THE FACTS

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Inside the Chaoulli ruling: The role of drugs in rising health costs

What are the true cost pressures in the Canadian health care system?

In the wake of the recent Supreme Court ruling on private health insurance, pro-privatization Doctor Jacques Chaoulli and his supporters have claimed the "monopoly" character of medicare is inefficient and that health care workers are to blame for rising costs. In fact, frontline workers' incomes have remained stable or eroded, depending on the province. The biggest driver of rising health care costs, and one that we can rein in without compromising quality, is pharmaceuticals.

Canadian Institute for Health Information data on hospital spending shows that support services fell from 22.1 per cent of hospital spending in 1993/1994 to 16.9 per cent in 1999/2000. Hospital spending as a whole has fallen over the past 30 years in relation to total health spending. During the 1990s, hospitals' share of total health spending declined 7.7 per cent. Canadian spending on hospitals totalled $34.4 billion in 2002.[1]

In contrast, drug spending has steadily increased. Prescription drug costs rose 62.3 per cent between 1994 and 2004.[2] Adjusted for inflation, the amount that we spend on drugs is going up at between 7 and 8 per cent each year – three times the rate of inflation.[3]

Drugs now rank second after hospitals in terms of share of total health care spending, having overtaken spending on physicians in 1997. The share of total spending going to drugs rose from 9.5 per cent in 1985 to 16.2 per cent in 2002. Spending was expected to hit $21.8 billion, or 16.7 per cent of total health care spending in 2004.[4]

The rapid rise in drug costs is primarily due to the ongoing substitution of newer, more expensive drugs in place of older, less expensive products. The newer drugs, in the majority of cases, have no added benefit. Assessments of new drugs from Canada, France and the USA show that at best one quarter of new drugs offer some additional clinical benefit and likely as few as three per cent are major therapeutic advances.[5]

The multiplicity and fragmentation of Canadian drug plans impedes better management of drug benefits, including decisions on what drugs get funded and the ability to negotiate lower prices. Australia manages to buy drugs at a cost 10 per cent below Canada's by having a single national buyer, and New Zealand achieved

50 per cent savings using coordinated bargaining methods.[6] The move to bulk purchasing in some provinces is a step forward, but a national pharmacare program would achieve far greater savings and would improve the quality of prescribing.[7]

Other factors behind high drug costs include: pharmaceutical companies' influence on research, education and clinical practice[8]; aggressive advertising,[9] and patent protections enjoyed by brand-name pharmaceutical companies.[10]

One in a series of six fact sheets on the Chaoulli Supreme Court ruling. Other titles in the series are: What the court did (and did not) say, Assessing the international evidence, Real solutions for shorter wait lists, Trade dangers of privatization and Taking action.

All are available at cupe.ca.

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[1] Canadian Institute for Health Information (2003). *National Health Expenditure Trends, 1975-2000*, p. 63.

[2] Canadian Institute for Health Information (2004). *Drug Expenditure in Canada, 1985–2003,* Table A.2. Roughly 80 per cent of drug costs in Canada are for prescription drugs.

[3] Lexchin, J. (2005). *50 Years of Waiting for Pharmacare is Long Enough*. Fact sheet released by the Canadian Federation of Nurses Unions, August 11. Retrieved Aug. 15, 2005, from http://www.nursesunions.ca/en/Press%20Releases/2005-08-11-Fact_Sheet_Lexchin.pdf

[4] Canadian Institute for Health Information (2005). *National Health Expenditure Trends, 1975-2004*, p. 19.

[5] Lexchin, J. (2005).

[6] Ibid.

[7] Lexchin, J. (2001). *A National Pharmacare Plan: Combining Efficiency and Equity*. Ottawa: Canadian Centre for Policy Alternatives; Lexchin, J. (2005).

[8] Angell, M. (2004). Excess in the pharmaceutical industry. *Canadian Medical Association Journal* 171(12): 1451-1453; Bordemier, T. (2000). Uneasy alliance: clinical investigators and the pharmaceutical industry. *New England Journal of Medicine* 342: 1539-44; Choudhry N. K., Stelfox H. T., & Detsky A. S. (2002). Relationships between authors of clinical practice guidelines and the pharmaceutical industry. *Journal of the American Medical Association* 287: 612-7; Lenzer, J. (2002). Alteplase for stroke: money and optimistic claims buttress the 'brain attack' campaign. *British Medical Journal* 324: 723-9; Wazana, A. (2000). Physicians and the pharmaceutical industry. *Journal of the American Medical Association* 283(3): 373-380; Ziegler,

M. G. & Singer, B.C. (1995). The accuracy of drug information from pharmaceutical sales representatives. *Journal of the American Medical Association* 273 (16): 1296-8.

[9] Mintzes B., Barer M. L., Kravitz R. L., Bassett K., Lexchin J., Kazanjian A., Evans R. G., Pan R., & Marion, S.A. (2003). How does direct-to-consumer advertising (DTCA) affect prescribing? A survey in primary care environments with and without legal DTCA. *Canadian Medical Association Journal* 169(5): 405-412.

[10] Lexchin, J. (2003). Intellectual Property Rights and the Canadian Pharmaceutical Marketplace: Where Do We Go From Here? Ottawa: Canadian Centre for Policy Alternatives.

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