HEALTH INSURANCE IN CANADA AND BRAZIL, ACESS TO DRUGS, CO-PAYMENT CARDS, LOYALTY PROGRAMS AND BRAND NAME DRUGS

SEGURO DE SAÚDE NO CANADÁ E BRASIL, ACESSO À MEDICAMENTOS, CO-PAGAMENTO, PROGRAMAS DE FIDELIDADE E OS MEDICAMENTOS DE MARCA

SEGURO DE SALUD EN CANADÁ Y BRASIL, ACESS A LAS DROGAS, TARJETAS COPAGO, PROGRAMAS DE FIDELIZACIÓN Y LOS MEDICAMENTOS DE MARCA

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Abstract
Insurance schemes play a key role for drug access by populations in need. The interplay between public and private insurance is one of the main dimensions of the delicate design for drug coverage. Canada and Brazil have a distinct approach, briefly presented on the basis on the OECD typology for health insurance. The pharmaceutical industry is currently facing a 'patent cliff' where many 'blockbuster' drugs come to the end of their patented life. The industry is setting up new 'loyalty programs' enticing patients and health professionals to stick to the brand name drug instead of switching to the generic. With the bioequivalence of generic drug, there is no additional health benefit to stick to brand name drugs when generics are available at a fraction of the price. The best part of the additional costs of such commercial programs is not paid by the pharmaceutical industry. Instead, programs are based on the possibility to transfer the increased cost to the insurer.
Keywords: Health insurance in Canada and Brazil. Access to drugs. Co-payment cards. Loyalty programs. Brand name drugs.

Resumo
Os sistemas de seguros desempenham um papel fundamental para o acesso a medicamentos pelas populações carentes. A interação entre o seguro público e privado é uma das principais dimensões do processo delicado para a cobertura de medicamentos. Canadá e Brasil possuem uma abordagem distinta, brevemente apresentada sobre a base da tipologia da OCDE para o seguro de saúde. A indústria farmacêutica está enfrentando atualmente um "precipício de patentes", onde muitos medicamentos 'blockbusters' chegam ao fim de sua vida patenteada. A indústria está tentando usar novos programas de fidelidade para convencer pacientes e profissionais de saúde a manter o medicamento de marca em vez de mudar para o genérico. Com a bioequivalência de medicamentos genéricos, não há benefício de saúde adicional para continuar com os medicamentos de marca, quando os genéricos estão disponíveis por uma fração do preço. A melhor parte dos custos adicionais de tais programas comerciais não é pago pela indústria farmacêutica. Em vez disso, os programas são baseados na possibilidade de transferir o aumento do custo para o segurador.
Palavras chaves: Sistema de seguros no Canada e Brazil. Acesso a medicamentos. Sistema de co-pagamento. Programas de Fidelidade. Medicamentos de marca.

Resumen
Los planes de seguros juegan un papel clave para el acceso a los medicamentos por la población necesitada. La interacción entre el seguro público y privado es una de las principales dimensiones del

diseño delicado para la cobertura de medicamentos. Canadá y Brasil tienen un enfoque distinto, presentado brevemente sobre la base de la tipología de la OCDE para el seguro de salud. La industria farmacéutica se enfrenta actualmente a una "caída de patentes ', donde muchos fármacos' blockbuster 'llegan al final de su vida patentado. La industria es la creación de los pacientes que tientan nuevos "programas de fidelización y de profesionales de la salud a pegarse al medicamento de marca en lugar de cambiar al medicamento genérico. Con la bioequivalencia de medicamentos genéricos, no hay ningún beneficio adicional para la salud de atenerse a los medicamentos de marca cuando los genéricos están disponibles a una fracción del precio. La mejor parte de los costos adicionales de tales programas comerciales no es pagado por la industria farmacéutica. En lugar de ello, los programas se basan en la posibilidad de transferir el aumento del costo a la aseguradora.
Palavras Clave: El seguro de salud en Canadá y Brasil. El acceso a los medicamentos. Tarjetas de co-pago. Los programas de fidelización. Los medicamentos de marca.

Outline

Access to drugs by populations in need is a delicate and complex topic in all countries, including Canada. I am all too aware of the severe limits of my knowledge concerning this great and amazing country, Brazil, to venture and comment on the topic of access to medicines by poorer populations in Brazil. I will limit the comparison between Canada and Brazil to the types of private insurance in our respective countries.

The presentation will be in two parts. The first part will address the role of governments in designing insurance scheme for healthcare and in particular for drugs. The second part will deal with the role of the pharmaceutical industry when setting up new sales strategies designed to improve their balance sheet for drugs with expired patents.

Government: Insurance Schemes

Insurance matters

Countries have discovered long ago that access to care requires some sort of insurance scheme, both for medical and hospital services as well as for pharmaceutical products. Healthcare costs can be so high that even middle class families can face financial hardship and even bankruptcy in order to access needed care. Drugs are now consuming a larger part of healthcare costs than they did in the past. Chronic medical conditions are also now imposing a constant burden on families. Without insurance, families live on the brink of disaster and it is the responsibility of governments to avoid such precarious conditions for their population.

In all systems, at all times, need for care is not evenly distributed across populations. Furthermore, if aging comes with increasing need for care, acute need may also show up at any time in life, such as if cancer breaks out or if serious accidents happen. Insurance schemes thus have a huge impact on access to care and determine who has access to what level of services, and when and how.

In this context, the relative absence or weaknesses of regulation by a State is, in itself, equivalent to regulation by public authorities giving *carte blanche* to the industry to determine the rules for access to care. When left free from effective regulation from the state, the private

sector sets its own rules in favour of their balance sheet, with minimal concern for equity of access to care or drugs for citizens unable to purchase insurance.

The consumption chain of medicines

I do not know who first suggested that we imagine the consumption chain of medicines through the peculiar metaphor of a meal with three persons sitting at a table in a restaurant: the patient, the physician and the insurer. The image helps to understand the odd and complex chain for drug sales and prescription. The person who orders the meal (the physician) does not eat it. The person who eats the meal (the patient) does not pay for it. And the person who pays (the insurer) does not order it, nor does he eat the meal. While the chef (the pharmaceutical company) may suggest the most expensive dish, the waiter (the pharmacist) delivers it at the table. This odd chain of medicine delivery generates real challenges for public policy, and in particular for the control of drug costs and the relevance of prescriptions. The metaphor stresses well the point that medicines are in no way akin to ordinary consumption goods and cannot be left to the simple market rules. Drugs are in dire need of regulation by the State to protect not only the safety of the patient, but also the economic contributions required from the insurer and the patient. Regulation should also focus on equity of access for all citizens.

Insurance typology

Insurance schemes have a huge impact on access to care. The structure of the insurance determines who has access to what, at what cost. When it comes to healthcare, most countries have a mix of private and public insurances, regulated in different ways. In order to help comparison between countries, it is important to share the same typology for private insurance. The OECD suggested in 2004 a typology for the main categories of private insurance in OECD countries (OECD, 2004). The report recognizes that the nature of public and private insurance is complex and varies from one country to the other. The OECD report suggests we characterize private insurance in its relation to public insurance. The main categories suggested by the OECD are presented in Table 1 below with a summary of their main characteristics.

Insurance coverage in Canada

Different countries have adopted different types of insurance schemes, both public and private.Canada is ratherisolatedamongst OECD countriesfor the narrow public coverageof drugs. The *Canada Health Act* covers medically necessary drugs only if they are delivered in a hospital.

Duplicative insurance is by nature duplicating public insurance and as such may lead to important problems of public policy. In countries where the insurance industry is allowed to sell duplicative insurance, it normally covers only a selection of services already provided by the public regime.

The industry will typically focus on more profitable services or clienteles for which private delivery may be easily organized and garnered. The duplicative private insurance can only be voluntary and, as such, creates two categories of citizens, those with and those without

duplicative insurance coverage. Thus, it is recognized that duplicative private insurance may lead to important equity problems in access to care (OECD, 2004, p. 21).

Table 1 — Typology for Private Insurance in Healthcare

Types of private insurance	Main characteristics
Primary	Insurance covering all primary needs for healthcare for those who don't have access to public insurance. For example, this is the role played by private insurance in the USA for those who don't have access to Medicare or Medicaid.
Supplemental	Insurance covering services not insured by the public system. For instance private insurance for dental care or drugs outside hospitals, which is generally not insured by the public system in Canada.
Complementary	Insurance covering the co-payment patients have to pay when receiving publicly insured services not reimbursed at 100% by public insurance (covering what is called the *ticket modérateur* in France).
Substitutive	Insurance covering the equivalent of all services covered by the public system for a subset of the population. The substitutive private insurance becomes the primary insurance for the patient who, as a consequence, is barred to claim any additional funding from the public insurance in order to have access to services covered by the private plan. No queue jumping is allowed for the patient with the substitutive private insurance when served in public hospitals. Only major example known: Germany.
Duplicative	Insurance covering services already included in the public system. This kind of private insurance usually covers only some of the services offered by the public insurance. The insurer is often left free to cherry-pick the most profitable services and the more solvent clienteles.

Source: based on OECD, 2004.

In order to avoid such problems, duplicative private insurance is simply prohibited in a hospital setting and for medical services across Canada, by provincial legislation. Thus, private insurance cannot cover medical services or hospital care or drugs administered in a hospital. Public healthcare across Canada is structured in such a way that, for 90% of the Canadian population, private insurance cannot be sold for the services and care already covered by the public system. The prohibition of duplicative private insurance keeps at bay the overlapping of public and private insurance covering the same health services. It also prevents unjust

competition from private delivery of care to attract health professionals with higher pay and better working conditions.

As a general rule, Canadian public policy is more favourable to private insurance for drugs delivered outside of the hospital setting. Private insurance for drugs is then *supplementary* as opposed to *duplicative*. In other words, private health insurance in Canada is only allowed for services for which there is no public coverage available. Therefore, public and private insurance do not *compete* in a harmful way against one another. They rather *complement* each other in trying to cover different segments of the population.

Public policy tries to ensure that all segments of the population be covered as much as possible, which is not an easy task. In order to accomplish this, public coverage of drugs in Canada focuses on segments of the population for whom private insurance is less accessible.

In all Canadian provinces, public drug insurance outside the hospital generally covers vulnerable populations, like people on welfare and the elderly. This is why we find a patchwork of different programs for drugs delivered outside hospitals in most provinces. Despite some differences from one province to the other, we can summarize the Canadian situation with two large categories of insurance. First, most employed people tend to be covered by an employer-sponsored collective private insurance scheme. On the other hand, people on social security and 65 years of age and over are usually covered by a provincial public insurance for drugs delivered outside the hospital. Drug insurance is structured in most cases with a deductible and co-payments paid by the patient, with important exceptions for populations in need who may be exempted from any user-fees and premiums.

Quebec has adopted a more comprehensive regime in 1996 to fill the gaps left by Canada's general model, in particular for unemployed adults (but not on social security, like adult students for example) and their families, or for working people without access to an employer-sponsored drug plan. The Quebec plan maintained the public regime for the elderly and people on social welfare, but added to the public regime all those who could not adhere to a private plan (Pomey et al, 2007). Furthermore, the Quebec drug scheme requires individuals who have access to a private plan to join with their families. The end result is that all residents of the province of Quebec are covered by a drug insurance plan. Overall, the private industry covers about 57% of the population and the public regime about 43%.

Insurance coverage in Brazil

Health insurance legal structure in Brazil is quite different to Canada's. The first striking difference lies in a constitutional anchor for healthcare protection that we do not find in the Canadian constitution. Section 196 of the 1988 Constitution of the Federal Republic of Brazil[1] sets a very demanding program for the country when mandating that health should be the right of every citizen and the duty of the State. On the other hand, it is important to notice that the right of private health industry to do business in Brazil is also protected in the Constitution by section 199[2]. This double constitutional protection for both public and private healthcare will have a strong impact on the duties of the State and the structure of healthcare in Brazil.

Of course, the right to health for all citizens is a programmatic statement (although *constitutional*) for which legislation drafting will be just as important as the Constitution in laying down the contours of these rights of the citizens and the duties of the country, as well as the relationship between the private and the public sectors in health. In order to implement the high demanding mission for Brazil, the country enacted in 1990 Law 8.080 concerning conditions for the promotion, protection and recovery of health, the organization and operation of services, giving life to the Sistema Único de Saúde (SUS).

Implementing public universal healthcare is an ambitious program for any country. Brazil has embarked on the path traced, to some extent, by the country's constitution. As a comparison, when Canadian provinces implemented their public healthcare systems, most of them declared moot all pre-existing and future private insurance contracts covering the same services as the public regime would cover. This is what we call the prohibition of duplicative private insurance found in most Canadian provinces and covering about 90% of the Canadian population.

Brazil has gone a different path and maintains private insurance, as stated in the Constitution of the country. The details of the relation between public and private healthcare insurance and delivery had to be set by legislation. Section 4 §2 of the 1990 statute states that the private sector may participate to the objectives of the SUS in a *complementary* manner[3], reproducing exactly the wording used in the Constitution.

Although the Brazilian statute uses the word "complementary", the private insurance of Brazil authorized to participate to the same objectives as the SUS, appears to share some of the characteristics of the *duplicative* insurance as well as the *substitutive* (or maybe *primary*) insurance, according to the OECD typology. Private insurance may cover citizens who still enjoy the protection provided by the Constitution. The statute 9.656 enacted in 1998 regulates in more details private health insurance in Brazil. According to section 1 of the law, private insurance may choose which services it offers on the market. One could then argue that the Brazilian legislation authorized and anchored *duplicative* private insurance. But we will see that this is debated as the SUS argues that private insurance should be more of a *substitutive* nature.

Private health insurance has been growing ever since the SUS was implemented. Coverage by private healthcare plans reached 26% of the population of Brazil in 2008 (around 50 million people), representing more than the whole population of Canada (Paim et al, 2011, p. 1782). Private healthcare costs account for more than half of total health spending in Brazil (Paim et al, 2011, p. 1787).

The complex network of public and private coverage and delivery represents a real challenge for the Brazilian public administration layered at the three levels of government: federal, state, and municipal. "The public and private components of the system are distinct but interconnected, and people can use services in all three subsectors [1. SUS; 2. private delivery financed with a mix of public-private money; and 3. private insurance], depending on ease of access or their ability to pay" (Paim et al, 2011, p. 1785).

Even though access to drugs is theoretically covered under the SUS, the literature reveals a gap between the program envisaged by the law and reality. The problem has been made worse since 1996 when Brazil could no longer produce generic equivalent of patented drugs (Micai Lanza, 2009).According to Paim et al (2011, p.1788), people in need in Brazil spends most of their out-of-pocket money for healthcare on medications, whereas private health insurance is the

main out-of-pocket item for the richest part of the population. “It is estimated that the richest 15% of the population is responsible for over 40% of medicines expenditure” (BMI, 2012).

The OECD study highlights the difficulties generated by the free flow of duplicative private insurance that Brazil has to tackle with. Solutions are not easily found as municipalities and governments are struggling to close the gap between hopes and feasibility. There is no doubt that the generous programmatic standard stated by the Constitution for a population the size few countries have to care for represents a daunting challenge.

The overlap of private and public insurance in Brazil raises complex issues with profound impact on public policies. Two phenomena illustrate the acute legal problems Brazil has to face.

The first one relates to the attempts from the government, based on section 32 of the Law 9.656 of 1998 to get reimbursed from private insurers for treatments or services paid by the SUS for patients who were covered by a private insurance contract for the same services. The insurance industry refuses to pay for the services provided by the SUS for patients under insurance contracts, saying that these people should enjoy the same constitutional protection of the SUS than people without a private insurance. The private insurers argue that section 32 of the 1998 statute is therefore unconstitutional. In other words, the SUS is arguing that private insurance should be considered as the *primary* insurance of the policyholders or as a *substitutive* insurance to the public one, as opposed to a *duplicative* insurance, as the industry sees itself. The High Court (Supremo Tribunal Federal) has ruled that private healthcare providers had to reimburse the SUS, just as private hospitals are paid for treating privately insured patients (BMI, 2012, p. 46). Therefore, could private insurance in Brazil be of a *sui generis* type, somewhere between *duplicative* and *substitutive*?

The second hint at the complex issues raised by the overlap of public and private insurance relates to the multiplication of trials and judiciary decisions ordering the SUS to pay for high cost medicines that are not on the national list of essential drugs generally covered by the public regime (Hamacher, 2013; Avelas Nunes & Facury Scaff, 2011). Some of those judicial petitions are presented to the Court following refusal of coverage from private insurers, if I understand correctly. Judicial decisions mandating the SUS to provide the unlisted medication to the privately insured patient reveal that the double constitutional protection for public and private health insurance represents a daunting challenge for the country and the control of health costs.

Gaps, overlap, and competition between Constitutional rights, legislative regulation of the SUS on the one hand and duplicative or substitutive private insurance on the other, creates a complex web of rights and duties where judicial decisions may interfere with compounded social policies. The gap between constitutional program and the actual services available on the ground leads the Courts to trample with public policies for access to drugs. The end result is that judicial decisions have a huge impact on the budgets of public authorities delivering services of the SUS.

It is extremely instructive to note that a recent book on current issues in municipal law features in chapter one a discussion about the impact of judicial decisions in healthcare on municipal budgets, demonstrating the acute impact on municipalities of the interrelation between public and private insurance in Brazil (Anunciação Ianque, 2014).

Should governments have differentiated insurance schemes for poorer populations?

Populations in need and vulnerable people do not represent an attractive market for private insurance because of their limited financial capacity or the high financial risk they represent. When public insurance covers the insurance needs of populations in need, private insurance is only too happy to be left free to concentrate its offer of services to lower risk and better-off populations. This is more or less the Canadian situation with drug coverage outside hospitals, where the private insurance may generally cover working people with collective employer-sponsored insurance contracts. We saw that the insurance schemes for drugs delivered outside of hospitals in Canada are generally structured on differentiated insurance schemes for the more vulnerable populations, the elderly and people on social assistance. This policy leaves the door open to private insurance to reap the betterrisks through group insurance. Private insurance is thus only too happy when governments take the lead in covering health needs from the poorer and higher health risks segments of the population. Premiums for healthier and working segments of the population covered by the private industry don't have to cross-subsidize the poorer and sicker populations leading to a more lucrative market for the industry.

However, in doing so the government deprives itself of a more efficient system for risk hedging. An adequate insurance pool should not be mainly composed of bad risks. It is important to seek a balanced pool of good and bad risks, the first to support the latter.

This is the reason why there has been a strong advocacy in Canada and Quebec to implement a real universal public regime that would cover medication outside hospitals in a single pool (Lexchin, 2001; Gagnon, 20??). This is a contentious issue raising constitutional and economic concerns leading to some political stalemate.

Pharmaceutical Industry: Loyalty Programs for Expired Patent Drugs

Worldwide context: Patent cliff

Drug insurance and public policies are currently facing important challenges on the worldwide scale with a threat coming from the pharmaceutical industry. Major anticipated savings from the substitution of patented drugs for generic drugs are being diverted in favour of the pharmaceutical industry of patented drugs. This is imposing enormous additional costs to be borne by public and private insurers and their patients.

Contrary to healthcare delivery and insurance, the pharmaceutical industry operates on a worldwide scale. Over the last few years, the industry has been undergoing important restructuring, with significant mergers and acquisitions (European Commission, 2008). The industry is currently facing an unprecedented 'patent cliff' where many of the blockbuster drugs[4]are coming to the end of their patent protection, opening the door to generics. Drugs, and in particular for populations in need, could then become more accessible.

Loyalty programs

However, the industry is opposing its loss of market share by setting up new strategies designed to entice patients and healthcare professionals to stick to brand name medication and not switch to the generic drugs coming on the market. According to trading rules, the commercial value of a drug diminishes with the end of the patent, when generic drugs gradually replace the brand name drug with its bio-equivalent for a fraction of the price (Hudson, 2000). This is what the pharmaceutical industry is trying to change in order to cling as much as possible to their market share and postpone the normal decline of their expired patent drugs market.

An array of loyalty programs are bourgeoning across countries publicizing increased choice offered to patients at no extra or little out-of-pocket costs for them. Co-payment cards are accessible to patients from the web, from physicians, or from pharmacists. In Canada, the programs advertise to patients and professionals that patients will not pay more than for the generic drug (or at a minimal extra cost of $5) to keep the treatment on the brand name medication.

Loyalty programs from the pharmaceutical industry are based on extensive commercial strategies and management scenarios. In countries where direct-to-consumers publicity for drugs is allowed (like in the USA), TV and magazine can relay the messages to patients to subscribe to the program in order to reap the so-called benefits of brand name medication treatment. In all cases, the programs require the active participation of health professionals, like physicians who are invited to make a "no substitution" inscription on the prescription, or the pharmacist who has to deliver the brand name medication without substitution and manage the payment request to the insurer and, for the necessary portion, to the pharmaceutical company.

Loyalty programs first appeared in 2006 in the United States of America, the largest pharmaceutical market in the world. Promotion of similar programs has vastly expanded over the last few years. In March 2013, co-payments cards or coupons were available for over 374 brand name medicines, of which 75% are for chronic diseases (Ross &Kesselheim, 2013). The market for statins was particularly prone to such loyalty programs. Pfizer had cashed US$13 billions in 2010 for Lipitor only, the year before the expiry of the patent. The company then launched an unprecedented offensive to maintain the sales of their blockbuster drug (Sanburn, 2011; Avorn, 2011).

A study published in 2012 in the *New England Journal of Medicine* stresses that the manufacturers of brand name statins (Pfizer for Lipitor, Merck for Zocor and Astra Zeneca for Crestor) were competing in loyalty programs and ingenuity to try to extend the commercial life of their medication (Jackevicius et al, 2012). The authors concluded that the enormous anticipated savings for the U.S. health care system with the arrival of generic statins were likely to be severely constrained unless a vigorous reaction of stakeholders would hold back such commercial strategies.

In Canada, loyalty programs are managed by two large groups: InnoviCares [5] and RxHelp [6]. Like their American counterpart, Canadian loyalty programs basically rest on the ability of the manufacturer to switch on the patient's insurance plan the better part of the increased cost for the brand name drug. The stratagem benefits the pharmaceutical company to

save a market share which should decline according to regular market rules, at the expense of the generic drugs and mainly, at the expense of the insurer who has to bear the main portion of the additional cost. Ultimately, the strategy leads to higher insurance premiums for all. Experience in Canada also shows that as soon as it becomes impossible for the manufacturer to transfer the program costs on the shoulders of the insurer, the manufacturer reduces the loyalty program benefits or simply terminates the program. Table 2 below shows some examples of brand name drugs with expired patents on loyalty programs in Canada.

Table 2 — Examples of drugs covered by Loyalty Programs in Canada

Drug	Use	Drug	Use
Alesse	Contraceptive	Norvasc	Blood Pressure
Andriol	Testoterone Replacement	Plavix	Blood Platelets
Caduet	Cholesterol / Blood Pressure	Proscar	Prostate
Clorazil	Schizophrenia	Seasonale	Contraceptive
Cordarone	Heart Rythm	Sebivo	Hepatitis B
Cosopt	Glaucoma	Sinemet	Parkinsons Disease
Crestor	Cholesterol	Singulair	Asthma
Depo-Provera	Contraceptive	Timoptic	Glaucoma
Effexor XR	Depression	Trusopt	Glaucoma
Elocom	Skin Infection	Valtrex	Herpes
Lipitor	Cholesterol	Xalatan	Glaucoma
Marvelon	Contraceptive	Xeomin	Muscle Spasm
Maxalt	Migraine	Zoloft	Depression

Source: Martinez, 2013.

These commercial strategies from the pharmaceutical industry raise numerous and acute questions and concerns for governments and private insurers. They may clash with major public policy concerning access to medicines and better use of medication, cost control of healthcare, as well as privacy protection for sensitive information about patients' medication transmitted to the pharmaceutical industry by pharmacists.

Conclusion

Drug insurance schemes are the first responsibility of governments. The design of insurance legal structure is central to provide access to medication, not only for populations in need, but for the whole population. Insurance plans should preferably pool together good risks as well as bad risks. This is easier said than done, as both Canada and Brazil must do so within the constitutional framework and political climate available to them.

The legal structure of the relations between the public and the private insurance is also key. Both Canada and Brazil have to tackle with constitutional challenges from the private industry trying to make the most out of the healthcare markets. But, there is no doubt that the responsibility of our respective countries to design and fine-tune the legal framework for healthcare is of the highest importance for the benefit of the population.

The pharmaceutical industry is also trying to get the most out of the medication market, relaying the bill to patients and insurers, public and private. Governments need to react to the commercial strategies used to maintain patients on brand name drugs with expired patents, when cheaper and safe generic drugs are available on the market at a fraction of the price. It is of the utmost importance that governments don't let the pharmaceutical industry frustrate public policies designed forefficient and rational drug use.

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[1]Art. 196 *Constituiçao da Republica Federativa do Brasil*: "A saúde é direito de todos e dever do Estado, garantido mediante políticas sociais e econômicas que visem à redução do risco de doença e de outros agravos e ao acesso universal e igualitário às ações e serviços para sua promoção, proteção e recuperação."
[2] Art. 199*Constituiçao da Republica Federativa do Brasil*: "Assistência à saúde é livre à iniciativa privada.
§ 1º As instituições privadas poderão participar de forma complementar do sistema único de saúde, segundo diretrizes deste, mediante contrato de direito público ou convênio, tendo preferência as entidades filantrópicas e as sem fins lucrativos. (...)"

[3]Art. 4, § 2º "A iniciativa privada poderá participar do Sistema Único de Saúde (SUS), em caráter complementar."
[4] A blockbuster drug is defined by worldwide annual sales exceeding 1 billion US$.
[5]https://www.innovicares.ca/en: with nearly one hundred brand name products available.
[6]https://www.rxhelp.ca/en/default.aspx.