Is pharmacare the prescription Canada needs?

The debate on universal pharmacare

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CONTEXT

The mounting costs of pharmaceuticals are an emergent concern for Canadians. With the highest per capita drug expenditure in the Organisation for Economic Co-operation and Development (OECD), apart from the United States, the sustainability of Canada's drug coverage system has been called into question. Universal pharmacare, defined as the federal provision of drug coverage for all Canadians, has been suggested as a potential solution to the sustainability issue, which would also help mitigate some of the inequities of the current fragmented system.¹ At present, provincial drug plans cover anywhere between 26% and 45% of prescription drug costs depending on the province while voluntary private insurances cover up to 38% of costs, except in Quebec where insurance is mandatory.² Public funding for prescription costs is at most 44% compared to 99% funding for hospital costs and 90% for medical costs.¹ This article will present the benefits and limitations of implementing universal pharmacare in Canada.

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The largest benefit of universal pharmacare would be the reduction of pharmaceutical costs for insurers and individuals. One strategy used by Australia, New Zealand and several European countries is the negotiation of bulk purchase agreements where federal governments purchase large quantities of pharmaceuticals from a provider pharmaceutical company.^{3,4} Savings for individuals and insurers are multifactorial. Decreased redundancy lowers administrative expenses, reduces dispensing fees on large volume orders accepted by provider pharmacies and secures more favourable deals through bulk purchasing agreements.^{3,4} The provinces already engage in separate less-efficient bulk purchasing agreements.^{5,6} A single unified federal agreement would markedly increase our collective purchasing power, shifting the economic surplus away from producers.^{3,4,6,7}

Implementation of universal pharmacare could also result in savings for the federal government. The report entitled *The Economic Case for Universal Pharmacare* projects that Canada could save up to \$2.9 billion yearly—about 12% of the federal government's spending on drugs.⁴ The April 2015 *Canadian Medical Association Journal* article by Dr Morgan et al argues that universal pharmacare could reduce total spending on prescription drugs by \$7.3 billion, with \$8.2 billion in savings accruing to the private sector. Government costs were projected to increase by \$1.0 billion.⁷

Public funding for subsidizing pharmaceutical costs of individuals is currently administered on a provincial basis. Unfortunately, provinces have disparate coverage plans, which undermine purchasing power, contribute to excessive administration costs

and force patients to bear expensive out-of-pocket costs. Ontario's age-dependent drug plan is a fixed subsidy per pharmaceutical for seniors (above the age of 65 years) while nonseniors can register for a drug plan where the deductible is a function of household income. For nonseniors, the government is a payer of last resort, diminishing its purchasing power and leaving uninsured nonseniors exposed to high drug costs. The effects of fragmented financing are worse in British Columbia with its solely income-based drug coverage plan.⁸

Comparing expected out-of-pocket drug costs for median-income seniors (income of approximately \$52 000 in 2012) shows that the highest costs are in British Columbia (\$1000 deductible and 25% copay) with the lowest in Ontario (\$100 deductible and \$6.11 copay/prescription).⁹⁻¹¹ For median income (approximately \$77 000 in 2012) nonseniors, expected out-of-pocket drug costs are higher in Ontario (deductible 4% of net income and \$2.00 co-pay/prescription) than British Columbia (\$2250 deductible and 30% co-pay), but costs would be comparable for individuals exceeding Ontario's deductibles.^{8,9,11,12} In the end, it is the patient who suffers, with noncompliance rates paralleling the out-of-pocket costs borne.¹³ Ironically, noncompliance spurred by excessive drug prices costs the system even more money in the form of unnecessary future hospitalizations.¹⁴ Having a single-payer-funded drug coverage plan would increase the purchasing power of Canada and reduce out-of-pocket drug costs for Canadians.

As it stands, Canadians spend too much money on pharmaceuticals and costs are still growing. From 2000-2010, the drug share of national healthcare costs rose from 15.4% to 16.3%.¹ Implementing universal pharmacare offers a chance to reduce pharmaceutical costs for patients, potentially increase savings for the federal government and resolve the fragmented financing of provincial drug plans in order to ensure fair and equitable access to pharmaceuticals.

LIMITED POLITICAL AND PUBLIC SUPPORT

Canada is a poor performer when it comes to drug spending and population coverage among OECD countries. It is often implied that there is an association between Canada's performance and the fact that it is the only country with universal health insurance that excludes drug coverage.⁴ There have been calls for a national drug strategy dating back to 1964, but barriers to implementation have prevented a national strategy from coming to fruition.¹⁵ This section will review these barriers and argue that universal pharmacare may not be necessary to reduce drug expenditures, nor be sufficient to improve coverage.

Evidence is mounting against cost as a barrier to implementation; a number of recent studies claim that universal pharmacare

has the potential to be cost-saving.^{4,7} However, these estimates are derived from computer simulations which simplify real interactions in the health system and must be viewed through a critical lens. Furthermore, with a federal government that skirted the issue of universal pharmacare in its platform, it is unlikely that economic evidence will be used to inform decision-making on this front in the near future.¹⁶

The most significant barrier to implementation has been the reluctance of federal governments to consider a national pharmaceutical strategy.¹⁶ Aside from the upfront costs of reforming the current system, national pharmacare would require that governments that currently maintain heterogeneous formularies agree on which drugs should be covered. Although steps have been taken to standardize drug prices and coverage on a national scale through the Pan-Canadian Pricing Alliance (PCPA) and the Common Drug Review, adherence to these strategies is not uniform across public drug plans.¹⁷ Until Canada can achieve improved participation on such initiatives, it is unlikely that a federal government could successfully negotiate a national system with the provincial governments that hold the health care bargaining power. Additionally, the federal government must consider the interests of stakeholder groups, namely pharmaceutical manufacturers and private insurers, who stand to lose if Canada succeeds in cutting costs and achieving universal coverage.¹⁸ For successful implementation, the government must counter the rhetoric of these groups which has led 61% of Canadians to believe that “no matter what the research shows, a national pharmacare plan will end up costing taxpayers lots of money.”¹⁹ Finally, the government faces a lack of constituent support for the potential increases in public spending and the reduced patient choice that would be associated with switching from a predominantly private system to a predominantly public system. The majority of Canadians would oppose increasing the goods and services tax (GST) or income tax by 1% for incomes over \$40 000 to achieve the additional \$1 billion in public funds needed for pharmacare.¹⁹ Public support may fall even further considering that a universal system would likely mean reduced patient choice and delayed access to new drugs.²⁰ Depending on the extent to which choice and access are limited, universal pharmacare may not be sufficient to improve inequities in coverage.

CONCLUSION

There is hope for Canada still. Targeted solutions to inefficiencies in the pharmaceutical system minimize the need for complete reform and are therefore more likely to be adopted by federal and provincial governments. Proponents of universal pharmacare claim that savings will be primarily achieved by reducing generic and brand name prices and increasing cost-effective product selection. A national system is not required to improve performance on these indicators. In fact, where we do have a national model for drug provision (fractionated biologics), Canada has not demonstrated that it can achieve prices that are competitive with other OECD countries.¹⁸ Reviewing inefficient drug policy is a key first step. Reduced drug prices could be realized by eliminating the Patented Medicine Prices Review Board policy of artificially inflating drug costs to encourage research and development, and removing the set ceiling on

generic prices by switching to the competition model used in comparator countries. Avoiding unnecessary polypharmacy in the elderly and actively deprescribing superfluous drugs could also save Canada up to \$1 billion annually.⁷ Moreover, the PCPA could expand to include federal and private plans, increasing its negotiating power. Cost effective product selection could be achieved by increasing the prescription rates of off-patent medications and increasing rates of generic substitution, which is a source of significant cost savings in the United Kingdom.⁷ Clinical leadership is needed to influence prescribing patterns. It is unlikely that a national formulary would be necessary or sufficient to fulfill this objective.

Fingers often point to the lack of a national pharmacare strategy when considering Canada's international ranking on drug expenditures, but universal pharmacare may not be the magic bullet many perceive it to be. Although it has the potential to be cost-saving, the federal government has not expressed interest in overseeing and funding its implementation. There would be more value in further research investigating the potential costs and benefits of targeted strategies to improve system inefficiencies, which do not have the same political barriers impeding their uptake.

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