Intelligence MEMOS

From: Bill Robson

To: Canada's Health and Finance Ministers

Date: August 27, 2018

Re: **PHANTOM SAVINGS – WHY NATIONAL PHARMACARE WILL NOT DISPLACE PUBLIC EMPLOYEE DRUG PLANS**

Pharmacare is a hot issue in Canada. Federal support for provincial drug programs will likely feature in party platforms in the next federal election.

With drugs becoming more central in preventing, treating and curing, differences between how provinces pay for and manage drugs and how they pay for and manage doctors and hospitals are becoming more urgent. Like tax support for doctor and hospital services, tax support for drugs can fill gaps private insurance cannot cover.

Less happily, some of the appeal of more tax-funding is the simple desire to have someone else – preferably in far-off Ottawa – foot the bill. Healthcare costs are already crowding other worthy programs in government budgets, contributing to deficits and pushing taxes up. New drug programs will be under immediate and chronic pressure to expand.

Faced with concerns over cost, pharmacare advocates will likely cite a 2015 article in the *Canadian Medical Association Journal*. Working from 2012/13 numbers, its authors said national pharmacare would reduce spending on prescription drugs in Canada. Their base case showed direct purchases of drugs by government rising about $1 billion, with a best-case fall of $2.9 billion and a worst-case rise of $5.4 billion. But more than offsetting that was a base-case fall in other drug-related spending of $8.2 billion (best-case fall: $9.6 billion; worst-case fall: $6.6 billion).

If pharmacare could produce such savings – $7.3 billion cost reduction economy-wide in the base case – one wonders why provinces have not already done it on their own. Key tools the CMAJ article's authors advocate – stricter drug formularies and pooled purchasing to drive prices down –require no coordination through Ottawa.

Maybe it's not that straightforward. A key assumption in the article is that national pharmacare will displace all employer drug plans. Their elimination yields $8 billion of savings in all the authors' scenarios. It is critical to the claim that national pharmacare will reduce spending. And it is not credible.

More first-dollar tax-funded drug coverage might displace some employer plans. But pharmacare will no more eliminate them than the advent of the Canada and Quebec Pension Plans in the 1960s eliminated all employer-sponsored retirement saving. It did not. Employer-sponsored pensions typically changed to integrate with the Canada and Quebec plans, often resulting in more comprehensive retirement income.

The parallel with pensions is also instructive because we find generous employer-sponsored drug plans, like generous employer-sponsored pension plans, predominantly in the public sector. Will government employees exchange their plans for the formularies and coverage limits that apply to people covered only by pharmacare? In 2013, the B.C. Nurses' Union agreed to a drug benefit tied to the provincial formulary – but the consequent restrictions on access and delays for approvals inspired it to go back to a private plan in 2016.

Sound reasons for better integrating drugs with other tax-funded health services, plus the inevitable desire to shift costs onto the taxpayer, will keep the movement toward more extensive pharmacare in Canada alive. But Canadians should be skeptical when pharmacare advocates promise savings from eliminating employer-paid drug coverage. You can bet the implementers of pharmacare will not willingly give up their own plans. Pharmacare should be about extending coverage to those who do not have enough of it, not shrinking what already exists. And extending coverage will cost.

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