Session II: Pharmacare

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Pharmacare is a fascinating policy area. Drug expenditures account for a rapidly growing component of the overall health budget and $420 billion is spent roughly, worldwide, on prescription drugs each year. Of that, $19 billion is spent in Canada. Prescription drug expenditures grow by 10 to 15 percent per year and have surpassed physicians' services as a cost driver in terms of the health care budget. And growth is relatively uncontrollable, unlike hospital, medical, rehabilitation, and other health services.

New drugs and a responsive pharmacare policy can have huge impacts. For example, when TB drugs were discovered, TB sanatoriums were closed. The same is true with mental illness. When you discover a new and effective drug, you can actually dramatically change the health and service delivery package in the population.

On the other hand, of course, drugs can also cause harm. Drug-related illness is now the sixth-leading cause of death. For every 200 admissions, at least one is going to result in a preventable drug-related adverse event. And for every visit, about two to five percent results in some sort of adverse drug event. So it's easy to get it wrong.

Unlike other essential health services, drugs were not included in the Canada Health Act as a comprehensively defined essential service. Drugs were only included as an essential service when they were administered in the hospital. When you're out of the hospital, those same prescription drugs you got in the hospital were assumed to be no longer necessary.

For whatever reason, drug management in the Canadian health care system has been, for the most part, either not insured or privately insured, unless you're in the hospital. It was one of those omissions in the Canada Health Act that immunized this sector of health care from preoccupation with privatization. If anything, it has been going in the reverse direction. Rather than private insurance eating away at essential health services, it's really been the other way around. Public insurance has increasingly supported considerable expenditures by the individuals for their drugs. Catastrophic drug insurance policies are part of the pharmaceutical strategy that will be discussed by Wayne Critchley.

Another interesting dimension of pharmacare policy is that it crosses different sectorial policy silos. It is the only aspect of health care that regularly crosses health, industry and science. So policies in industry and science have quite a remarkable effect on health when it comes to the drug sector. For example, the extension on patent protection that was provided to industry to build a healthier Canadian climate for R & D has had measurable consequences on the dollar amount spent by health ministries on prescription drugs.

Aidan Hollis will raise some of the policy dilemmas related to drug development for rare disease where you have an industry that is creating the innovation engine that you need in disease management while simultaneously providing the return on investment for their share-holders. Although he is going to talk about the rare disease phenomenon, in fact, what we may see happening, maybe in our lifetime, is that everybody is going to become a rare disease. If we have genetically customized therapy, we may have to develop a registered drug insurance saving plan for each of us to have our own genetically modified drugs.

Drug policy is the land of social experimentation. Things change rapidly in the drug policy world because with a minor change in policy, you can dramatically influence drug expenditures. This makes drug policy an interesting area to study because things change so dramatically. And that can change the health of the population fairly dramatically. Sebastian Schneeweiss and Steve Morgan will talk about what effects these policies have, not just on the utilization of drugs, but on what is called the essential health service basket in health care, and what happens to health outcomes.