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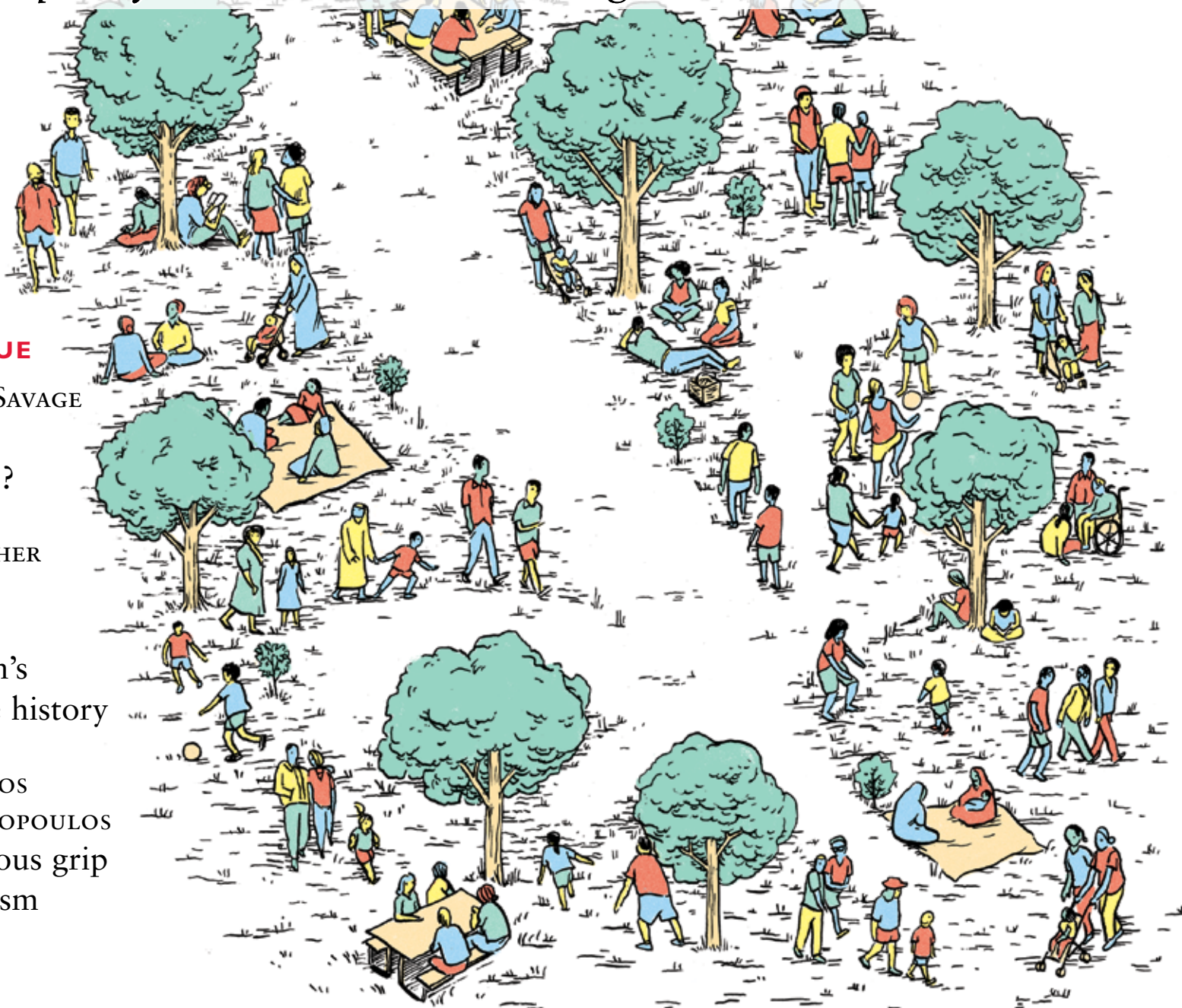
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Drug Deals

How to shift policy toward universal pharmacare.

DANIELLE MARTIN

Ideas and the Pace of Change: National Pharmaceutical Insurance in Canada, Australia and the United Kingdom

Katherine Boothe

University of Toronto Press

217 pages, hardcover

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I REALIZED MY PATIENT “Julie” probably had multiple sclerosis. She did not know it yet. She had come in to see us in the family practice clinic because she had suddenly lost her vision in one eye. What followed was a blur of specialist appointments, MRI scans, difficult moments breaking the news to her family and friends, and the slow process of coming to terms with life as a young woman with two small children living with a chronic and potentially debilitating disease.

That should have been enough for her to deal with. But when the price tag for the medication she needed came in, things got worse. The annual cost for the medicine Julie needs is \$25,000—and she probably has to take it for life. She has insurance coverage through her husband’s employer, but like many private insurance plans, it does not cover the full cost. Julie and her husband were left wondering where they were going to find the balance.

Across Canada, one in ten people do not take medication as prescribed because of concerns about cost. I see those people in my practice every day. Some have no drug coverage at all: they are self-employed consultants, people working part-time jobs, nannies, taxi drivers. Others have coverage through private or public drug plans but, like Julie, they cannot afford their co-payments or deductibles.

Danielle Martin is a family physician and the vice-president of medical affairs and health system solutions at Women’s College Hospital in Toronto. She is a senior fellow at the WCH Institute for Health System Solutions and Virtual Care and an active researcher, policy expert and unabashed advocate for national pharmacare in Canada. She is grateful to Jay Shaw for his assistance in preparing this review.



Canada is the only developed country in the world that has universal hospital and medical insurance but lacks equivalent pharmaceutical coverage. In a country where so much national pride is invested in our healthcare system, how can this be?

In *Ideas and the Pace of Change: National Pharmaceutical Insurance in Canada, Australia and the United Kingdom*, Katherine Boothe tries to answer this “understudied empirical puzzle.” An adaptation of her doctoral dissertation, the book uses archival, interview and polling data to compare the pharmaceutical policy histories of Canada, the United Kingdom and Australia. The purpose of the analysis is to understand why, when it comes to pharmaceutical insurance, Canada has followed a path of policy stasis.

This book is aimed primarily at an academic audience, but it addresses an issue that should concern us all. We have a drug problem in Canada: a problem of high prices, poor access and variable quality of prescribing. Change is needed, so a book about how it happens should be welcomed by all of us, especially in an election year.

I cracked the spine of this book with hope in my heart. In doing research for my own upcoming book on how we can make good on the promise of Canadian medicare, I have been seeking to understand how change occurs, and how it can be

accelerated. The dusty shelves of parliamentary libraries are replete with recommendations spanning decades for universal public pharmacare from royal commissions; yet still many patients take their medicine every other day when it gets close to the end of the month.

The burning question in Canadian pharmaceutical policy reform is not whether change is needed. It is how we can make that change happen.

This is the kind of question that political scientists thrive on, and Boothe does not disappoint. She proposes a framework for how change in pharmaceutical policy has taken place in three countries based on the notion that the pace of change matters. For Boothe, three key factors drive whether and how quickly policy change occurs: the degree of centralization of institutional decision-making power, the particular policy ideas that are

entrenched in the minds of political elites, and the motivations of voters to rally behind certain policy proposals or ideas.

For me, like many Canadian physicians and advocates determined to push, pull and, if necessary, drag Canada toward universal public pharmacare, this analysis is not purely academic. I read Boothe’s book with an eye for strategy, seeking some instruction on what is needed to achieve a breakthrough. The decentralization of power in Canadian health care is unlikely to change and public support for universal pharmacare in Canada is already high. So I zeroed in on her concept of policy ideas among elites. Where do Canadian political elites get their policy ideas from? And what will it take to convince them that it is time to make a big change in the world of pharmaceutical policy in Canada?

Ideas about the feasibility and wisdom of pharmacare have been highly resistant to evidence and common sense. Boothe politely explains that this is because “both radical and limited ideas share a tendency to become sticky: early ideas become entrenched and difficult to change over time.” In other words, once a politician—or a political policy advisor—has made up his or her mind about whether pharmacare is worth an expenditure of political capital or public funds, it is going to be hard to change that person’s mind.

This is not specific to those working in politics—ideas are sticky for all of us. A study in *Medical Care* in 2013 demonstrated how the beliefs of those with knowledge of politics were more resistant to fact checking about “death panels” in the United States than those with less knowledge of politics. The more we know, the less we think we can learn.

So where do the “restricted policy ideas of elites” on pharmacare come from? Boothe traces a long history of ideas passed on from government to government, including the idea that “initiating this type of benefit would result in an expensive program with no potential for cost control.”

The concern about the potential cost of pharmacare is a sticky idea that has proved hard to push back against. This is ironic, given the fact that countries with universal public pharmacare spend much less than we do on drugs. A year’s supply of cholesterol-lowering Lipitor, for example, costs at least \$811 in Canada (\$140 for the generic version); in New Zealand, where a public authority negotiates prices on behalf of the entire country, it costs \$15. On the basis of numbers like those, a recent economic analysis I co-authored with my colleague Steve Morgan and others estimated that Canada could save \$7.3 billion annually under universal, single-payer pharmacare.

If we negotiated centrally for prices more as is done in other countries, bought our medicines in bulk and substituted generics where appropriate, the billions of dollars saved could be reinvested in ensuring that everyone has access to the medicines they need. Yet concerns that pharmacare would be too expensive persist among decision makers, dragging the file to the bottom of their priority lists.

In the face of resistance among elites, there are two possible approaches to making policy change. The first is incremental: start small, and go slow. In 2002, the Romanow Commission recommended that the place to start would be catastrophic drug coverage, a type of public plan that protects patients with very high drug costs from going bankrupt.

In the 13 years since that recommendation, nearly every province has adopted some form of catastrophic plan, so that once a person spends between 3 percent and 10 percent of income on prescription medicine, public coverage kicks in.

In theory, incremental change should lead to more small steps along the path. In practice, at least in Canada, it seems to have led nowhere. The strategic intent of the Romanow Commission was that “starting with a more limited universal program [i.e., catastrophic coverage] would allow for later expansion.” Despite this hope, the views of elites about the feasibility of subsequent steps on the road to universal pharmacare remain unchanged. And on the ground, few people have 5 percent of their income available to spend on medicine in order to meet the bar for public coverage. So the change cannot be over yet.

There is another school of thought besides that calling for incremental change. Known as the “big bang” approach, it has been highlighted in the work of University of Toronto health policy scholar Carolyn Tuohy, and now by Boothe.

This is the policy equivalent of ripping off the Band-Aid. Herein lies the key to the argument of Boothe’s book: contrary to theories of incremental change, in practice it is the pace of policy change that itself dictates opportunities for future policy reform. Big bang change reinforces its own outcomes. Incrementalism makes big change more difficult.

Why? In part it is because the narrowed scope of those sticky ideas held by political elites has a strong tendency to resist growing any wider. We are prisoners of our own history, and the prospects for health policy reform are held captive by the relatively narrow ideas of those who set our health system in motion.

Boothe demonstrates the importance of these central ideas through her in-depth case studies of policy change in Canada, the United Kingdom and Australia. The three countries examined have much in common, but a study of their approaches to developing health insurance policies reveals important differences.

The UK implemented universal public pharmacare simultaneously with the forming of the

Across Canada, one in ten people do not take medication as prescribed because of concerns about cost.

National Health Service in the 1940s. In other words, it did “radical” change all at once, and subsequent refinements have generally respected the basic structure of a national public health service that supports hospital, medical and pharmaceutical needs.

Australia, like Canada, implemented its health insurance plan in phases—but unlike Canada, it started with pharmaceutical insurance. Boothe therefore compares the UK, in which national public insurance was established all at once (a big bang or radical approach to policy implementation), to two countries that chose more incremental approaches.

The central argument presented in this book is that “a country’s pace of policy development in a given policy area is predictable ... [and the] early approach to policy development has a crucial effect on the scope of program adoption, as it produces and maintains restricted ideas among elites and the public that limit future program expansion.” The history of the healthcare policy portfolio acts on the ideas of political elites, and vice versa. When they inherit a limited scope, prospects for meaningful change are slim.

So where does that leave us on pharmacare in Canada? Having started with incremental ideas, and then allowed sticky concepts to shape the view of what is possible and achievable in the minds of policy leaders, can we hold out any hope?

Despite the incremental path we have followed in Canada, pressure for universal public pharmacare is mounting. Provincial ministers of health are increasingly recognizing that, with the rise of expensive “blockbuster” drugs that save lives but cost huge amounts of money, their only hope of controlling budgets is to drive prices down to the levels seen in other member countries of the Organisation for Economic Co-operation and Development. This can be done only if they band together and pool their purchasing power in the global market for pharmaceuticals.

Employers, who currently provide drug coverage for a slim majority of Canadians, are increasingly vulnerable as the costs of their insurance plans rise. Private insurers have no incentive to control costs or ensure appropriate prescribing. In short, we are in a pickle. So if there is something to be learned about how to do better, we should learn it—and fast.

Tinkering around the edges, as we have done for the last 50 years, is clearly inadequate. But in order for quick, radical change to happen in health care, many constellations of stars have to align.

Boothe suggests that “perhaps the first goal for setting reforms in motion is to convince a broad range of Canadians that the problem of public pharmaceutical insurance is worthy of attention and action, even amid other pressing concerns about health policy reform.” Considering the entrenchment and divisiveness of political ideologies, perhaps remaining focused on the public is indeed the only way ahead.

I closed this book with a heavy sigh, because at the end of all that analysis one comes back to a painfully obvious observation: if you want the politicians to do something, the people have to demand it. No amount of economic analysis, policy doomsday predictions or international shaming will cut it.

There is some sign of movement on the political front—the NDP, the Liberals and the Green Party of Canada have expressed varying degrees of support for some amount of change. The centrality of the issue in their platforms and during the campaign will depend on us. Until the phones of the country’s constituency offices ring off the hook and candidates are questioned on front stoops and in local debates, change will come slowly, if it comes at all. If only all those people who suffer from a lack of drug coverage could take time away from their precarious employment to commit to such advocacy for their needs.

But pharmacare is not just a policy for the poor. Even for those Canadians who have drug coverage or can afford considerable out-of-pocket spending on drugs, the rising cost of prescription medicines and the potential for avoidable health system costs if they are not used correctly should be of concern. One can hope, then, for a coalition of advocates across income lines on this issue in the months to come.

Books about political economy face a test of relevance to present-day struggles. If we are to use rigorous analysis of history to make the world a better place, that analysis needs to offer us a way forward. *Ideas and the Pace of Change* sketches a pretty bleak picture of our prospects for change when it comes to pharmacare in Canada, but it also suggests fairly convincingly that with the right political will, there is a route to universal coverage. If “major change is rare but not impossible,” the current election cycle may offer that rare moment where it happens, perhaps first among the public and then among policy makers themselves.

My patient Julie found a way to pay for her MS medication. Her private insurance plan picks up part of the tab. A paid employee in the public hospital MS clinic whose job it is to figure out how to get medicine for patients with MS helped her apply for a “compassionate access” program run by the pharmaceutical company that covers much of the rest of the cost. Extensive system navigation skills, persistence and savvy are required for patients like Julie to get their basic medical needs met in our country. Boothe calls our history on this file “not encouraging.” I think it is downright depressing.

The major lesson to be drawn from *Ideas and the Pace of Change* is that big change requires the “rare conditions” of a strong idea, a strong government and an energized electorate with high expectations. If change is going to happen it needs to happen quickly. To my mind, it cannot come fast enough. LRC