Canadian Diabetes Association

2016 Pre-Budget Submission

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The Canadian Diabetes Association (CDA) is a registered charitable organization that leads the fight against diabetes by helping those affected by diabetes to live healthy lives, and preventing the onset and consequences of diabetes while we work to find a cure. Our staff and more than 20,000 volunteers including healthcare professionals provide education and services to help people in their daily fight against the disease, advocate on behalf of people with diabetes for the opportunity to achieve their highest quality of life, and break ground towards a cure.

The CDA believes that Canadians with diabetes have the right to be treated with dignity and respect, and have equitable access to high quality diabetes care and supports. Such are the guiding principles within the CDA's Diabetes Charter for Canada.[1] Our vision through the Charter is a country where all people with diabetes can live to their full potential.

Executive Summary

Today, more than 10 million Canadians are living with diabetes or prediabetes. The increasing rate of diabetes and its complications pose a serious burden on Canada's publicly funded health care system and our economy.

To alleviate cost pressures on our publicly funded health care system, and to address the Government of Canada's identified priorities for the upcoming budget – increasing the productivity of Canadians and using tax measures to promote positive outcomes for Canadians – the Canadian Diabetes Association recommends that the government address the following issues in its upcoming budget:

1. Ensure fairness in the access to the Disability Tax Credit (DTC) and Registered Disability Savings Plan (RDSP) in supporting Canadians living with type 1 diabetes;
2. Implement taxation on sugar-sweetened beverages with a commitment to reinvest funds back into diabetes prevention and management programs; and
3. Ensure equitable and affordable access to needed medications for people with diabetes and related complications by introducing a national pharmacare program.

Introduction

Today, over 10 million Canadians are living with diabetes or prediabetes.[a] The prevalence of diabetes is expected to increase by more than 40% by 2026.[2] Diabetes is a leading cause of blindness, end stage renal disease and non-traumatic amputation. In Canada, 30 per cent of strokes and 40 per cent of heart attacks occur in people with diabetes, as are half of dialysis due to kidney failure, and 70 per cent of non-traumatic amputations. All Canadians are paying the cost of treating diabetes-related complications.

Recommendations for the 2016 federal budget

1. Diabetes, the Disability Tax Credit (DTC) and the Registered Disability Tax Credit (RDSP): Ensuring fairness in supporting Canadians with type 1 diabetes to the DTC and the RDSP.

Background

There is currently an estimated 174,000 to 348,000 Canadians living with type 1 diabetes. Depending on individual circumstances, the estimated financial burden assumed by people with type 1 diabetes to manage the disease can be as high as $4,900 per year on average.[2]

A person is usually diagnosed with type 1 diabetes at a young age. With the diagnosis begins a lifelong rigorous self-management regimen which includes many daily activities related to balancing food, activity and insulin in order to keep blood sugar concentration within a target range. For people with type 1 diabetes, insulin is a life-sustaining therapy.

People with type 1 diabetes may be eligible for the Disability Tax Credit (DTC) because the insulin they administer is life-sustaining therapy and its administration multiple times a day takes time away from normal, everyday activities. Qualifying for the DTC, in turn, qualifies individuals for a Registered Disability Savings Plan (RDSP). An RDSP provides an opportunity to young Canadians living with type 1 diabetes to save for the future financial burden of managing this life-long disease and the potential long-term complications, including heart attack, blindness, amputation, stroke and kidney failure.

Unfair access to the DTC and RDSP

Currently, children and youth living with type 1 diabetes generally qualify for the DTC. However, when they turn 18, eligibility is usually terminated. As a result of no longer qualifying for the DTC at age 18, their Registered Disability Savings Plans (RDSP) are also terminated. Also, when adults living with type 1 diabetes apply for the DTC, some are denied while others are

[a] Prediabetes is diagnosed when blood glucose is elevated, but not as high as type 2 diabetes. About 50% of Canadians with prediabetes will go on to develop type 2 diabetes in their lifetime.

approved. Consequently, there is significant inequity in the access to the DTC and RDSP for Canadians living with type 1 diabetes.

The current eligibility criteria for the DTC state that individuals on insulin therapy may be eligible if a physician certifies that the patient requires an average of at least 14 hours per week on the following four activities related to determining the dose of insulin required each time it is administered:

- Monitoring blood glucose levels;
- Preparing and administering the insulin;
- Calibrating necessary equipment; and
- Maintaining a logbook of blood glucose levels.

The CRA generally approves children with type 1 diabetes for the DTC because the CRA counts the time their parents or guardians spend on the four permitted activities together with their child's time to meet the 14 hour criteria. Unfortunately, when a child with type 1 diabetes turns age 18, the DTC and RDSP are usually terminated because most physicians acknowledge that it is difficult to certify if each of their patients with type 1 diabetes meets the current criteria.

In reality, there are several additional activities undertaken by all people with type 1 diabetes in order to adjust their insulin dose. These activities also require them to take time out of their normal, everyday activities, including:

- Counting carbohydrates to calculate bolus meal insulin doses;
- Meal planning related to time activity profile of the insulin used; and
- Treating and recovering from blood sugar lows.

Permitting time spent on **all activities** related to calculating insulin doses to be counted toward the 14-hour-per-week criteria would ensure young adults with type 1 diabetes rightfully qualify for the DTC and are permitted to grow their RDSP investments. The CDA estimated the cost as a result of expanding the permitted activities to include all other activities within the DTC eligibility criteria to be $100-150 million for 2015[b].

Recommendation 1:
The Canadian Diabetes Association recommends the federal government either expand the CRA interpretation of the Income Tax Act, or amend Section 118.3 of the Income Tax Act, to include <u>all activities</u> related to insulin administration in the DTC eligibility criteria. This would enable young Canadians with type 1 diabetes to invest in an RDSP for their future.

[b] A detailed analysis of this estimated cost is available upon request.

2. Taxation on sugar-sweetened beverages: Reducing unhealthy weights and burden of chronic diseases including diabetes.

Background

Type 2 diabetes is a national health crisis — a new case is diagnosed every three minutes. The personal health burden is tragic — heart attack, stroke, dialysis, blindness, amputation. Many studies have linked excessive consumption of sugar-sweetened beverages (SSBs) to an increased risk of type 2 diabetes and gestational diabetes. SSBs, including soft drinks and other beverages with added sugars such as sports drinks, fruit drinks, blended coffees, and iced tea, contain large amounts of readily absorbable sugars and are considered nutrient poor. While consumption of SSBs leads to rapid consumption of large quantities of sugar at once, it may also promote overconsumption of calories from liquids due to a less satiating effect compared to solid food, leading to weight gain. It is important to note that SSBs also independently increases the risk for developing type 2 diabetes. That means that even with a healthy weight, if a substantial portion of calories are from sugar-sweetened beverages, an individual would have a 20 percent higher risk of developing type 2 diabetes compared to others of the same weight whose calories come from other sources.

Canadians consume, on average, 100 litres of sugary drinks per year that contain about 40 grams (10 teaspoons) of sugar per serving. SSBs contribute to 35% of Canadian adults' daily sugar intake which has been estimated at 110 grams or 26 teaspoons of sugar.[3] Soft drinks are the primary source of beverage containing sugar for children aged 9-18, and 53% of boys and 35% of girls aged 14-18 self-reported having had soft drinks in the previous day when surveyed by Statistics Canada.[4]

Urgent action is needed now on several fronts to reduce consumption of SSBs and thereby lessen the burden of obesity and type 2 diabetes in Canada. No one intervention will itself result in drastic reductions in type 2 diabetes. Population-based interventions, such as SSB taxation along with education, improved food distribution policies, and healthy food procurement by public institutions will together promote healthier food consumption, reduced intake of free sugars[c] and better health.

Taxation of Sugar Sweetened Beverages

To reduce the burden of type 2 diabetes, overweight and obesity, as well as other chronic diseases in Canada, a combination of measures across sectors and levels of governments is required. A framework to tackle childhood obesity has been established by health ministers who collectively agreed to "decrease the availability and accessibility of foods high in sugar" in

[c] Free sugars are those sugars that are removed from their original source and added to foods as a sweetener or as a preservative. - See more at: http://www.diabetes.ca/about-cda/public-policy-position-statements/sugars#sthash.VS0RfmVW.dpuf

Canada. Taxation to promote health is a necessary step to reduce the consumption of SSBs among Canadians.

Internationally, some governments have used this policy lever to influence SSB consumption. Mexico, France, Hungary, Finland and some jurisdictions in the U.S. (Vermont and Berkeley, California) have applied taxes on sugar-sweetened beverages as a means to deter consumption and redirect revenues toward health-promoting initiatives. In January 2014, the Mexican government introduced a 10% tax to non-dairy and non-alcoholic drinks with added sugar. Published results demonstrate a 6% decline in purchases in 2014 which increased to 12% by December that same year. These results were observed across socioeconomic groups with the greatest effect in the low income category (a 17% decrease in SSB purchases). These changes occurred in tandem with an increase in purchase of bottled water.[5]

A tax on SSBs has been shown to reduce consumption and would generate substantial revenues to support health promotion activities. In addition, the revenues could be used to support the other key strategies identified in the framework to reduce diabetes and obesity, including increasing the accessibility and availability of nutritious foods in northern, remote and rural communities, where the burden of unhealthy weights and diabetes is higher. The Mexico example is the most recent and credible evidence to show that implementation of SSB taxation is an effective tool to reduce consumption so Canadians can reduce their risk of the harm.

Recommendation 2:

The Canadian Diabetes Association recommends that federal government introduce and implement a tax on sugar-sweetened beverages and use the revenues for health promotion initiatives.

3. A National Pharmacare Program: Ensuring equitable access to needed medications for people with diabetes and related complications

Except for Canada, all developed countries with a universal healthcare system also have universal drug coverage, including Britain, France, Germany, Australia, New Zealand, Norway and Sweden. The Canadian Diabetes Association has described the shortcomings of the existing drug reimbursement landscape in Canada. The current system does not provide prescription medications for all Canadians and there is increasing consensus about the importance of equitable access to necessary prescription drugs.

Equal and timely access to medications is an important issue for the 16 million Canadians with at least one chronic condition,[6] including diabetes and related complications (e.g., cardiovascular disease, stroke, kidney failure, amputation, blindness and depression). This is because 90% of Canadians with these conditions take at least one prescription drug, and 54% take four or more.[7]

Since pharmaceuticals outside of those administered in hospitals are not covered by the Canada Health Act, Canadians with chronic diseases without specific forms of public coverage (e.g. social assistance, benefits to seniors, etc.) or private insurance (employers or other sources) can have high out-of-pocket costs. These costs can be a significant barrier to adherence with prescribed drug therapy: while about 10% of Canadians overall skipped medications due to cost, 23% of those with a chronic disease did.[7] While one in 10 Canadians has difficulty paying for medications even if they have insurance, this rises to one in four for those without coverage. Those with the most difficulty have chronic conditions with recurring drug costs.[8]

These costs are particularly onerous for people with diabetes and complications: most have catastrophic drug costs (>$1,500 or 3% of individual annual income). As a result, many do not adhere with prescribed therapies, compromising their diabetes management and leaving themselves vulnerable to complications.[9]

While provinces have enhanced coverage for those on low incomes or with high drug costs, a national coordinated plan remains stalled.[10] The result is "a jumbled assortment of public and private plans in which individual coverage is no longer based on patients' needs, but subject to where people live and work, as well as on each person's and family's financial means."[11]

Over the last decade, rates of the major complications of diabetes such as heart attack, amputation and kidney failure have been cut in half. That improvement is attributed almost entirely to the use of evidence-based medicines.[12] Unfortunately not all Canadians stand to benefit from these advances because about 24% have no drug coverage and about two-thirds of households have out-of-pocket spending for prescriptions.[8,11]

There are several ways for the healthcare system to provide medically necessary drugs to Canadians. There are several approaches to ensure Canadians without adequate prescription drug coverage are able to access needed medications, each with its own costs and benefits. It is critical that people with diabetes are active participants in the design, development and implementation of a system that will ultimately be serving their medical needs.

Recommendation 3:

The Canadian Diabetes Association recommends the establishment of a National Pharmacare Program that includes people with diabetes as active participants in its development. The program would ensure access to needed medications for people with diabetes and related complications and save public funds.

Conclusion

The recommendations contained in the Canadian Diabetes Association's pre-budget submission represent our priorities for federal investments that will meaningfully improve the lives of people living with diabetes. These strategic investments will improve productivity of Canadians and reduce cost pressures on our healthcare system and economy.

The Canadian Diabetes Association will continue working with the government and other stakeholders in the diabetes community towards achieving optimal health outcomes for people with diabetes and those at risk of diabetes. We thank the Committee for the opportunity to provide these recommendations.

References

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