NATIONAL PHARMACARE:

Update and Implications for Members

PURPOSE

The Advisory Council on the Implementation of National Pharmacare's Final Report was published on June 12th 2019. This policy brief serves to advise members on the Council's recommendations and present implications for members and for HealthCare*CAN*'s advocacy going forward.

BACKGROUND

Prescriptions dispensed outside of hospitals are not covered in the same way as are other essential medical services, and affordable medications have long been a subject of public debate in Canada's health landscape. In early 2018, the House of Commons Standing Committee on Health published a report advocating a universal, single-payer public prescription drug program.

As part of Budget 2018, the federal government convened an Advisory Council on the Implementation of National Pharmacare to be chaired by Dr. Eric Hoskins who formerly served as Ontario's Minister of Health and supervised the implementation of Ontario's OHIP+ pharmaceutical insurance expansion.

To inform the debate, HealthCare*CAN* published an Issue Brief on considerations for Canada's healthcare organizations in the development of national pharmacare. The implications highlighted included: reducing unnecessary hospital admissions related to the cost of drugs, harmonizing drug formularies, rationalizing limited use criteria, and pharmacare's implications for health and biosciences research funding.

The Interim Report of the Advisory Council, published in March 2019, emphasized three pillars: creating a national drug agency, developing a comprehensive and evidence-based national formulary or list of subsidized medicines, and investing in drug data an information technology (IT) systems capable of tracking prescriptions to ensure smooth deployment of pharmacare and an improved continuum of care overall.

CURRENT SITUATION

The Advisory Council's Final Report lists 60 recommendations, which collectively amount to an ambitious programme of universal, public, single-payer national pharmacare embodying the same principles as Medicare.

Under the Council's proposal certain responsibilities of Health Canada, the Canadian Agency for Drugs and Technologies in Health, the pan-Canadian Pharmaceutical Alliance, and possibly the Patented Medicines Prices Review Board would be consolidated into an arms-length Canadian Drug Agency. That agency would develop and administer a national formulary of subsidized medications, perform health technology assessments, and negotiate prices and supply agreements with drugs manufacturers, monitor the safety and effectiveness of prescription drugs on the market, and administer a strategy to improve access to expensive drugs for rare diseases.

The Council envisions an opt-in financing model governed by a freestanding piece of legislation separate from the Canada Health Act and administered separately from the Canada Health Transfer. Under this model, provinces and territories would receive financing for pharmaceuticals in exchange for meeting certain standards that mirror those of the Canada Health Act. The transfer would take into account demographics and other variables that impact prescription drug consumption, and be reviewed every five to ten years. Under the proposal, any changes to the key elements of pharmacare, including funding, would require approval by the Parliament of Canada and 70 percent of participating provinces and territories, representing two-thirds of their combined populations.

The Council's implementation strategy involves developing an essential medicines list covering most major conditions and representing about half of all prescriptions by January 2022. A more comprehensive list would grow over the ensuing years into a more comprehensive list to be in force by January 2027.

The model contemplated by the Council would involve minimal costs to consumers. Drugs on the essential medicines list would carry a copayment of $2 while all other drugs would have $5 copayments. People receiving social assistance, government disability benefits, or the federal Guaranteed Income Supplement benefit would be exempt from copayments, and no person or household would pay more than $100 per year.

The Council estimates that the annual incremental costs of the program would reach $15.3 billion per year by 2027, and acknowledges the fiscal implications of such a program. The council does note; however, that these costs are lower than what Canada as a whole would be paying otherwise. In effect, the proposal involves shifting costs from private insurers, public insurers, and out-of-pocket expenses onto the federal government. Net costs to Canada as a whole would be lower because of price reductions arising from the larger bargaining power that would accrue to the Canadian Drug Agency.

IMPLICATIONS

The Advisory Council's report was received with greater enthusiasm than expected, given that both the Finance Minister and Prime Minister have previously been on-record expressing reticence towards broad universal programs. While stopping short of an overt endorsement the Prime Minister, the Health Minister, and several prominent Liberal MPs have publicly lauded the Council's work. This may suggest that Pharmacare will feature prominently in the Liberals' party platform for the upcoming election; a possibility with implications for HealthCare*CAN*'s advocacy and the broader administration of healthcare.

Considerations: Advocacy

Liberal enthusiasm for pharmacare would mean that three of the four major national parties have a stake in pharmacare. This opens avenues for HealthCare*CAN*'s public advocacy in the pre-election period. Pharmacare is implicitly connected to two of HealthCare*CAN*'s 2018/2019 advocacy priorities, which HealthCare*CAN* can leverage for the coming election; namely: (1) research support, and (2) investments in digital health.

*Research Support***:** It has been argued that an ambitious Pharmacare programme would limit industry investment in Canada's health research ecosystem as a result of lower drug prices. This may choke off the supports needed to maximize our sector's potential and meet the projections of Canada's Economic Strategy Table (Health and Biosciences). This raises the question: *how will the government compensate Canada's health researchers for lost supports resulting from implementation of national Pharmacare?*

Recommendation 60 of the Advisory Council's final report recommends that "the federal government continue to work with universities, research hospitals and industry to sustain and grow our world class health innovation ecosystem and ensure Canada continues to contribute to the development of innovative drugs and related therapies." HealthCare*CAN*'s continued advocacy will emphasize this recommendation in view of the possible implications of pharmacare for innovation.

Digital Health: As noted above**,** the link between Pharmacare and digital health was made explicit in the Advisory Council's interim report, which advocated. "Invest[ing] in drug data and information technology systems" as one of three 'Foundational Elements' for deploying national pharmacare in any form. The Council elaborated on this theme in Recommendations 56 and 57 of its final report, recommending that "the federal government invest in information technology systems to ensure provincial and territorial governments have sufficient capacity to deliver national pharmacare", and that "the federal government invest in data collection….to address gaps in data and support ongoing management of national pharmacare."

The natural product of this recommendation would be IT infrastructure that can track prescriptions from the doctor's office to the pharmacy. The potential of such investment extends beyond pharmacare, however. With strategic investments in IT, the sector can dispense with the fax machine, develop innovative tests and treatments using wearables or implanted medical devices, and devise new methods of generating and validating clinical insights outside the expensive conditions of a clinical trial.

Considerations: Health Services

In the longer term, the Council's recommendations, if implemented, would carry some implications for the administration of healthcare. These are explored in greater detail in HealthCare*CAN*'s Issue Brief on this topic. Healthcare organizations should be prepared for the transition period if the Council's recommendations are deployed nationwide. Two issues are particularly salient to the delivery of health services.

Local (e.g. hospital) formularies would need to align with a national formulary in the same way they currently do with their provincial or territorial drug formulary. During the transition period the local formulary will likely need to be restructured so as not to encourage prescriptions in-hospital that are not covered in the community setting. Organizations may need to mobilize their Pharmacy and Therapeutics Committees to manage this transition if and when it occurs.

Public drug formularies tend to include more restrictive access criteria than private ones. As a result, a number of patients may lose access to coverage that they held when privately insured. During the implementation of OHIP+ in Ontario there were instances where some facilities admitted patients who otherwise would not have received reimbursement for their medications. National pharmacare may place healthcare organizations in the position of having to make a similar choice. The incidence of such events will depend on how agile the Canadian Drug Agency proves to be in bringing its reimbursement criteria up to speed with current medical practice.

FOR FURTHER INFORMATION

HealthCare*CAN* remains attentive to developments in the healthcare landscape as they relate to pharmacare and will keep members apprised of any developments along these lines. If your organization has any questions, concerns, or feedback in connection with these developments we encourage you to contact us so we can ensure your voice is heard.

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