middle of a provincial election where drug coverage is an issue.

"It is a coincidence that we are here du

ng an election

"One of the biggest threats to medicare is skyrocketing drug costs."

In making the case for a universal drug plan, the co-ordinator of the Canadian Health Coalition pointed to the plan in New Zealand. The cost of four categories of drugs

People 'falling through the cracks'

Health Coalition hears from

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