

Leave the Patchwork for the Quilts: The Case for Pharmacare



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Outline

- A bit of history
- What's wrong now
 - No Equity
 - No Economic efficiency
- Criteria for pharmacare
- What will it cost



What is Pharmacare

- Public coverage for prescription drugs
 - All drugs or just some?
 - For everyone or just specific groups?
 - First dollar or partial coverage?



Current Canadian Situation

- Not included in Canada Health Act
- Therefore individual provinces have their own plans
 - Usually some coverage for elderly (≥ 65) and those on social assistance
 - Variable deductibles/copayments



Pharmacare Is Not A New Idea

- 1965 Hall Report:
 - 50% cost sharing by federal government for purposes of introducing Prescription Drug Benefit
 - \$1 copayment but not for medications for long-term therapy
- 1997 National Forum:
 - “We therefore call on . . . governments . . . to chart a course leading to full public funding for medically necessary drugs”
- 1997 Liberal election platform:
 - “Ensure that all Canadians have access to medically necessary drugs within the public health care system”



Kirby and Romanow

- Kirby
 - Catastrophic drug coverage
 - No one would pay more than 3% of family income on drugs
- Romanow
 - Catastrophic drug coverage
 - Federal government would cover 50% of cost of provincial plans above \$1500 per year
 - Provinces would use extra money to reduce deductibles, copayments, expand insurance coverage



And On It Winds . . .

- 2002 Health Accord:
 - “First Ministers will take measures, by the end of 2005/06, to ensure that Canadians . . . Have reasonable access to catastrophic drug coverage”
- Summer 2004:
 - Provincial premiers call on Ottawa to take over and run a national pharmacare plan”
- September 2004 First Ministers Meeting:
 - “By June 30, 2006 . . . develop, assess and cost options for catastrophic pharmaceutical coverage”
- June 2006 National Pharmaceutical Strategy Report
 - “Further policy, design, and costing analysis . . . blah blah blah”

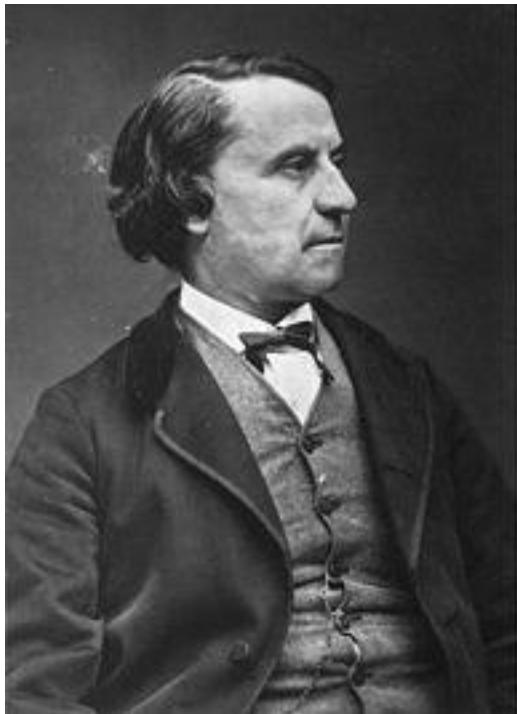


Why Do We Need a Universal Pharmacare Plan?

- Equity
- Economic efficiency
- Improve appropriateness of prescribing

Equity

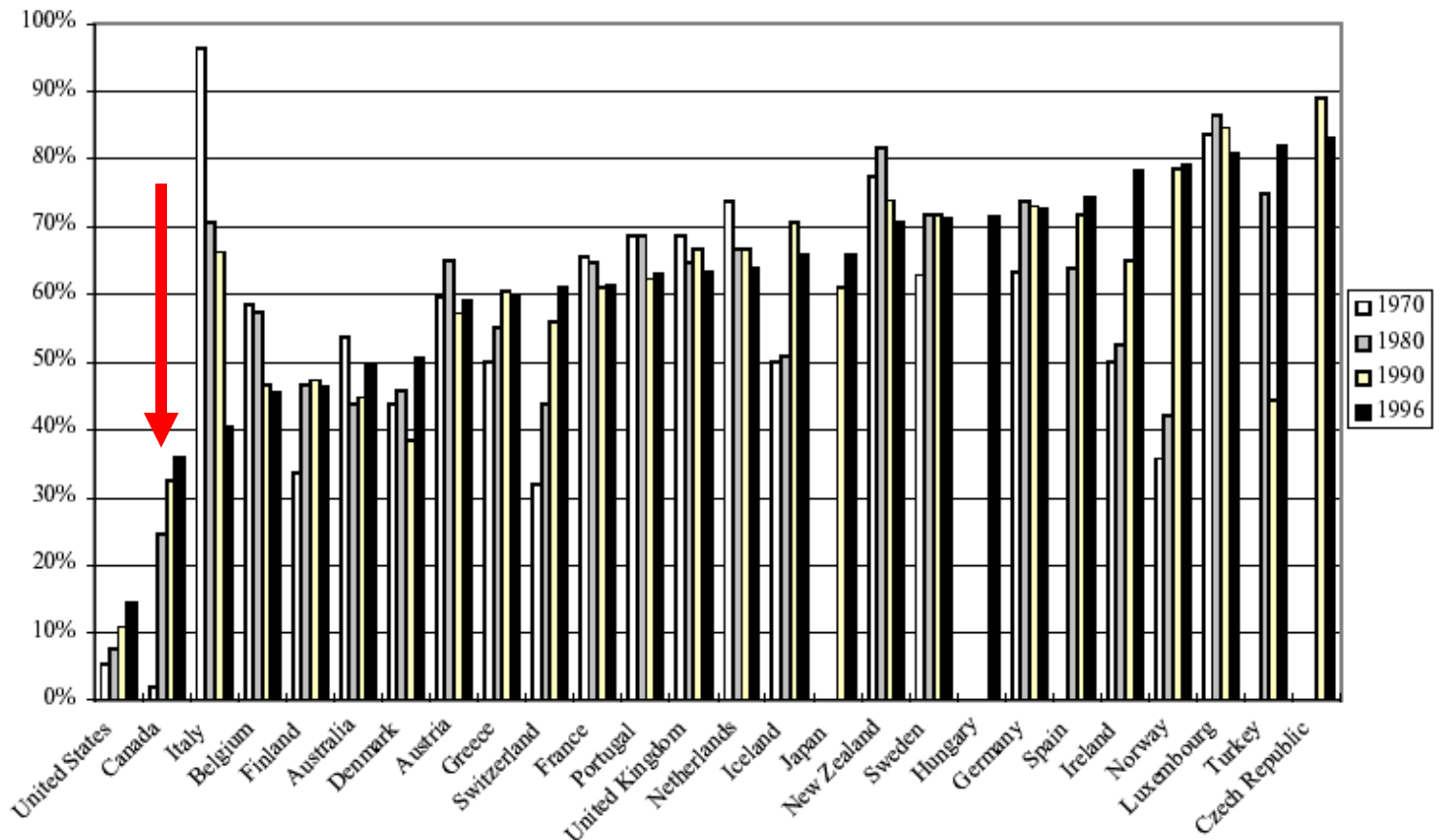
“à chacun selon ses besoins,
de chacun selon ses facultés”



Louis Blanc, French
Socialist 1811 - 1882

Where Does Canada Stand?

Figure 3. Public pharmaceuticals expenditure within total pharmaceutical expenditures





How Many Canadians Are Uninsured?

- 3% (~1 million) considered uninsured because they pay >4.5% of gross family income for prescription drugs
- 10% (~3.3 million) considered underinsured because they pay 2.5-4.5% of gross family income

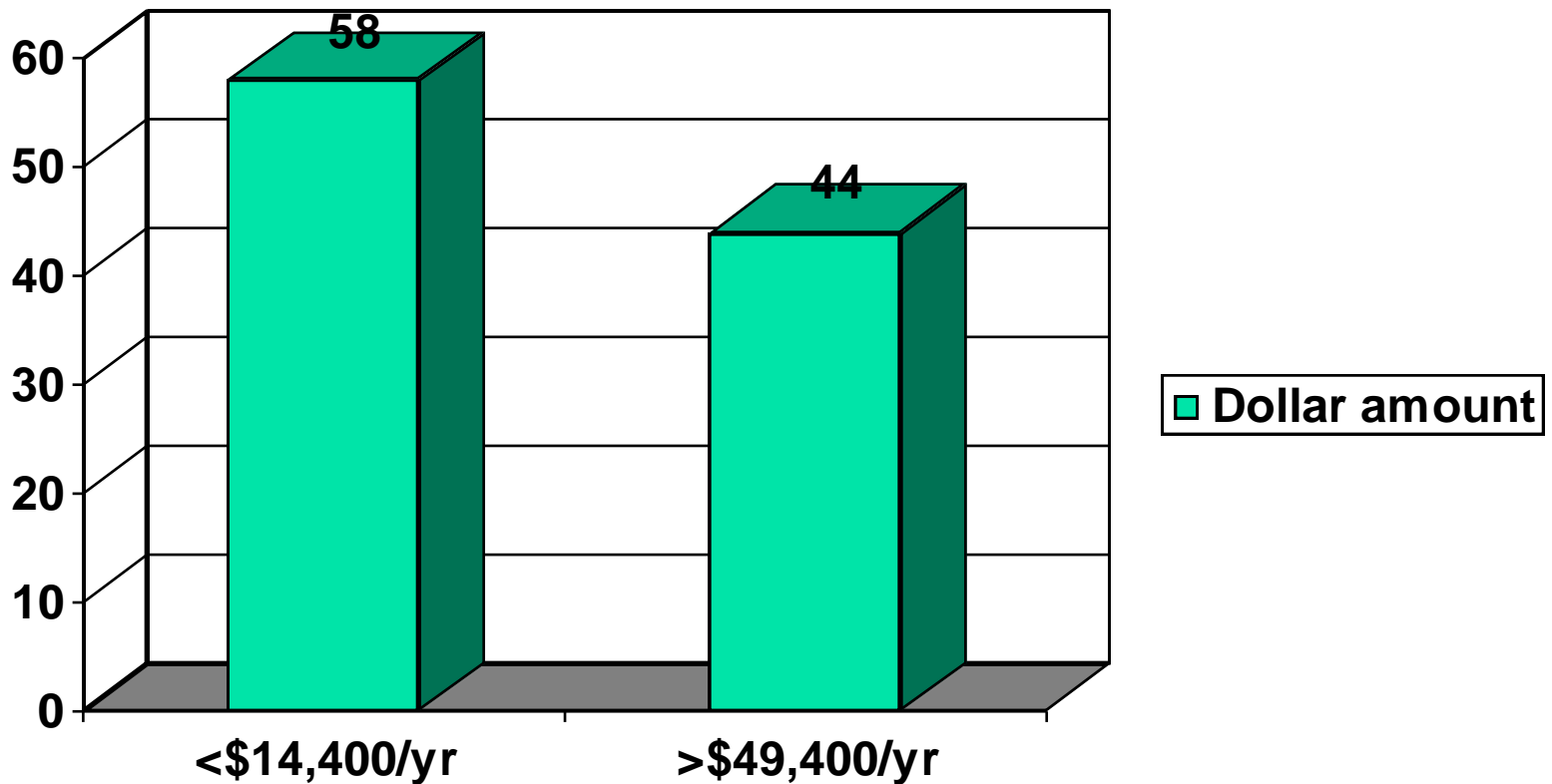


Who Has Drug Insurance?

Income Level	%
Lowest income	58%
Lower middle income	66%
Upper middle income	80%
Highest income	87%
Not stated	73%

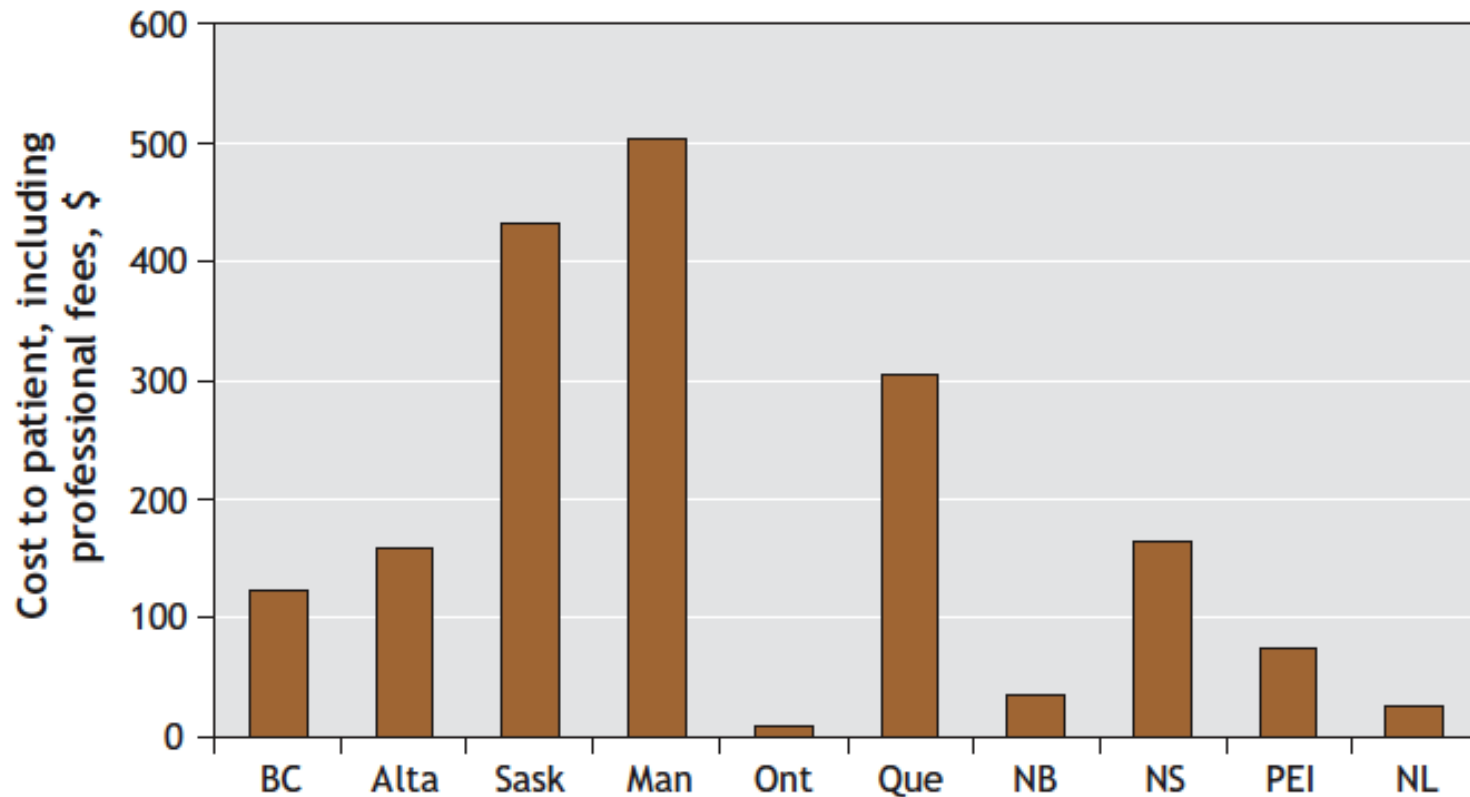
CIHI, 2002

Per Capita Out-of-Pocket Expenditure, 1984-1990



Lexchin, Canadian Journal of Public Health 1996

Differences in Out-of-Pocket Payments by Seniors, 2006



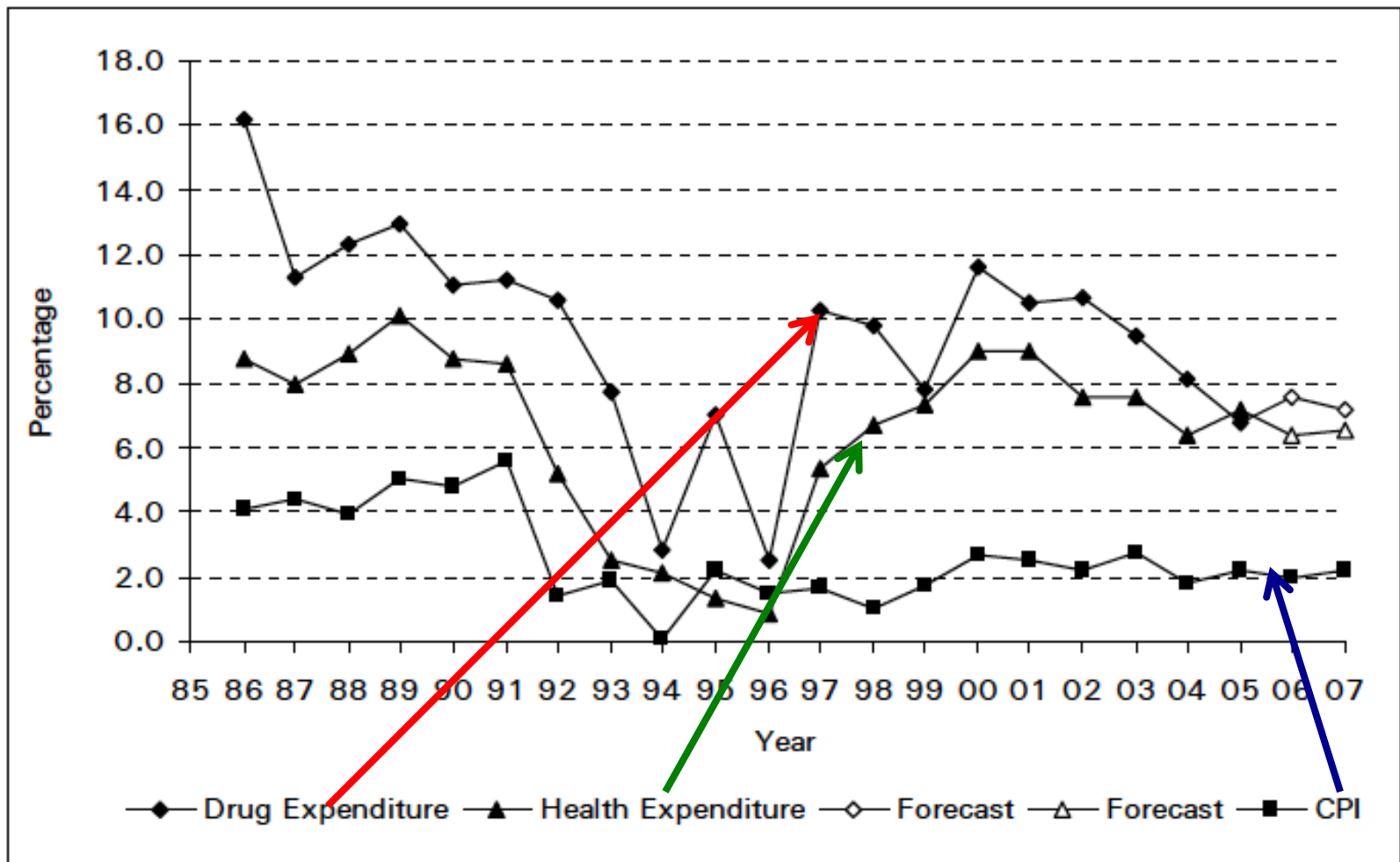
65 year old woman with diabetes, hypertension & insomnia - annual household income \$23,315 (CMAJ 2008;178:405-9)



Economic Efficiency

Controlling drug spending

Growth in Overall Health and Drug Spending & CPI





New Drugs Are Driving Costs

Patented and Non-Patented Drugs – Drug Cost per Claim

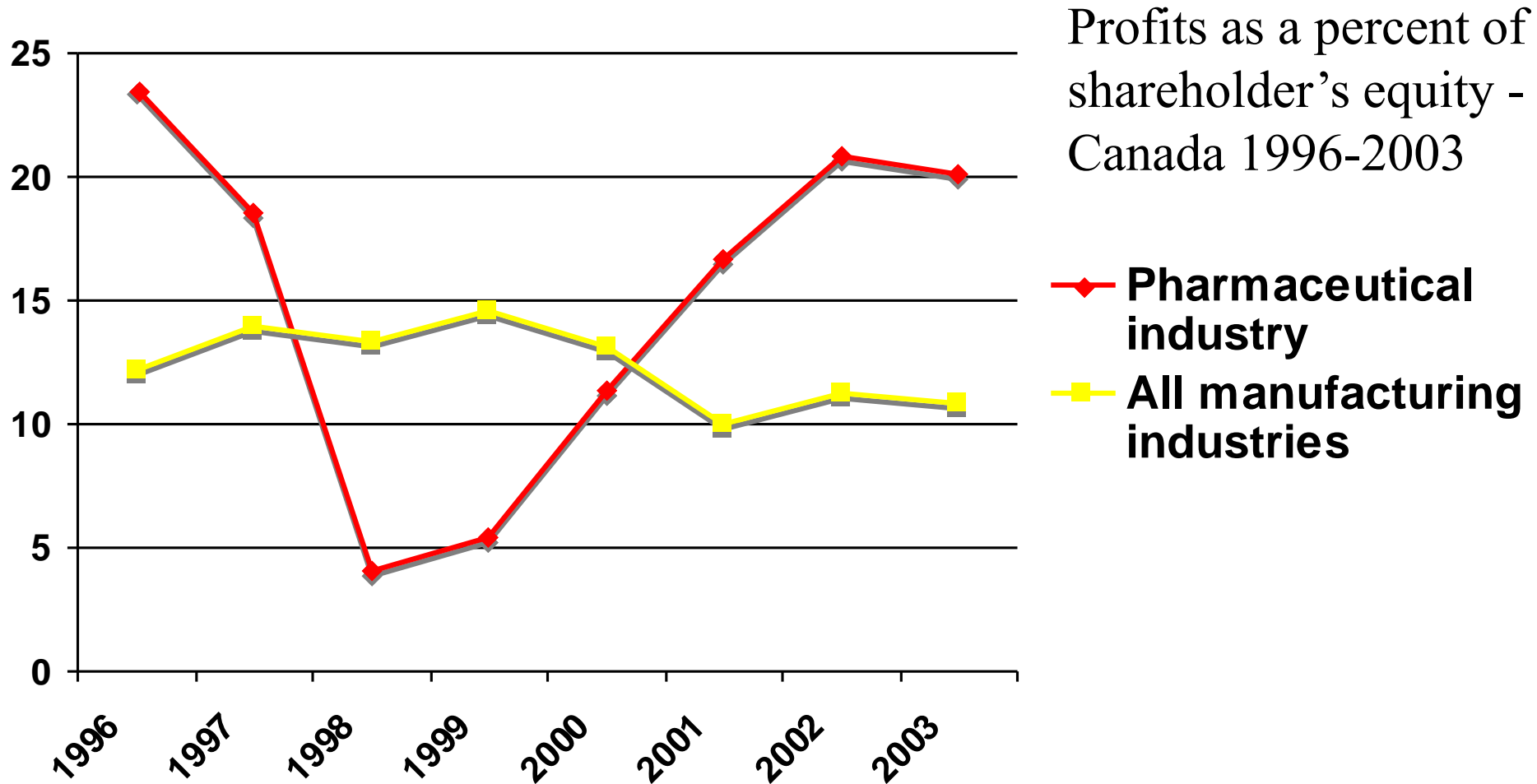
Year	Patented	Non-Patented	Ratio
1997	\$65.58	\$21.43	3.1
1998	\$70.91	\$21.60	3.3
1999	\$75.07	\$21.47	3.5
2000	\$79.14	\$22.17	3.6
2001	\$82.90	\$23.49	3.5
2002	\$88.59	\$24.99	3.5
2003	\$91.18	\$26.76	3.4
2004	\$95.67	\$27.88	3.4
2005	\$101.06	\$29.63	3.4
Average Annual Rate of Change	5.6%	4.1%	



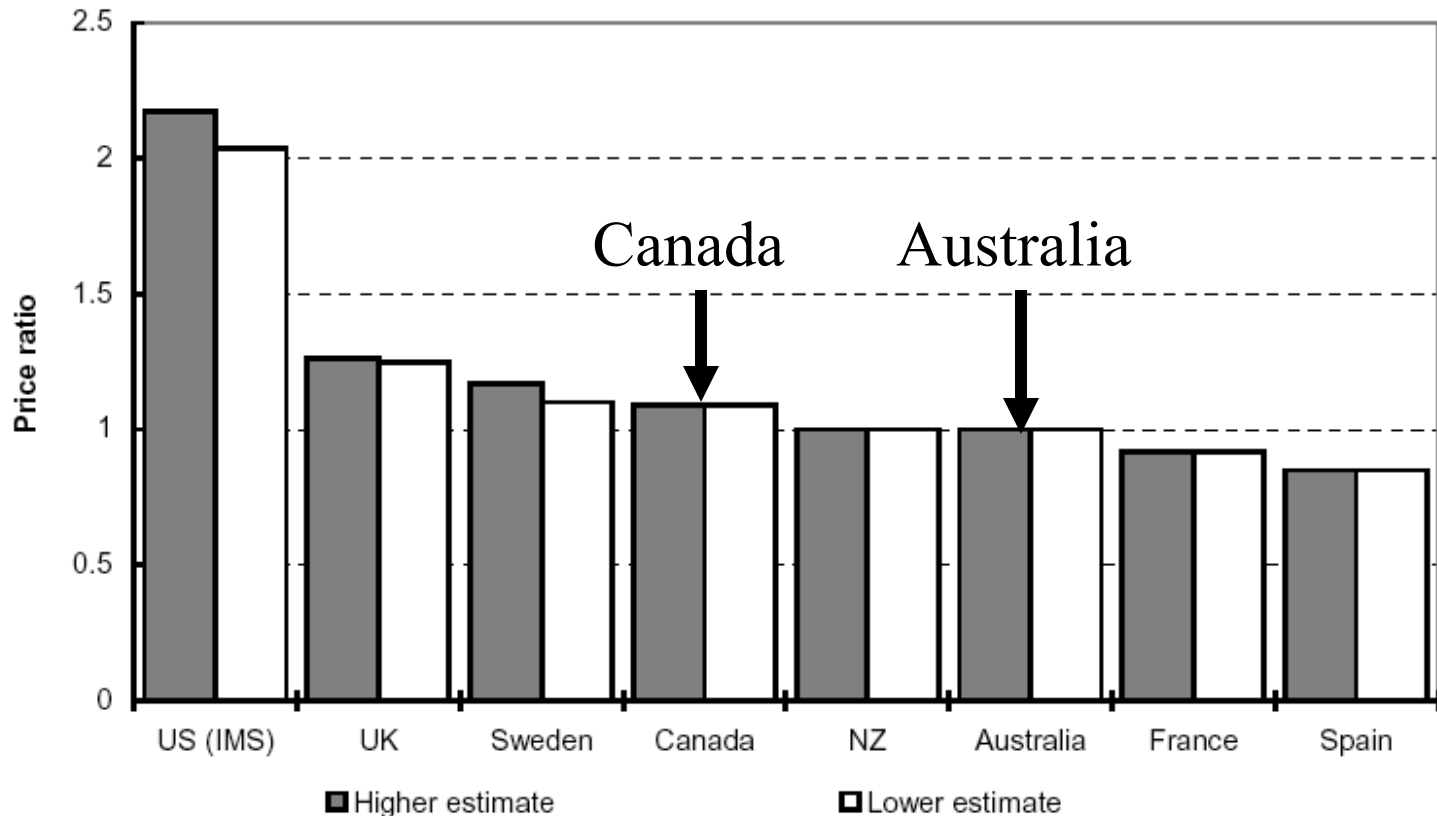
Costs, Coverage and Profits

- Pharmacare without controlling costs just means more profits for the pharmaceutical industry

The Drug Companies Don't Need More Profits



Monopsony Buying Power Can Help Control Costs

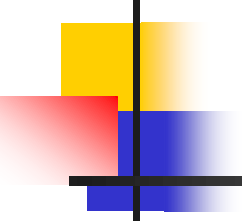


Canadian prices for new innovative medications 9% higher than in Australia -- Australian Productivity Commission Report, July 2001



More Public Spending May Control Costs

Percent Public Expenditure and Per Capita Expenditure		
Country	Percent public expenditure (2002)	Per capita expenditure (2002)
Ireland	84.2	259
Czech Republic	77.4	253
Germany	74.8	408
Greece	71.5	278
Sweden	69.3	329
Japan	68.3	391
Switzerland	67.0	354
France	67	570
Hungary	62.5	298
Iceland	61.8	375
Australia	53.8	346
Finland	53	309
Denmark	52.5	239
Korea	52.4	208
Italy	52.1	484
Canada	37.6	485
United States	19.5	673



Administrative Costs are Lower

- Private plans in Canada
 - 8%
- Large public plans (Ontario, Quebec)
 - 2%

Better Prescribing



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Are We Getting Value for Our Money?

Category	Number	Percent
Major therapeutic innovation in an area where previously no treatment was available	2	0.2
Important therapeutic innovation but has limitations	38	3.9
Some value but does not fundamentally change the present therapeutic practice	106	10.8
Minimal additional value and should not change prescribing habits except in rare circumstances	251	25.5
May be new molecule but is superfluous because does not add to clinical possibilities offered by previously available products	442	45.0
Without evident benefit but with potential or real disadvantages	77	7.8
Decision postponed until better data and more thorough evaluation	67	6.8
Total	983	100.0

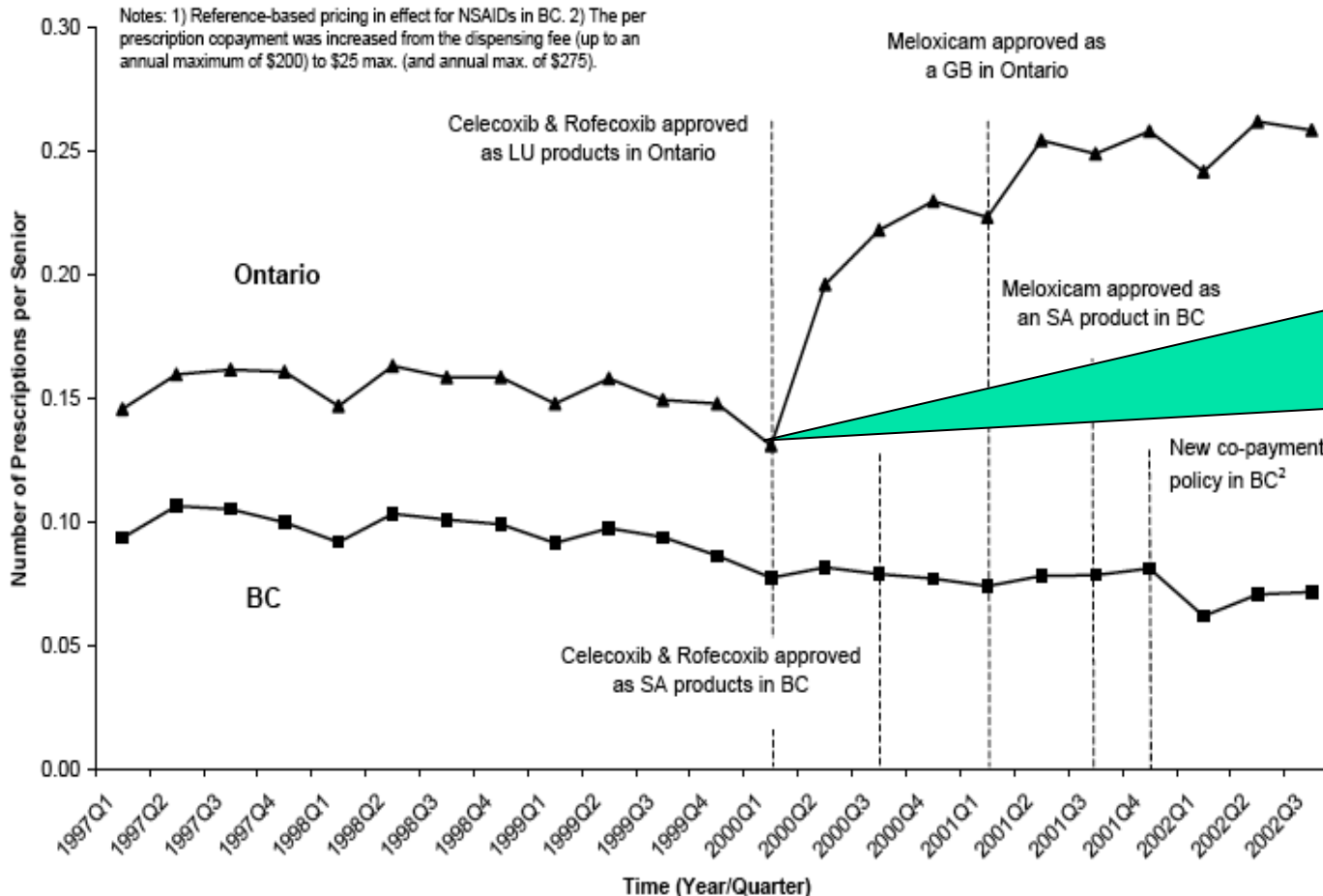
A look back at pharmaceuticals in 2006: aggressive advertising cannot hide the absence of therapeutic advances. *Prescrire International* 2007;16:80-86.



Vioxx (Rofecoxib)

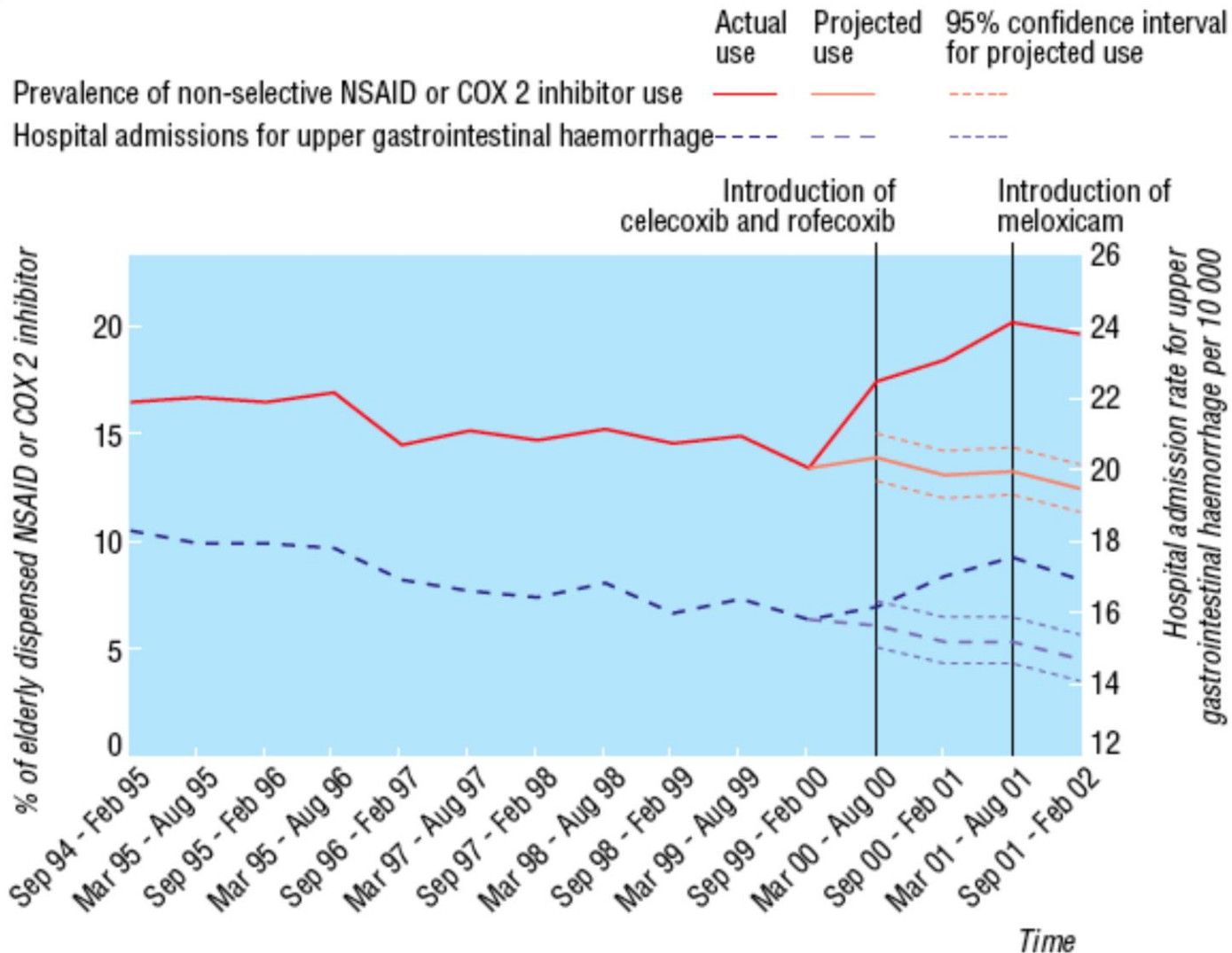
- Studied only in selective patients (those with MI excluded)
- Heavily promoted
 - 2000 (Canada)
 - 48,000 details
 - >1 million samples left with doctors
- Heavily prescribed to population groups where not studied
- In the US estimated to have lead to 88,000 – 140,000 additional MI

Prescribing of Some New Products is Additive Not Replacement



Total NSAID prescribing increased when COXIBs came on the market

The Result: More GI Bleeds





Controlling Use of New Drugs

- Controlled listing of new drugs can help regulate early use
 - Much less effective if multiple payers with different criteria
- Government much more interested in appropriate use if paying bulk of costs
 - More willing to finance initiatives for appropriate use
 - Australian National Prescribing Service funded at AUS \$35 million/year
- Single database for monitoring prescribing



Catastrophic Drug Insurance Isn't Good Enough

- Could still leave people with high out-of-pocket costs
 - Even adjusting for income, expenses could be high, e.g., maximum 5% income (One NPS proposal)
 - Ontario minimum wage \$9.50/hour = \$19,760 per year x 5% = \$988 per year
- Will only spending on formulary drugs count to maximum?
- Where will adjudication occur? (Shoebox effect?)



What Happens When People Have to Pay Relatively Large Amounts Out-of-Pocket?

- Quebec Mid 1990s
 - Elderly: copayment of \$2.00 per prescription → coinsurance & deductible with maximum charge of \$200-\$925 per year
 - Social assistance: no copayment → coinsurance & deductible with maximum quarterly charge of \$50



The Outcome

	Changes in		
	Hospitalization	Physician visits	Emergency department visits
Elderly	+35%	+13%	+50%
Welfare recipients	+194%	+22%	+106%



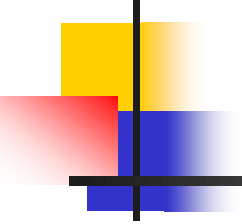
What About a Public/Private Mix as in Quebec?

Private plans are a subsidy to the wealthy

- Employer contributions to supplemental health benefits are tax free for the employee
- Subsidy employee receives is based on marginal income tax rate
- Given Canadian progressive tax system top quintile (by income) gets subsidized 3X more than bottom quintile (1995 data)

What Will It Cost?





How Much Are We Currently Spending (2008)?

CIHI:

Public insurance	\$11.2 billion
Out-of-pocket	\$4.6 billion
Private insurance	\$9.3 billion
Total	\$25.1 billion



What Would Happen Under a First-Dollar Pharmacare Plan?

Some spending will go up

- Those currently with no insurance
- Those with high copayments

+

Public spending would

replace the \$14 billion currently

being spent privately



But There Will Be Savings

- 9% from monopsony buying power (based on Australia - Canada comparison)
- Lower administrative costs from the conversion of private to public insurance



And . . .

We are already spending the money

The question is: What's the best way of organizing the spending?

Physician and hospital services: **single payer**

Drugs: **public, private, out-of-pocket**



Other Countries Do It

- U.K.: 80% of prescriptions in NHS not subject to user fees
- Wales: eliminated user fees for entire population in 2007



Conclusion

- We need a national pharmacare for
 - Equity
 - Economic efficiency
 - Improving prescribing
- We're already paying for drug costs
- National pharmacare can save money

We've Waited Long Enough

