

## **The Pharmacare Promise**

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One of the first casualties of Mr. Romanow's decision to rely on surpluses rather than recommend more stable and robust funding, is his own unwillingness to recommend the establishment of a Canadian Pharmacare plan. Warning that including prescription drugs in the Canada Health Act would come at too high a cost, Mr. Romanow has proposed the following as incremental steps towards a future Pharmacare:

- The expansion of provincial drug formularies through a cash transfer, the Catastrophic Drug Transfer, so that high cost treatments would be covered for all Canadians in need;
- A new National Drug Agency, to review, monitor and evaluate pharmaceuticals on behalf of all provinces and territories;
- The development of a national drug formulary, by the National Drug Agency;
- The integration of medication management into any primary care reform; and
- The review and revision of patent laws to enable fast and affordable access to generic drugs in Canada.

These five steps are what Mr. Romanow has prescribed, in the interim, to set the stage for Pharmacare.

The reliance on prescription drugs in Canada is astounding: over 300 million prescriptions are filled each year, costing the average Canadian family an average of \$1,210. Increasingly, drugs are used as a substitution for alternative therapies, such as surgery. And yet, despite the benefits, estimates using data from the U.S. suggests that drug errors are the sixth leading cause of death. The Canadian Pharmacists Association estimates that the misuse, underuse, and over use of drugs in Canada costs us from \$2 to \$9 billion each year.

Access to drugs for the poor and elderly varies considerable across the country, with Maritime provinces providing the least amount of coverage. In addition, drug benefits are not portable, so that Canadians moving to new provinces generally face a three-month period without access to medications. In 1999, Canadians paid 22 per cent of total drug costs, or \$2.3 billion, out of pocket. Provinces insurance plans covered 44 per cent of the costs, and private insurance picked up 34 per cent of the tab for prescription drugs.

According to Romanow, the relative private to public share of spending of 56 per cent/44 per cent on drugs has not changed significantly since 1985. What has changed dramatically has been the amount spent on drugs: from 5 per cent of the total health care budget in 1980, to 12 per cent, or \$12.3 billion in 2001. It is this increasing cost, rather than the proportion of private funding, which is driving the prescription drug agenda and robbing governments of any desire to assume more costs. That is why the brakes are on when it comes to Pharmacare, despite efforts of groups like the MRG who continue to lobby for universal coverage.

What we don't want, and Mr. Romanow agrees, is extending universality as a trade-off to higher deductibles and co-payments, or limited formularies. Experience from Quebec has taught us that the cost in human suffering is too dear a price to pay. So, instead, the Commission has made its five recommendations. The recommended Catastrophic Drug Transfer would reimburse 50 per cent of a province or territory's total drug costs over a threshold of \$1,500 per person per year. Using Manitoba data to calculate costs, Mr. Romanow has recommended \$1 billion annually for transfer. The Catastrophic Drug Transfer does not appear to have an expiry date.

The new National Drug Agency being proposed would undertake and address Canada's flawed new drug approval process as one of its mandates. Negotiating and reviewing prices for both brand name and generic drugs, currently partially done by the Patented Medicines Prices Review Board, would also fall under the purview of the new agency, as would the bulk-buying of drugs for provincial and territorial formularies.

Post-marketing surveillance, monitoring and evaluation, developing and disseminating evidence-based guidelines, and monitoring patent legislation have all been described as important roles for the new

agency. In addition, the new National Immunization Strategy has been given to the drug agency to implement.

Much of the chapter in the report dealing with drugs is devoted to describing the potential work of the new National Drug Agency. Clearly, the Commission sees the establishment of the agency as providing the necessary infrastructure for any future progress in addressing issues in the use and procurement of prescription drugs.

The fifth and final recommendation dealing with drugs addresses the problem with prolonged patent protection as an obstacle for manufacturing lower cost generics. Specifically, the Commission calls for an end to "evergreening", which is the practice, by patent-holders, of prolonging patent protection by making small modifications to the product. Problems with existing patent laws, which lead to costly delays in the introduction of generics, must be addressed, according to Mr. Romanow. And finally, existing gaps in patent protection for genes and DNA are highlighted in the report as requiring urgent attention. In the past 18 months, Commissioner Romanow has often used the analogy of house building and home renovations to describe the work of securing a future for Medicare. When it comes to Pharmacare, it is obvious that he has been spending his time in the basement, pouring the concrete for the foundations. We can't wait another 40 years to complete construction.