Canada 2020

POLICY LAB

# National Pharmacare Initiative Policy Lab

Report on Findings and Resolutions

August 14th, 2018

# AREAS OF BROAD CONSENSUS

At the end of the session the attendees identified several broad areas of consensus through a voting process.

1. National Pharmacare should ensure Canadians have consistent, equitable, timely and fiscally sustainable access to a formulary of prescription drugs reviewed according to clinical, economic and patient-centered principles.

2. National Pharmacare should be able to optimize spending and administration to improve health outcomes and quality of life.

3. National Pharmacare should address the problems of coverage and lack of access to prescription drugs.

4. National Pharmacare administrators need to work hand-in-hand with all relevant stakeholders to set, monitor and analyze outcomes.

5. National Pharmacare should be structured such that it is future-oriented, anticipating changes and challenges.

6. National Pharmacare should allow for public-payers to top-up a national, mandatory standard.

7. National Pharmacare should not lead to businesses eliminating extended health and dental plans.

8. National Pharmacare should be portable and consistent when Canadians change residency, move, or visit other provinces and territories.

9. National Pharmacare should be economically and fiscally sustainable.

10. National Pharmacare should ensure that any co-pays or deductibles should not act as a barrier to use of care.

# ISSUES TO RESOLVE

During the session, participants created several resolutions that failed to receive broad consensus. We have reframed these resolutions as open-ended questions and summarized the debate that occurred in the room.

1. **Should the National Pharmacare Initiative assure appropriate access to innovative medicine or technologies?**

   Some participants believed that national pharmacare should not be an 'open bar' for drugs, that is it should not be used as a platform for all drugs to enter the market. Furthermore, they felt it should not encourage unnecessary and unproven new medicines to enter the market. Alternatively, another set of participants worried that a poorly implemented national pharmacare, which focused on "preventing unnecessary and unproven new medicines entering the market" could prevent access to valuable and innovative medicines or technologies. They believed that the focus should be allowing patients to access a wider range of medicines or reducing side effects. There were concerns raised that the implementation of national pharmacare could delay the introduction of some pharmaceutical products into the Canadian market. There was consensus that access to innovative medicines should not worsen from the current situation; the debate was on how to structure pharmacare such that this would not happen.

2. **Should National Pharmacare lead to a lowest common denominator formulary?**

   Some participants argued that the formulary, either by design or by accident, could become a "lowest common denominator," limiting access to certain drugs. One example given was the case of Australia, where citizens have to travel to different countries to gain access to different medicines that may not be on the formulary, as the formulary is set out to cover only certain drugs. Any drug that is not present on the formulary will not be covered by the Australian Government. Many participants believed that the registry should be able to respond to individual patient needs, that is if a patient were to benefit from a different drug that is not on the formulary they could still get covered by the pharmacare plan in place, however, others felt this could make the program cost prohibitive.

3. **Should a National Pharmacare plan prioritize the needs of Canadians, beginning with the under-insured, indigenous communities, and those who require catastrophic drug coverage?**

   Participants liked this idea in theory, but worried that in practice it may be difficult to address specifically what needs to be prioritized and who should be the targeted groups. Some participants worried that a prioritization approach could cause people outside the targeted groups wouldn't immediately benefit from coverage, whereas others felt that it was important to prioritize the biggest needs.

4. **Should National Pharmacare lead to improved practices from prescribers to patient to prevent and reduce the inappropriate use and/or need for drugs?**

   The participants did not disagree with the premise, but there was disagreement on where the emphasis should be placed. There was near consensus that reducing dependence on drugs of patients should be a priority, though there were concerns that such a focus may cause those needing pharmaceuticals to stop taking them. There was significant consensus in the room that that there should also be a focus towards non-drug technology and improved accountability for prescribers. There was also discussion on the fact that there should be a focus towards non-drug health-care solutions that the pharmacare initiative could end up crowding out. A big point of debate was in what the "improved practices" would be, who would be accountable, and what measures would be put in place to judge effectiveness.

# BACKGROUNDER ON NATIONAL PHARMACARE

The federal government's 2018 budget calls for an Advisory Council on the Implementation of National Pharmacare:

> Canadians are proud of our publicly funded, universal medicare system which is based on need and not on ability to pay. Yet, we know that at least one in ten Canadians cannot afford the prescription drugs they need. Every year, almost one million Canadians give up food and heat to afford medicines. And those who can pay for their drugs face some of the highest costs among the world's most advanced countries. The unaffordability of many medications leads to Canadians being less healthy, with significantly higher health care costs for us all.

> The Government has demonstrated its commitment to improving access to necessary prescription medications, by taking concrete steps to lower drug prices, streamline regulatory processes for drug approval, support better prescribing practices and explore a national drug formulary. These steps will significantly improve the accessibility and affordability of prescription medications, but there is an opportunity to do even more.
>
> As part of Budget 2018, the Government is announcing the creation of an Advisory Council on the Implementation of National Pharmacare. We are appointing Dr. Eric Hoskins, who recently served as the Minister of Health of Ontario, to chair this initiative. He and board members will begin a national dialogue that will include working closely with experts from all relevant fields as well as with national, provincial, territorial and Indigenous leaders. The Advisory Council will report to the federal Minister of Health and the Minister of Finance and will conduct an economic and social assessment of domestic and international models, and will recommend options on how to move forward together on this important subject.

In order to assist Dr. Hoskins with this initiative, the Canada 2020 Policy Lab will examine National Pharmacare from three broad themes, taking the Ontario Government's Ministers' Roundtable on Pan-Canadian Pharmacare as an inspiration. Their report developed a set of "Areas of Broad Consensus" and "Issues to Resolve". We have taken this set, divided them into three broad themes, and will use them as a starting point in our discussion.

**Theme 1: What is National Pharmacare meant to accomplish? What are the primary problems it is trying to solve?**

In order to develop sensible policy, we must know what problems we are trying to solve. The Ontario initiative adopted the following resolutions as areas of broad consensus:

- There are too many Canadians who have either no coverage for prescription drugs or insufficient coverage.
- We could spend less on prescription drugs in Canada and get the same or better value.
- Without substantial policy reform, the current situation could get worse.
- A good pharmacare plan would focus not just on providing coverage to the entire population but also on improving the quality of prescribing
- The goals of pharmacare should be a program that produces better health, at lower total cost than we currently spend, and that provides a good experience for patients

Are these still valid from a federal perspective? Are there others we should be considering? What does a National Pharmacare success look like? How can we measure that success, in terms of both inputs and outputs?

**Theme 2: What are the potential unintended consequences from a system of National Pharmacare? How can a system be designed to reduce the severity of those consequences and/or reduce the likelihood that they occur?**

The Ontario initiative developed two areas of consensus on this theme:

- We do not want a poor pharmacare plan – for example, one that provides "universal" coverage but where patients still cannot afford to take their medications, or one where costs continue to increase at the rate they have over the past 15 years

- The development of a good pharmacare program would require ongoing evaluation and refinement

Along with an issue to be resolved:

- What will the reaction to pharmacare be from the public and from employers?

Are there other areas of consensus we can develop when it comes to mitigating unintended consequences from national pharmacare? What are the biggest unintended consequences we should concern ourselves with? Opioid addiction? Antibiotic resistance? Others?

**Theme 3: How should a National Pharmacare program be structured?**

The Ontario initiative developed a single area of broad consensus in this area:

- Decisions about which drugs should be paid for publicly should be based on evidence and de-politicized to the extent possible

Along with several issues to resolve:

- Should a pharmacare program be "first dollar," or should there be some private contribution? If the latter, what should that look like?
- How should those interested in developing a pharmacare program engage with the private health insurance, pharmacy, and pharmaceutical sectors?
- Should the development of pharmacare proceed in an incremental fashion, or would it be better to proceed with a "Big Bang" approach?
- Is federal government participation necessary for the development of pharmacare?

Are there other resolutions that we can develop in this area that can receive broad consensus? How can we resolve our outstanding issues? Should a national pharmacare initiative be a part of broader set of innovations to the Canada Health Act? If so, what could those Canada Health Act reforms look like?

**Resources**

We have compiled a resource library of studies and other useful literature in a separate document. Below are a few highlights from those resources that should help motivate the discussion.

The Parliamentary Budget Officer (PBO) was asked by the house standing committee on health to calculate the cost of national pharmacare program. Their program design incorporated the following features:

- Be a universal plan
- Replace existing public and private drug plans
- Use the Quebec Medications List as the national formulary;
- Require a $5 co-payment for all prescriptions of brand-name drugs, with exemptions for the following:

    o Individuals aged 15 and under;
    o Students aged 16-18; o Individuals aged 65 and over;
    o Pregnant women;
    o Physically disabled;
    o Recipients of Employment Insurance and their dependents; and,
    o Recipients of welfare or social assistance and their dependants.

The PBO summarized their findings as follows:

> While there is a range of prescription rates for generics across Canadian provinces, the mean Canadian value is assumed to be most representative as it reflects existing prescribing practices among doctors and pharmacists.
>
> Roughly 84 million prescriptions would require the $5 payment, for a total out-of-pocket expense of roughly $420 million.
>
> The out-of-pocket expenses for patients under the new national Pharmacare framework would be about 90 per cent lower compared to the existing regime.
>
> PBO applied this calculation separately for prescriptions that are exempt from a $5 co-payment and prescriptions facing the co-payment.

The PBO concluded that:

> PBO estimates this Pharmacare program would have cost the federal government $20.4 billion if it had been implemented in 2015-16, or 83 per cent of actual 2015-16 drug expenditure for pharmaceuticals listed on the RAMQ formulary.
>
> After taking into account the $397 million in revenues from a $5 co-payment, net of exemptions, and the current $645 million the federal government spends on pharmaceuticals, the total net federal cost is an estimated $19.3 billion. These values include total markups and professional fees.
>
> The results indicate that the total cost of Pharmacare will reduce the estimated expenditure on the same pool of drugs (that is, those listed on the RAMQ formulary).

Similarly, the CMAJ attempted to estimate the cost of universal public coverage of prescription drugs in Canada. They found such a program would reduce total spending on prescription drugs by $7.3 billion. The private sector would save $8.2 billion. Government spending would increase by $1 billion.

The national pharmacare issue was also examined by the House's Standing Committee on Health, which issued their Pharmacare Now report, which developed the following five recommendations:

> Recommendation 1 : That the Government of Canada work in collaboration with provinces and territories, health care providers, patients and Indigenous communities to develop a common voluntary national prescription drug formulary.
>
> Recommendation 2: That the Government of Canada amend the Canada Health Act to include drugs prescribed by a licensed health care practitioner and dispensed outside of hospitals in accordance with a common voluntary national formulary, as part of the definition of an "insured health service" under the Act.
>
> Recommendation 3: That the Government of Canada provide additional funding to provinces and territories through the Canada Health Transfer to support the inclusion of prescription drugs dispensed outside of hospitals as an insured service under provincial and territorial public health insurance programs under the Canada Health Act.
>
> Recommendation 4: That the Government of Canada undertake consultations with employers, unions, private plans and Canadians at large to identify possible

approaches towards financing the expansion of the Canada Health Act to include prescription drugs dispensed outside of hospitals as an insured service.

Recommendation 5: That the Government of Canada undertake consultations with First Nations and Inuit communities to determine whether it is their preference to obtain prescription drug coverage under the Canada Health Act or through the NonInsured Health Benefits Program, with the ultimate goal of recognizing the authority of First Nations and Inuit peoples in providing health services to their communities.

## International Experience

Each country of the world deals with the issue of pharmacare differently. Here are three examples, quoted directly from the Pharmacare Now report.

### Australia

…the Therapeutic Goods Administration is responsible for assessing drugs for efficacy, quality and safety. The Pharmaceutical Benefits Advisory Committee then makes evidence-based recommendations to the federal minister of health about which drugs should be listed on the national evidenced-based drug formulary and provides advice on the price at which the drug represents value for money. The Pharmaceutical Benefits Pricing Authority negotiates drug prices based upon recommendations from the Pharmaceutical Benefits Advisory Committee. Once this negotiation is complete, the Minister adds the drug to the national formulary. A national prescribing service also provides education to family physicians regarding the use of medications.

### Sweden

Sweden provides universal drug coverage to its residents through the National Drug Benefits Scheme, which is financed through general taxation.

Levels of reimbursement are determined at the national level and are based upon the Act on Pharmaceutical Benefits, which outlines the three main principles of the program: the human value principle, the need and solidarity principle and the cost-effectiveness principle. Under the scheme, individuals cover the full costs of prescription drugs until they reach an annual threshold amount, after which they contribute co-payments until they reach a maximum annual out-of-pocket payment cap of SEK 2,200 (C$341) per year in 2017.

### Netherlands

…in the Netherlands, individuals are required by law to purchase private health insurance, but a minimum basket of services provided is established through legislation. Therefore, all private insurances companies must provide the same broad health benefits package, which includes coverage for prescription pharmaceutical drugs. Out-of-pocket payments are capped annually at approximately C$574, including copayments for pharmaceuticals. He explained that though maximum out-of pocket payments in the Netherlands are relatively low, it is important to have mechanisms in place for individuals who cannot afford them to ensure that people take their medications