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Pharmacare…Long Overdue

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Matter Commented On: Interim report from the Advisory Council on the Implementation of National Pharmacare

Canadian Medicare has traditionally focused on hospital and physician services due, in large part, to the fact that the *Canada Health Act*, RSC 1985, c C-6, provides for federal/provincial cost-sharing for these services. The exclusion of pharmaceuticals made sense at the inception of Medicare in the 1950s, as there were few effective drugs at the time. However, the ensuing decades have seen a proliferation of new drugs that significantly reduced morbidity and mortality. For example, statins, which lower cholesterol and decrease the risk of heart attack by approximately 25%, came into clinical use in the late 1980s. They are now taken by millions of Canadians and represent the second largest category of pharmaceutical spending (after certain types of cancer drugs). The increasing prevalence and efficacy of pharmaceuticals and their growing costs have led to calls for universal pharmaceutical insurance (referred to as pharmacare).

On Wednesday, the federally-appointed Advisory Council on the Implementation of National Pharmacare released their initial recommendations. Notably, they recommended that "Canadian residents have access to prescription drugs based on medical need, without financial or other barriers to access." Universal pharmacare would make Canada's health care system more equitable and prevent needless morbidity and mortality. It would also bring Canada in line with other countries. According to a recent report, "every developed country with a universal health care system provides universal coverage of prescription drugs—except Canada."

Pharmaceuticals are currently funded through a patchwork of out-of-pocket payments, private insurance, and government programs. For example, in Alberta, the primary payers of non-hospital drugs were as follows in 2015-2016: out-of-pocket payments 15%, private insurance 45%, and public funding 39%. With regard to public funding, Alberta has programs that cover individuals from low-income households and those with high drug costs. The province also has a program to supplement the cost of drugs for individuals over the age of 65. In addition, drugs that are provided to hospital in-patients are publicly insured. Alberta spends approximately $221 million per year on drugs provided in hospitals. Apart from Quebec, other Canadian provinces have broadly similar public drug benefit programs.

Although these public programs provide access to drugs for many people who would otherwise go without, many people still struggle with the costs of necessary medications. For example, in Alberta, a single adult's annual income must fall below $16,580 before he or she can access the Alberta Adult Health Benefit. The Advisory Council on the Implementation of National

Pharmacare heard from families with seriously ill children who had moved across Canada solely to access another province's public drug plan, and employees who remained in undesirable workplaces due to reliance on their employer's drug benefits program.

There is a sizeable body of evidence showing high rates of medicine non-adherence due to drug costs. Non-adherence can take several forms, including not filling a prescription, not renewing a prescription, or making an existing prescription last longer (i.e. by skipping doses or breaking pills in half). For example, according to one study, approximately one in ten Canadians who received a prescription reported cost-related non-adherence. Unsurprisingly, people in poor health, those with lower incomes, and those without insurance were more likely to report cost-related non-adherence. Recent data confirm that while 10% of Canadians report cost-related non-adherence, this figure is 17% for individuals with below-average incomes.

Canadian studies have linked patient cost-sharing for pharmaceuticals, which results in lower rates of adherence, to increased adverse events and greater use of other, more expensive, health care services like emergency room visits (see e.g. here and here). Medication non-adherence is also costly. Although Canadian data is sparse, estimates of the cost of non-adherence (for cost or other reasons) are as high as $9 billion per year.

In short, proposals to increase public funding for pharmaceuticals would be expected to reduce morbidity and mortality and their associated costs. Although some worry that universal pharmacare could be expensive for taxpayers, several economic analyses suggest that the program would actually result in cost savings. For example, the Parliamentary Budget Office estimated that although expanded coverage would lead to an 11% increase in prescriptions, this would be associated with an annual savings of $4.2 billion. While Canadians currently pay some of the highest prices for pharmaceuticals in the world, it is expected that the federal government could negotiate lower prices if it were purchasing drugs in bulk on behalf of the entire population. A single payer system would likely lead to lower administrative costs and greater use of cheaper generic drugs.

Although there would certainly be challenges in getting pharmacare off the ground, as it would require cooperation and coordination between different levels of government, the evidence indicates that the health-related and cost-related trade-offs are worth it. In the 1964 report of the Royal Commission on Health Services, Justice Emmett Hall wrote that "in view of the high cost of many of the new life-saving, life-sustaining, pain-killing, and disease-preventing medicines, prescribed drugs should be introduced as a benefit of the public health services program." This recommendation has been repeated many times since 1964 (for example, in the 2002 Romanow Report) and is now long overdue. It is time that the federal government revisit the *Canada Health Act* and its focus on physician and hospital services. Instead of focusing on who delivers care or where it is delivered, governments should determine which services attract public funding through transparent and evidence-based criteria such as cost-effectiveness, which would certainly include public funding for pharmacare.

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