Government of Canada Gouvernement du Canada

Towards Implementation of National Pharmacare

Discussion Paper

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Towards Implementation of National Pharmacare Discussion Paper

A Message from the Minister of Health and the Minister of Finance

Canadians are proud of our publicly funded health care system, which is based on need and not ability to pay. However, prescription drugs are not covered in a consistent way across the country, and too many Canadians cannot afford the medicines they need.

In Budget 2018, the Government established an Advisory Council on the Implementation of National Pharmacare ("the Council"), led by Dr. Eric Hoskins, to provide independent advice on how to best implement national pharmacare in a manner that is affordable for Canadians and their families, employers and governments.

The Council will conduct a fiscal, economic and social assessment of domestic and international models relating to pharmacare. It will consult with Canadians, provincial and territorial governments, Indigenous Peoples, experts, patients, the private sector, and other stakeholders in the drug coverage sector. The Council will deliver its report within a year.

This discussion paper is designed to provide a starting point for the Council's dialogue with Canadians about the implementation of national pharmacare in Canada. The paper provides an overview of the current system and its challenges, and identifies key objectives and questions to frame the work of the Council and support a focused dialogue.

It will be essential for the Council to consider the crucial role of provinces and territories in Canada's health care system, including the important role they play in providing drug coverage to Canadians.

We look forward to receiving the Council's final report, which will include options and recommendations as to what measures the federal government should take.

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A. What is Pharmacare?

Pharmacare is a system of health insurance coverage that provides people with access to necessary prescription drugs. There are different ways this can be accomplished.

In most industrialized countries, pharmacare is part of a universal health care system. Prescription drugs are included as part of the basket of insured health services along with hospital care, medical care and a range of other health services.

Most Canadians have some form of prescription drug coverage, but the terms of coverage vary considerably, leaving many households facing cost barriers when they have prescriptions to fill.

As Canada considers how to move forward on a national approach to this issue, it has a number of options available. No decisions on a particular model or approach have yet been made. Understanding what will work best for Canadians is key to enabling the Government to make an informed decision. To that end, the Government is asking the Council to engage with Canadians and a wide range of stakeholders to develop a better understanding of the practical mechanics, and potential trade-offs, of implementing those options.

B. The Case for Pharmacare: An Overview

Prescription drugs are a vital part of health care, helping patients to manage and cure disease. But unlike other foundational pillars of medicare—doctors and hospitals—prescription drugs used outside of hospitals are not part of basic health insurance. In this respect, Canada is unique among all other industrialized countries with universal systems of public health care coverage.

The logic of national pharmacare is indeed compelling. From the origins of medicare in the 1960s the plan had always been to eventually cover prescription drugs as part of the national basket of publicly-insured services. But Canada never got there, as changes in economic and fiscal conditions, shifting public policy priorities, and an evolving federal-provincial dynamic made it impossible to secure the consensus necessary to move forward.

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).

More recently, on April 18, 2018, the Standing Committee on Health (HESA) tabled a report recommending that Canada establish a universal single-payer public prescription drug system by expanding the *Canada Health Act* (CHA) to include prescription drugs dispensed outside hospital. The report contains a total of 18 recommendations intended to lay the framework for the provision of pharmacare for all Canadians. The Council will review these recommendations closely with a view to building on HESA's extensive work.

The access problem: Canada's patchwork of drug coverage leaves too many behind

Today, prescription drug coverage in Canada is provided through a patchwork of more than 100 public and 100,000 private insurance plans. Only prescription drugs administered in hospitals are included as part of basic medicare coverage. Coverage for drugs prescribed outside of hospitals, for example by a family doctor or specialist, varies from person to person and province to province:

- Many working Canadians and their dependents have much of their prescription drug expenses covered through a private benefit plan funded by their employer.
- Seniors, individuals receiving social assistance, and patients with certain specific diseases are generally covered at least partially by public plans administered by provinces and territories.
- Certain populations, notably many First Nations and Inuit, members of the military, veterans, federal inmates and some refugees receive coverage through federally-funded drug plans.
- For many Canadians—particularly those who are self-employed, employed part-time or have low-paying or precarious work—the reality is that they must pay out-of-pocket for any needed prescription drugs. Low-income Canadians also often suffer from poorer health leading to greater prescription drug needs. Furthermore, and given that they are more likely to hold part-time employment, women typically have less access to drug coverage than men.

The way drug coverage is currently organized in Canada has profound consequences for patients. A recent study suggests that 95% of Canadians (more than 34 million) are eligible for some form of prescription drug coverage (Conference Board of Canada, 2017). But even those with drug coverage can face deductibles, co-payments and annual maximums that make affording drugs a challenge. Despite the multitude of drug plans, too many Canadians must make difficult choices, foregoing other necessities of life in order to cover the cost of drugs, or leaving prescriptions unfilled because they cannot afford them. A recent study found that almost one million Canadians reduced spending on food and heat in order to afford their medication (Law, 2018). Nearly two million Canadians reported not being able to afford one or more drugs in the past year,

often resulting in additional doctor visits and hospital admissions (Law, 2018). Another recent report estimates that hundreds of premature deaths occur each year among working age Canadians unable to afford their prescription medicines (Canadian Federation of Nurses Unions, 2018).

Access to public drug coverage varies considerably across provinces and territories. Some provinces provide coverage by age group, e.g., coverage for seniors. Others provide coverage by income bracket with a focus on covering low-income residents. Several provinces combine both approaches, e.g., covering seniors below a certain income threshold. A few provinces offer coverage to all their residents, with the level of coverage depending on a person's income and drug costs. Quebec is the only province that requires all residents to have prescription drug coverage, either through a private plan or the provincial drug plan. As a result, two patients with the same need, but living in different parts of the country, will have very different access to prescription drug coverage and will face significant differences in out-of-pocket costs.

The cost problem: Canada's spending on prescription drugs is unsustainable

On average, Canadians spend $926 per person on prescriptions per year, through a combination of public, private and out-of-pocket expenditure (Canadian Institute for Health Information, 2017). Drug spending in Canada has grown significantly over the past few decades, from $2.6 billion in 1985 to $33.8 billion in 2017, and the share of GDP spent on drugs has more than tripled from 0.5% to 1.6% over this period (Canadian Institute for Health Information, 2017).

Canada lags many of its international peers in terms of costs and health outcomes achieved by our patchwork system of public and private drug plans, and weaker price regulation. Canadians pay among the highest prices and spend more on prescription drugs than citizens of almost every other country in the world. Among Organization for Economic Co-operation and Development (OECD) member countries, only the United States and Switzerland spend more per person each year on prescription drugs and pay higher patented drug prices than Canada. In 2016, median OECD prices for patented drugs (commonly referred to as brand or innovative medicines) were on average 20% below those in Canada (Patented Medicine Prices Review Board, 2017).

The Government is taking steps to lower prices to make prescription drugs more affordable. Through the Patented Medicine Prices Review Board (PMPRB), the federal government regulates the maximum allowable price of patented drugs. For the first time in more than 20 years, the Government is updating the *Patented Medicines Regulations* which, together with the *Patent Act*, provide the PMPRB with the tools it needs to protect consumers from excessive patented drug prices. It is estimated that these changes could result in savings in the range of $13.2 billion over the next decade. The federal government is also working with the provinces and territories as an active member of the pan-Canadian Pharmaceutical Alliance (pCPA) to negotiate lower prices for brand name drugs

for public plans and to reduce prices for many generic drugs. As of March 31, 2017, it was estimated that the pCPA had achieved approximately $1.28 billion in annual cost savings.

Improving the affordability of prescription drugs for Canadians is becoming more urgent as the cost of medications continues to rise and new developments such as precision medicine and biologic therapies promise new cures—but also much higher prices. In 2006, there were 44 drug products on the Canadian market with an average annual cost per patient of $10,000 or more. By 2016, that number had tripled to 135 (PMPRB, 2016). While these products represent only a fraction of the over 12,000 drug products available on the Canadian market, they represent more than one quarter of public and private drug plan costs while treating only 2% of beneficiaries.

The patchwork of coverage that has evolved in Canada is not only inadequate for too many Canadians, it is also not designed to handle the increasingly expensive drugs coming down the innovation pipeline. Escalating costs impose a financial strain on individual Canadians and their families, employers and governments. Canadians pay for these high and rising drug costs either directly through out-of-pocket expenses, or indirectly through costs passed on by their employers or through the taxes they pay.

Employer-sponsored benefit plans face difficult trade-offs as drug costs for the working population increase. Some employers choose to shoulder the increased costs by paying the higher insurance plan premiums. Others have employees pay a greater share through increased use of deductibles, co-payments and/or annual or lifetime plan maximums, or through limiting salaries and health benefits. The use of lifetime or annual maximums on health benefits in private drug plans, for example, has been increasing over the past decade and many companies have reduced retirement health benefits. These trends mean individuals' contributions to their drug costs will increase.

As drug costs rise, private plans will become less affordable and as Canada's population ages and chronic health conditions become more prevalent, federal, provincial and territorial governments will also experience increasing costs, especially since public plans typically cover seniors. This places pressure on public plans to also scale back drug coverage or other critical health and social services, since money spent on drugs cannot be spent elsewhere.

A more cohesive approach would not only be fairer for Canadians struggling to pay the bills, it would help everyone get a better deal on an increasingly pricey necessity.

C. The Challenge: Building Consensus on How to Move Forward

The time has come to find a way forward on this important issue. A broad coalition of stakeholders and experts have mobilized to marshal the evidence and build momentum. Provincial and territorial Premiers have initiated joint work. Federal Parliamentarians have studied the issue extensively and have called for action. And governments have been working to put key building blocks in place to support national pharmacare, such as initiatives to lower drug prices.

A more cohesive system of drug coverage would offer many advantages. It would ensure equity by providing all Canadians with access to needed drugs, providing citizens with more uniform coverage in a manner that is consistent with the concept of medicare. It would also lower the costs of drugs by bringing the collective buying power of Canadians to the table. And it would create a more rational and efficient system by ensuring that decisions on whether to cover drugs are guided by evidence of clinical and cost-effectiveness.

Other countries have useful lessons for Canada. Some countries, such as the UK and Australia, cover drugs through a national program that is funded through taxes. Others, such as Germany and the Netherlands, have mandatory private (often not-for-profit) insurance systems that are regulated by the national government. In some of these systems, employers play an important role in drug coverage because they are required to provide insurance for their employees and dependents. Some countries provide prescription drugs at little to no cost to patients, but many require patients to pay a small fee for each prescription. Each of these models has its benefits and drawbacks, and the experience of other jurisdictions shows that no system is flawless.

Choosing the right model for Canada will be difficult, and the implementation challenges are numerous. The benefits of pharmacare, while significant, require compromise and accommodation by many parties with diverse interests. The following sections of the discussion paper will explore these issues in greater detail and identify questions that will guide the Council as they develop options for the implementation of national pharmacare.

D. Key Issues to Consider About National Pharmacare

There are many issues and perspectives that need to be taken into account in deciding the best path forward for Canadians. The most basic questions are perhaps the most important—who will be covered and under what circumstances, what drugs will be covered, and who will pay. To answer these questions, we need to understand why these issues matter, how the current system works, and what are some possible ways forward for Canada.

1. Who will be covered and under what circumstances?

Why is this important?

Equity in coverage has been a hallmark of Canadian medicare for the past 50 years. Canadians know that regardless of where they live, they can expect to have access to medically necessary physician and hospital services under uniform terms and conditions. In other words, Canadians can be confident that for doctor and hospital services, everyone is treated the same. That doesn't mean that all services are available in all communities at all times; this was never the intent of medicare. Rather the idea is that all Canadians are covered by the public system, and access to services is based primarily on need, not on ability to pay or other criteria.

As we move towards national pharmacare, we need to have a clear vision of what equity in drug coverage should look like in the future.

How it works now

Currently, drug coverage for Canadians is not determined by medical need alone, but by a range of other factors including age, province/territory of residence, employment status, and income. There are currently about 100 different provincial and territorial drug plans providing coverage for approximately 24 million Canadians. In addition, approximately 500,000 businesses provide private drug coverage for some 23 million Canadians (Conference Board of Canada, 2017). There is often overlap between public and private plans. For example, some provinces offer income-tested drug coverage to all their residents. Someone with private health benefits through work may choose not to enroll in the provincial public plan unless they 'max out' their private coverage.

Each of these public and private plans has different rules governing who is eligible, what drugs are covered, and how much patients must pay when they access drugs. For example, people working several part-time jobs may have little to no drug coverage, while people in more stable positions at large companies usually have a quite comprehensive drug plan. Seniors in some jurisdictions pay only a small flat fee for each prescription while in other jurisdictions, seniors may pay hundreds of dollars in co-payments and deductibles. Prescription drugs for children in some jurisdictions are provided free of charge, while in other jurisdictions there is little or no public coverage for children.

For Canadian households with inadequate drug coverage there is some relief for drug costs available through the federal Medical Expense Tax Credit and similar programs at the provincial level. Health charities, community fund-raising and drugs donated by the pharmaceutical industry can also help to offset drug costs for families in need. But the reality for too many Canadians is that they are unable to afford the medications they need. And with poorer access to needed medications come poorer health outcomes.

Possible ways forward for Canada

Different approaches have been suggested in Canada over the past few decades to improve equity in prescription drug coverage.

One approach would be to provide Canadians with **comprehensive universal coverage** for prescription drugs. Equity in this approach is defined as treating everybody the same way, with access based on need and not ability to pay. This was what the Hall Commission originally proposed in 1964, subject to a co-payment of $1 per prescription, which is equivalent to about $8 today. The proposal resurfaced in the final report of the National Forum on Health in 1997, which called for a universal pharmacare program that would resemble the coverage offered for hospital and medical care in Canada, and has again been proposed by the House of Commons Standing Committee on Health. This approach would mean individuals currently covered by private insurance plans would be largely covered by a public plan, and governments would assume some costs that today are paid through private insurance and out-of-pocket spending by Canadians. However, this approach could also reap significant savings—estimated by the Parliamentary Budget Office at more than $4 billion annually—through combined purchasing power and lower administrative costs of a single-payer program.

Another approach that has been suggested would be to provide drug insurance to protect Canadians from exceptionally high drug costs. Equity in this approach is about providing a basic **safety net** so that individuals do not need to go into debt or sell their house to cover the costs of drugs. A pharmacare plan designed in this way would provide public coverage for drug costs above a certain threshold, such as 3% of household income. Individuals, or their existing drug plans, would be responsible for drug costs below the threshold. Finding the right threshold is key to ensuring Canadians can afford the drugs they need. Variants of this approach were proposed by the Romanow Commission and the Kirby Senate Committee in 2002. The Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy under the 2004 Health Accord analysed several scenarios to improve catastrophic drug coverage for Canadians, but did not reach consensus on a way forward. This safety net approach provides more flexibility for governments to raise or lower the threshold of coverage as budgets allow, but would be less effective at improving equity and reducing drug costs.

Another approach consists of leaving the structure of existing public and private drug insurance plans intact, but putting more rules and public funding in place to **close the gaps**. This could involve requiring firms of a certain size to provide coverage to employees. Alternatively, all Canadians could be required to obtain public or private coverage. In either case, public subsidies or expanded public coverage would be needed to support those without access to drug coverage. Equity under this approach means that all individuals have either public or private drug coverage, though the nature of coverage (drugs covered, how much it costs

the individual) would vary from one plan to another. This gap filling approach could perpetuate existing inequities and inefficiencies of our existing patchwork system unless standards are developed. New laws could be put in place to define basic coverage requirements and minimize disparities between plans.

Questions for discussion:

1. *Who should be covered under national pharmacare?*
   - ☐ *All Canadians on similar terms and conditions, regardless of their ability to pay (i.e., universal coverage)*
   - ☐ *Only Canadians whose drug expenses exceed a certain portion of their income (i.e., income-tested coverage)*
   - ☐ *Another approach—please describe your suggestion for who should be covered and for which drug expenses*

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2. *How should national pharmacare be delivered?*
   - ☐ *Mainly through public insurance, like coverage for hospital and physician services*
   - ☐ *Through a mix of public and private insurance, like existing drug coverage and some other health services (e.g., dental care)*
   - ☐ *Another approach—please describe your suggestion for the appropriate approach for delivering national pharmacare*

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2. Deciding what drugs get covered

Why is this important?

Implicit in the idea of national pharmacare is the notion that Canadians would have access to a reasonably comparable list of prescription drugs under similar terms and conditions. To support effective management, many drug plans develop a ‘formulary’: a list of drugs that are eligible for reimbursement along with criteria for their use (e.g., reimbursement for a drug may be limited to individuals who suffer from specific conditions) and any related cost-sharing provisions (i.e., the share of the drug cost that will be covered by the plan member and by the plan sponsor).

There are thousands of drugs on the market at any given time and dozens of new ones are introduced each year—many of them very expensive. Drug plans must make difficult choices about which drugs are eligible for reimbursement based on a range of factors including the needs of the population served by the drug plan, evidence of how well the drug works in different circumstances and

conditions, and how cost-effective it is relative to other treatment options. The list of drugs approved for reimbursement, and any related criteria for their use, can also serve to guide prescriber decisions and ensure that the right patient is matched with the most appropriate drug therapy.

Ultimately, drug plans must make the best use of their limited budgets to achieve the best possible health outcomes for the populations they serve. This challenge is more pronounced in public drug plans, which must be accountable to tax payers for providing good value for money. Private drug plans have more flexibility, and tend to provide a wider choice of prescription drugs even if they cost more and there is less proof of their clinical benefits. However, as more and more costly drugs enter the market, private drug plans may also have to more actively manage which drugs they reimburse to remain viable.

How it works now

Public and private drug plans in Canada each have their own list of drugs that are eligible for reimbursement under the plan. A Common Drug Review conducted by the Canadian Agency for Drugs and Technologies in Health examines the evidence on how well a new drug works (clinical effectiveness) relative to how much it costs (cost-effectiveness) and provides recommendations to drug plan managers. Public plans rely extensively on the Common Drug Review to decide which drugs will be eligible for reimbursement.

For their part, the employers who sponsor the majority of Canada's private drug benefit plans have traditionally viewed these plans as tools to attract and retain employees and have preferred to offer more choice in the drugs available to their plan members. As a consequence, the majority of private plans have what is known as an 'open formulary' and provide reimbursement for most new drugs as soon as they arrive on the market, regardless of proven clinical effectiveness or cost-effectiveness.

The number of drug products listed on Canadian public drug plans ranges from approximately 4000 to 8000. A 2017 PMPRB study found that, for those drugs used to treat common medical conditions seen in primary care, there is a high degree of alignment across public drug plan formularies. There is, however, more variability across the country with regard to specialized and high cost drugs, which are becoming increasingly common.

Possible ways forward for Canada

The development of a common approach to listing drugs as part of the implementation of national pharmacare would help to ensure Canadians have similar access to drugs across the country. This could be done through the adoption of clear principles and criteria for listing drugs or through the creation of a single national formulary that would have the same effect. This could be applied to public or private drug plans. Individuals could also have the option to access drugs not approved for reimbursement through national pharmacare via

supplemental insurance or out-of-pocket spending. The scope of drugs approved for reimbursement under national pharmacare would need to be determined.

One approach could be to focus on **essential medicines**, particularly those used in primary health care. The World Health Organization (WHO) defines essential medicines—a few hundred in total—as those that meet the priority health care needs of the population and should be available within the context of functioning health systems at all times in adequate amounts and at a price the individual and the community can afford. Individual public and private plans could top-up this list of drugs with additional medication that would be made available to their residents or clients. This approach would ensure that all Canadians have access to a basic set of medicines, but would not cover the full complement of drugs normally used in our health care system. It would also not address the challenges of newer, high cost drugs.

Another approach would be to focus on the **most frequently prescribed drugs** across a broad range of common medical conditions (e.g., diabetes, high blood pressure, etc.). As mentioned above, there is already a good degree of alignment across public drug plan formularies for these drugs. Here again, allowance could be made for individual public and private plans to top-up the list of drugs on the national formulary. This approach would ensure all Canadians have similar access to the drugs commonly prescribed in family practice, but again it would not address the challenges of higher cost prescription drugs.

Alternatively, a more **comprehensive approach** could be taken by providing coverage for a larger list of drugs equivalent to what some of the more generous provincial formularies currently provide (although not an open formulary where all drugs approved for sale are included). This could entail higher costs for drug plans but would ensure greater equity in coverage and provide more purchasing power across a wider range of drugs, including many of the newer, high cost drugs entering the market, and including drugs for rare diseases.

In each of the above approaches, input from patients and prescribers, evidence on safety and effectiveness, and budgetary factors would all have a part to play in the decision-making.

Questions for discussion:

3. *Which drugs should be covered as part of a national pharmacare plan?*
   - ☐ *Only safe, effective prescription drugs for which there is good evidence of value for money (this would result in a less costly plan, but provide fewer options for some patients)*
   - ☐ *The above drugs, plus safe, effective prescription drugs for which there is less evidence of value for money (this would result in a more costly plan, but provide more options for some patients)*
   - ☐ *Another approach—please describe your suggestion for which drugs should be covered*

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4. *How much variability across different drug plans or jurisdictions should there be in the list of drugs covered by national pharmacare?*
   - ☐ *There should be a common national list with no variation across drug plans or jurisdictions*
   - ☐ *There should be a common approach with some allowance for variability depending on unique employer or jurisdictional circumstances*
   - ☐ *Another approach—please describe your suggestion for the appropriate level of variability in the list of drugs covered across different drug plans or jurisdictions*

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3. Figuring out who pays

Why is this important?

To implement national pharmacare, difficult decisions will need to be taken on how the costs of the program will be shared between governments, the private sector, and individual Canadians.

How it works now

Canada currently spends $34 billion annually on prescription drugs (Canadian Institute for Health Information, 2017). According to the Canadian Institute for Health Information, $14.5 billion (43%) of prescribed drug spending is financed by public drug plans. The public share of prescribed drug spending varies among provinces, ranging from 29% in New Brunswick to 48% in Saskatchewan. Prescribed drug spending financed by private insurance (mostly employer-sponsored plans) was $12.1 billion (36%), with the remaining $7.4 billion (22%) financed by Canadian households in the form of co-payments, deductibles, premiums and out-of-pocket payments.

One of the issues that will need to be decided is whether Canadians should pay a share of the cost of drugs through deductibles, co-payments or annual premiums, and if so, how much. There is currently wide variability in this respect across public drug plans. Some plans cover all drug costs, particularly for low-income residents. But in many cases, an average-income household has to pay several thousand dollars before the public plan starts covering its drug costs. This can lead to families making difficult trade-offs between medicine and other necessities such as food and heat.

Research has shown that fees at the point of care (such as co-payments or deductibles) can deter people from obtaining necessary medical care. Even prescriptions costing $25 or less can be a barrier for some (Law, 2018). At the same time, some believe it is important for individuals to share directly in the cost of their medication, so they have an incentive to avoid waste. The reality is that in many countries, patients pay a portion of the cost of prescription drugs. In Australia, patients pay approximately C$35 per prescription. Patients in Germany and New Zealand pay modest co-payments—approximately C$7 to $17 in Germany, and C$2 to $8 in New Zealand. Patients in the UK and the Netherlands face little or no costs for prescription drugs (Morgan, Daw & Law, 2013).

An important feature of Canada's current approach to funding drug coverage is the inclusion of private drug coverage as an employment benefit. Labour unions negotiate these benefits with employers in both the public and private sector. The cost of providing these benefits is counted as a business expense for employers that is not subject to taxation. It is also a non-taxable benefit for employees (except in Quebec). This means there is an implicit public subsidy provided to Canadians that are covered by private plans—Finance Canada estimates that this tax treatment cost the federal government over $2.6 billion in 2016.

Possible ways forward for Canada

The evidence suggests that Canada's current system of prescription drug coverage is expensive and Canadians could be getting better value for money. Depending on how pharmacare is designed, implementing national pharmacare could represent a significant shift in drug spending from the private to the public sector. At the same time, a national program that is managed more efficiently and that consolidates buying power to negotiate lower drug prices could result in significant cost savings, relative to what government, employers, and Canadians are collectively paying now. Under any model, difficult decisions would need to be made on how the costs of the program would be distributed across governments, the private sector and individuals.

Individual Canadians and many employers are already paying a high cost for prescription drugs, whether by paying the full cost of their drugs at the pharmacy, paying premiums for a private plan, and/or paying taxes that support existing

public plans. Depending on the model of national pharmacare, the nature of Canadians' contributions to drug costs could change.

Requiring a co-payment for each prescription, either as a small flat fee or a percentage of the cost of the prescription, is one means to offset the cost of a national pharmacare program. Importantly, it could also help steer people towards safe, cost-effective options. Many countries use reference-based pricing, where the public purse covers the most cost-effective option within a drug class, and the patient can choose to pay the difference for a more expensive alternative. Exemptions and maximums would need to be considered to protect vulnerable populations, including those with multiple chronic conditions.

Currently, many employers support drug coverage for Canadians as part of the benefit package they provide to employees and their dependents. Employers could continue to do so under a public or a private plan. For example, a public plan could levy a premium on employers to effectively redirect the current premiums they pay for private coverage to the public plan. Alternatively, employment-based coverage could be expanded by requiring employers of a certain size to provide coverage for their employees. In this case, some of the funding required to support national pharmacare would continue to be financed by large employers.

Any approach to raising revenues should consider whether contributions should be based on ability to pay, the impacts on Canada's economy and competitiveness, as well as the administrative and compliance costs for tax payers and governments.

Questions for discussion:

5. *Should patients pay a portion of the cost of prescription drugs at the pharmacy (e.g., co-payments or deductibles)?*
6. *Should employers, which currently play a significant role in funding drug coverage for their employees, continue to do so (either through contributions to a private plan or through a public plan)?*

E. Key Perspectives to Consider in the Dialogue on National Pharmacare

Reaching consensus on a model for national pharmacare and a way forward to implement the new model will be a challenge. As the Council embarks on a dialogue with Canadians on the implementation of national pharmacare, it will be mindful of the important role, contribution, and interests of key players in this area.

Individual Canadians

Patients must be at the centre of any conversation about health care reform. In carrying out its mandate, the Council will reach out to patient groups and individual Canadians who have experience with the health care system to better understand their concerns and ideas on the implementation of national pharmacare. Canadians who do not currently qualify for public or private coverage for their routine drug expenses are likely to be supportive of expanded coverage, while those who currently have access to employer-sponsored drug coverage may have concerns about possible changes.

In addition, sex influences our risk of developing certain diseases, how well we respond to medicines, and our access to health care services. As women, men and gender-diverse people may experience policies, programs and initiatives differently, it will be important to consider sex, gender and other diversity factors in the design, cost and effectiveness of national pharmacare.

Provinces and territories

Consistent with their lead role in health care, provinces and territories have enormous experience and expertise in providing drug coverage to their populations through existing public drug plans. The Council will actively engage throughout the process with provincial and territorial health and finance officials, recognizing that each jurisdiction will approach the discussion from a unique starting point.

As previously noted, jurisdictions have taken fundamentally different approaches to structuring their coverage (e.g., age-based, income-tested, disease-based plans). As work is done to assess different options and models it will be important to understand the implications each will have on the ease of implementation across provinces and territories and how pan-Canadian coordination and collaboration can best be supported.

Indigenous Governments and Representative Organizations

Over 830,000 First Nations and Inuit clients, regardless of their place of residence in Canada or level of income, receive drug coverage through the federal Non-Insured Health Benefits (NIHB) Program. Indigenous Canadians currently experience much poorer health outcomes than non-Indigenous Canadians. However, under a renewed relationship with the Government of

Canada—one based on the recognition of rights, respect, cooperation and partnership—Indigenous peoples are increasingly leading the governance, design, delivery and control of their own health services. The Council will need to be mindful of this and explore how national pharmacare could be implemented in a way that supports self-determination and better health outcomes for Indigenous Peoples.

Health Care Providers

Health care institutions and clinicians are key players in the prescribing and dispensing of drugs. Physicians, nurses, dentists, pharmacists and other clinicians are on the frontlines of the health care system and their knowledge and experience will be invaluable to the Council's work. Many health care providers are likely to favour approaches that support improved access to drugs for their patients, but may resist changes if they are perceived to constrain prescriber autonomy or choice.

Private Insurers

Private insurers design and manage over 100,000 drug benefit plans under contract with employers or groups such as unions or professional associations, in addition to offering individual plans. In the face of rising drug costs, insurers are supportive of measures to improve drug affordability. A key question for the Council to consider is the role for private insurance in different models of national pharmacare. Any transition in the role for private insurers will also need to consider the impact on businesses and employees within this industry.

Businesses

Many larger businesses provide prescription drug coverage to their employees as an employment benefit, but this is not always the case for smaller businesses for whom such costs can be prohibitive. It will be important for the Council to hear the business perspective on how national pharmacare could be funded and how it could help make Canadian businesses more competitive.

Labour

Labour groups have been a strong advocate for universal pharmacare and have advocated for improved coverage for the uninsured. Organized labour also has an important stake in employer-sponsored drug benefit plans. The Council will engage with labour experts and organizations to take this perspective into account.

Pharmaceutical Industry

Canadian pharmaceutical sales represent 2% of the global market, making Canada the tenth largest world market. Implementing national pharmacare could increase the size of this market, but would likely come with changes to the way prescription drug coverage and reimbursement are regulated. The views of

pharmaceutical manufacturers and distributors on these issues will be an important input into the Council's dialogue.

Key Enablers at the National Level

The Council will also need to take into account the role of several organizations at the national level that provide regulatory functions and support the activities of public drug plans.

- Health Canada assesses the safety, quality and efficacy of drugs before they are allowed to go onto the market.
- The Patented Medicines Prices Review Board protects consumers from excessive drug prices.
- The Canadian Agency for Drugs and Technologies in Health assesses the clinical effectiveness and cost-effectiveness of drugs, and makes recommendations to public drug plans.
- The Canadian Institute for Health Information collects information on spending and utilization of drugs in public drug plans.
- Canada Health Infoway is helping provinces roll out electronic prescribing systems.
- Through the pan-Canadian Pharmaceutical Alliance, public drug plans have banded together to consolidate their buying power and negotiate lower drug prices.

Efforts are already underway to better coordinate the work of these national players to help improve the affordability, accessibility and appropriate use of prescription drugs.

F. Engaging Canadians

As Canada considers how best to put pharmacare in place, it is important that Canadians have a voice in helping shape it. If you have views on any of the questions in this Discussion Paper, please go to canada.ca/pharmacare to share your views.

In addition to collecting feedback from Canadians, Council Members will be meeting with provincial, territorial and Indigenous leaders over the coming months to gather their views and hopefully build consensus on a path forward.

All of this input will form the basis for the Council's report to the federal Minister of Health and Minister of Finance, in a year's time.

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