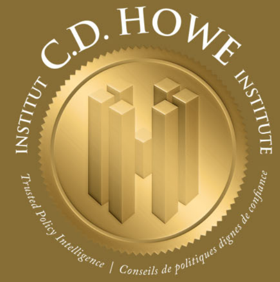
Intelligence MEMOS



From: Chris Bonnett

To: Pharmacare Watchers

Date: April 24, 2024

Re: **Aspiration and Ambiguity. That's the Pharmacare Story**

For decades, pharmacare has been a day late and a dollar short. How much did **Bill C-64** change that?

Very few Canadians have no drug insurance, but a much larger number probably need more coverage. The lack of an integrated national drug system limits our ability to describe the unmet need, and this need is as important for that cohort as hospital and medical insurance is for everyone.

The Feb. 29 pharmacare bill has "the aim of continuing to work toward the implementation of national universal pharmacare." At the onset, it proposes universal, no-cost access to selected diabetes and contraception drugs and devices – included in last week's budget – along with work on a new national formulary, refinement of today's bulk purchasing strategy, and creation of a new expert committee. To its credit, the bill would significantly expand access to glucose monitoring devices that **do not have universal coverage**.

Many, many questions remain, but the three most important are about timing, funding, and value.

Timing is leisurely. The start of negotiations with the provinces, territories, and Indigenous groups (the jurisdictions) is to follow royal assent, likely later in 2024. Then, there will be up to one more year to develop the following:

1. A "list of essential prescription drugs and related products." This list is only a teaser to a formulary, however, which could be very limited, and sounds equivocal: "Canadians *should* have access" [emphasis added] to the formulary. Each jurisdiction will continue to decide what it covers for the foreseeable future, as will private insurers.
2. A bulk purchasing strategy. It is unclear how this might be different from the work of the pan-Canadian Pharmaceutical Alliance, or similar work done by insurers and pharmacy benefit managers. Our existing approach could be improved if this new strategy wrapped around all 41 million Canadians. This is a steep hill to climb.
3. A strategy on appropriate use of drugs and related products for prescribers and patients. Progress will be reported every three years, the only clear and durable accountability requirement.
4. Recommendations by an expert committee outlining options to operate and finance "national, universal, single-payer pharmacare." The committee's mandate, resources, independence, and skillset are unknown. We need a **permanent committee** with broad expert and independent advice.

The presumptive goal is to fund and implement the plan in one or more jurisdictions before the next federal election. Current polling suggests all bets are off after that.

The bill commits the federal government to "maintaining long-term funding" but the word 'adequate' is missing. Health Minister Mark Holland has suggested initial annual costs of about $1.5 billion. That depends on the scope and pace of the bilateral agreement, and the budget only earmarked $300 million a year over five years. He has also described Bill C-64 as a proof of concept, so a more pragmatic approach may still be possible for everything else that pharmacare may one day include.

Value for money is arguably the least clear because we cannot measure unmet need, or what health, financial, or social benefits should be or are actually achieved from each new dollar of drug spending. For example, **new data** estimate that types 1 and 2 diabetes now affect 9.5 percent of Canadians aged one or more, but we don't know how many need better coverage. Absent any evidence to the contrary, we can conclude the same about access to contraceptives. To understand and maximize value, **we should know why** the government chose this odd-duck model, and those two therapies over others. Politics over public health, perhaps? A big opportunity cost, certainly.

The initial policy decision to replace existing private drug plans is particularly troubling given strong public support, the plethora of other new federal spending commitments, and such limited federal spending headroom. Private plans cover two-thirds of Canadians and $15 billion in current spending. That noted, while "single-payer" is referenced twice in the short bill, it is framed as aspirational and investigational rather than defined as the chosen model. Further, it applies only to listed products in two therapeutic categories. If future expansion of the formulary is similarly limited, then supplemental private drug insurance will be needed, and likely commercially viable.

Pharmacare legislation has been proposed just once in the last 80 years. Bill C-64 was indeed a rare – and now likely missed – opportunity to address important unmet needs. Pervasive ambiguity in timing, funding, and value, plus the opacity of the whole decision process are not advantages outside Ottawa. Its ambition has been diluted to look more like a political compromise than a rational, health-focused program.

The transition to a national, universal, and comprehensive pharmacare plan may be a little closer now, but more likely it is a long way off, if it happens at all.

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