Intelligence MEMOS

From: Chris Bonnett

To: Pharmacare Watchers

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Re: Two Options to Get Better Pharmacare Faster

Nothing is more dangerous than an idea.

Émile Chartier is credited with those words or similar, finishing with "…when it's the only one we have."

Canada has tried for nearly 80 years to implement "national pharmacare" – defined here as a fully public national drug insurance plan – without success. We should ask why.

One reason is an unrelenting insistence that only a fully public plan will work. Fifty years ago that may have been true. When Ottawa didn't act, we found an alternative: provinces and employers stepped in.

Between us and a good-quality universal drug insurance plan lie four problems, all of which matter right now. The Liberal-NDP supply-and-confidence agreement promises national pharmacare legislation in 2023, perhaps very similar to June's NDP Bill C-340. Essentially, the New Democrats, and perhaps the Liberals, have just one model in mind: a fully public drug plan.

The first problem is that a small percentage of Canadians have no access to any drug insurance. They live in Alberta, New Brunswick, and Newfoundland and Labrador. There are two solutions for the uninsured: either make coverage mandatory, as in Quebec, or expand each province's safety net so that everyone is covered above some threshold, perhaps 5 percent of net household income.

The second problem – bigger and very persistent – is that the quality of drug coverage depends on where you live or work, not on medical need. To state the obvious: this isn't fair. The solution to this problem is also a national standard of income-based limits on out-of-pocket costs. Access to a universal, comprehensive national formulary (drug list) of high-value drugs would also help.

The third major problem is Canada's drug prices and costs. For decades, the logic has been that we should first control prices, and only then add drugs to medicare. We're still fighting that battle. Our prices and costs are still very high – third among OECD nations – despite a decade of better management.

The fourth problem is public finance and opportunity costs. Every government dollar spent on drugs is money not spent on other health needs, childcare, the environment, or defence. The solution is either new taxes or billions of dollars in other savings, a bridge no government has crossed. The public can't have it all, and the choices are tough and contentious.

Given these four problems, where does that leave us with national pharmacare?

A national public single payer drug plan will still work. However, implementation requires massive administrative changes and costs that must be absorbed by our deeply indebted governments. It requires $22 billion in current private drug spending to shift to the public purse, disrupting as many as two-thirds of Canadians with generally good quality private drug plans. It's also a distraction: provincial governments already struggle with primary care, long-term care, surgical wait times, community care, and mental health care.

True to the spirit of Chartier's full sentence, there are two other ideas beyond a national single player plan: Social insurance has been used in Canada and in many countries that have broader, higher quality universal health systems, most at lower per capita costs. A second, more targeted approach is a portable health benefit plan that uses a similar mixed funding model to help workers with no health insurance.

Social insurance is comprehensive, universal, principled, and practical. In Canada, it underpins the Canada and Quebec Pension Plans, workers' compensation, and Quebec's universal drug plan. It includes insurer regulation and shared funding by employers, individuals, and the government, spreading costs and increasing resources.

But is this model better than a public single payer plan? My doctoral research concluded that European social health insurance models – specifically in Germany and the Netherlands – are essentially more comprehensive, co-ordinated, robust, and well-regulated versions of our 50-year accident of provincial and private drug plans.

Driven by interest from the Ontario government, portable health benefits were explored in my recent C.D. Howe Institute report. In February 2022, the province struck an advisory panel which was to complete its work this summer. When its report is publicly released, it may provide a pathway to extend supplementary workplace health benefits to millions of Ontario workers and their families. The model could be easily adapted to other provinces: British Columbia has also shown interest.

These alternative models present two other important advantages. We can avoid the complexity of a whole new federal plan and the delay while 14 governments hammer out a compromise. They both work with and improve our existing private-public model rather than replacing it.

These models also open up other possibilities, like better governance and accountability by accessing broader expertise – think health professionals, insurers, employers, and unions. Germany's Federal Joint Committee is an excellent model.

These approaches do not just "fill the gaps." They present legitimate and tested opportunities to do more, better and probably faster. Since no model is perfect, we must always think beyond just one idea.

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