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Prescribing Federalism

The intergovernmental
implications of a national
pharmacare program

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Mowat Centre

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EXECUTIVE SUMMARY

The federal government is deciding how to proceed on national pharmacare. A major milestone is expected this fall, when the Advisory Council on the Implementation of National Pharmacare recommends an approach.

But a national pharmacare program will not be landing in an empty field. Rather, whatever path the federal government chooses will have to interact with a varied landscape of existing, and mostly provincial, pharmacare programs, or risk likely failure.

How should the federal government navigate this potential intergovernmental minefield? The present paper tackles this question. We analyze existing provincial programs and models, identifying the gaps that existing programs leave in Canada's pharmacare landscape, and assess how well different approaches to national pharmacare would address these gaps. We also assess how these models fare in ensuring equity across provinces.

We then analyze a core set of established fiscal federalism principles and approaches that both put the intergovernmental challenges of each model into sharper focus and point to ways forward that can help each model successfully navigate this potential intergovernmental minefield.

We conclude that each model can be accompanied by an appropriate use of the established principles and approaches of fiscal federalism. This will be critical to getting provinces on board, an essential component of success for any approach to national pharmacare.

Should the federal government choose to implement a catastrophic coverage model, this choice would be best served by the use of federal spending power to replace provincial programs. A mandatory coverage model and a gap-filling model would be best served by the federal government setting and fully funding national standards that apply in all provinces. A universal coverage approach would be best served by direct payments from the federal government to individual Canadians, similar to other federal transfers to individuals such as Old Age Security or the Canada Child Benefit. The expense of a universal coverage approach could be defrayed by reduced federal health transfers as compensation for the federal government's assumption of a greater degree of fiscal risk.

1 INTRODUCTION

The debate around national pharmacare in Canada has once again come to the fore. Earlier this year, the Standing Committee on Health called on the federal government to implement a single payer public drug coverage program under the *Canada Health Act*. As part of its 2018 budget, the federal government announced the creation of an Advisory Council on the Implementation of National Pharmacare to provide advice on how to best a national policy or program in a manner that is affordable for Canadians.

This fall, the Advisory Council is scheduled to begin narrowing down options for its proposed approach to national pharmacare. This decision will not happen in a policy vacuum. It will take place against a backdrop of the existing pharmacare program landscape in Canada, one that has evolved significantly over the past 50 years.

Canada's current approach to pharmacare is often described as a patchwork. It is a mix of coverage provided by private insurance and publicly-funded programs. The vast majority of public drug coverage is provided by provincial governments. There is considerable variability in the approaches to public drug coverage, both across provinces and within individual provinces as well. Each of those approaches achieve a different policy goals to varying degrees and often involve trade-offs.

Canada's patchwork approach to pharmacare also leaves many policy problems unaddressed. Eligibility for public coverage is inconsistent across Canada. Issues regarding access to coverage and enrollment in programs remain.

These issues can be linked to affordability challenges posed by high out-of-pocket costs. Canada also pays some of the highest prices for prescription drugs in the developed world.


The federal government must decide what approach it will take to national pharmacare against both the backdrop of this policy patchwork and the gaps existing approaches have left unaddressed. In general, the models available to the federal government will be catastrophic coverage, mandatory coverage, a gap-filling approach or a universal program. Each of these models will address certain policy problems better than others and will involve some degree of trade-off between policy objectives and cost to government. However, if no consideration is given to how the approach to national pharmacare interacts with existing provincial programs, each model will wind up benefitting the residents of some provinces more than others.

The federal government's approach, therefore, cannot be agnostic to how it will interact with provincial programs or it will run afoul of many of the principles that should inform discussions on fiscal federalism. Primary among those is interprovincial equity. If the federal approach to national pharmacare is simply layered on top of the existing system of public and private coverage, for example, it could result in vastly different treatment of Canadians at the hands of the federal government, depending on province of residence. Inequitable treatment of Canadians based on province of residence is not likely to be a sustainable approach for national pharmacare and is certain to be met with resistance from provinces whose residents are unfairly disadvantaged.

However, principles that are commonly used in the sphere of fiscal federalism can also be used to inform potential ways forward. This paper attempts to map out some of those potential approaches guided by those principles. They include replacing provincial programs with federal ones, compensating provinces for early action, and federal-provincial swaps such as uploading programs in exchange for reduced federal transfers.

Overall, overcoming interprovincial equity issues will entail increased cost to the federal government. Either ignoring or embracing the principles of fiscal federalism, however, could be the difference in charting a successful course toward national pharmacare.





Building
a national
pharmaceutical
policy has been
a perennial
policy issue

2 A BRIEF HISTORY OF NATIONAL PHARMACARE IN CANADA

Building a national pharmaceutical policy has been a perennial policy issue, one that has risen onto and fallen from the policy agenda time and time again. Over the past 75 years, proposals have ranged from comprehensive strategies for a universal system of pharmaceutical coverage, embedded in the Canada Health Act, to more incremental or limited proposals, such as a national catastrophic drug program that would shield Canadians from the burdens of high pharmaceutical bills.

The earliest proposals for a national program for universal pharmaceutical insurance accompanied the discussions on models for Canada's national health insurance program through hospital and physician services. In 1943, the Report on Social Security for Canada and a report by the Advisory Committee of Health Insurance included calls for the inclusion of pharmaceutical coverage. At the time, both the Canadian Medical Association and the private insurance industry supported the calls for national coverage. However, low public interest regarding the inclusion of pharmaceuticals into the national health system meant that there was little incentive for politicians to act to include them.

The issue of national pharmaceutical coverage remained on the public agenda into the 1960s. In 1964, the Royal Commission on Health Services recommended a 50/50 cost-sharing model to support a provincial drug benefit program. However, consensus was hard to reach on the model for national pharmacare. In the interim, political focus shifted to favour the more incremental approach of introducing only comprehensive physician services, setting

the stage for a national healthcare system that excluded pharmaceutical coverage.

In all of these discussions, pharmaceutical prices were an overarching concern. Studies of drug prices began in 1958, and over the next decade, pharmaceutical monopolies (due to patents) and subsequent drug prices were the subject of at least four government inquiries at the federal level.¹ The focus on price, moreover, underscored the conservative approach by federal politicians. Not only could they beg off a national model of pharmacare by pointing to jurisdiction, they could point to federal action by initiating policy aimed at regulating price and reviewing drugs, a much more limited (and less costly) policy intervention.

Despite these concerns, modest interest in a national pharmacare program persisted in some circles at the federal level. In 1971, the Minister of Health proposed the introduction of a drug price program that would include extending the existing system of national health insurance to include

1 Boothe, Katherine. 2013. "Ideas and the Limits on Program Expansion: The Failure of Nationwide Pharmacare in Canada Since 1944," *Canadian Journal of Political Science* 46(2): pp.433.

coverage for prescription medication. The Drug Price Program, however, did not make it beyond Cabinet meetings. Though the Minister of Health did not anticipate much resistance or reticence on the part of provincial governments,² the Prime Minister expressed reservations over the challenges associated with getting the provinces to contribute their share, the costs associated with drug expenditures, and the implications for controlling the federal budget.³

Provincial Policy Innovation in Pharmacare

By the early 1970s, with little serious movement by the federal government to address the costs of pharmaceuticals or to integrate a pharmacare program into the national framework, provincial governments began to take up the mantle, introducing a range of programs that experimented with different models of pharmacare delivery.

One of the first movers on provincial pharmacare was Alberta, which introduced prescription drug coverage for recipients of social assistance in the early 1960s. In 1970, Alberta became the first province to introduce a program for seniors – subsidizing prescription drug coverage based on an income-tested premium and co-payment structure of 20 per cent (by 1972, the premium had been phased out, though the co-payment of 20 per cent prescription remained). By the mid-1970s, Ontario and Quebec had adopted similar programs, attenuating their programs to populations of greatest ‘need’ – primarily seniors and welfare recipients. Quebec’s model also directed free outpatient drugs to specific high-cost populations, including patients with cystic fibrosis, cancer, tuberculosis, and diabetes (among others), and by the mid-1980s, the Ontario government had followed suit.

Like Ontario and Quebec, British Columbia introduced a pharmacare program aimed at addressing the pharmaceutical needs of seniors and low-income residents. However, unlike the other programs in existence at the time, BC PharmaCare contained elements of catastrophic coverage for all other residents (regular-income non-seniors). In addition to full coverage for seniors and low-income populations, BC PharmaCare covered 70 per cent of costs exceeding \$1,000 and 100 per cent of costs exceeding \$4,333 for the regular-income non-senior population.

Meanwhile, Saskatchewan adopted an entirely different approach to provincial pharmacare, introducing a voluntary, premium-free drug program for all provincial residents – in essence, expanding the provincial healthcare system to include an opt-in universal pharmacare program. The program utilized fixed co-payments that were intended to rise modestly over time, offsetting the cost of providing drugs to Saskatchewan residents.

2 Boothe, 2011; pp. 434

3 Boothe, Katherine. 2018. “Pharmaceutical policy reform in Canada: lessons from history,” *Health Economics, Policy, and Law* 13(3-4): pp.

The concerns of the federal government over cost were by no means unfounded. Drug prices rose dramatically over the 1970s and 1980s, such that by the mid-1990s many of the provincial programs that had emerged in the federal policy vacuum were struggling to stay afloat. Nowhere was this more true than in Saskatchewan, which had introduced one of the most comprehensive provincial pharmacare programs in the country. After only 15 years of universal provincial pharmacare, the Saskatchewan government was forced to re-think its approach to public coverage. The provincial government started modestly, introducing an annual deductible of \$125 per family, and co-payments of 20 per cent in 1987. Still the government faced down escalating. The government increased annual deductibles several times in the early 1990s until 1993, at which point the rate skyrocketed to \$1,700 annually, with co-payments of 35 per cent, making Saskatchewan's provincial program largely unaffordable for many families.⁴

Heading into the late-1990s, the strain on provincial programming in pharmacare drew the attention of policymakers, and there was a flurry of policy activity re-imagining Canada's national health insurance program. The early 1990s saw years of healthcare retrenchment and re-organization at both the provincial and federal levels, prompting a re-think regarding the future of Canadian health care. That re-think came in the form of the National Forum of Health, launched in 1997 and chaired by the Prime Minister.

4 Pomey, Marie-Pascale, Steve Morgan, John Church, Pierre-Gerlier Forest, John N. Travis, Tom McIntosh, Neale Smith, Jennifer Petrela, Elisabeth Martin, and Sarah Dobson. 2010. "Do Provincial Drug Benefit Initiatives Create an Effective Policy Lab? The Evidence from Canada," *Journal of Health Politics, Policy and Law* 35(5): pp. 715.

The National Forum of Health took a holistic approach to the Canadian healthcare system. It provided recommendations on issues such as evidence-based medicine, home care and aboriginal health. The final report, published in February of 1997, made a proclamation in favour of a national model of pharmaceutical insurance. It argued that "because pharmaceuticals are medically necessary and public financing is the only reasonable way to promote universal access and to control costs, we believe Canada should take the necessary steps to include drugs as part of its publicly-funded health care system."⁵ The policy prescription was adopted into the 1997 Liberal platform, which endorsed pharmacare as a long-term national objective.

However, despite the initial enthusiasm, serious prospects for policy reform died out as early as January 1998. Comments made by the Health Minister at a Conference on National Approaches to Pharmacare emphasized that a national universal pharmacare program was not a short-run political or policy goal for the government:

*In an ideal world, were the slate clean and money not a factor, few would doubt that a first dollar, publicly-funded, single payer universal system would be the best outcome. It would be the least expensive to society as a whole. And it would be the most fair... **But, we do not, of course, live in an ideal world, with that clean slate and unlimited money.***⁶

Certainly, financial pressures remained an overarching concern for the federal government, but increasingly, it was not the only concern impeding national policy change. Whereas earlier attempts to create a national program

5 National Forum on Health, 1997.

6 Canada. 1998. *Speaking Notes for Allan Rock, Minister of Health, at the Conference on National Approaches to Pharmacare, Saskatoon, Saskatchewan*. Ottawa: Health Canada. Emphasis added.

saw little reluctance on the part of provinces (including Quebec), by the late 1990s, the intergovernmental relationship on health care had changed dramatically. The 1990s saw a significant restructuring for the fiscal relationship on health and social services, in which the federal government progressively shifted the fiscal risk onto provinces in an effort to balance its own books.⁷ As well, the relationship with Quebec had soured dramatically, and the Quebec government was progressively moving forward on the pharmacare file.⁸ Quebec's aim to solidify a national identity through social programs like pharmacare, combined with the reticence on the part of the other provinces to sign onto a program that relied on a promise of federal spending, seriously undermined attempts at reform.

By the time the policy issue made its way back onto the national agenda in the early 2000s, the scope of the policy had been significantly curtailed. The 2002 Kirby and Romanow Reports (*The Report of the Standing Senate Committee on Social Affairs, Science and Technology* and *The Commission on the Future of Health Care in Canada*, respectively) both backed a restricted version of pharmaceutical coverage, pushing competing models of catastrophic drug coverage that would protect citizens against drug expenses exceeding some portion of their annual income. While the Kirby report recommended a catastrophic policy in recognition of the fact that many Canadians have extended health insurance through private insurance providers, the Romanow recommendation was strategic insofar as it

viewed national catastrophic coverage as the *first step* in achieving comprehensive national pharmacare.^{9 10}

Neither approach ultimately advanced beyond the paper it was written on,¹¹ which brings Canada to today and making it the only country with a national universal healthcare system that does not have a national pharmacare policy.

7 Hartmann, Erich and Alexa Greig. (2016). "Partnership Renewed: Transforming Canada's Health Funding Arrangements." Mowat Centre. https://mowatcentre.ca/wp-content/uploads/publications/125_partnership_renewed.pdf.

8 . In 1997, it mandated individual insurance for prescription drugs, a programmatic shift that moved the province in a distinct direction relative to other provincial pharmacare plans, thus complicating the potential for national-level reforms (Pomey et al. 2010; pp. 723).

9 According to the Canadian Life and Health Insurance Association (CHLIA), 25 million Canadians have extended health insurance through private insurance providers, while a good portion more are covered, at least in part, by provincial pharmacare plans. CHLIA. (2017). "Canadian Life and Health Insurance Facts: 2017 Edition."

10 Boothe, Katharine. (2013). "Ideas and the Limits on Program Expansion: The Failure of Nationwide Pharmacare in Canada Since 1944." *Canadian Journal of Political Science*: 46:2 (June/juin 2013) pp. 419–453.

11 The calls for a national approach were supported by Liberal Prime Minister Paul Martin, and integrated once again into the Liberal platform. However, facing the potential for electoral defeat, he opted for political incrementalism, pushing pharmacare reform to a majority government he never won.

3 PATCHING TOGETHER PHARMACEUTICAL COVERAGE IN CANADA

In the absence of an overarching national framework on pharmaceutical coverage, provincial programs and private markets have emerged to address individual pharmaceutical expenses in Canada.

The result, however, is that coverage for pharmaceutical costs in Canada is a patchwork. Patchwork, however, is not necessarily a pejorative term. It is the result of decades of drug policy development by individual provinces, largely independent of the federal government. This has led to a variety of approaches to addressing the issue of drug coverage in Canada. This section will explore the patchwork by discussing the four main sources of pharmaceutical coverage in Canada: (1) provincial programs; (2) federal programs; (3) private insurance; and (4) the ‘pockets’ of Canadians.

Provincial programs

Public investment in pharmaceutical coverage is primarily the purview of the provinces and territories. And in the absence of a national policy, provincial pharmacare plans have emerged and evolved.

Provincial programs have developed along several tracks, and today there is considerable variation between the policy approaches taken by provincial governments with respect to how pharmaceutical costs are managed, who is eligible for coverage under a provincial program, and where the gaps are.

Provincial pharmacare policies in Canada can generally be categorized into one of three models:

- » Catastrophic models;
- » Public Insurance models; and
- » Needs-Based models based on one of: (a) income; (b) age; or (c) health status.

Catastrophic coverage and public insurance models account for the majority of provincial programs, though most provinces also mix in some element of a needs-based approach to their coverage.

Catastrophic models

Catastrophic coverage is the most widely-used model of pharmaceutical coverage for the non-senior population in Canadian provinces. The catastrophic model is a universal model of coverage designed to offset extremely high costs of pharmaceuticals for residents within a province, protecting individuals from experiencing high drug costs by reimbursing pharmaceutical expenses beyond some per cent of their annual income. As of 2018, seven provinces utilized this model to cover at least a portion of their provincial populations.

FIGURE 1

Parameters of Catastrophic Drug Programs, by Province where Applicable¹²

Province	Upper Payment Limit: Out-of-Pocket Expenses
Prince Edward Island	3%, 5%, 8%, or 12% of net family income, progressive
Newfoundland & Labrador	5%, 7.5%, or 10% of net family income, progressive
Nova Scotia	Variable percentage of total adjusted family income
Ontario	4% of net family income
Manitoba	3.09%-6.98% of total adjusted family income
Saskatchewan	3.4% of total adjusted family income
British Columbia	1.3%-3.2% of net family income

Source: <https://lop.parl.ca/Content/LOP/ResearchPublications/2016-10-e.html?cat=health#a10>.

The seven provinces that use this some type of catastrophic program nonetheless vary significantly in the amount of coverage extended, and the payment structures used to implement the program. In some programs, the provincial government will set a co-payment amount for a family based on the combination of the previous year's income and drug expenditures.¹³ Other

12 The Quebec public insurance program also places a maximum on out of pocket expenses, capping individual out of pocket spending on pharmaceuticals at \$1,046. However, the pharmaceutical caps only apply to those enrolled in the public insurance program, and Quebec does not operate a separate catastrophic program for individuals served by private insurance providers.

13 For example, Newfoundland administers its catastrophic program – The Assurance Plan – using a copayment model. The government website describes program eligibility and administration as follows: “Qualifying applicants will be responsible for a co-payment depending on their income levels and drug costs. For example, a family with a net income of \$30,000 had \$5,000 in eligible drug costs in the previous year. As their drug costs exceed 5% of their net income (\$1,500) they would be eligible for the Assurance plan. They would be responsible for paying \$1,500 of their drug costs, resulting in a co-payment rate of 30%. Eligibility and co-payment rate are re-assessed every six months using the most recent income and drug cost data available.

provinces administer their catastrophic programs through deductibles, whereby individuals or families are responsible for the first portion of drug costs, with the balance of payments to be covered by provincial governments. Nova Scotia uses a balance of the two (co-payments and deductibles), to balance the costs to the consumer and the costs to the provincial government.

Ultimately, what makes each of these programs catastrophic programs is the fact that each set an upper payment limit as protection against catastrophic drug expenditures (see Figure 1).

As seen in the table above, not only is there variability in the program administration, there is considerable variability between provinces in setting the upper limit on out-of-pocket expenses. This results in considerable inequity across provinces. For example, whereas an individual making \$55,000 in British Columbia would pay no more than \$2,150 in out-of-pocket expenses before being eligible for provincial coverage of remaining pharmaceutical costs, that same individual would have to pay \$3,063 in Manitoba or \$4,400 in PEI before being eligible for coverage.

One of the primary benefits of a catastrophic model of coverage is that it can be used to pay for any pharmaceutical cost, and need not be limited to a set of drugs listed in a provincial formulary. While this helps to ensure that the program is available to anyone with eligible drug expensed, and can reduce the impacts of rare and costly diseases, individuals may still face high up-front costs that impede access to drugs.

In Prince Edward Island, for example, the catastrophic program covers pharmaceutical expenses beyond some percentage of family income (the percentage itself is progressive, and depends on family income – as seen in Figure 1). For a family with an annual household income of \$49,000, prescription drug expenses are capped at 5 per cent meaning that the provincial government will pay for any expenses beyond the first \$2,450. However, the program uses a deductible model of payment, whereby individuals and families must meet some threshold dollar amount before provincial support kicks in. Programs such as this may not help to alleviate the pain of short-term high-cost pharmaceuticals and, thus, may not adequately address issues associated with access to pharmaceuticals or skipping medications due to cost. For some families, that first \$2,450 may still stretch a family financially, particularly if those costs are concentrated over a relatively short time horizon. As well, families on the other side of an income gradient will see their expenses jump considerably (a family making \$51,000 would see their annual cap jump to \$4,080).¹⁴

The Ontario Trillium Drug Program uses a similar calculation to determine the annual deductible based on family income (capped at 3-4 per cent of family income). By comparison, however, the program in Ontario divides the annual deductible into four equal amounts, spreading the cost of the deductible over the course of the whole year. Thus, rather than asking individuals to max out their spending prior to assistance by the provincial government, expenses are moderated over a much longer period. If an individual does not spend enough in a quarter to meet the quarterly deductible, the unpaid portion of the

deductible is carried over to the next quarter, ensuring that the variability in pharmaceutical spending is smoothed out and accounted for.¹⁵

Public insurance models

The next most widely-utilized model, available to the general population. Four provinces utilize this type of drug coverage: Quebec, through its Public Prescription Drug Insurance Plan; Alberta, through its Non-Group Coverage Benefit; New Brunswick, through its New Brunswick Drug Plan; and Prince Edward Island, through its Generic Drug Program. These programs are generally available as a public option for individuals who do not have access to private insurance through group-based (employer) or individual plans.

Three out of the four public insurance models rely on a combination of annual premiums and co-payments. The program in Prince Edward Island is the only one that does not have annual premiums associated with it, though those enrolled in the program are required to pay a co-payment to a maximum of \$19.95 per prescription. While there are no annual premiums, PEI residents have to certify that they do not hold private drug insurance. The program further limits drug coverage to a list of approximately 1,000 generic drugs.

For individuals who do not have access to private insurance, the public option may not always appeal (Quebec is the only province mandating that its residents have either public or private insurance). For healthy individuals with low annual drug costs, the monthly premiums associated with the public program may be over and above their anticipated annual drug costs. For example, the annual premium for a

14 Government of Prince Edward Island. "Catastrophic Drug Program," online: <https://www.princeedwardisland.ca/en/information/sante-i-p-e/catastrophic-drug-program>.

15 Government of Ontario. "Get help with high prescription drug costs," online: <https://www.ontario.ca/page/get-help-high-prescription-drug-costs#section-0> [accessed August 1, 2018].

FIGURE 2

Eligibility Criteria of Public Insurance Models in Provincial Programs

	Eligibility	Annual premiums	Co-Payments	Maximum
PEI	PEI residents w/out private insurance	–	max. \$19.95	N/A
New Brunswick	NB residents w/out private insurance and those with outsized costs not covered by insurance	\$200-\$2000 per adult based on income	30% drug cost to max. \$30 based on income	N/A
Quebec	Quebec residents not eligible for private insurance are mandated to enroll in the public option	\$0-\$667 per adult based on income	34.8% drug cost	\$1,066/year
Alberta	All residents are eligible regardless of insurance status	\$762 single person \$1,416 family	30% drug cost to max. \$25	N/A

single individual in Alberta is \$762, before the associated co-payment costs of up to \$25 per prescription (subsidized premiums are available for low-income individuals and families).

Meanwhile, for an individual earning \$55,000 in New Brunswick, the annual premium to enroll in the public program is over double that of Alberta, at \$1,600 (and before the co-payment costs of up to \$25 per prescription).

In addition to the expense associated with enrollment, only Quebec’s public insurance model guards against catastrophic costs by setting an upper limit on payment amounts (set at \$1,066 in 2018), while Prince Edward Island has a separate catastrophic program. Neither the New Brunswick nor the Alberta program places an overall cap on out-of-pocket expenses. Though both place caps on co-payment amounts, individuals with high prescription medication needs (and thus a relatively high number of annual prescriptions) and/or limited incomes may still face barriers to access. Moreover, in the absence of a catastrophic program, there is no offset for expenses associated with drugs not listed on the provincial formulary.

Targeted or population-specific programs

Most provinces supplement their primary model of coverage (catastrophic or public insurance) through a combination of programs based on definitions of ‘need.’ All provinces offer public insurance programs to specific parts of the population, usually based on age, an individual’s eligibility for other services (such as social assistance), or based on having a specific condition or disease. Across all provinces, ‘need’ is generally determined along one of three lines: income, age, and/or health status.

INCOME-BASED MODELS

The most widely-utilized needs-based approach is income, with special programs or full public coverage without associated premiums available for families and individuals on social assistance. In several provinces, including New Brunswick and British Columbia, coverage of the seniors population is similarly based on income, with no or lower premiums for seniors on the Old Age Supplement (OAS) or Guaranteed Income Supplement.

In Ontario, individuals who receive income support through Ontario Works or the Ontario Disability Support Program may also be eligible for drug coverage through the Ontario Drug Benefit, which covers the cost (or most of the cost) of over 4,400 medications listed on the provincial formulary.

AGE-BASED MODELS

The age-based model of care has traditionally focused on seniors, those over the age of 65 who tend to have much higher health care burdens, and thus, higher associated costs of pharmaceuticals. This extended coverage for seniors also generally fits with the broader Canadian welfare state, which expanded on the flat-rate and tax-financed OAS program in 1965 with the introduction of the contributory Canada Pension Plan, with the explicit aim of reducing the rates of elder poverty.¹⁶

Increasingly, provinces are also developing age-based programs directed at ensuring coverage of children and youth populations. The public insurance models in Quebec, New Brunswick and Alberta all include children under the age of 18 (and full-time students under the age of 25) under family premiums. Meanwhile, while catastrophic coverage forms the foundation of provincial pharmacare in Saskatchewan, the provinces also provides universal coverage for children under the age of 14 and for adults above the age of 65 with patient co-payments of \$25 per prescription.¹⁷

Most recently, Ontario expanded its age-based programming by extending pharmaceutical coverage to all children and youth under the age of 25 without private insurance.

¹⁶ Alan Jacobs. 2011. *Governing for the Long Term: Democracy and the Politics of Investment*. Cambridge University Press: New York.

¹⁷ <https://www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/extended-benefits-and-drug-plan/childrens-drug-plan>.

HEALTH-STATUS MODELS

The third type of needs-based approach emphasizes access for populations that face consistently higher costs due to a medical condition. These are targeted programs that identify certain populations as facing costs over and above typical pharmaceutical or medical device costs. However, the creation of these types of targeted programs means that there is considerable variability in coverage. For example, Prince Edward Island has 17 such programs directed, among others, toward pharmaceutical costs related to cystic fibrosis, diabetes, organ transplant patients and tuberculosis. By comparison, Newfoundland only has one such program – the Select Needs Plan – which covers disease specific medications and supplies for individuals with Growth Hormone Deficiency or Cystic Fibrosis. Thus, where an individual is located within Canada can have major implications for their access to specific high-cost pharmaceuticals.

Federal coverage

The federal government provides extended health benefits to certain portions of the population not covered by provincial programs. The federal government provides coverage to the following populations:

- » First Nations and Inuit
- » protected persons or refugee claimants
- » members of the military
- » members of the RCMP
- » veterans and their families
- » inmates in federal penitentiaries.

Unlike provincial models of public insurance coverage, federal programs do not require co-payments or annual premiums as part of enrollment. Like provincial models of public

FIGURE 3**Private Drug Insurance Coverage by Province**

Province	Private Coverage	Prov. Population	% Coverage
Newfoundland & Labrador	370,000	520,000	71.2%
Prince Edward Island	110,000	145,000	75.9%
Nova Scotia	650,000	925,000	70.3%
New Brunswick	530,000	750,000	70.7%
Quebec	5,700,000	8,200,000	69.5%
Ontario	9,800,000	13,500,000	72.6%
Manitoba	860,000	1,300,000	66.2%
Saskatchewan	680,000	1,100,000	61.8%
Alberta	2,900,000	4,100,000	70.7%
British Columbia	3,000,000	4,650,000	64.5%

Source: Data from Canadian Life and Health Insurance Association. (2017). "Canadian Life and Health Insurance Facts: 2017 Edition."

Cost-Sharing Mechanisms for Drug Coverage

Co-payment:

The portion of the cost individuals must pay each time they make a claim. This may be a fixed amount or a percentage of the total cost of the prescription.

Deductible:

The amount of spending individuals must pay out of pocket in a year before their drug costs will be paid by the drug program. This may be a fixed amount or a percentage of income.

Premium:

The amount individuals must pay to enrol in the drug program. This may be charged on an individual basis or tied to family-size.

insurance, extended health coverage through federal programming generally includes access to prescription pharmaceuticals and over-the-counter medications based on an established drug benefit list. Pharmaceuticals not listed are generally not covered, though individuals may apply for an exception on a case-by-case basis.

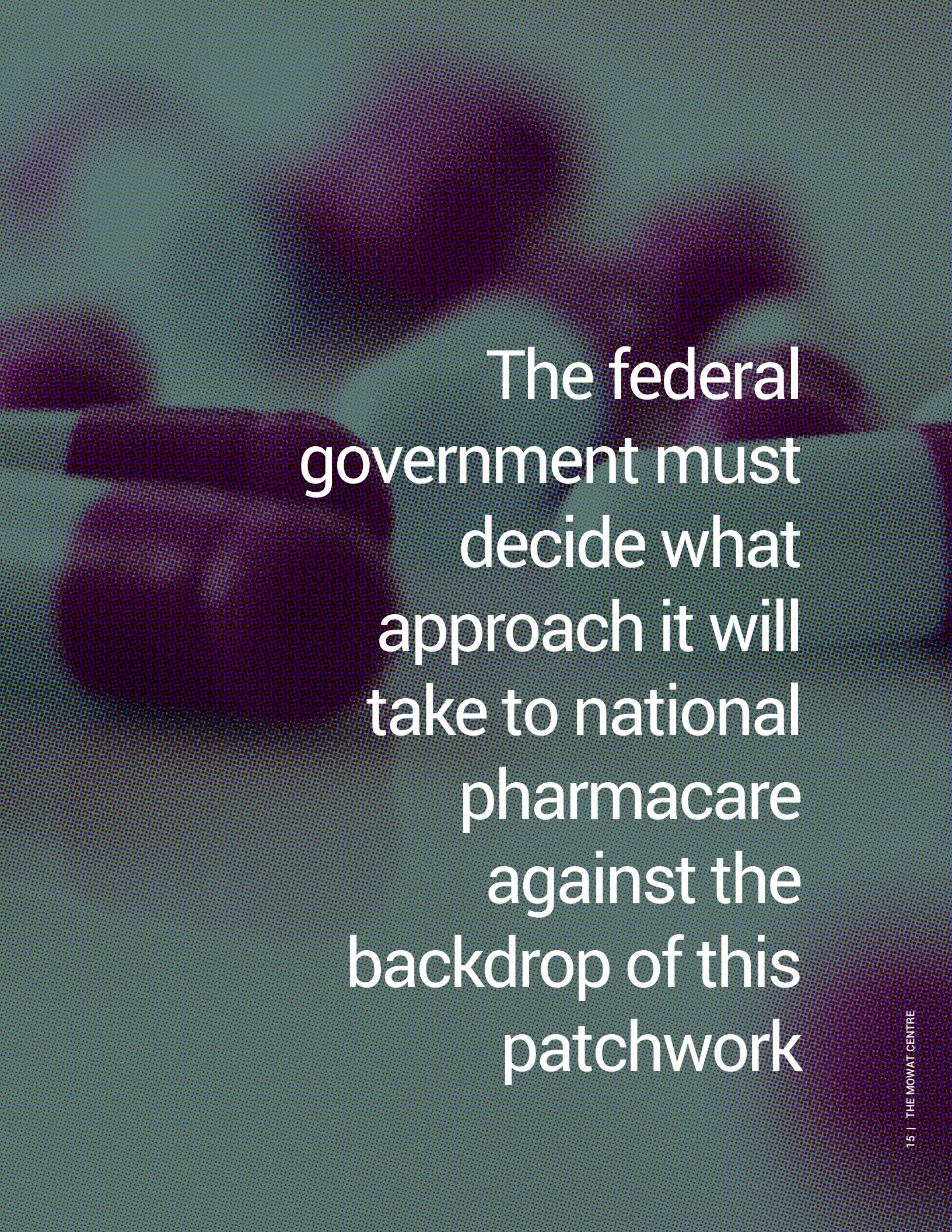
Private insurance

While new public programs emerged to address specific policy failures and target specific populations, governments have been reticent to introduce programs that would incentivize individuals to shift off of private insurance and onto public models. Indeed, private coverage rates in Canada are relatively high (See Figure 3).

The 'pockets' of Canadians

Given the variability in public and private coverage in Canada, in terms of both access to coverage and the extent of coverage (i.e. how many drugs are covered by private or public insurance), there is considerable variation in how much Canadians from different provinces have to spend out of pocket on their prescription medications.

Both public and private drug plans in Canada use a variety of cost-sharing mechanisms to share the costs of drug programs between the plan provider and beneficiaries. These mechanisms include co-payments, deductibles, and premiums (see Text Box).



The federal
government must
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against the
backdrop of this
patchwork

4 POLICY PROBLEMS

As discussed above, the provincial and territorial governments have taken a variety of approaches to addressing the issue of drug coverage in Canada. The dozens of public drug programs across Canada have been designed to pursue different policy goals at different times.

The federal government must decide what approach it will take to national pharmacare against the backdrop of this patchwork and the gaps existing approaches have left unaddressed. That approach must first be informed by what policy problem – or problems – the federal government intends a national pharmacare program to solve. Questions around access to drug coverage and enrollment in programs, affordability, the cost of prescription drugs, and the role of private coverage are all key issues about which the federal government will need to make choices and trade-offs between competing goals and outcomes. Each approach will address certain issues better than others and will involve some degree of trade-off between policy objectives.

Access: Eligibility vs. enrollment

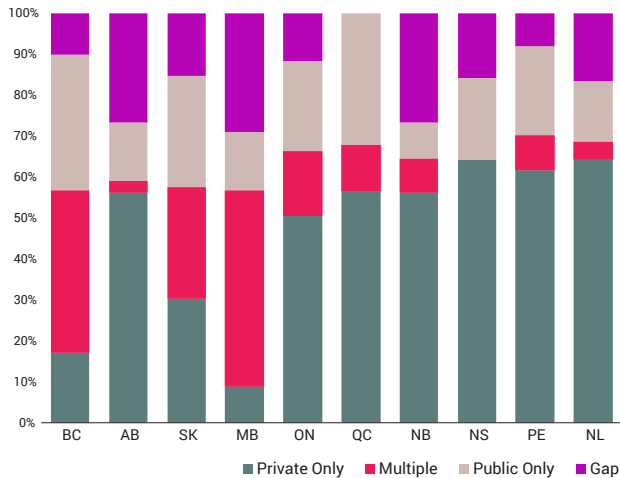
The vast majority of Canadians are eligible for drug coverage of some kind. According to a 2018 report from the Conference Board of Canada, 98.2 per cent of Canadians are either eligible for public drug coverage or enrolled in a private drug insurance plan.¹⁸ Among those Canadians eligible for coverage, 65.3 per cent are eligible for coverage under a public plan, 62.2 per cent are enrolled in a private plan, and 29.2 per cent have multiple eligibility.¹⁹

Conversely, only 1.8 per cent Canadians are neither enrolled in a private drug insurance plan nor eligible for public coverage. These uninsured Canadians are concentrated in two provinces, Ontario and Newfoundland and Labrador. In Ontario, the uninsured population is entirely made up of the 8.0 per cent of working-age adults with no coverage. In Newfoundland, there are uninsured in all age groups, but the issue is primarily concentrated in the population under 25 years of age.

Although eligibility for drug coverage is extensive in Canada, many do not take that coverage up. Some programs have high barriers to access with complex registration protocols that place an administrative burden on individuals, while

18 Sutherland, Greg and Thy Dinh. (2018). "Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage." *Conference Board of Canada*.

19 Sutherland and Dinh. (2018). The detailed figures outlined in the original report did not account for the introduction of OHIP+ in Ontario, which has made an additional 1.2 million Ontarians aged 24 or younger eligible for public coverage. All figures related to coverage rates in this report have been adjusted to account for the impact of OHIP+.

FIGURE 4**Percentage of Populations Not Enrolled in Either Public or Private Coverage**

Source: Mowat Centre calculation based on data from Conference Board of Canada (2018).

others use high deductibles or co-insurance payments to reduce uptake.²⁰ Of those eligible for public coverage, only 60.8 per cent are enrolled in public drug programs. After accounting for private coverage, 4.1 million Canadians are not enrolled in a public program, despite being eligible for coverage.²¹ But the share of the population affected by enrollment issues differs considerably across provinces (see Figure 4).

A number of factors contribute to this phenomenon. Many public drug programs do not automatically enrol those eligible for coverage. Data from public opinion surveys indicates that part of the problem may also be informational. A Nanos survey that was conducted as part of the 2018 Conference Board study suggests that “54 per cent of respondents who received a prescription but did not take it as prescribed were

unaware of publicly-funded programs that would help them.”²² Another factor is the affordability, or unaffordability, of the out-of-pocket expenses that come with drug coverage.

Affordability

Whether insured or uninsured, covered publicly or privately, many Canadians face considerable out-of-pocket drug expenses. Nearly two-thirds of Canadian households paid out of pocket for at least a portion of their prescription drug expenditures in 2015.²³ According to the Canadian Institute for Health Information, Canadians spent \$7.4 billion out of pocket on prescribed drugs in 2017, or just over \$200 per capita.²⁴ Many Canadians are “unable to obtain necessary drugs because of their cost.”²⁵

Those without public or private coverage are faced with the prospect of shouldering the entire cost of a prescription on their own. Canadians who are covered also face out-of-pocket expenses, created by cost-sharing mechanisms for drug coverage.

Because of the variation in program design of provincial drug programs, residents of different provinces experience these costs differently. Even for those enrolled in a public program, out-of-pocket costs such as deductibles and co-payments can be a financial burden for some. This is especially the case in British Columbia, Saskatchewan, Manitoba, Nova Scotia and New Brunswick.²⁶ The application of deductibles also tends to disadvantage lower-income Canadians who still participate in the labour force because

20 Demers et al. 2008. Comparison of provincial prescription drug plans and the impact on patients’ annual drug expenditure” *Canadian Medical Association Journal*. <http://www.cmaj.ca/content/178/4/405.short>.

21 Sutherland and Dinh. (2018). p. 10.

22 Sutherland and Dinh. (2018). p. 10.

23 Sutherland and Dinh. (2018). p. 76.

24 Canadian Institute for Health Information: National Health Expenditure Trends, 2017 – Series G.

25 Office of the Parliamentary Budget Officer. (2017). “Federal Cost of a National Pharmacare Program.”

26 Sutherland and Dinh. (2018). p. 76.

they do not benefit from the access to free public coverage generally offered to those on income assistance programs.²⁷

The precise impact that the various forms of cost sharing have on adherence to prescriptions is not well-understood in the Canadian context.²⁸ However, a 2015 report by the Angus Reid Institute suggests 23 per cent of Canadians either skip doses, split pills, or do not fill their prescriptions due to cost.²⁹

In certain instances, the level of out-of-pocket expenses required to access public programs can drive individual behaviour and serve to reduce enrollment in public programs. In Alberta, for example, the province's reliance on premiums can create situations in which it is advantageous to opt out of public coverage, "such as when one's medication burden, even when paying 100 per cent per cent of the cost, remains less than the cost of premiums and copayments."³⁰ Enrollment for public coverage for working-age adults in Alberta is 7.3 per cent, as many forego the province's premium and rely on the private market or pay out of pocket for drug coverage.³¹ However, substantial drug costs are not always easy to spot in advance. While the diagnosis of a chronic medical condition may indicate a future of increased drug expenditures, giving individuals time to forecast future expenses and opt into public programs, acute health events may

introduce significant pharmaceutical expenditures that can place significant stress on an individual's finances and that can undermine patient access.

For a small proportion of the Canadian population, out-of-pocket expenses can sometimes be considerable. A 2015 study found that 8.2 per cent of Canadian households face out-of-pocket drug expenses greater than 3 per cent of their total household budget, and 1.1 per cent of households faced expenses greater than 9 per cent. These levels of expense, which meet many standards of the term "catastrophic," are disproportionately experienced by low-income households and seniors.³² Since provincial programs often require considerable out-of-pocket spending before catastrophic coverage kicks in, and "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."³³ The incidence of catastrophic drug costs is also uneven across provinces, and is more prevalent in Newfoundland, Prince Edward Island, Manitoba and Saskatchewan.³⁴

27 Sutherland and Dinh. (2018). p. 77.

28 Campbell, David J.T., Braden J. Manns, Lesley J.J. Soril and Fiona Clement. (2017). "Comparison of Canadian public medication insurance plans and the impact on out-of-pocket costs." *Canadian Medical Association Journal*: 2017 Oct-Dec; 5(4): E808–E813.

29 Angus Reid Institute. (2015). "Prescription Drug Access and Affordability an Issue for Nearly a Quarter of All Canadian Households." <http://angusreid.org/wp-content/uploads/2015/07/2015.07.09-Pharma.pdf>.

30 Campbell, David J.T., Braden J. Manns, Lesley J.J. Soril and Fiona Clement. (2017). "Comparison of Canadian public medication insurance plans and the impact on out-of-pocket costs." *Canadian Medical Association Journal*: 2017 Oct-Dec; 5(4): E808–E813.

31 Sutherland and Dinh. (2018). p. 63.

32 Caldbick, Sam, Xiaojing Wu, Tom Lynch, Naser Al-Khatib, Mustafa Andkhoie and Marwa Farag. (2015). "The financial burden of out of pocket prescription drug expenses in Canada." *International Journal of Health Economics and Management*: 15, p. 332.

33 Blomqvist, Åke and Colin Busby. (2015). "Feasible Pharmacare in the Federation: A Proposal to Break the Gridlock." *CD Howe Institute*. p. 4.

34 Caldbick et al. (2015). p. 332.

Consistency: Program parameters and formulary harmonization

While most Canadians are eligible for some sort of drug coverage, there is next to no consistency across provinces regarding the terms under which eligibility is determined. While coverage for seniors is near universal, “there is less consistency in the coverage of non-seniors across jurisdictions.”³⁵

The substantial variation in the use of age-based and income-based coverage in public plans leads to considerable differences in enrollment and across provinces. Additionally, the vast differences in the use of cost-sharing mechanisms both between and even within provinces “leads to different out-of-pocket costs for the same type of patient, depending on the province of residence.”³⁶

As discussed earlier, in provinces that use universal catastrophic coverage to defray costs to individuals, including Ontario, Manitoba, and Newfoundland and Labrador, public coverage of drugs does not begin until an individual (or family) has met their deductible, which is calculated as some percentage of income. Deductible rates for catastrophic programs vary considerably across provinces. For a two-person household earning the median income in Canada, based on the 2016 Census (Gross: \$70,336 – Net: \$52,900) and with no dependent children, the annual deductible would be approximately \$1,600 in British Columbia, \$2,120 in Ontario, \$4,200 in Prince Edward Island, and \$7,070 in Nova Scotia.

On the other hand, the evidence suggests that with respect to the particular drugs covered by public programs, “there is a reasonably high degree of alignment among public drug plan formularies in Canada.”³⁷ While each province creates and manages its own unique formulary, the uniformity in public drug listings between provinces is 95 per cent when drugs were weighted by cost.³⁸

A good deal of the consistency between provincial formularies can be attributed to the significant intergovernmental collaboration that occurs in this policy space (see Text Box). A recent study showed that provincial decisions to list drugs on their formularies aligned with recommendations from the Common Drug Review between 74.5 per cent of time in Quebec and 81.1 per cent of the time in British Columbia.³⁹

35 Canadian Institute for Health Information. (2016). “Prescribed Drug Spending in Canada: 2016.” p. 26.

36 Campbell, David J.T., Braden J. Manns, Lesley J.J. Soril and Fiona Clement. (2017). “Comparison of Canadian public medication insurance plans and the impact on out-of-pocket costs.” *Canadian Medical Association Journal*: 2017 Oct-Dec; 5(4): E808–E813.

37 Patented Medicine Prices Review Board. (2017). “Alignment Among Public Formularies in Canada – Part 1: General Overview.” p. 2.

38 Patented Medicine Prices Review Board. (2017). “Alignment Among Public Formularies in Canada – Part 1: General Overview.” p. 8.

39 Allen, Nicola, Stuart R. Walker, Lawrence Liberti, Chander Sehgal and M. Sam Salek. (2016). “Evaluating alignment between Canadian Common Drug Review reimbursement recommendations and provincial drug plan listing decisions: an exploratory study.” *Canadian Medical Association Journal*: 2016 Oct-Dec; 4(4): E674–E678.

Intergovernmental Collaboration on Formulary and Pricing

The Patented Medicine Prices Review Board (PMPRB)

The PMPRB is the arms-length federal agency mandated to evaluate the drug prices of all patented drugs. The PMPRB assesses the “factory gate” price to ensure that the price at which patented drugs are sold to wholesalers, pharmacies and other distributors are not excessive. In cases where the PMPRB has found a price to be excessive, the PMPRB has the authority to order a price reduction or a repayment on the part of suppliers.

The Canadian Agency for Drugs and Technologies in Health (CADTH) and the Institut national d'excellence en santé et en services sociaux (INESSS)

The CADTH and INESSS are public bodies that make recommendations on new pharmaceuticals and their inclusion on provincial or territorial formularies. Formularies are inclusive lists of drugs that provinces and territorial public insurance programs (pharmacare) will cover, in some cases depending on eligibility requirements. CADTH administers the Common Drug Review (CDR), which provides reimbursement recommendations and advice to the federal, provincial and territorial public drug plans, with the exception of Quebec.

The pan-Canadian Pharmaceutical Alliance (pCPA)

The pCPA was established in 2010 by the Council of the Federation to leverage intergovernmental cooperation to increase governments' negotiating power with respect to drug prices. The pCPA seeks “increase access to drug treatment options, achieve lower drug costs and consistent pricing, and improve consistency of coverage criteria across Canada,”⁴⁰ by coordinating pharmaceutical purchasing across jurisdictions.

Cost of drugs

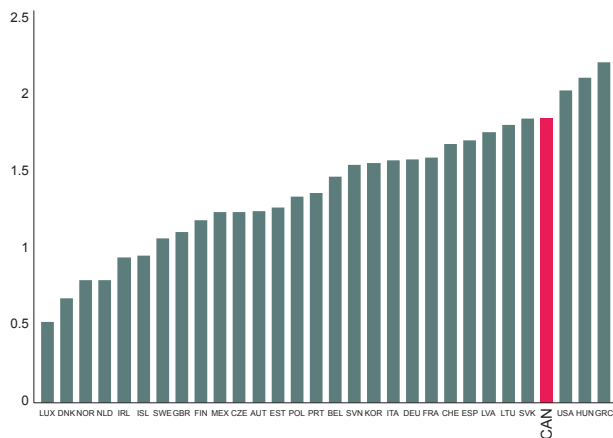
Despite recent coordinated intergovernmental efforts to engage in joint negotiations for drug prices through the pan-Canadian Pharmaceutical Alliance (pCPA), Canada's spending on drugs is very high by global standards. In 2016, Canada's total private and public spending on pharmaceuticals was the fourth highest in the OECD at 1.86 per cent of GDP, behind only Greece, Hungary and the US. This is despite the fact that 4.1 million Canadians (11.3 per cent) not enrolled in a private or public drug program.

Despite its coverage gaps, Canada's per capita expenditure on drugs is one of the highest among OECD countries and over 35 per cent above the OECD average. However, the public share of drug spending in Canada is among the lowest at just 36 per cent.⁴¹

Canada's fragmented system comprising of multiple players greatly reduces bargaining power. An example of the vast difference in prices of drugs can be seen for the cholesterol drug Lipitor. While a year's supply of the brand name drug costs at least \$811 in Canada, the same brand name drug costs only \$15

40 Council of the Federation. Pan-Canadian Pharmaceutical Alliance. Available from: <http://www.canadaspremiers.ca/pan-canadian-pharmaceutical-alliance/>. Accessed August 10, 2018].

41 <https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf>.

FIGURE 5**Total Pharmaceutical Spending (Public and Private) as a Percentage of GDP. OECD and Canada, 2016**

OECD (2018), Pharmaceutical spending. doi: 10.1787/998feb6-en (Accessed on 17 July 2018).

in New Zealand. According to a study, Canada would save \$9.6 billion annually if the drug prices in the country were brought to the OECD average.⁴²

According to the Patented Medicine Prices Review Board (PMPRB)'s Generics360 report, the per capita expenditure on generic drugs in Canada was one of the highest among OECD countries in 2016, second only to the United States. Further, the report found that the substantially high price differences for higher priced top-selling generic drugs in Canada compared to other countries cost about half a billion dollars to public drug plans or 5% of the overall drug costs.⁴³

42 <https://canadians.org/sites/default/files/publications/report-pharmacare-16.pdf>. p. 6.

43 <http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1347&lang=en#a8>.

As opposed to Canada, in many other developed countries such as Australia, the UK and New Zealand, the government is the primary financier of prescription drugs where a government or arms-length public body is responsible for determining the national formulary and setting drug prices,⁴⁴ (see Appendix A: Canada in International Context for a fuller discussion on the price-setting and cost-sharing mechanisms used in Australia, the UK and New Zealand). This provides these countries greater bargaining power in negotiating drug prices. Apart from creating cost-efficiencies, a single nation-wide formulary is also key to ensuring equitable access.⁴⁵ In Canada, while the Common Drug Review (CDR) conducts a cost-efficiency analysis on a pan-Canadian basis, its role is limited to advising.⁴⁶ A single payer national pharmacare program that expands its authority to negotiate nation-wide prices for drugs has the potential to greatly increase bargaining power and reduce drug prices in the country.

About 80 per cent of the private insurers in Canada are for-profit companies, with administrative costs higher than the public sector. Over the past 20 years, the gap between the premiums collected and benefits paid by private insurance companies in Canada has greatly increased. In 2011, this gap between premiums and payouts reached \$6.8 billion. They are also less cost-efficient. Compared to public plans, private insurers pay about 7 per cent more for generic drugs and 10 per cent more for brand name drugs.

44 <http://www.cmaj.ca/content/cmaj/189/23/E794.full.pdf>. p. 795-796.

45 <https://www.ourcommons.ca/Content/Committee/421/HESA/Brief/BR8215558/br-external/McMasterUniversity-Boothe-2016-04-20-e.pdf>. p. 1-2.

46 <https://www.ourcommons.ca/Content/Committee/421/HESA/Brief/BR8215558/br-external/McMasterUniversity-Boothe-2016-04-20-e.pdf>. p. 3.

Many private companies also do not use cost-saving activities such as generic substitution or caps on dispensing fees, which are common in public plans.⁴⁷ Research commissioned by CBC's *The Fifth Estate* found that private insurance plans wasted more than \$3 billion each year from 2011 to 2015 by covering expensive drug options where cheaper alternatives were possible and by paying unnecessary dispensing fees. One reason for this is that doctors often prescribe expensive drugs rather than generic brands or trying cheaper alternatives first. These misinformed prescribing practices, which often go against the clinical guidelines, are largely influenced by marketing from drug companies. It is drug companies, rather than an independent body without conflict of interest, that are largely responsible for educating doctors in Canada about new drugs.⁴⁸

Role of private insurance: Payer of first or last resort?

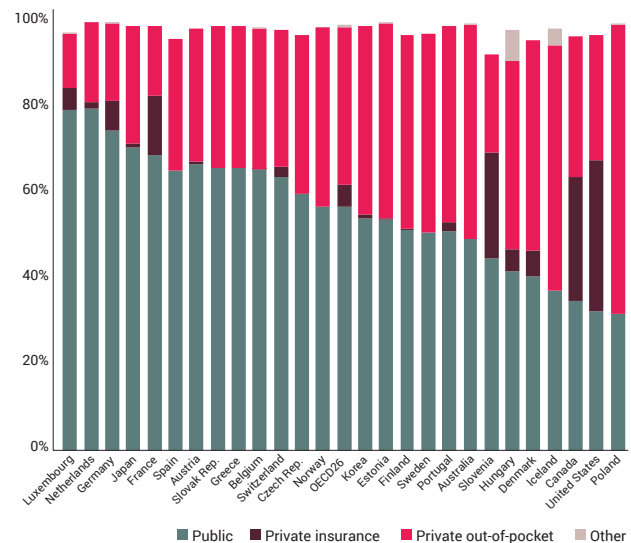
Reliance on private drug coverage is particularly high in Canada. In terms of the amount of drug spending covered by private insurance, Canada ranks second only to the US in the OECD (see Figure 6).⁴⁹

As discussed above, 62.2 per cent of Canadians are enrolled in a private plan, and 29.9 per cent have multiple eligibility. A key design element of the federal government's approach to pharmacare, therefore, will be the role it envisages for private drug insurance plans within its framework. Provinces currently take a variety of policy approaches with respect to private drug coverage, including mandating private coverage

47 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4150733/>.
48 <http://www.cbc.ca/news/health/drug-costs-canada-1.3927989>.
49 OECD. (2015). "Pharmaceutical spending trends and future challenges." *Health at a Glance: 2015*.

FIGURE 6

Expenditure on Retail Pharmaceuticals By Type of Financing: Canada and OECD, 2013



Source: OECD (2018), Pharmaceutical spending. <http://dx.doi.org/10.1787/888933280689>. (Accessed on 17 July 2018).

for certain populations, permitting opting into private coverage in lieu of public coverage, and using private coverage as either the payer of first resort or last resort in various programs.

"Every major study of Canada's health care system in the past 50 years has singled out the lack of public coverage of prescription drugs as a major gap. This includes the Royal Commission on Health Services (Hall, 1964), the National Forum on Health (1997), the Commission on the Future of Health Care in Canada (Romanow, 2002) and the report of the Standing Senate Committee on Social Affairs, Science and Technology on the State of the Health Care System in Canada (Kirby, 2002)."

Advisory Council on the Implementation of National Pharmacare⁵⁰

50 Canada. (2018). "Towards Implementation of National Pharmacare: Discussion Paper." *Advisory Council on the Implementation of National Pharmacare*. p. 3.

Recap: What are the gaps and issues?

- » Most Canadians who do not have access to private drug coverage are eligible for public drug programs. Despite this eligibility, many Canadians are not enrolled in public drug programs, indicating that eligibility does not equal accessibility or affordability.
- » Children and working-age adults comprise the majority of the uninsured population.
- » High out-of-pocket expenses, and even low co-payments in many cases, can contribute to non-adherence to prescriptions and low enrollment rates in public programs.
- » Many Canadians face catastrophically high front-end drug expenses before public catastrophic coverage kicks in.
- » There are differences in provincial drug formularies, but the differences tend to be small and at the margins.
- » In a relatively small number of cases, special drugs for rare diseases can lead to considerable expenses, particularly if the drug is not covered by a provincial formulary.
- » Eligibility criteria for public coverage vary considerably across provinces.
- » Canada pays a significantly higher retail cost for drugs than most developed countries.
- » Canada relies heavily more than most developed countries on private insurance for drug coverage.

5 MODELS

Existing provincial policy approaches to drug coverage – and the gaps they leave unaddressed – will not only inform what policy problem, or problems, the federal government intends a national pharmacare program to solve. The spectrum of existing approaches will also serve as a list of potential models the federal government could pursue in implementing its own approach to national pharmacare.

Broadly speaking, four models are available to the federal government: a catastrophic coverage model, a targeted model designed to fill gaps in need left unaddressed by existing programs, a mandatory coverage model and a universal coverage model. Below is a brief description of the overarching purpose and broad policy parameters assumed for each model.

The cost estimates included in this section are high-level estimates to illustrate the scope of the costs involved in each option. Importantly, they assume that the costs involved would be incremental to the coverage the provinces are currently providing. As such, these cost estimates do not contemplate the effects of interactions with existing provincial programs, or any potential behavioural changes on the part of provincial governments in response to the design of a national pharmacare program. These interactions will be discussed in the following section.

Catastrophic coverage

The catastrophic model would be a universal model of coverage designed to offset extremely high costs of pharmaceuticals for individuals. It would be designed to provide catastrophic coverage to those currently not afforded such coverage. Coverage would be available to all residents that meet the out-of-pocket spending

thresholds as a percentage of their income.

Expenses would be reimbursed on an application-basis. All out-of-pocket prescription drug costs would be covered and need be not limited to a specific formulary.

In terms of cost, a 2015 study by the Conference Board of Canada estimated that it would cost the federal government \$1.7 billion in 2018 to provide catastrophic coverage to households that spend \$1,500 per annum or over 3 per cent of their annual income on medication to Canadians without existing coverage in that regard.⁵¹

Mandatory coverage

The mandatory coverage model would seek to provide a public backstop for those currently uninsured. Uninsured individuals or families would

51 Conference Board of Canada. (2015). "Federal Policy Action to Support the Health Care Needs of Canada's Aging Population." <https://www.cma.ca/Assets/assets-library/document/en/advocacy/conference-board-rep-sept-2015-embargo-en.pdf>.

FIGURE 7

Purpose and Policy Parameters Assumed for Each Model

	Catastrophic	Mandatory Coverage	Gap-Filling	Universal
Purpose	Offset very high out-of-pocket expenses	Public backstop for uninsured	Provide coverage to uninsured populations and others facing high costs	First-payer public coverage
Eligibility	Universal, scaled to income	Targeted at unenrolled in public or private coverage	Targeted at unenrolled in public or private coverage and without catastrophic coverage	Universal
Enrollment	Application-based	Automatic	Mixed	Automatic
Formulary	N/A	National	National	National
Additional Cost to Federal Government (2018)	\$1.7 billion	\$1.4 billion	\$3.1 billion	Replace \$19.5 billion in private and out-of-pocket spending (not actual cost)

be mandated to buy into either private coverage or a public insurance program managed by a governmental body.⁵²

It is extremely unlikely that the federal government would have the jurisdictional authority to mandate coverage (matters around federal jurisdiction will be discussed more fully in a later section). Instead, it would have to set a national standard of coverage and provide funding to provinces to enable them to meet that standard. In order to achieve universal coverage, enrollment would need to be automatic provided that the individual or family could not provide evidence of existing public or private coverage. Some form of national formulary would be required to ensure consistency of coverage.

The cost of extending coverage to those currently not covered by public or private coverage is estimated to be \$1.4 billion.

Gap-filling

A gap-filling model would be targeted at populations that disproportionately face under-coverage. These groups tend to be youth

and working-age adults. Enrollment would be automatic for uncovered groups. Some form of national formulary would be required to ensure consistency of coverage.

As insufficient protection from extremely high costs of pharmaceuticals for individuals also represents a gap, this approach could be combined with a national catastrophic program.

As a combination of both catastrophic and mandatory coverage, the cost of this model is estimated at \$3.1 billion.


Universal

The universal model would extend first-payer public coverage to all Canadians. Enrollment would be automatic and some form of national formulary would be required to ensure consistency of coverage.

Extending first-payer public coverage to all Canadians would involve replacing the \$12.1 billion currently covered by private insurance, as well as substantially addressing issues created by the \$7.4 billion of out-of-pocket spending on prescription medications.⁵³

52 Another model the federal government could potentially employ to achieve the same goal as mandatory coverage would be to provide insurance subsidies to uninsured Canadians. This model was out of the scope of this analysis and could be pursued in further research.

53 Canadian Institute for Health Information. *National Health Expenditure Trends, 1975 to 2017*: Data Tables - Series G.



All models
will involve
trade-offs
between
objectives

6 FIRST-LEVEL ASSESSMENT: ADDRESSING POLICY PROBLEMS

The federal government has at its disposal four broad models as it chooses its approach to delivering a national pharmacare program. Each model addresses certain issues better than others. Whichever model the federal government chooses, will inevitably involve some degree of trade-off among policy objectives and between policy objectives and cost.

The present section conducts a high-level assessment of how each of these models would address the gaps the existing patchwork of provincial programs has left unaddressed. Each model will be assessed according to how well it addresses issues of access, affordability, consistency and cost, as well as how it would impact the role of private sector coverage.

This, however, is only the first level of assessment that will be undertaken by this report. It assumes the federal government could layer these models on top of the existing system of public and private coverage and therefore does not take into consideration interactions with provincial programs or implications for fiscal federalism. These issues form a second level of assessment that we undertake in the next section.

Assessment: Catastrophic coverage

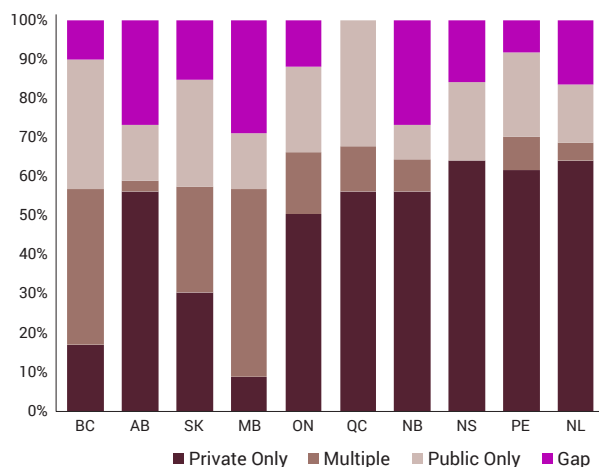
A national catastrophic drug plan would provide many Canadians with a greater degree of protection from extremely high out-of-pocket drug expenses. Residents of certain provinces would particularly benefit from extended catastrophic

coverage. As noted above, the incidence of catastrophic drug costs is more prevalent in Newfoundland, Prince Edward Island, Manitoba and Saskatchewan.

The impact of such a program could be extended further if eligibility thresholds for coverage were below those found in catastrophic drug coverage programs currently administered by the provinces (see Figure 1). Similarly, the impact could be extended further if the program covered all drug costs once the threshold was met, not just the incremental costs above the threshold. For example, the deductible for Saskatchewan's Special Support Program is 3.4 per cent of family income, and once it is met, the program only picks up the remainder of the costs after the deductible.⁵⁴

On the other hand, residents of certain provinces would see little to no benefit. Quebec would be the prime example as monthly spending on deductibles is capped or exempted for certain populations. Moreover, based on the experiences of the provinces to date, a national catastrophic

54 Sutherland and Dinh. (2018). p. 61.

FIGURE 8**Percentage of Population Not Enrolled in Either Public or Private Coverage, Purple Bar**

Source: Mowat Centre calculation based on data from Conference Board of Canada (2018).

program may have limited potential for efficiency gains (through lower drug costs) or for improving patient access to drugs.

A national catastrophic drug program, however, would not address more general access and affordability issues. Out-of-pocket expenses that do not meet the definition of “catastrophic” can still deter or even preclude enrollment in public programs.

Similarly, while a national catastrophic drug program would lead to more consistency in the coverage for catastrophic costs, it would not address more general issues around the inconsistency of enrollment for public coverage.

A national catastrophic drug program would not need to depend on a particular formulary either. As such, it would not include any innate mechanism to address the cost of drugs for governments.

A national catastrophic drug program would not substantially alter the degree of reliance on private coverage.

Assessment: Mandatory coverage

Mandatory coverage would address the specific problem of increasing access to coverage. Increases in access would be seen across the board, except in Quebec which already has 100 per cent access to coverage. The largest gains percentage-wise would be seen in Alberta, Manitoba and New Brunswick where the populations not enrolled in either public or private coverage represent the largest share of the total populations (see Figure 8).

Mandatory coverage would not necessarily address affordability issues on its own, because such models generally come with cost-sharing parameters, which can lead to out-of-pocket expenses. However, cost-sharing parameters can be designed to ensure that they do not unduly affect access. For example, Quebec places monthly spending caps on deductibles and exempts certain populations from premiums.

Mandatory coverage would not necessarily address consistency issues, such as variance in out-of-pocket expenses across provinces. This would be particularly true if provinces were left to administer a mandatory coverage model. Inconsistencies could be addressed however, by federal standards.

The marginal differences in formularies would need to be closed to ensure that gaps in coverage are not created by inconsistencies in listings. This would not necessarily entail complete uniformity in formularies, but comparable access to necessary drugs would be required to ensure consistent access. If provinces are to maintain their own formularies under this model, additional financial support to promote greater consistency between formularies would be necessary.

Because increased consistency between provincial drug listings would not necessarily require a single national formulary, a mandatory coverage model would not solve the issue of the cost of drugs on its own.

Mandatory coverage could have an effect on the degree of reliance on private coverage. For example, Quebec mandates that its public employees enroll in private coverage.

Assessment: Gap-filling

Similar to the mandatory coverage model, a gap-filling model would be specifically designed to address gaps in populations that currently face disproportionate under-coverage or high out-of-pocket expenses. Increasing access would be the *raison d'être* for such an approach; access to coverage would be the specific problem a gap-filling model is meant to address. A gap-filling model would also impact roughly the same uncovered populations as the mandatory coverage and catastrophic models. The largest gains percentage-wise would be seen in Alberta, Manitoba and New Brunswick.

Addressing affordability issues is part and parcel with increasing access to coverage. Part of the approach to gap-filling would therefore need to include a mechanism to decrease out-of-pocket costs that impede access, which tend to be more of an issue in British Columbia, Saskatchewan, Manitoba, and some Atlantic provinces.

While a gap-filling model would extend coverage to populations that are currently under-covered, it would not necessarily solve all of the issues regarding inconsistencies across provinces with respect to differences in out-of-pocket expenses required to enroll in public programs.

Similar to the mandatory coverage model, addressing marginal differences in formularies would be desirable in a gap-filling model. This would not necessarily entail complete uniformity in formularies, but comparable access to necessary drugs would be required to ensure consistent access. Mandatory coverage would not be effective if the type of drug an individual requires is not covered. If provinces are to maintain their own formularies under this model, additional financial support to promote greater consistency between formularies would be necessary.

Because increased consistency between provincial drug listings would not necessarily require a single national formulary, a gap-filling model would not solve the issue of the cost of drugs on its own.

A gap-filling model would not substantially alter the degree of reliance on private drug coverage.

Insufficient protection from extremely high costs of pharmaceuticals for individuals also represents a gap in coverage. A national catastrophic program could also be layered on top of a gap-filling model. This would create all the benefits listed above as well as those listed in the assessment of a catastrophic model. The addition of enhanced catastrophic coverage would also add to the cost.

Assessment: Universal

Universal drug coverage would address access issues by offering first-payer public coverage to all Canadians. Access to coverage would increase in all provinces, except Quebec, which already has full coverage.

The degree to which universal coverage addresses affordability issues, would be contingent on decisions around cost-sharing

parameters. Out-of-pocket spending on prescription drugs was \$7.4 billion in 2017.

A recent study from the Parliamentary Budget Officer (PBO) has estimated that a \$5 co-payment included as part of a universal drug program would generate roughly \$400 million in revenue. However, it would reduce out-of-pocket expenses by up to 100 per cent depending on eligibility for co-payment exemptions.⁵⁵ This estimate does not include the effect of the possibility for the elimination of premiums under a national universal program, which would also reduce out-of-pocket expenses. Targeted programs for special drugs for rare diseases, or inclusion of those drugs on a formulary – or formularies – would be required to address the potential for catastrophic cost issues to emerge under a universal program.

A universal coverage model would lead to the greatest consistency in program parameters. The framework for a federally administered universal program covering all Canadians could be consistently applied across the country. Some scope for interprovincial variation could remain if the provinces were left to administer universal drug coverage.

A federally administered universal program would operate with a single, uniform formulary across the country. This would lead to consistency in coverage with respect to drug type across the country, but could also be used to leverage overall cost savings. According to the PBO, a significant reduction in drug prices could be driven by a stronger negotiating position to obtain at least the lowest price currently obtained by public and private insurance plans in Canada, and universal application of generic drug substitution where

generic drug alternatives exist. Taken together, these would create over \$4.2 billion in savings.⁵⁶ Other studies indicate that universal pharmacare could reduce total spending on drugs by considerably more.⁵⁷

If provinces are left to administer universal coverage, more consistency in formularies would be desirable, but as with the gap-filling and mandatory coverage models, a national formulary would not be required.

A universal model would crowd out private sector coverage for drugs, by shifting those costs onto the public sector. Currently, 62.2 per cent of Canadians are covered by private insurance. Extending first-payer public coverage to all Canadians would involve replacing \$12.1 billion of drug spending currently covered by private insurance. However, the increased negotiating power that would come from a single payer would lead to savings, meaning that those costs would not have to be replaced by government on a dollar for dollar basis.

Assessment: Overall

Overall, certain models will address certain problems better than others. Each will also involve some degree of trade-off between policy objectives and cost to government. To reiterate, these cost estimates do not contemplate the effects of interactions with existing provincial programs or potential behavioural changes on the part of provinces.

56 Office of the Parliamentary Budget Officer. (2017). "Federal Cost of a National Pharmacare Program." p. 3.

57 For example, Morgan et al. (2015) estimate that total spending on prescription drugs would have been reduced by an estimated \$7.3 billion in 2012-13 under a universal pharmacare program. See: Morgan, Steven G., Michael Law, Jamie R. Daw, Liza Abraham and Danielle Martin. (2015). "Estimated cost of universal public coverage of prescription drugs in Canada." *Canadian Medical Association Journal*: March 16, 2015. DOI: <https://doi.org/10.1503/cmaj.141564>

55 Office of the Parliamentary Budget Officer. (2017). "Federal Cost of a National Pharmacare Program." p. 3.

FIGURE 9

First-Level Assessment

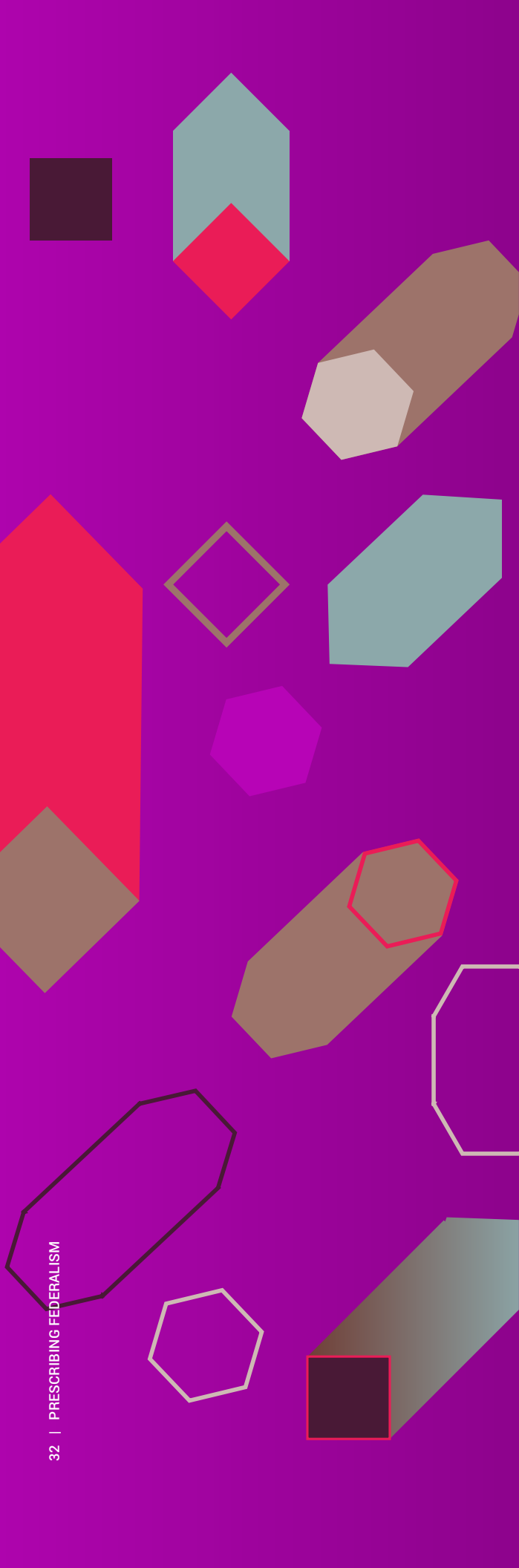
	Catastrophic	Mandatory Coverage	Gap-Filling	Universal
Access	Addresses only a limited set of access issues	Yes	Yes	Yes
Affordability	Addresses only a limited set of affordability issues	Yes, but depends on program parameters	Yes, but depends on program parameters	Yes, but depends on program parameters
Consistency: Formulary	N/A	Requires greater consistency to achieve goals	Requires greater consistency to achieve goals	Requires greater consistency to achieve goals. Single formulary under federal administration
Consistency: Parameters	Addresses only a limited set of consistency issues	Yes, but depends on program parameters	Yes, but depends on program parameters	Greatest degree of consistency
Cost: Efficiency	No	No	No	Yes
Role of private	No change	Potential for some shift	No change	Crowds out private
Additional Cost to Federal Government (2018)	\$1.7 billion	\$1.4 billion	\$3.1 billion	Replace the \$19.5 billion in private and out-of-pocket spending (not actual cost)

With respect to improving access, the gap-filling, mandatory coverage and universal models all perform well. A catastrophic model would also increase access, but only to those currently facing exceptionally high out-of-pocket expenses.

The degree to which the gap-filling, mandatory coverage and universal models address affordability issues would all depend on design choices for cost-sharing parameters. However, as access and affordability issues are often interrelated, both would have to be addressed in order for the model to be successful. A catastrophic model would also improve affordability – considerably in many cases – but again, only to those currently facing exceptionally high out-of-pocket expenses.

A universal model would lead to the greatest degree of consistency across the country with respect to program parameters and formulary. However, the gap-filling and mandatory coverage models could also be used to drive greater consistency in both of those areas. A national catastrophic model would reduce inconsistencies in catastrophic coverage, but would have no effect on formularies.

A universal model would have the greatest effect on the cost of pharmaceuticals. The increased negotiating power that would come from a single buyer could lead to a dramatic reduction in costs. The other models would have little effect in and of themselves.



The universal model would lead to a transformative shift in the degree of reliance on private drug coverage. The other models would have little to no effect.

While the universal model might address most of the gaps left by the current patchwork of programs, it would also come at the highest cost to government.

Finally, if no consideration is given to interactions with existing provincial programs, each model would benefit the residents of some provinces more than others.

7 SECOND-LEVEL ASSESSMENT: FEDERAL-PROVINCIAL IMPLICATIONS

The first-level assessment was conducted as if the federal government could layer these models on top of the existing system of public and private coverage. But could the federal government do that? Given Canada's federal structure and existing patchwork of provincial pharmaceutical coverage, and any of the models we are assessing would create significant. This is largely because the design of provincial drug programs is so vastly different, both across provinces and within individual provinces.

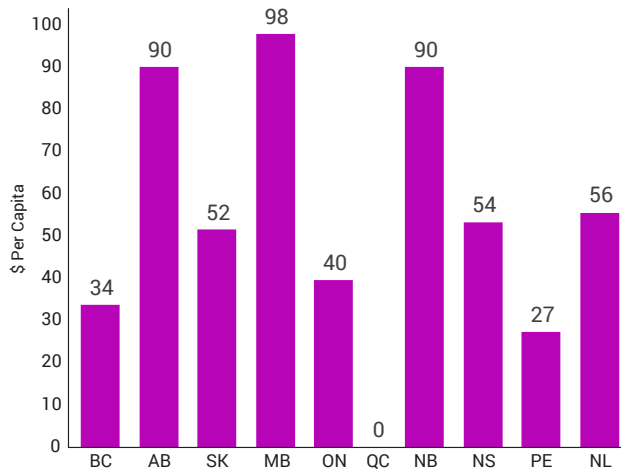
The main shortcoming of each of the four models as outlined above is that each would result in vastly different treatment of Canadians at the hands of the federal government. For example, the national catastrophic drug coverage model described above would provide compensation for out-of-pocket costs that were above \$1,500 annually or 3 per cent of income. The program design contemplated would be agnostic to the degree of pre-existing public coverage provided by provincial governments. As discussed, eligibility thresholds for catastrophic coverage vary considerably across Canada (see Figure 1).

Furthermore, some provinces cover all catastrophic costs once the eligibility threshold is met (e.g. Ontario) and some only cover marginal expenses beyond the threshold amount (e.g. Saskatchewan). Alberta and Prince Edward Island do not provide catastrophic coverage and in Quebec, the provision of catastrophic coverage is not generally an issue because out-of-pocket expenses are capped or exempted for certain populations.

Similarly, an approach to mandatory coverage that only sought to extend coverage to populations currently enrolled in neither public nor private programs would result in vastly differential treatment of Canadians across provinces. Because the relative size of unenrolled population differs considerably across provinces, the cost of extending coverage to all would also vary by province. A federal transfer to provinces that provided funding equivalent to the national average provincial-territorial public drug spending per capita to each unenrolled Canadian would create extremely unequal results (see Figure 10). For example, such a transfer would provide Manitoba with an estimated \$98 per capita, and nothing to Quebec.

FIGURE 10

Per Capita Amount Required to Extend Coverage to Populations Not Enrolled in Either Public or Private Coverage (\$ per capita)



Source: Mowat Centre calculation based on data from Conference Board of Canada (2018) and Canadian Institute for Health Information (2017)

A gap-filling model would replicate and add together the inequities of the catastrophic and mandatory coverage models discussed above.

Even a universal coverage model might not be immune to such horizontal equity issues if existing provincial policies and their idiosyncratic relationships with private drug coverage are left in place. If a universal coverage model is pursued, each province would be entering into that process from substantially different starting places with respect to their reliance on private drug coverage (see Figure 11).

Differential treatment is not in itself a vice with respect to fiscal federalism. It can be used as a means to achieve greater equality of outcomes. The Equalization program is a good example in that regard. It provides differential levels of funding to provincial governments so that their unequal capacity to raise revenues does not affect their ability to deliver reasonably

FIGURE 11

Share of Provincial Populations Either Only Covered by Private Drug Insurance or with Access to Both Private and Public Coverage (per cent)

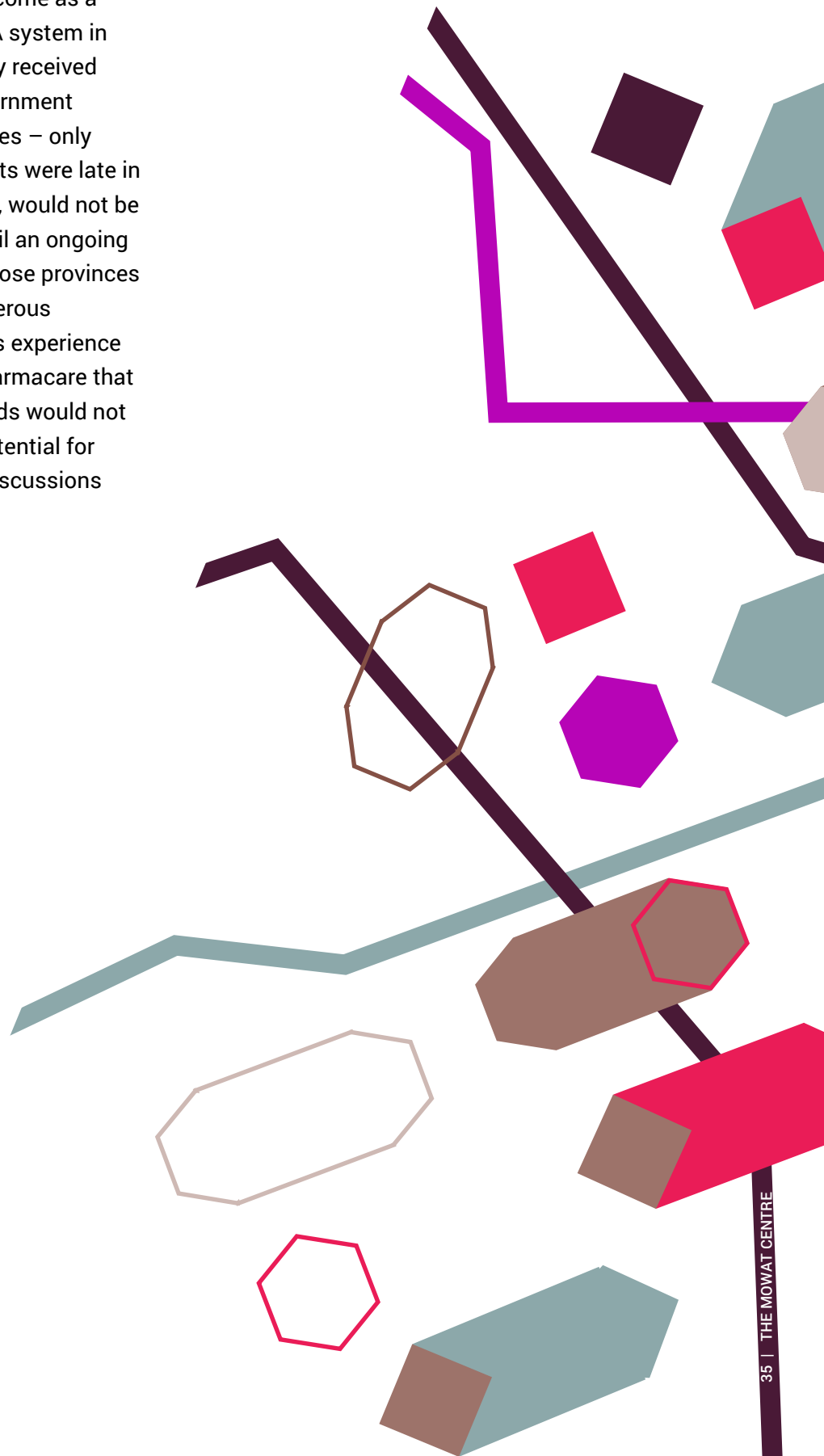


Source: Mowat Centre calculation based on data from Conference Board of Canada (2018)

comparable programs at reasonable comparable levels of taxation. The differences in revenue-raising capacity that the program attempts to iron out reflect varying levels of strength in underlying taxable activity available to individual provinces. The strength of those tax bases is not something over which provincial governments have much control. Differential treatment by the federal government through the Equalization program to compensate for those differences which are outside governments' control is entirely justifiable, if done on a principled basis.⁵⁸

58 The Equalization program is not without its shortcomings and substantial improvements to its design, such as the incorporation of a measure of expenditure need, would make the program more principled. For a full discussion, see Thies, Andrew, Jordann Thirgood and Erich Hartmann. (2018). "A Fair Fiscal Deal: Towards a more principled allocation of federal transfers." *Mowat Centre*. <https://mowatcentre.ca/a-fair-fiscal-deal/>.

However, differential treatment at the hands of the federal government should not come as a result of provincial policy choices. A system in which some Canadians permanently received more benefits from the federal government – while paying the same federal taxes – only because their provincial governments were late in addressing a current federal priority, would not be an equitable one. It would also entail an ongoing penalty to provincial taxpayers in those provinces that had opted to provide more generous coverage in the first place. Canada's experience shows that a model for national pharmacare that fails on interprovincial equity grounds would not be tenable and would jeopardize potential for progress in any federal-provincial discussions seeking to move this issue forward.



8

PROVEN FISCAL FEDERALISM PRINCIPLES AND APPROACHES: CHALLENGES & OPPORTUNITIES

As we have seen so far, in the case of pharmacare, the federal government is operating not in a vacuum but in a complex pre-existing patchwork of mostly long-standing provincial programs serving entrenched policy goals. The degree to which the federal government would be able to use a national pharmacare program to achieve its desired policy outcomes is therefore directly informed by the degree to which individual provinces have already addressed those issues.

This is not to say that attempts to introduce a national pharmacare program would be futile. It is to say that any such attempt will have to navigate a complex and potentially thorny intergovernmental reality. But there is no need to reinvent the wheel here. Rather, principles and approaches that are already commonly used in the sphere of Canadian fiscal federalism can be used both to better understand potential roadblocks and to inform potential ways forward.

In the present section, we present these principles and approaches and use them to shed sharper light on the intergovernmental challenges and provincial opposition that a national pharmacare program is most likely to face. In the following section we then outline how these principles and approaches can show a way forward for either model of a pharmacare program that the federal government may undertake.

Principles of fiscal federalism

A national pharmacare program will necessarily entail fiscal and programmatic interactions between the orders of government. Because these interactions will be so large and complex, the federal approach to national pharmacare should be informed by principles that are commonly used in the sphere of fiscal federalism. They will also prove useful in informing when and how the general approaches that the federal government uses to overcome jurisdictional issues should be employed.

These principles will be instructive for assessing each model for potential shortcomings and identifying grounds on which federal proposals are likely to receive pushback from provinces. However, these principles can also inform potential ways forward, enabling the federal government to overcome those shortcomings. These principles also require trade-offs, and as such will often be discussed in conjunction with each other.

Horizontal equity, interaction with provincial programs and incentives

First and foremost, the federal government's choice of national pharmacare model will require trade-offs between horizontal equity, integration with provincial programs and (more broadly) incentives for provincial decision-making.

Horizontal equity "requires the equal treatment of equals... Not only does it offer protection against arbitrary discrimination, but it also reflects the basic principle of equal worth."⁵⁹ Ideally, a national pharmacare program would meet the test of horizontal equity and treat all Canadians who find themselves in similar positions alike. Factors that might be considered in such a determination could include income, the proportion of an individual's income spent on drugs, or age. Given the varied array of existing provincial drug programs, however, achieving the goal of horizontal equity may prove exceptionally difficult and will depend largely on how a national pharmacare program would interact with these programs.

In that vein, the federal government will also have to decide whether a national pharmacare program would complement or ultimately replace existing provincial programs. A national program that seeks to complement existing programs by limiting its role to strictly filling gaps in existing coverage would pose the lowest fiscal cost proposition for the federal government. However, it would also likely mean that federal coverage would only be provided in certain parts of the country where provinces did not already provide coverage for the target population. This would have clear implications for horizontal equity.

Canadians who found themselves in similar positions would not be treated alike by the federal government.

Furthermore, taxpayers in jurisdictions that had previously decided to provide more generous coverage would be expected to continue to support those programs through their provincial taxes. Without some form of abatement of federal tax, these provincial tax rates would need to stay artificially higher, thereby penalizing those taxpayers on the revenue side in an uneven fashion as well (see section on the ability to opt out with compensation to follow). This scenario would create clear incentives for provinces to roll back provincial drug coverage to the point where it was replaced by federal coverage, ultimately creating room to lower provincial taxes.

If on the other hand, the federal decision is to have national coverage replace provincial drug coverage, either completely or in part, provinces with more generous coverage in the areas targeted by a national pharmacare would be disproportionately advantaged. While this would improve the federal government's ability to achieve horizontal equity goals, it would also come at increased fiscal cost to the federal government. This approach would also provide an opportunity to disentangle federal and provincial programming, which "produces inefficiencies, poor policy outcomes, confused service delivery and, ultimately, public displeasure with the ability of governments to deliver effectively on key priorities."⁶⁰

59 Musgrave, Richard A. (1990). "Horizontal Equity, Once More." *National Tax Journal*: Vol. 43, No. 2 (June, 1990), pp. 113-122.

60 Mendelsohn, Matthew, Joshua Hjartarson and James Pearce. (2010). "Saving Dollars and Making Sense: An Agenda for a More Efficient, Effective and Accountable Federation." *Mowat Centre*.

Jurisdiction, accountability and financing

Although the provincial and territorial governments have constitutional authority over health care, “the federal government has a substantial constitutional foothold when it comes to outpatient prescription drugs.”⁶¹ The federal government must therefore decide whether it intends to directly administer a national pharmacare program by itself, or whether it plans to transfer funding to the provinces and territories to achieve its policy goals.

While federal transfers can be useful tools for achieving national policy goals, or for addressing intergovernmental finance issues such as vertical and horizontal fiscal imbalances,⁶² they also tend to blur accountability for programs. This blurred accountability increases the potential for parties to act in bad faith.

The federal government is very effective at insulating itself from the possibility of such occurrences. Agreements or legislation governing federal transfers to provinces and territories typically have mechanisms built into them that allow the federal government to claw funding back from recipients if standards are not met.

On the other hand, beyond appealing to public opinion, provinces and territories have little recourse if the federal government decides

to unilaterally withdraw financial support for programs it funds through federal transfers. The Canadian experience with health care is the poster child for this phenomenon. Universal health care in Canada was initially established as an agreement between provinces and the federal government to be equal funding partners through cost-sharing arrangements. In the decades following this original bargain, the federal government has moved, often unilaterally, away from the cost-sharing model for health care. What was started as a partnership under which costs were to be shared equally, has degenerated to the state where the federal government covered only 23.4 per cent of provincial-territorial health spending in 2017-18.⁶³ No institutional changes have been made since that would preclude a similar scenario playing out with respect to a cost-shared national pharmacare in the future.

Comparative advantage

Both the provincial-territorial and federal governments bring their own comparative advantages into the arena of pharmacare policy. For their part, provinces and territories have long-running public drug programs, supported by established legislative and regulatory frameworks. As purveyors of the health care system more generally, provincial and territorial governments have a greater set of tools to integrate pharmacare policies with the rest of health system and stakeholders within it.

The federal government also has several comparative advantages that it could bring to bear. For example, the federal government already plays a role in pharmaceutical policy. This includes the Canadian Agency for Drugs and Technologies in Health’s (CADTH) role in

61 Marchildon, Gregory. (2017). “Two Options for a National Pharmacare Program: Individual Submission to the House of Commons Standing Committee on Health Regarding a National Pharmacare Program.” p. 4.

62 A vertical fiscal imbalance refers to a situation whereby the federal government occupies more revenue room than it needs to discharge its constitutional responsibilities and the provincial-territorial governments occupy less. Transfers such as the Canada Health Transfer and Canada Social Transfer are used to address, in part, this imbalance. Individual provinces also vary horizontally between themselves in both their capacity to raise revenues and their expenditure need. Equalization is the federal program that is designed to address horizontal fiscal imbalances between provinces.

63 This share increases to 34.8 per cent if the tax points attributable to health care that were transferred to the provinces in 1977 are counted as federal support.

administering the Common Drug Review (CDR), which provides reimbursement recommendations and advice to the federal, provincial and territorial public drug plans, with the exception of Quebec. The federal government is also responsible for the Patented Medicine Prices Review Board (PMPRB), which regulates, but does not negotiate, the prices for patented medicines.⁶⁴

The federal government has considerable experience in delivering its own drug programs, such as First Nations and Inuit Non-Insured Health Benefits and drug benefits for the military, veterans, the RCMP and federal inmates. The federal government also delivers many of Canada's largest income-based transfers to individuals, such as Old Age Security (OAS) and children's benefits. A national pharmacare program could be designed to leverage the program architecture from existing drug benefit and income-based programs.

With respect to fiscal capacity, the federal government has more room to manoeuvre than the provinces and territories do. While the federal government is currently running a deficit, the PBO has deemed the federal government's spending structure to be fiscally sustainable. The provinces and territories taken together, however, are in an unsustainable fiscal position, largely due to the projected growth in health care spending that will be created by an aging population (see Text Box).⁶⁵ The federal spending power, underpinned by a sustainable fiscal structure, could be used to finance an expansion of pharmacare beyond where the provinces collectively could do on their own.

64 The PMPRB price is largely considered a ceiling price from which to begin negotiation, rather than a means to achieve lower prices. See: Husereau et al. (2014). "Evolution of Drug Reimbursement in Canada: The Pan-Canadian Pharmaceutical Alliance for New Drugs." *International Society for Pharmacoeconomics and Outcomes Research*.

65 Office of the Parliamentary Budget Officer. (2017). "Fiscal Sustainability Report 2017."

Fiscal Sustainability: Federal and Provincial Governments

In 2018 the PBO estimated that the federal government has a negative fiscal gap of 0.7 per cent of GDP, or \$14 billion in current dollars. That means that the federal government could permanently increase spending or decrease revenues by \$14 billion annually and remain fiscally sustainable.

Conversely, the PBO deemed the current fiscal policy for the consolidated subnational government sector to be unsustainable over the long term. The PBO estimated that permanent tax increases or spending reductions amounting to 0.9 per cent of GDP, \$19 billion in current dollars, would be required to stabilize the consolidated subnational government net debt-to-GDP ratio at its current level.⁶⁶

66 Office of the Parliamentary Budget Officer. (2018). "PBO and Finance Canada Long-term Projection Comparison."

Finally, the federal government has significantly greater purchasing power than any one province has on its own. The PBO has estimated that the federal government, acting as a single payer for drugs, would be able to achieve significant overall savings on pharmaceutical outlays due to its larger negotiating power.⁶⁷ The potential for greater numbers leading to enhanced bargaining has been demonstrated by the pan-Canadian Pharmaceutical Alliance (pCPA). Its process, however, is not without its limitations and does not have all of the same advantages a single payer system would (see Text Box).

Pan-Canadian Pharmaceutical Alliance

Since its inception in 2010, the pCPA has been able to leverage its increased buying power into lower drug prices. The pCPA's efforts have reportedly led to \$1.28 billion a year in estimated combined jurisdictional savings. Currently, the pCPA focusses on new drugs listed by the Common Drug Review (CDR) for negotiation but does not seek to renegotiate existing pricing arrangements. Participation in individual negotiations is voluntary for all members of the pCPA on a case-by-case basis. There is no guarantee that a manufacturer will be able to gain full access to the entire Canadian market as a result of a pCPA negotiation.

Risk sharing

Provinces have responsibility for delivering most of Canada's important open-ended programs – including health care, social services and education – which are subject to significant demographic pressure and citizen demand. The pressures associated with these programs are only projected to mount (see Text Box: Fiscal Sustainability). An aging population, for example, will strain the health care system and the increasing demand for an innovative workforce will highlight the value of education systems across the country. Provinces will face the choice to either meet these demands, or risk the alternatives. A considerable degree of provinces' fiscal risk profile therefore is structural in nature.

The federal government, however, has managed to insulate itself from much of this fiscal risk, reserving for itself a considerable degree of control over its budget. Because much of the federal government's spending profile is discretionary in nature – including federal transfers for health care, social services and post-secondary education - it can pick and choose the degree to which it is exposed to fiscal risk. A rebalancing of fiscal risk toward the more fiscally sustainable order of government would benefit government finances overall.

67 Office of the Parliamentary Budget Officer. (2017). "Federal Cost of a National Pharmacare Program."

Voluntary provincial participation and asymmetry

Regardless of whether the federal government opts to deliver a national pharmacare program directly, or to lever provinces into achieving national goals in the pharmacare space, provinces must be willing partners.

The federal government may be able to successfully argue the case that it has the jurisdiction to deliver a national pharmacare program. However, provincial jurisdiction over health care will create significant barriers for the federal government to doing so on a unilateral basis. There is a range of possible outcomes that could emerge from a unilateral federal choice to deliver pharmacare directly. These could include the possibility of duplicative or uncoordinated federal and provincial programs on one end of the spectrum, to constitutional challenges over federal jurisdiction on the other.

Should the federal government choose to engage the provinces in the delivery of national pharmacare by, for example, establishing national standards and transferring federal funding to support meeting those standards, provincial agreement will be equally important. If some combination of national standards for coverage being too high or federal compensation being too low emerges, the federal government risks having a province or provinces walking away from the table.

Premiers reiterated their support for the principle of asymmetrical federalism and that any jurisdiction that wishes to maintain full control over drug insurance should have the right to opt out unconditionally, with full financial compensation, should the federal government participate financially in the establishment of a pharmacare plan. Québec has already indicated its intention to follow that path and all Provinces and Territories reserve the right to do the same.

Council of the Federation, Final
Communiqué: 2018

Irrespective of the choice of model, then, provincial participation must be voluntary for the program to succeed. Canada's Premiers have already signalled their stipulation for voluntary participation, along with their support for asymmetry.⁶⁸ For its part, Quebec has already signalled that it will opt out, meaning that the debate over national pharmacare will not take place without a parallel discussion about asymmetrical treatment

In the Canadian context, the tool generally used to give effect to asymmetrical federalism with respect to fiscal matters is the opting-out mechanism. An opting-out mechanism is one "under which a province can choose to opt out of a shared-cost programme negotiated with the other provinces and the federal government, and receive funding anyway so long as it maintains the same type of programme."⁶⁹

68 Council of the Federation. (2018). "Final Communiqué: 2018." <http://www.canadaspremiers.ca/final-communique/>.

69 Smith, Jennifer. (2005). "The Case for Asymmetry in Canadian Federalism." *Asymmetry Series*. Institute for Intergovernmental Relations, p. 2.

Discussions around voluntary provincial participation in federal programs and asymmetrical treatment typically centre on Quebec, and for good reason. Due to its unique position within the federation, the “clear right to opt out with financial compensation, [is] a sine qua non for its ability to interact effectively with the rest of Canada.”⁷⁰

Furthermore, Quebec has for the most part been the only jurisdiction to choose the route of opting out of federal programs. Perhaps the most well-known example is the Quebec Pension Plan, which the province administers more or less in parallel with Canada Pension Plan.

Quebec and the federal government also employ the opting out with financial compensation model in the sphere of federal transfers. As federal-provincial cost-sharing agreements for universal health care and social programs were being negotiated in the 1960s, Quebec opted to forego a portion of those transfers in exchange for increased personal and corporate tax room for the province. To this day, Quebec continues to have its federal taxes abated and its Canada Health Transfer and Canada Social Transfer reduced dollar for dollar along the lines of those opt-out arrangements.⁷¹

More recently, the 2004 Federal-Provincial-Territorial Health Accord also included the provision of asymmetrical treatment for Quebec, which exempted the province from many of the nationally defined targets established through the Accord.

70 Dufour, Christian. (2003). “Restoring the Federal Principle: The Place of Quebec in the Canadian Social Union.” In Eds. Fortin, Sarah, St-Hilaire, France, Noël, Alain. *Forging the Canadian Social Union: SUFA and Beyond*. Montreal: Institute for Research on Public Policy, c2003, p. 84.

71 The Quebec Abatement consists of a reduction of 16.5 percentage points of federal personal income tax and one point of federal corporate income tax for all tax filers in Quebec. 13.5 percentage points of federal income tax are abated under the Alternative Payments for Standing Programs, which are applied to the CHT and CST. An additional 3 percentage points are abated for the discontinued Youth Allowances Program.



Quebec Asymmetrical Health Accord, 2004

“Recognizing the Government of Quebec’s desire to exercise its own responsibilities with respect to planning, organizing and managing health services within its own territory, and noting its commitment with regard to the underlying principles of its public health system – universality, portability, comprehensiveness, accessibility and public administration – coincides with that of all governments in Canada, and resting on asymmetrical federalism, that is, flexible federalism that notably allows for the existence of specific agreements and arrangements to Quebec’s specificity, the Prime Minister of Canada and the Premier of Quebec have agreed that Quebec’s support for the joint communique following the Federal-Provincial-Territorial First Ministers’ Meeting is to be interpreted and implemented as follows:

Quebec will apply its own wait time reduction plan, in accordance with the objectives, standards and criteria established by the relevant Quebec authorities, including health human resources management, family and community care reform, home care, drug access strategies, and health promotion and chronic illness prevention strategies. With respect to wait times, evidence-based benchmarks established by December 31, 2005, will help Quebec have a more effective action plan. Quebec will pursue its objective of providing more first-dollar coverage for short-term acute home care, short-term acute community mental health home care and palliative care, in accordance with its financial capacity.

The Government of Quebec will report to Quebecers on progress in achieving its objectives, and will use comparable indicators, mutually agreed to with other governments. In this respect, Quebec will continue to work with other governments to develop new comparable indicators.

Quebec’s Health Commissioner is responsible for reporting to the Government of Quebec on Quebec’s health system. He will cooperate with the Canadian Institute for Health Information.

Funding made available by the Government of Canada will be used by the Government of Quebec to implement its own plan for renewing Quebec’s health system.

The Government of Quebec will continue to report to Quebecers on the use of all health funding.”

Quebec Asymmetrical Health Accord 2004

Quebec already stands apart on the pharmacare file, as a unique model within the federation. Quebec is the only province that mandates pharmaceutical coverage, thereby helping to ensure access to drugs. Quebec has the largest and most comprehensive drug formulary, far exceeding other provinces (the Quebec drug program covers over 8,000⁷² drugs listed on its formulary while Ontario covers just over 4,400).⁷³

The reaction of Quebec will have broader implications for the overall federal strategy, as the federal government has historically reacted to Quebec's position through a principle of provincial equality – whatever options to opt out provided to Quebec must similarly be applied and provided to every other province.

Given the possibility of a potentially large intrusion into provincial jurisdiction, particularly if the full universal pharmacare model is chosen, the provision for opting out with financial compensation may need to be extended beyond Quebec. Depending on the model that is chosen for national pharmacare, these opt-out provisions could lead to a province or provinces being financially compensated for programs that they are already running, provided that they meet national standards.

A province's decision to opt out of a federal program need not be final, and should not preclude the possibility of joining a national program at a later date.

Approaches to addressing issues outside of explicit federal jurisdiction

Health care in Canada is primarily provided by provincial governments, through universal insurance that covers hospital and physician services, including in-hospital pharmaceutical usage. With the exception of certain populations within Canada,⁷⁴ the federal government does not administer a federal health insurance plan, does not allocate health care budgets, nor does it determine how or how much money should be spent on health care services.⁷⁵ Instead, ten provincial and three territorial health care systems operate, largely independently, to serve the health needs of their populations. This delivery model makes Canada look like one of the most decentralized federal systems in the world.⁷⁶

This system of health governance flows from the constitutional foundations of the Canadian federation. Under the Constitution Act of 1867, provinces are given primary responsibility over health care. Section 92(7) of the Constitution Act assigns provincial legislatures exclusive authority to enact legislation for the “establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions,” while Section 92(16) gives them jurisdiction over “generally all matters of a merely local or private nature in the province.” However, as a more expansive concept, ‘health’ and ‘health care’ are not necessarily limited to the provincial arena. The federal government does have

72 <http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/prescription-drugs-covered.aspx>.

73 Sutherland and Dinh. (2018).

74 Populations covered by the federal government include including First Nations, Inuit, members of the armed services, and federal inmates.

75 Maioni, Antonia. 2008. “Health Care,” in *Canadian Federalism: Performance, Effectiveness, and Legitimacy*, Herman Bakvis and Grace Skogstad (eds.), Oxford University Press: Toronto; pp. 162.

76 Maioni. 2008; pp. 162.

constitutional authority related to public health matters, and it has responsibility for the delivery of health care services for certain populations within Canada (listed in the paragraph above). Moreover, in a 1982 decision, the Supreme Court of Canada decided that “health is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by federal or provincial legislation” according to the circumstances present in a case-by-case basis, or the nature of the health problem being addressed.⁷⁷

The introduction of the *Canada Health Act* (CHA) in 1984 codified common principles of provincial health insurance, and thus universalized norms of care and access. The CHA secured the role of the federal government in the policy space, specifying the conditions and criteria that provinces and territories must conform to in order to receive intergovernmental transfers to support the delivery of health care services at the provincial level.

Approach 1: Federal spending power

In advancing new and large-scale social policy, a ‘federal spending power’ approach would see the federal government identify specific spending priorities or a model for national implementation. This could involve inviting the provinces to take part through cost-matching. Such an approach has been used in a variety of social policy spaces of interest to the federal government in the face of fuzzy jurisdictional boundaries.

A ‘federal spending power’ approach relies heavily on the federal spending power to implement policy by incentivizing provincial involvement or incentivizing specific types of provincial spending. For example, under the new National Housing Strategy, the federal government announced spending priorities and pots of money for implementation, with participating provinces expected to share in parts of the program through cost-matching. The Canadian federal government has succeeded in getting most provinces and territories to engage on the national strategy, the exception here being Quebec, which has rejected direct federal involvement in the housing sector.⁷⁸

As a means of addressing pharmacare, a ‘federal spending power’ approach similarly has the potential to unify provinces in a coherent national strategy. However, there are several barriers to successful implementation. The institutional dynamics are quite different than past periods of issue-attention in the national pharmacare debate, and are also different than in other policy areas.

Firstly, the decentralized nature of the Canadian health care system generally, and pharmacare programming specifically, has become institutionally embedded. Provinces have been engaged in designing and implementing pharmacare policy for over 50 years, and will likely be reticent to abandon the policy space in favour of a national plan.

Secondly, unlike in past periods of national discussions on pharmacare, provinces are not asking for direct federal support on pharmacare. The recent communique by the provinces at the 2018 Council of the Federation calls for general federal support on health care financing,

77 Tiedemann, Marlisa. 2008. “The Federal Role in Health and Health Care,” Library of Parliament: <https://lop.parl.ca/content/lop/ResearchPublications/prb0858-e.htm>.

78 <https://www.cbc.ca/news/politics/national-housing-provinces-territories-agree-1.4612501>.

but eschews direct federal involvement in the pharmacare file. That communique reinforced the position that provinces and territories “retain responsibility for the design and delivery of public drug coverage” and that “any jurisdiction that wishes to maintain full control over drug insurance should have the right to opt out unconditionally, with full financial compensation.”⁷⁹

Finally, provinces are increasingly reticent to engage with this approach over long time horizons. Short, term-limited commitments like the funding under the National Housing Strategy are less risky for the provinces, as they can better forecast future expenditures or gaps. Long-run fiscal promises, however, are much less secure and the federal government has a history of shifting fiscal risk downwards onto provinces, particularly in the area of health, as already noted.

Despite these barriers, the model does offer up some opportunities for the federal government, particularly in the development of more narrow policy prescriptions. The Romanow recommendation for the creation of a national catastrophic plan would fall under this type of programmatic model. Romanow recommended that the federal government put money on the table and called for 50-50 federal-provincial cost sharing for a catastrophic program that would reimburse individual drug spending above \$1,500 per year (2002 dollars).⁸⁰ A more narrow ‘federal spending power’ design may succeed in successfully targeting a specific gap in pharmaceutical coverage for key populations within Canada, freeing up provincial dollars to be reallocated within provincial pharmacare programming or the provincial health care systems more broadly.

79 <http://www.premier-ministre.gouv.qc.ca/actualites/communiqués/details-en.asp?idCommunique=3446>.

80 <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>.

Approach 2: Setting a policy floor

Alternatively, the federal government may be able to influence provincial policy in areas of provincial jurisdiction by intervening in the creation of national standards or norms of practice. The most relevant example of this type of federal policy intervention is the development of the CHA, which set out universal principles for health care delivery in an effort to standardize health care access across thirteen⁸¹ separate provincial and territorial health systems.

In this model of ‘setting a policy floor,’ federal intervention can help secure common principles while still enabling provincial and territorial variation in programmatic elements. Under the CHA, the federal government ensures access to universal hospital and physician services, but provinces can adopt different strategic plans for service provision. They can also vary significantly in their approaches to the delivery of other health services, including dental, vision and pharmaceutical coverage.

The CHA, as a potential framework for universalizing pharmaceutical coverage in Canada, points to some important political and institutional considerations for the national pharmacare debate.

Setting a policy floor, however, likely cannot occur in a vacuum, and federal dollars are likely required to facilitate change. In the case of the CHA, the development of universal standards and norms of practice came with significant federal dollars. All provinces must comply with the principles and standards laid out in the CHA in order to receive approximately \$1,000 in per capita funding in annual health transfers.

81 At the time of implementation, in 1984, the CHA only applied to twelve subnational jurisdictions, and Nunavut did not yet exist within the federation.

Given the costs associated with pharmacare, any national policy framework would likely require a similar federal contribution. However, as noted in the last section, the evolution of intergovernmental cooperation since the introduction of the CHA may shape provincial willingness to enter into a similar framework, keeping in mind both short-term and long-term costs associated with agreeing to a national program based, to some degree, on cost sharing.

The Principles of the Canada Health Act

The *Canada Health Act* (CHA), enacted in 1984, is federal legislation that sets out the principles of universal public health insurance in Canada. The primary objective of the CHA is to “protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” In order to meet this primary objective, the CHA sets out five core principles:

- » **Public Administration:**
Requires that provincial and territorial health insurance plans be administered and operated on a non-profit basis by public authorities.
- » **Comprehensiveness:**
Ensures that provincial and territorial health insurance plans cover all health services provided by hospitals, physicians, or dentists in a hospital setting.
- » **Universality:**
Ensures that insured residents of a province or territory be entitled to all health services provided by the provincial or territorial health insurance plans.
- » **Portability:**
Ensures that insured residents moving from one province or territory to another will maintain health insurance coverage until they satisfy the residency requirements of the new province or territory (up to three months). The portability criterion also ensures coverage for residents who are temporarily absent (such as for business or vacation) from their home province or territory, or from Canada.
- » **Accessibility:**
Ensures reasonable access to insured hospital, medical, or surgical-dental services on a uniform basis and unimpeded by financial or other barriers (including discrimination based on age, financial circumstances, health status, or other issues).

The provinces and territories must fulfill these criteria in order to receive the full federal contribution to health services through the Canada Health Transfer (CHT).

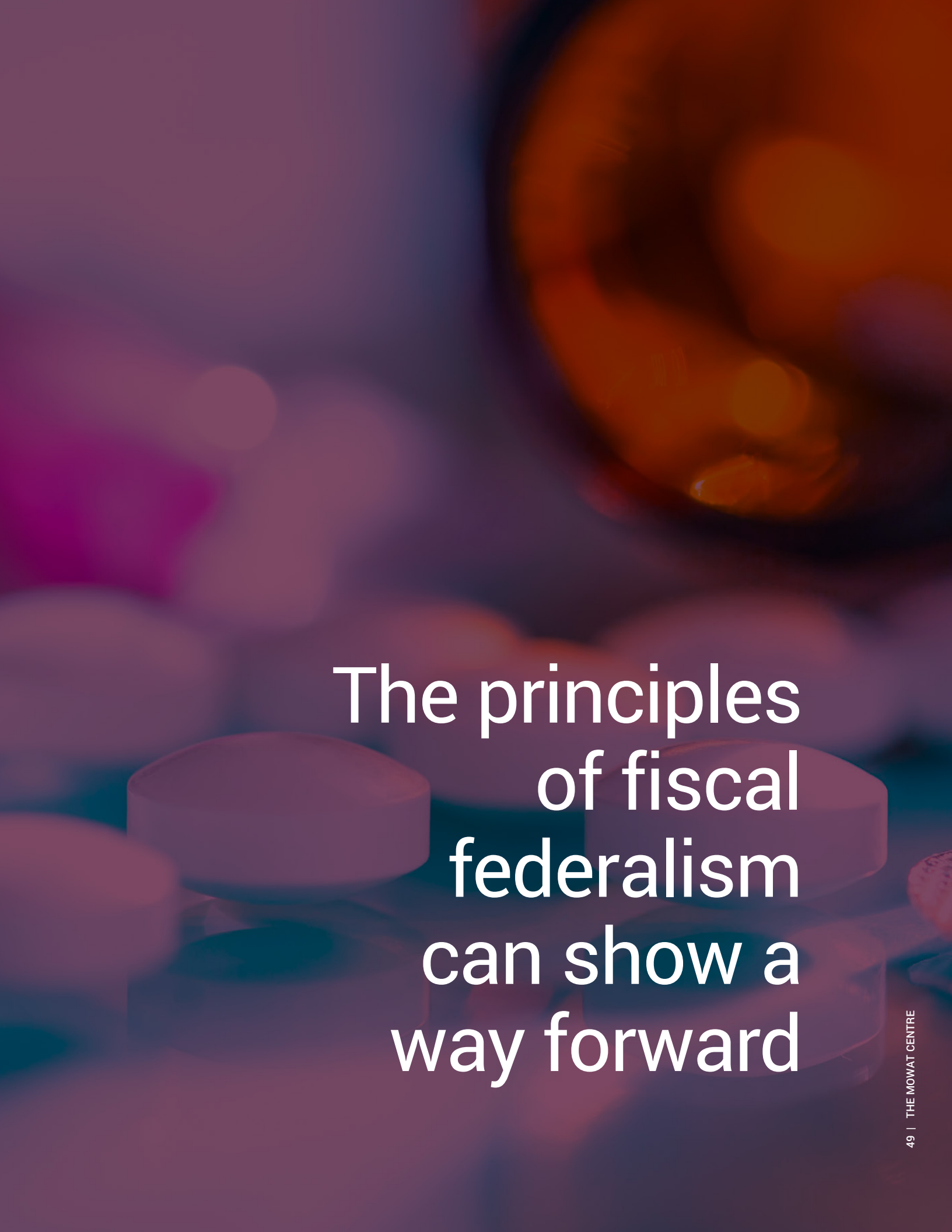


Approach 3: Cutting cheques to Canadians

A ‘Cutting Cheques to Canadians’ approach is one of the least jurisdictionally ‘messy’ ways for the federal government to introduce universal social services, though it is not without its intergovernmental challenges.

A ‘cutting cheques to Canadians’ approach is the most direct approach for the federal government to set standards in growing or maintaining the national social safety net. The federal government ‘cuts cheques’ for seniors through income support programs including Old Age Security (OAS) and the Guaranteed Income Supplement, and through the management of the Canada Pension Plan. The federal government ‘cuts cheques’ for Employment Insurance, assisting Canadians who lose their jobs, and for parental leave benefits for new mothers and fathers. The federal government also introduced supplementary income assistance for parents, with the introduction of the Universal Child Care Benefit, which was transformed into the income-tested Canada Child Benefit in 2016.

This approach has several benefits for the federal government. It reduces intergovernmental complexity by largely cutting out provinces and territories from the policy space. It also allows the federal government to clearly lay claim to any programmatic wins or positive policy outcomes; though it conversely means that any risks of program failure are shouldered by the federal order of government. However, as an approach to pharmacare development, this approach does limit the potential mechanisms through which policy change can occur.



The principles
of fiscal
federalism
can show a
way forward

9 PRINCIPLED APPROACHES FORWARD

The principles outlined above are not meant merely to poke holes in certain approaches to national pharmacare. They can also offer insights on potential ways forward. The following section discusses how the principles and approaches outlined above might be used to inform the design of a national pharmacare program.

These proposed approaches are not meant to be prescriptive of the path that should be taken, but are meant to illustrate the types of solutions that these principles might provide. The following section therefore will propose one potential way forward for each model, will discuss how those principles would inform the approach and where trade-offs would still be required. To overcome the issues regarding interprovincial equity, the main trade-off will come in the form of increased cost to the federal government.

Catastrophic coverage: Federal spending power to replace provincial programs

A catastrophic coverage model that does not take into account the varying levels and degrees of protection already provided by provincial programs is destined to lead to unequal treatment by the federal government. One approach that would prevent such an outcome would be for a national catastrophic coverage model to entirely replace the current grab-bag of provincial approaches.

The most obvious trade-off that the federal government would be confronted with if it opted for this approach would be increased cost. While the incremental coverage model described in Section 5 was estimated to cost roughly \$1.7 billion annually, a model which replaced all elements of provincial programs that behave as a form of catastrophic coverage would be considerably more expensive. A 2015 report by Ake Blomqvist and Colin Busby noted that, according to data from Ontario, annual prescription costs greater than 3 per cent of median family income made up around 64 per cent of all costs within provincial drug plans.⁸² If that percentage still holds and is reasonably consistent across provinces, provincial governments are currently spending somewhere in the order of \$8.3 billion to provide drug coverage that would meet the definition of catastrophic. This does not include the costs of covering the unenrolled or any behavioural effects of Canadians potentially opting for enhanced public coverage.

82 Blomqvist, Ake and Colin Busby. (2015). "Feasible Pharmacare in the Federation: A Proposal to Break the Gridlock." *C.D. Howe Institute*. p. 9. https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/e-brief_217_0.pdf.

A comprehensive national catastrophic coverage model could be achieved either through a directly administered federal program or through a federal transfer to the provinces. A federally delivered program could leverage the federal government's experience in running income-based programs. The federal government would also be directly accountable for the operation of such a program. However, it would come at the cost of a reduced level of integration for the health system more generally. At the margins, provinces might have the incentive to shift to costs to the federal government, by not aggressively containing their own prices for drugs.⁸³ To avoid this, greater intergovernmental collaboration with respect to negotiation and formulary listings would be required.

A federal transfer to the provinces could also be used to achieve greater consistency in catastrophic coverage across the country. Funding from the transfer would be contingent upon the provincial governments meeting certain criteria to ensure standards are met. This model would be similar to the requirement for provinces to meet the principles of the CHA to be eligible to receive funding from the Canada Health Transfer (CHT). However, a model based on a federal transfer would result in less consistency than a directly administered program, as the federal government would only be able to incentivize provinces to meet minimum standards. Furthermore, the blurred accountabilities associated with transfers and the federal government's unfettered ability to unilaterally reduce or even terminate federal transfers means that there is no guarantee that a federal transfer would endure over the long term

83 While catastrophic levels of coverage represent 64 per cent of costs within provincial programs, only 19 per cent of beneficiaries require this level of coverage. Blomqvist and Busby. (2015). p. 9.

Quebec's pharmacare model already effectively provides catastrophic coverage. Should the province choose to opt out of such a model, annual financial compensation would be approximately \$2.5 billion.⁸⁴

Federal assumption of the role of funder of catastrophic drug costs would entail a significant shifting of fiscal risk away from the provinces toward the federal government. The federal government is more fiscally sustainable than the provinces as a whole, and the \$8.3 billion cost of such a program would be well within the \$14 billion worth of fiscal room that the PBO has identified as available to the federal government.

Mandatory coverage and gap-filling: Setting a policy floor and funding it

A mandatory coverage or gap-filling model that does not take into account the significant variability in the shares of populations unenrolled in either public or private coverage across provinces will also lead to unequal treatment by the federal government. It is extremely unlikely that the federal government would be able to effectively mandate coverage for all Canadians. It could however, set broad national criteria to establish a minimum standard of coverage in an expanded CHA. To give effect to these criteria, the federal government would need to provide provinces with funding to support them in achieving those standards.

As discussed above, the approach of extending coverage only to populations currently enrolled in neither public nor private programs was estimated to cost roughly \$1.4 billion. This

84 This assumes that annual prescription costs greater than 3 per cent of median family income made up around 64 per cent of all costs within province's public drug plan.

approach, however, would entail significantly different levels of per capita support to each province. Across all provinces except Quebec, provinces would receive a transfer of \$52 per capita on a weighted average basis (see Figure 12).

FIGURE 12

Per Capita Amount Required to Extend Coverage to Populations Not Enrolled in Either Public or Private Coverage (\$ per capita)

BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Average
34	90	52	98	40	-	90	54	27	56	52

To alleviate potential interprovincial equity concerns, each province could instead be offered the greater of the level of funding it would take to extend coverage to everyone in their province, or the national per capita average as outlined in Figure 12 (see Figure 13).

FIGURE 13

Greater of Per Capita Amount Required to Extend Coverage to Populations Not Enrolled in Either Public or Private Coverage or National Per Capita Average from Previous Model (\$ per capita)

BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
52	90	52	98	52	52	90	54	52	56

While this would increase the cost of the transfer, the additional cost would not be significant, at least not compared to the costs of achieving equity in the other pharmacare models contemplated in this paper. The cost of a program which also offered the option of a national average level of funding would be \$2.1 billion annually (see Figure 14).

FIGURE 14

Cost of Offering the Option of a National Average Level of Funding (\$ millions)

BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Total
246	382	59	131	723	430	69	51	8	30	2,128

If the decision were that all provinces should receive more equal funding, all provinces would need to receive the exact same amount per capita, such that no province was worse off. That would mean each province would receive the same \$98 per capita offered to Manitoba in the first proposed iteration of the transfer. Such a model would cost \$3.5 billion.

FIGURE 15

Cost of Offering the Option of a National Average Level of Funding (\$ millions)

BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Total
466	415	111	131	1,369	815	74	93	15	52	3,540

Because this model would be delivered through a federal transfer, the implications for blurred accountability and the lack of predictable, long-term funding would remain.

The model proposed would already include a built-in opt-out provision for Quebec as it would receive federal funding without having to alter its policies.

The model would also represent a small exchange in risk sharing between the orders of government, but the lack of predictability regarding federal transfers over the long run could mean that this risk-transfer might not be a permanent one.

A gap-filling model would combine the design elements of a catastrophic and mandatory coverage model.

Universal coverage: Cutting cheques to Canadians

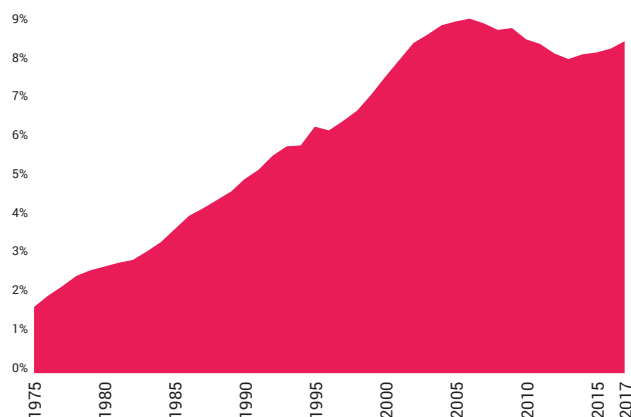
Currently, provinces vary substantially with respect to their reliance on private drug coverage. A universal coverage model that sought only to replace current levels of private coverage while leaving existing provincial public plans in place would also fail on interprovincial equity grounds. One potential way forward that would alleviate these concerns would be for the federal government to directly fund and administer a national universal pharmacare program. Broadly speaking, such an approach could be designed similarly to federal income support programs and would involve cutting cheques directly to Canadians.

On its own, the cost of such a program would be significant. The PBO has estimated that the cost of a national universal pharmacare program – based on Quebec’s formulary, eligibility requirements, co-payment levels, and eligibility requirements for co-payment exemptions – would be \$21.6 billion in 2017-18.⁸⁵

Uploading this expense from the provinces to the federal government would represent a significant transfer of both responsibility and fiscal risk. Prescription drugs represent a large and growing proportion of provincial health spending. Provincial spending on prescription drugs has grown from 1.7 per cent of total health spending in 1975 to 8.6 per cent in 2017 (see Figure 16).

FIGURE 16

Drugs as a Share of Provincial-Territorial Public Health Spending



Source: CIHI NHEX 2017

85 Office of the Parliamentary Budget Officer. (2017). "Federal Cost of a National Pharmacare Program." p. 2.

Over the last few years, despite some success in constraining costs, growth in public spending on drugs has once again begun to outstrip growth in the rest of the health sector (see Figure 17).

FIGURE 17

Annual Growth Rate in Drugs versus Rest of the Health Sector, 2009 to 2017



Source: CIHI NHEX 2017

Over the long term, the cost of drugs will add increasing cost pressure to provincial finances. Canada's population will age significantly in the coming years and "more and more people will need prescribed pharmaceuticals in the near future. Indeed more than three-quarters of all seniors have at least one chronic condition, and many are on five or more classes of drugs."⁸⁶ Having the federal government assume responsibility for a universal pharmacare program would represent an important shift of both current and future fiscal risk away from the provinces.

86 Conference Board of Canada. (2015). "Federal Policy Action to Support the Health Care Needs of Canada's Aging Population." <https://www.cma.ca/Assets/assets-library/document/en/advocacy/conference-board-rep-sept-2015-embargo-en.pdf>.

Direct federal delivery of a universal pharmacare program would ensure that the federal government was directly accountable for the program. The adoption of a universal coverage model would represent a massive expansion of the public sector's role in financing drug coverage. Any attempt to engage in such an expansion through the use of federal transfers would expose the provincial governments to a great deal more fiscal risk than they currently face. The risk that the federal government might reduce or even eliminate a federal transfer supporting a universal model should give provinces significant pause. Even a scenario under which the federal government slowly decouples the size of a universal drug transfer from the actual costs of delivering universal drug coverage would further erode the fiscal sustainability of the provincial governments.

A federally administered universal pharmacare program could be designed to leverage the federal government's experience in delivering large, income-based social programs. It has been correctly pointed out, however, that a drawback of a federally administered drug program would be "less integration in the management of overall health costs and less incentive for cost-effective choices among drugs and other inputs in health care. For example, the federal government cannot directly influence doctors' prescribing behaviour."⁸⁷ An intergovernmental institutional arrangement that afforded the federal government a greater deal of influence should be part of a package to compensate the federal government for the assumption of this fiscal risk.

87 Blomqvist, Åke and Colin Busby. (2015). "Feasible Pharmacare in the Federation: A Proposal to Break the Gridlock." *CD Howe Institute*. p. 2.

The more important element of compensation for the federal government, however, could come from a significant alteration of Canada's federal-provincial fiscal arrangements. In exchange for the federal government's agreement to directly and permanently assume the fiscal risk associated with delivering a universal pharmacare program, the provinces should be willing to accept a trade-off in terms of a reduction in the CHT base at roughly the current level of provincial drug spending.

In 2017-18, the federal government transferred \$37.1 billion to the provinces and territories through the CHT. In that same year, provincial-territorial governments spent \$13.6 billion on prescription drugs. The first step of the arrangement would be to calculate the impact of a \$13.6 billion reduction of the CHT for all provinces on a per capita basis. To ensure that no province was worse off, the option would be given to accept either the per capita reduction in CHT, or by the amount the province currently spends on its public drug program. It is expected that all provinces expect Alberta, Ontario and Quebec would accept the latter. This reduction in CHT would give the federal government an additional \$12.4 billion to fund a national pharmacare program (see Figure18).

FIGURE 18

Parameters of a Potential CHT Reduction to Fund a Universal National Pharmacare Program, 2017-18 (\$ millions)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	TERR	Total
CHT	4,875	4,338	1,177	1,354	14,362	8,496	769	966	154	536	122	37,149
PT Drugs	1,583	1,668	339	330	5,599	3,857	207	284	36	148	23	13,554
Reduce CHT	1,779	1,583	429	494	5,240	3,100	281	352	56	196	45	13,554
Minimum	1,583	1,583	339	330	5,240	3,100	207	284	36	148	23	12,352

The additional funding made available to the federal government by reducing the CHT would reduce the net cost of introducing a national universal pharmacare program from \$21.6 billion to \$9.2 billion (see Figure 19).

FIGURE 19

Net Cost of a Universal Pharmacare Program after a Reduction in the CHT, 2017-18 (\$ millions)

Gross Cost of Universal Pharmacare	21,600
Additional Fiscal Room from CHT Reduction	12,352
Net Cost of Universal Pharmacare	9,248

Provinces should only agree to consider such an option if and only if the federal government agrees to permanently and directly assume the responsibility for delivering and financing a national universal pharmacare program. Direct federal delivery would be the only model that would give the provinces certainty that the federal government would be permanently assuming the ongoing fiscal risk. A federal transfer would not be predictable enough over the long term to justify such an arrangement.

Federal direct delivery and financing of a national universal pharmacare program would represent a transfer of risk from the provinces, which are not fiscally sustainable, to the federal government, which is. Furthermore, the \$9.2 billion net cost of a national universal pharmacare program would be within the \$14 billion of fiscal room that the PBO has identified as available the federal government to remain fiscally sustainable over the long term.

While a reduction in the CHT would reduce the federal government's current level of support for the rest of provincial health care spending, provinces may still come out better off. Currently, the annual growth in the CHT is tied to growth in national GDP, with a 3 per cent floor. It is not tied in any way to growth in provincial health care spending or needs. The federal government has stated that it does not intend to revisit the arrangement around the CHT escalator until 2027-28. Insofar as provincial spending on drugs is projected to grow at a rate higher than GDP or the CHT escalator, provinces would be better off uploading pharmacare to the federal government. Over the last five years, growth in provincial-territorial spending on drugs has averaged 4.7 per cent.⁸⁸ The 2018 federal budget projects nominal GDP to be 4 per cent or below until the end of its forecast horizon in 2021.

Finally, with respect to potential asymmetrical arrangements, the trade-off between reduced CHT and the federal adoption of a national pharmacare program contemplated above includes a built-in opt-out provision. Quebec could choose to continue to deliver its own pharmacare program and opt to retain the CHT funding that other provinces might forego. This could be done as a continued cash transfer or an additional abatement of federal tax in Quebec.

88 Canadian Institute for Health Information: National Health Expenditure Trends, 2017.

Interactions
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10 CONCLUSION & OVERALL ASSESSMENT

Provincial jurisdiction over health care and decades of provincial presence in the provision of drug coverage are defining elements of the pharmacare policy space. Interactions with the existing landscape of provincial programs will be a key design consideration with respect to any approach to national pharmacare. Failure to do so will inevitably lead to differential treatment of Canadians based on province of residence.

While preventing differential treatment will entail increased cost to the federal government, ignoring these issues would be neither politically sustainable nor justifiable from an interprovincial equity perspective. Embracing the principles of fiscal federalism, however, could be the difference in charting a successful course toward national pharmacare.

For each model, multiple approaches are possible and require important trade-offs between principles. However, some approaches are more likely to succeed than others.

A national catastrophic coverage program would provide support to many Canadians who currently face high out-of-pocket costs for drugs. However, a catastrophic program that is directly federally administered and replaces provincial catastrophic coverage would lead to greater consistency in such coverage without coming at the expense of interprovincial equity.

Providing support to provinces to extend mandatory coverage to all Canadians would substantially address issues around access to coverage. Compensating provinces that already provide more extensive or mandatory coverage would ensure those provinces are not penalized for early action.

Finally, a national universal pharmacare program would extend first-payer public drug coverage to all Canadians. Having the federal government permanently and directly assume the responsibility for delivering and financing such a program would place accountability for the program squarely on Ottawa. This direct line of accountability would significantly increase the long-term viability of such a program. An intergovernmental swap that involved reduced federal health transfers in exchange for uploading pharmacare to the federal government would represent a significant transfer of fiscal risk from the provinces to the federal government. It would also make such a proposition much more affordable for the federal government.

APPENDIX

CANADA IN THE INTERNATIONAL CONTEXT

Compared to other developed countries that provide universal health coverage, Canada's system does not provide universal coverage for outpatient prescription drugs. Despite lower access, per capita expenditure on drugs in Canada is significantly higher than the OECD average.⁸⁹ This Appendix provides an in-depth discussion on universal pharmacare systems in three commonwealth countries whose governance structures are similar to Canada's – Australia, New Zealand and the United Kingdom. The case studies discuss the approaches these countries take to manage their pharmacare systems to provide equitable access in a cost-efficient manner.

Australia

In Australia, the government subsidizes prescription drugs through the Pharmaceutical Benefits Scheme (PBS). The PBS is managed by the Department of Health, and is administered through the Department of Human Services. All Australians with a Medicare Card have access to PBS, as well as overseas visitors from 11 countries⁹⁰ that have a Reciprocal Health Care Agreement (RHCA) with Australia.⁹¹

Co-payments⁹²

Australians pay up to \$39.50 for most medicines covered by the PBS or \$6.40 if they have a concession card. The government covers the remaining cost. The Safety Net threshold is \$1,521.80 per family or \$384 for those with concession cards. Once the threshold is reached, concession cardholders pay no further charges, while general families pay the concession rate. If patients opt for more expensive drug brands, a price premium is paid in addition to the co-payment amount, as the government subsidizes each brand to the same amount, and this premium does not count toward the Safety Net threshold.⁹³

Additional subsidies

A Repatriation Pharmaceutical Benefits Scheme is available to veterans through the Department of Veterans' Affairs (DVA), which further subsidizes medicine costs at different rates for veterans who hold a DVA White, Gold or Orange Card. In addition, concessional benefits are available for those with a Pensioner Concession Card, Commonwealth Seniors Health Card or Health Care Card.⁹⁴

89 2015, Canadian dollar purchasing power parity. <https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf>.

90 Countries include United Kingdom, Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands, Finland, Norway, Belgium and Slovenia. <http://www.pbs.gov.au/info/about-the-pbs>.

91 <http://www.pbs.gov.au/info/about-the-pbs>.

92 All figures in the Australian case study are in Australian Dollars.

93 <http://www.pbs.gov.au/info/about-the-pbs>.

94 <http://www.pbs.gov.au/info/about-the-pbs>.

Private health insurance rebate

In Australia, about 47 per cent of the population has some form of private hospital cover, and 56 per cent have some form of general treatment coverage.⁹⁵ While private insurance is not mandatory, Australians who choose to get it receive a means-tested rebate from the government to help cover the cost of their premiums.⁹⁶ While there are different tiers of coverage, private insurance in Australia is not risk-rated, i.e. those opting for the same level of coverage are charged the same premium regardless of their risk profile.⁹⁷ In some cases, private insurance covers the cost of drugs not listed on the PBS schedule.⁹⁸ However, private insurance in Australia has been criticized for eroding the country's Medicare system by providing large subsidies (around \$11 billion) to the private sector. Critics argue that this significant sum of taxpayer money can be better utilized to add other services to Medicare such as dental care, which would cost about \$6 billion to the country.⁹⁹

Governance

The Australian Government is responsible for managing the Medicare Benefits Schedule and the PBS.¹⁰⁰ The Pharmaceutical Benefits Advisory Committee (PBAC) is an independent body comprised of medical experts that recommends drugs that should be subsidized through PBS. It assesses the medical effectiveness as well as cost-effectiveness of proposed drugs compared to alternative therapies. Further, PBAC provides advice to the Pharmaceutical Benefits Pricing Authority on the cost-effectiveness of a drug compared to its alternatives.¹⁰¹ The country also saves billions of dollars through supply chain efficiencies as a result of the Community Pharmacy Agreement.

New Zealand

The Pharmaceutical Management Agency (PHARMAC) is responsible for negotiating drug prices, setting subsidies and their conditions, and making decisions on the formulary in New Zealand. The funding for pharmaceuticals comes from the District Health Boards (DHBs).¹⁰²

Co-payments¹⁰³

In New Zealand, patients are required to pay a prescription charge of \$5 for each medication covered by the government.¹⁰⁴ For a small number of medicines, patients have to pay manufacturer charges or other costs in addition to the co-payment.¹⁰⁵ Children under 13 are exempt from the \$5 prescription charge. Starting in December 2018, this exemption will extend to under-14s.¹⁰⁶ If a family has received

95 <https://www.aihw.gov.au/getmedia/f2ae1191-bbf2-47b6-a9d4-1b2ca65553a1/ah16-2-1-how-does-australias-health-system-work.pdf>, p. 8

96 <https://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/insurancerebate.htm>.

97 <https://www.privatehealth.gov.au/healthinsurance/whatiscovered/privatehealth.htm>.

98 <https://www.aihw.gov.au/getmedia/f2ae1191-bbf2-47b6-a9d4-1b2ca65553a1/ah16-2-1-how-does-australias-health-system-work.pdf>, p. 8.

99 <https://www.theguardian.com/australia-news/2017/apr/20/propping-up-private-health-insurance-is-like-putting-lipstick-on-a-pig>.

100 <https://beta.health.gov.au/about-us/the-australian-health-system>.

101 <http://www.pbs.gov.au/info/general/faq#WhatisthePharmaceuticalBenefitsAdvisoryCommittee>.

102 <https://www.pharmac.govt.nz/about/your-guide-to-pharmac/factsheet-01-introduction-to-pharmac/>.

103 All figures in the New Zealand case study are in New Zealand Dollars.

104 <https://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/prescription-charges>.

105 <https://www.pharmac.govt.nz/about/your-guide-to-pharmac/factsheet-01-introduction-to-pharmac/>.

106 <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/zero-fees-under-13s>.

20 prescription items in a year, they can get a prescription subsidy so that they do not have to pay the \$5 fee for further prescriptions in the year through the prescription subsidy scheme.¹⁰⁷

Additional subsidies and exemptions

Apart from the prescription subsidy scheme, the government also subsidizes citizens to reduce the cost of prescription fees and other health care benefits through the Community Services Card (CSC). CSC is administered by the Work and Income program on behalf of the Ministry of Health. Citizens and permanent residents on a low to middle income are eligible to apply for it, as well as refugees or those with protection status, and those who have applied for refugee or protection status may be eligible to apply.¹⁰⁸ In addition to CSC, subsidies are also provided to those with high health needs through the High Use Health Card (HUHC), which lowers the cost of prescription fees as well as other health care costs. Unlike CSC, HUHC is not means-tested, but patients need to have visited a health care practitioner 12 times or more in a year for a particular condition to be eligible.¹⁰⁹ A number of other subsidies are also available including the Very Low Cost Access scheme that subsidizes general practices with high numbers of high needs patients that agree to maintain lower fees.¹¹⁰

Governance

In New Zealand, the Minister of Health is responsible for developing policies for the health care sector, while the DHBs are responsible for the day-to-day operations as well as administering about three-quarters of the funding. DHBs are responsible for planning, managing, providing and purchasing health services for the populations of their respective districts including managing the pharmaceutical subsidies.¹¹¹ The Pharmacology and Therapeutics Advisory Committee, comprised of clinicians, advises PHARMAC on which new drugs should be subsidized. In addition, a Consumer Advisory Committee provides the patient's point of view.¹¹²

The Combined Pharmaceutical Budget (CPB) is set annually by the Minister of Health based on recommendations from DHBs and PHARMAC.¹¹³ As PHARMAC manages the CPB, it has saved an estimated \$5.99 billion for the DHBs in 11 years.¹¹⁴

107 <https://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/prescription-subsidy-scheme>.

108 <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/community-services-card>.

109 <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/high-use-health-card>.

110 <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services>.

111 <https://www.health.govt.nz/new-zealand-health-system/overview-health-system>.

112 <https://www.pharmac.govt.nz/about/your-guide-to-pharmac/factsheet-01-introduction-to-pharmac/>.

113 <https://www.pharmac.govt.nz/about/your-guide-to-pharmac/factsheet-01-introduction-to-pharmac/>.

114 <https://www.pharmac.govt.nz/about/your-guide-to-pharmac/factsheet-01-introduction-to-pharmac/>.

United Kingdom

In the United Kingdom, the National Health Service (NHS) is collectively used to describe the four publicly-funded health services including NHS England, NHS Scotland, NHS Wales and Health and Social Care in Northern Ireland.

Co-payments, subsidies and exemptions

Whereas NHS prescriptions are free of charge in Wales, Scotland and Northern Ireland, patients in England have to co-pay per item or through methods such as prepayment certificates.¹¹⁵

The current prescription charge in England is £8.80 per item and those who anticipate that they will need more than one prescription per month can buy three-month or twelve-month prescription prepayment certificates. Certain medications such as those administered at the hospital or by a GP, as well as prescribed contraceptives are available free of charge.¹¹⁶ Various groups are exempt from co-payment, including those over 60 years old or under 16 years old, those aged 16-18 in full-time education, NHS inpatients, pregnant women, those on income support, cancer patients etc. Those on low incomes may also be subsidized through the NHS Low Income Scheme.¹¹⁷

NHS prescription charges were abolished in 2007 for Wales¹¹⁸ and in Scotland in 2011.¹¹⁹

Governance

The NHS regulates drug prices through the Pharmaceutical Price Regulation Scheme (PPRS) which places a cap on the profits that pharmaceutical companies can make when selling drugs to the NHS. In addition, the National Institute of Health and Clinical Excellence (NICE) is responsible for assessing the cost-effectiveness and efficacy of drugs. NICE does not recommend the addition of a new drug to the formulary if it exceeds £20,000 - £30,000 per Quality Adjusted Life Year.¹²⁰ While the NHS uses a value-based pricing system, there is some flexibility through flexible pricing where PPRS members (manufacturers and suppliers) can apply for increase or decrease in the list price based on new evidence, and through patient access schemes which facilitate access to medicines where NICE's assessment of value is unlikely to support the list price.¹²¹

115 <http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2014/general/6114.pdf>, p. 7.

116 <https://www.nhs.uk/nhsengland/healthcosts/pages/prescriptioncosts.aspx>.

117 <https://www.nhs.uk/nhsengland/healthcosts/pages/prescriptioncosts.aspx>.

118 <http://www.wales.nhs.uk/nhswalesaboutus/budgetcharges>.

119 <https://www.nhsinform.scot/care-support-and-rights/nhs-services/pharmacy/prescription-charges-and-exemptions#prescription-charges>.

120 <https://international.commonwealthfund.org/countries/england/>.

121 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675465/The_pharmaceutical_price_regulation_scheme_2014.pdf, p. 23.

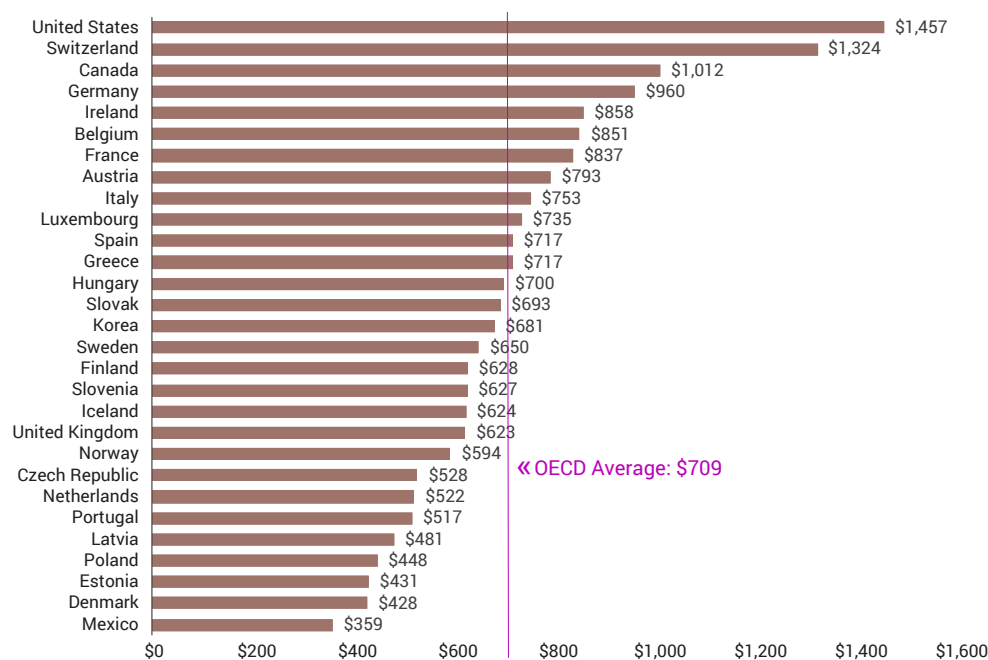
Where does Canada stand?

As mentioned above, Canada’s universal health coverage does not include pharmacare. However, depending on their age, income, occupation and province of residence, many Canadians may have access to public or private prescription drugs coverage. Compared with other countries, Canadians also pay more for prescription medicines. This is mainly because Canadians obtain prescription drug coverage from a patchwork of public and private plans, rather than a national pharmacare program that is part of the public health system as in most advanced countries.

Overall, Canada’s per capita expenditure on drugs is among the highest in OECD. However, compared to other OECD countries, Canada’s public share of drug spending is among the lowest at 36 per cent.¹²² In 2015, the total expenditure on drugs per capita in Canada was \$1,012 – significantly higher than the OECD average of \$709.¹²³ A study of ten advanced economies with universal health coverage found that the list prices of drugs in Canada are about 61 per cent higher than the average.¹²⁴ The patented drug prices in Canada are also the third highest among OECD countries. Despite this, the R&D investment by pharmaceutical companies as a percentage of sales in Canada is just 5 per cent, compared to 20 per cent for other countries.¹²⁵

FIGURE 20

Total expenditure on drugs per capita, Canadian dollar purchasing power parity, 29 selected OECD countries, 2015



Source: <https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf>.

122 <https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf>.

123 2015, Canadian dollar purchasing power parity - <https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf>.

124 <http://www.cmaj.ca/content/cmaj/189/23/E794.full.pdf>. p. 797.

125 http://publications.gc.ca/collections/collection_2018/parl/x62-1/XC62-1-1-421-14-eng.pdf. p. 36-37.

Generic drug prices in Canada are also higher than the OECD average. The Generics360 report from the Patented Medicine Prices Review Board (PMPRB) found that Canadians spent \$165 per capita on generic drugs in 2016 – one of the highest among OECD countries, and second only to the United States. Further, the report found that the substantially high price differences for higher priced top-selling generic drugs in Canada compared with other countries cost about half a billion dollars to public drug plans or 5 per cent of the overall drug costs.¹²⁶ Given these realities, it is not surprising that more than 1 in 5 Canadians reported in 2015 that either they or members of their household were unable to take prescription drugs in the past year due to unaffordability.¹²⁷

Generic drugs

Looking at examples from other countries, particularly the case studies discussed above, can provide valuable ideas to Canadian policymakers as they work toward developing Canada's pharmacare model. In particular, it is important to note the presence of a public body that has the responsibility to determine the national formulary, conduct cost-efficiency analysis and negotiate drug prices in all the countries described above. This seems key to increasing bargaining power and getting the highest value for money. For example, Australia was able to provide universal drug coverage at the cost of \$588 per capita in 2011, compared to \$771 for Canada.¹²⁸ In Canada, while the CDR conducts such a cost-efficiency analysis on a pan-Canadian basis, its role is limited to advising.¹²⁹

While many countries use co-payment systems, there is strong evidence that even small co-payments can deter low-income individuals and families from filling their prescriptions.¹³⁰ The 2016 Canadian Community Health Survey of 28,091 Canadians showed that out-of-pocket charges for prescription medicines led to patients not taking prescription drugs, not using additional health services and foregoing other household spending. These outcomes are particularly common for vulnerable populations such as low-income individuals, those with poorer health status, those without drug insurance, young adults, females and Indigenous peoples.¹³¹ Even in countries with very modest co-payments such as New Zealand, cost still remains a barrier to access and deters individuals

FIGURE 21

Average foreign-to-Canadian price ratio at market exchange rates for patented drugs, 2005

	Country	Ratio
PMPRB comparator countries	France	0.85
	Germany	0.96
	Italy	0.75
	Switzerland	1.09
	United Kingdom	0.90
	United States	1.69
Non-comparator countries	Australia	0.78
	Finland	0.88
	Netherlands	0.85
	New Zealand	0.79
	Spain	0.73

Source: Chapter 2, Drug Pricing in Canada, Joel Lexchin; Springer International Publishing Switzerland 2015 Z.-U.-D. Babar (ed.), *Pharmaceutical Prices in the 21st Century*, DOI 10.1007/978-3-319-12169-7_2.

126 <http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1347&lang=en#a8>.

127 <http://www.ourcommons.ca/Content/Committee/421/HESA/Brief/BR8352162/br-external/AngusReidInstitute-e.pdf>.

128 http://publications.gc.ca/collections/collection_2018/parl/xc62-1/XC62-1-1-421-14-eng.pdf, p. 59

129 http://publications.gc.ca/collections/collection_2018/parl/xc62-1/XC62-1-1-421-14-eng.pdf, p. 59

130 http://publications.gc.ca/collections/collection_2018/parl/xc62-1/XC62-1-1-421-14-eng.pdf, p. 65

131 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5878943/pdf/cmajo.20180008.pdf>.

from buying essential prescription drugs.¹³²

To overcome this barrier to access, many jurisdictions have either abolished co-payments entirely, created exemptions for vulnerable groups or provide subsidies to reduce the burden.

FIGURE 22

Average foreign-to-Canadian price ratios for generic drugs at market exchange rates, by bilateral comparator, 2007

Country	Ratio
Australia	0.95
France	0.63
Germany	0.57
Italy	0.71
Netherlands	0.77
New Zealand	0.19
Spain	0.56
Sweden	0.45
Switzerland	0.74
United Kingdom	0.63
United States	0.47

Source: Chapter 2, Drug Pricing in Canada, Joel Lexchin; Springer International Publishing Switzerland 2015 Z.-U.-D. Babar (ed.), *Pharmaceutical Prices in the 21st Century*, DOI 10.1007/978-3-319-12169-7_2.

132 <http://cc-arcc.ca/wp-content/uploads/2016/02/PDCI-Pharmacare-Costing-Study-Report-Feb-28-2016-Final.pdf>, p. 27

