

# Romanow on Pharmaceuticals: A Strong Case for Access to Quality Medication Therapy

Anita L. Kozyrskyj  
*University of Manitoba*

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Anita L. Kozyrskyj, PhD  
Department of Community Health Sciences  
Faculty of Medicine  
Manitoba Centre for Health Policy  
408-727 McDermot Ave.  
Winnipeg, MBR3E 3P5  
kozyrsk@cc.umanitoba.ca

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Given the expanding role of prescription drugs in the lives of Canadians, the Romanow Commission identified two critical issues which demand attention. One is to ensure that financial barriers do not prevent Canadians from accessing the prescription drugs they need. The second is to improve the quality, safety, and cost-effectiveness of prescription drug use.<sup>1</sup> The Commission put forward five recommendations to address these issues. First, they recommend a Catastrophic Drug Transfer, whereby the federal government would reimburse 50 per cent of the costs of provincial drug insurance plans above a threshold of \$1,500 per person per year. Next are three recommendations to ensure uniform access for Canadians to cost-effective drugs, including the creation of a new National Drug Agency, the establishment of a national formulary system, and the revision of Canada's patent laws. A fifth recommendation is directed at improving the quality of drug therapy through the establishment of medication management programs, as part of a reformed primary health care system.

Despite stating that a "strong case"<sup>1</sup> can be made for including prescription drugs as medically necessary services under the Canada Health Act, the Commission fell short of making this recommendation. Why did it not honour the 50-year legacy created by Hegearty in 1945, Hall in 1962, and the National Forum on Health in 1997, in unambiguously supporting prescription drug insurance as an entitlement for all Canadians?<sup>2</sup> This omission is in glaring contrast to the Commission's willingness to propose that diagnostic services become medically necessary services, especially when there are many similarities between

diagnostic services and pharmaceuticals. Both are insured benefits for hospitalized patients and the cost-effectiveness of each is regularly challenged. The reason may have something to do with the Commission's unease that growing reliance on private advanced diagnostic services was eroding equal access. Did the Commission not have the same trepidation about unequal access to pharmaceuticals? In part due to efforts to keep people out of hospital, increased reliance on private funding has already occurred for pharmaceuticals. Is this because Canadians were silent on the issue of unequal access to prescription medications? According to the Policy Dialogue on the Commission's Web site they were not. Canadians did express concern over this issue and about increasing gaps in coverage, as new drugs from the human genome project became available. Are these issues of particular relevance to Canadian seniors? Let us examine the evidence.

All provinces offer prescription benefits for seniors. However, in contrast to two-thirds of younger Canadians, only 50 per cent of seniors reported having drug insurance in 1996.<sup>3</sup> This is because every province operates its own drug plan for seniors and there is substantial variation in the amount of coverage. While many provinces offer coverage to all seniors, some, like New Brunswick, only provide benefits to seniors receiving guaranteed income supplement (GIS), a federal subsidy targeted at low-income seniors.<sup>4</sup> Manitoba seniors, like other residents, are reimbursed 100 per cent of prescription costs, once their deductible level is reached. The deductible is income-based, corresponding to 3 per cent of annual house-

hold income above \$15,000 and 2 per cent for incomes below this value. Using simulation methods, Willison et al. observed that across Canada in 1997 there was up to a 10-fold variation in out-of-pocket payments made by seniors of similar incomes for the same drug consumption.<sup>5</sup> Seniors receiving the GIS would pay a maximum of \$50 in Ontario, while those in Saskatchewan would pay \$500. Out-of-pocket costs for low-income Manitobans would be in the order of \$300. It is interesting to note that under Manitoba's income-based system, in 1999, 35 per cent of all out-of-pocket prescription drug costs paid by Manitobans were paid by seniors.<sup>6</sup>

Expenditures for prescription drugs in Canada continue to rise at a rate of 10 per cent per year.<sup>4</sup> Prescription drug costs among Manitoba seniors increased over 40 per cent from 1995 to 1999; for seniors 85 years and older prescription costs doubled.<sup>6</sup> A common reaction of drug insurance plans to rising prescription costs is to increase levels of prescription cost-sharing. These "policy experiments" serve as valuable lessons in human nature. When the New Hampshire Medicaid program capped the number of prescriptions covered, not only did seniors decrease their use of essential medications, but a greater number were admitted to hospitals and nursing homes.<sup>7</sup> But Canadians do not have to look across the border for these types of examples. In 1997 the Quebec government introduced universal prescription coverage, along with a 25 per cent co-insurance for seniors, who previously had paid a nominal co-payment or nothing at all for their prescriptions.<sup>8</sup> The outcome was a 9 per cent decrease in use of essential drugs by seniors and a doubling of the rates of hospitalization and nursing home admissions. Even more powerful examples are narratives of seniors with chronic illnesses who cannot afford to pay for their medications. What do they do? They try to obtain free samples from physicians, they decrease their spending on food and clothing, they take less of their medication, they borrow money from friends to pay for their prescriptions, and they stop taking the medication.<sup>9</sup>

So there is no question that unequal access to pharmaceuticals exists for seniors living in Canada, and when faced with increases in prescription costs, seniors opt to economize their use of prescription medications. The Romanow Commission's recommendation for the Catastrophic Drug Plan was intended as a gradual integration of prescription drugs into the Canada Health Act. Individual provinces would use this money to expand their existing drug plans. But will the Catastrophic Drug Transfer alleviate the burden of prescription costs for seniors, under the current system? Many provinces already offer more generous benefits for low-income seniors, with deductible lev-

els that are lower than the \$1,500 threshold recommended by the Commission. In the Manitoba context, a low-income senior would pay \$300 per year. Let us assume that Manitoba's Pharmacare program did not change its existing income-based policy and used the Catastrophic Drug Transfer to expand prescription coverage. In the fiscal year 2000, 50 per cent of Manitoba seniors had annual prescription costs that exceeded the \$1,500 threshold level.<sup>10</sup> In order for a Manitoba senior to be paying the \$1,500 out-of-pocket under Manitoba's Pharmacare program, s/he would require an income in excess of \$50,000 (deductible level is equivalent to 3% of annual income). Approximately one quarter of seniors living in Manitoba have annual incomes greater than \$50,000.<sup>6</sup> Thus, at most, the Catastrophic Drug program would benefit an additional 25% of the senior population, namely wealthier seniors with high medication needs. Of course, this estimation represents the best case scenario, where the income-based program remains intact and the Catastrophic Drug Plan is an add-on. The real danger of not defining prescription drugs as medically necessary services is that it leaves the provinces to expand—or restrict—prescription coverage as they wish.

### **The Case for Appropriate Drug Therapy**

Access to prescription drugs does not ensure optimal drug therapy. Almost 50 per cent of drugs prescribed for the elderly have been reported to be either inappropriate or unnecessary.<sup>11,12</sup> Drug-related problems in the elderly not uncommonly lead to hospitalization. The greater the number of drugs a senior is taking, the more likely s/he is to be hospitalized for an adverse effect.<sup>13</sup> The average Manitoba senior receives anywhere between 18 and 28 prescriptions per year.<sup>6</sup> Repeatedly, the Commission heard that quality of medication therapy was important to Canadians. In this regard, the Commission is to be applauded for recommending the ongoing collection and dissemination of data on medication utilization, a function that would be coordinated by the proposed National Drug Agency. However, medication utilization review alone will not guarantee optimal drug therapy. With a new drug on the market every 4 to 5 days, we must provide better decision support at the time a prescription is written. We need to change our models of patient care to ensure that communication among health professionals and patients is an integral process of patient care. Again the Commission is to be commended for its proposal to integrate medication management programs into a reformed primary health care system, where the health of individuals is managed by a team of health care providers. As part of this primary health care team, pharmacists, the Commission urged, should have an increased role in

medication management. This makes sense when one reads that medication reviews conducted on seniors by pharmacists have identified medication-related issues in at least 80 per cent of therapies.<sup>14</sup> An in-home medication review program offered by pharmacists under the auspices of home care would be an example of a viable medication management program directed at seniors living in the community. Close collaboration among the patient, physician, pharmacist, and home care workers would be requisite for the success of this model.

In the Commission's search for incremental steps to improve drug utilization among Canadians, there exists an opportunity for linking prescription reimbursement to medication management in settings that guarantee ongoing medication review. In essence, this is the situation in the hospital sector, where prescription drugs are provided free of charge, a formulary system defines the list of cost-effective drugs, and prescription orders are reviewed by pharmacists. Interestingly, hospital prescription expenditures in hospitals have increased at a much lower rate than prescription expenditures in the community setting.<sup>4</sup> An in-home medication review program provided by home care could easily be tied to prescription reimbursement. In this proposed model, seniors undergoing regular medication therapy review would be eligible for 100 per cent reimbursement of their prescriptions. By ensuring good quality drug therapy and decreasing financial barriers to needed prescription medications, this model will make it easier for seniors to live independently in the community. The outcome would be advantageous for many.

Canadians are the ones who pay for their prescription drugs, whether they pay through taxes, through premiums to insurance companies, or out-of-pocket. The tax base for our public health insurance system is eroding, as our population ages and the percentage of persons working decreases.<sup>15</sup> In some provinces, seniors have become more wealthy over the last decade.<sup>6</sup> The cost of universal prescription insurance under the Canada Health Act, which would prohibit user fees, would be high. Choices need to be made. The Romanow Commission did not make a recommendation for a national pharmacare program but did propose the first steps towards better integrating drugs into the Canadian health care system. If implemented by provincial plans, the Catastrophic Drug Transfer should ensure that no single Canadian senior faces financial ruin from medication therapy. What is most noteworthy about the Commission's report is that its proposals for catastrophic drug insurance were combined with other steps to improve prescription medication use. Preventing further wasting of Canadian tax dollars on unnecessary or harmful drug therapies

may pave the way for an affordable universal prescription insurance system. Romanow makes the statement, "In the coming months, the choices we make, or the consequence of those we fail to make, will decide Medicare's future."<sup>16</sup> While universal insurance is a desirable goal, getting the right drug to the right person at the right time at the right price should be our priority. Canadian seniors should be demanding the best medication therapy possible.

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