The idea of a Canadian national pharmacare program has received a lot of attention over the past few months. Sparked by its unanimous endorsement by Provincial and Territorial leaders at the First Ministers meeting, the media,1 health economists,2 and health policy experts3,4 have quickly weighed in on the issue. Arguments for and against have also been presented in a previous UTMJ publication.5

For many, however, the issue is not whether or not a pharmacare program is a good idea. The benefits are obvious. A national pharmacare program would extend the Canada Health Act (CHA) to include necessary prescription drugs for all Canadians, thus improving accessibility and equity. The most glaring examples of prescription drugs inequity are between provinces and more so between socio-economic status. Overall, national pharmacare would also be cheaper. Economist Armine Yalnizyan explains we are going to pay for drugs regardless of policy: you either pay out of pocket or you pay through tax dollars. So the real question is, which way is the better way of paying?2

If we believe that a national pharmacare program is the best route, then we need to debate how best to implement a national pharmacare program that will achieve the best cost savings. As such here are some legitimate concerns to be addressed:

1. Should the federal government investigate how much money would be saved by a) buying drugs in bulk and b) introducing reference based pricing?

In Australia and New Zealand, where national pharmacare programs exist, significant costs savings have been realized.6

2. Should the federal government adopt a 50:50 payment strategy with the provinces?

A mixed payment strategy would ensure provinces continue to play a pivotal role in upholding the CHA.

3. Should the federal government set up an independent body to create a national drug formulary?

An independent and open advisory panel could use existing essential drugs lists (e.g. the World Health Organization essential drugs lists) to create a national drug formulary for Canadians.

Despite recent attention, few have attempted to answer how to best implement national pharmacare.7 The current debate is also lacking a comprehensive understanding of the pharmaceutical market itself. Indeed it is complex. But it is safe to say that governments are fighting a losing battle against the pharmaceutical industry. A critical analysis reveals some of the harsh realities for policy decision-makers.

**Pharmaceutical Economics and Profit Margins**

- According to the Fortune 500 magazine, the pharmaceutical industry is the single most profitable industry. In 2001 it enjoyed an 18% return on revenues (next came commercial banks at 13%, and the oil industry at 9%). In Pfizer’s 2003 annual report, the world’s largest pharmaceutical company boasted of $43 billion (USD) in sales for the year (an increase of 40% from 2002).8

- A lot of attention is paid to how much it costs to develop a “new molecular entity” (NME). The pharmaceutical industry estimates this number to be $500 - $800 million (USD) in R&D dollars. In all likelihood, this number is grossly exaggerated. As a primary example, this internally generated number is not an out-of-pocket cost per se. Instead it is a “capitalized cost”, whereby a percentage of this total comes from lost investment opportunities.9 These speculative calculations, while may be common place in economics circles, bloat the cost of drugs and make industry come across as disingenuous.

**Pharmaceutical Innovation and R&D**

- Contrary to claims by industry, the majority of R&D drug discovery happens as a result of research in public institutions (i.e. universities), with the public’s tax dollars at work. In 1998 in the U.S. only 15% of articles cited in patent applications came from industry, while 54% came from academic centres.9

- A feature article by Scherer provides one explanation why the pharmaceutical industry is not driven by innovation principally (10). He explains that gross profit margins and R&D spending are highly correlated: “as profit opportunities expand, [pharmaceutical companies] compete to exploit them by increasing R&D investments, and perhaps also promotional costs, until the increases in costs dissipate most, if not all, supra-normal profit returns”. One could argue R&D is an adjunct effect of carving out a larger market share.

**Health Outcomes and New Drugs**

- The French drug bulletin, Prescrire International, has published summary statistics on almost 2500 new preparations or new
A pharmacare program steered by a national agenda has the potential to add vigilance and legitimacy that Canadians deserve. If done properly, a national pharmacare program would accomplish two health care goals: in terms of health economics it would contain drug costs more effectively, and in terms of health outcomes it would improve equity, access and prescribing patterns by physicians. Building on the scope and range of the CHA is a worthwhile initiative. Whether Canadian health policies are incremental (catastrophic drug plan) or monumental (national pharmacare plan) in reaching these goals, this is the direction we should be going.

References