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Commentary

Pharmacare and the Health Care Communiqué

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Over the past few months, Canadians have witnessed two important intergovernmental meetings that have attempted to lay to rest the apparently endless 'health care debate' that has preoccupied so much of Canadian politics in the past two decades. First, the premiers met at Niagara-on-the-Lake to develop a common strategy and approach for dealing with the federal government. And, more recently, the Prime Minister convened a First Ministers Meeting, dubbed a 'Health Care Summit', with the hope of securing the 'ten year fix' for medicare that he had made a cornerstone of his election campaign this summer. Interestingly, the premiers meeting resulted in moving one health reform issue, the creation of a national pharmacare program, from the margin to the centre of the political agenda, something that appeared to take the public, the federal government and a range of health policy analysts by surprise.

Despite ongoing assertions from many premiers that health care is an 'exclusive' provincial jurisdiction the meeting in Niagara on the Lake resulted in a proposal that would have seen the federal government effectively take responsibility for the existing provincial public drug plans. This, the premiers argued, would bring coherence to the current patchwork of eligibility across the provinces and allow the federal government to use its status as the single purchaser of drugs as a vehicle to contain costs in what is now the fastest growing health care expense. Going into the First Ministers Meeting in September, the federal government had expressed significant doubts about the feasibility and the expense of simply assuming control of ten very different drug plans. The premiers, and especially BC premier Gordon Campbell, held fast to their belief that the provincial proposal was both feasible and desirable insofar as it gave the federal government a clear role in health care and it would reduce the fiscal pressures that rising costs and demands for prescription drugs were placing on provincial budgets, allowing provinces to make reform changes in other health sectors.

Prescription drugs are one of the greatest single cost-drivers in the health-care system and exist outside of the provisions of the Canada Health Act (unless delivered in hospitals). Thus, the principles of the CHA (accessibility, universality, public administration, portability and comprehensiveness) do not apply to provincial drug programs and this means there are very different levels of coverage, co-payments, deductibles and eligibility from province to province.

The perpetual roll-out of new – but not necessarily better, and always more expensive – pharmaceuticals is one of the most difficult problems faced by provincial governments. With each "new" drug comes pressure to add that drug to the provincial formulary. Meanwhile, attempts to either increase co-payments or reduce coverage of provincial drug plans is met by fierce political opposition – much of it abetted by drug manufacturers. As new drugs are developed, they often replace other, less expensive, forms of health care. It is little wonder that the provinces and territories would like to "upload" to Ottawa the cost of prescription drug coverage for those without private insurance.

Ironically, provinces have longstanding and legitimate complaints about federal attempts to off-load services and program responsibility to the provinces. Coupled with cuts to transfer payments and a faulty equalization formula, such moves hamstring the policy options open to provincial governments. But, while turnabout may be fair play, it is not the basis for sound public policy.

In 2002, Roy Romanow's Commission on the Future of Health Care in Canada, for which I worked as Research Co-ordinator, made a series of recommendations concerning how best to deal with the rising cost of prescription drugs and the sometimes-perverse incentives that exist in the current drug-policy landscape. The real problem with prescription drugs, Mr. Romanow argued, is the fact that their financing and delivery exist in virtually complete isolation from the rest of the health-care system. In short, he recommended that if the Canadian health care system wants to deal effectively with rising drug costs, it will take a combination of federal money and inter-provincial leadership to integrate the approval, assessment and use of prescription drugs into a reformed primary health-care system.

In exchange for federal money to relieve pressure on the growing cost of the provincial drug programs, Romanow proposed a multi-step process to integrate prescription drugs into the system he envisaged. First, create a new national agency that would not only insure drug safety but also their economic and pharmaceutical effectiveness. Second, provinces would be required to step up their ongoing work on the development of a national formulary of drugs to be covered. Drugs that are demonstrably effective (in both medical and economic terms) for particular illnesses or conditions would need to have clear guidelines as to when and how they are prescribed. Only these drugs would be listed in the national formulary and hence be eligible for coverage under provincial drug programs.

All of these changes, dubbed "medication management," would be linked to the ongoing efforts that provinces are making at reforming primary health care. As patients are increasingly linked to teams of health-care professionals (including pharmacists) that can provide a co-ordinated continuum of care, it becomes possible to insure that patients not only get the prescription drugs they need, but also those that we know are economically and medically effective.

While there was much posturing in the press prior to the first ministers meeting, and the provincial plan received endorsements from a range of health care advocacy groups (many of whom traditionally side with Ottawa in the debate over ‘national standards’ and ‘provincial

accountability' for federal health dollars), the federal government held fast to the idea that the provincial proposal was premature and unlikely to do anything to contain costs.

In the final communiqué issued by the first ministers the premiers appear to have backed off from their 'pharmacare in a single bold stroke' strategy in favour of a more incremental process much along the lines proposed by Romanow. During the televised portions of the summit itself the breakdown in provincial solidarity on this issue was hinted at when Saskatchewan premier Lorne Calvert admitted that perhaps the country was three to five years away from being ready and able to integrate the ten provincial and three territorial drug plans into a single program. He intimated that there was an immense amount of work to be done before that happened to insure that it is done correctly in the first place.

What is encouraging about the commitments made by the first ministers on drug policy is that the communiqué clearly recognizes that this is going to be a difficult job. It will require not only better federal-provincial collaboration, but also a significant degree of inter-provincial cooperation around measures like a national formulary. Leaving aside the communiqué's general weakness on exactly how progress will be measured and reported to Canadians, there is some reason for cautious optimism that the governments have acknowledged the real complexity of moving from separate drug programs, operating in isolation from the rest of the health system, to a national pharmacare program that is integrated into provincial primary health care delivery.

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