National Pharmacare Cost Impact Update Study

Executive Summary

Objective

The purpose of this study is to estimate the cost of funding a national pharmacare program in Canada. This research updates the previous study conducted in 1997.

The study was conducted by Palmer D'Angelo Consulting Inc. (PDCI) and supported by an unconditional research grant from Canada's Research Based Pharmaceutical Companies (Rx&D). PDCI is solely responsible for the findings and opinions contained in the report.

Background

With the exception of drugs dispensed for patients receiving hospital care, there is no national insurance program that provides universal access for prescription medicines. Unlike hospital and medical care, multiple payers are involved in the financing of prescribed drugs, including federal, and provincial governments, private insurers and individual consumers. In 1997, the National Forum on Health recommended a national pharmacare program but this recommendation has not been acted on. The Commission on the Future of Health Care in Canada (the Romanow Commission) will be issuing its final report later this fall and may be considering whether a national pharmacare program is needed and affordable.

Drug costs represent a rapidly growing portion of total healthcare spending. Total prescription drug expenditures in 2001 are estimated to be $12.3 billion, with 45% ($5.5 billion) funded by public plans. Total spending has almost doubled from the $6.8 billion for 1996 that was reported in the previous study. The private sector portion of spending is calculated to have been just under $6.8 billion in 2001, with private insurers accounting for almost $3.7 billion and individuals (insured and uninsured) for $3.1 billion.

Approximately 10% of Canadians have no form of drug insurance and must therefore cover the full cost of their prescription medications. The prescribed drug expenditures for these individuals account for about 6.4% of total prescription drug expenditures.

Scope

The study quantifies the total and incremental costs to government of funding a national pharmacare program. The feasibility or practicality of a national pharmacare program is not considered as these political and constitutional issues are beyond the scope of this study. However, the study does consider a variety of pharmacare models and the impact a national pharmacare program would have on private payers. To add to the discussion, models of "national" drug programs in place in the United Kingdom, France, Sweden and Australia are reviewed, along with current initiatives in Canada.

Methods

Seven models of national pharmacare programs were developed ranging from a public only, fully funded, comprehensive plan with no co-payments or deductibles, as proposed by the National

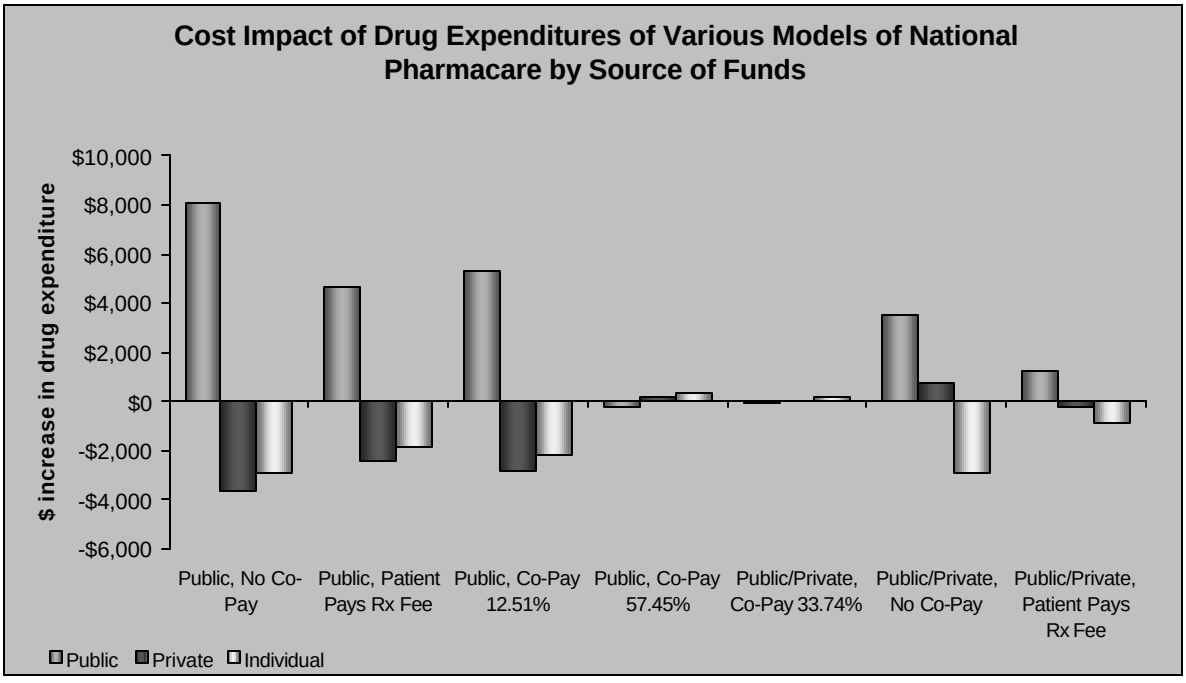
Forum on Health, to plans with both private and public funding that also require a patient co-payment.

The analysis assumes that all prescription drugs are "medically necessary" and would be insured and that over-the-counter products would be excluded from coverage. In practice it is likely that a formulary would be introduced that would limit coverage and exclude some treatments. Any restrictions on access to prescription drugs under the public plan could create a need for private insurance plans and individuals to provide additional funding.

Results

Overall Cost. The total cost of funding the national pharmacare models ranges from $13.8 billion for the fully funded, public only model with no co-payments to $12.4 billion for the public/private funding models with co-payments. The greatest impact is in the proportion of funding provided by government, private plans and individuals which varies substantially depending on the model. Models with large co-payments have the largest cost burden for individuals and the lowest cost for the public sector.

Incremental Cost. Under a fully funded, publicly administered, national pharmacare program (as envisaged by the National Forum on Health), government spending on prescribed drugs would increase by approximately $8.1 billion. This would be the result of a dramatic shift in funding from the private sector to the public sector. Spending by private plans would be eliminated (a decrease of $3.7 billion) and spending by individuals would decrease by $2.9 billion. Total impact would be a 12.5% increase in expenditures for prescription drugs over the current level (primarily from increased utilization by individuals currently with no or inadequate drug insurance).



Other publicly administered pharmacare models with a moderate co-payment or with patients paying the dispensing fee would entail increases in public expenditures ranging from $4.7 billion to $5.3 billion. Private plan expenditures would decrease substantially, but would not be totally

eliminated as supplementary health insurance plans would cover some costs. Individual spending would decrease in the range of $1.9 billion to $2.2 billion. Total impact would be a 2.5% increase in drug expenditures.

Public/private plans have considerably less impact on the public purse than the public only plans. Public costs decrease by 1.5% or $84 million under a system similar to a current plan in Quebec with a co-payment/deductible averaging 33.7%. However, a public/private model providing first dollar coverage with no co-payments or deductibles increases public costs by almost 65% or $3.5 billion. Total impact of the first dollar coverage model would be a 10.8% increase in expenditures (slightly less than the public only fully funded model). Model 7 has public/private funding and the patient pays only the dispensing fee. Under this approach, public spending increases by 22% while the overall impact is minimal - a slight increase in spending of 0.97%.

Private drug insurance is usually provided as part of employer sponsored extended healthcare benefit plans. These plans may no longer be viable if the prescription drug component is eliminated as it generally accounts for a large proportion of extended healthcare benefits.

Conclusion

Ultimately, individuals (or their employers) are paying the bill for prescription drugs either through taxes, insurance premiums or out-of-pocket expenses. An evaluation of the costs and benefits of each model is necessary to determine which, if any, approach would best meet the needs of Canadians and satisfy the objectives of universality, comprehensiveness and affordability. Public/private hybrid plans may be easier to introduce as they would have little impact on the drug plan coverage enjoyed by those with private plans but would provide or improve the benefits for those with no or inadequate coverage.

The models presented in this study offer a wide range of possibilities however, the focus should be on the approaches that offer the greatest incremental access/coverage for Canadians that have no coverage or are under-insured while not adversely affecting those that currently enjoy good coverage through private drug plans. Moreover, just as there are important differences in the delivery of provincial healthcare systems, it is likely that each province will want to continue to provide drug benefits that best fit the needs of their population. Perhaps the greatest immediate need is to identify population groups that lack drug benefit coverage or that have inadequate coverage and propose ways in which coverage can be introduced or enhanced.

An international comparison of drug benefit schemes indicates that the UK, Australia, Sweden and France offer more extensive public coverage of pharmaceuticals than do the government-sponsored systems in Canada. The public share of total prescribed drug expenditures is also higher in these countries than in Canada[1]. However, all of these countries have reimbursement schemes that require some form of co-payment or deductible which in some cases, is covered or reimbursed by private insurance. None of these industrialized countries with publicly funded healthcare systems provide full coverage for the full cost of drugs to its residents.

[1] Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Volume Three: Health Care Systems in Other Countries*, January 2002.