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A MANDATE FOR CANADA

True North in Canadian public policy

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In advance of the 2019 federal election, MLI has released a new series designed to offer practical public policy recommendations for the post-election government. Titled "**A Mandate for Canada**," this series of short analyses will cover a range of pressing issues that any incoming government will need to address, including Indigenous affairs, foreign and security issues, and economic and fiscal policy.

A Dose of Reality: The Need for a Targeted Approach to Pharmacare

Sean Speer

Introduction

Health care issues have not been the subject of much political divergence in Canada for several election cycles and thus have not loomed large in the various campaigns. This pending election may be somewhat different. While we are unlikely to see fundamental disagreements on the *Canada Health Act* or the single-payer model, there is a reasonable chance that there is divergence on the subject of pharmacare.

The New Democratic Party's party platform will almost certainly commit to a federal single-payer pharmacare model that would see Ottawa extend public insurance to prescription drugs. The Liberal Party's platform will probably have a similar commitment, though it may come in the form of an increase of the Canada Health Transfer or creation of a new federal transfer dedicated to the expansion of provincial drug coverage, as envisioned in the new report by the Advisory Council on the Implementation of National Pharmacare. The Conservative Party's platform is harder to judge. It may choose the path of least resistance and essentially match the Liberal policy promise, or it might propose a more targeted alternative.

This short essay, which is part of the Macdonald-Laurier Institute's "A Mandate for Canada" series, aims to contextualize the pharmacare debate and to consider the strengths and weaknesses of different policy options. It starts with a discussion about drug coverage in Canada. Then it considers the case for policy reform, including the relative roles of different levels of government. It ends with broader considerations about the future of work-based benefits and personalized medicine.

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As part of its analysis, the essay advances the argument that a major source of the confusion and tension in the pharmacare debate derives from the absence of common definitions or a shared understanding of the problem. Activists, stakeholders, scholars, and politicians are speaking past each other.

The issue has thus come to be polarized along various lines and the result is a binary debate about a national, single-payer pharmacare model or an affirmation of the status quo. We think this is a false choice and the wrong way to think about universal drug coverage and the role of public policy in Canada. The new report by the Advisory Council on the Implementation of National Pharmacare (hereafter Hoskins Report) regrettably succumbs to this false dichotomy. Its recommendations effectively amount to wiping away the current model and starting anew with inadequate consideration of what this will mean for Canadians.

> "A national pharmacare model irrespective of its design or implementation is the wrong answer to the right question."

The essay instead argues that while there is a solid case for policy reform to expand access to drug coverage in Canada, a national pharmacare model irrespective of its design or implementation is the wrong answer to the right question. Instead we put forward an alternative, more targeted approach that we believe represents the proper response to the right question.

In order to come to the felicitous combination of the right answer to the right question, we need to work through a series of broader questions about the problem that we are trying to solve, who is affected, and the strengths and weaknesses of different policy options.

What is the problem?

Public policy analysis and development should start with the fundamental question: What problem are we trying to solve?

It seems like a straightforward question. But it has become clear in the past 24 months that it is not. There is a multiplicity of answers including (but not limited to):

- Providing drug coverage for the uninsured or "underinsured";
- Establishing a cap on "catastrophic drug costs";
- Lowering drug prices and out-of-pocket spending for individuals;
- Equalizing access to drugs among individuals and across the country;
- Reducing costs for the provinces and territories; and
- Solving for Medicare's "original sin" of excluding drugs from public coverage roughly 50 years ago.

The Hoskins Report seemingly wields every one of these arguments at various points. It cannot settle on the problem it is aiming to solve. But it nevertheless knows that a single-payer model is solution that we need. And so, rather than having a policy solution flow logically from the identification of a clear, public problem, there

are vague appeals to "great national projects," "complet[ing] the unfinished business of universal health care," and other rhetorical flourishes (Canada 2019f). The imprecision about the problem but the certitude about the solution can lead one to think that the panel's recommendations are shaped more by ideology than the evidence (Speer 2019b).

An auxiliary problem is that we have different conceptions of universality. The World Health Organization (n.d.) defines universal as "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." This definition is agonistic on how health care is financed or delivered. Past MLI research has shown how different countries achieve universality through various forms of public and private financing and delivery (Lundbäck 2013; Peng and Tiessen 2015).

But our political debate in Canada has frequently come to characterize universality as synonymous with the single-payer model. It effectively conflates means and ends. The single-payer model is one means of achieving universality. It is not the only one. Universality can also be realized through various forms of regulations and subsidies. In fact, past MLI analysis has argued that the single-payer model is a flawed method for universality because it is costly and as a result can often lead to narrow or even rationed coverage in order to minimize costs (Speer and Lee 2016).

The point here is that the pharmacare policy debate would be greatly improved by a clear, common understanding of the problem and a correct interpretation of universality.

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Let us now be clear about how we have come to see and understand this issue. We have principally viewed it through the lens of the first problem listed above, of the insurance gap in Canada. That a small yet real share of the population does not have access to drug insurance is, in our view, a legitimate problem that justifies policy thinking. Put differently: while the current hybrid system of public and private drug insurance is achieving near-universal coverage, there is scope for further policy reforms to better deliver on the goal of universal coverage.

Our research has identified approximately 10 percent of the population as uninsured. The Hoskins panel cites 20 percent when one also incorporates those who are "underinsured," which it does not define (Canada 2019f).

But notwithstanding these definitional or measurement differences, we agree that policy-makers should be concerned with the uninsured in part because out-of-pocket spending can be regressive (Speer 2018d) and in part because, as we describe later, there is a strong likelihood that this group continues to grow due to labour market trends (Speer 2019b).

Who are the uninsured or underinsured?

The next question is: Who are these people?

The good news is we know a bit about them.

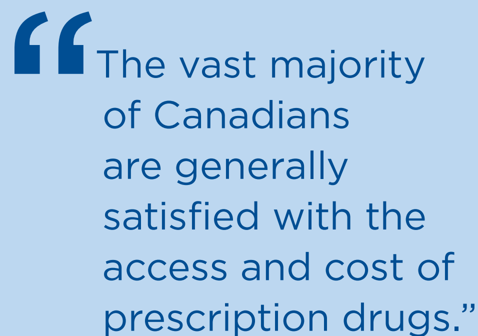
A large share is neither poor nor old. They are also unlikely to live in a rural or remote community. Otherwise they would ostensibly be covered as 23 percent of the population is by provincial programs that target low-income people, seniors, or rural residents, such as Ontario's Trillium Drug Program (CIHI 2018).

Incidentally, the Conference Board (2018), Canadian Health Policy Institute (Skinner 2018), and others (Barua, Jacques, and Esmail 2018) have pointed out that the percentage covered by public programs could be even higher, but a significant number of Canadians – ranging between 3.6 million and 4.1 million – are eligible yet unenrolled in public programs due to either a lack of awareness or no need for coverage. This gap in take-up may mean that the programs need to be better designed or governments need to do a better job promoting awareness.

Unlike another 66 percent of Canadians, our uninsured cohort does not have private drug coverage through an employer, a spouse, or as an individual (Skinner 2018). This presumably means that they are unattached or work for small firms or are involved in non-standard employment such as "gig" economy, non-profit work, or self-employment.

It is worth emphasizing this point: MLI research estimates that 2.8 million (or roughly 80 percent) of the non-insured cohort actually fall into this self-employed category (Speer 2019b).

These characteristics mean that this cohort is generally working-age and earning income that exceeds the means-testing thresholds for public programs. It does not mean policy-makers shouldn't care about the group. But it might change how we think about the role of government and public policy. While this is a unique cohort, it is not necessarily a vulnerable one.



There is, however, a good chance that it grows. Changing patterns in the labour force – in particular, the rise in non-standard work – probably mean that a traditional model of work-based benefits will face strain. We have already seen shifts in workplace pensions. It is conceivable we begin to observe similar declines in other employer-provided benefits such as drug coverage.

As an example: A recent discussion paper released by the Expert Panel on Modern Federal Labour Standards observes that such coverage falls significantly for "permanent part-time employees" or "temporary employees" (Canada 2019a). As a growing share of our work force finds itself in these non-standard forms of employment, it is possible that the uninsured cohort increases.

This does not mean that we face a crisis as some have argued (BCFED 2018). Even the Hoskins panel's 20 percent figure implicitly recognizes that the current mix of public and private insurance is providing near-universal coverage to the Canadian population. Various polls tell us that the vast majority of Canadians are generally satisfied with the access and cost of prescription drugs (Anderson 2018; Picard 2018).

But there is certainly potential for reform. One in 10 Canadians currently do not have insurance, and that figure may rise over time. It seems sensible for policy-makers to consider how best to address the needs of this small yet possibly growing cohort. Closing the insurance gap would get us to the legitimate and broadly-accepted goal of universal drug coverage.

Is a targeted or comprehensive solution the right answer?

Now that we have a goal, the next question is: how do we get there?

The Hoskins panel describes two basic approaches: (1) a "fill the gaps" policy response that targets the uninsured or (2) a broad-based, single-payer model with the coverage ranging from essential medicines to a more comprehensive formulary (Canada 2019c).

There are different variations embedded in each approach. But as a policy-making framework, it is useful for judging the various policy options.

As many readers know, we have written extensively in favour of the "fill the gaps" approach (e.g., Speer 2018a). That is to say MLI has sought to develop policy solutions that build on the existing model and target the uninsured as opposed to ones that replace the existing model and transform drug insurance for all Canadians.

Put differently: We have come to the view that the overriding question for policy-makers is "How can we expand access to drug insurance for those without it now and in the future?" It is about building on the 80 to 90 percent foundation to reach closer to 100 percent coverage as opposed to tearing down the foundation and starting over in the pursuit of universal coverage.

We have come to the view that it would be a huge mistake to throw the baby out with the bathwater on this file. The hybrid system of public and private insurance has evolved over decades and is broadly serving the vast majority of Canadians. It is now part of collective bargaining and people's expectations about access to drugs and their pricing. A comprehensive solution such as a national, single-payer model would necessarily put the current model's strengths at risk in order to try to solve for its weaknesses. The threshold for such a sweeping policy change should be much higher in our view – especially given the downside risks, which the essay addresses in a later section.

In practice, then, this means developing policy solutions that build on the existing system in order to complete the project of universality as opposed to fundamentally reshaping the existing system in the name of universality.

What is a targeted solution?

The next question, of course, is: How can we design an effective, targeted solution?

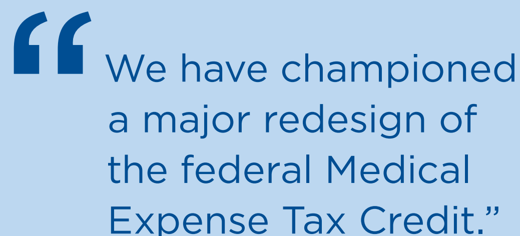
There are various proposals up for consideration including provincially-led initiatives such as OHIP +. We will not analyse their strengths and weaknesses here. Instead, as part of our "A Mandate for Canada" essay series, the goal is to put forward a recommendation for the various federal parties to consider.

We have championed a major redesign of the federal Medical Expense Tax Credit (METC) as a means to closing the insurance gap and realizing the goal of universality.

The METC is a non-refundable tax credit for certain itemizable, above-average medical or disability-related expenses. It has been around in different forms since 1942. Roughly five million tax filers claim it each year. It costs the government approximately $1.8 billion in foregone revenue (Canada 2019d).

The METC's design is complex. The value of the tax credit is calculated by applying the lowest personal income tax rate of 15 percent to the amount of qualifying medical expenses in excess of the lesser of 3 percent of net income or $2302. There is no upper limit on the amount that can be claimed except for certain specific expenses (Canada 2019d).

Premiums paid to private health insurance plans are currently an eligible expense (Canada 2019b). But the METC is presently too small to make a significant difference. It is non-refundable, its minimum threshold is too high, and the overall value is too low. It provides minimal support for those who earn too much to be eligible for public insurance but who do not have employer-provided insurance to be able to acquire their own private coverage. We have written in favour of a fundamental redesign to help uninsured Canadians to acquire private insurance (Speer 2018c; Speer 2018d; Speer 2019a).



The tax credit should be refundable. The thresholds should be reset. The value should be higher. Basically the new tax credit would apply to first dollar spending and be more generous than 15 percent.

Suppose you set the value of the credit at $5000 per family or $2500 per individual for purchasing insurance. There would be room to adjust these amounts on a sliding scale based on income or health status. But the key point is it would provide substantial public support for individuals and families to purchase different forms of private insurance ranging from basic plans to more enhanced benefits. It would leverage the best features of the current model by achieving universality and preserving the flexibility and choice inherent in the private insurance model. Economist Jack Mintz has estimated it could cost roughly $5 billion per year depending on its design and any offsetting changes elsewhere (Canada 2019b).

There are various benefits, in our view, to this targeted solution. It is worth flagging two.

The first is that reforming federal support for acquiring supplementary insurance (including for drugs) would presumably reduce the number of uninsured households and in turn reduce fiscal pressure on provincial and territorial budgets. Think of it as a way for Ottawa to help sub-national governments move closer to universal drug coverage without offending federalism or harming the strengths of the current system.

The second is it would recognize the current policy asymmetry between the non-taxation of employer-provided health and dental benefits and the lack of public support for those who must purchase them with after-tax dollars (Crowley and Speer 2016). Levelling the playing field would not only address a basic inequity, it may also shift the insurance model over time from a work-based one to an individual-based framework. This would better reflect labour market trends by ensuring that drug insurance is portable and protected irrespective of one's workplace circumstances.

We happen to believe therefore that this is a clever solution that policy-makers ought to seriously consider. But the more fundamental point is that they should focus on a targeted solution for the small yet real share of the population that presently doesn't have drug insurance. This can come in the form of a redesigned METC, possible expansions of provincial programming similar to the OHIP + model, or some other proposal. These incremental steps would make progress on the 10 or 20 percent problem that the Hoskins panel has rightly identified in its interim report.

Why is Pharmacare the wrong answer?

We have made the affirmative case in favour of a targeted solution. We would be remiss if we did not address the case against a more comprehensive solution to the insurance gap. There are, in our view, four principal problems with a single-payer model.

The first is the fiscal cost. The Institute for Fiscal Studies and Democracy estimates that a national, single-payer pharmacare model can cost as much as $20 billion per year and be expected to grow by more than 3 percent annually (Blatchford 2018). At a time Ottawa is running deficits and the provinces face long-term fiscal sustainability challenge, it seems irresponsible to enact a large-scale, new entitlement program, especially since in basic terms it involves effectively nationalizing at least $12 billion in drug spending currently divided between private plans and patients (Canada 2017).

The second is that the formularies would be much narrower than under most private plans. This is not inadvertent. It is at the core of the pharmacare model. Comparisons between the Quebec public model and typical private plans affirm this (Labrie 2015). Some people will no longer have access to medicines that they currently use due to the government's judgment about utility and cost.

The decline in drug access could be significant. Just consider a recent study that compares public and private formularies in Canada (Speer 2018b). Of 39 new drugs approved by the Department of Health in 2012, 36 were covered by at least one private drug plan compared to only 11 that were covered by at least one public plan. And the average timeline for extending coverage was more than twice as long for public plans (ibid).

This is especially important in light of the increasing trend towards personalized medicine. One's ability to choose and design his or her own drug plan will only grow more important as different forms of personalized medicine become widely available. Yet a single-payer model would necessarily limit one's options and force us into pre-designed public plans focused principally on minimizing public costs.

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The third is how disruptive its implementation would be for those currently with private insurance. Remember the vast majority of Canadians are satisfied with their current drug coverage. Disrupting the status quo for 80 or 90 percent of the population in order to address the needs of 10 or 20 percent just seems wrong-headed – both substantively and politically. Think, for instance, of union members who have collectively bargained for generous employer-provided plans. It is a losing policy and political strategy to tell nearly 24 million people that they must give up their prescription drug plans in exchange for poorer ones in order to better serve roughly 3.5 million people (Speer 2018b).

A fourth, depending on its eventual design, is the risk of federal intrusion in provincial health care. The Macdonald-Laurier Institute published a paper last year that examined the history of the federal role in health care (Canada 2019d). One of the main takeaways is that episodes of top-down policy-making (including more federal conditionality) have tended to be associated with higher costs and poorer results. There is little reason to believe that a new pharmacare model would produce different results. The risk would be a halt to the policy innovation we are witnessing such as the OHIP + model in Ontario or British Columbia's Fair PharmaCare plan.

The federal role thus should, in our view, be limited to enabling provincial experimentation. Such an enabling role is basically incompatible with a pharmacare model that would need to be either administered by the federal government or significantly financed through intergovernmental transfers due to provincial budgetary challenges. This basic point is under-scrutinized in the political debate about pharmacare. Is Ottawa going to impose a top-down model on Alberta or Quebec? It seems highly unlikely – especially in an election context.

Why is the Hoskins Report wrong?

This short essay has come out in the immediate aftermath of the Hoskins Report. Readers will know that the analysis and perspective of this essay do not accord with the panel's report. It is worth addressing some of the key differences here.

One of the causes for our different conclusions is how we interpret the panel's data and evidence related to "significant gaps" in the current model for drug coverage in Canada. We do not, by and large, disagree on the facts. A 10 to 20 percent share of the population is uninsured or underinsured. Some number between 1 and 3 million have faced significant financial challenges acquiring the drugs that they need. Almost 1 million people have needed to borrow to purchase drugs.

The panel sees these figures as a justification for sweeping reforms. We see these figures as evidence that the current model is working reasonably well. The panel concludes that we need to be prepared to fundamentally change the model to better support this small yet vulnerable cohort. We conclude that that we need to build on the current model to better serve this small yet vulnerable cohort. Part of the difference in in our conclusion may therefore be dispositional. We just see the data and evidence differently.

Another dispositional difference relates to our divergent views about the role of the federal government in the administration and delivery of health care. The report decries "patchwork" and affirms "federal leadership." We view decentralization as a means for reflecting different provincial circumstances and preferences. The panel prefers standardization. We prefer policy and delivery experimentation. The panel is confident that an intergovernmental model will produce better outcomes. We are concerned that it will reduce accountability and produce stasis. These differences are difficult to reconcile.

A further difference reflects our competing views about the cost of pharmacare. The panel claims it will save $5 billion per year relative to the status quo. The argument is that current hybrid model is inefficient and the consolidation into a single-payer plan run by the provincial and territorial governments will be more efficient. This idea, in our view, belies the theoretical and empirical evidence. A combination of bureaucratic inefficiency, political economy pressures, and government borrowing capacity are more likely to inflate the costs relative to the status quo than lower them over the long-term.

The panel's report emphasizes that a national formulary should cover drugs that "offer good value" but refrains from describing how this ought to be determined. The report should be clearer about the panel's intentions here. Let us be blunt: It envisions rationing in the form of narrower formularies than what is typically eligible under private plans based on "value-for-money" decisions. This will invariably mean that a significant share of Canadians lose access to drugs that they are currently taking under a single-payer model.

Yet the report is essentially silent on the potential differences between a public formulary and private ones and what it will mean for Canadians. This has been, in our experience, a common tendency for pharmacare proponents. It is easier to ignore away this issue rather than confront it. This may ultimately be a risky strategy however. Canadians will react negatively when they discover a single-payer scheme threatens their access to certain drugs.

Conclusion

In closing, it is worth summarizing this essay's key points for the various political parties as they prepare their respective policy platforms.

The first is that we need to break out of the polarized constraints around the pharmacare debate. This is not a binary choice between sweeping change or nothing. It is about identifying the right problem and developing the right solution.

The second is that the current hybrid model of public and private drug coverage is serving most Canadians reasonably well. Access and cost are generally not problems for most households. But that does not mean there is no room for policy reform. Roughly 10 to 20 percent of Canadians are facing insurance challenges. And this number is likely to grow due to labour market trends. The right policy reforms can help us close the insurance gap and in so doing better achieve the goal of universal coverage.

The third is that the cohort affected by the insurance gap is neither old nor poor. They tend to be working-age and middle class. A significant share is self-employed. We should keep this in mind as we develop a solution.

The fourth is that policy-makers should focus on a targeted solution that preserves the strengths of the current model and seeks to better support the small yet growing share of the population that is presently under-served. We have proposed a new Medical Expense Tax Credit that can help the uninsured acquire private coverage. This proposal should help us go a considerable way in realizing universality.

The final is that single-payer pharmacare is the wrong answer to the right question. Its various flaws including costs, drug access, and disruption for people would represent a net harm to drug coverage in Canada. We need to get this right.

About the Author

Sean Speer is a Munk Senior Fellow at the Macdonald-Laurier Institute. He previously served in different roles for the federal government including as senior economic advisor to the Prime Minister and director of policy to the Minister of Finance. He has been cited by *The Hill Times* as one of the most influential people in government and by *Embassy Magazine* as one of the top 80 people influencing Canadian foreign policy. He has written extensively about federal policy issues, including personal income taxes, government spending, social mobility, and economic competitiveness. His articles have appeared in every major national and regional newspaper in Canada (including the *Globe and Mail* and *National Post*) as well as prominent US-based publications (including *Forbes* and *The American*). Sean holds an MA in History from Carleton University and has studied economic history as a PhD candidate at Queen's University.

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- First book, *The Canadian Century: Moving out of America's Shadow*, won the Sir Antony Fisher International Memorial Award in 2011.
- *Hill Times* says Brian Lee Crowley is one of the 100 most influential people in Ottawa.
- The *Wall Street Journal*, the *Economist*, the *Globe and Mail*, the *National Post* and many other leading national and international publications have quoted the Institute's work.

"The study by Brian Lee Crowley and Ken Coates is a 'home run'. The analysis by Douglas Bland will make many uncomfortable but it is a wake up call that must be read."
former Canadian Prime Minister Paul Martin on MLI's project on Aboriginal people and the natural resource economy.

Ideas Change the World

Independent and non-partisan, the Macdonald-Laurier Institute is increasingly recognized as the thought leader on national issues in Canada, prodding governments, opinion leaders and the general public to accept nothing but the very best public policy solutions for the challenges Canada faces.

Where You've Seen Us

About the Macdonald-Laurier Institute

What Do We Do?

When you change how people think, you change what they want and how they act. That is why thought leadership is essential in every field. At MLI, we strip away the complexity that makes policy issues unintelligible and present them in a way that leads to action, to better quality policy decisions, to more effective government, and to a more focused pursuit of the national interest of all Canadians. MLI is the only non-partisan, independent national public policy think tank based in Ottawa that focuses on the full range of issues that fall under the jurisdiction of the federal government.

What Is in a Name?

The Macdonald-Laurier Institute exists not merely to burnish the splendid legacy of two towering figures in Canadian history – Sir John A. Macdonald and Sir Wilfrid Laurier – but to renew that legacy. A Tory and a Grit, an English speaker and a French speaker – these two men represent the very best of Canada's fine political tradition. As prime minister, each championed the values that led to Canada assuming her place as one of the world's leading democracies. We will continue to vigorously uphold these values, the cornerstones of our nation.

SIR JOHN A. MACDONALD

SIR WILFRID LAURIER

Working for a Better Canada

Good policy doesn't just happen; it requires good ideas, hard work, and being in the right place at the right time. In other words, it requires MLI. We pride ourselves on independence, and accept no funding from the government for our research. If you value our work and if you believe in the possibility of a better Canada, consider making a tax-deductible donation. The Macdonald-Laurier Institute is a registered charity.

Our Issues

The Institute undertakes an impressive program of thought leadership on public policy. Some of the issues we have tackled recently include:

- Aboriginal people and the management of our natural resources;
- Making Canada's justice system more fair and efficient;
- Defending Canada's innovators and creators;
- Controlling government debt at all levels;
- Advancing Canada's interests abroad;
- Ottawa's regulation of foreign investment; and
- How to fix Canadian health care.

True North in
Canadian public policy

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What people are saying about the Macdonald-Laurier Institute

In five short years, the institute has established itself as a steady source of high-quality research and thoughtful policy analysis here in our nation's capital. Inspired by Canada's deep-rooted intellectual tradition of ordered liberty – as exemplified by Macdonald and Laurier – the institute is making unique contributions to federal public policy and discourse. Please accept my best wishes for a memorable anniversary celebration and continued success.

THE RIGHT HONOURABLE STEPHEN HARPER

The Macdonald-Laurier Institute is an important source of fact and opinion for so many, including me. Everything they tackle is accomplished in great depth and furthers the public policy debate in Canada. Happy Anniversary, this is but the beginning.

THE RIGHT HONOURABLE PAUL MARTIN

In its mere five years of existence, the Macdonald-Laurier Institute, under the erudite Brian Lee Crowley's vibrant leadership, has, through its various publications and public events, forged a reputation for brilliance and originality in areas of vital concern to Canadians: from all aspects of the economy to health care reform, aboriginal affairs, justice, and national security.

BARBARA KAY, NATIONAL POST COLUMNIST

Intelligent and informed debate contributes to a stronger, healthier and more competitive Canadian society. In five short years the Macdonald-Laurier Institute has emerged as a significant and respected voice in the shaping of public policy. On a wide range of issues important to our country's future, Brian Lee Crowley and his team are making a difference.

JOHN MANLEY, CEO COUNCIL