50 years of waiting for Pharmacare is Long Enough
by Joel Lexchin, MD

Fifty years ago Canada decided to adopt a single public payer for hospital care, 40 years ago we made the same decision for doctors' services and the1984 Canada Health Act reaffirmed these decisions. Everyone should be covered, no one should pay out of pocket and money to cover doctors and hospital care should come from the public purse. As a result of these decisions we spend 50% less than the United States on health care, but we live longer and have significantly lower infant mortality rates.

However, when it comes to pharmaceutical care we are still where we were more than 50 years ago. Some people are covered by provincial plans, some people have private insurance and an unacceptable number of people – somewhere in the range of 4.3 million Canadians - either are not covered at all or their coverage is not adequate. The poorest fifth of the Canadian population spends more money out-of-pocket on prescription drugs than the richest fifth. For people over 65 it makes a significant difference which province you live in when it comes to drug therapy. A low-income senior in Saskatchewan with average drug use in 1998 would pay $500 out-of-pocket but the same person with the same drug use in Ontario would pay less than 1/10 that amount.

Internationally, Canadian public spending on drugs as a percent of total drug costs or on a per capita basis ranks near the bottom of the list of industrialized countries. The only place that consistently has a worse record than Canada is the United States.

So, purely from the point of view of equity there is a strong argument to move away from our current chaotic mess to the same system that we use for doctors and hospitals. But there are other compelling reasons to go that route. Even adjusting for inflation the amount that we spend on drugs is going up at about 7-8% per year or 3 times the rate of inflation. Since the late 1990s we have been paying more for drugs than for doctors.

One of the main factors accounting for this continual inflation is the use of newer more expensive drugs in place of older, less expensive products. For example, by 1998/99 over half of the $1.9 billion being spent by the Ontario Drug Benefit Program was on drugs introduced since 1992/93. Concentrating spending on newer drugs does not mean spending on more effective products. Assessments of the value of new drugs from Canada, France and the USA all show that at best one quarter of new drugs offer some additional clinical benefit and perhaps as few as 3% are major therapeutic advances. Encouraging prescribing of older, less expensive, but still effective drugs makes rational economic sense but is difficult to achieve in an environment of multiple payers.

Having a single national buyer, as in the Australia that produces prices 10% lower than those in Canada, is significantly diluted when the state does not pay for the bulk of the drugs prescribed. Other measures like tendering for products available from multiple sources and cross price subsidization (requiring lower prices for already listed drugs in return for accepting new listings) that have cut the New Zealand drug budget by almost 50% stand little chance of success in a world of multiple payers.

A third and final reason for having pharmacare is to help improve the quality of prescribing. When new drugs come onto the market, we know relatively little about their safety profile because rarer side effects will often be missed. Unless these drugs are major therapeutic breakthroughs, and that happens relatively infrequently, it makes sense to introduce these drugs gradually. Economic incentives and disincentives can be used to limit prescribing of new drugs but these are only going to be successful when they apply to the majority of prescribing decisions. If government is covering most of the cost it is also going to be concerned that it is getting good value for its money and will have an incentive to ensure appropriate prescribing. In Australia, the federal government is providing the independent National Prescribing Service about $8 million a year to help improve physicians' prescribing and patients' use of prescription drugs.

The latest proposals from the inquiries conducted by Kirby and Romanow and the First Ministers have called for a national catastrophic drug insurance plan. While better than nothing for those without any insurance, this proposal is still far from adequate. Under the plan proposed by Kirby, drug insurance would only start after people had spent somewhere between 2-4% of their annual income. In Ontario where the minimum wage is $7.10 per hour that would mean paying between $286-$572 before getting any benefits.

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More private insurance through the workplace is also not the answer. Since workplace benefits are tax free, that translates into larger benefits the more one makes, just the opposite of what we should be striving for – larger benefits for those at the bottom end of the income scale.

Financing pharmacare through user fees or deductibles should not be an option. The problems of shifting expenses onto disadvantaged populations are highlighted by the experience in Quebec. A significant increase in cost sharing for the elderly and those on welfare there lead to a drop in essential drug use in both groups and corresponding increases in visits to emergency departments, doctors and hospital admissions.

When the provincial premiers proposed a federal national pharmacare plan last summer, the excuse for not implementing it was that the federal government could not afford the expense. Certainly there would be increased costs – probably on the order of about $7.7 billion above what federal and provincial governments are currently spending. However, it is important to recognize that as a society we are already spending the money, what we are choosing is how to spend it: through a combination of public and private insurance and out-of-pocket payments with all the problems that this leads to, or rationally the way we already do on doctors and hospitals. Moreover, overall costs would actually drop under pharmacare – administrative costs are lower in a public system than in a private system and a single national system would allow for greater bargaining power with the drug companies. Another frequent excuse is that every country has deductible or copayments for drugs. While this is true, in England 80% of the prescriptions written are exempt from the copayments and Wales will eliminate copayments entirely by 2007.

Pharmacare makes sense on all three grounds – equity, economic efficiency and improving prescribing – it's time we mustered the political will power at the federal level and just got on with it.

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