

A National Pharmacare Plan: Combining Efficiency and Equity

By Dr. Joel Lexchin

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About the Author:

Joel Lexchin is an emergency physician in downtown Toronto. He is the author of over 40 papers on all aspects of prescribing and the pharmaceutical industry. He has served on the Ontario Drug Quality and Therapeutics Committee and has worked as a consultant in Australia, New Zealand and is currently completing a project on prescription drug promotion for the World Health Organization.

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Summary

A national program to cover drug costs—Pharmacare—was recommended by the Royal Commission on Health Services in 1964, and again by the National Forum on Health in 1997. Later that year, the Liberal party endorsed “Pharmacare as a long-term national objective” and promised to “ensure that all Canadians have access to medically necessary drugs within the public health care system.”

Since then, however, Pharmacare has dropped off the political agenda. There was no mention of it in last year’s federal-provincial agreement, nor was it included in the Liberals’ list of promises in the election last November.

The main excuse offered by politicians for delaying action on Pharmacare is that its costs would be prohibitive, since drugs now consume nearly 13% of the health care dollar. (The opposition to such a plan by the multinational pharmaceutical companies—who see it as a threat to their profits—is undoubtedly another significant deterrent.)

There is compelling evidence, however, that a national drug plan would actually **reduce** costs, not increase them. One study projected that, under a national Pharmacare plan, overall drug costs that year would

have dropped by \$294 million, and dispensing fees by \$110 million—even with an anticipated 5% rise in the consumption of drugs under a public plan. (Australia has a national drug plan that has been able to keep its drug costs more than 30% lower than the OECD average, at a time when Canada’s were almost 30% **higher**.)

As suggested here, a national Pharmacare plan that provides first-dollar coverage for prescription drugs for all Canadians would cost the public treasury an additional \$3,151 million per year—but **overall drug costs to Canadians would be 10% or \$650 million less than what is now spent.** (This figure adjusts for an anticipated increase in consumption.)

Pharmaceutical costs have been rising steadily in Canada and now outstrip costs for physicians. **More than 3 million Canadians, mainly the poor and those with low incomes, lack any drug insurance, despite medical need, and even seniors have to meet hefty out-of-pocket expenses in some provinces.** The result is poorer health for millions of people, and increased costs in terms of additional physician visits and hospitalizations.

If we ever hope to be able to provide pharmaceutical care for the entire population without further straining the health care budget, then we need to take some bold steps. **A national Pharmacare program is one such step.**

Introduction

Pharmacare, a national plan to cover drug costs, has been on the Canadian political agenda for a couple of generations. In 1964 the Royal Commission on Health Services¹ recommended that prescription drugs be included in a national medicare system; in 1997 the National Forum on Health recommended that “Canada should take the necessary steps to include drugs as part of its publicly funded health care system.”² Later that year during the national election campaign the Liberal Party endorsed “pharmacare as a long-term national objective” and pledged to “ensure that all Canadians have access to medically necessary drugs within the public health care system.”³ Despite all of these recommendations, promises and pledges over the decades, Canada is only barely talking about pharmacare. A conference in Saskatoon in January 1998 seems to have been the most the Liberals did to fulfill their promise.⁴

The failure of pharmacare to make it into the legislation establishing medicare in the 1960s was centred around worries about the financial cost of including drug coverage. Now drugs are even more expensive. From 8.4% of total health care spending in 1980, by 1996 they consumed 12.5% of the health care dollar.⁵ The escalation in costs during the 1980s and early 1990s forced the Saskatchewan government to abandon its original drug plan which provided medications to the entire population and required a co-payment of only a few dollars.

The perception that costs make pharmacare unaffordable continues to be a reason for inaction. At the Saskatoon meeting Health

Minister Allan Rock backed off endorsing a universal first-dollar plan by claiming that “with money—provincial and federal—being what it is and with very real competing demands on it, it seems improbable to me that there would be sufficient consensus in the near term to move immediately to [a] kind of full-blown system.”⁶ If there is extra money to put into the health care system, the provinces are demanding that it be used to restore existing services to historic levels rather than to start up new ones.⁷ The recent federal-provincial agreement for a new infusion of cash from Ottawa did not make any mention of pharmacare.

Finally, a new obstacle to pharmacare has emerged in the form of resistance from the multinational pharmaceutical industry. Drug companies are extremely concerned that a national program could restrict prices for their products and, potentially even more serious, some of their products might not get listed on a national formulary of products, that is, a list of drugs that would be covered under a pharmacare plan. Products that are excluded would effectively be cut out of most of the Canadian market except when people were willing to pay out-of-pocket for them. The industry maintains that it wants to ensure that everyone receives “appropriate care.” Appropriate care seems to be code for a position that once a drug has been approved by the Health Protection Branch then public drug plans should automatically pay for it. Witness the position taken by Merck Frosst, the largest of the multinational companies operating in Canada, in a commentary on the recommendations of the National Forum on Health: “. . . restricting access to appropriate pharmaceutical therapy can result in harm to patients” and “Institution of a drug policy that

provides less than we currently enjoy will jeopardize our position among the healthiest persons in the world.”⁸

Current prescription drug coverage

What Canada has today is a hodge-podge mixture of public and private coverage, with a substantial number of Canadians left without any drug coverage at all. Accurate figures are hard to come by, but in 1995 it was estimated that 88% of Canadians had some

form of coverage: 62% had private insurance, 19% were covered under public provincial plans, 7% were covered under both private and public plans and 12% lacked any form of insurance.⁹ The 1998/99 National Population Health Survey¹⁰ estimated that 74% of people aged 12 years and older had some form of drug insurance but the accuracy of this figure is questionable. In the 1996/97 survey only 51% of people 65 and over reported having insurance¹¹ despite the fact that provincial plans provide benefits to virtually this entire population.

Table 1: Public And Private Expenditure On Prescription Drugs In The Outpatient Sector, 1975-1996 (\$Millions)

Year	Public sector	Private sector	Total	% Public
1975	198.1	613.1	811.2	24.4
1976	253.2	667.6	920.8	27.5
1977	301.8	721.4	1,023.2	29.5
1978	361.5	724.7	1,086.2	33.3
1979	418.8	776.5	1,195.3	35.0
1980	495.3	833.3	1,328.6	37.3
1981	593.9	1,110.2	1,704.1	34.9
1982	705.8	1,240.5	1,946.3	36.3
1983	835.5	1,289.8	2,125.3	39.3
1984	956.8	1,312.7	2,269.5	42.2
1985	1,121.6	1,447.7	2,569.3	43.6
1986	1,312.7	1,698.8	3,011.5	45.1
1987	1,477.5	1,800.4	3,277.9	45.1
1988	1,685.0	2,031.8	3,716.8	45.3
1989	1,942.4	2,290.1	4,232.5	45.9
1990	2,243.2	2,591.1	4,834.3	46.4
1991	2,557.6	2,858.4	5,416.0	47.2
1992	2,844.0	3,187.4	6,031.4	47.2
1993	2,942.4	3,373.2	6,315.6	46.6
1994	2,978.8	3,552.8	6,531.6	45.6
1995	3,048.5	3,748.7	6,797.2	44.9
1996	2,956.1	3,969.8	6,925.9	42.7

Includes spending on prescription drugs by federal and provincial governments, workers' compensation boards and public health departments. Excludes spending by hospitals and other institutions.

Spending on non-prescription drugs has been removed from the totals.

Source: Dingwall, D.C., "Drug Costs in Canada," Submitted to the House of Commons Standing Committee on Industry for the review of the Patent Act Amendment Act, 1992. Ottawa, 1997.

Table 1 gives the breakdown between public and private expenditures on prescription drugs in the outpatient sector over the period 1975-1996.* Spending in the public sector increased from 1975 until the early 1990s owing to the expansion of provincial drug programs but since then, as the programs have instituted various forms of cost sharing¹² to limit cost increases, there has been a shift in favour of the private sector. As we can see from Table 2, people with both private and public coverage pay a large proportion of their drug costs through co-payments and deductibles** and uninsured in-

dividuals paid out over half a billion dollars in 1996.***

Public drug coverage: Canada versus the OECD

Even when public spending reached its apex in 1991-1992, Canada was still far behind nearly every other country in the Organization for Economic Co-operation and Development in every measure of public participation in the provision of pharmaceuticals: public expenditure on pharmaceutical goods per capita,**** public expenditure on

Table 2: Public And Private Payments For Prescription Drugs, 1996

Source of funds	\$ million	%
Public plans	2,976.6	43.9
Private plans	1,894.0	27.9
Individuals		
Co-payments and deductibles		
Individuals covered by public plans	563.3	8.3
Individuals covered by private plans	751.3	11.1
Uninsured individuals	516.6	7.6
Other out-of-pocket expenditures	77.6	1.1
Total	6,779.3	100

Source: Palmer D'Angelo Consulting Inc. National Pharmacare Cost Impact Study, Ottawa, September 1997.

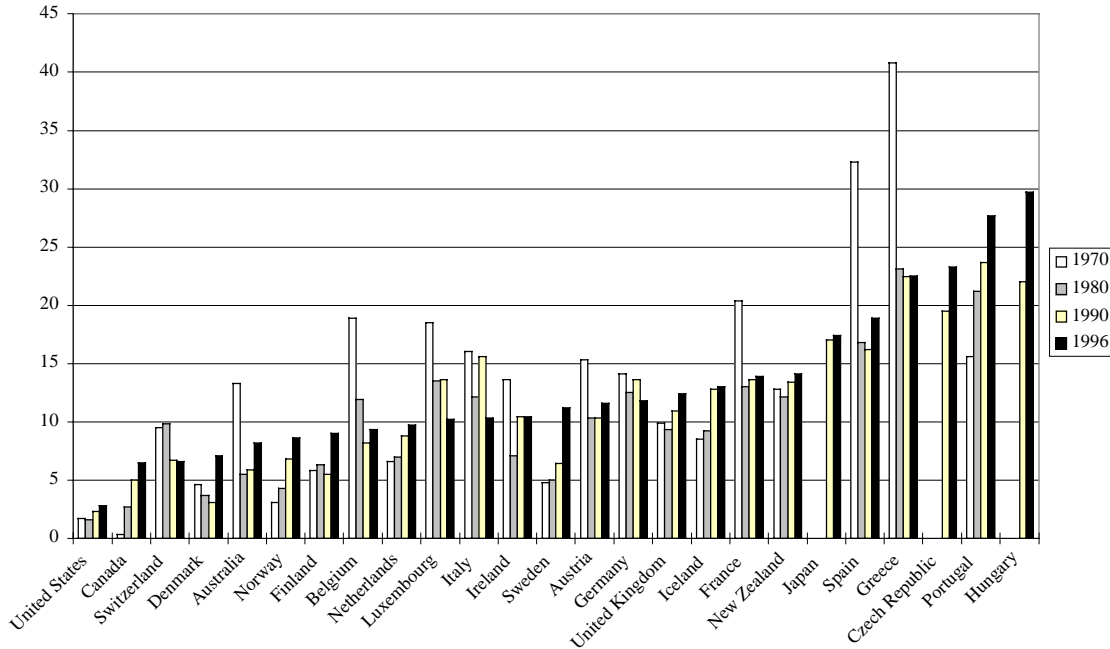
* Prescription drugs administered in hospital are covered under Medicare.

** Copayments are out-of-pocket payments that cover part of the cost of a prescription. In some provinces people must pay a certain amount of money for prescription drugs before they are eligible for benefits. This sum of money is termed a "deductible."

*** Numbers in Tables 1 and 2 are slightly different due to the way in which nonprescription drug costs are treated and owing to estimates being made at different times.

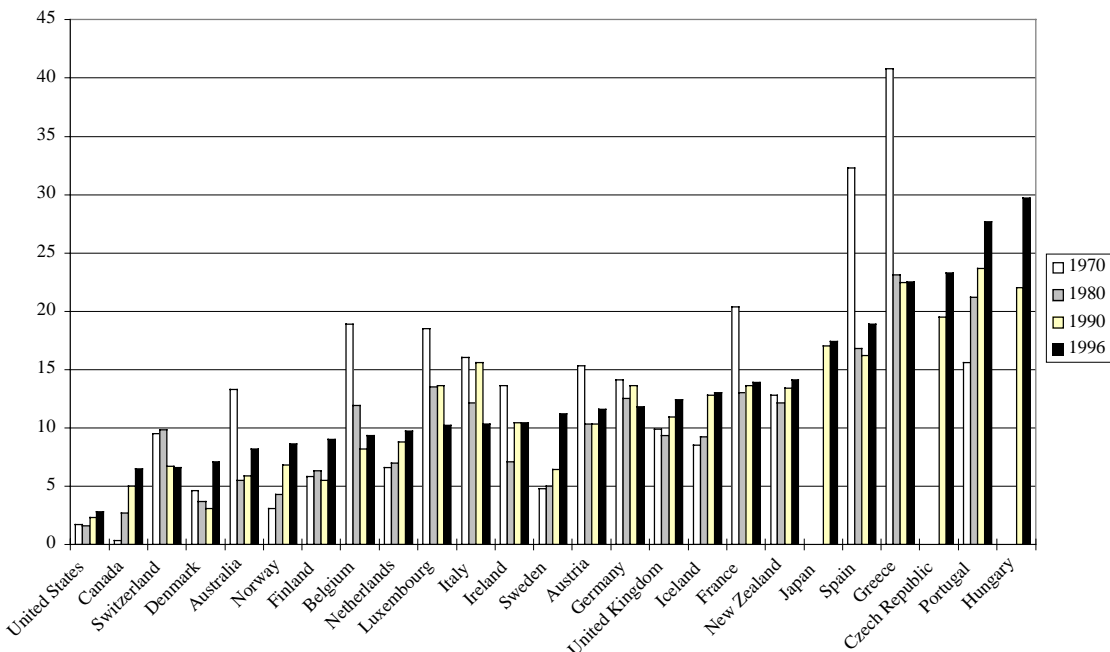
**** The OECD numbers in Figure 1 do not match the numbers in Table 1 because of differences in collecting and interpreting data and because the OECD includes spending on nonprescription items.

Figure 1. Public expenditure on pharmaceutical goods per capita (constant US dollars, current exchange rates)



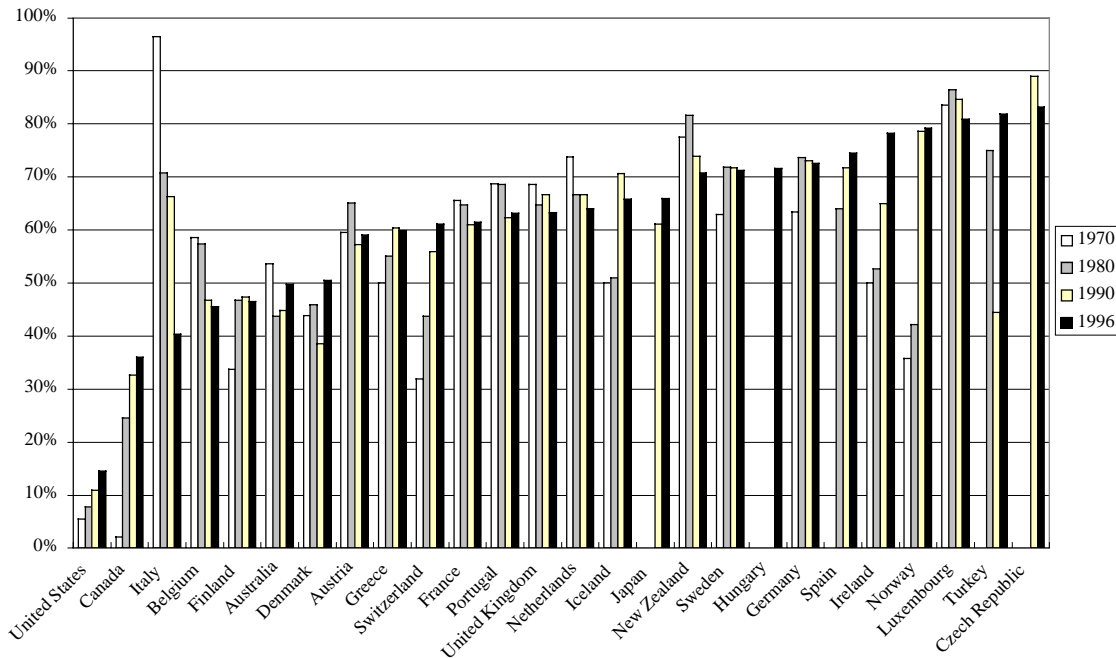
Source: Jacobzone S. "Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals." Labour Market and Social Policy Occasional Papers No. 40. Paris: OECD, 2000. [www.oilis.oecd.org/OLIS/2000DOC.NSF/LINKTO/DEELSA-ELSA-WD\(2000\)1](http://www.oilis.oecd.org/OLIS/2000DOC.NSF/LINKTO/DEELSA-ELSA-WD(2000)1).

Figure 2. Public expenditure on pharmaceutical goods as a percentage of public expenditure on health



Source: Jacobzone S. "Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals." Labour Market and Social Policy Occasional Papers No. 40. Paris: OECD, 2000. [www.oilis.oecd.org/OLIS/2000DOC.NSF/LINKTO/DEELSA-ELSA-WD\(2000\)1](http://www.oilis.oecd.org/OLIS/2000DOC.NSF/LINKTO/DEELSA-ELSA-WD(2000)1).

Figure 3. Public pharmaceuticals expenditure within total pharmaceutical expenditures



Source: Jacobzone S. "Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals." Labour Market and Social Policy Occasional Papers No. 40. Paris: OECD, 2000. 2000)1 [www.oilis.oecd.org/OLIS/2000DOC.NSF/LINKTO/DEELSA-ELSA-WD\(2000\)1](http://www.oilis.oecd.org/OLIS/2000DOC.NSF/LINKTO/DEELSA-ELSA-WD(2000)1)

pharmaceutical goods as a percentage of public expenditure on health and public pharmaceuticals expenditure within total pharmaceutical expenditures.^{*13} (See Figures 1-3). Out of the industrialized countries surveyed only the United States consistently ranked below Canada.

A failure in social equity

Gross figures on public coverage also give a false impression about how many people actually receive benefits from public plans. In Saskatchewan, although all residents are nominally covered by the provincial plan, for those not on social welfare or 65 years and over, there is a family deductible of \$850 every 6 months before people become eligible for any public contribution. In British

Columbia it is an \$600 annual family deductible. The elderly face gross regional disparities in out-of-pocket costs associated with an average drug consumption pattern. Among seniors of similar income there is a ten-fold variation in these payments for the same drug consumption; \$40 in Ontario to \$450 in Saskatchewan for low income seniors receiving the federal Guaranteed Income Supplement.¹⁴

There are also marked differences in out-of-pocket expenditures between low income groups, who are covered by public plans in all provinces, and high income groups who rely on private insurance.¹⁵ During the period 1984-1990, when provincial plans were probably at their most generous, individuals in low income groups (average income

* An argument can be made that the global third party reimbursement rate is significantly understated in Canada because the impact of employment related or private insurance should be included.

in constant 1986 dollars less than \$14,400) had out-of-pocket expenditures that were more than seven times as much as individuals in high income groups (average income in constant 1986 dollars greater than \$49,400) when measured as a percent of total expenditures.* In absolute dollar terms, individuals in the high income group actually had lower out-of-pocket spending than individuals in the low income group (\$43.8 versus \$61.2). Combining out-of-pocket expenditures for high income individuals with the cost of their private drug insurance still left them spending less of their total expenditures on drugs than low income individuals, 0.58% versus 0.97%.

Perhaps the people most severely affected under the current arrangement are those without any insurance. At 12% of the population there are over 3.5 million Canadians in this category. In Quebec in the early 1990s the figure was 15% of the population and most had only a modest income—nearly 70% were poor, very poor, or had a lower than average income and nearly two-thirds were unemployed.**¹⁶ The most vulnerable people are those whose income is just above the level necessary to qualify for social assistance and who then become ill or must cope with a chronic condition and who are ineligible for private insurance. In general, it is likely that people without insurance are actually the ones most in need of it due to their low income status as there is solid evidence linking low income to poor health status.¹⁷

Lack of drug insurance and overall levels of health care spending

Surveys in Canada have documented that one of the major reasons why people do not fill their prescriptions is lack of income.^{18, 19} Some of the prescriptions not filled will be for non-essential medications that do not seriously influence overall health status but some of the medications foregone will be critical for people's health. Work in both Canada and the United States has shown that putting barriers in the way of accessing prescription medications can have negative financial and health consequences. In the early 1980s New Hampshire imposed a cap of three prescriptions per month on beneficiaries of the state's Medicaid plan. For psychiatric patients savings in drug costs were estimated at just over \$5.00 per month, but increased costs due to more visits to and services at mental health clinics were more than 17 times greater.²⁰

Beginning in 1996, seniors, social assistance recipients and other program beneficiaries in Quebec faced large increases in drug user fees. User fee revenues were used to finance the expansion of public drug coverage to the previously uninsured population in the province. The imposition of co-payments on social assistance recipients caused an increase in hospitalizations/ institution-izations, physician visits and emergency department visits of 194%, 22% and 106%, respectively. Among the elderly the increase in co-payments caused increases in the same

* For the low income group out-of-pocket expenditures would have been for nonprescription items, prescriptions items not covered by the provincial drug plan and any required copayments.

** These figures refer to those without private insurance. Some of this group may have been covered by the provincial plan.

three categories of 35%, 13% and 50%, respectively. These changes were even more marked among those with psychiatric problems and those with asthma, diabetes, epilepsy and heart disease.²¹

Options for change

One option for tackling the problem of the uninsured is to use a public/private split similar to what Quebec did. As of January 1997, Quebec mandated insurance coverage for every resident of the province. Anyone who was not eligible for private insurance was required to purchase coverage through the public insurance plan. However, Bill 33 which legislated the changes also had as its aim a significant reduction in overall government spending. Money to cover the uninsured came from the imposition of user charges on previously exempt sections of the population with the results that were described above. Government spending dropped from \$922 million before the changes to \$551 million.²²

A blended public/private model is also advocated in a study financed by the Pharmaceutical Manufacturers Association of Canada (now Canada's Research-Based Pharmaceutical Companies).²³ That study rejected a comprehensive public model with no copayments because the calculated incremental cost of \$4.3 billion was judged to be prohibitive.

Superficially, the Quebec model may seem to be attractive, especially if government expenditures were maintained or even in-

creased so that there would not be the problems associated with copayments that Quebec experienced. However, a public/private model forfeits the potential to actually decrease overall costs. While all public plans utilize generic drugs to reduce their costs, fewer than 16% of 401 companies surveyed by the Conference Board of Canada had introduced generic substitution in their private drug plans, and even fewer companies were using other methods such as formularies or caps on pharmacists dispensing fees.²⁴ Dispensing fees represent 21.7% of prescription costs for public plans but 25.8% of private plans.²³ Administrative costs in private plans run at about 8% of total costs versus figures as low as 2% in large provinces such as Ontario and Quebec.²³ Retaining private coverage means the loss of as much as \$118 million in nationwide savings in reduced administrative costs.*²³

There is also the cost of complying with competing insurance plans' procedures and regulations which are borne by pharmacists and physicians. Competing companies might eventually arrive at an agreement to standardize claims processing and regulations but such agreement will involve additional costs of negotiation which in all likelihood will be passed on to the consumer.²²

Finally, retaining private coverage diminishes the purchasing power of the provinces. Acting together the provinces could use their monopsony buying power to lower overall drug costs. Australia has a national drug plan and has been able to keep its drug costs more than 30% lower than the OECD average as of 1993. At that point Canada's

* The figure of \$118 million annually might be conservative. Morgan²² estimated that administrative savings in Quebec alone would be \$70 million per year under a fully public model.

were almost 30% above the average.*²⁵ Table 3 shows that Australia was much more successful than Canada at controlling drug price inflation in the 1980s. While factors other than buying power were certainly involved, most observers agree that the fact that the public plan was in such a dominant position in Australia gave the government significant bargaining power when it came to prices.

What would a national pharmacare plan cost?

Table 4 shows the breakdown between drug costs and dispensing fees for public and private plans and for individuals without insurance.**

In estimating what a pharmacare plan with first dollar coverage would cost, there are a number of assumptions that need to be made: out-of-pocket expenses would not be affected; dispensing fees would fall to the level paid by public plans (21.7%); administrative costs would go from an average of 3.5% in the public sector and 8% in the private sector to 2%; consumption among those previously insured and those without any insurance would rise; drug costs would drop.

How much consumption would rise and drug costs would drop is difficult to estimate. Studies in managed care situations in the U.S., where people are covered by private insurance, have either failed to show any change in drug consumption with an increase in co-payments²⁶ or the results have

Table 3: Purchasing Power Parities Per Capita—Public Pharmaceutical Expenditures 1981-1989

Year	Canada	Australia
1981	18	29
1982	21	29
1983	25	31
1984	29	35
1985	34	37
1986	40	42
1987	43	49
1988	49	49
1989	56	54
% change 1981-89	211	86

Source: Kennedy W., Reinharz D., Proulx M., Contandriopoulos A-P., "Selected National Drug Programs Description and Review of Performance," Prepared for the Pharmaceutical Policy Division, Drugs Directorate, Health Canada, October 1995.

* These expenditures are in purchasing power parities (PPPs). PPPs are the rates of currency conversion that equalize the purchasing power of different currencies. This means that a given sum of money, when converted into different currencies at the PPP rate, will buy the same basket of goods and services in all countries. In other words, PPPs are the rates of currency conversion which eliminate the differences in price levels between countries.

** Numbers in Tables 1 and 4 are slightly different due to the way in which nonprescription drug costs are treated and owing to estimates being made at different times. Costs in Table 4 for public and private plans include copayments and deductibles.

Table 4: Drug Costs And Dispensing Fees, 1996

Type of plan	Drug costs (\$ millions)	Dispensing fees (\$ millions)
Public plans	2,771.5	768.3
Private plans	1,962.8	682.5
Individuals with no coverage	383.3	133.3
Other out-of-pocket expenses	57.6	20.0
Total	5,175.2	1,604.1

Source: Palmer D'Angelo Consulting Inc. National Pharmacare Cost Impact Study, Ottawa, September 1997.

Table 5: Drug Costs And Dispensing Fees Under A Pharmacare Plan

Type of plan	Drug costs (\$ millions)	Dispensing fees (\$ millions)
Public plan	2771.5	768.3
Previously covered privately	1668.4	462.4
Previously uninsured	383.3	106.2
Other out-of-pocket expenses	57.6	20.0
Total	4880.8	1356.9

been confounded because the drop in the number of prescriptions was accompanied by an increase in the number of units in each prescription.^{27, 28} For purposes of this paper it is assumed that consumption among those with private insurance would go up by 5%. Changes are likely to be different in the public sector as those receiving benefits have, on average, poorer health status either because of low income (those on social benefits) or age (seniors). Drawing on the U.S. experience with Medicaid recipients^{29, 30} it is assumed that consumption in this group will rise by 10%. The only data for those previously uninsured comes from the Medicare population in the U.S. Adding a prescription drug benefit was expected to increase spending by 20%.³¹ How much drug costs would decrease will in large part depend on how aggressive the provinces are willing to be in their bargaining. A relatively

conservative position is that costs in the public sector would decline by 10% and those in the private sector and for people previously uninsured by 20%.

In summary, for those covered by public insurance and for those without any insurance, the decline in drug costs would balance the rise in consumption; in the private sector the net decrease in drug costs would be 15% (5% rise in consumption – 20% decrease in drug costs).

Table 5 shows the results of these changes. In addition, administrative costs would drop by \$110 million.²³

Therefore total expenditures would be \$6127.7 million compared to \$6779.3 million now, a saving of over \$650 million.*

* This model ignores any tax revenues and expenditures that might occur when private benefits are lost. Also the Canadian Life and Health Insurance Association has indicated that the elimination of private drug plans could have a negative impact on all extended health care benefits as it is the drug plan portion that represents the majority of these benefits.

Conclusion

The present system of drug coverage in Canada fails in terms of social equity. Depending on which province seniors live in, they face significant out-of-pocket expenses, as do the poor. A sizeable portion of the population does not have any insurance despite medical need. The lack of insurance, and co-payments for those with insurance, leads to poorer health and increased costs in terms of additional physician visits and hospitalizations. A public/private plan misses opportunities for significant cost savings. A national pharmacare plan that provides first dollar coverage for prescription drugs for the entire population would cost the public purse an additional \$3,151 mil-

lion per year, but overall costs would be less than what is now being spent.

There will be voices pointing out that no other OECD country offers this level of insurance, but Canada provides first dollar coverage for medical and hospital costs without having a parallel private system, a situation which is also unique in the OECD.

Pharmaceutical costs have been rising steadily in Canada and now outstrip costs for physicians. If we hope to be able to provide pharmaceutical care for the entire population without further straining the health care budget, then we need to take bold steps. A national pharmacare program is one such step.

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