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Putting National Pharmacare on the Federal Agenda: Creation of an Advisory Council

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Abstract

In June 2018, the Federal Government of Canada created an Advisory Council on the Implementation of National Pharmacare, scheduled to report one year later on the best strategy to implement such a program and give Canadians access to affordable prescription drugs outside of the hospital. The current state of coverage through employer-sponsored plans and public plans conditional on income and age is increasingly perceived as unfair and inefficient. The Council used a mixture of expert consultations, an online survey, and discussion forums for the general public to explore three options: a universal public plan, a catastrophic spending plan, or a patching of current coverage to include non-insured individuals. Creating such a Council was seen by the government as a solution for navigating a complex policy problem with difficult federal-provincial dimensions.

Le gouvernement fédéral canadien a créé en juin 2018 un Conseil consultatif sur la mise en œuvre d'un régime national d'assurance médicaments, dont le rapport sur la meilleure stratégie pour mettre en œuvre un tel régime et permettre aux Canadiens d'accéder à des médicaments abordables hors de l'hôpital est attendu un an après. La situation présente couvrant les individus à travers une combinaison de plans d'employeurs et de plans publics sous condition de revenu et d'âge est de plus en plus perçue comme injuste et inefficace. Le Conseil devra donc explorer trois options, en s'appuyant sur des consultations d'experts, un sondage en ligne, et des forums de discussion pour le grand public : un régime public universel, un régime couvrant les dépenses catastrophiques, et un régime modeste offert à ceux n'ayant pour l'instant aucune couverture. La création de ce Conseil était vue par le gouvernement comme une solution pour négocier une question délicate affectant l'équilibre des prérogatives provinciales et fédérales.

Key Messages

- The current situation of prescription drug coverage in Canada is perceived as unfair and too costly.
- The federal government of Canada launched an Advisory Council to explore three options: creating a universal national plan, creating a catastrophic insurance plan, or patching existing gaps in the system.
- The federal government wants to keep public spending limited while acknowledging concerns about rapidly escalating costs of prescription drugs.

Messages-clés

- *L'état actuel de la couverture des médicaments au Canada est jugée injuste et trop coûteuse.*
- *Le gouvernement fédéral canadien a créé un Conseil consultatif pour explorer trois pistes : créer un régime public universel national, créer un plan de couverture des dépenses catastrophiques, ou bien un régime modeste pour ceux n'ayant actuellement pas de couverture.*
- *Le gouvernement fédéral veut limiter la dépense publique tout en réagissant aux peurs suscitées par les coûts en augmentation rapide des médicaments.*

Non-financial Competing Interests: Two authors of the present HRA declare that they signed Dr. Morgan's letter advocating for the creation of a national, single-payer, universal Pharmacare in Canada.

EDITOR'S NOTE: *This manuscript was written and accepted for publication before the Advisory Council published its final report in June 2019. This HRA is about the decision to create such a Council.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

In the 2018-19 budget, the federal Minister of Finance announced the creation of an Advisory Council on the Implementation of National Pharmacare, chaired by Dr. Eric Hoskins, former Minister of Health and Long-Term Care of Ontario. Launched on 20 June 2018, the Council comprised seven members: the Chair, a patient, a health care provider, a health policy expert, an economic policy expert and two former provincial politicians. The Council was mandated by the federal government to consider three options: a universal public plan for all Canadians; a public catastrophic insurance plan that would kick in once spending on prescription drugs reaches a given threshold; and a patching of existing gaps, providing coverage to those who are not eligible for any form of coverage (with a minimum basket of coverage). We analyze the policy decision to implement such a time-limited expert panel.

2 HISTORY AND CONTEXT

Canada is the only OECD country with universal health coverage that does not provide universal coverage for outpatient prescription drugs. Drugs prescribed to non-hospitalized patients are covered through a patchwork of plans, some public (43% of outpatient prescription drugs spending) and some private (36%, CIHI 2017). Households that spend more than 3% of their income on prescription drugs can be partially reimbursed through the federal medical expense tax credit. While 21% percent of the costs of outpatient prescription drugs are paid out-of-pocket—with some of these costs accruing to individuals who are covered through co-payments or deductibles (CIHI 2017)—20% of Canadians report no coverage for prescription drugs (Law et al. 2018). Law et al. (2018) observe that, as a result, affordability is an issue: in 2016, 8% of Canadians with a prescription reported not being able to afford it, and 700,000 had to cut back on food to pay for a prescription.[1]

The present patchwork of plans is generally perceived as inequitable. The discussion paper provided by the government of Canada to the Council (Government of Canada 2018) noted that financial protection for therapeutic treatments for individuals with the same

[1]This conclusion is challenged by the Conference Board of Canada (CBoC 2017). Law *et al.* (2018) drew on the most reliable survey available in Canada (the Canadian Community Health Survey). Law and Kolhatkar (2018) have criticized the validity of the survey used by the Conference Board (CBoC 2017).

need varies across geography (various provincial plans) and employment (not all are offered a plan and plans vary in generosity). It is also perceived as inefficient, for two reasons. First, each private plan can decide on its own formulary and each provincial plan negotiates prices with pharmaceutical companies independently, making prices for drugs in Canada the third highest in the OECD—25% higher than the median OECD price (PMPRB 2017). Second, the multitude of private plans—more than 100,000 according to the Government of Canada (2018)—generates tremendous administrative costs. A recent report of the Parliamentary Budgetary Office estimated that a single-payer plan would save C$4bn per year to Canadians, translating to close to 15% of spending on prescription drugs in 2015 (PBO 2017). The perception is that a single-payer plan would be more efficient and more equitable at the same time.

Equitable prescription drug coverage has long been identified as a gap that needs to be filled. In the early 1960s, the Hall Commission urged that public coverage of prescription drugs should be the next step for health insurance in Canada. In 1997, the National Forum on Health called for public universal coverage of prescription drugs and their inclusion in the Canada Health Act. However, public coverage of all prescription drugs would imply a massive redistribution of income from the rich (who would pay more in taxes than they currently do in premiums) to the poor. The rich also benefit currently from the tax exemption of contributions to private plans, amounting to a fiscal transfer of C$2.9bn per year in 2016 (Department of Finance 2016), that they would lose under a public universal plan. This is why the early 2000s saw more incremental proposals, starting with public catastrophic drug expenditures insurance (for example, the Romanow Commission and Kirby Committee in 2002 and the Ministerial Task Force to develop and implement the National Pharmaceuticals Strategy in 2006). The Romanow Commission also recommended the establishment of a National Drug Agency, changes to the Patent Act, and price regulation of generic drugs in order to set the stage for the eventual establishment of national, single-payer Pharmacare (Commission on the Future of Health Care in Canada 2002). Not much happened, though, as a result of this incremental strategy and, in 2018, the House of Commons Standing Committee returned to the recommendation of full public coverage and extending the *Canada Health Act* to prescription drugs.

3 GOALS OF THE REFORM

3.1 Stated

The stated goal of the Advisory Council is "to provide independent advice on how to best implement national Pharmacare in a manner that is affordable for Canadians and their families, employers and governments." More precisely, the Council was tasked with answering three questions: Who should be covered and under what circumstances? What should be covered (essential or most often prescribed drugs)? And who should pay? The government wants a pragmatic solution, which means a plan that solves the perceived

problems and has a reasonable chance to be accepted by a majority of stakeholders.

3.2 Implicit

The mandate from the government, as implied by the budget speech, is that the option recommended should be fiscally responsible, minimizing any potential increase in federal taxes. This implicit mandate of fiscal moderation implies that two issues should be discussed: could the plan save enough in prescription drugs costs to allow it to be fiscally neutral (or almost neutral)? And what amount of income redistribution would such a plan involve?

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda

We use the Kingdon (2011) framework to describe how Pharmacare became an issue on the political agenda of the federal government. This framework posits that a problem needs to be identified, a plausible solution (or several options) should exist to address it, and, lastly, that a government decides to do something based on the proposed options (political will).

4.1.1 Identification of the problem

The gap in coverage has long been perceived as a problem, both of access and cost, but what was a minor problem when spending on prescription drugs represented around 10% of total health care spending (in the 1980s) has become a growing concern since the early 2000s, when it reached 16% (CIHI 2017). The problem has taken a more serious turn in the past 10 years, for two main reasons: a) an increase in outpatient treatments sometimes substituting to inpatient ones (that are covered publicly), and b) an increase in the average (due to pharmaceutical companies charging more for each new molecule) and variance (due to personalized medicine) of the cost of medicines. The issue of affordable access to life-saving drugs has recently drawn attention in the media (Morgan and Boothe 2016) and, in the 2015 federal elections, the Green Party, the New Democratic Party (NDP) and the Liberal Party all had a section of their platform dedicated to the federal government's role in reducing the costs of prescription drugs in Canada (Adams and Smith 2017).

The equity problem is also perceived more acutely due to the recent publication of indicators showing the extent of the unmet need problem (Law *et al.* 2018). Many politicians (such as members of the 2006 F/P/T Ministerial Task Force and the 2018 House of Commons Standing Committee), health policy experts (Law *et al.* 2018; Busby and Blomqvist 2016), stakeholders (Lopert, Docteur, Martin 2018) and the Canadian public (Ekos Politics 2013) describe the problem of prescription drugs in Canada as access being driven by ability to pay and not by need. This is why the mandate of the Council has been largely framed in terms of affordable access to prescription drugs.

4.1.2 Plausible solutions

Discussions in academic and think-tank communities have yielded the three plausible policy options which the Advisory Council was tasked to consider: universal public plan (Gagnon and Hébert 2010; Morgan *et al.* 2013; Gagnon 2017; Martin, Daw, Law *et al.* 2013), catastrophic insurance (Blomqvist and Busby 2015), or patching holes in existing coverage and strengthening regulation of the private health insurance (CBoC 2017). Each of these options has been discussed in the media (e.g., Scoffield, 2019 for a recent example) and the general public expects some public policy movement on that front. This comes at a time when provincial governments (with the exception of Québec) have mounting debts and are attempting to restrain health care spending in general, and spending on prescription drug programs in particular. While the relatively healthy fiscal situation of the federal government gives it the responsibility and the ability to do something on that front, it is likely to face opposition from some provinces, as well as other stakeholders such as patients, insurers, providers and pharmaceutical companies (Adams and Smith 2017), resulting in a desire to consult broadly before making any bold move. A time-limited Advisory Council would allow the government to consult and seek agreement before proposing a plan or, more cynically, pretend to do something while not taking any political risk.

4.1.3 Political will

After nine years of Conservative governments with an expressed interest in containing public spending rather than expanding any public program (Morgan and Boothe 2016), the Liberal government was elected on a platform reaffirming the central role of the state in social matters (Liberal Party of Canada 2015). Moreover, it is also committed to improving the federal-provincial-territorial relationships and such a Council is a way of demonstrating goodwill in seeking agreement before acting. More than half-way through its 4-year mandate in 2018, and approaching a federal election in the fall of 2019, the Liberal Party of Canada needed a social accomplishment to fend off opposition from other parties—namely, the NDP. Pharmacare is a prominent progressive request and an important plank in the NDP's platform, which comprised a detailed plan on a national, single-payer Pharmacare that would add a defined formulary of outpatient drugs to the definition of insured services under Medicare.

4.2 A final decision was made or not made

A key idea, supported by research evidence, was that greater public involvement at the federal level could reduce the total cost of prescription drugs in Canada (Gagnon and Hébert 2010; Morgan, Daw, Law 2013; Gagnon 2014; Blomqvist and Busby 2015; Martin *et al.* 2018). Steve Morgan, a well-known Canadian health economist, spearheaded an advocacy movement, together with clinical groups (Canadian Doctors for Medicare and the Canadian

Federation of Nurses Unions) to petition the federal government to push for the establishment of universal Pharmacare in Canada, first writing a letter to the Prime Minister of Canada (2016) and then launching an online petition (2017). Publications estimating the impact of lack of coverage on adherence to treatment (Law *et al.* 2018) and lack of adherence on health outcomes (Lopert, Docteur, Morgan 2018) helped to demonstrate the costs of inaction. Wisdom among health economic experts and providers was that a more efficient prescription drugs financing plan would permit expanded coverage and improve health, without costing taxpayers too much. These ideas indeed appear to underpin how the government has framed the mandate of the Council, and lend legitimacy to the strategy of setting up an Advisory Council to discuss options for improving access to prescription drugs, without committing to an overhaul of the current financing mechanism.

In terms of the landscape of interests, there may have been a movement toward greater convergence, suggesting the moment was ripe to consult, discuss and achieve consensus. Some interest groups, such as employers or insurers, who were previously opposed to any public intervention became more receptive to a national Pharmacare plan, owing to the increasing costs of prescription drugs. Provincial governments may have seen the creation of the Council as a way to bypass federal/provincial/territorial negotiations, but none voiced particular concern at the time of the announcement. Patient groups are generally in favour of expanding coverage and addressing unmet needs, but reject any trade-off between depth and breadth of coverage. Consequently, they remain opposed to the narrow formulary behind single-payer plans (BMC 2018). Most large employers used to consider supplementary health insurance as a way to attract and retain employees, but now see it as a major and increasing cost of labour and a potential liability. A report by an actuary (Mercer 2011), forecast that costs per capita for private plans will increase dramatically in the coming decades. Employers therefore have a strong interest in some change to the current system, with the government taking on a bigger role in the financing of drugs. The insurance industry itself (mostly life and health insurers, represented by the Canadian Life and Health Insurance Association), while still opposed to a single payer (for obvious reasons) is concerned by the increase in the cost of drugs, mostly because the proportion of employees in pooled plans, where the insurer underwrites the risk, is not negligible (Hurley and Guindon 2008) and would welcome some form of public catastrophic insurance. Interests are varied within the pharmaceutical industry: the generic drug industry could benefit from a plan using reference-pricing and expanding coverage. The pharmaceutical industry vehemently opposes any single-payer (which would bulk purchase and lower prices) and has threatened to close its R&D in Canada. Yet, the industry may be prepared to participate in a broad discussion aimed at solving the access problem without necessarily putting all patients under a single payer with a strong purchasing power. Retailers are reluctant to tinker with, much less overhaul, a system that works well for them now due to unofficial rebates from generics manufacturers as well as off-patent brands. The main opposition, however, might come from taxpayers currently benefiting from the tax exemption on private insurance and who might fear that any extension of public coverage might mean the end of the exemption

(Adams and Smith 2017).

From an institutional perspective, the decision to form an Advisory Council can be seen as a way to associate provincial governments with the discussion. Even though health care is a provincial jurisdiction, the federal government plays an important role in the regulation of pharmaceutical products and supplementary health insurance in Canada, and would have legitimacy in implementing any of the three competing solutions. Yet, the decision to go ahead with a federal universal public plan (such as that recommended by the House of Commons Standing Committee 2018) would have been seen as too audacious as well as contrary to the political climate in some provinces. The striking of a time-limited consultation led by an Advisory Council provided a solution for navigating a complex policy problem with growing support from insurers and providers, and without antagonizing the provinces and middle-class taxpayers.

5 HOW THE DECISION TO ESTABLISH THE ADVISORY COUNCIL WAS ACHIEVED

5.1 Policy instruments

Implementing an advisory council is simple and requires a minimal amount of money and resources. The government took three and a half months to appoint the members of the Council (from the budget speech in March 2018 to the press release of 20 June 2018), making sure all regions of the country were represented, as well as broad types of stakeholders and viewpoints. A discussion paper was produced as a "starting point" for the reflections of the Council and a mission statement was delivered to the group (Government of Canada 2018).

5.2 Implementation plan

The Advisory Council consulted experts and stakeholders, used online tools (a forum and a questionnaire) as well as town hall meetings to elicit the views of the general public.

5.3 Communication plan

The Council was announced during the budget discussion in the House of Commons and has communicated mostly through a website hosted by the Government of Canada, and town hall meetings.

6 EVALUATION

An evaluation of the work of the Council has not yet been put forward and it is not clear whether the methodology used to collect data (mainly, the online tool) has been or will be evaluated.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 presents the strengths, opportunities, weaknesses and threats of the decision to create an Advisory Council on Pharmacare.

Table 1: SWOT Analysis

Strengths	Weaknesses
• The Council builds on strong evidence produced by several government reports, academic research and think tanks. • The Council has collected data from an online consultation that will add to the evidence base on public preferences (specifically, previous opinion surveys showing support for national Pharmacare but not inquiring about fiscal costs or implementation). • There was no strident opposition to the Council from any interest group.	• The quality of data collected by the Council may not allow it to claim to know the organizational design of Pharmacare preferred by Canadians. In particular, the issue of income redistribution is never explicitly mentioned in the consultation with the public and it is unclear whether the Council will add much evidence on this crucial question. • The conclusions of the Council will, by necessity, rely on "what-if" scenarios and fiscal simulations of the effect of the various plans that can be disputed. • Provincial governments may not feel associated enough with the Council and its consultations or ultimate conclusions and recommendations.
Opportunities	**Threats**
• The Council will report before the fall 2019 federal election and its recommendations can be part of the national political debate.	• The Council will report almost immediately before the next federal election and its recommendations may become inaudible in a highly partisan debate.

8 CONCLUSION

The goal in creating an Advisory Council was to provide the federal government with evidence on how best to proceed to improve access to prescription drugs in a fiscally re-

sponsible (and politically feasible) way. The federal government has legitimacy to drive a change in the financing of prescription drugs in Canada and the recent increase in the cost of therapeutic treatment makes the issue more salient. On the other hand, the transfers required (from private to public funding) and potential opposition to the implementation of a national single-payer scheme can explain why the government sought more evidence, notably on the state of public opinion on the matter. It remains to be seen whether the method followed (a group of experts conducting surveys, a dialogue and town hall meetings) will provide the federal government with the evidence it needs to make a decision and reach a consensus with provincial governments, among others.

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