



## Notes from the Editor-in-Chief

Peggy Leatt, PhD  
Editor-in-Chief

REPORTING IN THE *British Medical Association Journal* in March 2004, Ray Moynihan indicated that almost half the world's drug sales occur in the United States and Canada, and that together they spent \$230 billion last year. Spending on drugs in the two countries rose 9% in 2003, which confirms a long-term trend of rising pharmaceutical costs. Coincidentally, drug costs have increased less in other countries – for example, the increase was 8% in the European Union, 6% in Latin America and 3% in Japan.

Higher drug prices, a continuing switch to newer drugs and an overall increase in prescriptions are all contributing to the increase in drug expenditures. Top-selling drugs are cholesterol-lowering drugs, anti-ulcer agents and antidepressants. While pharmaceutical costs are only one part of total health expenditures, the burden for drug costs falls more heavily on the elderly, who are increasingly vocal in expressing their views in both Canada and the United States.

Pharmacare policies are under review in both countries. In the United States, media headlines capture the congressional debate as proposals are put forward to extend the Medicaid coverage of drugs. Meanwhile, citizens of the United States are using cross-border tactics to buy prescription drugs being sold at a cheaper price in Canada.

In this issue of the *Healthcare Papers* Morgan and Willison review the most recent proposals for pharmacare reform in Canada. Beginning in the 1960s there was concern about varying access to drug therapies across the country. In 1997 the National Forum on Health recommended universal access through public coverage of all drugs in keeping with the Canada Health Act. In 2002 the Commission on the Future of Health Care in Canada (the Romanow Commission) proposed a different set of reforms that included a national standard for a catastrophic drug benefit. Morgan and Willison contrast these two approaches to policy reform as the “first dollar” pharmacare reform versus the “last dollar” program. The first-dollar program as recommended by the National Forum on Health has no deductibles, and the public program would pay for all or part of the drug costs starting with the first prescription. In contrast, the last-dollar program pays a household's drug costs beyond an annual deductible. The authors explore the merits of both programs in terms of protection for the vulnerable and cost-containment. They recommend that provinces should move forward on a catastrophic drug benefit plan and also develop networks of centres

of excellence in research and innovation in pharmacy policy that will promote equity, access and efficiency. They conclude that a blend of first-dollar and last-dollar programs would be the most appropriate direction for Canada.

Seven commentaries extend the debate on pharmacare policies for Canada. Forest, formally Director of Research for the Romanow Commission, kicks off the debate by reviewing the historical background and the larger constitutional context where responsibility for approving drugs rests with the federal government and the application lies with the provincial governments. He concludes there is no easy answer, and as with other health issues there needs to be negotiation and agreement by both levels of governments. Deber points out the political difficulties in moving forward but endorses the Morgan and Willison strategy to develop a blended approach that incorporates patients' circumstances and their disease. Lexchin compares the current debate to a "merry-go-round" and makes a plea for a quick solution. As he indicates, the money all comes from the same pocket, and the question is whether it can be distributed more equitably through a public system.

Sketris, Brown and Murphy from Dalhousie University provide an excellent review of the experience of other countries and apply this to the Canadian context. In their review they discuss determination of drug eligibility – that is, who will be eligible for coverage and which drugs will be covered – medication management strategies and approaches to evaluation. They conclude that a new Canadian approach will require much planning and innovation as well as a clearly defined plan for evaluation across provinces.

French takes on the perspective of employers and their role in drug coverage. French draws an analogy between the current drug debate and the plan for designing dental programs in the 1970s. The idea was that if employees had easy access to preventive dental care there would be a lower incidence of or less need for more expensive dental treatments. This prediction has not been supported in practice. French supports the view that the federal government should design and fund a catastrophic drug program and work with the provinces to develop specific payment mechanisms. Also from the private sector perspective, Montague and Cavanaugh begin their commentary with the important potential that new and innovative drugs have for improving the population's health and economic outcomes. They describe supply-side approaches that restrict access to control costs as well as management strategies that focus on the demand side. They conclude that a combination of strategies is probably needed and use the example of disease management

approaches where interventions can be more easily defined and controlled.

Laupacis is a renowned clinical epidemiologist and health services researcher who has focused a great deal of his career on drug issues. In his commentary he admits that the issue of a pharmacare program for Canada is complex and will require difficult choices. He reports that a number of European countries have redesigned their drug policies, but none has been able to truly balance effectiveness, equity, efficiency and affordability. In fact, some countries were planning to introduce policies that had clearly failed in other environments. Laupacis focuses his comments on the cost-ineffective use of cost-effective therapies, balancing the influence of the pharmaceutical industry and managing the government's drug budget. He points out that evidence-based cost-effective drug therapy can be expensive, especially if cost-effective drugs are applied to patients who are at too low a risk or at too high a risk for value. He indicates the startling fact that most clinical guidelines do not take into consideration cost-effectiveness. In terms of the supply side he suggests that use of drugs may be more complex because of the direct advertising the pharmaceutical companies do with individual physicians as well as with direct consumer sales. He suggests that information about drugs should be developed nationally, with clear messages that can produce better-informed patients and improved prescribing practices. Laupacis's comments on innovation and the drug budget are noteworthy. While he certainly supports innovation, the price of continuous high-level innovation may be too expensive for the healthcare system to bear. He suggests that such innovation might more appropriately be financed through means other than the healthcare system responsible for delivery of services – for example, through other government arms such as those responsible for innovation and industry.

I would like to thank Morgan and Willison for writing their thoughtful lead paper and for stimulating debate on this very interesting and complex issue. Nothing will happen unless there is the political will to move forward at both the provincial and federal levels. As with other aspects of health services, there are limits on the dollars available for distribution, and difficult and perhaps unpopular choices must be made. Meanwhile, the public and individual consumers are waiting, and the costs of drugs are spiralling uncontrollably.