Notes from the Editor-in-Chief

THE CANADIAN INSTITUTE FOR HEALTH INFORMATION (CIHI) recently reported that millions of Canadians take some kind of medication every day. Specifically, the report noted that about 78% of Canadians said they had used one or more prescribed or over-the-counter medications in the last month in 1998/99. The drugs most commonly used by Canadians are painkillers, followed by heart medications, stomach remedies, penicillin or other antibiotics, sleeping pills and tranquilizers, and antidepressants. As with other healthcare utilization statistics, the report showed that women, older Canadians, and those with lower incomes were more likely to report using medications (CIHI, "Health Care in Canada, 2002"). The report re-enforces – from the viewpoints of both consumers and providers – that the way drugs are managed in Canada is in critical need of attention.

Canadians are no different from citizens of most Western countries in their use of medications. A major policy issue, however, is where the funding for medications should come from. As will be the focus of this issue of Healthcare*Papers*, the costs of drugs are sky-rocketing, and yet there has been little public debate about the procedures for drug approvals and the administration of drugs across the country. Certainly, this is a pressing concern for the Romanow Commission as it struggles to understand relationships between public and private sector involvement in healthcare delivery systems.

The idea for a Healthcare*Papers* issue on drug policy sprang originally from the report of the National Health Forum published in 1997, which recommended the establishment of a national pharmacare program. At that time, the general philosophy and proposal was that drugs would become equally accessible to all Canadians, with no financial barriers, as part of our national health insurance program. The pharmacare program seemed to receive favourable public support through the media at that time. Attention waned, however, as all levels of government focused on the sustainability of existing levels of funding for medical and hospital services. Nevertheless, drug costs are mounting at an alarming rate, and it is time that serious thought be given to renewing discussions of public policies for drug program administration and management.

In their lead paper, Laupacis, Anderson and O'Brien, Canada's leading experts on this topic, provide an excellent overview of the severity and complexity of the use of drugs and offer some potential strategies for more cost-effective usage. It is clear from this invited essay that medications are increasingly a major component of treating most illnesses in Canada. The authors explain that while the federal government has responsibility for approval of drugs for use in Canada, and for price regulation, the provincial governments still hold responsibility for how drugs will be paid for. There appears to be considerable variation among the provinces as to which drugs are paid for from the public purse as well as who is eligible for free drugs at point of service. Commenting on the increases in drug costs, the authors outline the complexities that contribute to this

trend – such as the development of extremely expensive drugs for albeit some fairly rare diseases, and the use of moderately expensive drugs for less rare conditions. One of the contributing factors as to why drug costs are increasing at a faster rate than other treatment interventions, such as surgery, is that each physician is able to prescribe medications as long as he or she has a licence to practise. Drugs are also more likely to be prescribed than other treatments when there is uncertainty about diagnosis or the best treatment – drugs are more likely to be "tried out" in situations of unsure diagnosis than, for example, surgery. In addition, the pharmaceutical industry contributes to overall expenditures on drugs by their aggressive marketing to prescribers as well as, more recently, their increased marketing to consumers through television and other advertising means.

Laupacis, Anderson and O'Brien outline several suggestions for moving forward: first, provide better evidence for decisions about drug effectiveness prior to approval; second, improve the type of outcome measures being used to evaluate effectiveness of drugs; third, tighten the methodologies of pharmacoepidemiological studies being conducted to enhance their reliability and validity; and fourth, make sure the information about the evidence reaches prescribers so that they can make the most appropriate decisions. It is clear, as in other aspects of healthcare, that the production of best evidence about the practice of medicine and the use of this information is essential for the most effective decisions. Only through better communication of the evidence and the implementation of changes following the research will the most effective use of drugs become a reality. In summary, Laupacis, Anderson and O'Brien do not wish to imply that the prescribing of drugs may be bad or not do good – in fact, they suggest that the increase in drug costs may be appropriate. Their point is that we need a better understanding of what works and what doesn't and how to keep the costs under control.

Our commentators on the lead essay add substantially to the debate from different points of view. Levy and Gagnon from British Columbia agree with our experts that something must be done to rein in the increasing costs of medications in Canada and outline some of the hurdles that must be addressed. McFarlane, an assistant deputy minister in British Columbia's Ministry of Health Planning, discusses the experiences so far with that province's pharmacare program. Some of the experiences illustrate the need for better electronic information systems to communicate drug information. This factor adds fuel to the fire for provincial governments who are already petrified by the financial burden that could mushroom if a comprehensive drug program were to be imposed. Lindberg, a former assistant deputy minister of health in Ontario, suggests a multi-pronged approach in which governments, clinicians and pharmaceutical manufacturers work together to develop innovative strategies around access to drugs and the effective control of costs in the interest of all Canadians.

Willison provides an excellent review of potential public policy strategies for handling the drug cost situation. He describes the historical limitations of finding ways to control the use of drugs through utilization management techniques, such as traditional rationing, and outlines the problems with traditional cost-sharing arrangements where consumers bear some of the drug costs with governments. While cost-sharing

strategies have the advantage of increasing consumer awareness of drug costs, they act as financial barriers to the accessibility of drugs for everyone who needs them.

From a clinical point of view, Gray from Nova Scotia elaborates on the problem of patients, especially the elderly, who are often prescribed several drugs at the same time (polypharmacy) without a full understanding of drug interactions and complications. From the pharmaceutical industry point of view, Montague and colleagues provide background on how we have arrived at the current situation in Canada and explain the industry's role in ensuring that safe drugs are on the market. In looking to the future, they emphasize the importance of examining the cost of *not* treating people when the costs of drugs are being considered. The authors describe the potential for improving the appropriateness of drug use through the use of disease management strategies. This approach is increasingly being used across the country as well as internationally.

Disease management as a strategy to control costs is also advocated by Fernandes, who discusses the wide variation in publicly administered programs. The author points out that drug insurance coverage tends to be low among the young and the old – the latter category being the heaviest users of drugs. He notes that approximately 10% of Canadians have no drug coverage at all. In examining the issue of what is covered, the author notes that there is a rigorous process of evaluation in place for addressing and regulating which drugs are available. In this process, historically there has been heavy reliance on expert opinion because of the lack of adequate outcome data. The commentary concludes with a discussion of ethics in pharmacare policy, stressing the need to consider the values of patients and other stakeholders as public policy evolves and to provide a genuine forum for discussion of the ethics of drug access, availability and management.

Dugal, Mani and Potvin argue that focusing greater attention on ensuring the appropriate use of medicines, with less concentration on restricting Canadians' access to effective drugs available in other countries, will yield the greatest benefit to the health of the population.

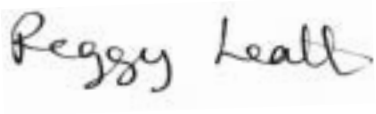
Finally, Brougham, Metcalfe and McNee in New Zealand discuss that country's national drug subsidy program but include a word of advice – begin by setting a budget. They content that budget-setting creates incentives for both suppliers and purchasers to increase cost-effectiveness and cooperation. They also point out that nine years after the creation of the PHARMAC drug subsidy program, New Zealand's pharmaceutical spending is contained despite ongoing growth in volume.

In conclusion, the situation is complex, and our writers have provided many insights and suggestions for moving forward. Clearly, there is no single solution to the problem. Greater use of generic versus brand-name drugs is often suggested as a possible way to control costs. In *Business News of the Week* (May 23, 2002) it was reported that Highmark and Trigon, two large Blue Cross and Blue Shield managed-care plans, have boosted their use of generic drugs over brand-name drugs. This change appears to have been successfully achieved through physician education, cost-conscious medicare beneficiaries

seeking lower out-of-pocket expenses, and pharmacies that find a better margin on generic rather than brand-name drugs.

While the focus in this issue of Healthcare*Papers* is on the public policy perspective and how to ensure cost-effective medication policies, the patient safety perspective on drugs should not be forgotten. In Canada as elsewhere, a current preoccupation is with the potential problem of ensuring that the healthcare environment for patients is safe. Through the publication of reports such as the Institute of Medicine's *Crossing the Quality Chasm*, our attention has been drawn to the potential hazards of medical errors. Much of the research in this area now focuses on medication errors, especially in hospital settings since this type of error is relatively easily documented on a routine basis. However, research to date suggests that even the reporting of errors may not be a sufficient deterrent. U.S. hospitals were reported by Pharmacopoeia (USP) to continue to repeat medication errors even after the mistakes were discovered.

Clearly, we have a long way to go with improving drug utilization and administration as well as with establishing an appropriate policy framework. In the June 2002 issue of *Medical Care Research and Review*, Stuart and Briesacher in their article "Medication Decisions – Right or Wrong" clarify the essential roles and responsibilities for ensuring appropriate use of drugs. They describe the need to clarify accountability of the "right drug, right patient, right way and right price." The authors assign responsibility for the "right drug" with the pharmaceutical manufacturers and governments. Responsibility for ensuring the drugs get to the "right patient" and are taken the "right way" is that of the prescriber, the dispenser and the patient. The role of ensuring the "right price" is the responsibility of the pharmaceutical industry, insurers, other purchasers, prescribers and patients combined. Stuart and Briesacher outline a comprehensive research strategy for helping to set right some of the wrongs in drug administration and management.



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