CHARTING THE PATH TO

NATIONAL PHARMACARE IN CANADA

INSTITUT BROADBENT INSTITUTE

GREG MARCHILDON AND ANDREW JACKSON

ABOUT THE AUTHORS

GREG MARCHILDON

Greg Marchildon is the Ontario Research Chair in Health Policy and System Design at the University of Toronto's Institute of Health Policy, Management and Evaluation. Prior to this, he was a founding member of the Johnson-Shoyama Graduate School of Public Policy at the Universities of Regina and Saskatchewan.

In addition to being a faculty member and research chair, Greg regularly provides advice to governments and international organizations on health reform. He also sits on the editorial board of the European Observatory on Health Systems and Policies, and is a director at the Broadbent Institute.

Greg received his PhD from the London School of Economics, after which he taught for five years at Johns Hopkins University's School of Advanced International Studies in Washington, DC. In the 1990s, he served as deputy minister of intergovernmental affairs and subsequently as deputy minister to the premier and cabinet secretary in the Government of Saskatchewan. From 2001-2002, he was executive director of a federal Royal Commission on the Future of Health Care in Canada, known as the Romanow Commission.

Greg is the author of numerous journal articles and books on Canadian history, comparative public policy, public administration and federalism, including a survey of the Canadian health system for the World Health Organization and the European Observatory on Health Systems and Policies that has gone through two editions.

ANDREW JACKSON

Andrew Jackson is the Broadbent Institute's Senior Policy Advisor.

In September, 2012 he retired from a long career as Chief Economist and Director of Social and Economic Policy with the Canadian Labour Congress.

In 2011, he was awarded the Sefton Prize by the University of Toronto for his lifetime contributions to industrial relations. Educated at the University of British Columbia and the London School of Economics and Political Science, where he earned a B. Sc. and an M.Sc. in Economics, Andrew is the author of numerous articles and five books, including Work and Labour in Canada: Critical Issues, which is now in its second edition with Canadian Scholars Press.

EXECUTIVE SUMMARY

National Pharmacare has been a topic of discussion in Canada for over half a century, yet we remain unique among the world's high-income countries with universal health coverage in that we still do not include outpatient prescription drugs in our national benefit package. There is a growing sense that we will never be able to achieve the full potential of universal health coverage without national Pharmacare.

Consideration of a national Pharmacare plan now sits at the top of the Government of Canada's agenda, with the Advisory Council on the Implementation of National Pharmacare due to report its findings in the spring of 2019. While the country may be on the precipice of finally providing universal coverage for prescription drugs, conflicting signals from the federal government make the path forward uncertain. What remains clear is that there is broad agreement among experts that a single payer plan is needed to provide adequate coverage for all Canadians and to remedy the major gaps in coverage which now exist. It is also agreed that a single payer plan would lower administrative costs and, even more importantly the ability to control and reduce the cost of pharmaceutical drugs.

A majority of Canadians, healthcare providers, labour organizations and employers also agree that a national single-payer system is an idea whose time has come. Growing income inequality, decreasing access to employer-sponsored plans, and the rising cost of private insurance are stark reminders that further delay will lead to poorer health outcomes for our population.

While there is widespread support for a national single payer plan, there has been little consensus about a specific detailed policy architecture and role for the federal government. There are two possible ways to achieve single-payer Pharmacare in Canada. One is through 13 provincial-territorial program in which the federal government provides funding to the provinces and sets national standards, perhaps through the Canada Health Act, or through separate legislation. In return for the cash transfer, which would likely only cover incremental costs, PT governments would agree to provide universal coverage to their residents for an agreed upon schedule of medically necessary pharmaceuticals.

The second major option is a federally financed, regulated and administered Pharmacare program. This is constitutionally feasible because of the federal government's current jurisdiction over drug safety, price regulation and patent protection. While it is generally assumed that federalism and provincial jurisdiction over health stand in the way of a federal government public single payer program, the provinces have supported this option in the past, with the caveat that special arrangements may have to be made for Quebec.

On balance, we see considerable advantages for the second option. Strong federal leadership is needed to make Pharmacare a reality, because it is far from clear that expanding public health insurance is a current priority for all provinces. Fiscal capacity varies a great deal between the provinces but the federal government has the fiscal means to act if it finds the political will to do so. The federal tax system could be used to recoup some of the cost savings of employers, workers and individuals which would result from a more cost efficient single-payer plan. A federal program would make it easier to establish a national drug formulary and to achieve the savings of co-ordinated drug purchasing. Finally, a federal Pharmacare plan could be implemented more quickly. Canada has already waited too long.

After years of being pushed aside by successive Liberal and Conservative governments, many progressives are cheering the fact that national Pharmacare is finally at the top of the Government of Canada's agenda. But we are still far from a Pharmacare program and the Trudeau government is giving some very conflicting signals about what it will do, if anything, about a truly national prescription drug plan.

After almost two years of reviewing the evidence and hearing from stakeholders and members of the interested public, the House of Commons Standing Committee on Health delivered a majority report in favour of a national Pharmacare program.[1] However, the federal government chose to defer the matter rather than act on the Committee's recommendations. In fact, just weeks before it even received the Standing Committee's final report, the Trudeau government announced the creation of an Advisory Council to further review the matter headed up by Dr. Eric Hoskins who left his job as Ontario's Minister of Health to chair the Council.[2]

More troubling is the federal government's formal response to the Standing Committee. The Trudeau government seemed to be of two minds about the key recommendation. While stating that the government supported "the intent of the Report and its recommendations" it must nonetheless "consider the full range of options available" in terms of the implementation design.[3] These options could include something other than the single-payer plan recommended by the Parliament Committee, including a plan which involves multiple private insurance companies (i.e. multi-payer plan) instead of a simpler, less expensive government-administered system (i.e. single-payer plan).

In fact, unlike the Parliamentary Committee made up of backbench Liberal, NDP and Conservative members of Parliament, there are at least some members of the Trudeau cabinet who still do not accept that there is a problem with the status quo. In a post-budget speech to the Economic Club of Canada, finance minister, Bill Morneau, defended the current system of private pharmaceutical coverage, stating that it was working well for those it covered. While he admitted the need for "a strategy to deal with the fact not everyone has access" he argued in favour of an approach that "deals with the gaps, but doesn't throw out the system that we currently have."[4] This likely means keeping private insurance plans in place, and providing or subsidizing insurance through some needs- or income-based

assessment. However, this multi-payer and non-universal approach was exactly what the majority of the Standing Committee had rejected, arguing instead for truly universal and national plan to replace our inefficient, fragmented and unfair system of private and public coverage.

There is broad agreement among experts that a single payer plan is needed to provide adequate coverage for all Canadians and to remedy the major gaps in coverage which now exist between different groups of Canadians based upon age, province of residency and quality of employment. It is also agreed that a single payer plan would lower administrative costs and, even more importantly the ability to control and lower the cost of pharmaceutical drugs. The key issue is how we transition from the current non-system to a single payer system given that some benefit from current arrangements, given very different starting points in the various provinces, and given that costs will have to be reallocated among public and private payers.

National Pharmacare is long overdue – a half century *overdue* to be exact. The truth is we will never be able to achieve the full potential of universal health coverage without national Pharmacare.[5] Based on the best public opinion evidence available, we know that the majority of the general public *and* the majority of healthcare providers in this country are in favour of national Pharmacare.[6] However, not all Canadians agree on Pharmacare in part because they do not see how they will benefit from the redistribution that such a policy change will cause.

We will first describe how often we have come close to implementing national Pharmacare and why we have fallen short. We then describe who supports – and should support – national Pharmacare. We will describe who might lose from Pharmacare and why these potential losers pose a continuing threat to its implementation. Finally, we will then go through how national Pharmacare can be approached, in terms of governance, design and financing.

SINGLE-PAYER PHARMACARE – MEDICARE'S MISSING PIECE

Canada is unique among high-income countries with universal health coverage in that it does not include prescription drugs in its national benefit package.[7] This is despite the fact that numerous federal and provincial governments as well as Royal Commissions have recognized for many decades that prescription drug coverage is a necessary part of Medicare. However, for various reasons, universal coverage of drugs was never implemented.

We can start at the end of the Second World War and the federal government's Green Book proposal on national health insurance. This federal proposal was intended to provide a comprehensive package of coverage, including drugs, but failed in part because it was tied to tax sharing arrangements that were rejected by the governments of Ontario and Quebec.[8]

When Tommy Douglas and his social democratic government in Saskatchewan decided to go it alone after the failure of federal-provincial negotiations in 1946, the province only had the fiscal capacity to include inpatient drugs with hospital and diagnostic services. At the time, this was a significant addition given the high proportion of drugs administered in hospitals relative to outpatient settings. Over a decade later, when the federal government provided cost-sharing for those provinces willing to adopt Saskatchewan-style universal coverage, the plan was again limited to inpatient prescription drugs.

Federal-cost sharing for hospital care freed up provincial resources allowing Douglas and the Saskatchewan government to move to the next stage of Medicare. In 1959, Douglas put together an interdepartmental committee made up of his most experienced officials and talented advisors to recommend the design for universal coverage of comprehensive medical care services. After much consideration, the committee admitted that pharmacy services and products "including biologicals, anaesthetics, appliances, blood and blood products" whether dispensed inside or outside hospitals, should logically be part of a comprehensive package of health insurance.[9] However, the committee went on to recommend that, for fiscal reasons, outpatient drugs should not be included immediately in the Saskatchewan coverage package, citing "the extremely difficult problem of cost control" due to the "public acceptance of medication and the extensive pressures of the pharmaceutical industry." At the same time, the committee urged that consideration be given for the full (or close to full) coverage of drugs for chronic, long-term conditions for individuals suffering from diabetes (e.g. insulin), chronic pain (e.g. cortisone) and vitamin B12 deficiency.[10] Although Douglas accepted this limitation in order to get the new program implemented as quickly as possible, he viewed this limited version of Medicare as merely the beginning of what would eventually become a comprehensive program of coverage that would include outpatient drug therapies along with home care, long-term care and basic vision and dental care.[11]

In 1964, two years after the implementation of universal medical coverage in Saskatchewan, the Royal Commission on Health Services delivered its report to the Pearson government. The Hall Commission, as it came to be known, also recommended the addition of outpatient prescription drug services (as well as other health services) to universal medical care coverage.[12] For cost reasons, the Pearson government restricted its cost sharing to a narrow band of medical care (i.e. physician) services when it passed the Medical Care Act in 1966, once again leaving prescription drugs for another day and another government.

By the 1970s, in the absence of federal cost-sharing, provincial governments began to fill in the gaps left by private health insurance by establishing drug plans that provided prescription drug coverage to seniors as well as those on social assistance. Most of these targeted plans, as they evolved, were far from universal plans and of course did not benefit from the national standards that applied to Medicare. In an interview conducted decades later, Tom Kent, Pearson's chief policy advisor, said that there was a general belief in the 1960s (shared by policy advisors in Saskatchewan in the late 1950s) that containing the cost of prescription drug coverage was far more difficult than hospital and medical care.[13] This belief about the much greater difficulty of cost control for prescription drugs compared to other health goods and services, would remain a recurring theme in the decades that followed.[14]

In the mid-1990s, for example, the federal government rejected a recommendation of the National Forum of Health to establish universal coverage for pharmaceuticals. Given the reality of budget cutting and federal transfer cuts at the time, the Forum was careful to say that any plan to increase public coverage would "hinge on the availability of fiscal resources.[15] Following the report, in its 1997 speech from the throne, the Chrétien government promised to "develop a national plan, timetable and a fiscal framework for providing Canadians with better access to medically necessary drugs", but nothing further was done.[16]

The next opportunity would come after 2002. That year, the Chrétien government received the Senate and Romanow

reports recommending immediate national action on catastrophic drug coverage.[17] Shortly after, Ottawa and the provinces began negotiating and in their 2003 health accord, the premiers committed themselves to implementing catastrophic coverage by 2006. However, Roy Romanow went further in his report than the Senate in recommending the establishment of a National Drug Agency and a national formulary – the building blocks for national Pharmacare.[18]

In 2004, in the wake of the Romanow report, every provincial and territorial premier (except the Quebec premier) agreed that a "national pharmaceutical program should immediately be established" and called "on the federal government to assume full responsibility for these programs across the country."[19] This could have been an historic opportunity for national Pharmacare except for two problems. First, the premiers did not then use the time following the meeting to prepare a blueprint plan for the federal government's consideration. Second, Ottawa punted the issue by proposing a ministerial task force to develop a national pharmaceuticals strategy with no timeline other than to deliver a progress report by June 30, 2006, a strategy that produced little more than incrementalism.[20]

FALSE STARTS AND MISSED OPPORTUNITIES: A HISTORY OF DRUG COVERAGE IN CANADA.

2004 — Provincial and territorial premiers (except Quebec) call on the Federal government to immediately establish anational pharmaceutical program.

2002 — The Romanow Report and the Senate Committee recommend catastrophic drug coverage, which becomes part of the 2003 Health Accord.

1997 — The National Forum on Health recommends universal coverage of pharmaceuticals. Instead the government promises to develop a national plan but little done.

1970 — Provincial governments began to fill in the gaps left by private health insurance by establishing drug plans for seniors and those on social assistance.

1966 — the Federal Medical Care Act is passed without outpatient drug coverage, due to cost.

1964 — The Hall Commission recommends outpatient drugs be part of a Federal universal health coverage plan.

1962 — Saskatchewan implements universal medical coverage without outpatient drug coverage due to financial constraints.

1947 — Saskatchewan Premier Tommy Douglas implements hospital coverage including inpatient drugs (medications administered within a hospital).

1945 — Federal "Green Book" proposals for health coverage, including drugs, fails due to a Federal-Provincial dispute over tax sharing.

SUPPORT OF FEDERAL PHARMACARE BY THE GENERAL PUBLIC AND HEALTHCARE PROVIDERS

Despite the many false starts and failures in the last seventy years, Canadians have not lost their desire for Pharmacare. If anything, the majority want it more than ever.[21] Moreover, the need for national Pharmacare has only grown with time as the extremely high cost of our current arrangements only become more obvious. Little wonder that the majority of health providers – given their proximity to patients and their needs – also see the need for national Pharmacare.

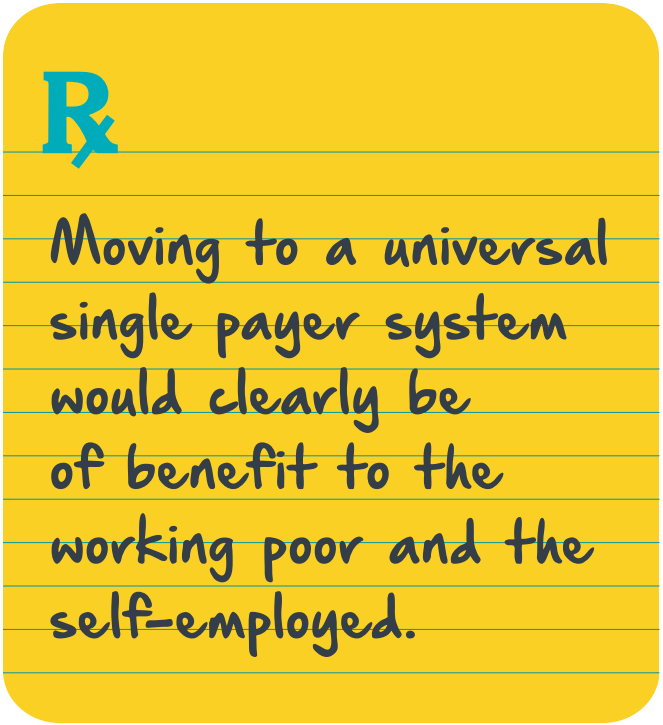
This need is exacerbated by growing income inequality in Canada.[22] With the emergence of the "gig economy"[23], the ranks of part-time and low-paid contractors grow while the number of higher-paid jobs with health and drug benefit plans shrink. These are the new working poor and unlike those Canadians receiving social assistance, they have limited eligibility in terms of most provincial drug plans which are the only safety nets for those Canadians without employment-based drug coverage. Although they stand to gain the most from national Pharmacare, low-income workers have had little voice in the Pharmacare debate. This is unlike the middle-class whose voice is heard and whose vote is sought at every turn.

One of the most cherished myths by both proponents and opponents, is that national Pharmacare has little policy salience because it is of so little consequence to the middle class. The belief that, since so many middle-class Canadians (along with their dependents) have drug benefit plans through their jobs, they simply don't experience the problems faced by Canadians without private insurance or limited to no access to government safety net plans. In other words, out of sight, and out of mind. While this may seem like a logical proposition, it is not at all true.

To start with, Canadians are attached to Medicare not only because of the benefits they and their immediate families receive from the program but also because of their desire to live in a country in which other citizens receive the same benefits as they do. In particular, they support Medicare because of their desire to have all Canadians receive care universally and as a right of citizenship.[24] This proposition was further tested in an opinion survey of Albertans in which there was strong support (85%) for the continuation of Medicare rather than a more free-market approach based on commitment to values as well as perceived material benefits they receive from the program.[25] More recent polling shows an overwhelming majority of Canadians support a National Pharmacare program.[26]

As can be seen, a large slice of the general public, including the broad middle class, most of whom are middle or high-income earners with existing employment-based drug coverage, support national Pharmacare. Whether they benefit or not personally depends on a careful calculation of the value of their current private plans (including the co-payments and deductibles they currently play) versus any additional tax for a public plan, this broad support of Canadians clearly extends beyond self-interest. Most middle-class Canadians truly see national Pharmacare as the missing piece of Medicare. This contradicts a vocal and powerful minority, including the pharmaceutical industry, private health insurance companies and the current Finance Minister Morneau who argue, contrary to the evidence, that the current system is largely working for Canadians.

Moving to a universal, single payer system would clearly be of benefit to the working poor and the self-employed. These individuals are not covered by an employer and are only rarely covered under provincial plans which mainly apply to seniors and social assistance recipients. Theoretically, these individuals could purchase plans from the private insurance industry, but such plans are extremely expensive and often offer only limited coverage in terms of caps on claims in a year. In contrast, unionized workers generally have good (if unnecessarily expensive) coverage as part of their employment benefit plans. Yet, organized labour remains in support of a broader-based Pharmacare plan for all Canadians. Let's explore why.



SUPPORT BY ORGANIZED LABOUR

Currently, about one fourth of all prescription drug costs are covered by private insurance,[27] with much of this being accounted for by workplace plans paid for by employers and workers. Though many of these plans are considered to be more comprehensive and generous than individual and existing public plans, they vary a great deal in terms of the extent of coverage, including which drugs are covered and the extent of co-payment required. Recognizing this, it is essential to determine whether the workers who benefit from private health insurance, and the unions which represent them, would support a major shift to public coverage.

Organized labour has expressed strong support for a universal, public, single payer drug plan adhering to the principles of the Canada Health Act with a national drug formulary and no co-payments.[28] This was proposed to the Parliamentary Committee by the the Canadian Labour Congress (CLC), the Canadian Union of Public Employees (CUPE), and the Canadian Federation of Nurses Unions (CFNU).[29] The CLC is currently engaged in a major national political campaign for a national Pharmacare program, building upon earlier advocacy for an expanded Canada Pension Plan to expand public pensions and reduce reliance upon private employer-sponsored pension plans.[30]

Union workers share the cost of these drug plans with employers either directly or out of foregone wages. Employer plans have also been subsidized by the non-taxation of contributions as income. Organized labour supports folding such plans into a universal system because many non-union members are excluded from such benefits, because of large and growing differences in coverage between different groups of workers, including between unionized workers, and because the rising cost of private insurance plans is causing major tensions in collective bargaining. As CUPE argued in its brief to the Parliamentary Committee: "(a)ccess to private insurance is fundamentally inequitable. Canadians either have private insurance because they work for an employer who provides coverage or because they have sufficient income to purchase a plan themselves. But statistics show that the lower a person's income and the more precarious their work, the less likely they are to receive benefits from their employer."[31]

Unions also point to the fact that rising drug costs, the most costly component of benefit plans, are causing many employers to demand reduced coverage or higher co-payments or annual maximums at the bargaining table. Indeed, drug costs have increased well over the rate of inflation for the last three years.[32] As a result, plans are becoming progressively less adequate and/or are resulting in lower increases in wages. Unions are "unfairly put in the position of deciding the extent of availability of and access to prescriptions drugs for workers, a process based on affordability of the insurance plan rather than an evidence-based public system that is based on workers' medical needs."[33]

Unions argue that a national drug plan would improve industrial relations in Canada. "Getting employers and labour unions out of the business of providing insurance for medically necessary healthcare to employees will also relieve some of the pressure on employers and unions related to the cost of benefits, allowing us to focus on other priorities at the bargaining table and potentially improving labour relations by eliminating one of the most contentious issues from bargaining."[34]

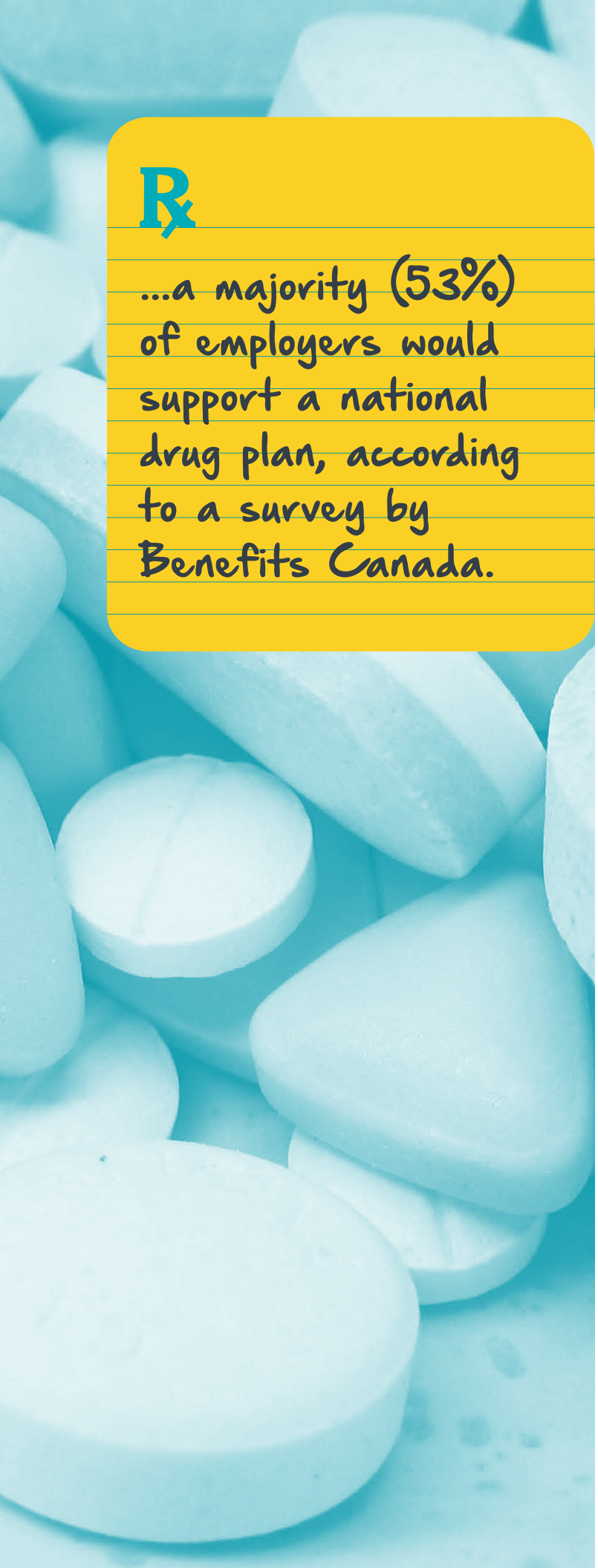
There's strong evidence and reasoning as to why organized labour may support national Pharmacare; but what about the businesses who negotiate with these unions on their benefit packages?

SUPPORT BY BUSINESS

Employers who support drug plans clearly incur some significant financial cost (though this is shared with workers) and also face significant administrative costs managing the cost of benefit plans. This places them at a competitive disadvantage with employers who do not provide such coverage, particularly the many small businesses and United States based enterprises which provide little or no coverage even to permanent, full-time workers. Shifting prescription drug costs from employers and workers to a national, universal, single payer plan would improve the overall climate for business investment. In addition, this would add to the competitive advantage of Canadian-based enterprises, who currently, already do not have to provide health benefits for hospital and medical care compared to American-based companies which provide comprehensive health benefits to their workers.

The House of Commons Committee refers to studies by the Conference Board of Canada and Benefits Canada which show that the costs of employer plans have been rising rapidly and are a growing concern to sponsors, not least because of the rising costs of new drugs. Employers are also often obliged to cover the cost of drugs which are not the least costly option and may even be medically unnecessary. The Committee reports that a majority (53%) of employers would support a national drug plan, according to a survey by Benefits Canada.[35]

Both the Surrey Board of Trade and the B.C. Chamber of Commerce have called for universal Pharmacare, citing that rising and unpredictable costs of private insurance as well as the economic efficiencies of a single payer system.[36] National business organizations have, unfortunately, been



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> ...a majority (53%) of employers would support a national drug plan, according to a survey by Benefits Canada.

relatively silent on the issue. This likely reflects the fact that some sections of the larger business community, including the pharmaceutical drug industry and the financial and insurance industry, benefit from current arrangements. As in the debate over the expansion of the Canada Pension Plan in recent years, it is likely that most large employers who provide coverage to their employees will see at least some advantage in moving to a universal, single employer plan.

There are clear grounds to believe that many employers would support an extension of public health care to prescription drugs to relieve a significant and growing cost burden. This reduced burden could improve competitiveness or be shared with workers in higher wages. The major obstacle to change would arise if a universal, public plan was much less generous than current private plans, but private plans could remain in place to provide additional coverage for those prepared to pay for at least a transitional period.

THE LOSERS

So, if both labour and business are potential winners from a national, single-payer plan, who loses? There are two obvious candidates: the health insurance industry and the pharmaceutical companies. There are 133 private insurers that sell insurance to employers and their business is put at risk by a publicly-administered single-payer plan.[37] The pharmaceutical companies could also lose if this national plan has the market power to demand considerable discounts and if the national formulary is limited only to those drugs that are proven to be have therapeutic value and are economically effective.

Naturally, these interests have been lobbying against national Pharmacare for decades. Expect them to present persuasive arguments on the merits of gap-filling through boutique government programs and public subsidies for those who are unable to pay premiums. And if they eventually feel that they just can't prevent some type of national Pharmacare from emerging, bank on the fact that they will argue in favour of a public-private plan like the Quebec drug plan rather than a single-payer plan. It is to be expected that they will argue that single-payer universality is needlessly radical, causing economic disruption in the insurance and pharmaceutical sectors along with major job losses. We need to be well prepared for these arguments.

TWO WAYS TO GET SINGLE-PAYER PHARMACARE

As suggested above, there are different ways to achieve national Pharmacare. However, from the beginning, the goal should be to eliminate any multi-payer plan as a long-term viable candidate for both cost and access reasons. We may want to accept some very limited transitional role for private insurance for individuals and employers who want to insure against non-medically necessary drugs which would not be included in the public formulary but we should be very careful and deliberate about this.

While it is theoretically possible to regulate insurance companies in a way that you could guarantee access for all Canadians, this would come at a very high administrative cost. We know this from our experience with the Quebec plan, the only private-public (multi-payer) drug plan in the country.[38] Comparing the Quebec plan to provincial plans in the rest of Canada, out of pocket costs (through higher co-payments) for Quebec residents were almost double those for the average resident in the rest of Canada in households spending $1,000 annually on drugs. The system of financing for such private-public plans through premiums and tax subsidies is far more regressive, and therefore inequitable, than general tax-based financing. Finally, single-payer systems are far better regulators of pharmaceutical prices and this is borne out in the considerably higher per capita cost on drugs in Quebec than in countries with single-payer mechanisms for universal health coverage, including pharmaceuticals.[39]

Accepting a multi-payer approach ultimately means accepting significant differences in coverage among different groups of Canadians, likely reinforcing growing income inequality even if there was extended coverage for the very poor. A multi-payer approach also increases administrative costs and would undermine the savings of bulk buying through a national formulary.

This leaves two possible ways to achieve single-payer Pharmacare in Canada. One is a Federal-Provincial-Territorial (FPT) program in which the federal government sets national standards, perhaps through the Canada Health Act, and provides some transfer funding to the provinces and territories. In return for the transfer, the PT governments would add an agreed upon schedule of medically necessary pharmaceuticals to its existing Medicare coverage. The second is a federally financed, regulated and administered coverage program, an option that is feasible in part because of the federal government's current jurisdiction over drug safety, price regulation and patent protection.[40]

OPTION 1: PROVINCIAL-TERRITORIAL PROGRAMS UNDER NATIONAL STANDARDS

This option is 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 PT 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 PT governments through the Canada Health Transfer. A portion of these transfers can, theoretically, be held back in situations where PT 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 PT 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 PT 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.

The amount of time required of PT governments (and perhaps the federal government itself)[41] to move from publicly funded drug plans, which were designed to assist individuals without 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*.

One of the more challenging aspects of the FPT negotiations would be the establishment of a single, national formulary. The institutional vehicle for this agreement on a national formulary could be an intergovernmental agency established by federal and PT governments, which 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 PT 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

Due in large part to the history of Medicare in Canada, the option of a Pharmacare program financed, regulated and administered by the Government of Canada is rarely proposed. However, it's worth noting that Australia, a somewhat comparable federal system, administers universal, single-payer Pharmacare plan exclusively at the federal level. There are at least three solid reasons for considering such an option which have been echoed in recent studies completed for the Institute for Research on Public Policy and Institute of Fiscal Studies and Democracy.[42] 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. 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 logic in favour of the federal Pharmacare option is political feasibility. Financing and managing PT drug plans is expensive and onerous. As mentioned above, in 2004, all provinces and territories with the exception of Quebec wanted the federal government to relieve them of the financial and administrative burden of their drug plans. Would this still be the case? Not very much has changed in terms of the fiscal pressures that drug plans place on provincial government budgets so the result is likely to be the same as in 2004. Provincial deficits have grown making many governments unwilling or unable to improve their own drug plans. And one of the first casualties of Premier Doug Ford's newly elected government in 2018 was the elimination of OHIP+, the policy that provided free drug coverage to Ontario residents under 25 years old with a promise to eventually extend the same coverage to all residents, a policy widely seen as a step in the direction of universal Pharmacare.[43]

The third is the ability of the federal government to quickly establish a national drug formulary. This 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 PT governments (Quebec is not a member) 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.

The argument can be made that the Quebec government would never agree to a federal Pharmacare program. However, the Quebec government would likely demand compensation so that the province could continue to support its private-public plan in either option 1 or option 2. A blank cheque from Ottawa to help any province fund its multi-payer (private-public) plan would undermine the national program and weaken the federal government's potentially considerable bargaining power with the pharmaceutical companies.

There is another option. The federal government could offer compensation to Quebec if that provincial government establishes a plan consistent with federal Pharmacare plan. 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.

Another argument against federal Pharmacare is that it saddles the federal government with the entire bill. This is true but this may still be preferable to a situation in which Ottawa pays one-half the cost but has limited say concerning the administrative approaches, including cost-control mechanism, put in place by PT governments. However, the full cost of Pharmacare, estimated to be roughly $24 billion by the Parliamentary Budget Office, would likely require some additional taxation by the federal government.[44]

SURVEY SHOWS MOST CANADIANS AND HEALTH PROFESSIONALS **WANT A SINGLE-PAYER NATIONAL PHARMACARE PLAN.**

SOURCE: HEALTHCARE IN CANADA SURVEY, 2016. AVAILABLE AT HTTPS://MCGILL.CA/HCIC-SSSC/FILES/HCIC-SSSC/HCIC_2016_RESULTS_10-LOOKING_FORWARD.PDF

Some may argue that Canadians have a strong preference for what they know – provincial Pharmacare programs under federal standards as in Medicare. However, there is evidence that directly contradicts this belief. In 2016, a large sample of representative Canadians and health professionals, including doctors, nurses, pharmacists and administrators, were surveyed in order to determine their priorities and strategies in terms of improving healthcare.[45] The two strategies that received the most support from both groups were creating national supply systems to reduce prices for new medical treatments and offering less expensive but similar versions of expensive biologic drugs. And when the professionals were asked about their preferred option to increase access to prescription drugs, a clear majority pointed to a single national Pharmacare plan managed by the federal government. All professions, including doctors, preferred this to the private insurance plan approach supplemented by a national catastrophic plan or a federal-provincial-territorial (FPT) plan in which the federal government would set some standards and provide some funding for plans operated by provincial and territorials (PT) governments.[46]

One key problem for policy makers is the fact that provincial plans as they now exist vary a great deal in terms of who is covered, deductibles and co-pays, and the drug formulary. We want to transition to a system which covers all Canadians in the same way. This means that a cost-sharing approach would mean that provinces with currently inferior plans, generally the poorer provinces, would have to increase spending proportionately much more than those with superior plans. This could be considered to be unrealistic given the strained public finances and deficit and debt situations of the poorer provinces, especially those in Atlantic Canada.

By contrast, public finance experts, including the Parliamentary Budget Office, agree that the finances of the federal government are more sustainable in the long-term than those of the provinces. If the federal government launched a national drug plan, it would implicitly raise all provinces to the same standard regardless of the starting point, and thus lessen the fiscal burden for the more fiscally challenged provinces. The wealthier provinces might object, but they would still benefit significantly from a transfer of all or some portion of their drug costs to the federal government. Indeed, it is possible to envisage a modest transfer of tax points from the provinces to the federal government or an agreed reduction in federal transfers to the provinces to help finance a federal plan.

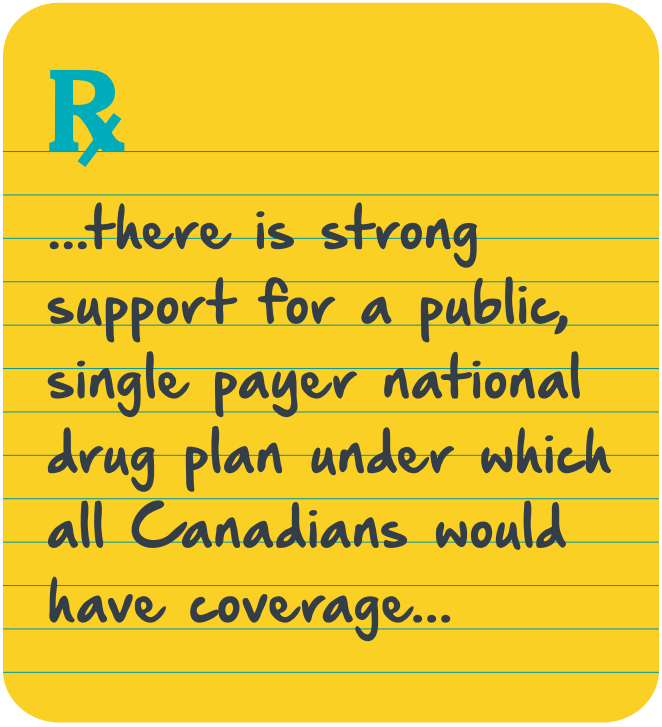
Further, it is desirable that the federal rather than provincial tax base should be used to fund an expansion of public expenditure on pharmaceutical drugs, since the same tax changes would apply uniformly to the residents and businesses of all provinces. Employers in one province would not be disadvantaged relative to those in another, and there would be no increase in current differential rates of taxation of income and capital of individual taxpayers between provinces. A federal plan would mean an increase in federal taxes, offset in part by the elimination or reductions of deductions for private plans, but the incidence could be progressive if Pharmacare was paid for in part by higher corporate taxes and higher income taxes for those with higher incomes. This would be justifiable in that public insurance would be reducing or eliminating the costs of employer plans.

Federal assumption of costs would, as noted, be likely to be supported by the provinces (with the exception of Quebec). By contrast, a federal-provincial cost shared agreement might be opposed not only by the poorer provinces, but also by the wealthier provinces in the current political moment. The Ford government in Ontario has already partially reversed the expansion of public drug coverage to children promised by the previous Liberal government and has clearly taken the philosophical position that there should be a significant continuing role for private insurance. In short, there seems to be limited provincial support for a cost-sharing route to universal Pharmacare, and a corresponding need for federal government leadership if progress is to be made towards that goal.

CONCLUSION

There is widespread agreement among experts, the general public, employers and labour that our currently fragmented non system of public and private pharmaceutical insurance programs is unnecessarily costly and fails to provide adequate coverage for far too many Canadians. This is especially true of those Canadians with insecure employment who are forced to buy costly individual insurance, or to pay for their own drug costs. There are major differences in the extent of cost coverage and formularies in group private insurance plans, and there is also significant variation between public plans in the different provinces. The cost of private insurance is a costly and rising burden on most employers and a drag on economic competitiveness.

By the same token, there is strong support for a public, single payer national drug plan under which all Canadians would have coverage for out of pocket costs for medically necessary drugs similar to physician and hospital services under Medicare. Indeed, Pharmacare was part of the original vision of universal health coverage for over half a century, and there have been repeated calls for filling this critical gap over the years. Considerable momentum in this direction has been generated by the recent report of the House of Commons Committee on Health, and the appointment of Dr. Eric Hoskins to develop an implementation plan for the federal government.



Moving from the current non system to a national single payer plan, including a national drug formulary, is a complex task given our patchwork quilt starting point. Some vested interests are threatened and, while significant overall cost savings can be achieved, there will also be additional costs as coverage gaps are closed.

While there is widespread support for a national single payer plan, there has been little consensus about a specific detailed policy architecture and role for the federal government. There are two possible ways to achieve single-payer Pharmacare in Canada. One is through 13 provincial-territorial programs in which the federal government provides funding to the provinces and sets national standards, perhaps through the Canada Health Act, or through separate legislation. In return for the cash transfer, which would likely only cover incremental costs, PT governments would agree to provide universal coverage to their residents for an agreed upon schedule of medically necessary pharmaceuticals.

The second major option is a federally financed, regulated and administered Pharmacare program. This is constitutionally feasible because of the federal government's current jurisdiction over drug safety, price regulation and patent protection. While it is generally assumed that federalism and provincial jurisdiction over health stand in the way of a federal government public single payer program, the provinces have supported this option in the past, with the caveat that special arrangements may have to be made for Quebec.

On balance, we see considerable advantages for the second option. Strong federal leadership is needed to make Pharmacare a reality, while it is far from clear that expanding public health insurance is a current priority for all provinces. Fiscal capacity varies a great deal between the provinces but the federal government has the fiscal means to act if it finds the political will to do so. The federal tax system could be used to recoup some of the cost savings of employers, workers and individuals which would result from a more cost efficient single-payer plan. A federal program would make it easier to establish a national drug formulary and to achieve the savings of co-ordinated drug purchasing.

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