Intelligence MEMOS

From: Åke Blomqvist and Rosalie Wyonch

To: Ginette Petitpas Taylor, Federal Minister of Health

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Re: **PHARMACARE: NOT SO FAR NOW**

The 2019 federal budget outlined the next steps towards implementing national pharmacare and they make a lot of sense. Much work remains and snags will inevitably arise, but it is now possible to imagine a path that would take us to universal national pharmacare during the lifetime of the government that will be in power after the October election.

The federal government is allocating money to two specific pharmacare initiatives: creating a national strategy for high-cost drugs for rare diseases, and establishing a Canadian Drug Agency with a mandate that includes assessing effectiveness of new prescription drugs and negotiating prices on behalf of Canada's drug plans. The former, allocated $500 million annually starting in 2022/23, may help provinces and territories create a coordinated response to a very controversial and intractable problem. The latter may indirectly create the conditions for reaching an agreement between the federal and provincial/territorial governments to finally implement some form of universal pharmacare.

Those who support the establishment of a single-payer government pharmacare plan have argued that as the only buyer in Canada of the drugs it would cover, a single-payer plan would be able to negotiate prices that would be considerably lower than they are now. But if the new Canadian Drug Agency is given authority to negotiate prices on behalf of all Canadian buyers, public or private, its bargaining power would be as strong as that of a single-payer plan, meaning that it could create similar savings in nation-wide drug costs. That is, the new agency could substantially lower the national drug budget even if the federal and provincial/territorial governments are not able to agree on a single-payer government plan.

The Canadian Drug Agency's mandate would also include "identifying which drugs could form the basis of a future national formulary." An evidence-based common formulary that sets out what drugs are recommended for different patients and takes into account their likely effectiveness and cost, would be a useful tool even if there is no single national pharmacare plan.

In negotiating prices with pharmaceutical companies and making decisions about what drugs should be in the formulary, the Canadian Drug Agency should rely heavily on the type of cost-effectiveness analysis that the Canadian Agency for Drugs and Technologies in Health (CADTH), and INESSS, its Québec counterpart, currently undertake. Cost effectiveness has also figured prominently in the recent discussion about new rules for the Patented Medicines Prices Review Board, whose regulatory mandate should obviously be integrated with the new agency's.

Once the Canadian Drug Agency is up and running, the federal government's next step should be to offer provinces and territories a new deal under which it raises the Canada Health Transfer to those that have implemented an acceptable version of universal pharmacare . The increased transfer should be conditional on universal coverage by a plan that meets a set of minimum standards with respect to the drugs covered, using the national formulary as a guideline, and the maximum annual out-of-pocket payments for patients or families.

Provincial and territorial governments may respond to this offer either by enrolling every resident in one of the government plans that currently cover specific population groups (retirees, social assistance recipients, youth etc.), or, as in Québec, by requiring every resident to be covered either by a government plan or by an approved private plan. Either response is a form of universal pharmacare. If every province signs on to this deal, the goal of national pharmacare in Canada would be achieved.

Advocates of a single-payer universal public plan will object to this approach because it would allow provinces to maintain a mixed public-private model. But a single national universal pharmacare plan would be politically much more difficult to accomplish than one that maintains a high degree of provincial flexibility and a continued role for private insurance plans. The fiscal implications of governments becoming the sole insurers would be daunting: 57 percent of prescription drug costs – almost $18 billion in 2016 – are currently paid by private sources.

If the objective is to promote economic equality and help society's most vulnerable, spending that money on things like enhanced social assistance benefits or better mental health and addiction services, seem to us a better bet than using all of it to pay for benefits already largely covered by private insurance.

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