Q & A with Chris Bonnett

Chris Bonnett, MHSc, PhD (Cand.) provides practical prescription drug policy research for private and public drug plan leaders, and consults on workplace health strategy. Chris has been a volunteer director on four health organization Boards. Early in 2020, he expects to complete his PhD at the University of Waterloo, examining how Canada can achieve universal drug insurance.

Why has national pharmacare (NPh) become such an important issue now, when there are so many other health care priorities?

Discussion in Canada about a national health insurance plan that included drugs started at the end of the Second World War – alongside the introduction of Britain's national health service – but it found no traction. It was next discussed by governments in 1955 and has come and gone several times since.

The main culprit seems to be high and unpredictable costs and a lack of political vision and courage. As part of my doctoral research, I read some of Emmett Hall's 1964 Royal Commission on Health. The commission recommended drug coverage as a second phase because of its cost. Back then, the average per capita drug cost was about $9, which equates to about $80 today. Since our actual per capita prescription drug cost was forecast at $919 for 2019, maybe they were right.

However, the need for NPh remains because there are still serious problems accessing medicines. Across Canada, coverage depends on where you live or work, not on medical need. Since almost 700 million prescriptions were filled in 2018, that need touches almost everyone. There are many other important problems in the health system – better community and long-term care certainly – but those are narrower issues. When we consider the slate of new immensely high-cost gene and cell-based therapies, in addition to expensive specialty drugs and a small percentage of very high-cost patients, it's clear that coasting into the future is not a viable option. The problems we face now in drug costs and a poorly performing health care system will only worsen unless policy, program and governance improve.

Now that the election is over, what is your prediction about how the government will roll out pharmacare and the other big changes to pricing and drug approvals?

I was disappointed that NPh was barely mentioned by the Liberals and ignored completely by the Conservatives in October's election. Unfortunately, that's entirely consistent with the history of NPh.

Right now, there are more moving parts in drug policy than ever before. Predictions are not easy because drug insurance itself is very complicated, politics are ingrained and the Liberals have not made NPh their signature issue. There are also other changes that ought to be considered together, including reform to the Patented Medicine Prices Review Board, establishing the Canadian Drug Agency (CDA), an innovation strategy that includes pharmaceutical research and development, and of course a plan to access drugs for rare diseases. This is only speculation, but the first iteration of national pharmacare could happen within five years, and maybe less, depending on how long the Liberals stay in power with NDP support. However, it will not be the grand scheme envisioned by academics, the House of Commons Standing Committee on Health (HESA) and the advisory council on the implementation of national pharmacare (the advisory council). It will almost certainly include enough federal money to fill the gaps so that Canada has universal drug coverage, a national formulary and the ability to operate the CDA. Less certain but also imperative is federal funding for national standards to limit out-of-pocket cost and to pay for drugs for rare diseases.

However, what hasn't been discussed is even more important in the long run. Canada needs a national strategy for prescription medicines and a robust, multi-stakeholder forum to improve drug insurance governance and accountability.

A model I like is Germany's federal joint committee which reports to the federal Minister of Health and includes insurers, health professionals, hospitals, its states, patients as observers and an independent chair. With minimal adaptation, this could work in Canada and allow governments to draw from a much broader and deeper pool of expertise in these complex times.

Will the NDP use support for the Liberals as leverage to move more quickly on pharmacare than perhaps the Liberals had planned?

The NDP has made a very public promise for a public single-payer plan, similar to what HESA proposed and supported by the Canadian Labour Congress. If the Liberals want NDP support on other files, they will have to show some progress toward the NDP's "Medicines for All" vision. However, Bill Morneau is still finance minister and he is on record favouring more incremental change: a fill-the-gap approach. Both parties will want bragging rights to launching NPh however that term is finally defined. I suspect the Liberals may tout their practicality by offering just enough of a plan to satisfy the NDP. For their part, the NDP will claim victory because it is very likely their policy and determination that will push the Liberals to act. Not only could both parties claim a 'win', but Canadians without any or enough drug coverage would of course be the biggest winners.

What about funding? The provinces and territories have been pretty clear they are in different places with respect to tying in any national programs to their provincial and territorial priorities.

My first point is that NPh will not cost more in aggregate, although the distribution of costs will shift so that the federal government pays more and patients pay far less. Provincial costs will not change much. Rather than premiums paid to insurers, all employers will likely see a small corporate tax increase or possibly a new payroll tax that should not change their costs.

It's also likely NPh will not save Canada billions of dollars because the economic models used to forecast savings are untethered to the real world and there are too many confounders to determine cause and effect. This includes the passage of time, population growth, changes in health status, new drug entries and treatment knowledge and changes in prescribing practices and utilization.

Pharmacare requires intense negotiation about funding and national standards between 14 governments that offer varying formularies, eligibility and cost-sharing. In their communiqué following the July 2019 Council of the Federation meeting, the Premiers stated that "any jurisdiction that wishes to maintain full control over drug insurance should have the right to opt out unconditionally, with full financial compensation." All the jurisdictions are rightfully concerned the federal government could agree to fund pharmacare only to pull back in future years. The rest of us may be concerned that the provinces will resist accountability for progress towards national goals as the health council reported in monitoring the 10-year plan to strengthen health care.

In the end, I expect that if there is adequate and permanent federal funding, provinces and territories will introduce NPh one by one. This is consistent not only with what happened after the introduction of national hospital (1957) and medical (1966) insurance when the federal government covered about half those costs, but also with the bilateral health funding agreements that were signed by all provinces except Manitoba by April 2017.

For business, the most difficult thing to manage is uncertainty. Can you see a pathway for the new government to provide the insurance and pharmaceutical industries with some clarity about their direction? At least this would allow the industry to plan for changes.

As a first step the federal government must set the mandate of its new drug agency and ensure it has all the resources necessary to operate quickly and effectively and with appropriate consultation. That would likely end the three-year odyssey of updating the PMPRB's strategy, regulations and operating guidelines. It would also presumably settle any future role for CADTH and the pCPA and thereby address much of the uncertainty facing the pharmaceutical industry, its revenue, cost of compliance, profitability and new product stream for Canada.

Private and public payers also face uncertainty about drug prices and costs; and so they will act until meaningfully lower prices are achieved either through negotiation or by imposition. Perhaps Canada's per capita drug cost (US PPP $806 in 2017, 4th in the OECD) will need to drop closer to the OECD median ($569) or perhaps align more closely with Canada's GDP per capita (ranked 16th). While global headquarters will resist this reduction, drug manufacturers are facing similar price pressure across their markets.

NPh is much less certain because federal budget impacts will be determined by plan design, national standards and F/P/T negotiations – all unknowns. Insurers have far more at stake with NPh than with PMPRB reform, but while NPh may cut revenue by up to $12 billion, the profitability of drug insurance is far less certain. If the advisory council provides any guidance, NPh changes will take several years. The council proposed only a very limited essential medicines list by January 2022 with a Quebec-style formulary to follow five years later. That should allow insurers and employers enough time to adapt.

Uncertainty for patients must also be considered, amplified by recent experience with OHIP+. Even Quebec's formulary is less generous than private plans that now cover perhaps two-thirds of Canadians. If behavioural economic theory is correct and people fear losses more than they value gains, governments will have to ensure a viable, affordable private drug plan market for top-up coverage.

It's clearly going to be a bumpy road for pharma for a few years. Any thoughts or advice on adapting to the changes?

Canada's struggle for lower costs and prices is hardly unique, although some of its tactics may be. Even the United States government is exploring ways to lower its national drug bill, although hopefully it sees a more fulsome solution than simply importing drugs from Canada. Almost all wealthier OECD members have much lower per capita drug costs than Canada. Those are at least bumps in the road, and maybe hurdles. I imagine the industry is using its expertise in all major markets to find a new balance between cost and access that adequately rewards shareholders and respects payers' concern about sustainability and affordability.

The pharmaceutical industry may not prevail in either of the two lawsuits it launched against the federal government, but at least those actions will buy the industry time to adapt.

The messages I've heard directly from IMC leadership about its willingness to adapt and create more value for payers and patients are exactly right. Pharmaceutical manufacturers must find payers willing to pay, and patients absolutely need payers willing to pay for timely and sufficient access. In truth, all three parties need each other to succeed. Once this mutual dependency is acknowledged, more constructive dialogue can follow.