Individual Submission: House of Commons Standing Committee on Health Regarding a National Pharmacare Program

Two Options for National Pharmacare

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Introduction

The Parliamentary Standing Committee on Health has received considerable evidence concerning the advantages of a national Pharmacare program to address current inequities of access to prescription drug therapies. In terms of a model to reduce the price that Canadians pay for prescription drugs as well as contain administrative costs, the preponderance of evidence supports a single-payer rather than a mixed public-private model, as it can achieve annual savings of between $1 billion to $2 billion (Morgan et al. 2015).

At the same time, there has been virtually no evidence provided to the Committee on the governance and administrative structure that a single-payer Pharmacare program might assume in Canada. The purpose of this submission is to explore the two potential options for national Pharmacare. The first option is a program built on 13 provincial-territorial single-payer programs under a set of national standards including a pan-Canadian formulary. The second option is a single federal program covering all Canadians.

The two options and their respective implications are described below. Neither option can be considered obviously better in policy terms or easier to achieve from a political perspective. Each option has different advantages and disadvantages. However, presenting both options makes clear some of the tradeoffs involved with selecting one approach over the other.

Option 1: Federal-Provincial-Territorial Pharmacare Programs under National Standards

This option is most familiar because it follows the basic logic and structure of Medicare in Canada. Under broad national standards set through the five criteria of the *Canada Health Act*, each provincial/territorial (P/T) government operates a universal, single-payer hospital and medical care coverage program. The federal government enforces the *Canada Health Act* through the contributory funding it provides to P/T governments through the Canada Health Transfer. A portion of these transfers can, theoretically, be held back in situations where P/T governments are in violation of the five criteria and the prohibition on physician extra-billing or facility user fees.

Consistent with the way in which universal hospital coverage was introduced in the 1950s and universal medical care coverage in the 1960s, there would likely be a negotiation between the federal government and P/T governments to determine their respective interest in such a program with all 14 governments reviewing a proposal on its basic principles, architecture and fiscal arrangements. The federal government would most likely be responsible for preparing an initial proposal.

If these negotiations prove successful, then the federal government could introduce a set of national standards linked to either shared-cost transfer funding or block

transfers to the P/T governments that meet the eligibility requirements. In the alternative, the federal government could open up the *Canada Health Act* to include medically necessary outpatient prescription drugs therapies (inpatient drugs are already included under medically necessary hospital care). In either case, the new Pharmacare law or the amended *Canada Health Act* would have to be passed in Parliament. This law would also set the implementation starting date.

Similar to the original *Hospital Insurance and Diagnostic Services Act* (1957) or the *Medical Care Act* (1966), the federal government would have the option of: 1) requiring a minimum number of P/T governments as a pre-condition for Pharmacare to proceed; 2) requiring (or not) a formal bilateral accountability agreement between the Government of Canada and each P/T government on the precise responsibilities of each government to the other (Marchildon 2016); and 3) establishing any potential deadlines for the P/T governments to meet federal requirements to be eligible for the federal shared-cost or block transfer.

The amount of time required of P/T governments (and perhaps the federal government itself[1]) to move from publicly funded drug plans, which were designed to assist individuals without the benefit of private insurance, to comprehensive, single-payer Pharmacare plans could be significant. Using the example of Ontario, which had high penetrations of private health insurance when it introduced universal hospital coverage in the late 1950s and universal medical coverage in the late 1960s, it could take at least two years to implement a Pharmacare plan in which access was based on "uniform terms and conditions" as currently stipulated in the *Canada Health Act*.

The province in which the transition to a single-payer plan would be most difficult is Quebec. This is the only province that mandates the subsidized purchase of private (employment-based) insurance for pharmaceutical coverage rather than providing coverage directly as in other provinces and territories. In effect, the government of Quebec has a multi-payer plan that would likely have to be scrapped in order to create a single-payer plan and comply with any agreed-upon national standards.

One of the more challenging aspects of the negotiations would be the establishment of a single, national formulary. Since federal and P/T governments would run their own single-payer Pharmacare plan, they would remain legally responsible for their respective formularies. The only way in which to create a single, compulsory pan-Canadian formulary in these circumstances is through intergovernmental agreement or by Ottawa making a national formulary a condition for eligibility.

The institutional vehicle for this agreement on a national formulary could be an intergovernmental agency established by federal and P/T governments, which

[1] The federal government would have to reformulate its own public drug plans including the drug coverage offered to eligible First Nation individuals and Inuit under the Non-Insured Health Benefits (NIHB) program.

would be responsible for establishing and maintaining a single formulary for all 14 governments. This would require each government to relinquish, voluntarily, a considerable degree of sovereignty and control to this arm's-length pan-Canadian agency. Since this intergovernmental body would not have law-making authority, the formulary would be a policy recommendation that could then be adopted into law and regulation by the 14 respective governments. Any P/T government refusing to adopt the recommendation could be subject to a withdrawal of its federal transfer from the Government of Canada.

Option 2: Federal Pharmacare Program

Due in large part to the history of Medicare in Canada, the option of a Pharmacare program financed, administered, regulated and delivered by the Government of Canada is rarely proposed. However, there are at least two solid reasons for considering such an option. The first is that, unlike other domains in health such as hospital and medical care where the provinces have jurisdiction, the federal government has a substantial constitutional foothold when it comes to outpatient prescription drugs (Marchildon 2007). The federal government already exercises control over drugs through various means including: the right to market any prescription drug in Canada through the regulatory control of the Therapeutics Products Directorate in Health Canada; patent protection for prescription drugs under the federal *Patent Act*; and price regulation of branded patented drugs, as well as the monitoring of patented and generic drug prices in Canada, through a quasi-judicial federal tribunal—the Patented Medicine Prices Review Board.

The second reason is political feasibility. Financing and managing P/T drug plans is expensive and onerous. Naturally, the majority of P/T governments would welcome being relieved of this burden in order to free up fiscal room to focus on other pressing priorities. In fact, at the annual Council of the Federation meeting in the summer of 2004, the premiers in their communiqué called on the federal government to "assume full financial responsibility for a comprehensive drug plan for all Canadians" (Council of the Federation 2004). Instead of launching the negotiations on a single-payer Pharmacare program, the federal government instead chose to initiate a very modest National Pharmaceuticals Strategy and focussed on increasing federal health transfers to bolster other areas of health care (Lazar et al. 2013).

A national formulary in this case would be a federal formulary solely legislated and regulated by the federal government. This would allow for a federal agency to conduct clinical and cost-effectiveness analyses in order to determine what prescription drugs should and should not be on the formulary. This federal agency would have legislative powers not currently available to the Canadian Agency on Drugs and Technologies in Health (CADTH), an intergovernmental body that operates on consensus among 12 P/T governments (Quebec is not a member of CADTH) and the federal government. Through this national agency, the federal government would have considerable bargaining power in any negotiations with the

pharmaceutical industry that would permit substantial discounting of the prices of prescription drugs on the formulary.

Observations and Conclusion

The purpose of this submission is not to recommend one Pharmacare option over the other, but simply to indicate in the broadest way possible a few of the advantages and disadvantages of each approach. The first option allows for the integration of Pharmacare into existing P/T Medicare systems, which is an important consideration given their existing universal coverage of inpatient drugs. It is also based on an approach that is well known, at least historically, and is likely more comfortable to the majority of Canadians. The second option allows for a more rapid implementation of Pharmacare and a national formulary. It also creates the potential for greater governmental bargaining power with the pharmaceutical industry for the future.

In both cases, there remains the question of an opt-out by the government of Quebec. This was recognized in the premiers' Council of the Federation communiqué in 2004 where, as part of their bid to get the federal government to assume responsibility for pharmaceutical coverage, also asked the federal government to provide compensation to Quebec for its drug plan (Council of the Federation 2004). This would create a major policy exception for Quebec's multi-payer plan in either version of a Canadian Pharmacare plan based on the single-payer principle (option 1 or 2).

There is another option. The federal government could offer compensation to Quebec if that provincial government establishes a plan consistent with national standards in option 1 or the federal Pharmacare plan in option 2. The parallel would be the Canada Pension Plan-Quebec Pension Plan solution that was devised in the mid-1960s (Marchildon 2006). Beyond Quebec agreeing to relieve itself of drug plan responsibilities and cost to the federal government, this would likely be the only viable solution to the policy problem created by having two such conflicting policy approaches to pharmaceutical coverage in Canada.

It should also be recognized that national Pharmacare in whatever form it takes addresses the problem of inconsistent and inadequate access to prescription drug therapies in Canada. It is the unfinished business of Medicare. Moreover, because inadequate coverage problems has grown with time, and is likely to be worsened by the decline in the sustainability of private drug plans in employment benefit plans and the introduction of more specialized and expensive specialty drugs in the future, the need for national Pharmacare will only increase. The next step should be the mapping out of both options in detail to determine which might be most effective and acceptable to the federal, provincial and territorial governments, and the people of Canada. Hopefully we have moved beyond the question of whether Pharmacare is required to the question of how best to implement national Pharmacare.

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