National pharmacare

Time to move forward

Leila Salehi MD CCFP(EM) MPH

Canada is unique among highly developed countries in its curious exclusion of prescription drug coverage from its universal health insurance program, as well as its comparatively high per capita costs for prescription medications. It is time to address this notable coverage gap in our health care system, both in order to improve access to health care within our population and to stem the rapidly rising costs of prescription medications.

Rising costs, shrinking resources, "patchwork" coverage

The omission of prescription medications from the definition of *medically necessary services* (which are largely defined in provincial and federal health insurance programs as those carried out by a physician or within a hospital) is likely a reflection of their marginal role in health care and health care delivery at the time of the *Canada Health Act's* enactment.[1,2] Before the 1980s, prescription medication costs made up a relatively small proportion of health care spending. The 1980s marked a period of rapid growth for the pharmaceutical sector, owing to multiple factors such as scientific and technological advances in pharmacology; changes in population size, demographic characteristics, and health status; and shifts in patent laws and innovations in the marketing of pharmaceutical products. This has led to a surge of newer and more expensive medications on the market, in tandem with a greater prominence and influence of the pharmaceutical industry within the realm of health care.[3-6]

As a result, prescription and retail drugs have become 1 of the top 3 largest contributors to health expenditure in Canada, alongside hospital and physician services.[7-9] Total spending on prescription drugs has nearly quadrupled since the 1990s, of which 42% is financed by the public sector and 23% is paid out of pocket by patients. The per capita cost of prescription medications has undergone a more than 5-fold increase since 1984.[7,10]

In order to address the drug coverage gap, Canada's provinces and territories began, one by one, to organize and establish public drug benefit programs, mainly targeted at elderly and low-income populations.[11,12] The federal government itself oversees a number of drug insurance programs for certain subsets of the population. In total, Canada's health care system consists of 19 publicly funded drug plans: 10 provincial, 3 territorial, and 6 federal. In addition, there are numerous private drug insurance programs offered by employers, unions, and professional associations across the country, creating a veritable patchwork of drug coverage for beneficiaries.[4,13,14] Each of these programs varies in its coverage, eligibility, and benefit-payment scheme. Given most drug insurance programs' requirement for some degree of cost sharing on the part of the beneficiary, coupled with the varying coverage and payment schemes between provinces, beneficiaries can expect to pay more or less—and have varying access to essential medicines—depending on where they live.[15]

Both the health care and the economic effects of this lack of equitable access to drugs have been explored in several studies, which have shown that higher copayments are associated with lower rates of medication compliance.[16,17] Further, while higher cost sharing might be associated with lower medication use—which would lead to cost savings for the drug plan—it is also associated with higher rates of physician and emergency department visits, hospitalizations, and adverse health events, which have been shown to result in greater costs than those saved by the drug plan.[16,18] Another fiscally pragmatic objection to the current Canadian model is the added marketing and underwriting costs present in a private program, as well as the extra costs borne by the organizational and administrative redundancy inherent in a multipayer system.[19] Further, given that a private drug insurance plan can pass on any increases in expenditures to the beneficiaries in the form of higher premiums, there is little incentive to attempt to stem the growing costs within the program itself. In essence, private sector health insurance increases overall costs without improving the quality of health care delivery, given that the overarching goal of the private sector is not cost containment or improved health outcomes, but rather the maximization of profit.[19,20]

Working toward sustainable pharmacare

Calls for a national pharmacare program have been motivated by both matters of equity and the right to universal health care (values that are foundational to

This article has been peer reviewed.
Can Fam Physician 2016;62:544-6

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro **de juillet 2016** à la **page e361**.

Canada's health care system), as well as more pragmatic matters of potential cost savings inherent in a single-tier, single-payer, publicly administered system. Recent economic analyses placed the administrative costs of the public plans at a fraction of those in the private sector.[21-23] Multiple other reports and cross-national comparisons have highlighted the cost savings—estimated at several billion dollars—of a national universal drug insurance plan brought about by the increased efficiency of a publicly administered system and reduced spending on drugs through the use of a common drug formulary, generic medications, and more aggressive price negotiation and regulation of pharmaceutical products.*[24-26] These potential cost-containment strategies have been largely untapped in the past, in large part owing to the lack of coordination between provincial drug plans. Currently, the provincial programs collectively finance well over a third of the national prescription drug expenditures.[7] Were they to act collectively, this would give Canada's public sector a considerable degree of bargaining power in negotiating drug prices with the pharmaceutical industry. One strategy adopted by provincial programs that showcases the potential cost savings in collective negotiation is the creation of the pan-Canadian Pharmaceutical Alliance. Established in 2010, the pan-Canadian Pharmaceutical Alliance leverages the joint purchasing power of all 13 provincial drug programs (and, as of February 2016, the federal programs) through joint provincial-territorial negotiations with pharmaceutical companies for a limited number of medications purchased by the drug plans.

Another missed opportunity lies within the area of price monitoring and regulation of medications. The Patented Medicine Prices and Review Board is an independent quasi-judicial federal body that monitors the prices of patented medications to ensure that they are not excessive. The limit on the allowable price for a particular drug is set at the median price charged for that drug in 7 competitor countries.[21] However, given that drug prices in these countries are among the highest in the world, this policy has few favourable effects on drug pricing in Canada.

The issue of spotty and inadequate drug insurance has been a constant presence in Canada's health care system over the past several decades.[2] Calls for a national pharmacare plan—and a resultant federal, provincial, and interprovincial collaboration—date back to the 1960s with the Royal Commission on Health Services recommendation for universal drug coverage, and most recently within the Romanow report and the National Pharmaceuticals Strategy launched in 2002 as a result of its recommendations.[22,27]

Unfortunately, despite the initial public enthusiasm and political momentum around national pharmacare, the National Pharmaceutical Strategy's attempts became mired in budgetary constraints, jurisdictional battles, and shifting political and public interests.[28,29] The failure of a national drug formulary, as well as that of a common pricing and purchasing strategy, likely arose from the already entrenched provincial drug review processes, formularies, and existing negotiating relationships with private pharmaceutical companies.[21,27] The political momentum all but disappeared when the Conservative Party was voted into a minority government in 2006 and into a majority government in 2011.

National pharmacare: moving forward

This past October the Liberal Party swept into government on a wave of optimism, hopefulness, and a promise of "real change." The Liberals have already made inroads in reversing the previous government's lack of engagement with the provinces in issues of health and social welfare. The party's stated commitment to investing in expanding home care and long-term care, and a promise to engage with the provinces in improving access to prescription medications, increasing common purchasing strategies, and developing strategies to ensure safe and effective prescribing, raises hopes that a national pharmacare plan might now have a chance at becoming a reality. As well, public opinion polls indicate that by far most Canadians are in favour of a national pharmacare plan.[30] The creation of a federal-provincial working group on pharmaceutical strategy during the most recent provincial, territorial, and federal health ministers' meeting is an important first step. What is now needed is strong leadership at the federal level and a strong shared vision among the provinces, starting with an explicit commitment to developing universal pharmacare, followed by a timeline and specific goals and objectives, in order to capitalize on the current momentum and to ensure equal access to comprehensive, high-quality health care free of financial barriers for all Canadians.

*A common drug review, national formulary, and treatment guidelines will also improve prescribing practices by limiting the use of newer, costlier medications with little or no therapeutic benefits over older, less expensive drugs. Models for this type of policy include the BC PharmaCare program and its partnership with University of British Columbia's Therapeutics Initiative, and the UK National Institute for Health and Care Excellence.

Dr Salehi is Adjunct Assistant Professor in the Department of Family and Community Medicine at the University of Toronto in Ontario and at Northwestern University Feinberg School of Medicine in Chicago, Ill, and is completing a Masters in Health Policy and Management at Columbia University Mailman School of Public Health in New York, NY.

Competing interests
None declared

Correspondence
Dr Leila Salehi; e-mail **leila.salehi@utoronto.ca**

References

1. Al-Sukhni M, Ballantyne P. Pharmaceutical-related strategies for health care reform in Canada: federal party principles, priorities, and actions 2004-2006. *Can Pharm J* 2007;140(1):38-45.
2. Morgan SG, Daw JR. Canadian pharmacare: looking back, looking forward. *Healthc Policy* 2012;8(1):14-23.
3. Canadian Institute for Health Information. *Drug expenditure in Canada 1985-2005.* Ottawa, ON: Canadian Institute for Health Information; 2006.
4. MacDonald K, Potvin K. Interprovincial variation in access to publicly funded pharmaceuticals: a review based on the WHO Anatomical Therapeutic Chemical Classification System. *Can Pharm J* 2004;137(7):29-34.
5. Morgan SG. Quantifying components of drug expenditure inflation: the British Columbia seniors' drug benefit plan. *Health Serv Res* 2002;37(5):1243-66.
6. Morgan S. Drug expenditure trends in the Canadian provinces: magnitude and causes from 1998 to 2004. *Healthc Policy* 2005;1(1):85-99.
7. Canadian Institute for Health Information. *Exploring the 70/30 split: how Canada's health care system is financed*. Ottawa, ON: Canadian Institute for Health Information; 2005.
8. Canadian Institute for Health Information. *National health expenditure trends, 1975-2014.* Ottawa, ON: Canadian Institute for Health Information; 2014.
9. MacKinnon JC. The arithmetic of health care. *CMAJ* 2004;171(6):603-4.
10. Morgan S, Kennedy J. Prescription drug accessibility and affordability in the United States and abroad. *Issue Brief* (Commonw Fund) 2010;89:1-12.
11. Morgan SG, Barer ML, Agnew JD. Whither seniors' pharmacare: lessons from (and for) Canada. *Health Aff* (Millwood) 2003;22(3):49-59.
12. Detsky AS, Naylor DC. Canada's health care system—reform delayed. *N Engl J Med* 2003;349(8):804-10.
13. Grootendorst P. Beneficiary cost sharing under Canadian provincial prescription drug benefit programs: history and assessment. *Can J Clin Pharmacol* 2002;9(2):79-99.
14. Blanchette C. *Provincial and private drug insurance plans in Canada*. Ottawa, ON: Parliamentary Research Branch; 1996.
15. Demers V, Melo M, Jackevicius C, Cox J, Kalavrouziotis D, Rinfret S, et al. Comparison of provincial prescription drug plans and the impact on patients' annual drug expenditures. *CMAJ* 2008;178(4):405-9.
16. Lexchin J. Effects of prescription drug user fees on drug and health services use and on health status in vulnerable populations: a systematic review of the evidence. *Int J Health Serv* 2004;34(1):101-22.
17. Doshi JA, Zhu J, Lee BY, Kimmel SE, Volpp KG. Impact of a prescription copayment increase on lipid-lowering medication adherence in veterans. *Circulation* 2009;119(3):390-7. Epub 2009 Jan 12.
18. Colombi AM, Yu-Isenberg K, Priest J. The effects of health plan copayments on adherence to oral diabetes medication and health resource utilization. *J Occup Environ Med* 2008;50(5):535-41.
19. Law MR, Kratzer J, Dhalla IA. The increasing inefficiency of private health insurance in Canada. *CMAJ* 2014;186(12):E470-4. Epub 2014 Mar 24.
20. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med* 2003;349(8):768-75.
21. Gagnon MA, Hebert G. *The economic case for universal pharmacare: costs and benefits of publicly funded drug coverage for all Canadians*. Ottawa, ON: Canadian Centre for Policy Alternatives; 2010.
22. Morgan SG, Martin D, Gagnon MA, Mintzes B, Daw JR, Lexchin J. *Pharmacare 2020: the future of drug coverage in Canada.* Vancouver, BC: Pharmaceutical Policy Research Collaboration; 2015.
23. Morgan SG, Law M, Daw JR, Abraham L, Martin D. Estimated cost of universal public coverage of prescription drugs in Canada. *CMAJ* 2015;187(7):491-7. Epub 2015 Mar 16.
24. Morgan S, Bassett K, Mintzes B. Outcomes-based drug coverage in British Columbia. *Health Aff* (Millwood) 2004;23(3):269-76.
25. McMahon M, Morgan S, Mitton C. The common drug review: a NICE start for Canada? *Health Policy* 2006;77(3):339-51. Epub 2005 Oct 6.
26. Morgan S, Hanley G, McMahon M, Barer M. Influencing drug prices through formulary-based policies: lessons from New Zealand. *Healthc Policy* 2007;3(1):e121-40.
27. Health Council of Canada. *A status report on the National Pharmaceutical Strategy: a prescription unfilled.* Toronto, ON: Health Council of Canada; 2009.
28. Daw JR, Morgan SG, Thomson PA, Law MR. Here today, gone tomorrow: the issue attention cycle and national print media coverage of prescription drug financing in Canada. *Health Policy* 2013;110(1):67-75. Epub 2013 Feb 6.
29. MacKinnon NJ, Ip I. The National Pharmaceuticals Strategy: rest in peace, revive or renew? *CMAJ* 2009;180(8):801-3.
30. Angus Reid Institute. *Prescription drug access and affordability an issue for nearly a quarter of all Canadian households*. Vancouver, BC: Angus Reid Institute; 2015. Available from: **http://angusreid.org/wp-content/uploads/2015/07/2015.07.09-Pharma.pdf**. Accessed 2016 Jun 1.