Zombies, myths and pharmacare

Enterprising computer geeks have periodically created "whack-a-mole" websites at which visitors can take sledgehammers at cartoon politicians or quack hypotheses.

They might well create such a site for national pharmacare, offering as targets the now-lengthy list of reasons that have been advanced for why it simply can't be introduced in Canada: cost, jurisdictional quagmires, pharmaceutical and health insurance industry opposition, inertia, etc.

A national pharmacare program has become the "zombie of healthcare ideas" because it "pops up every 5–10 years," says Dr. Neil MacKinnon, associate director of research and professor of community health and epidemiology at Dalhousie University in Halifax, Nova Scotia. It was first proposed in the 1960s by the Royal Commission on Health Services headed by Justice Emmett Hall. Among more recent manifestations was the National Pharmaceutical Strategy, a component of the 2004 intergovernmental Health Accord that has since seen "muted progress on a few items" but in large measure "has fallen apart," according to MacKinnon.

Why?

Somewhat surprisingly, many experts say the primary culprit is a lack of political will.

When Prime Minister Stephen Harper and the Conservative Party were elected to a minority government in 2006, "federal willingness to talk about this dried up," says John Abbott, CEO of the Health Council of Canada.

Others argue that political parties have not taken up the banner because voters appear disinterested. "Middle- and higher-income Canadians have not rallied behind calls for pharmacare because they really don't see much in it for themselves," says Dr. Steve Morgan, associate director of the Centre for Health Services and Policy Research at the University of British Columbia in Vancouver. "Most Canadians with moderate incomes are at least partially insured through work and many recognize that they would pay a large portion of the bill for a tax financed system that would generate benefits for those less well off."

Health Council of Canada

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Such voter apathy or fears about perceived costs have created a "perfect storm of inaction" with respect to adoption of a national pharmacare program or pharmaceutical strategy, MacKinnon says.

Most experts reject the notion that the cost of a national pharmacare program has been the primary barrier to its introduction.

Rather, they say, private interests have a vested interest in maintaining the current system of paying for drugs. "Private insurers and pharmaceutical manufacturers make a lot of money under Canada's very expensive multipayer system," says Morgan. Being able to reform our current system and implement a national strategy would be difficult with "opposition from such interests."

That sentiment is shared by Steven Lewis, an adjunct professor of health policy at the University of Calgary in Alberta, who also views provincial economic policies as a barrier.

"Ontario and Quebec are home to most of the drug R & D [research and development] in Canada and these provinces perceive an interest in policies and practices that are sufficiently attractive to pharma to maintain their R & D spending levels," Lewis says.

But Wendy Zatylny, vice president of federal affairs and communications for Canada's Research-Based Pharmaceutical Companies (Rx&D), the national association of drug makers, says costs are not strictly the issue.

Rather, it's how drug costs impact on overall health care costs, she says. Focusing strictly on drug costs "doesn't take into account the other costs savings and efficiencies elsewhere in the healthcare system … where drugs do save costs downstream, where they reduce the need for hospitalization or surgeries."

In national pharmacare programs, like that of New Zealand, which has often been cited as a model for Canada to emulate, there are "certainly decreased costs in the short term. … But it shifted the burden to other parts of the healthcare system" such as emergency room visits and hospitalizations, Zatylny says.

The experts also say that there's no doubt that jurisdictional wrangling has also played a factor in the failure to establish a national pharmacare program.

As Lewis notes, the provinces are responsible for health care delivery and are in charge of health spending, making it "very difficult to implement any truly national health care programs. … So there is a patchwork of pharma programs that among other things creates a barrier to exercising purchasing power." Among the advantages held

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out for anything like a national pharmacare program is the capacity to negotiate lower prices for bulk purchases. Ontario was recently able to use the technique to cut the cost of generic drugs in half.

The various barriers have not proved insurmountable to nations like New Zealand, the United Kingdom and France, which have implemented national pharmacare plans despite industry interests. That indicates that it boils down to political will, and without a government in power that sees national pharmacare as a priority, it will inevitably "die a natural death," Abbott says. That is until the next time the zombie surfaces. — Daniel Rosenfield, Toronto, Ont.

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