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Summary

National Approaches to Pharmacare

Opening Address

Canada's social contract was implemented step by step. Health insurance is part of our mythology, sustained by the political will of Canadians. Has the time come for Pharmacare?

What do we mean by this term? Pharmacare might mean filling the gaps: 90 percent of Canadians have some coverage and several provinces already have universal coverage. Pharmacare might mean starting all over to replace a system which is full of holes/inefficiencies.

Why now? The substitution of drugs for insured interventions has increased, integration of health services is in full swing, several provinces are already there and there is a growing concern about inequities. People with high incomes and no earned income are covered while the unemployed and those in non-standard jobs have little or no coverage. Full-time workers in small businesses may not be covered but many will have access via a spouse. No measures of the burden have been done to size the extent of the inequity – more research is needed. While equity is a major concern, so is efficiency. People without access are at higher risk, and heavier users of health care. People on welfare may be reluctant to take a job if they have to give up drug coverage- this is part of the poverty trap.

Are there alternatives to Pharmacare? Some provinces are extending health benefits for one year after leaving welfare, but drugs are not yet included. Others are requiring employers to provide insurance for non-standard workers. Are these options effective and are they complements or substitutes to Pharmacare?

Why is Pharmacare so difficult? There are four solitudes in health care: the political, the regulatory, the curing and the caring. Each has its own philosophy/incentives and each requires analysis. In the political solitude, there is a debate about public vs private boundary; there is federal-provincial competition; and there is a mistrust of the private players. In the regulatory solitude, the focus is on cost containment. Because of the weak federal-provincial harmonization, there is no national market. There is also limited commitment to drug utilization management and competition between physicians and pharmacists.

The curing solitude is characterized by the risk of distortions in health care decisions: Insurance in hospital creates an incentive to keep patient in and universal insurance would encourage shifting

the patient and keeping the money. There is a need to adapt hospital funding formulas. In the caring solitude, many questions: How will insurance affect prescribing patterns? Will there be incentives to overuse if the cost to patient declines? How will insurance impact commitment to drug utilization management?

Where Do We Go From Here? Naming the problem is just the beginning. Health care systems are open and dynamic, not clockwork machines. The objectives of the Conference are to understand the strengths and weaknesses of current practice, identify gaps in knowledge, explore system, research and planning issues and examine the tools needed to implement national approaches to Pharmacare.

(Saskatoon January 18, 1998)