5 MYTHS ABOUT PHARMACARE

Myth 1: National purchasing will save so much money that it will support a national drug benefit program.

NOT TRUE. Bulk purchase savings are onetime savings; the benefit and administrative costs of a national drug plan will be incurred over a longer time span.

Myth 2: Reducing drug prices is the key to reducing drug expenditures.

WRONG. There is a belief that drug prices are increasing. This is occurring in the United States but not in Canada. CIHI has shown that utilization is the major cost driver not price. There is no evidence that a lot of cheap drugs provide better healthcare than newer drugs. There is evidence that new, often more expensive, drugs do provide better care.

Myth 3: Pharmaceutical expenditure takes place in isolation from the role of pharmaceuticals in the health system therefore changes in the drug budget are not linked to resulting changes in other parts of the health system.

NOT TRUE. This reflects poor planning and mismanagement. Canada's health care system ranks last amongst OECD nations. The continued reliance on generics (now 60 years) and bulk purchasing (40 years) is no longer tenable. Canada is 35 years behind the US in dealing with orphan drugs. Canada needs to catch up with the rest of the world in using new approaches such as precision medicine and integrating medicines into the system of healthcare.

Myth 4: The key element in pharmacare is the preparation of a national formulary.

WRONG. The report from the House of Commons' Casey Committee is a rehash of conventional wisdom with a lot of misleading generalizations and major flaws. A formulary (a restricted list of drugs and drug benefits) limits the medication available to patients. The greater the restriction is, the greater the number of patients without needed care. There is no evidence that a short list of drugs provides better care than a long list, in fact the opposite is true.

Myth 5: "Pharmacare" as proposed will close the existing gap between drug benefits and patient needs.

FALSE. In fact, pharmacare as proposed may even widen it. The gap needs to be closed between drug benefit programs that provide treatment to "most people most of the time" and health care needs that require treatment for "all patients all of the time". The current direction of disease treatment is based on biological entities that are complex, targeted, and more effective and, yes, costly. Only universal, comprehensive drug coverage will close this gap, which so-called pharmacare absolutely is not.