



**RENEWING CANADA'S
SOCIAL ARCHITECTURE**

MODERNIZING MEDICARE

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PROBLEM STATEMENT

Canadian Medicare was established in the 1960s at a time when the nature of illness and treatment, as well as Canadian demographics, were far different than they are now. The Canada Health Act, the central piece of federal legislation governing health care in Canada, sets out the “medically necessary services” that must be covered by provincial health insurance plans. These are defined as “hospital services, physician services and surgical-dental services.”¹ This may have been an adequate way of defining health care services in the 1970s, when care provided by a physician or in hospital represented 60% of total health care expenditures. Today, that figure is only about 40%.² The definition leaves out important services, including outpatient prescription drugs, dental care, much mental health care, and most long-term care — services that are playing an ever increasing role in the context of an aging society and the rise of chronic disease. These services are covered to some extent in all provinces, often with co-payments and deductibles charged to patients. This rigid way of defining medical necessity is problematic for several reasons including:

- 1) It means that Canada’s health care system is less comprehensive than it should be;
- 2) Inter-provincial equity is threatened, since some services may be covered in one province and not another;
- 3) It hinders our ability to achieve economies of scale and control cost increases, especially in the area of prescription medications;
- 4) It hinders our ability to implement strategies to improve the quality and consistency of health care services based on best evidence.

1 *Canada Health Act, R.S.C.*, 1985, c.C-6. <http://laws-lois.justice.gc.ca/eng/acts/c-6/>

2 Tuohy, Carolyn Hughes. "Health Care Policy after Universality: Canada in Comparative Perspective." *Inequality and the Fading of Redistributive Politics* (2013): 286-7.

POLICY OBJECTIVE

Governments should expand coverage to areas not originally covered under the Canada Health Act, that represent important treatments or services. Coverage should be based on need and not ability to pay and should not cause any Canadian to suffer undue hardship as a result of paying for medically necessary care. This paper focuses primarily on one area where the policy problem is especially acute: medically necessary prescription medicines outside of hospitals.

CURRENT STATUS

Medicare is Canada's most cherished social program. Canadians have reaffirmed their support for universal health care in poll after poll. A persistent large majority of Canadians polled believe the federal government should spend more on health care.³ Support for universal health care is so strong amongst Canadians that many are willing to reduce spending on other services for the sake of medicare.⁴ Health policy expert Carolyn Tuohy described health care's prominence in Canadian society by saying, "Health care has become not a pillar of the Canadian welfare state but a citadel: self-contained, impenetrable, and dominating."⁵

Starting in the 1940s and 1950s, Medicare was implemented incrementally in Canada. Provinces implemented universal hospital insurance schemes in a staggered fashion: starting with Saskatchewan in 1947, followed by British Columbia in 1948, and Alberta in 1949. The rest of the provinces followed suit after the passage of the Hospital Insurance and Diagnostic Services Act in 1957 — a federal law that offered to match funds to all provinces that established universal insurance plans for hospital care that met certain requirements — i. Insurance for outpatient services followed in the 1960s and 1970s, again, beginning with Saskatchewan in 1962, followed by Alberta in 1963, British Columbia in 1965, and Ontario in 1966. Following the passage of the federal Medical Care Act in 1966, the federal government offered to match provincial

3 Soroka, Stuart N. "Canadian perceptions of the health care system." Toronto: Health Council of Canada. http://www.queensu.ca/cora/_files/PublicPerceptions.pdf (2007):10.

4 Ibid., 10.

5 Tuohy, Carolyn Hughes. "Health Care Policy after Universality: Canada in Comparative Perspective." *Inequality and the Fading of Redistributive Politics* (2013): 287.

government expenditures on all insured health services so long as the insurance plans conformed to four conditions: universality, public administration, comprehensiveness and portability; the other provinces followed suit. By 1971, all provinces had a universal health insurance program in place that covered both hospital and outpatient services, funded half by the provinces and half by the federal government.

In 1977, the federal government began to transition away from cost-sharing schemes to block funding in many areas of social spending, including health care. The Canada Health Act (CHA) was passed in 1984, combining the provisions set out in the original two pieces of legislation and updating them to re-affirm the federal government's commitment to universal health care insurance. Accessibility was added as a fifth condition in the CHA, as well as specific prohibitions on extra-billing and user fees. The federal government is able to withhold its transfer to a province on a dollar-for-dollar basis if provinces allow either of these to take place, though this has rarely been exercised. In 1996, the federal government merged the block health transfers with Canada Assistance Plan transfers to form the Canada Health and Social Transfer (CHST). In 2004, the CHST was replaced with the Canada Health Transfer (CHT). The CHT is expressly dedicated to health care and is linked to the requirements of the CHA (the federal government can withhold one dollar of the CHT for every dollar collected through user fees and extra-billing).

Medicare is “owned” by the provinces in that they are responsible for administering their provincial health insurance plans, and for the delivery of health care services. Provinces negotiate fee schedules with provincial medical associations and other professional organizations, allocate hospital funding and make decisions broadly about how the system will be organized to serve that province's citizens. Aside from its obligations to provide health care services directly to some populations, including aboriginal communities and the military, the federal government's primary role is to provide funding to the provinces for health care. For example, in 2013-14, the federal cash transfer was \$30.3 million to all provinces,⁶ roughly 20% of total provincial health expenditures.⁷

Although the federal government does not make decisions about health care delivery in Canada, it can use its spending powers to influence the design of delivery. For example, the CHA's requirements of public administration, comprehensiveness, universality, portability and accessibility, as well as its provisions and conditions around user charges and extra-billing, help shape provincial and territorial health care systems without contravening the

6 Department of Finance Canada. “History of Health and Social Transfers.” <http://www.fin.gc.ca/fedprov/his-eng.asp> (accessed March 16, 2015).

7 Canadian Institute for Health Information. “National Health Expenditure Trends, 1975 to 2014: 2.0 Total Health Expenditure by Source of Finance.” http://www.cihi.ca/cihi-ext-portal/pdf/internet/nhex_2014_report_chapter2_en (accessed March 16, 2015). Note: CIHI data is reported in calendar year, so a weighted average of 2013 and 2014 expenditures was taken to convert data to fiscal year.

constitutional division of powers. The federal government can also leverage its spending power to “buy change”, as it did during the 2004 Health Accord. At that time, the federal government used the possibility of additional funding to create a collaborative and pan-Canadian strategy to address wait times by establishing a dedicated wait time reduction fund, securing commitments from the provinces, establishing wait time benchmarks and targets, and attempting to establish a common data reporting protocol. In this way, federal involvement can help ensure some degree of inter-provincial equity, an issue that enters into popular discussion of Canada’s health care system.^{8,9} Polling data suggest considerable support for the federal government to set national standards with roughly 70% support for conditional transfers to provinces.¹⁰

The total health expenditure in Canada was \$205.4 billion in 2012, or \$5,911 per capita.¹¹ This amounts to 11.3% of GDP and encompasses both public and private funding; public spending accounts for 70.5% of total spending.¹² Public spending on health care makes up a considerable proportion of government budgets. For example, in Ontario, health care accounts for 42% of the provincial budget.¹³

Private funding covers pharmaceuticals and care provided by other health professionals and accounts for the remaining 29.5% of total spending. Private spending can be further broken down by sources: 14.2% of total spending was out-of-pocket, 12.2% from private insurance, and 3.2% from “non-consumption” (a heterogeneous category that comprises hospital non-patient revenue, capital expenditures for privately owned facilities, and health research).¹⁴ Hospitals (29.6% of total expenditure), drugs (15.8%) and physicians (15.5%), are the top three uses of funds spent on health care, followed by other professionals, public health, administration and capital.¹⁵

8 Health Council of Canada. *Where you live matters: Canadian views on health care quality*. Ottawa: Health Council of Canada, 2014.

9 Ferguson, Rob. “Dying Milton woman pleads for funding of cancer drug.” *Toronto Star*, October 3, 2013. http://www.thestar.com/news/gta/2013/10/30/dying_milton_woman_pleads_for_funding_of_cancer_drug.html

10 Soroka, Stuart N. “Canadian perceptions of the health care system.” Toronto: Health Council of Canada. http://www.queensu.ca/cora/_files/PublicPerceptions.pdf (2007).

11 Canadian Institute for Health Information. “National Health Expenditure Trends, 1975 to 2014: 2.0 Total Health Expenditure by Source of Finance.” http://www.cihi.ca/cihi-ext-portal/pdf/internet/nhex_2014_report_chapter1_en (accessed March 16, 2015).

12 Canadian Institute for Health Information. “National Health Expenditure Trends, 1975 to 2014: 2.0 Total Health Expenditure by Source of Finance.” http://www.cihi.ca/cihi-ext-portal/pdf/internet/nhex_2014_report_chapter2_en (accessed March 16, 2015).

13 Institute for Competitiveness and Prosperity. *Building Better Health Care: Policy Opportunities for Ontario*. Toronto: Institute for Competitiveness and Prosperity, 2014. Accessed March, 2015. http://www.competeprosper.ca/uploads/WP20_BetterHealthCare_FINAL.pdf.

14 Canadian Institute for Health Information. “National Health Expenditure Trends, 1975 to 2014: 2.0 Total Health Expenditure by Source of Finance.” http://www.cihi.ca/cihi-ext-portal/pdf/internet/nhex_2014_report_chapter2_en (accessed March 16, 2015).

15 Canadian Institute for Health Information. “National Health Expenditure Trends, 1975 to 2014: 2.0 Total Health Expenditure by Source of Finance.” http://www.cihi.ca/cihi-ext-portal/pdf/internet/nhex_2014_report_chapter3_en (accessed March 16, 2015).

Canada's health care system can be thought of as two sets of systems: single-payer systems for hospital and physician services and "residual" systems for all other services.¹⁶ Residual systems are those with a mix of private and public finance — some government programs are created to provide coverage to certain groups while the majority of the population relies on the private market. This organizational structure makes Canada quite unique.

Canada stands alone as the only developed country with universal health care that does not cover prescription drugs.¹⁷ Canada is also unique in that it limits private financing into certain areas (physician and hospital services) and yet provides little public coverage in others, with little regulation in areas outside the single payer basket.¹⁸ Many countries with universal health care systems allow private financing for a myriad of health care services but the private financing is heavily regulated to ensure it is accessible to all citizens and is well integrated into the rest of the financing structure.¹⁹ Canada, by contrast, "leaves the privately financed area unregulated beyond basic safety provisions."²⁰

In the CHA, services in residual system are called "extended health care services." They include much of the care provided in the community, including home care or intermediate care provided in nursing homes; prescription drugs; optometric services; dental care; psychological counselling; some mental health care; care provided by health professionals other than physicians; and assistive devices. Strong cases for the medical necessity of each of these services can be made as many provinces pay for some of these services already. The current system raises important equity concerns as Canadians are often left to cover these services out-of-pocket or with private insurance, or go without.

There is considerable variation between provinces in terms of the extent to which they cover extended health care services and how they administer these programs. For example, provinces vary considerably in their approach to covering outpatient prescription drugs. In all provinces, there is some form of plan available to social assistance recipients.²¹ The Atlantic provinces cover citizens over the age of 65²²

16 Tuohy, Carolyn Hughes. "Health Care Policy after Universality: Canada in Comparative Perspective." *Inequality and the Fading of Redistributive Politics* (2013): 287.

17 Morgan, Steven G., Jamie R. Daw and Michael R. Law. *Rethinking Pharmacare in Canada*. Toronto: C.D. Howe, 2013. Accessed March 16, 2015. http://www.cdhowe.org/pdf/Commentary_384.pdf

18 Tuohy, Carolyn Hughes. "Health Care Policy after Universality: Canada in Comparative Perspective." *Inequality and the Fading of Redistributive Politics* (2013): 287.

19 Allin, S., Mark Stabile, and Carolyn Hughes Tuohy. "Financing models for non-Canada Health Act services in Canada: lessons from local and international experiences with social insurance." Ottawa: Canadian Health Services Research Foundation, 2010. Accessed March 16, 2015. http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/CHSRF_4FinancingModels_En-final2.pdf?sfvrsn=0

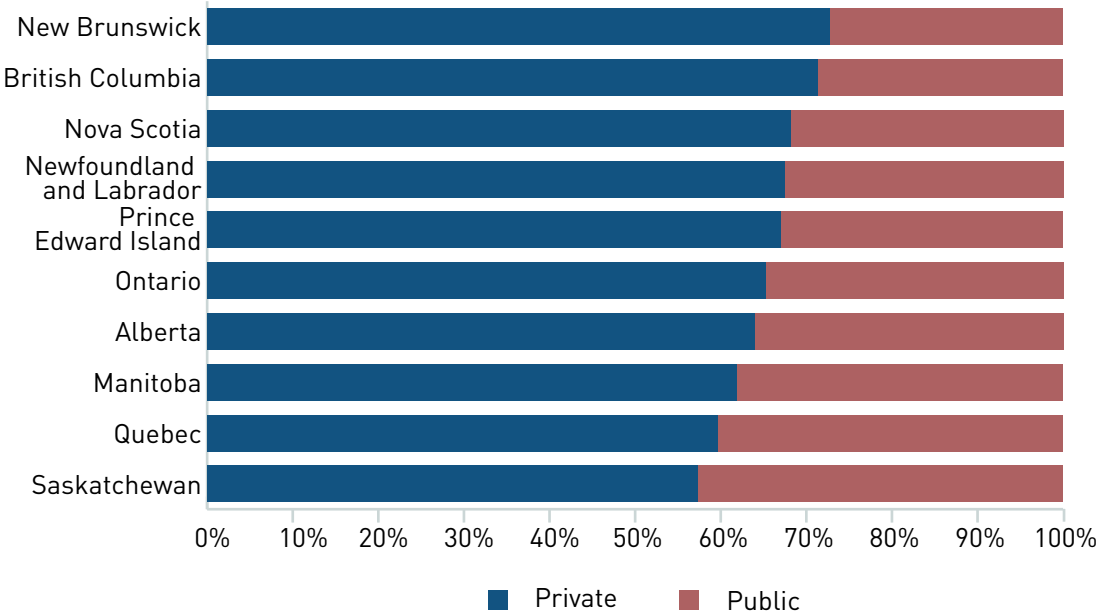
20 Tuohy, Carolyn Hughes. "Health Care Policy after Universality: Canada in Comparative Perspective." *Inequality and the Fading of Redistributive Politics* (2013): 287.

21 *Ibid.*, 302.

22 Morgan, Steven G., Jamie R. Daw and Michael R. Law. *Rethinking Pharmacare in Canada*. Toronto: C.D. Howe, 2013. Accessed March 16, 2015. http://www.cdhowe.org/pdf/Commentary_384.pdf

while British Columbia, Saskatchewan and Manitoba recently shifted from age-based coverage to income-based coverage for all citizens.²³ Ontario has “catastrophic” coverage for all citizens (albeit with considerable co-insurance) in addition to the Ontario Drug Benefit program that provides coverage for prescription drugs to seniors and those on social assistance.²⁴ Quebec comes closest to universal drug coverage in that it requires that all Quebec residents have prescription drug coverage, either purchased through their employer or through the government. Quebec pharmacare fully covers drugs for citizens under the age of 18 while charging a monthly deductible and coinsurance rate for other beneficiaries.²⁵ Correspondingly, there is considerable variation in the extent to which Canadians rely on the private sector for their prescription drug coverage (Figure 1).

FIGURE 1: ONTARIO AND OTHER CANADIAN PROVINCES, 2014 (FORECAST); SHARE OF PUBLIC AND PRIVATE HEALTH CARE EXPENDITURE ON DRUGS



SOURCE: INSTITUTE FOR COMPETITIVENESS AND PROSPERITY ANALYSIS BASED ON DATA FROM THE CANADIAN INSTITUTE FOR HEALTH INFORMATION.

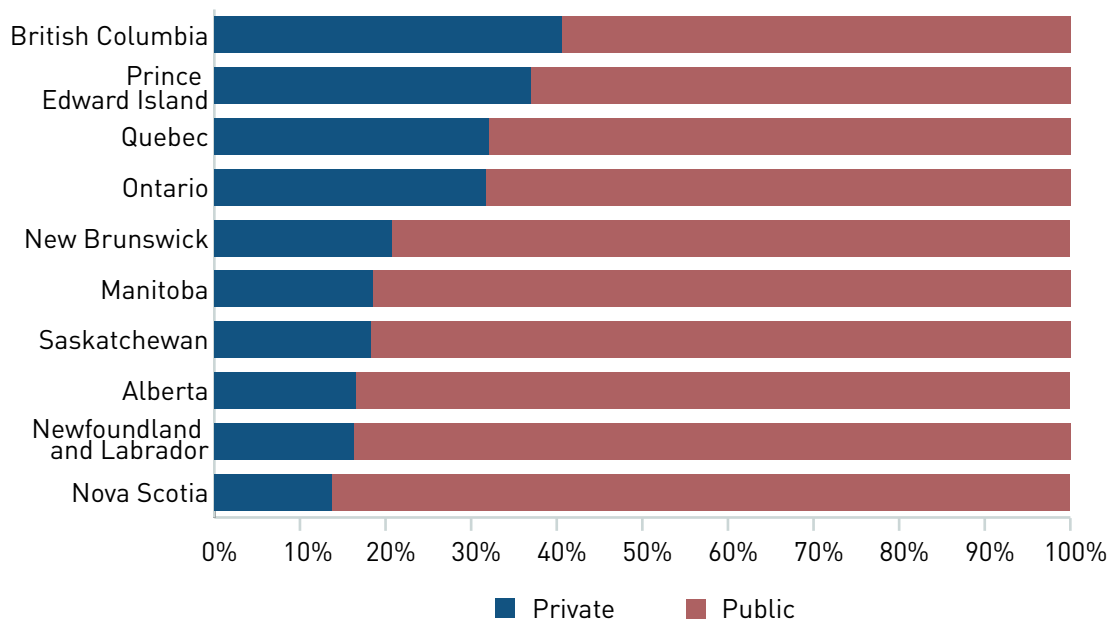
Long-term care is another critical area that falls into the residual system. This will become an increasingly important area of concern for governments as baby boomers reach the age where they begin to demand long-term care. Again, provinces have different programs to cover long-term care to varying extents and for different groups of the population (Figure 2).

23 Tuohy, Carolyn Hughes. "Health Care Policy after Universality: Canada in Comparative Perspective." *Inequality and the Fading of Redistributive Politics* (2013): 302.

24 Ontario Ministry of Health and Long-Term Care. "The Ontario Drug Benefit (ODB) Program." <http://www.health.gov.on.ca/en/public/programs/drugs/programs/odb/odb.aspx> (accessed March 16, 2015).

25 Morgan, Stevem G., Jamie R. Daw and Michael R. Law. *Rethinking Pharmacare in Canada*. Toronto: C.D. Howe, 2013. Accessed March 16, 2015. http://www.cdhowe.org/pdf/Commentary_384.pdf

FIGURE 2: ONTARIO AND OTHER CANADIAN PROVINCES, 2014 (FORECAST); SHARE OF PUBLIC AND PRIVATE HEALTH CARE EXPENDITURE ON LONG-TERM CARE



SOURCE: INSTITUTE FOR COMPETITIVENESS AND PROSPERITY ANALYSIS BASED ON DATA FROM THE CANADIAN INSTITUTE FOR HEALTH INFORMATION.

Dental care also falls outside the scope of “medical necessity” as defined in the Canada Health Act. Having good access to dental care is an important health issue as periodontal disease (an outcome of poor oral health) has been linked to respiratory infections, heart disease, stroke, diabetes, poor nutrition and a number of other serious illnesses,²⁶ not to mention general poor quality of life and other negative social and economic outcomes.²⁷ More Canadians rely on private insurance and out-of-pocket payments to pay for dental care compared to other services in the residual system (Figure 3). The privately funded share of dental care expenses has increased from an already extraordinary 80% in the early 1980s to 94% today.²⁸ A small majority of Canadians (62.6%) have private dental insurance and 16.5% of Canadians declined recommended care because of the cost.²⁹

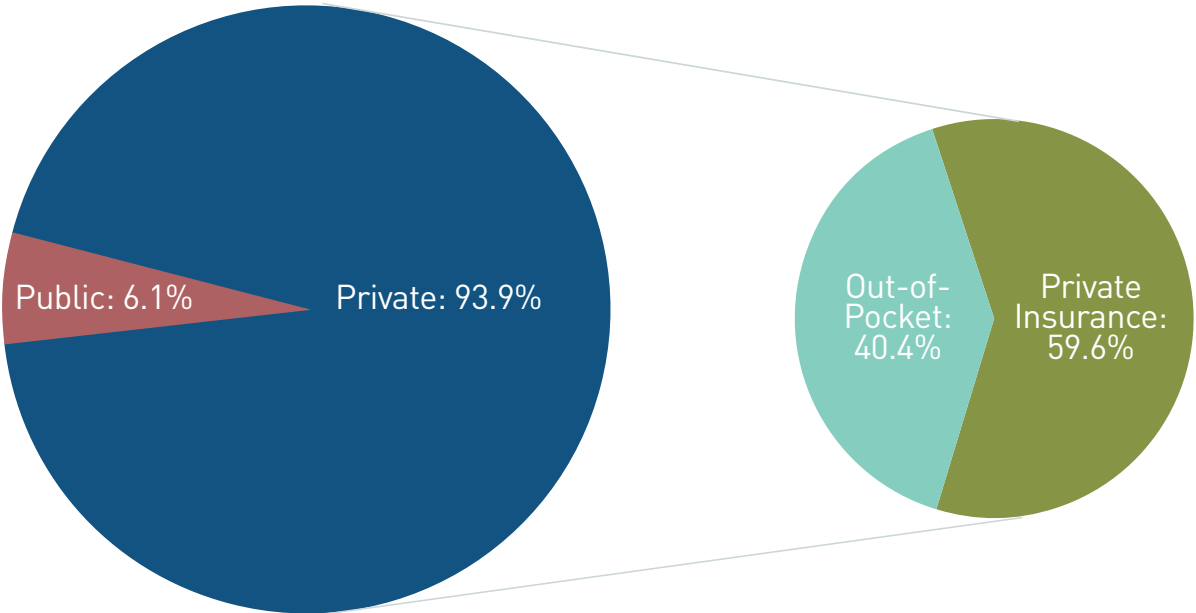
26 King, Arlene. *Oral Health – More Than Just Cavities: A Report by Ontario’s Chief Medical Officer of Health*. 2012. Accessed March 16, 2015: 7. http://www.health.gov.on.ca/en/common/ministry/publications/reports/oral_health/oral_health.pdf

27 Gladwell, Malcolm. “The Moral Hazard Myth.” *The New Yorker*, August 29, 2005. <http://www.newyorker.com/magazine/2005/08/29/the-moral-hazard-myth> (accessed March 16, 2015).

28 King, Arlene. *Oral Health – More Than Just Cavities: A Report by Ontario’s Chief Medical Officer of Health*. 2012. Accessed March 16, 2015: 8. http://www.health.gov.on.ca/en/common/ministry/publications/reports/oral_health/oral_health.pdf

29 Ibid., 8.

FIGURE 3: CANADA, 2014 (FORECAST) SHARE OF PUBLIC AND PRIVATE HEALTH EXPENDITURE ON DENTAL



SOURCE: INSTITUTE FOR COMPETITIVENESS AND PROSPERITY ANALYSIS BASED ON DATA FROM THE CANADIAN INSTITUTE FOR HEALTH INFORMATION.

DRIVERS OF CHANGE

The two main factors driving the need to adjust Medicare to meet the needs of 21st century Canadians are technological and demographic.

TECHNOLOGICAL

Technological innovation around the treatment of disease means that conditions that were once treated in hospital or by physicians now have (usually less costly) alternatives. Chronic diseases that once resulted in long hospitalizations can now be managed in the community and patients can rely more on self-treatment. To take one example, patients with diabetes were, up until the 1970s, managed primarily by specialists. Now, patients use highly sensitive blood glucose monitors and use micro-needles to inject synthetic human insulin. Hospitalization rates (according to data from the Centre for Disease Control in the United States) have been reduced from 379.4 per 1,000 diabetic patients in 1988 to 223.7 in 2009.³⁰

By defining medical necessity in terms of providers rather than in terms of illnesses (as has been done in other jurisdictions), the Canada Health Act was written too rigidly to allow our insurance plans to adjust for innovations in disease treatment technology. It is important to remember that this is as true now as it will be in twenty years. Though we now appreciate the short-sightedness in not covering prescription drugs under the Canada Health Act, amending the Act to include them, or enacting new legislation to ensure universal coverage in Canada, does not change the fact that Canadians could run in to these issues each time a new, better way to treat an illness arises. Each time, there will be confusion about whether or not to cover the technology, for which groups, and for what price, as well as a myriad of other decisions. These will be repeated thirteen times over in each of the provinces and territories. Alternatively, provinces may not engage in any of these decisions at all, and technologies will, by default, be left to the private sector with likely deleterious consequences for equitable access.

30 Centers for Disease Control and Prevention. "Crude and Age-Adjusted Hospital Discharge Rates for Diabetes as Any-Listed Diagnosis per 1,000 Diabetic Population, United States, 1988-2009." Diabetes Public Health Resource. <http://www.cdc.gov/diabetes/statistics/dmany/fig3.htm> (accessed March 16, 2015).

DEMOGRAPHIC

Demographic change is another important driver that contributes to the need for a new configuration of Medicare. It can be argued that the Medicare formulated in the 1960s at a time when most baby boomers were under ten years old³¹ is not adequate to meet the needs of Canadians in 2014, and certainly not the needs of Canadians in the future. Canada's aging population means that demand for prescription drugs³² and long-term care will increase in coming years. Both prescription drugs and long-term care fall in to the residual category and are provided in a patchy way across the provinces. Nonetheless, many provinces provide prescription drug coverage to citizens over the age of 65, and all provinces cover a significant portion of the cost of long-term care facilities (see Figure 2). Thus an aging population will place increasing demands on provincial finances and deserves significant policy attention in any reconfiguration of Medicare.

31 Statistics Canada. "Historical age pyramid." <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/pyramid-pyramide/his/index-eng.cfm> (accessed March 16, 2015).

32 Canadian Institute for Health Information. *Prescribed Drug Spending in Canada, 2012: A Focus on Public Drug Programs*. 2012. Accessed March 16, 2015. https://secure.cihi.ca/free_products/Prescribed_Drug_Spending_in_Canada_EN.pdf

COMPARATIVE CASE STUDIES

As mentioned above, Canada is unique in that it defines medical necessity and thus decides what to offer coverage for based on provider (hospital and physician). Other countries define medical necessity in broader terms. Though it may be surprising to some Canadians, the United States and their Patient Protection and Affordable Care Act (“Obamacare”), provides an excellent case study for how medical necessity could have been defined in a less rigid way. The Act delineates ten broad categories of “essential health benefits” that plans must cover. These are very broadly conceived and centre on the health issues themselves rather than shackling coverage to a specific provider. For example, some of the categories are: paediatric oral and vision care; mental health, substance use and behavioural health services; preventive and wellness services; and chronic disease management.³³ The benefits of this method of defining medical necessity are obvious: “the statutory definitions generally do not refer to specific types of providers and leave to evolving regulation decisions about what services will be covered. Over time, states, insurers and patients can decide whether a particular rehabilitative need is best met through a licensed therapist, a specialist physician, a drug or a therapeutic device. Coverage under the statute can accommodate this choice.”³⁴

Leaving aside examples of how best to define medical necessity, another interesting case study that could be instructive to Canadians, is the case of the United Kingdom’s National Institute for Health and Care Excellence (NICE). NICE was established in 1999 to reduce variation in health services between different regions in the UK,³⁵ an important goal in the context of the UK’s national health service. Over time, NICE’s mandate and designation has changed so that it is now responsible for developing guidance on public health and social care. Most relevant to this analysis, NICE evaluates and produces guidelines related to new and existing technologies and clinical best practice.

33 Glied, Sherry, and Mark Stabile. “What Canada can learn from Obamacare.” *The Globe and Mail*, October 19, 2012. <http://www.theglobeandmail.com/globe-debate/what-canada-can-learn-from-obamacare/article4621937/> (accessed March 16, 2015).

34 Ibid.

35 National Institute for Health and Care Excellence. “Who we are.” <https://www.nice.org.uk/about/who-we-are> (accessed March 16, 2015).

NICE has quickly become an international standard for excellence in evaluating health technologies because of its rigorous analytical methodology for making recommendations. Having a highly-respected and trusted agency that makes well-founded recommendations about public coverage is useful in the context of constant health technology innovation and in an era where policy makers and politicians are trying to control health care spending while maintaining or improving outcomes.

RECOMMENDATIONS

Canada should establish a NICE-like agency to make recommendations to provincial governments on new and existing health technologies and on clinical best practices. This agency could either be pan-Canadian (a joint project by the provinces) or federally run. The goal of the agency would be to produce recommendations that are taken up by the provinces and inform provincial health insurance coverage decisions. Legitimacy of the agency would be of utmost importance: having rigorous, transparent evaluation methods that are fair and above reproach would go a long way in making recommendations that provinces cannot ignore. It is also crucially important that evaluations are carried out on both new and existing technologies and practice. Regular evaluations of existing technologies should be assessed and readily recommended for delisting when the evidence base no longer supports the service in question as being the most efficacious treatment option.

This agency could be built on the existing Canadian Agency for Drugs and Technology in Health (CADTH), which provides evidence for decision makers on the optimal use of drugs and technology. The funding recommendations made by the CADTH are largely adhered to across the country and its mandate could grow.

Such an agency would address many of the issues raised above. It would evaluate services in both the single-payer system and the residual system, and would make recommendations about coverage regardless of which system the service is part of. It would also go a long way in improving inter-provincial equity, provided that provinces are all equally willing and able to follow the recommendations of the agency.

Canada should enact legislation to ensure at least a base level of prescription drug coverage for all Canadians. Ideally, the approach to drug coverage would come from the federal government in order to reduce administrative costs and ensure consistency. A national drug plan, instigated either by an amendment to the CHA or through entirely new legislation would probably provide the

most elegant, administratively simple and equitable solution to the problem,³⁶ and would be completely in line with the spirit, if not the letter, of the CHA as currently written. In the absence of federal leadership, this policy could be enacted at the pan-provincial level as well.

Coverage does not necessarily have to be single-payer, first-dollar coverage as Canadians have for hospitals and physician services. Rather, it could be a social insurance scheme established alongside existing private plans. The plan could be similar to Quebec's pharmacare system in which those who are eligible for coverage under a private, employer-based group plan are required to register and those not eligible for such a plan are required to enrol in the public plan.³⁷ Governments that have integrated private and public insurance in this way also heavily regulate private insurance in order to ensure accessibility and universality. This is done by placing limits on premiums and including requirements to cover all drugs on the public formulary.^{38,39} Given the pattern of use of prescription drugs amongst the elderly, it will be important that any scheme incorporate a mechanism for the elderly to contribute a fair amount to the plan in order to ensure inter-generational equity and the sustainability of the program.⁴⁰ This type of structure is more realistic given the significant and well-established presence of private drug companies in this area.⁴¹ Social insurance schemes also increase revenue available for health care services by adding an additional revenue stream separate from general taxation and federal transfers.⁴² Additionally, social insurance schemes tend to have more public support since there is a clear, direct link between the contribution and the benefit.⁴³

This recommendation addresses a number of the issues raised in this piece. It acknowledges the importance of prescription drugs, a major omission from the Canada Health Act. If enacted at a federal level, this policy would address inter-provincial inequity as well. Even if established provincially, the provinces

36 Morgan, Steven G., Michael Law, Jamie R. Daw, Liza Abraham, and Danielle Martin. "Estimated cost of universal public coverage of prescription drugs in Canada." *Canadian Medical Association Journal* (2015): cmaj-141564.

37 Colleen, Flood M., Mark Stabile, and Carolyn H. Tuohy. "Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance." (2008): 257-8.

38 Ibid., 267.

39 Allin, S., Mark Stabile, and Carolyn Hughes Tuohy. "Financing models for non-Canada Health Act services in Canada: lessons from local and international experiences with social insurance." Ottawa: Canadian Health Services Research Foundation, 2010. Accessed March 16, 2015. http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/CHSRF_4FinancingModels_En-final2.pdf?sfvrsn=0

40 Colleen, Flood M., Mark Stabile, and Carolyn H. Tuohy. "Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance." (2008): 253.

41 Ibid., 268.

42 Allin, S., Mark Stabile, and Carolyn Hughes Tuohy. "Financing models for non-Canada Health Act services in Canada: lessons from local and international experiences with social insurance." Ottawa: Canadian Health Services Research Foundation, 2010: 23. Accessed March 16, 2015. http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/CHSRF_4FinancingModels_En-final2.pdf?sfvrsn=0

43 Colleen, Flood M., Mark Stabile, and Carolyn H. Tuohy. "Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance." (2008): 255.

could collaborate on a common drug formulary and on bargaining with pharmaceutical companies in order to both lower costs and promote equality of coverage between the provinces. Social insurance schemes could eventually be rolled out for other services not covered by the CHA, for example home care. It would be beneficial to start in one area with pharmaceuticals in order to learn as many lessons as possible about social insurance scheme implementation, before moving on to other areas. Starting with prescription drugs also makes sense since it is the fastest growing area of total health expenditure⁴⁴ and is currently the largest area of growth in the health care technology field⁴⁵ — introducing a new, dedicated revenue stream will take some pressure off of ministry of health budgets. The report by the Mowat Centre for this project explores other options and issues related to addressing this glaring gap in Canada's social architecture.

44 Institute for Competitiveness and Prosperity. *Building Better Health Care: Policy Opportunities for Ontario*. Toronto: Institute for Competitiveness and Prosperity, 2014: 15. Accessed March, 2015. http://www.competeprosper.ca/uploads/WP20_BetterHealthCare_FINAL.pdf.

45 Colleen, Flood M., Mark Stabile, and Carolyn H. Tuohy. "Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance." (2008): 267.

CONCLUSION

Canadian Medicare enjoys pride of place as Canada's most revered and cherished social programs. The peculiar way in which medical necessity is defined in the Canada Health Act (medically necessary services are those provided in hospital or by a physician), was appropriate in the 1960s and '70s when it was originally established, a time when hospital and physician services accounted for 60% of total spending. That figure now stands at around 40% due to changes in technology and demographic pressures. Canada must address the gaps in coverage left by the Canada Health Act in a way that recognizes that health technologies are constantly changing. Establishing an arms-length agency that systematically evaluates and makes recommendations on new and existing technologies and clinical practices would go a long way in ensuring consistent and reasonable coverage of services outside and inside the Canada Health Act definition of medical necessity. Establishing a universal pharmacare system funded through a social insurance scheme is recommended in order to correct for a major omission in the Canada Health Act and is also an opportunity to learn about implementing social insurance schemes for use in other areas in the future. Ensuring that Medicare remains a point of pride for Canadians rests in ensuring that Medicare covers what is reasonable given modern realities, not what is convenient given outdated legislation.

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RENEWING CANADA'S SOCIAL ARCHITECTURE

Renewing Canada's Social Architecture is a collaborative project involving researchers from the Mowat Centre, the Caledon Institute for Social Policy, the Institute for Competitiveness and Prosperity and the Institute for Research on Public Policy. The purpose of the project is to advance public dialogue on our social architecture, and highlight areas where our core social programs and policies require modernization to meet Canadians' needs. Each report contributed to the project is the responsibility of the authors alone, and does not necessarily reflect the views of the other contributors or organizations.

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