Yes, to national pharmacare – because we already paid for it

TOM KOCH
CONTRIBUTED TO THE GLOBE AND MAIL
PUBLISHED JUNE 25, 2019
UPDATED JUNE 28, 2019

Tom Koch is a Toronto-based gerontologist and consultant in chronic and palliative care. He is the author of 14 books including Ethics in Everyday Places.

The battle lines were drawn earlier this month with the federal report of the Advisory Council for the Implementation of National Pharmacare. In the subsequent jockeying everyone was right, but both proponents and early critics missed an essential point.

The council's chair, Dr. Eric Hoskins, is right. Patients should not be beggared, as many are today, by the high cost of life-saving medications. Canada needs a co-ordinated strategy to rein in drug costs. As a consultant in chronic and palliative care, I've heard from patients for whom the cost of medications is a struggle.

The NDP made this a central plank in its platform leading toward the next election. It has promised not only a national program in pharmacare, but one that would eventually include other medical services now excluded from coverage.

But Official Opposition Leader Andrew Scheer and his Conservatives are also right. The federal program, projected to cost $15.3-billion annually when fully implemented, is a lot of money. But patchwork, semi-solutions of gradualism won't solve the problem.

Insurers charge that a national pharmacare program would "disrupt" the coverage of Canadians who currently purchase secondary insurance. That is correct. Many now buying supplemental programs would not need them any more. But insurers will find a way. They were similarly worried when the 1984 Canada Health Act was first passed. They survived and prospered in the end.

The council believes, correctly, that a national program with bulk purchasing would drive down costs countrywide.

But it ignores a central problem: Drug companies would still be free to set the market price for their products.

Big Pharma argues it needs to charge sometimes onerous prices for prescription medications to cover the costs of bringing life-saving drugs to market. Giving credit to that argument is hard when older drugs such as epinephrine (in the EpiPen) and insulin are priced unconscionably high.

As I wrote in my book, Thieves of Virtue, almost half of all drug research is funded by government agencies. Their testing usually is carried out in the country's publicly funded hospitals and universities. Billions more in research monies are donated annually by non-profit organizations dedicated to raising research monies for research on Alzheimer's disease, cancer (think Terry Fox runs), Down syndrome, heart disease, multiple sclerosis, etc.

We are paying, in effect, three times: through federal research grants, through disease-focused charities and then at the pharmacy.

A national pharmacare program could change this if – a radical idea – the cost of a drug over the life of its patent was calculated to recognize the public support its development received. Manufacturers would submit a funding history with a tentative pricing. A fair rate of return would be permitted for the life of a patent based on that information. If drug companies exceeded a fair price point their patent would be shortened as a result, permitting others to produce it as well.

Canada could do this on its own, setting pricing as a condition of federal drug approval. But, since Canada is not alone in its concerns, it could propose other countries join in on a multinational drug policy based on fair return. Certainly, it would be a program welcomed by many in the United States where drug costs, generally far higher than here, are a political issue.

Drug companies would scream foul if a policy of fair return were implemented. But, such as the insurers who, in the 1960s, opposed from the start the idea of the Medical Care Act, they would adapt.

Medicine was never meant to be a maximizing, corporate, for-profit bonanza. When Frederick Banting and Charles Best developed insulin they made it available to all in need. Early genetic testing in the 1960s – for instance for Phenylketonuria (PKU) – was carried out in the spirit of altruism by researchers seeking public-health benefits rather than personal or corporate profit. So it should be today.

Yes to a national pharmacare program. The fragile among us will be the beneficiaries. It can be done without financial hardship – for patients, provinces and suppliers – if we make reasonable cost basis a benchmark for approval of drugs on a national formulary.