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HEALTH POLICY

Feasible Pharmacare in the Federation: A Proposal to Break the Gridlock

by

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- Pharmacare is a top-of-mind issue for Canadians. As a share of overall health costs, prescribed drugs rose from 6.3 percent in 1975 to 13.4 percent in 2014. There is widespread agreement among provincial health ministers and health policymakers that Canadians need improvements to the existing arrangements for drug policies.
- This E-Brief proposes a politically feasible way to start addressing the major shortcomings of the current system, which include: 1) access and equity (coverage), 2) the drug prices paid by Canadians, 3) the lack of a common formulary, or list of drugs covered, based on cost-effectiveness criteria, and 4) the quality of prescribing by physicians.
- We argue for an expanded federal role that would involve partial funding to provinces aimed at reducing barriers to access. This would require a nationwide network of geared-to-income (catastrophic) plans that would improve the level of coverage in all provinces.
- A greater federal role in financing would set the stage for improved cooperation in drug pricing, formulary design, and in the creation of a drug strategy for rare and high-cost diseases.

When Canada's system of provincial health insurance was in its early stages, pharmaceuticals played a relatively minor role in the care of patients. But drug costs have grown in relative importance: As a share of overall health costs, prescribed drugs rose from 6.3 percent in 1975 to

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13.4 percent in 2014. Meanwhile, in other countries with government-organized health insurance, the universal plans include most drug costs. In Canada, however, we still do not have universal drug coverage.

On June 8, 2015, most of Canada's provincial health ministers met to discuss plans for "national" or "pan-Canadian" pharmacare, stating that the timing of the meeting would help to keep pharmacare as an issue for the federal election.¹ Participants had much to discuss. Commonly identified issues in Canadian pharmaceutical policy over the last decade include i) access and equity (coverage), ii) the drug prices paid by Canadians, iii) the lack of a common formulary, or list of drugs covered, based on cost-effectiveness criteria, and iv) the quality of prescribing by physicians (Dixon 2014). The severity of each problem is the subject of some debate among experts, but there is wide agreement that these concerns should be addressed by policymakers.²

While there was no consensus among the provincial health ministers on what role the federal government should play, many expressed the view that Ottawa should be involved. Defining the appropriate federal role in drug financing is not straightforward, however. In spite of many suggestions that Ottawa establish a national drug plan (Morgan et al. 2013, Gagnon 2010), there is a strong case for limiting the role of the federal government in financing drugs. Critically, the federal government is not directly responsible for paying most other healthcare costs, such as those for hospitals and doctors. So were the federal government to take on all drug costs there would be less integration in the management of overall health costs and less incentive for cost-effective choices among drugs and other inputs in healthcare. For example, the federal government cannot directly influence doctors' prescribing behaviour, which greatly impacts the overall costs and effectiveness of any hypothetical federal plan.

Given the strength of the argument for integrated financing and management of drugs and other components of the healthcare system, we do not think it wise to create a separate federally funded and managed pharmacare system. Instead, the federal role that we envision would involve partial funding to provinces aimed at reducing barriers to access, mainly for low-income Canadians. This would require a nationwide network of geared-to-income (catastrophic) plans that would resemble those existing in some provinces. Importantly, it would also include an expanded federal role not only in financing, but also in drug pricing, formulary design, and in the creation of a drug strategy for rare and high-cost diseases.

1 See Keith Leslie's article in *The Globe and Mail*, "Provincial Health Ministers call for National Pharmacare Program," June 9, 2015.

2 The perceived severity of the access issue, for instance, varies widely across research studies. Some surveys have shown as many as 23 percent of Canadians' saying that they cannot afford prescribed medications and compensate by skipping doses, splitting pills, or not filling prescriptions (Angus Reid 2015). Other studies have shown as many as 10 percent of patients in Canada saying that there had been instances in which they had altered or not filled a prescription because of cost considerations, even when they had some insurance coverage (Morgan et al. 2013, Law et al. 2012). In countries like the UK, Germany, or the Netherlands, this percentage was lower. Other research, however, has shown that the financial burden of prescription drug expenditures on Canadians is relatively small, with a small share of households facing catastrophic costs (McLeod et al. 2011). Finally, as observed in Kirby (2002) only a small share of Canadians, roughly 2 percent, concentrated mainly in the Atlantic provinces, have neither public nor private drug coverage. On balance, we think this last statistic understates the problem (because some plans require considerable patient cost-sharing), and that there is an undesirable amount of prescription avoidance due to cost in Canada, particularly in the Atlantic Provinces.

Affordable Pharmacare: A Proposal

In our view, every province, no matter its size, should ensure that no one fails to fill a prescription because of lack of financial means. In considering how this could be accomplished, however, one must pay close attention to the additional burden that such an initiative would put on government budgets, which will be increasingly strained as Canada's babyboomers retire and working-age taxpayers become a smaller share of the population.

In our view, recent proposals (Morgan et al. 2013; 2015, Gagnon 2010) for a universal pharmacare plan under which governments would pay essentially all drug costs, with only very limited patient charges, are not realistic in this respect. Even if one accepts the suggestion that such a plan could lead to reduced *total* (private and public) spending on drugs in the long run, the immediate impact would be large increases in government spending.³ To politicians, whether at the federal or provincial level, this will seem like a risky gamble. Voters will hold them to account for the immediate spending increases, and may not be convinced that the reductions in future total drug costs will be as large as predicted, or that the reductions would directly benefit them.

In this E-Brief, we propose instead a less costly federal initiative under which a substantial share of total drug costs would continue to be privately funded, but in which the main problems – gaps in access, the high cost of pharmaceuticals and varied provincial coverage – would be eased. Under this initiative, the federal government would:

- transfer additional funds to provinces whose existing or new programs respect minimal conditions for an income-tested upper limit on annual family payments, and timing of such payments;
- become a partner in an expanded version of the Pan-Canadian Pharmaceutical Alliance (PCPA);
- cooperate with provinces on a model drug formulary and financing of exceptionally high drug costs for patients with certain “rare diseases”; and
- work with the provinces to improve quality of prescriptions.

A federal initiative with these elements would go a long way toward achieving the same objectives as those of a federally funded universal drug plan, but would do so in a way that would be much less costly to governments, and less disruptive of the current system. The provinces may be willing to implement whatever changes the new model would require simply to improve their existing plans. But an offer from the federal government to share in the cost of the new financing system would give the strongest incentive.

A tax-based upper limit on private drug costs

Low-income citizens without access to group insurance are a major component of those who fail to fill prescriptions (Morgan et al. 2013, Busby and Pedde 2015). Most provinces have already developed geared-to-income (catastrophic) plans that reduce the extent to which one's income remains a barrier to access, with various income-based limits on out-of-pocket annual drug spending. A federal initiative to create such plans everywhere would extend this principle to the country as a whole.

3 The total cost of prescription drugs in Canada in 2014 was almost \$29 billion; only about \$12 billion was covered by existing government programs, so 100 percent government coverage would require an extra \$17 billion. A portion of the incremental costs would be offset, however, because the costs of private drug plans for public-sector employees are already incurred by governments.

Eight Canadian provinces have upper limits on annual drug costs geared to income (Table 1, column 2). But only three provinces have limits below about 5 percent of family income for all families. We propose a limit of 3 percent, which is lower than in any of the current provincial catastrophic plans, to create a common, low floor across all provinces.⁴

A plan that pays for a family's drug costs only if they exceed an upper limit obviously does not imply the same degree of protection against the financial risk associated with illness that the provincial health insurance plans do. But it also is much less costly to taxpayers than a plan that doesn't require patients to pay anything out of pocket, and it targets those with the largest drug costs and hence the greatest financial risk. Moreover, specifying the upper limit as a fraction of the family's income is consistent with the equity objective underlying our medicare system: those with low incomes on average will pay a smaller amount of their drug costs out of pocket than high-income earners.⁵

An income-dependent upper limit on out-of-pocket drug costs would help protect families against major, long-term financial consequences of high drug costs. However, depending on how high the limit were set, many patients could still have access problems in the short run. For example, a limit set at 4 percent of family income, as in the catastrophic plan that Ontario currently offers to those with no other coverage, implies that a family would have to have out-of-pocket drug costs equivalent to roughly half a month's income before the plan would pay. For families with little in the way of liquid assets and limited access to credit, raising that much money on short notice could obviously be difficult. As a result, even prescriptions for urgently needed drugs could go unfilled because patients had difficulty paying for them.

Short-term access problems of this kind could be reduced if most patient charges under the provincial plans were made payable as part of their income tax liability, not at the time that their prescriptions were filled. That is, the government plans would function in part as a credit card to which patients could charge their prescription drug costs, without any limit. There would be no interest charges, and the balance would be payable at the same time as the patient's provincial income tax.⁶

Administration of such a model need not be complicated. Pharmacists would bill the plans for the cost of each prescription. At income tax time, patients would receive statements from the plan with information about the balance in their account, and the out-of-pocket portion owing would be calculated with the same information used to calculate each person's income tax liability.⁷

4 In 2008, 21 percent of households spent more than 1 percent of their after-tax income on prescription drugs; 8 percent of households spend more than 3 percent of income on drugs; and 3 percent of households spent over 5 percent (Statscan Table 109-5012).

5 In this respect, our proposal is similar to one that was made in the Kirby report (2002).

6 Tax-based patient charges of this type for hospital and physician services have been discussed by Abo, Goodman and Mintz (2002). If the upper limit is specified as a percentage of income, the need for special provisions for low-income people is reduced, but the income concept used in the calculation could be adjusted so that those at the bottom of the scale were entirely exempted.

7 The calculation determining a person's maximum out-of-pocket payment would be similar to that which governs the calculation of the medical expenses tax credit in the current tax system, in which a claim can be made only if eligible expenses exceed a specified percentage of a taxpayer's 'net income.' In our model, the amount that would be added to the patient's tax bill would be equal to the balance in his or her prescription drug account, up to the specified maximum percentage of his or her net income. Out-of-pocket expenses for drugs would no longer be claimable under the medical expenses tax credit.

Table 1: General and Catastrophic Public Drug Plans in Canadian Provinces

	General	Geared-to-Income (Catastrophic)
BC	Voluntary participation in plan with income-based deductible.	Yes, general plan is a geared-to-income plan with deductibles from 0 percent (min) to 4 percent of income (max.)
AB	Plan for seniors, social assistance recipients, and an income-based premium plan for others without private insurance.	No, income-based premiums in voluntary plan (Non-Group Coverage Benefit). Max. individual premium of \$760 (with annual income above \$21k); Max \$25 co-pay for each prescription.
SK	Plan for low- and middle-income seniors and social assistance recipients.	Yes, max. costs of 3.4 percent of adjusted family income (Special Support Program).
MB	Income-based deductible plan for all without private group insurance.	Yes, max. costs of 2.97 to 6.73 percent of adjusted family income.
ON	Plan for seniors and social assistance recipients.	Yes, max. costs of 4 percent of net family income (Trillium Plan).
QC	Plan for seniors, social assistance recipients and mandatory plan for those without private group insurance.	Yes, max. costs of \$1,029 annually (Mandatory public plan).
NB	Plan for low-income seniors and plan for social assistance recipients; voluntary plan for all others without private group insurance.	No, income-based premiums in voluntary plan (New Brunswick Drug Plan). Max. individual premium from \$800 to \$2,000 (with annual income above \$22k); Max \$15-\$30 co-pay for each prescription.
NS	Income-based plan for seniors and plan for social assistance recipients.	Yes, max deductible from 1 to 20 percent of income, max copayment from 4 to 15 percent of income (Family Pharmacare Program).
PE	Plan for seniors and social assistance recipients.	Yes, max. costs range from 3 to 12 percent of income (Catastrophic Drug Plan).
NL	Plan for low-income seniors and plan for social assistance recipients.	Yes, max. costs of 5 to 10 percent of income; no max for those with annual family income above 150k (The Assurance Plan).

Note: The formularies for catastrophic plans vary across provinces.
Source: Various government documents.

Addressing the pricing issue: An expanded Pan-Canadian Pharmaceutical Alliance

Giving the federal government a larger financial stake in pharmaceutical costs would also strengthen its incentive to work with the provinces on drug price negotiations. The prices charged for patented brand-name drugs are already restricted by federal regulations; the Patented Medicine Prices Review Board (PMPRB) prevents the patent holders from charging prices in Canada that are significantly higher than in certain other countries. But the effectiveness of these regulations is reduced by the difficulty of getting accurate information on what prices the sellers are charging in the comparator countries. While some of the large provincial drug plans have also been able to negotiate significant discounts from the regulated prices, these discounts have been confidential and applicable only to the buyers who have negotiated them. As a result, drug plans in other provinces, as well as private insurance plans, have to pay the higher regulated prices.⁸

We recognize the argument that prices of newly developed drugs must be high enough so that the pharmaceutical companies can recoup the large costs of research and testing incurred before marketing the drugs. However, it is neither efficient nor equitable to have a system in which large provincial plans pay lower prices than do plans in smaller provinces, private plans, or uninsured individuals.

To remedy this problem, the federal government should pass new regulations to move towards a more transparent and uniform model of pricing of patented drugs in a way that is consistent with Canada's implicit commitments to contribute toward covering the cost of developing and testing new pharmaceuticals. The natural way to do this would be to build on the model that has already been created through the Pan-Canadian Pharmaceutical Alliance (PCPA), under which a number of Canadian provinces have jointly negotiated the prices of selected drugs that are supplied under existing provincial plans.⁹ As a major purchaser of drugs (under plans for veterans and the military, Non-Insured Health Benefits for First Nations and Inuit, among others), the federal government already has a direct interest in negotiating lower drug prices. Integrating these negotiations with those under the PCPA and with the regulations under the PMPRB makes sense. Joint purchasing should be extended to all types of drugs, and all drugs should be available at the negotiated prices to private insurance plans as well as to the provincial and federal ones. In these respects, our model is inspired by the way other countries with public and private plans, like Germany, pursue drug pricing negotiations.

A common formulary and a rare-diseases strategy

Formularies – lists of drugs that are approved for coverage – are used by both private and public insurance plans. As more new and sometimes very expensive drugs are developed and marketed, clear and explicit rules regarding which drugs are eligible for reimbursement, and for what patients, are becoming more important for containing pharmaceutical costs and streamlining access. Collection and evaluation of evidence with respect to the comparative effectiveness of different drugs in relation to their cost are activities that have played an important role in countries such as the UK and Australia where the publicly funded health care system pays for most drugs. Even though the decisions of the agencies that are responsible for making formulary

8 A referee has noted that comparisons of drug prices across countries are made more difficult because of slight differences from country to country in things like packaging, drug formulation, and so on.

9 The Pan-Canadian Pharmaceutical Alliance claims to have saved over \$315 million dollars annually, based on negotiations for 49 brand name drugs and 14 generic drugs, as of December 31, 2014.

recommendations in these countries often are controversial, their evaluations are transparent and public, and their recommendations are typically accepted and implemented by the authorities.

Existing Canadian provincial drug plans already have formularies that govern what drugs they cover, and there are national agencies (such as the Canadian Agency for Drugs and Technologies in Health, CADTH) that are engaged in the evaluation of drugs and medical technologies. But the procedures for selecting cost-effective drugs for Canadian drug plans are nowhere near as transparent and rigorous as they are in the UK and Australia. As part of a new pharmacare initiative, the federal government should strengthen the role of CADTH and give it a mandate to develop a model drug formulary, based on principles such as those used by agencies such as the National Institute for Clinical Excellence (NICE) in the UK, or the Pharmaceutical Benefits Advisory Committee in Australia.

Controversy often arises when decision-makers rule out coverage for sometimes very expensive drugs to treat individuals with certain “rare diseases.” Because these diseases only affect small numbers of people, the pharmaceutical industry will only continue developing drugs for such diseases if they can charge very high prices, and it is sometimes argued that they should be exempted from standard cost-effectiveness tests.

Canada’s health ministers implicitly recognized that there is a case for them to work together in addressing this difficult cost issue when they announced their intention to create a working group on the subject (CORD 2014). We believe it makes sense for the federal government to assume a leadership role in this area as well, as part of developing a national model formulary. Moreover, we propose that as part of a new national pharmacare initiative, the federal government should offer to take responsibility for a share of the costs of a special program to pay for approved drugs for an agreed list of rare diseases, or, more generally, of diseases for which the cost of approved drug treatments would exceed a specified level.

Quality of prescribing

Prescribing quality refers to the potential for drug overuse, misuse, safety and other adherence issues. The elderly with multiple prescriptions are often at the highest risk of issues arising from misuse – in 2009, two-thirds of seniors on public drug plans were taking five drugs or more and one-quarter were taking more than 10 drugs (CIHI 2012, 59).¹⁰ Research has shown that around half of seniors taking five or more medications experienced a side effect requiring medical attention (Reason et al. 2012), and all face increased risks of hospitalization.

There is a cost-efficiency component to prescribing quality as well. Information from provincial drug plans regarding the cost of a patient’s prescription drugs could be used to make family physicians and other prescribing providers more aware of these costs. One commonly overlooked aspect in the debate about drug costs is the lack of cost incentives for prescribers. There has been little mention of policies to make family doctors more sensitive to the costs of the prescriptions they make, or to the possibilities for cost-reducing generic substitution by physicians or pharmacists. Cost-effectiveness and prescribing quality are important

¹⁰ Medical professionals often use the term “polypharmacy” to describe the use of multiple medications (five or more).

aspects of pharmaceutical policy, and should feature prominently in a joint federal-provincial initiative to strengthen Canada's system of paying for drugs.¹¹

Offering provinces a deal they can't refuse

While we think the federal government should take the initiative to ensure that every province offers residents a plan with at least a minimum degree of coverage, it should be left up to the provinces to decide how they would integrate a plan of this type with their existing drug plans. In contrast to those who have called for replacing all existing provincial plans with a unified national pharmacare program, we believe that an initiative that builds on and existing provincial programs would have a better chance of succeeding politically than a nation-wide federal plan.

Because health policy is a provincial responsibility under the Canadian constitution, the federal government does not have the authority to require the provinces to extend their pharmacare plans so that they become universal and have an upper limit on out-of-pocket expenditure. However, Ottawa can give the provinces a strong incentive to do so by offering to transfer a portion of federal revenues to provinces that fulfil this condition. Legally, this is the approach that governs the Medicare model: Provinces must offer health insurance plans that fulfil the conditions of the *Canada Health Act* to receive the Canada Health Transfer (CHT) from the federal government.

Today, the CHT comes in the form of a fixed per capita transfer to each province, but an earlier version took the form of the federal government sharing a portion of the provinces' expenditures for their health insurance plans. We believe a cost-sharing version would be a good choice for a federal pharmacare initiative of the sort we advocate. It would be possible, for example, to estimate the total nationwide cost of outpatient prescription drugs attributable to families with drug costs in excess of 3 percent of nationwide median income. The federal subsidy could then take the form of, say, 40 percent of these excess costs, distributed on a per capita basis. Per capita allocation along these lines would ensure that provinces are not individually subsidized for increased costs in their own programs, since the federal transfers would be based on the nationwide total, not on the amounts spent in the receiving province.

The federal government would make these per capita transfers to any province that guaranteed every family was covered either by an approved private plan or by a government plan that met the conditions specified above (that is, an income-dependent upper limit on out-of-pocket expenditures, and tax-based patient charges). To give provinces an added incentive to sign on to the new system, a federal offer to pay a larger share of the drug costs of those with rare and costly diseases should also be made conditional on them doing so.

11 They are also issues that feature prominently in the attempts that some provinces have made to implement reforms that strengthen the role of primary care providers in managing chronic diseases and give each patient a "medical home" (Blomqvist and Busby 2012). A cost-sharing arrangement or the kind we describe in the text would give the federal government an incentive to support these reform efforts.

Other things equal, federal cost sharing weakens the incentives on the provinces to effectively manage drug costs to some extent.¹² We nevertheless favour the cost-sharing approach in this context, because it aligns federal and provincial incentives with respect to policies to contain drug costs, such as in the development of a common evidence-based formulary and in the joint price negotiations with pharmaceutical suppliers. The aggregate costs of government drug programs depend on decisions taken at both levels of government, and the degree of cost-sharing (i.e., what share the federal government offers to pay) should be chosen so as to create incentives on provincial and federal decision-makers to work effectively together.

Having the federal government assume new cost-sharing responsibilities of this kind will, of course, create additional pressure on its budget. It's hard to accurately estimate the cost of our proposed plan, but we feel that an annual cost around \$2.8 billion is reasonable.¹³ The impact on government budgets could be partially offset by repealing the non-taxation of employer-based health and dental benefits, which costs the federal treasury over \$2 billion annually, as recommended in the final report by the Advisory Council on Healthcare Innovation (The Naylor Report, Government of Canada 2015).¹⁴ If an employer purchases group health and dental insurance coverage on behalf of an employee, taxes are not paid on premiums and employer contributions are considered a non-taxable benefit to the employee (individuals who purchase insurance by themselves would need to use after-tax income to pay for premiums). By removing this non-taxation provision, like Quebec did in 1993, those fortunate enough to have an employer-paid plan would help pay some of the cost for expanding drug coverage to those less fortunate.¹⁵

The Role of Private Insurance in a Reformed System

A pharmacare system reformed in the way we propose would still allow a role for private insurance. Relying on a mixed private-public model of this kind obviously reduces the need for additional government revenue, and

12 Notice again, however, that this effect is attenuated, especially in the smaller provinces, when the per capita transfer is calculated based on a nationwide average, not on actual past spending in the province receiving the transfer. The logic here is similar to that in Shleifer (1985) who demonstrates the value of what he calls “yardstick competition” in health financing. In Shleifer’s model, each provider’s funding per unit of output is based on the observed average cost of other providers in the group.

13 The Ontario Drug Benefit Plan’s annual report (2013) showed that annual prescription costs greater than 3 percent of median family income made up around 19 percent of all beneficiaries but 64 percent of all costs within provincial drug plans. Assuming these percentages apply across Canada, a 40 percent share of the total annual prescription drug costs above the 3 percent cut-off would amount to roughly \$2.8 billion. We see this as a high range, ballpark figure. A lower federal share of, say, 30 percent would make for an annual cost of roughly \$2.1 billion – roughly equivalent to the savings of abolishing the tax-exemption for group-based private insurance, as discussed in the text.

14 When an employer purchases group health and dental insurance coverage on behalf of an employee, employer contributions are not considered a taxable benefit to the employee. Implicitly, this is equivalent to a partial public subsidy for group-based health insurance. The budgetary impact of our plan would be further reduced by the savings from removing drugs from the medical expense tax credit, which covers a wide range of health-related services and cost the federal government \$1.4 billion in 2014.

15 Removing the tax subsidy would reduce the attractiveness of private coverage. Finkelstein (2002) studied the impact of Quebec’s removal of the non-taxation provision on employee group benefits and found that removing the tax benefit led to a decrease of about 18 percent of workplace coverage – a rather large impact. This argues in favour of a gradual removal of the subsidy.

Table 2: Aims and Actions under this Policy Proposal

Policy Concern	Actions and Intended Progress Under Proposal
Access and Equity	<ul style="list-style-type: none"> • Provinces must put in place geared-to-income (catastrophic) plans to qualify for conditional federal transfers. • “Geared-to-income” plans should help improve access and alleviate cost burdens for the nearly 1 million Canadians with more than 3 percent of after tax income spent on drugs costs. • Tax-based copayments help with point-of-purchase constraints for filling prescriptions.
Pricing Coordination	<ul style="list-style-type: none"> • The federal government would join an expanded PCPA with all provincial governments and private insurers participating.
A Common Formulary and Rare-Diseases Strategy	<ul style="list-style-type: none"> • The federal government and the provinces would work on creating a “model” formulary. The federal government would not cost share for drugs paid for outside of this formulary. • The formulary decisions would utilize evidence to promote cost-effective choices. • A parallel federal drug plan would be created for agreed upon rare diseases.
Quality of Prescribing	<ul style="list-style-type: none"> • The proposed plan does not make major inroads to improve the likelihood of effective prescription decisions by physicians. • Blomqvist and Busby (2012) discuss ways of primary care design and integrating drug budgets with family physician practices to encourage more cost-effective choices. • Other reforms would look at scope of practice to allow pharmacists a greater role in substitution and renewals.

some degree of competition between public and private plans is likely to be beneficial in itself. With a monopoly public plan, key parameters such as payments to pharmacists, and rules with respect to generic substitution and access to new drugs, would be determined entirely through bargaining in the political arena between interest groups (such as those representing pharmacists and drug providers), and government officials. Even if there are additional administrative costs, allowing some competition from private insurers who can operate a separate formulary, negotiate discounted prescription charges or apply different generic substitution rules, for example, adds to the incentive on the managers of the public plans to pay careful attention to both cost and quality of coverage. We discuss the details and complexities of the public/private split in drug insurance in Box 1.

Conclusion

In this E-Brief, we have outlined a set of reforms that would go a long way toward addressing the major issues regarding pharmaceuticals in the Canadian health system (Table 2). Provincial health ministers are trying to keep pressure on Ottawa to help out in this area of health policy, but have not staked out clearly how they would like Ottawa to intervene.

Under our proposal, Ottawa would offer to pay a share of the cost of provincial drug expenditures, on two conditions: first, that the province offer a plan under which no family would pay more than a fixed percentage of its income as out-of-pocket drug costs; and second, that out-of-pocket payments under the government plans

Box 1: A Mixed Financing Model for Drugs

In order to be sustainable, competition between the two types of plans in a mixed model where individuals and employers would have a choice between public and private coverage, must be on a reasonably level playing field. A private plan that must finance the benefits it pays from the premiums it charges cannot compete effectively with a similar government plan that is paid for out of government revenue and charges no premium.

In the model we envision, a province's plan would automatically include anyone without private insurance (or coverage through another provincial plan), as in the model used in Québec today: In Québec, every resident is covered either by a (government-approved) private plan offered through employment or membership in an occupational group, or by one of the government plans. Those enrolled in a provincial catastrophic plan, like we propose, would be charged a tax-based premium (collected as part of their income tax, along with the drug costs they would be responsible for under the plan's deductible).^a

In order to be approved, a private plan would have to provide coverage at least equivalent to that in the provincial catastrophic plan, in terms of any required deductibles or patient co-payments, or with respect to what drugs were included in its formulary. Setting the detailed rules for approving private plans would be up to the provinces, but subject to federal approval.^b

Provinces could also allow individuals and families to combine public and private insurance. For example, those enrolled in a basic government catastrophic plan could be allowed to sign up for complementary private insurance that covered the out-of-pocket payments for which they were responsible under the government plan. In BC, where the government currently offers a form of universal catastrophic insurance with income-related upper limits on out-of-pocket costs, private insurance already plays this complementary role for some individuals. If this were allowed, employers would then have a choice between offering their employees a plan that extended the government catastrophic plan, or having them opt out of the government plan and be covered by an independent private plan instead.

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- a The ability of employment-related private insurance to compete with an alternative public plan will be, of course, reduced if employer-paid insurance is treated as a taxable benefit, as we proposed earlier. An alternative way to make the playing field more level could then be for the provincial governments to subsidize private insurance to some extent; this is the model used for public health insurance in Australia.
- b A referee raised the question whether, in order to be approved, a private plan would have to the same rules as a tax-based catastrophic plan under which little or no out-of-pocket payment would be required at the time a prescription was filled. On balance, we don't think this should be required, as such a feature would be complicated to administer for a private insurer. Kirby (2002) does however discuss mechanisms by which a private plan might qualify for public subsidies.

would not be payable at the time a prescription was filled, but only later on as part of the insured's provincial income tax. Further the federal government would redesign its regulation of drug prices and join with the provinces in an expanded PCPA to create a more transparent and uniform model of drug pricing. It would also work with the provinces to create drug formularies based on systematic cost-effectiveness analyses, along the lines of the models being used in the UK and Australia. And along with the joint formulary efforts, there would be a nationwide effort to address the problem of exceptionally high drug costs for patients with certain rare diseases.

Because it would rely on a combination of public and private coverage, the approach we advocate would imply less cost and short-term risks to provincial governments than the single-payer public monopoly model that has featured in several recent reports. And because it builds directly on existing provincial plans, our approach would also stand a better chance of overcoming the political hurdles that any proposal for a joint federal-provincial initiative inevitably faces in this complex area. None of the provincial models that exist today is perfect, but some are better than others, and we think it is time to break the political gridlock and start moving towards a model that makes important inroads into the biggest shortcomings of the expensive and flawed system we have today.

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