Canada doesn't have one system of funding medications. It's a patchwork, a missing jewel of Canadian healthcare. Shutterstock photo

A Crack in the Canadian Jewel of Healthcare

Gail Attara

Coverage for medications in Canada is a patchwork. Sometimes eligibility for coverage is based on postal code, age, and income. These inconsistencies are tough on vulnerable patients. Each stakeholder has a perspective on how to fix this, and it's long past time for pharmacare programs to be reconstructed with the patient—the end user—at the centre.

In 1976, the parents of a woman in her early 20s who died of Crohn's disease founded the organization where I have worked as CEO for almost 20 years, serving individuals who have gastrointestinal and liver conditions. Today, there are medications that almost certainly would have kept her alive and with a good quality of life. I'm encouraging our government leaders to create better coverage of medications for every person in Canada, so we can all live life abundantly.

Today in Canada, about 20 million (out of more than 35 million) people have their prescription medication covered by a private plan, but millions still rely on restricted public plans, and some have no coverage at all. One in 10 individuals living in Canada simply cannot afford to take medications as prescribed. If you have to decide between food and medication, food wins.

Tommy Douglas, the former Premier of Saskatchewan, who is warmly called the father of Medicare in Canada, once said to his daughter, "My dream is for people around the world to look up and to see Canada like a little jewel sitting at the top of the continent." Douglas's most notable achievement in health was the introduction of universal healthcare legislation in 1961, building on Prime Minister Diefenbaker's decree in 1958 that any province seeking to introduce a hospital plan would receive 50 cents on the dollar from the federal government. Further milestones of interest are the *Medical Care Act* (1966) and the *Canada Health Act* (1984).

Right now, there is a crack in the Canadian jewel. The crux of our chal-

lenge is that we don't actually have one system; it's a fractured, complex, cat's cradle of funding transfers and responsibility.

We have a publicly funded system that covers physician and hospital visits no matter where you live, but we don't have a similar program for many other health-related matters, such as medications. Of course, there are some exceptions, as the *Canada Health Act* covers only those medicines prescribed for use in hospital, and the many provincial, territorial, and federal public plans cover medicines for certain individuals under a complex set of varied criteria. The coverage does not transfer with you if you move out of jurisdiction, so many people fall through the cracks when it comes to getting the medications they need.

Throughout the past century, we have come a long way from the availability of a few simple medications, primarily dispensed in hospital, to having a host of complex, highly effective medications administered in hospital and at home that keep us alive and living well. So many conditions are still untreated, so there is room for more innovation and new medications to help those waiting for treatments and cures. We have also learned an incredible amount about the remarkable genetic variances among us, leading to more treatments that are targeted and increasingly effective.

I've read many articles lately suggesting that we're spending too much on medicines and that the pressures on government budgets to provide pharmaceutical care are increasing. While not entirely attributed to medications, our Canadian life expectancy has risen from 71.4 years in 1961 to 81.2 years in 2012. Clearly, achieving 10 additional years of life means we invested wisely.

In June 2015, at a roundtable on pharmacare that included eight provincial health ministers, all agreed that there are too many of us who have either no or insufficient coverage for prescription drugs. They contend that without substantial policy reform, the current situation will only get worse. I am encouraged that the health ministers want a good pharmacare plan that focuses on providing coverage to the entire population while improving the quality of prescribing, producing better health results, and offering good experiences for patients—all while saving money.

The heads of the various public drug plans say they have to manage decreasing budgets and that the newer medications, some of which work miraculously and transform lives, are too costly for them to cover. If I were working in a provincial finance department, I would be looking over the shoulders of those managing the public drug plans to make sure they are spending *enough*, since cutbacks there could cause an undesirable consequence in other parts of health and beyond.

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In simple terms, we buy and use hand soap to ward off sickness; likewise with many pharmaceuticals, they are good investments as they keep us from getting sicker. Medications have a tremendous role to play in our society; we should treat them with respect, and use them appropriately, not treat them as if they (and their cost) are the enemy. Since government is not the primary driver of medication research and development, the private sector has risen to the challenge, offering us many options, but they come with a cost.

There is too much focus on the upfront, silo costs to the various pharmacare budgets and not enough on the effect that a generous pharmacare program would have on our society. In most cases, when a person receives the right medication at the right time, at the right dose, and for the right duration, that person will become well again and not use further resources in other parts of our social systems. They will return to work sooner and healthier, and will be less likely to use our employment insurance or welfare plans. They will even use the medical system less, as they will need fewer visits to physicians and hospitals.

I'm the current chair of the Best Medicines Coalition, a national alliance of patient organizations with a shared goal of equitable and consistent access for all Canadians to safe and effective medicines that improve patient outcomes. Our hope is that we can create a system for providing pharmaceutical care that is national, broadly inclusive, and allows for the uniqueness of the individuals it would serve by including a wide array of therapeutic options and timely access. It would include both public and private coverage. Most importantly, we must ensure that patients, the end users of this program, be included in its design.

There are many stakeholders involved in this discussion, most with conflicting perspectives. What we really need is acceptance that we all have differing, valuable, and valid views. I would like to see a uniquely Canadian concept evolve quickly from open discussions and hard work including all stakeholders. I hope we can work in harmony to construct a system—with give and take—that meets the needs of us all.

In a perfect world, without sickness, injury, or genetic anomalies, we would not need medical and pharmaceutical help, but patients need medications. Our pharmacare coverage needs to change with the times. I want Canada's pharmaceutical care to be that jewel on the top of the continent, of which Douglas spoke. P

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