ANALYSIS

National pharmacare: a dog's tale

Even before the first parliament of our newly elected government is in session, health care funding is once again under the spotlight as the provincial premiers call on the new federal government to fund and manage a national pharmacare program. The federal government's response has been to throw cold water on this long-smouldering debate by offering to cover Canadians against catastrophic drug expenditures as well as promising to spread their health care dollars on other priorities such as the reduction of waiting times. No doubt health care will dominate if not highjack the First Ministers conference on health care on Sept. 13–16. What are Canadians to make of the rhetoric that so fiercely pits federal leaders against their provincial counterparts? An examination of the competing proposals reveals that, given the lack of specifics for each plan, the overall economic and health implications of either option are unknown.

One gaping hole in Canadian medicare is the lack of universal public insurance for outpatient drugs. The benefits of prescription drugs are undeniable, but their full potential, as Roy Romanow noted in the report of his Royal Commission,[1] will be realized only once they are fully integrated into the health care system in a way that ensures their appropriate utilization.

Recognizing that drug insurance coverage across the country is quite disparate, Romanow called for the establishment of a new national drug agency, a national formulary, a medication management program (national treatment guidelines), patent review and, most importantly, a catastrophic drug transfer program (CDTP). In essence, the CDTP proposal called for the federal government to establish a mechanism to direct additional funds to each of the provincial drug plans according to the number of people in the province with catastrophic drug expenditures. Any expenditures over $1500 per person per year would be eligible for 50:50 cost-sharing with the federal government. The only condition for receiving this money would be that the provinces would have to direct the federal transfers back into their provincial drug plans, essentially improving the level of drug coverage or reducing patient cost-sharing (by lowering deductibles and copayments), or both. To date, none of the provinces has embraced this proposal. Moreover, there has been no discussion or debate about the merits of Romanow's CDTP proposal. Rather, approximately 18 months after publication of Romanow's report, the provincial premiers have finally pre-empted any such debate by floating an alternative proposal, calling on the federal government to fully fund and manage a national pharmacare plan. Although details of the premiers' plan are sketchy, it essentially asks that Ottawa fully fund and manage a national pharmacare plan that provides coverage for all Canadians.

For provinces that already operate a universal drug insurance plan, the implications of buying into Romanow's proposal would appear, at least on the surface, to be quite beneficial. British Columbia, for example, would receive, for all those beneficiaries whose annual expenditures exceeded $1500, 50% of all subsequent expenditures — a gift horse from Ottawa! Several provinces, such as Ontario and Quebec, would be similarly situated: that is, they currently have universal drug assistance plans in place and would be able to access the federal money immediately. For provinces that do not currently have such universal plans, the Romanow proposal is less attractive: to access the federal money, they would have to expand their existing drug plans so that all residents were eligible under the provincial plan. A priori, it is difficult to assess whether, on balance, these provinces will have to put out more money to qualify under the proposed program than they will get back. Nonetheless, the reason for the provinces' unanimous opposition to the proposal remains unclear; the debate would benefit from a detailed evaluation of the costs and benefits for each of the provinces.

CP Photo/Fred Chartrand

First ministers line up to face the feds.

One explanation for the unwillingness of the provinces to embrace Romanow's proposal for covering catastrophic drug expenditures is that it is somewhat of a Trojan horse, a gift from the federal government whose proper implementation would put the provinces in the poorhouse by requiring them to use the monies transferred under the plan to expand the overall level of public drug coverage and reduce patient cost-sharing. To accommodate continually rising health care costs, most provinces have been doing the opposite by adopting cost-containment policies such as cost-sharing between patients and provincial drug plans. In addition to shifting expenditures from governments to consumers, the appeal of this financing mechanism lies in the fact that it supposedly reduces medically unnecessary expenditures: the patient who is

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required to pay out of pocket for a proportion of all expenditures is presumed to become more cost-conscious and to consume fewer unnecessary services. Because prescription drugs are outside the jurisdiction of the Canada Health Act (which prohibits such cost-sharing), most provinces feel that co-payments and deductibles on prescription drugs are the only viable cost-containment instruments available to them and that participating in the catastrophic drug plan would mean losing this mechanism of cost control.

Whether consumer co-payments for drugs actually reduce overall costs is debatable. Most of the international literature on cost-sharing in health care has shown that there are "complementarities" between various types of health resource expenditures. On the contrary, in Canada, where outpatient drug therapy (with deductibles and co-payments) may be freely substituted for other types of care, including drug therapy in hospitals or physician visits, although co-payments reduce patient expenditures for outpatient drugs, care is shifted to hospital programs and physician billings.[2]

Nonetheless, in the most recent turn of events, the provinces have done a complete about-face. Not only are they willing to give up on the cost-control mechanism of co-payments and deductibles, they are also willing to let the federal government take complete control of their drug plans and let the two solitudes operate independently of each other. The current national pharmacare proposal, although very sketchy, completely ignores the relationships between the different sectors within the health care system. Hence, the federal government is being asked to provide for drugs that can both substitute and complement other medical inputs in the provision and delivery of health care without any mechanism for coordination.

If the federal government indeed takes responsibility for a national pharmacare program, it could set restrictions and cost-sharing policies that have the effect of increasing hospital costs and physician billings. Alternatively, if a pharmacare program under federal management provided first-dollar coverage, the provinces could adopt policies that maximize outpatient prescription drug costs while reducing inpatient costs.

Given the current climate of distrust and continuous financial haggling between the levels of government, it is difficult to see the merits of a national pharmacare plan from a patient care perspective. The advantage for the provinces in the short run — off-loading drug plan costs — is clear, whereas a more reasoned analysis for the long term suggests that the provinces would be seriously handicapped if they were unable to manage increased drug utilization levels while trying to manage the rest of the health care system.

Prescription drugs are medically necessary and are an integral part of the health care system. In Canada we have deluded ourselves into believing that we can continue to claim to have a publicly funded universal system when in fact drug coverage is highly variable across the country.[3] To solve this problem, new money is needed to make up the shortfall. Romanow's estimate for the CDTP was approximately $1 billion, whereas the cost of a national pharmacare program is being projected at $10 to $12 billion. These numbers are guesses: the actual costs would depend on the scope and design of the plan.

There is no doubt that certain economies might be achieved though centralized purchasing, treatment guidelines and other means. However, such coordination cannot be implemented for pharmaceuticals alone: the integration has to be system wide, so that the incentives of all parties involved in the delivery of health care and the recipients are properly aligned. Instead of the tail (pharmaceuticals) wagging the dog (the health care system), it is time to let the dog exercise its rightful control by including outpatient pharmaceuticals in the Canada Health Act. It is only when our federal and provincial politicians stop exchanging offers (the CDTP, holding the dog down by its tail) and counter offers (national pharmacare, amputation of the tail) that Canadians will no longer be forced to substitute hospital care for outpatient prescription drugs or to be denied appropriate care altogether.

Aslam H. Anis
Department of Health Care and Epidemiology
University of British Columbia and Centre for Health Evaluations and Outcomes Sciences
Providence Health Care
Vancouver, BC

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