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National Pharmacare – Time to Get On With It

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A presentation to "Pharmacare Back on The Radar: Canada's Need for Federal-Provincial Cooperation," a C.D. Howe Institute webinar held on October 26, 2023.

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Introduction

It has been over four years since the Advisory Council on the Implementation of National Pharmacare (ACINP), led by Dr. Eric Hoskins, published its roadmap to implementing national universal pharmacare in Canada. By now, Canada should have been well on its way to rolling out improved coverage for prescription drugs for Canadians.

Things got off the ground in Budget 2019 with commitments to set up a Canadian Drug Agency, create a national formulary of included drugs, and introduce a new program to pay for high-cost drugs to treat patients with rare diseases. But something happened along the way, and four years on, Canada finds itself with little progress to show. The disruption caused by the pandemic has been a major factor, dramatically shifting the focus of federal and provincial governments and increasing the federal debt. However, this has not prevented other big ticket initiatives – including a pan-Canadian early learning and child-care initiative and a new dental-care benefit for low-income Canadians – to move forward.

It isn't as if nothing has happened on national pharmacare. Some foundational steps have been taken. A transition office has been created to set up the Canadian Drug Agency, and the Canadian Agency for Drugs and Technologies in Health (CADTH) has developed a framework for a national formulary. Further, $1.5 billion in funding for a rare disease drug strategy has been unveiled, and a bilateral initiative worth $35 million over 4 years has been launched with PEI to expand its drug program. For their part, provinces have been making improvements to public drug plans, including adding new

drugs to their formularies, expanding access for certain groups, reducing deductibles and mandating switching to biosimilars. But time is marching, and absent a bigger push on the federal side, it's doubtful that national pharmacare will move forward.

The reality is that the delivery of drug coverage for Canadians is a provincial responsibility. The federal government has certain responsibilities for the regulation of drugs and funds drug coverage for First Nations and Inuit populations, but needs to use its spending power and moral suasion to get provinces and territories on board with national pharmacare. Politically, the gap has widened between the federal and provincial governments since 2018. At the provincial level, conservative-minded governments are now in power everywhere except for BC, Manitoba, and Newfoundland and Labrador. Nationally, the federal Liberals have aligned with the NDP under a supply and confidence agreement that commits the federal government to introduce legislation on national pharmacare by the end of this year and develop a bulk purchasing plan for drugs. According to recent reports, the NDP has rejected the first version of the draft bill and have indicated they will not accept anything short of a single-payer, fully publicly-funded system.

The fact that the recent federal-provincial-territorial health funding agreement reached by First Ministers did not mention national pharmacare speaks volumes. This deal represents the most significant federal investment in healthcare since the early 2000s– close to $200 billion over 10 years – to address the most pressing issues in Canada's healthcare system, including access to primary care, addressing surgery backlogs and increasing the supply of health workers, addressing the crisis in mental health and substance use, and leveraging data and digital tools to modernize the system. National pharmacare was nowhere to be found. In parallel, as required by the Liberal/NDP deal, the government introduced a new dental care benefit for low-income Canadians.

Yet the imperative to move forward with national pharmacare has not gone away. If anything, it has become even more pressing as Canadians without adequate coverage struggle to pay for their drugs in a context of high inflation and the rising cost of living, and as healthcare systems – stretched to the breaking point – seek ways to keep patients healthy and out of ERs and hospital beds.

Why National Pharmacare?

A lot has been written about why Canada needs national pharmacare. It all boils down to one thing: too many Canadians don't have adequate prescription drug insurance and are unable to afford necessary medicines. Although the vast majority of Canadians have some form of prescription drug coverage through private or public drug plans, many lack adequate coverage, leaving them vulnerable to high out-of-pocket costs.

Without adequate insurance, drug costs can have a significant impact on personal finances and health outcomes. A 2018 study found that 5.5 percent of Canadians could not afford their drugs, with many forgoing basic necessities such as food or heat to pay for their medication. The results are additional doctor appointments, ER visits, and hospitalizations. This is not just an issue for the small minority of Canadians without any insurance. High deductibles and co-payments in both public and private plans can require individuals to fork out thousands of dollars before their coverage kicks in. A 20 percent co-payment, common in private drug plans, may not amount to much when applied to a low-cost generic drug but can generate prohibitively high patient costs when applied to newer high-cost drugs.

Inadequate and uneven coverage across public drug plans is another key driver for national pharmacare. A 2021 study by the Patented Medicines Prices Review Board (PMPRB) found that for the 240 medications given a positive recommendation by CADTH's Common Drug Review between 2003 and 2019,

public drug plan "listing rates" varied from only 64 percent of those medications to 90 percent, with an average of 77 percent. The discrepancy in listing rates across provincial and territorial plans was even greater for biologics (from 48 percent to 89 percent) and for expensive drugs for rare diseases (from 10 percent to 93 percent). The sad truth is that drug coverage for many Canadians continues to be a postal code lottery.

The impact of inadequate or no drug insurance on health outcomes and on the healthcare system is significant. One study[1] commissioned by the ACINP found that removing out-of-pocket costs for medications used in treating only three diseases – diabetes, cardiovascular disease and chronic respiratory conditions – would result in as many as 220,000 fewer emergency room visits and 90,000 fewer hospitalizations annually, representing potential savings to the healthcare system of up to $1.2 billion a year. At a time when hospital beds and wards are overcrowded and health human resources are struggling to keep up, improved drug coverage could help to keep more people healthy and avoid adding unnecessary burden to an over-stretched system.

Underlying these deficiencies is a fragmented and inefficient governance model with over 100 distinct public drug plans and over 100,000 private drug plans operating largely independently from each other with no national standards and weak data infrastructure. Some of the key ingredients for improved governance are in place, including a well-functioning pan-Canadian health technology assessment process and common drug review under the auspices of CADTH, and a purchasing alliance of public drug plans managed by the pan-Canadian Pharmaceutical Alliance (pCPA) created by the premiers. But much remains to be done. The aforementioned proposed establishment of a Canadian Drug Agency announced by the federal government in 2019 could be a step in the right direction if it results in a consolidation of existing organizations, but it has floundered as momentum for national pharmacare has waned.

Sorting Through the Debate on Potential Pharmacare Models

Despite numerous studies over the past decade, there is still rampant debate on what national pharmacare should look like. Several national studies and commissions – including the ACINP – have recommended a single-payer universal system that looks and feels like medicare: an inter-locking set of provincial and territorial drug plans covering all Canadians with a broad formulary of covered medications, low or no co-payments, and a relatively minor role for private drug plans to provide insurance medications not covered by pharmacare. But there is also strong support for a mixed public/private drug plan that would leave the existing array of private plans in place and expand public plans to "fill the gap" of uninsured and under-insured individuals. Recent polling suggests that a plurality of Canadians (45 percent) prefer a "fill in the gaps" pharmacare model, followed by a single-payer model (27 percent), with 14 percent preferring that the government not expand pharmacare.

The Parliamentary Budget Officer recently estimated the cost of a single-payer program at $11.2 billion in the first year, rising to $13.4 billion

1 Tamblyn, R., Bartlett, S., Thavorn, K., Weir, D. & Habib, B. (2019)." Burden and Health Care System Costs Associated with Cost-Related Non-Adherence to Medications for Selected Chronic Conditions in Canada," (a report prepared for the Advisory Council on the Implementation of National Pharmacare). Available from Health Canada by request.

in the fifth year.[2] This funding would augment existing provincial/territorial spending on drugs and enable public drug plans to expand eligibility, reduce deductibles and co-payments, and displace a good portion of the coverage currently provided by private drug plans. The "fill the gaps" approach would be less disruptive and less costly to implement as additional public funding would target under- and uninsured individuals and would not displace existing private insurance coverage.[3]

There is also debate on what the initial starting point for universal national pharmacare should be. Some experts think we should start with public coverage for essential medicines. Others advocate for a focus on high-cost drugs and catastrophic drug costs. Jurisdictions could build on income-tested drug coverage programs already in place and reduce deductibles and co-payments, and align formularies in such a way as to eventually displace a portion of private insurance coverage and achieve universal national pharmacare. The Quebec approach could also serve as another model for the implementation of national universal pharmacare, enabling public and private drug plans to co-exist. However, this would require provinces and territories to mandate drug insurance coverage and regulate private drugs plans to ensure no residents would be uninsured, something that no other jurisdiction appears ready to do.

In reality, many different roads can lead to national pharmacare. Whether jurisdictions start with a focus on essential medicines, high-cost drugs, or reducing deductibles and co-pays for low-income families, the main point is that public drug plans need additional investments to address the most pressing gaps in coverage and affordability. There is no need to impose a single model at this stage – it's too early, the federal government does not have the necessary resources and political capital, and provinces will not accept a federally imposed solution. At some future date, when public plans have expanded to the point where they are starting to overlap more with private plans, achieving universal coverage will require provinces outside Quebec to decide whether they can effectively regulate private insurance and mandate coverage, or whether they want to move further down the track toward a single payer. But that is not today's problem.

The Federal-PEI Bilateral Agreement on Pharmacare: A Potential Model for Moving Forward

The recent bilateral agreement between PEI and the federal government on drug coverage could be an interesting model to emulate. Through this agreement, the federal government is providing about $70 per capita annually to PEI to improve drug coverage, including expanding the provincial drug formulary, reducing copays and deductibles and expanding eligibility for public programs. The agreement includes an implementation plan with commitments and performance measurement around three key goals: improving stakeholder planning and engagement, improving the drug formulary (expanding/modernizing the formulary, and

2 The PBO estimate does not include the cost of implementing national pharmacare in the context of provincial and territorial plans with vastly differing starting points. Provinces will expect the federal government to provide equal funding per capita so as not to penalize jurisdictions that already have better coverage. This means that if the province with the most generous public program needs $250 per capita to meet expectations under national pharmacare while the province with the least generous public program needs $500 per capita, the federal government may be compelled to provide $500 per capita to all jurisdictions, which would increase the overall cost by a considerable margin.

3 Estimates of the cost of a "fill the gaps" approach range from $2 to $5 billion annually.

simplifying formulary access), and improving drug plans (expanding coverage, simplifying access and reducing costs to residents).

This could be scaled up nationally, with the same offer made to other provinces. There would have to be some guardrails around how the money is used, built around the overall goal of addressing key gaps in public drug programs. Similar to the PEI example, provinces could use the money to reduce deductibles, copays and premiums, expand eligibility and add drugs to their formularies. Some may want to focus on improving access to essential medicines, others on access to high-cost and high-value drugs. By avoiding a one-size-fits-all solution, we would maximize the chances that provinces will engage and invest federal dollars in areas where they are most needed instead of displacing existing public or private plan spending.

Getting to National Universal Pharmacare – what needs to happen next?

It's not too late to get national pharmacare back on track. To do this, the federal government needs to lay out a credible approach and timeline to move forward and mobilize support from provinces and key stakeholders. Without strong federal leadership, the inertia built into the current system will simply overpower any attempt to change the status quo.

There are some inconvenient truths that need to be acknowledged. First, the nation's balance sheet is in much worse shape than before the pandemic, significantly reducing the fiscal room available to fund national pharmacare. Second, there are limits to how prescriptive the federal government can be in an area of provincial jurisdiction. Under medicare, Ottawa sets broad national standards but does not get to meddle in the precise details of how provincial health insurance plans are set up and operated; pharmacare would be no different. And third, provinces are not clamouring for national pharmacare and will guard their autonomy. They have a lot invested in their current approach to drug coverage and will be reluctant to make significant changes unless it fits with their worldview and comes with an iron-clad commitment of federal funding.

Given this context, successful implementation of national pharmacare will require attention to the following four key elements:

1. **New federal investments to scale up the PEI approach** – New federal funding for national pharmacare is critical to making any progress. Similar to the PEI deal, the federal government should offer all provinces a set amount – say $100 per capita -- targeted and tied to specific improvements in public-plan coverage, including expanded eligibility, increased alignment across formularies and reduced co-payments and deductibles. Targeted improvements could vary from province to province depending on the most pressing needs. These bilateral arrangements would have to fit within an overall framework laid out in legislation that works toward cross-jurisdictional alignment. The total cost would be about $4 billion annually – not a small amount of money – but meaningful enough to create momentum for change. This would be in addition to the commitment made in the 2019 budget to provide provinces and territories with $500 million annually for rare disease drugs.
2. **Federal legislation should be aspirational and enabling** – In the current intergovernmental environment, there is a risk that prescriptive federal legislation on national pharmacare could derail the project before it even starts. Provinces already underwrite 44 percent of national drug spending and will bristle at the notion of a one-size-fits all approach from Ottawa, which currently funds a very small proportion of drug costs. Now is not the time to throw down the gauntlet and tell provinces they need to commit to a single-payer approach. Instead, federal legislation should be aspirational, outlining the vision of national pharmacare and what it means for Canadians, recognizing that implementation will occur by phases over time. It will include working with interested jurisdictions, acknowledging the

important role provinces already play in delivering public drug coverage, creating a framework that enables governments to work collaboratively together and with stakeholders to set national standards on coverage and out-of-pocket payment, as well as providing legislative guarantees around long-term federal financial commitments.

3. **National minimum standards should be established** – Federal legislation should make provision for national minimum standards that all drug plans, both public and private, would strive to achieve. Standards should be established collaboratively once a critical mass of jurisdictions have accepted the federal funding offer, and should set out clear minimum expectations around eligibility for coverage, breadth of formulary, and out-of-pocket payments. Plans could exceed these expectations, for example, by providing a more comprehensive formulary of drugs and/or lower out-of-pocket payment. These expectations would be raised over time (in tandem with additional federal funding) to work toward universal coverage, a broader formulary, and lower out-of-pocket payments. Jurisdictions would need to commit not to reduce their current level of coverage, enabling new federal investments to support a more comprehensive program in some jurisdictions while supporting others to get there.
4. **Governance should be strengthened** – Canada's fragmented approach to pharmaceutical decision-making needs to be further strengthened. The creation of CADTH, the Common Drug Review and the pCPA have been positive steps that have served Canada well, but significant gaps remain. Private drug plans do not have access to pCPA negotiated prices for innovative drugs[4] and generally operate with little or no non-financial regulation.[5] A good step forward would be for the pCPA to pilot joint public-private plan price negotiations for a specific segment of innovative drugs (e.g., for the treatment of a defined chronic disease condition). In parallel to this, the pCPA – which recently transitioned to an independent not-for-profit model – needs to improve transparency and accountability to Canadians around the drug reimbursement process and the timeliness of listing decisions. There is also more work needed to build better partnerships in Canada's pharmaceutical management ecosystem. Recent misfires such as the failed implementation of reforms to the PMPRB drug pricing regulations underscore a climate of mistrust among regulators, payers, industry and patients. Whether through the proposed Canadian Drug Agency or expanding the mandate of established organizations, there needs to be a more inclusive table, focused on building the trust and collaboration needed to address the fragmented approach to pharmaceutical policy in Canada.

Conclusion

National pharmacare is overdue. In 21st century healthcare, drugs are not a luxury nor a discretionary add-on. They are an essential part of healthcare delivery that should be covered universally. Canadians have already waited too long, and far too many of them don't get the medication they need to stay healthy and manage chronic disease.

4 The pCPA-negotiated pricing framework for generic drugs applies to all generic drugs sold in Canada, regardless of whether they are reimbursed by public or private plans. However, pCPA-negotiated prices for innovative drugs are only available to pCPA members, which are the participating federal, provincial and territorial public drug plans.

5 Jurisdiction for the regulation of private insurance is shared between the federal and provincial governments. All private healthcare insurers in Canada are subject to regulation by the federal government to ensure financial solvency. Provinces and territories are responsible for regulating the terms and conditions under which insurance policies are sold, but in practice, only Quebec does this.

The federal government can act as a catalyst by making a credible and responsible financial commitment that opens the door to joint work with provinces and territories to improve public plan coverage. The PEI agreement is a good model and federal legislation can help to create a positive foundation for collaboration.

The political window to move things forward is open, but not for long. The federal government, working collaboratively with provinces and territories, has an opportunity to make this happen in a focused and realistic manner. Let's get on with it.

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