MINISTERS' ROUNDTABLE ON PAN-CANADIAN PHARMACARE

Summary Report Prepared by Health Quality Ontario

Submitted to the Ministry of Health and Long-Term Care on July 13, 2015

EXECUTIVE SUMMARY FOR MINISTERS

On June 8, 2015, the Honourable Dr. Eric Hoskins, Ontario's Minister of Health and Long-Term Care, hosted a roundtable on pharmacare, in Toronto, Ontario. Including Minister Hoskins, eight ministers participated in the roundtable. The other ministers who participated were:

- The Honourable Glen Abernethy, Northwest Territories' Minister of Health and Social Services
- The Honourable Sharon Blady, Manitoba's Minister of Health
- The Honourable Victor Boudreau, New Brunswick's Minister of Health
- The Honourable Dustin Duncan, Saskatchewan's Minister of Health
- The Honourable Steve Kent, Newfoundland and Labrador's Deputy Premier and Minister of Health and Community Services
- The Honourable Terry Lake, British Columbia's Minister of Health
- The Honourable Greg Ottenbreit, Saskatchewan's Minister Responsible for Rural and Remote Health

In addition to providing a summary of key points made during the presentations, this report provides an overview of the areas where there was broad consensus. Where there was not broad consensus, the report provides a high-level analysis of potential options.

AREAS OF BROAD CONSENSUS

Towards the end of the day, the chair identified several broad areas of consensus, which participants at the roundtable endorsed:

- 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
- 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
- Decisions about which drugs should be paid for publicly should be based on evidence and de-politicized to the extent possible
- A good pharmacare plan would focus not just on providing coverage to the entire population but also on improving the quality of prescribing
- The development of a good pharmacare program would require ongoing evaluation and refinement
- 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

ISSUES TO RESOLVE

The chair also identified several areas where there was not broad consensus; these are framed below as open questions. Some of the comments and thoughts shared by the roundtable participants on these issues are also shared.

Should a Pharmacare Program Be "First Dollar," or Should There Be Some Private Contribution? If the Latter, What Should That Look Like?

Some participants expressed a strong preference for "first dollar" coverage (i.e., patients would have no co-payments, co-insurance, or deductibles). Others expressed the view that this is neither economically efficient nor politically feasible. There was, however, strong support for the notion that cost considerations should not result in patients choosing not to take important medications. One possible option might be to consider a tiered approach:

- Some medications would be on a first tier, with no co-payment, co-insurance, or deductible
- Other medications would be on a second tier, where there might be one or more mechanisms to facilitate a private financial contribution

How Should Those Interested in Developing a Pharmacare Program Engage With the Private Health Insurance, Pharmacy, and Pharmaceutical Sectors?

There was a general consensus that the development of a pharmacare program that aligns with the Triple Aim goals of better health, better experience, and lower costs might have negative ramifications for the private health insurance, pharmacy, and generic pharmaceutical sectors. Some participants at the roundtable expressed the view that a proposal for a pharmacare program should be developed in isolation from the private sector. Others suggested that corporations from these sectors should, at the very least, be consulted in the development of a pharmacare program, and that strategies should be considered to mitigate against losses.

What Will the Reaction to Pharmacare Be From the Public and From Employers?

There was general agreement that we have an incomplete understanding about how the broader public and employers will react to pharmacare proposals, particularly since such proposals create winners and losers and some of the wins and losses would be experienced by the same person. For example, someone who currently holds private health insurance might experience a loss if the tax subsidization of private health insurance were removed, but there could also be a win if the elimination of the tax subsidy resulted in higher wages or if the availability of pharmacare allowed

for greater job mobility. One approach would be to develop a series of scenarios for individuals and employers so that they can see how their own circumstances might change under a range of policy options.

Should the Development of Pharmacare Proceed in an Incremental Fashion, or Would It Be Better to Proceed With a "Big Bang" Approach?

Some roundtable participants advocated strongly for simultaneous implementation of the following: a pan-Canadian formulary, the introduction of outpatient prescription drugs into federal legislation (e.g., the Canada Health Act), pan-Canadian pricing agreements for both generic and brand-name drugs, and the removal of tax subsidies for private health insurance.

Other participants felt that an incremental approach would be more likely to succeed in the current environment, and that many of the elements of a fully comprehensive pan-Canadian pharmacare program could be achieved in this fashion.

Is Federal Government Participation Necessary for the Development of Pharmacare?

Many participants noted that federal government involvement in the development of a pharmacare program would be ideal, and some expressed the view that it would be necessary, particularly from a cost-sharing perspective. Other participants stated however that just as coverage for hospital and physician services was first provided in one province, the development of a pharmacare program could start in one or a subset of provinces. Some participants noted that current differences in approaches to prescription insurance among provinces demonstrate that it is possible for provinces to proceed differently.

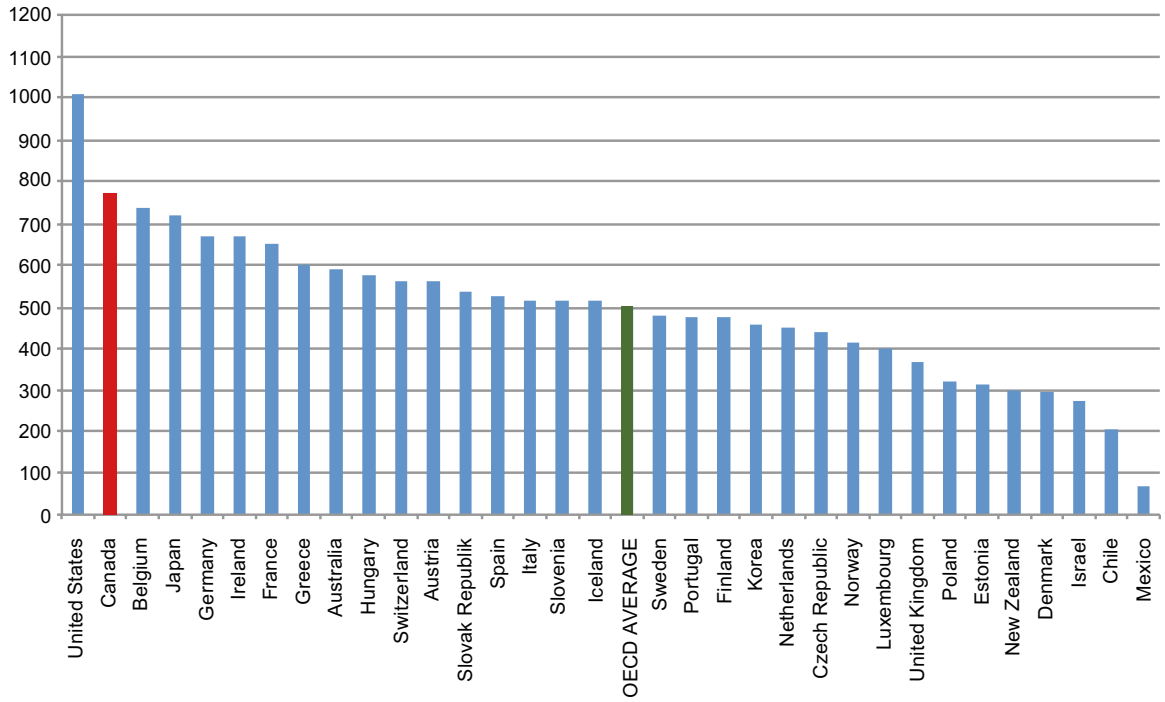
APPENDIX:
KEY POINTS MADE DURING EXPERT PRESENTATIONS

Including both private and public spending, **Canadians spend more per capita on prescription drugs** than residents of any other country in the Organisation for Economic Co-operation and Development (OECD), except the United States (Figure 1).

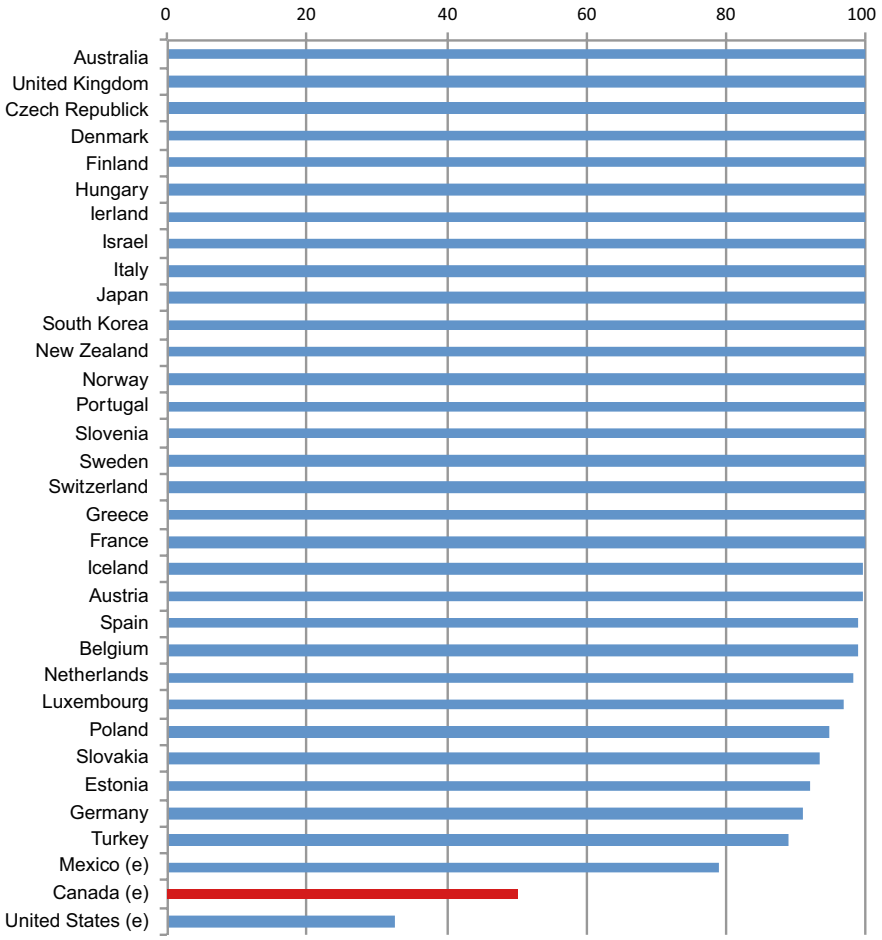
Total expenditure per capita on perscription drugs, 2012 or nearest year

US$, purchasing power party

Source: CIHI, OECD, Health Statistics 2014

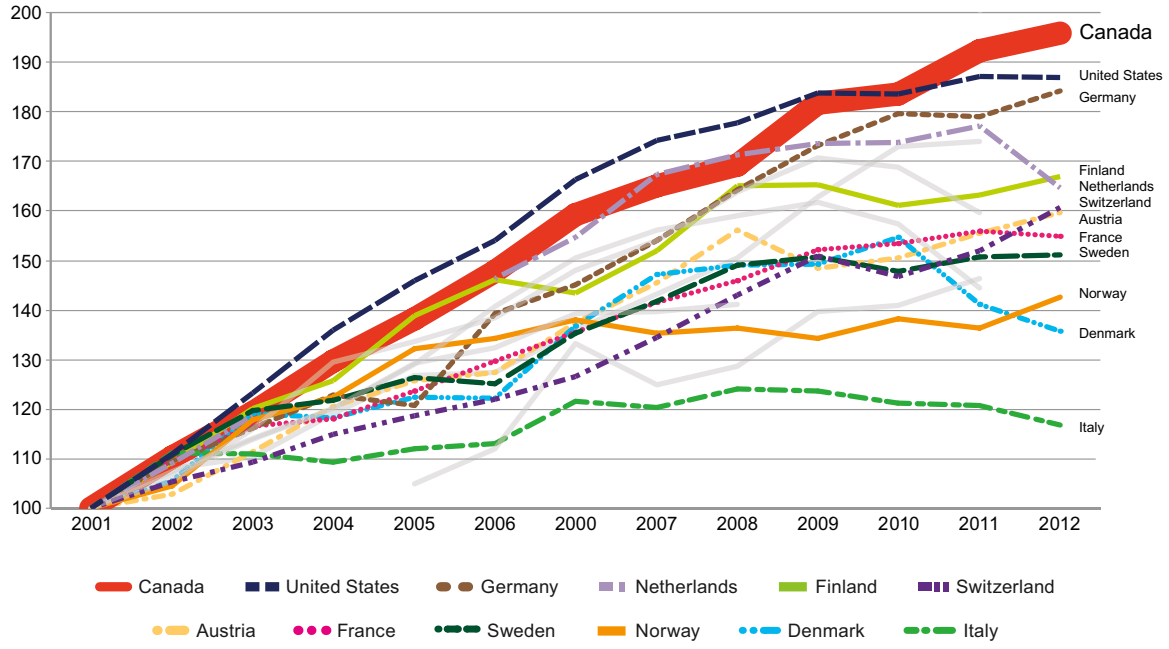


The proportion of people covered by a public drug insurance plan is much lower in Canada than in most other OECD countries (Figure 2).



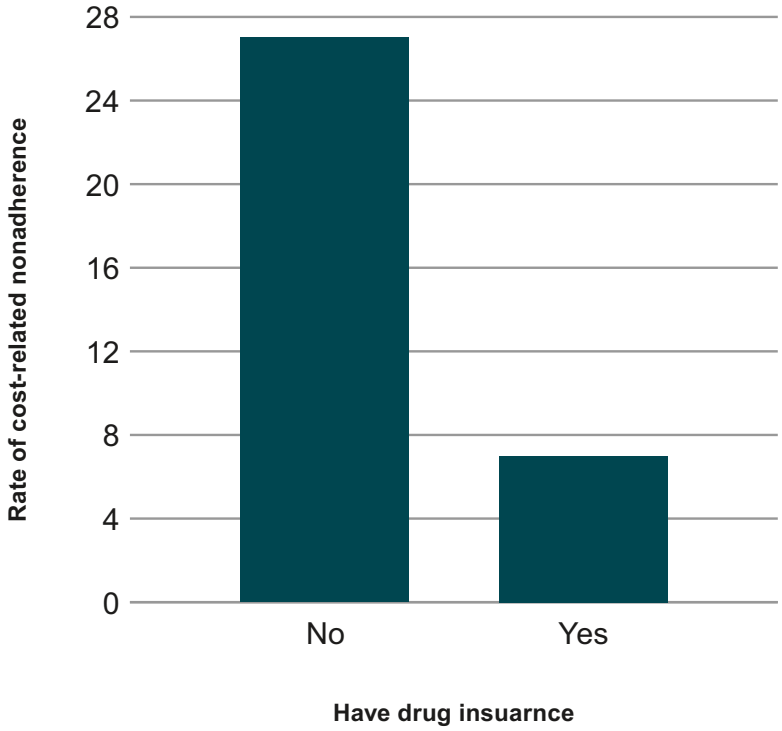
The growth in combined public and private spending on prescription drugs in Canada has been greater than in other countries over the past decade (Figure 3). Even the United States has been better able to control the rate of increase in prescription drug spending over the past few years. One speaker noted that if the approach to drug access had evolved in Canada as it has in Germany, we would be spending $1.7 billion less per annum; and similarly if it had evolved as it has in Denmark, we would be spending $8.5 billion less per annum.

Growth per capita for prescription drug costs, from 2000 to 2012 (international comparison based on PPP; 2000=100)



Several provinces have achieved universal coverage, at least for very expensive drugs, but these programs have not **eliminated patient concerns about affordability and access.**

The burden of medication affordability is disproportionately borne by the poor, those who are ill, and those without insurance. The most important of these factors is likely the lack of insurance for prescription drugs, (1) with cost-related non-adherence reported by about 26.5% of those with no insurance and only 6.8% of those who had insurance (Figure 4).



A good system would be easy for patients to use. Several participants noted that current programs are complicated for applicants. Many participants felt that a successful approach to pharmacare would eliminate confusing paperwork, complex eligibility rules, and long application processing times.

A good system would provide more transparency, especially about prices. Several participants noted that the current system of prescription drug regulation and pricing is unnecessarily opaque. In particular, several panellists noted that physicians are unable to make optimally cost-effective prescribing decisions without full information about the price at which prescription medications are being purchased.

Copayments are associated with a reduction in the use of prescribed medications, and an increase in adverse health outcomes. One study conducted by researchers in Quebec showed that the use of essential drugs decreased by 9% after the introduction of copayments, and that emergency department visits related to

reductions in the use of essential drugs increased by 14%. (2) Conversely, in a large American randomized trial, the provision of free medications to patients who had suffered a heart attack was shown to improve medication adherence and decrease patient spending, without increasing overall health costs. (3)

There are various mechanisms that can be used to control public spending, including closed formularies and "closed budgets." Several experts noted that Canada has been a leader in health technology assessment, but that with each jurisdiction maintaining its own formulary, the pressure to add individual prescription medications to provincial and territorial formularies may be greater in Canada than it is in other countries. Many experts suggested the creation of a national formulary, with the Canadian Agency for Technologies and Drugs in Health taking the lead role in its establishment. Several experts also noted that establishing a closed budget for prescription drugs, as is done explicitly in New Zealand, would force even more efficiency, as it would strongly encourage careful thinking about not just whether medications are paid for publicly, but also how medications are being prescribed and used.

Using independent experts would help ensure that decisions about resource allocation are based on evidence, not political considerations. Several experts noted that the "de-politicization" of decisions regarding which drugs are paid for publicly is highly desirable since it allows for a focus on evidence of clinical effectiveness and value for money, rather than on lobbying and advocacy. Several experts and participants also noted that the same principle holds for other resource allocation decisions (e.g., which patients should be eligible for particular medications, and what techniques the public payer can use to ensure that prescribing decisions are appropriate).

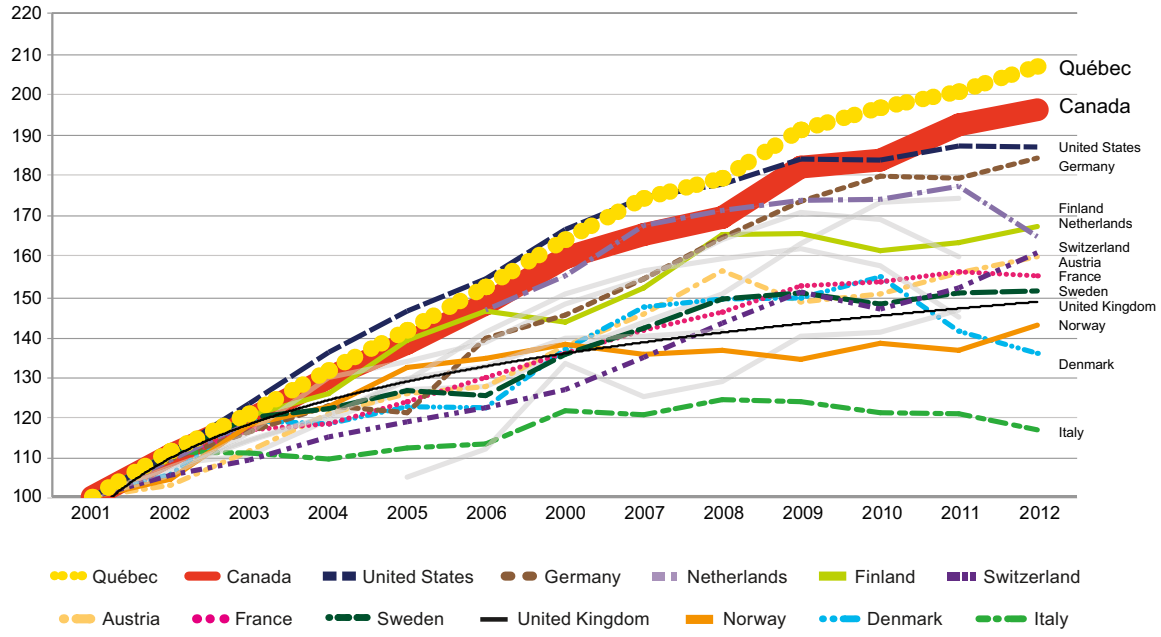
Private health insurance plans in Canada have generally been overly expansive in their coverage and too permissive in their approach to guiding and monitoring prescribing. While having fairly obvious advantages for patients and physicians, this has posed two problems for public insurers in Canada: first, patients expect similarly broad coverage from public plans; second, because private health insurance plans in Canada generally do not scrutinize prescribing decisions, some physicians have come to expect a similar lack of scrutiny and oversight from public plans and tend to resist efforts to improve the quality of prescribing through mechanisms such as prior authorization.

The subsidization of private health insurance is inefficient and inequitable. Several participants noted that the current system of exempting employer contributions to private health insurance premiums is both inefficient (because it encourages higher spending than might otherwise be the case) and inequitable (because the subsidy increases as individuals move into higher tax brackets).

Exploring different approaches to pricing and purchasing that are different from those used currently could save substantial amounts of money, especially with respect to generic medications. Several experts and participants argued that arbitrary thresholds (e.g., 18% of the price of a patented medication) result in Canada overpaying for generic medications. One expert noted, for example, that a major Canadian generic producer charges less for generic medications in New Zealand and the United States than it does in Canada. Several experts and participants noted the importance of cooperation among provinces and territories, and ideally also the federal government, in regulating and negotiating prices.

The Quebec approach to pharmacare has been more expensive than predicted. As shown in Figure 5, compared with Canada, Quebec has experienced a greater increase in combined public and private spending on prescription drugs.

Growth per capita for prescription drug costs, from 2000 to 2012 (international comparison based on PPP; 2000=100)



There will be "winners" and "losers" in the development of pharmacare. Several experts noted that although the development of pharmacare will be a net benefit to Canadians, it is important to recognize that there will also be losers, (4) and that developing strategies to mitigate against these losses will be helpful. Evidence suggests that the private health insurance industry in Canada has become increasingly inefficient over time (5); as a consequence, attempts to improve efficiency are likely to have a negative effect on this particular sector. The development of pharmacare may also adversely affect the pharmacy sector and the pharmaceutical industry, particularly the generic pharmaceutical sector.

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