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Universal prescription drug coverage in Canada: Long-promised yet undelivered

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Abstract

Canada's universal public healthcare system is unique among developed countries insofar as it does not include universal coverage of prescription drugs. Universal, public coverage of prescription drugs has been recommended by major national commissions in Canada dating back to the 1960s. It has not, however, been implemented. In this article, we extend research on the failure of early proposals for universal drug coverage in Canada to explain failures of calls for reform over the past 20 years. We describe the confluence of barriers to reform stemming from Canadian policy institutions, ideas held by federal policy-makers, and electoral incentives for necessary reforms. Though universal "pharmacare" is once again on the policy agenda in Canada, arguably at higher levels of policy discourse than ever before, the frequently recommended option of universal, public coverage of prescription drugs remains unlikely to be implemented without political leadership necessary to overcome these policy barriers.

Introduction

Canadians take pride in their universal public health insurance system, a system affectionately (though not formally) known as "Medicare." A 2005 poll even found 85% of Canadians believed the elimination of public healthcare would be a "fundamental change to the nature of Canada."[1] But Canada's Medicare system is unique insofar as it is the only universal public health insurance system among developed countries that does not include universal coverage of prescription drugs used outside the hospital setting. This is a significant health policy puzzle: given the importance of pharmaceuticals in modern healthcare, how can a system of universal health coverage in a wealthy country like Canada effectively end when a patient is handed a prescription to fill?

The absence of universal coverage for necessary medicines is a significant limitation of the Canadian healthcare system. It creates problems in terms of the accessibility of medicines, financial burdens on patients, and overall system costs. Approximately 1 in 10 Canadians cannot afford to take their medicines as prescribed, which is a far higher rate of cost-related non-adherence to prescribed treatments than is found in comparable countries.[2-5] Canadian and international research shows that such barriers result in worse health outcomes—including premature deaths for common conditions such as diabetes[6]—and increased demand on other components of the healthcare system.[7-9] Canadians who do fill their prescriptions bear greater financial burdens than patients in other countries, owing both to a lack of drug coverage for many citizens and to relatively significant cost-sharing in both public and private drug plans in Canada.[5,10] Finally, the fragmented nature of prescription drug financing in Canada, as well as its isolation from the financing of medical and hospital care, results in higher total per capita expenditure on pharmaceuticals in Canada than any other Organisation for Economic Co-operation and Development (OECD) country with universal health coverage.[5,11-13]

In this article, we use research findings on the failure of early proposals for universal drug coverage in Canada to help explain failures of similar proposals over the past 20 years. Based on the theory and available evidence, we offer cautious predictions about the prospect of Canada achieving a system of universal drug coverage stemming from current policy debates, which have arguably brought the issue to higher level of policy discussion than ever before. We argue that a key unknown factor in the current debates is the degree to which national leaders, particularly the prime minister, accept the importance of—and are willing to act on—the repeated recommendations to implement universal pharmacare in Canada. The policy ideas of federal policy-makers have been a barrier to pharmacare reforms in the past, and there is some indication they may be changing. However, we argue that if this change in ideas is to align with institutional and electoral opportunities for reform, it will have to occur quickly.

Health and pharmaceutical coverage in Canada

Healthcare in Canada falls under provincial jurisdiction; however, since the early 1970s, all Canadians have received comparable public insurance for physician services and hospital care through federal and provincial cooperation on related policies.[14,15] At the risk of oversimplifying, Canada's federal government provides financial transfers to provinces that offer health insurance meeting standards defined in federal

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legislation. The most recent version of these standards is set out in the 1984 Canada Health Act and includes requirements that health insurance be universal, publicly administered, portable across provinces, comprehensive of all medically necessary physician services and hospital care, and offered without direct charges to patients.[14,15] All provinces comply with those standards and receive approximately $1,000 per capita in annual federal health transfers as a result.[16]

Though medicines used in acute care hospitals are 100% publicly financed—in accordance with national standards of the Canada Health Act—there are no national standards for the coverage of prescription drugs outside of hospitals in Canada. As a consequence, prescription drug coverage in Canada is offered through a patchwork system of private and public drug plans that varies considerably across the country and leaves many Canadians with little or no drug coverage at all.[17,18]

The federal government provides drug coverage for select populations (eg, eligible First Nations people and Inuit), which account for 2% of prescription drug expenditure in Canada.[19] Provincial governments currently finance between 28% and 41% of prescription drug expenditure in their jurisdictions through public drug plans that differ significantly in terms of who is eligible (eg, the very poor, the very sick, and/or the elderly) and what beneficiaries must pay (eg, premiums, deductibles, and/or co-insurance).[18,19] Private drug plans are voluntary in all provinces except Quebec (where private insurance is mandatory for eligible workers) and account for 35% of total prescription drug costs in Canada.[17,19] Finally, 22% of prescription drug spending in Canada is financed out-of-pocket by patients because approximately 11% of Canadians have no prescription drug coverage and many Canadians with private or public coverage face sometimes considerable deductibles and other direct patient charges.[2,19]

A total of 20% of Canadians report being uninsured or underinsured insofar as a majority of their prescription drug costs are paid for out-of-pocket.[2] Though Canadians of almost any age or income may lack drug coverage depending on where they live and work, Canadians most likely to be uninsured or underinsured for prescription drugs are those working in small- and medium-sized businesses, low-wage earners, non-union workers, and part-time workers.[2,17-20] Without changes in policy, these numbers of under- and uninsured Canadians will rise because a growing share of Canadian employers are reducing workplace and retirement health benefits and placing annual and lifetime caps on coverage owing to high prescription drugs costs.[21-23]

The health and health system effects of the gaps in coverage in Canada are significant. Repeated surveys have shown that cost-related non-adherence to prescribed treatments is common in Canada and high by comparison to other countries—with the notable exception of the United States, where gaps in coverage are even greater than in Canada.[2-4,24-27] In Ontario, researchers have shown that income-related disparities in access to treatment are greater among working-age people with diabetes—who may or may not have private insurance depending on their occupation—than among people with diabetes over age 65—who received comprehensive public coverage by way of their age.[6] The disparities in access to diabetes treatment among working-age Ontarians were estimated to cause over 700 premature deaths per year.[6]

Patients who qualify for public drug coverage also experience barriers accessing necessary medicines in Canada. This is because of increased use of cost-sharing tools such as deductibles and co-insurance.[18,28] For example, in both Quebec (1997) and British Columbia (2003), increases in public drug plan deductibles and copayments for beneficiaries of public drug plans were associated with reduced use of essential medicines, increased hospitalizations, and increased use of medical care.[29-34] Such policies reduce government spending on drugs, but because they are known to impede access to essential treatments, they can end up costing the health system more money in the long run.[7-9]

Fragmentation of Canada's system also leads to increased costs. The direct cost of managing dozens of public drug plans and hundreds of private drug benefit programs—including the costs of public plan administration and coverage decision-making, as well as private plan marketing, risk adjustment, and profits[35]—are estimated to be $1 billion greater than the cost of managing a single-payer insurer in each province.[5,11] Furthermore, having multiple, competing payers in the Canadian system fragments purchasing power and thereby results in some of the highest brand name and generic drug prices in the world.[13,36-39] Finally, the separation of prescription drug financing from financing of medical and hospital care creates inefficiencies in resource allocation across components of healthcare: a classic "silo mentality" problem wherein managers of different drug plans do not have the opportunities or incentives to consider the net costs and benefits of pharmaceutical versus non-pharmaceutical care.[5]

Incentives and capacity for system-level efficiency are particularly low in the private insurance sector that operates within Canada's publicly financed medical and hospital care system. Most voluntary prescription drug plans are negotiated within the context of complex and politically charged labour negotiations that have more to do with the perceived generosity of the benefit than the clinical rationality of what is being covered for whom.[40] Furthermore, it is estimated that approximately $5 billion spent by employers on private drug benefits is wasted because private drug plans are not well positioned to manage prescribing and dispensing decisions of Canadian health professionals.[41]

As a consequence of these various forms of inefficiency, Canadians spend considerably more per capita on pharmaceuticals than comparable countries with universal, publicly financed healthcare systems that include universal, public coverage of prescription drugs.[5,11-13,42,43] As shown in Figure 1, the level of per capita spending on pharmaceuticals in Canada has long been higher and growing faster than in other countries. Pharmaceutical expenditures per capita in Canada is now 25% greater than the next highest-spending comparator country (Germany), 42% higher than the median of comparable health systems, and approximately double the

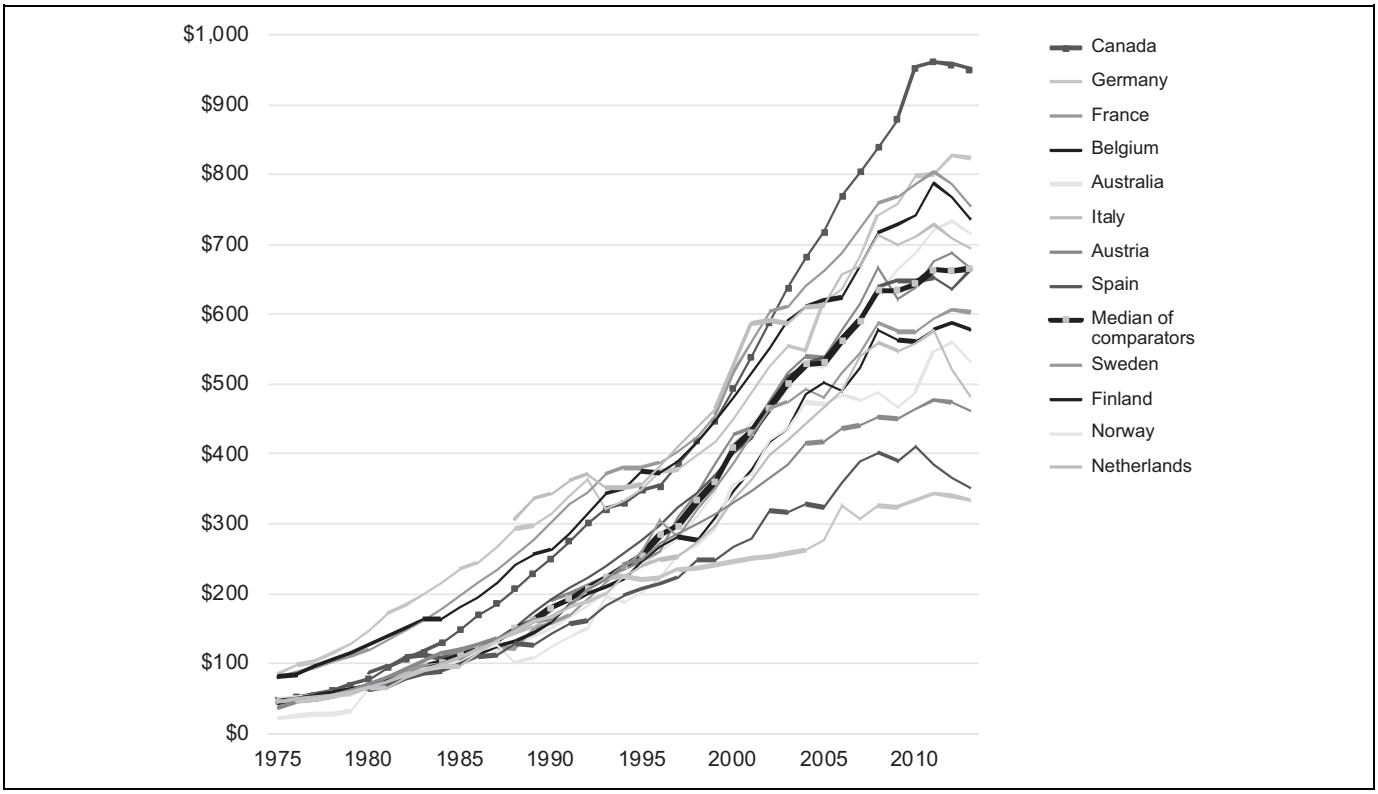

Figure 1. Total pharmaceutical expenditure per capita, Canada and comparator countries with universal health systems, 1975-2013, real (inflation-adjusted) 2013 Canadian dollars. Author's calculations based on Organisation for Economic Co-operation and Development (OECD) Health Data.[42]

levels found in the Netherlands, the United Kingdom, Denmark, and New Zealand.

Universal, public coverage for prescription drugs has been recommended by major national commissions on healthcare in Canada dating back to the 1964 Royal Commission on Health Services (the Hall Commission), which provided a blueprint for developing Canada's nationwide medical insurance program.[44] Then, as now, a policy of universal drug coverage within Canada's public health insurance system was referred to as pharmacare—to complement Canadian Medicare.

Though national standards for Medicare were established almost immediately following the Hall Commission, no progress was made on pharmacare. However, calls for pharmacare resurfaced with the 1997 National Forum on Health, an advisory commission chaired by then Prime Minister Jean Chrétien. The National Forum recommended that federal and provincial governments implement universal public coverage of prescription drugs selected based on the evidence of comparative cost-effectiveness.[45,46] Shortly after that, the 2002 Royal Commission on the Future of HealthCare in Canada (the Romanow Commission) recommended that federal and provincial governments " . . . begin the process of integrating coverage for prescription drugs within Medicare as part of a longer term strategy to ensure all Canadians benefit from comprehensive prescription drug coverage."[47(pxxxii)] The Romanow Commission made a variety of related recommendations concerning the evaluation, pricing, and prescribing of medications in Canada that were described as ways to " . . . lay the groundwork for the ultimate objective of bringing prescription drugs under the Canada Health Act."[47(p190)]

Barriers to reform

Elsewhere, one of us has described how pharmacare's initially low place on the policy agenda, combined with Canada's slow, incremental process of health policy development, created significant barriers to implementation of the early proposals for universal drug coverage in Canada.[48,49] These barriers can be viewed as the consequence of policy institutions, ideas held by policy-makers, and electoral incentives.

Institutions are the rules and regulations that govern the behaviour of actors within a policy system and include the allocation of responsibilities and patterns of policy-making in federations like Canada's. Ideas are beliefs about policy problems and solutions that influence the choices and actions of political actors,[50] including causal beliefs about the effectiveness and affordability of policy options—whether or not such beliefs are consistent with available evidence. Finally, electoral incentives are factors that motivate politicians to act, including the extent to which a particular course of action will be supported by voters and whether actions might be met with opposition of organized interests.

Table 1. Governing federal and provincial parties at key periods of policy debate concerning universal prescription drug coverage in Canada

Jurisdiction	2015 population (millions)	Hall Commission (1964)	National Forum on Health (1997)	Romanow Commission (2002)	Today (2016)
Canada (federal)	35.85	Liberal until 1979	Liberal until 2006	Liberal until 2006; CPC 2006-2015	Liberal
Ontario	13.79	PC until 1985	PC until 2003	PC until 2003; Liberal 2003 until present	Liberal
Quebec	8.26	Liberal until 1966; UN 1966-1970	PQ until 2003	PQ until 2003; Liberal 2003-2012	Liberal
British Columbia	4.68	Socreds until 1972	NDP until 2001	BC Liberals until present	BC Liberals
Alberta	4.19	Socreds until 1971	PC until 2015	PC until 2015	NDP
Manitoba	1.29	PC until 1969	PC until 1999	NDP until 2016	PC
Saskatchewan	1.13	Liberal until 1971	NDP until 2007	NDP until 2007; SK Party 2007-	SK Party
Nova Scotia	0.94	PC until 1970	Liberal until 1999	PC until 2009	Liberal
New Brunswick	0.75	Liberal until 1970	Liberal until 1999	PC until 2006; Liberal 2006-2010	Liberal
Newfoundland and Labrador	0.53	Liberal until 1971	Liberal until 2003	Liberal until 2003; PC until 2015	Liberal
Prince Edward Island	0.15	PC until 1966; Liberal 1966-1979	PC until 2007	PC until 2007	Liberal

Abbreviations: BC Liberals, British Columbia Liberal Party (conservative); CPC, Conservative Party of Canada; NDP, New Democratic Party (progressive); PC, Progressive Conservatives; PQ, Parti Québécois (progressive, separatist); Socreds, Social Credit (conservative); SK, Saskatchewan (conservative); UN, Union Nationale (conservative, separatist).

We review and extend lessons concerning the effects of these influences on pharmacare policy development in Canada since the 1997 National Forum on Health. We address the roles of institutions, ideas, and electoral incentives in turn, recognizing the interrelated ways in which they shape policy processes.

Policy institutions

Although the early pharmacare proposals faltered at the federal level before becoming a serious issue for intergovernmental consideration,[48,49] the federal government's lack of jurisdiction over healthcare is potentially an important obstacle to national pharmacare. Nationalizing standards for a policy like pharmacare would require considerable cooperation between federal and provincial governments. Prospects are greatest if the national vision and plan are acceptable to the federal government and a significant majority of Canada's 10 provinces, including the largest provinces of Ontario and Quebec, which, respectively, account for 38% and 23% of Canada's population (see Table 1).

Although the Liberal Party of Canada governed federally during the Hall Commission, National Forum, and Romanow Commission, provinces were not politically aligned at those times. As shown in Table 1, during key periods of policy debate concerning universal prescription drug coverage in Canada, separatist parties governed in Quebec and/or conservative parties governed in Ontario and several other provinces. And, shortly after Liberal governments were elected in Ontario and Quebec in 2003, the federal Liberal government was reduced to minority government status in 2004. In 2006, the federal Liberals were replaced by the Conservative Party of Canada—a party that took a strict constitutionalist stance that healthcare (including pharmacare) was strictly a provincial policy.

The failure of the 1997 National Forum pharmacare recommendation illustrates both the importance and the challenge of having provincial alignment with a national vision in Canada's federation. Just months prior to the National Forum's recommendation for universal, public drug coverage in Canada, Quebec implemented a universal prescription drug plan that was based primarily on compulsory private insurance for all eligible workers.[51] Having just implemented this policy, the Quebec government was unlikely to support any national approach that differed from it. Furthermore, at that time in Canadian history, the federal government was unlikely to even attempt to use its spending power to encourage Quebec to comply with differing national standards. Just 2 years earlier, 49% of Quebecers voted in favour of a referendum to proclaim Quebec's national sovereignty—a near majority that is attributed, in part, to the view that Quebec's local policy preferences were being ignored in federal efforts to achieve national standards on government programs.[52]

Similar assertions of Quebec independence in pharmaceutical policy followed the 2002 Romanow Commission. Quebec refused to participate in the Common Drug Review, a centralized review process for new drugs established in 2003 on behalf of all federal, provincial, and territorial drug benefit plans.[53] Quebec also refused to join a Ministerial Task Force that was to guide the development and implementation of the National Pharmaceutical Strategy, established as part of the 10-year federal, provincial, and territorial Health Accord signed in 2004.[54] Indeed, the 2004 National Pharmaceutical Strategy failed at least in part because of differing views of federal and provincial governments.[55]

The division of jurisdictional responsibility and provinces' desires for autonomy on matters under their jurisdiction are not the sole reasons that past recommendations for universal pharmacare have failed. But, in the context of Canada's relatively

decentralized federation, they were likely among the forces that explain the lack of action on recommendations of recent national commissions.

Ideas of policy-makers

Misalignment of ideas within governing parties at the federal level is another reason past pharmacare proposals have not been adopted. Federal policy-makers have been wary of the costs of public drug coverage since its earliest mention in Canadian health policy debates in the late 1940s and early 1950s.[48,49] It is unclear why concerns about costs were so powerful before the therapeutic revolution of the 1960s made pharmaceuticals significantly more effective and expensive, while similar countries such as Australia and the United Kingdom were adopting universal public drug programs. The idea nevertheless penetrated Canada's federal cabinet and shaped early policy outcomes.[48,49]

The idea that a universal drug plan would result in runaway demand and high program costs persisted among governing federal officials through the reform proposals of the 1990s and early 2000s. For example, a policy advisor reflected on the 1997 National Forum proposal, saying, "The fear of opening the floodgates to something hugely expensive and uncontrollable [like pharmacare], which you could never take away from anybody, was there for everybody."[48(p439)] Similarly, a senior federal official involved in planning intergovernmental Health Accords following the Romanow Commission noted, "We [had] a number of priorities overall. Getting deeply into in this one [pharmacare] could be very expensive and could detract from our focus on those other areas."[48(p444)]

A national plan for universal drug coverage would not be implemented by a federal government that did not believe it would succeed, regardless of whether that belief was grounded in evidence. As such, the ideas of governing political parties—particularly at the federal level—have undoubtedly been a barrier to Canadian pharmacare reforms in the past.

Electoral incentives and interests

A final obstacle to implementation of past recommendations for universal pharmacare in Canada is the lack of electoral incentives for such actions, which are a function of expected voter support and stakeholder opposition. In terms of issue salience in the minds of voters, pharmacare has historically received less attention than other health policy debates in Canada. At the time of early pharmacare recommendations, prescription drugs were not as critical to healthcare delivery as they are today. Yet, even in the 1990s, when medicines had become a cornerstone of modern healthcare, Canadian media coverage of pharmacare-related issues was far less extensive than other health policy topics in Canada.[56]

Over the past 20 years in particular, the way pharmacare has been framed as a policy issue has likely diminished political incentives for program adoption. The historical focus of Canadian Medicare on only physician services and acute hospital care may have created a framing effect wherein Canadians are more concerned about the erosion of existing entitlements than about the expansion of benefits.[57] Indeed, when media coverage of pharmacare contained substantive policy themes in the 1990s and early 2000s, those themes were often concerns about the viability of the existing public health insurance programs in the face of costs arising from expended pharmaceutical coverage.[58] As with the effect of the ideas of governing policy-makers, there would have been little public appetite for reform to the extent that the public perceived pharmacare as a possible threat to the quality or comprehensiveness of their core Medicare benefits—whether or not those beliefs were consistent with the evidence.

A related barrier to pharmacare reforms in Canada stems from how electoral incentives have been shaped by the institutional legacy of private drug coverage in Canada. As had happened with health insurance in the United States, the evolution of a patchwork of public and private insurance for prescription drugs in Canada altered interests in ways that gradually diminished electoral incentives for universal pharmacare.[59] With public drug coverage in place for the poor and the elderly in most provinces, and voluntary private insurance available for many (though certainly not all) working Canadians, by the time the National Forum was recommending a universal pharmacare program, such a policy would have offered few direct benefits for large portions of the voting population.

The institution of private drug coverage also created a relatively concentrated interest group that opposes universal pharmacare in Canada, particularly in the post–National Forum era. Until 1997, most private health insurance in Canada was offered through not-for-profit mutuals and cooperatives. However, following regulatory changes in 1997 and 1998, for-profit companies quickly grew to account for approximately 80% of the private health insurance market in Canada, whereas administrative costs and profits grew significantly as a share of total health insurance premiums collected.[35,60] Today, private insurers cover over $10-billion prescription drug costs in Canada.[19] Universal, public pharmacare would threaten a significant share of that revenue.

Other interests that benefit from the status quo include the manufacturers and retailers of prescription drugs. It is estimated that a universal, public drug plan in Canada could lower total spending on prescription drugs by approximately 30%.[11,12] Every dollar of spending in a healthcare system is a dollar of someone's income; thus, every dollar of savings from reduced drug costs is a dollar of lost income to someone.[61] Manufacturers and retailers therefore could lose billions of dollars in sales and markups under the recommended, single-payer pharmacare system for Canada, even if universal drug coverage increased the use of medicines for the under- and uninsured. As in the United States, significant opposition to the single-payer insurance model can be expected from such commercial interests.[62-64] As with governments around the world, Canadian governments are unlikely to take on such opponents unless there is strong public support for doing so.

Discussion

Canada's Medicare system is unique among developed countries insofar as it is the only universal public healthcare system that does not include universal coverage of prescription drugs. Universal pharmacare has been recommended by national commissions in Canada, dating back to the 1960s, but it has not been adopted owing to a confluence of barriers stemming from Canadian policy institutions, ideas held by federal policy-makers, and electoral incentives for reform. Universal pharmacare is, however, once again on the policy agenda in Canada.

Since 2010, provinces have been voluntarily collaborating on prescription drug pricing through a pan-Canadian Pharmaceutical Alliance; and some provinces, most notably Ontario, are calling for federal–provincial collaboration to establish a universal pharmacare program.[65-67] During the 2015 federal election, three political parties, including the now-governing Liberal Party of Canada, promised to make prescription drugs more affordable in Canada—some specifically promising a universal, public pharmacare program.[68] In January 2016, when Canada's federal, provincial, and territorial health ministers met for the first time in many years, they created a working group to explore policies aimed at improving coverage of and access to medicines for all Canadians.[69] And in March 2016, the multi-party Standing Committee on Health of the federal House of Commons began a study on the "Development of a National Pharmacare Program." This is arguably the most attention paid to the issue at federal and provincial levels since the 1960s.

Will this round of pharmacare policy debate result in significant national reforms in Canada? There are institutional-, ideational-, and electoral incentive-related reasons to believe the opportunity for reform is different now. In terms of policy institutions, moderately progressive parties are currently in power federally and in 7 of 10 provinces. Many of these governing parties—including parties governing in Ontario, Quebec, and federally—are Liberal parties that share a common base of political support. This is an exceptionally rare alignment of Canadian governments—arguably one not seen during the history of pharmacare discussions in Canada.

In terms of policy ideas, although it is unclear whether the current federal Liberal party holds the historical view that a pharmacare system would be excessively costly, it has allowed a standing committee to study the issue in-depth. There is also far more research evidence (and expert consensus) than ever before, with prominent peer-reviewed research highlighting the problems with Canada's fragmented system of drug coverage as well as the potential savings from a single-payer pharmacare program.[43]

Finally, in terms of electoral incentives, public opinion now seems to provide some incentive for action. A national survey in 2015 found that 91% of Canadians supported the concept of a national pharmacare program that would provide universal access to prescription drugs.[2] Furthermore, between 2014 and 2016, universal pharmacare was endorsed by the Canadian Nurses Association, the Canadian Medical Association, the Federation of Canadian Municipalities, a group of 281 university professors from across Canada, several national unions, and even the British Columbia Chamber of Commerce. The idea would therefore appear to have a broad base of support from a variety of constituencies.

Conclusion

Historical obstacles to universal pharmacare in Canada have been many. And while much has changed in this policy file, some obstacles remain and others appear as the debate gets closer to actual program adoption. A universal drug plan could improve access to care while reducing overall spending on pharmaceuticals in Canada. But to do this requires a compelling vision that is shared by a majority of governments in Canada and, importantly, by a majority of voters because such reforms are also a potential threat to provincial autonomy in health care and a real threat to commercial interests in the sector. Someone must champion pharmacare reforms at the national level; and, as of yet, the new federal Prime Minister Justin Trudeau has been silent on the issue.

The Prime Minister's silence may have to do with longer-term political strategies and aspirations that may not be well timed with political realities at the provincial level. The federal Liberal party has signalled that universal pharmacare is a reasonable goal for Canada but one that is not to be done during its current mandate. They may therefore be hoping that pharmacare can be among the promises that would make them re-electable in the next federal election, scheduled for October 2019. However, both Quebec and Ontario are scheduled to have provincial elections in 2018 and may well experience a change in government. In these provinces, governing Liberal parties are currently polling slightly ahead of their nearest opposition parties (Quebec) or slightly behind (Ontario).[70] Other key provinces, such as Alberta (provincial election in May 2019, with current government trailing in polls), may also see progressive governments lose office before the federal Liberals could play that political long-game with national pharmacare.[70]

There is no doubt that Canada needs a system of universal drug coverage, nor is there doubt that the best possible solution would be a program appropriately integrated with Canadian Medicare. But institutional, ideational, and interest-related barriers to such a policy are strong. There is still a chance that it might happen in the near future. Indeed, Canada's prime minister has a good deal of political capital at the moment, and he might wish to make this one of his lasting legacies. But windows of opportunity for national reforms of this scale in the Canadian federation are fleeting. So, if Prime Minister Trudeau wants to make pharmacare happen—60 years after it was first recommended—he will have to make it happen fast. Failing that, Canada will likely be waiting another decade before the issue comes back again—perhaps as a result of yet another national commission on the healthcare system.

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