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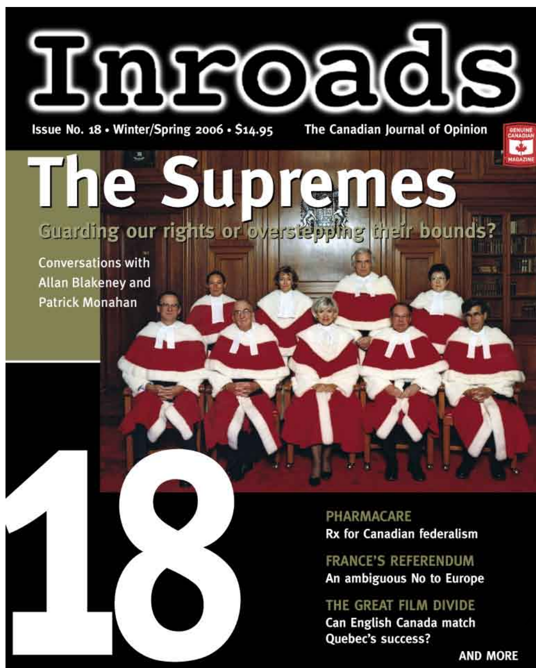

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JOURNAL Inroads 18

Federal pharmacare

Prescription for an ailing federation?

by Greg Marchildon

FOR THE PAST SIX YEARS, HEALTH CARE HAS BEEN AT THE TOP OF THE federalism music chart. During this time, first ministers' meetings have become a set piece. Before the meeting is called, the premiers demand more money for health care from Ottawa – knowing that they will not get what they are asking for. The prime minister brushes off these initial demands in public, but meanwhile the federal government enters into private negotiations with the provinces to reach an agreement. Once the dollar figure is in the federal ballpark, the prime minister schedules a formal meeting.

The exception to this pattern was the September 2004 first ministers' meeting that produced the so-called "Ten Year Plan to Strengthen Health Care." In contrast to earlier meetings, Prime Minister Paul Martin made no real attempt to get even a rough agreement in advance. The premiers went into the meeting with their largest-ever demand: that the Prime Minister put enough money into the Canada Health Transfer to close what they called "the Romanow gap" (see glossary on page 96) and that the federal government also take over provincial drug plans. While no precise dollar figure was produced for the drug proposal, the provinces were in effect asking Ottawa to pony up close to $8 billion annually, the amount they were collectively spending on prescription drugs for their respective residents.

At the time, Premier Ralph Klein of Alberta congratulated himself and the other premiers for their "stroke of brilliance." Indeed it might have been, but only if the premiers had walked in with a workable blueprint of how such a major innovation would improve prescription drug coverage at a reasonable cost and simultaneously facilitate health reform. Instead, they came to the first ministers' meeting without even a sketch of what a federal pharmacare program would look like, much less accomplish. They thereby confirmed the sceptics' conclusion that the premiers' offer was about cost-shifting, not about improving health care for Canadians.

Given the ephemeral nature of the provincial pharmacare proposal, it was relatively easy for Martin to brush it aside and focus on the reduction of wait lists. This was the item at the top of his agenda, even though it fell entirely within provincial control and jurisdiction. On the pharmacare proposal, the Prime Minister stuck to the short-term recommendations in the Romanow and Senate reports of 2002, and asked that some of the federal money be used to improve catastrophic drug coverage while shunting consideration of the pharmacare proposal to a federal-provincial ministerial committee. Here, it will be dead easy – and publicly justifiable – for Ottawa to veto any ambi-

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tious proposal on federal pharmacare given the already huge amount that it is transferring to the provinces as part of the Ten Year Plan deal.

It is also unfortunate. Only by transforming public drug policy will we be able to tackle the real sustainability problem in health care. Going one step further, by initiating major reform to the way in which drugs are currently prescribed and used, we can dramatically improve primary care, home care and long-term chronic care. Without major changes to our federal-provincial arrangements for the administration, delivery and funding of public prescription drug programs, we are unlikely to ensure "that the right patients are getting the right drugs ... at the right price," at a reasonable and sustainable cost to governments and taxpayers.[1] Drugs already constitute the second biggest piece of the health care pie, less than hospital care but more than physicians' care (see figure 1).

The Romanow Commission laid out an incremental strategy to achieve significant change in how we organize the use of pharmaceuticals in the provision of health care. The catastrophic drug transfer program it recommended was to be only the first step toward creation of a National Drug Agency, establishment of a national drug formulary, introduction of more effective management and monitoring of drug utilization, and regulatory changes aimed at lowering the price of generic drugs and limiting the inflationary impact of new patented drugs.[2]

There has been little to no movement on this transformative agenda, in part because of the current division of responsibilities for prescription drug care. The federal government has virtually all the regulatory tools, while the provinces are responsible for designing, administering and funding their respective prescription drug subsidy plans. Alone, neither order of government is capable of addressing the financial sustainability problem or initiating thoroughgoing change in drug utilization patterns. Given the current stalemate, the time may have come to consider a more radical proposal in which one order of government assumes responsibility for prescription drug policy in Canada.

A pharmacare glossary

COPAYMENT: Cost-sharing in the form of a fixed amount to be paid for a health service or health product.

COUNCIL OF THE FEDERATION: The organization of provincial and territorial governments established in response to Quebec proposals, succeeding the Annual Premiers' Conference. Via the Council, the premiers proposed in 2004 that Ottawa assume responsibility for drug expenditures.

FORMULARY: A list of prescription drugs established by a regulatory body. Hospitals may define formularies of drugs available for inpatient dispensing. Governments may define formularies of drugs covered by public insurance.

GENERIC DRUGS: Drugs produced by firms not holding a patent, either because the patent has expired or because a foreign patent is not respected in Canada (see also *patented drugs*).

MEDICARE: Medically necessary hospital and diagnostic services and medically required physician services administered as single-payer plans by the provinces and territories. Hospital and physician expenditures are a proxy for medicare expenditures.

PATENTED DRUGS: The company developing a new drug usually obtains a patent allowing it exclusive rights, for a specified time, to manufacture and sell the drug (see also *generic drugs*).

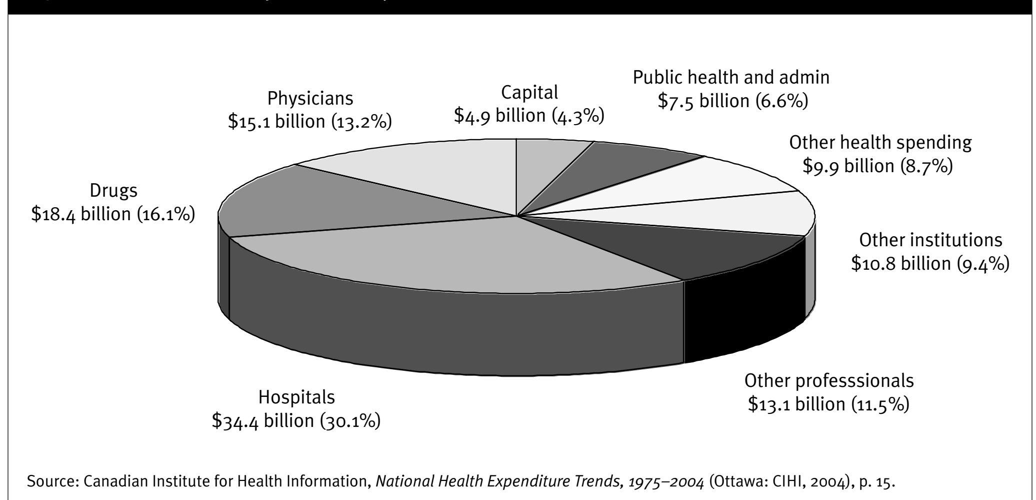
ROMANOW GAP: In the shorthand of intergovernmental relations, "closing the Romanow gap" has come to mean increasing federal transfers until they reach 25 per cent of provincial-territorial spending on health care. The Romanow Commission's actual recommendation was that federal transfers reach 25 per cent of provincial-territorial spending on a narrower band of Canada Health Act services. See *Building on Values: The Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), chapter 2.

USER FEE: Any type of charge – including *copayments* – imposed on a patient, or user, for health services or goods.

Prescription drugs: The real sustainability problem

The debate concerning sustainability of a primarily publicly funded universal health care system has been raging in Canada since the late 1990s. In the early to mid-1990s, all provincial governments restrained spending in their efforts to end deficits. As the largest spending envelope in each province, health care was not spared (the provinces undertake roughly 90 per cent of public health care spending). In constant inflation-adjusted dollars, per capita public health spending

Figure 1: Total health expenditure by use of funds, Canada, 2002



Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2004* (Ottawa: CIHI, 2004), p. 15.

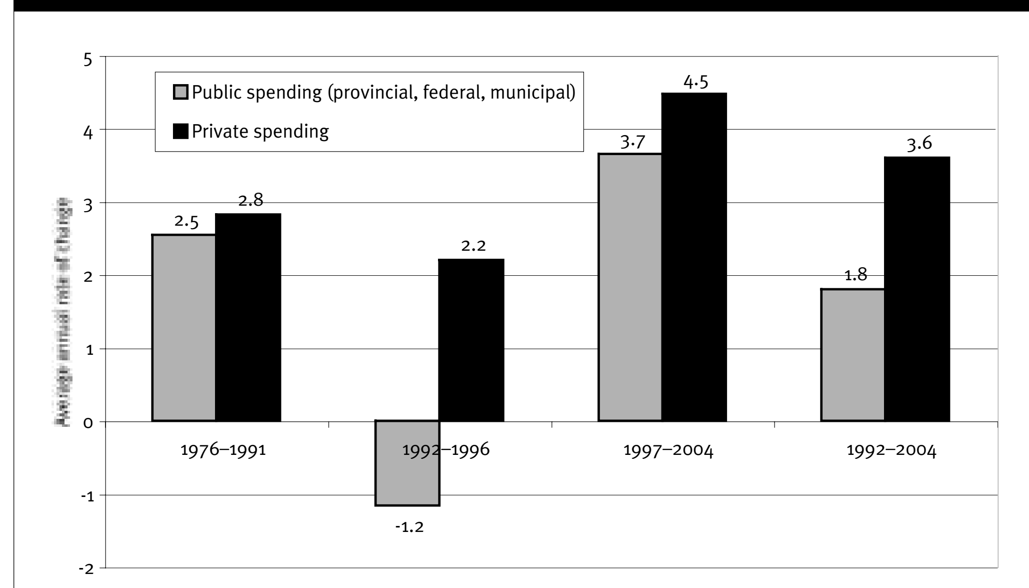
declined over these years. After 1997, with their accounts balanced, governments began to loosen the fiscal purse strings and spend on health care again (see figure 2).

On the basis of the growth in overall public health spending since 1997, some commentators and governments have argued that medicare – defined as medically necessary hospital, diagnostic and physician services covered under the general principles of the Canada Health Act – is no longer fiscally sustainable. These arguments ignore the fact that private health care spending has been growing even faster than public spending. Indeed, over the period 1992–2004, the rate of growth of private per capita spending was double that of public spending.

Table 1 documents rates of growth of expenditure in various health sectors. From 1998 to 2004, spending on provincial and territorial public drug plans and private drug insurance plans has grown, on average, by more than 12 per cent annually in nominal terms. This is double the rates of growth in the entire economy and in core medicare hospital and physician services.[3] Medicare expenditures are sustainable; what may not be sustainable are rates of growth in non-medicare sectors, drugs in particular. Perhaps governments focus on medicare spending because they feel they have some ability to control expenditures of their publicly administered and financed single-payer systems. In contrast, prescription drugs inhabit a multipayer world of mixed public/private funding and administration.

The federal government runs its own public drug plan for Inuit and registered First Nations individuals. This is the fastest growing component of the Non-Insured Health Benefits (NIHB) programs administered by the First Nations and Inuit Health

Figure 2: Average annual per capita rate of growth of real health expenditures (in 1997 dollars), selected intervals



branch of Health Canada. Currently, that growth rate matches the growth rate of the provincial and territorial drug plans.

What does all this mean? The growth in public and private drug plan expenditures greatly exceeds the rate of growth in medicare expenditures – despite generous wage, salary and fee schedule gains by health providers in recent years. Moreover, while the growth of medicare expenditures remains very much in line with the growth of the Canadian economy, the growth of prescription drug plan costs soars well above this rate. Growing at an annual average of over 20 per cent – almost four times the growth rate of the economy and medicare – the Quebec drug plan is in a league of its own in terms of both budget growth and program design. Implemented in 1997, the Quebec plan is in fact a public-private social insurance scheme rather than the tax-funded plans found in Quebec before that date, and in the other provinces today.[4]

Extrapolation of these trends leads to the conclusion that provincial and territorial governments are caught on the horns of a dilemma. They can continue to earmark an ever-growing share of their health budgets for their drug plans and try to improve their existing single-payer medicare systems with less money. Or they can increase copayments and reduce drug plan benefits (and beneficiaries) so that they can earmark more money for core medicare services.

Medicare expenditures are sustainable; what may not be sustainable are rates of growth in non-medicare sectors, drugs in particular.

The recent decision by the Supreme Court of Canada in *Chaoulli* v. *Quebec (Attorney General)* has raised the possibility that provinces will have to permit parallel private insurance for core medicare services unless they significantly shorten waiting lists for medically necessary elective surgeries

Table 1: Annual growth rates of prescription drug (Rx) plans, other components of health expenditures and Canadian GDP, 1998–2004 (current prices)

	1998	1999	2000	2001	2002	2003	2004	1998–2004
Provincial/territorial Rx plans except Quebec	10.7	13.3	16.6	14.6	12.2	10.4	11.7	12.8
Quebec Rx plan	26.8	21.0	25.9	14.3	18.6	22.4	12.5	20.2
NIHB Rx plan[a]	7.6	3.7	9.6	9.6	9.5	12.9	11.3	9.2
Private Rx plans	15.6	20.1	-12.4	32.5	11.5	9.6	9.8	12.4
Hospital expenditures	5.1	4.2	8.3	5.4	6.8	7.1	5.7	6.1
Physician expenditures	4.8	4.3	6.2	7.7	7.7	6.4	4.8	6.0
Gross Domestic Product	3.7	7.4	9.6	2.9	4.2	5.4	6.1	5.6

Note: [a]Federal prescription drug expenditures on behalf of registered First Nations and Inuit, paid via the Non-Insured Health Benefits (NIHB) program within the First Nations and Inuit Health Branch of Health Canada. Unlike the other data presented, NIHB data are in fiscal year format, beginning in 1997–98.

Sources: Derived from: Canadian Institute for Health Information, Drug Expenditure in Canada, 1985–2004 (Ottawa: CIHI, 2005), p. 56; Canada, Non-Insured Health Benefits Program Annual Report 2003/2004 (Ottawa: Health Canada, 2004), p. 22; Canadian Institute for Health Information, National Health Expenditure Trends, 1975–2004 (Ottawa: CIHI, 2004), p. 106; Statistics Canada, CANSIM, Table 380-0002.

(see “Two-tier health care and the Supreme Court,” p. 10, and “Law and politics,” p. 24). *Chaoulli* may have loaded the dice against any significant pharmacare initiative and in favour of judge-decreed priorities. Investing more public money in medicare at the expense of public investment in prescription drugs may be the path of least resistance, but it will mean offloading costs to private individuals and private insurance plans – and may actually raise total health care costs. Managers of private plans can be expected to pass on cost increases by use of larger copayments and higher premiums. For sure, the Supreme Court has hampered the ability of the provinces to make strategic health care decisions. In these circumstances, it is probably wise for the provinces and territories to transfer their public drug plan responsibilities to the federal government and for Ottawa to accept that, for the first time, it must assume administrative responsibility for delivering a major “slice” of public health care in Canada.

Federal pharmacare: Putting the pieces together

Before describing a federal pharmacare program, it is worth reviewing the existing pieces of the $19 billion prescription drug expenditure pie in Canada shown in figure 3. The size and nature of each piece could change depending on the design of any new pharmacare program – with the devil in the details.

The largest slice is the almost $8 billion spent (in 2004) by the provinces and territories (including Quebec) on their public drug plans. Between 1970 and 1986, every province introduced a prescription drug plan. Most were drug subsidy programs aimed at seniors and individuals receiving social assistance, two high-risk groups generally without access to private health insurance (which most often comes in the form of employment-based group plans). In the 1990s, provincial governments limited benefits and hiked copayments and other user fees associated with their drug plans, often hurting the poorest and most vulnerable. For example, Saskatchewan, faced with a severe debt crisis in the early 1990s, turned its universal plan into a targeted program; Quebec revamped its tax-funded plan into a public-private social insurance program. Almost all provinces shifted costs from the public purse to private pockets. Their experience with these short-term cost-saving measures followed a consistent pattern: drug plan costs originally declined only to surge upwards again within a year of the changes.

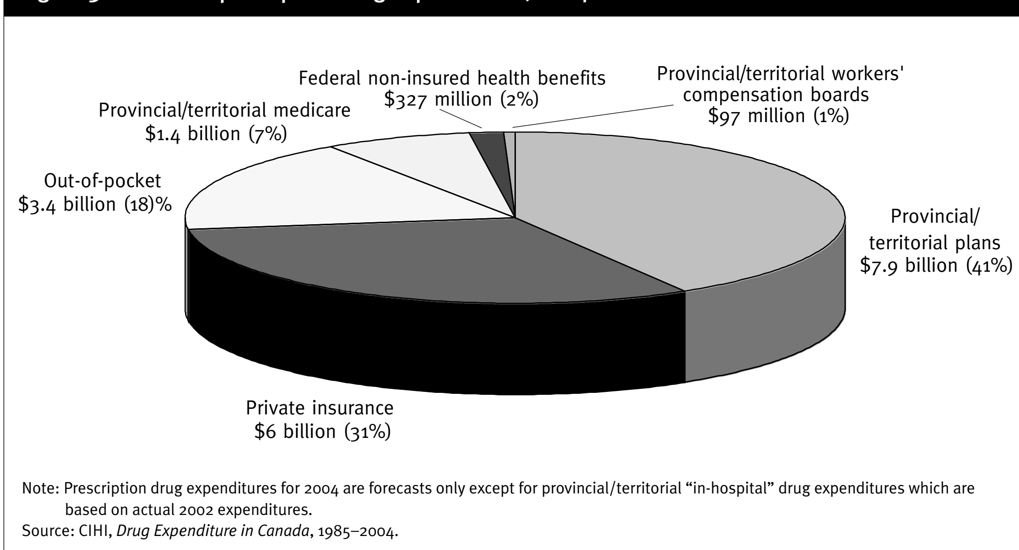
In contrast to single-payer medicare programs, there is considerable variation in the administration, delivery and benefits of provincial and territorial drug plans. In addition, each jurisdiction has its own drug formulary, and makes its own final decision concerning what pharmaceutical products it will list on the basis of clinical efficacy and, to a more limited extent, cost effectiveness. Recently, in another cost-saving effort, all provinces except Quebec have agreed to a Common Drug Approval assessment conducted by an intergovernmental body, the Canadian Coordinating Office of Health Technology Assessment (CCOHTA). While CCOHTA now provides assessments on the clinical and cost effectiveness of new drugs, the actual decision whether to include any new drug in its formulary, and the extent to which the assessment shapes the final decision, remains in the hands of individual provinces and territories.

A further provincial expenditure of $1.4 billion takes place on medicare-covered prescription drugs. Since these drugs are dispensed within hospitals and are considered medically necessary, there is no “patient participation” in paying for them. Individuals who are Inuit or registered First Nations receive $327 million in drug benefits not covered under the provincial and territorial plans. Finally, provincial and territorial workers’ compensation plans cover $97 million worth of drug benefits. All of these public plans supplement or complement $6 billion of private health insurance, most of which is in the form of employment-based benefit plans.

Investing more public money in medicare at the expense of public investment in prescription drugs may be the path of least resistance, but it will mean offloading costs to private individuals and private insurance plans – and may actually raise total health care costs.

There is also the critical regulatory role played by the federal government. On the basis of clinical evidence of a given drug’s safety, efficacy and quality, Health Canada’s Therapeutics Products Directorate decides whether any new prescription drug can be marketed in the country. A quasijudicial, arm’s-length federal tribunal, the Patent Medicine Prices Review Board, regulates the retail prices of new patented prescription drugs. Currently, generic drug prices are not regulated because neither level of government has clear constitutional jurisdiction. Ottawa’s authority to regulate the prices of patented prescription drugs comes from the explicit mention of patents as being under

Figure 3: Canadian presciption drug expenditures, 2004



Note: Prescription drug expenditures for 2004 are forecasts only except for provincial/territorial “in-hospital” drug expenditures which are based on actual 2002 expenditures.
Source: CIHI, *Drug Expenditure in Canada*, 1985–2004.

federal jurisdiction in the Constitution, but this authority does not extend to generic drugs. Nor do the provinces have any obvious constitutional foothold that would allow them to regulate generic drug prices.

Federal pharmacare would ensure that one level of government would be responsible for the regulatory functions as well as administering, delivering and funding a single national drug plan. With the simple administrative agreement of the provinces (if this is even necessary), price regulation could be extended beyond patented drugs to generic drugs, something desperately needed for a country whose generic prices are among the highest in the world.

Regulatory power over prescription drug prices may be necessary but is not the ideal

> **Federal pharmacare would ensure that one level of government would be responsible for the regulatory functions as well as administering, delivering and funding a single national drug plan.**

means to control the cost of a major pharmacare program. Many OECD countries with national drug plans negotiate discount prices from pharmaceutical companies on large-scale orders. The bargaining leverage exercised by national drug plans arises from the size of the market at stake and the power to include or exclude drugs from the national formulary. Discount prices negotiated between drug manufacturers and government are common practice in Australia, New Zealand and many western European countries (see sidebar on Australia's Pharmaceutical Benefit Scheme). They are also common practice among the larger Health Maintenance Organizations in the United States. But not in Canada: with few exceptions, governments in Canada do not purchase prescription drugs in bulk. Instead, they rely on user fees and formularies to control costs. With a national pharmacare plan, Ottawa could undertake such bulk purchasing at discounted prices.

The advantages of federal pharmacare

From the perspective of improving the workings of Canadian federalism, a pharmacare scheme operated by Ottawa presents several clear advantages over the status quo. First, this realignment would clarify roles and responsibilities in an area of health care where they have been ambiguous. While the provinces currently pay for almost all public drug coverage in Canada, they lack the regulatory powers of the federal government. Federal pharmacare would ensure that the order of government with the constitutional powers of regulation would also administer and pay for public prescription drug coverage.

Second, federal pharmacare would address the provincial claim of a vertical fiscal imbalance, the claim that Ottawa has rapidly increasing tax sources and the provinces have rapidly increasing spending responsibilities that are endangering the fiscal health of all but the most prosperous. A federal pharmacare program would be of particular benefit to "have not" provinces that can least afford such a large rapidly growing program.

While Ottawa vehemently denies the existence of a structural fiscal imbalance, the premiers may have seized the momentum in this debate by establishing an independ-

The Australian Pharmaceutical Benefit Scheme: A model for Canada?

There are good reasons to look to Australia's Pharmaceutical Benefit Scheme (PBS). First, Canada and Australia share a Westminster-style parliamentary system and a vigorous federalism in which subnational state/provincial governments play the dominant role in numerous social policy domains. Second, the PBS represents more than half a century worth of accumulated experience with regulating prescription drugs and managing a pharmacare program.

During this time, the PBS has achieved a deserved reputation for cost effectiveness, the main reason for its popularity with Australians and its unpopularity with the pharmaceutical industry. Indeed, the Australian public's attachment to the PBS – along with the unwillingness of successive Australian governments to tamper with it – is somewhat analogous to the Canadian public's attachment to medicare and the unwillingness of governments of all ideological stripes to tamper with its fundamental architecture.

Under the Australian system, prescription drugs go through a four-step process. The first is approval for marketing by the Therapeutic Good Administration of the Commonwealth (i.e. federal) Department of Health on the basis of evidence of clinical pharmacology, efficacy and safety. The second step involves application for the registered drug to be included in the PBS. At this point, the government's Pharmaceutical Benefits Advisory Committee (PBAC) evaluates the need for the drug and its effectiveness and safety relative to existing drugs as well as its cost advantages over existing drugs. The third step is for the Commonwealth minister of health to make a final decision on whether the drug should be subsidized (listed) under the PBS and what the amount of the subsidy should be. This decision is based on clinical effectiveness, cost effectiveness and likely clinical use of the new drug in the context of drugs already listed with the PBS. The final step is for the Commonwealth government, the sole purchaser of PBS-listed drugs, to negotiate a price with the manufacturer of the new drug. As a consequence of the Australian federal government's enormous bargaining leverage, PBS-listed drugs are generally priced well below the world average.

The first step is almost identical to the marketing approval and registration process conducted by the Therapeutics Products Directorate of Health Canada. The second step in Canada is the analysis provided on behalf of the provinces and territories by CCOHTA or by the Quebec government on its own behalf. The third step is currently a decision in the hands of individual provinces and territories, while the fourth step is virtually absent in Canada because of divided administration.

ent Advisory Panel on Fiscal Imbalance through their Council of the Federation. Due in March 2006, the panel's report is likely to provide a strong rationale for the transfer of further fiscal resources (or "tax room") to the provinces, thereby putting significant political pressure on the federal government. Federal politicians have little incentive to transfer tax room given past experience with the Established Programs Financing (EPF) deal of 1976–77. At the time, Ottawa lowered its taxes to give tax room so the provinces could raise theirs. Ever since, Ottawa has reminded Canadians of this major rejigging of the tax system by calculating transfers to the provinces as the sum of cash plus so-called "tax transfers."

With few exceptions, governments in Canada do not purchase prescription drugs in bulk. With a national pharmacare plan, Ottawa could undertake such bulk purchasing at discounted prices.

Thirty years on, the provinces offer no recognition of the fiscal benefits they received from this deal.

Federal pharmacare would be a proactive and constructive way of addressing the fiscal imbalance argument without repeating the EPF. Potentially, this is a "win-win" solution. The provinces would obtain significant ongoing fiscal relief while Ottawa would deliver a service that directly touches most Canadians and would be able to influence, very directly, the sustainability of public health care.

The advantages of federal pharmacare to Canadians should be obvious. The current patchwork of provincial, territorial and federal drug programs has created, in the words of one researcher, a "dog's breakfast" of benefits and exclusions that vary across the country.[5] In particular, there exists a major east-west cleavage: drug coverage programs are considerably thinner in the four Atlantic provinces than programs offered in all the jurisdictions west of those provinces. To the extent that federal pharmacare can both eliminate the disparities of public drug coverage across the country and level up to one of the more generous provincial programs, it will act as a national unifier.

Costs and other downsides

The single largest impediment to federal pharmacare is the program cost. In fact, the potential cost of a pharmacare program has perennially deterred the federal government from proceeding with a cost-shared provincial-territorial program for prescription drugs in the traditional medicare mould.

The annual operating cost of a federal-only pharmacare program could range from a low of $8 billion to a high of $19 billion, depending on the public program's relationship to private prescription drug insurance, the level of copayments and other user fees, and changes in prescription and utilization patterns in response to the new system of public coverage. The lower figure of $8 billion is the current cost of all provincial and territorial drug programs and assumes that the federal program would not disturb any of the other pieces in the prescription drug pie and would be about midway or less in its program benefits. The higher figure of $19 billion is the total prescription drug pie and presumes that federal prescription drug insurance replaces all other public and private plans in the country as well as all out-of-pocket costs in the form of the insurance copayments and deductibles paid by individual Canadians. Using 2001 data, a recent consultant's study arrived at a figure of $13.6 billion for universal, first-dollar-coverage (no copayments, deductibles or other user fees) federal pharmacare. After inclusion of drug price inflation since 2001, this amount is very close to the higher figure of $19 billion.[6]

Unless federal pharmacare "levels up" coverage and accessibility to the most generous provincial program today, some groups will see no advantage in the reform. To take an obvious example: if Ontario residents, who already have one of the more generous programs in the country, end up receiving fewer benefits while paying the same taxes, they will be understandably dissatisfied. By the same token, if federal pharmacare means levelling up to a more generous national drug plan, it should be possible to eliminate current federal NIHB drug benefits and the differential benefits and expenditures associated with it and the questionable distinctions it makes among Canadians – including the distinction between registered and nonregistered Indians.

One scenario is a universal program with copayments in line with one of the more generous provincial plans but one nonetheless designed to minimize the displacement of current private insurance arrangements. From the beginning, it would make sense to include the $1.4 billion cost of hospital-based prescription drugs in federal pharmacare. If that were not done, provincial and territorial governments would have a built-in incentive to cost-shift from inpatient to outpatient prescription drug therapy. A very rough "back-of-the-envelope" calculation would put the cost of this type of federal pharmacare at $12 billion.

How would the federal government pay for this, given that we may no longer be able to count on the level of budget surpluses (a total of just over $60 billion) of the last eight years?[7] There are two possibilities. Since the federal government will be taking responsibility for the riskiest portion of the health care portfolio – and assuming the provinces' in-hospital expenditures on drugs – it seems reasonable that $6 billion, or half the cost, should take the form of a reduction in the Canada Health Transfer, one of Ottawa's major transfers to the provinces. This is a substantial reduction, but leaves sufficient financial leverage for the federal government to enforce the Canada Health Act. The other $6 billion should come from a potential rollback of current federal programs or transfers that are clearly in areas of provincial jurisdiction or – if the federal cabinet prefers – a modest tax increase.

What would we get for this money? A truly universal program in which Canadians receive medically necessary drug therapies on the same terms and conditions wherever they live in the country, whatever their history and risk profile and whether they are inside or outside a hospital. These conditions of access could be spelled out in a new Federal Pharmacare Act that would parallel the Canada Health Act.

Beyond money, we would need to avoid a federal pharmacare program operated in isolation from provincial health reforms. As it is, provincial drug plans, administered in a silo separate from other health services, are generally disconnected from the provincial health reform agenda. Moving pharmacare to a different level of government could ex-

acerbate this problem by creating even more separation between prescription drug policy and health reform. To counteract this tendency, it will be essential for the two orders of government to have a meeting of minds as to how prescription drug therapy fits in the larger health reform agenda.

Those interested in primary care reform, in particular, need to address prescription and drug utilization patterns and behaviours as part of a larger effort to improve diagnosis and monitor ongoing treatment. With federal pharmacare, Ottawa would still depend on the provinces and regional health authorities to influence drug prescribing and utilization. While costs would be the federal government's primary concern, the provinces' primary focus should be on the overall health impact of prescription drug therapies. To avoid strategies that focus on cost-shifting, the two orders of government would benefit from a common reform strategy that simultaneously aimed at improving health outcomes and containing health costs.

Taking the broad view, federal pharmacare should be one element in a larger strategy of transforming and sustaining public health care in Canada. After hospitals, prescription drug therapies now constitute the largest sector of health care expenditures. Indeed, we now spend $3 billion more on prescription drugs than we do on all physician care (see figure 1). We now have a prescription drug therapy for virtually every illness or injury. Paradoxically, there is little evidence that this huge expenditure is leading to better health.[8] This raises the question of whether Canadian-style medicare systematically overweights the value of prescription drug therapy relative to alternatives.

Pharmacare would give the federal government a powerful incentive to fund an independent research institute capable of systematically and regularly testing prescription drug therapies against promising nondrug therapies. Public research that is not funded or compromised by the pharmaceutical companies is essential to determining whether there are superior alternatives to prescription drug therapies to treat certain conditions. If it were responsible for administering and funding pharmacare, the federal government would have a strong incentive to examine more effective and lower-cost alternatives to prescription drug therapies. For example, there is clinical evidence indicating that nondrug cognitive behaviour therapy (CBT) administered by psychologists can be at least as effective as antidepressant medication in treating severely depressed outpatients.[9]

Quebec: A separate but equal solution

In September 2004, one province stood outside the premiers' consensus in asking the federal government to take over responsibility for prescription drug care. Quebec Premier Jean Charest gave few reasons for his objections, but they can easily be inferred. On one level, his opposition simply reflected his province's historic opposition to federal involvement in all areas of social policy. On another level, Charest was protecting a provincial policy environment which has been supportive of the research-and-development-based pharmaceutical industry, almost half of which is located in Quebec.

The simple solution would be to proceed without Quebec's collaboration. This could take two forms. The first would be to impose a federal pharmacare program on Quebec. It is difficult to see how this could be done. Although the federal government has a strong constitutional foothold in this particular policy domain, it does not have sole jurisdiction. Moreover, any Quebec government would resist – strenuously – any unilateral initiative as an invasion by Ottawa of Quebec's jurisdiction over social policy.

The second, more plausible approach is simply to build a federal pharmacare program around the existing Quebec drug plan. While some might trumpet – or decry – this as asymmetrical federalism, the more important criticism is that such an approach could undermine the objectives of federal pharmacare. It would create an enormous policy doughnut in which program benefits varied enormously inside and outside Quebec. It would reduce Ottawa's negotiating leverage with a pharmaceutical industry either based in Quebec or threatening to move its manufacturing capacity from other parts of Canada to Quebec – or offshore. Finally, given two disparate health and industrial policy regimes, it would put Quebec and Ottawa on a major collision course, and generate new intergovernmental conflicts over prescription drug regulation, health policy and industrial development.

The best approach is neither of the above. Instead, we need to negotiate a compromise between Quebec and the rest of Canada. A precedent is the Canada Pension Plan/Quebec Pension Plan in which two programs, with very similar (but not identical) objectives and administrative design, are implemented simultaneously. This solution would require the Quebec government to deal with the potential wrath of some pharmaceutical companies for replacing its industry-friendly policies with a more health-oriented prescription drug program and policy environment. It would also require a resolute federal government, willing to pick up the tab only on the explicit agreement that Quebec fundamentally redesign its current drug program and that the other provinces, in turn, accept the CPP/QPP arrangement. The *quid pro quo* would be clear. For replacing its current program – likely unsustainable in any event – Quebec would retain control and receive an annual federal transfer for a Quebec drug plan that would be portable (and interchangeable) with the federal plan.

The provinces would obtain significant ongoing fiscal relief while Ottawa would deliver a service that directly touches most Canadians and would be able to influence, very directly, the sustainability of public health care.

A constructive response

During the past decades, we have seen continual intergovernmental squabbling over public health care, federal transfers, fiscal imbalance and equalization. These disagreements have produced very little in the way of improved programs and policies for Canadians. Federal pharmacare offers not only a constructive response to evidence of a growing fiscal imbalance between the provinces and the federal government but also a project whereby Ottawa could enhance national unity by "touching Canadians directly." More than this, given its existing regulatory powers, the federal government is the only level of government able to contain, effectively, the cost of

a public prescription drug plan in the long term. Whether it would have the political will to use its power to exact concessions from the pharmaceutical industry remains an open question, but federal pharmacare would provide the capacity.

Federal pharmacare would, overnight, give each of the provinces the fiscal breathing room within its health budget to increase its investment in medicare, home care, long-term care, mental health and public health, where necessary, as well to focus more heavily on the "upstream" determinants of health. With prescription drug plans removed from the equation, the annual growth of public health care costs in the provinces would diminish significantly, reducing or eliminating the crowding-out effect that health care budgets have had on other public budgets during the last few years. As for Quebec, federal pharmacare could help the provincial government curtail an unsustainable program that is already seen as providing limited coverage for seniors and the poor because of its high user fees. ■

Notes

[1] Steve Morgan, "Drug Spending in Canada: Recent Trends and Causes," *Medical Care*, Vol. 42, No. 1 (2004), p. 640.

[2] *Building on Values: The Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), chapter 9.

[3] Gregory P. Marchildon, *Health System Profile: Canada* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005), table 4.4.

[4] Because of the Quebec drug plan's different funding and administrative structure, Quebec plan data are tabulated separately from the other 12 provincial/territorial drug plans by the Canadian Institute for Health Information (CIHI).

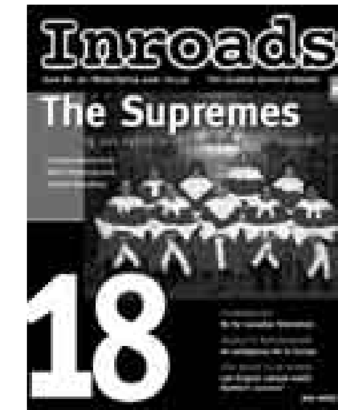
[5] A.H. Anix, D. Guh and X. Wang, "A Dog's Breakfast: Prescription Drug Coverage Varies Widely across Canada," *Medical Care*, Vol. 39 (2004), pp. 315–324.

[6] Palmer D'Angelo Consulting Inc., *Cost Impact Study of a National Pharmacare Program for Canada: An Update to the 1997 Report* (Ottawa: Palmer D'Angelo Consulting Inc. for Health Canada, 2002).

[7] France St-Hilaire, "Fiscal Gaps and Imbalances: The New Fundamentals of Canadian Federalism," notes for a panel presentation, Institute of Intergovernmental Relations, Queen's University, updated May 20, 2005.

[8] Barbara Mintzes and Joel Lexchin, "Do Higher Drug Costs Lead to Better Health?", *Canadian Journal of Clinical Pharmacology*, Vol. 12, No. 1 (2005), pp. 22–27.

[9] See the evidence canvassed in Roy J. Romanow and Gregory P. Marchildon, "Psychological Services and the Future of Health Care in Canada," *Canadian Psychology*, Vol. 44, No. 4 (2003), pp. 283–295.



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