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## Patchwork Policy: Catastrophic Drug Coverage in Canada

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Free access to physician and hospital services under Canadian Medicare defines universal healthcare as a pivotal feature of the national social security framework. Federal support for provincial health systems finances ‘medically necessary’<sup>1</sup> services via the Canada Health Transfers. Care excluded from mention in the *Canada Health Act* (CHA) falls under provincial jurisdiction. The inclusions and exclusions under ‘medically necessary’ demonstrate the tradeoff between equity and efficiency in healthcare financing decisions. The high costs of healthcare support the need for careful use of resources to maximize health outcomes while preserving equitable access to services. While the CHA supports public finance of ‘medically necessary’ care, the absence of uniform national coverage of prescription medication, highlights disparate provincial health policies. Exclusions are therefore not restricted to peripheral areas of the health sector but rather reflect cost-containment initiatives. It is thus appropriate to qualify universal healthcare in Canada by acknowledging the ten provincial health systems that operate independently of one another.

Prescription drugs represent the second largest area of provincial public expenditure (Canadian Institute for Health Information 2011). The high costs and varying levels of provincial wealth and political will to maintain comprehensive drug coverage, raise concern for inequitable health outcomes. Canada is one of the few countries in the OECD that does not finance a national drug program to protect citizens against catastrophic<sup>2</sup> out-of-pocket costs<sup>3</sup> (Phillips 2009). Analysis regarding a national catastrophic drug coverage (CDC) program can be approached from the perspective of the equity-efficiency tradeoff that defines health policymaking. Examining provincial CDC programs contextualizes the debate. Using British Columbia’s Fair Pharmacare program as a case example, one begins to understand the gains and losses experienced by different sub-populations.

### *Prescription drug coverage ‘patchwork’ in Canada*

Examining healthcare in Canada beyond the defined lines of the CHA highlights the importance of building and maintaining a health infrastructure to support evidence-based policy. Provincial coverage for prescription medication has recurrently been described as a ‘patchwork’ of policies with subsidies for seniors and social assistance recipients as their common feature (Phillips 2009). Yet the breadth of coverage for these groups varies by province. Furthermore, discrepancies in catastrophic drug spending protection are more apparent for the general population where private health insurance is expected to fill the coverage gap. Among the provinces that do implement a CDC plan,

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<sup>1</sup> Under the *Canada Health Act*, ‘medically necessary’ refers to care delivered by physicians and any service rendered inside a hospital.

<sup>2</sup> Catastrophic spending on healthcare refers to the financial hardship a household experiences in accessing health services.

<sup>3</sup> Out-of-pocket expenditures are the costs borne by patients to access a health service. Cost-sharing arrangements include deductibles, co-insurance and co-payments.

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the degree of protection differs. In New Brunswick and Prince Edward Island, there is no CDC initiative in place.

The latest Canadian Institute for Health Information (CIHI) report on provincial drug spending begins to reveal the patchwork of policies via differences in per capita expenditures. Ontario and British Columbia are found to spend the least at \$619 per capita and \$574 per capita respectively (Canadian Institute for Health Information 2011). At the other end of the spectrum are Quebec and Nova Scotia where per capita spending on drugs is the highest in Canada at \$883 and \$838 respectively (Canadian Institute for Health Information 2011). Of interest is why drug expenditures differ so vastly across provinces and whether these hint at health inequalities among Canadians. Do people in Ontario and British Columbia face worse health outcomes than those in Quebec and Nova Scotia? Or is it a matter of brand name drugs coming off patent to allow for generic drug production? Furthermore, provincial expenditures on prescription drugs are as high as 56% and 52% of health budgets in Saskatchewan and Quebec respectively. In contrast, Newfoundland and Labrador spends 37% while New Brunswick spends 33% of their health budgets on subsidizing prescription drug costs (Canadian Institute for Health Information 2011). Although these figures do not provide answers to questions related to health inequalities, they highlight the need for standardized data collection and cross-provincial pharmaceutical dataset linkages (Canadian Institute for Health Information 2011). This would provide information on public coverage policies, provincial approaches to drug pricing, and levels of out-of-pocket costs among sub-populations. Building and maintaining a Canadian health infrastructure would support comparative analyses and promote policy learning and diffusion.

### *A note on private health insurance*

Private health insurance is a key third-party payer in the general population's access to prescription medication. Unlike other areas of publicly funded healthcare, private policy prescription drug coverage is unregulated. Quebec is the exception in mandating private plans to match at a minimum the benefits offered in the public program. Comprehensive provincial data on private health plans is unavailable, leaving researchers to make assumptions on the breadth of coverage. The market is dominated by nationwide non-profit and for-profit firms. Blue Cross and Green Shield are the largest non-profit private insurance firms operating in Canada. The non-profit firms typically offer reimbursement for the same drugs listed on each province's formulary (Bonnett 2010). In contrast, the largest for-profit firms that operate nationwide, Manulife, Standard Life, and Great West Life, offer a wider range of reimbursement options. While they cover the drugs found on the provincial formularies, they also include some drugs approved by Health Canada (Bonnett 2010). Private health insurance plans via employment or individual arrangements cover approximately 60% of Canadians. Among the employed, full time and part time workers are estimated to have similar percentages of uninsured with 11% and 12% respectively (Applied Management 2000). Approximately 55% of private plans enforce annual out-of-pocket maximums in

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the protection against catastrophic drug spending. For the remaining 45% without such coverage, the plans are thought to cover up to 80% of drug costs and therefore offer no annual cap on out-of-pocket expenditures (Phillips 2009).

### **Balancing equity and efficiency: national and provincial CDC concerns**

The discussion that follows outlines the state of catastrophic health spending programs on the national and provincial scales. The policy absence and presence at each level reveals common concerns for striking the efficiency and equity balance. Efficiency deals with the distribution and use of resources. Allocative efficiency refers to organizing healthcare financing with aims to produce the greatest gains. Once funds are distributed, technical efficiency becomes the prime concern to ensure that resources are being used to maximize productivity (Wagstaff and van Doorslaer 1998). Equity is understood according to a horizontal and vertical conceptualization. Horizontal equity is defined in health financing terms as equal contributions for equal means. In other words, people with similar incomes finance their healthcare needs to the same degree. Vertical equity is conceptualized as a form of positive discrimination whereby people with higher incomes ideally bear a higher proportional financial contribution than those with fewer means (Wagstaff and van Doorslaer 1998). Vertical equity supports the concept of the gradient in population health: people will tend to have poorer health relative to those in a higher socioeconomic position. Those in lower income brackets tend to be in poorer health and therefore consume the most care. Given their lower incomes, it follows that they contribute less to financing health services compared to those with more resources.

#### *Calls for a national CDC program*

The rising costs of drugs coupled with the gaps in public and private coverage has led to provincial pressure on the federal government for a national CDC program. Overarching federal drug coverage aims to offset provincial financial burdens and address the concerns of those who face high out-of-pocket costs for outpatient drug therapy. The varying levels of drug coverage that is inherent to the policy patchwork enforces horizontal inequity across Canada. Horizontal inequity materializes when similar individuals diagnosed with the same illness and prescribed the same drug treatment face different out-of-pocket payments. For instance, the treatment costs for an individual diagnosed with hypothyroidism and hyperlipidemia was approximately \$807 in 2008/2009. If this individual had an annual household income of \$14,000, under Saskatchewan's Special Support Program, this person would pay \$490 out-of-pocket. In contrast, the same person covered by Ontario's Trillium Drug Program would pay \$375 in cost-sharing arrangements (Phillips 2009). Whereas this example compares two provinces with universal programs, 'universal' deserves qualification with regard to the breadth of coverage. The horizontal inequity lies in the individual's geographic location rather than household income and the absolute cost of drug treatment.

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Despite calls for a national CDC program by most premiers, efforts to develop and implement a strategy have lagged for close to a decade. In 2003, the First Ministers' Accord on Health Care Renewal set aside \$16 million in provincial transfers to address the gaps in coverage. The funds were intended to assist in the establishment of universal coverage within province-specific CDC programs. For provinces with established schemes, the emphasis was placed on expanding their drug formularies. At the time, no Atlantic province supported a universal CDC program. Although the Accord did not address calls for a national catastrophic drug spending initiative, it sought to assist in alleviating the high costs of public coverage. Notable successes were the CDC schemes set up in Newfoundland and Labrador (2007) and Nova Scotia (2008). New Brunswick and Prince Edward Island have yet to follow suit despite public pressure. Partly in response to the failure to meet targets, the Accord was critiqued for its lack of federal enforcement and provincial accountability as to how the funds were spent (Phillips 2009).

Since 2002, three national strategies have been proposed to develop the federal CDC program. The Romanow, Kirby, and the National Pharmaceutical Strategy (NPS) reports suggest different income thresholds to define catastrophic health spending. The NPS was the product of the Ministerial Task Force established in 2004 whose concerns, among others, were catastrophic health spending and access to prescription medication. The proposals from each report are broken down as follows:

**Table 1:** *National CDC program proposals*

<i>Proposal</i>	<i>Nature of coverage</i>	<i>Income threshold</i>
<b>Kirby Report</b>	Universal	3% of annual household income, or; 3% of annual household income for those under public coverage and/or \$1500 for those with private coverage
<b>Romanow Report</b>	Targeted to those under public coverage	\$1500 regardless of income
<b>NPS</b>	Universal	0%, 3%, 6% or 9% of annual household income (household specific), or; 4.3% of annual household income

Source: Zhong, 2008

The three strategies address horizontal and vertical equity differently, and suggest alternative perspectives on how to balance efficiency. The most glaring discrepancy is the targeted program and fixed income threshold outlined in the Romanow report. Conversely, the Kirby and NPS proposals offer a threshold levied at a percentage of household income rather than a flat absolute rate. Relative measures of catastrophic levels of spending suggest the potential for a progressive coverage scheme that absolute

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thresholds lack. However it is less the case if the threshold percentage is fixed at a given rate, as seen in some provincial CDC programs. The rationale for a graded income threshold is similar to that of progressive taxation policies that finance health systems. Accordingly, lower income families pay proportionately less for healthcare than those with greater means. As such, varying household incomes call for approaches to healthcare financing that support vertical equity where the wealthy contribute more than the poor. The first policy proposed by the NPS is the only one to fully support vertical equity for the CDC national program. The second NPS proposal of a single income threshold of 4.3% holds less regard for vertical equity though more than the absolute rate contained in the Romanow report. Lower income households bear the highest financial burden when faced with a flat rate cost-sharing arrangement, regardless of whether it is absolute or relative. Of further interest is the justification for how thresholds are determined. The literature does not propose a universal cut-off for catastrophic spending on healthcare (Xu et al. 2003). Defined thresholds should at least reflect the cost of living and the types of drugs available on the provincial formularies.

Since mobilization toward a national CDC program began in 2002, federal Liberal and Conservative governments have not followed through with a strategy. Although the three proposals highlight concerns for equity of access to prescription medication, none outlines the long term costs of maintaining a national CDC scheme (Zhong 2008). The plans only project the initial costs of introducing national coverage. As such, the expense of prescription drugs coupled with spending increases to maintain the program are factors delaying action (Zhong 2008). Although the equity concerns are evident in the reports, federal policy inaction indicates concerns for efficiency.

### *Qualifying CDC at the provincial level*

Provincial policies for catastrophic health spending in Canada focus on social assistance recipients and seniors as groups who face a higher risk of poor health based on their income and age. The general population benefits the least from public coverage protection against high drug costs. Private health insurance occupies a pivotal role in extending coverage to non-seniors and non-social assistance recipients. Yet gaps in private coverage leave a proportion of Canadians with little to no financial protection (Dewa et al. 2005). This is true across Canada with the exception of Quebec where public or private health insurance was mandated for all residents in the 1996 reforms (Tamblyn et al. 2001). The large role played by the private sector reflects the financial burden at the provincial level for funding a costly yet medically necessary aspect of the health sector. Although all medication provided to hospital inpatients is federally covered in the CHTs, a growing emphasis is placed on outpatient disease management (Han and Wang 2005). The greater pressure on provincial coffers has led over time to public coverage clawbacks, more cost-sharing, and consequently, an increase in out-of-pocket payments.

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The first CDC programs were introduced in British Columbia and Manitoba in 1975 and 1977 respectively (Grootendorst and Racine 2006). Eastern Canada was slower to implement such reforms with Ontario introducing one in 1995, Quebec in 1996, Newfoundland and Labrador in 2007, and Nova Scotia in 2008 (Grootendorst and Racine 2006; Phillips 2009; Tamblyn et al. 2001). The CDC schemes are offered as last resort programs for individuals who are either uninsured or underinsured<sup>4</sup> by their private plans. Although the developments in drug therapy lead to more effective outpatient treatment and disease management, the increase of treatment availability is met with greater risk of catastrophic health spending. The provinces have responded in varying degrees to the need for coverage beyond targeted groups.

The equity and efficiency lens used to describe the national efforts toward a CDC program can also be used to analyze the development of CDC schemes in the provinces that currently support one. Findings from Grootendorst and Racine (2006) map the coverage changes over time for seniors and the general population in British Columbia, Ontario, Quebec and the Atlantic provinces<sup>5</sup>. The study reports the trends in public drug policies over a 44 year period spanning 1960 to 2004. By 1982, all provinces, except Prince Edward Island, provided full coverage for their senior populations. In contrast, no province (with the exception of British Columbia) offered coverage to the general population (Grootendorst and Racine 2006).

Drug benefits for seniors reached their peak in the 1980s before clawbacks began in the early 1990s. By 1996, provincial governments were no longer providing 100% coverage for seniors (Grootendorst 2002). The clawbacks targeting seniors in Quebec and Ontario reached their height from 1992 to 1998 (Grootendorst and Racine 2006). Factors such as the economic recession of the early 1990s and the rising cost of drugs undoubtedly played a role in influencing program cut backs. Yet fiscal conservatism does not account for the introduction of universal CDC programs in Quebec and Ontario at this time. As such, there is evidence that the efficiency concerns underlying the clawbacks were initiated in tandem with policies to redistribute these resources to the general population. Redistribution of resources, rather than an addition of funds, was the key factor in creating universal CDC programs. Redistribution therefore illustrates the equity-efficiency tradeoff: greater public population coverage at the expense of comprehensive drug benefits for seniors. The period marks an emphasis shift from age-based subsidies to income-based ones. Similar policy reforms occurred in Manitoba in 1996. British Columbia began cutting benefits to seniors in 1987 to re-allocate resources to the general population via income-based subsidies. By 2003, British Columbia's Fair Pharmacare program essentially leveled the benefits offered to seniors and the general population (Grootendorst and Racine 2006).

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<sup>4</sup> Underinsured refers to annual caps on coverage. Beneficiaries may only claim up to a given amount per year.

<sup>5</sup> The Atlantic provinces include: New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador

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Since 1974, coverage for social assistance recipients remained comprehensive compared to that of seniors. Although cost-sharing arrangements have since been introduced, this demographic experienced fewer reductions in the breadth of coverage (Grootendorst 2002). Policy reforms in 2003 for the Fair Pharmacare program in British Columbia illustrate the equity-efficiency balance. The shift from an age-based criterion for public coverage to an income centered one upholds principles of vertical equity. While the deterioration of health in old age highlights a health inequality, households facing catastrophic health spending to access prescribed medication represent inequities amenable to health policy. In 2001, the Pharmacare program was labeled a ‘mixed’ model that supported social assistance recipients, seniors and catastrophic drug spending protection for individuals spending over \$2000 per year in co-payments (Morgan and Coombes 2006). In 2003, the Fair Pharmacare program combined the seniors’ coverage with that of the general population. The shift essentially removed age-based consideration for accessing subsidies. Consequently, any household earning below \$15 000 annually bears a maximum out of pocket payment of 2% of its income. For those earning \$15,000 to \$30,000, a 3% threshold is set. Finally, households earning over \$30,000 must meet 4% spending of annual income before CDC is initiated (Morgan and Coombes 2006). The age-based program was considered an inequitable distribution of resources that left low-income non-senior households, otherwise labeled the ‘working poor’, without sufficient protection. Proponents of Fair Pharmacare argued that coverage targeted for seniors absorbed an inequitably higher amount of resources. The targeted CDC program was also considered an inefficient allocation of resources since it assumed all seniors were low income with high drug costs (Rovere and Barua 2011). The shift toward the universal CDC scheme accounted for a 16.9% decline in public expenditure in 2004 (Morgan et al. 2006).

The graduated income threshold structure of Fair Pharmacare demonstrates recognition for the gradient in population health. It closely resembles the first strategy proposed by the NPS. The extent to which other provincial CDC programs account for the gradient reflects varying levels of vertical equity. Quebec distinguishes itself from other provincial CDC programs by levying a flat rate catastrophic spending amount. It is currently set at \$963 regardless of household income (Régie de l’Assurance Maladie 2011). Under Ontario’s Trillium Drug Plan, catastrophic spending is set at 4% of net annual household income (Phillips 2009). Although more progressive than a flat absolute threshold, 4% arguably represents a significant financial burden for low income families. Saskatchewan’s Special Support Program also sets a flat relative threshold of 3.4% with the added measure of adjusting for the number of dependents in a household who are under 18 years old. For every child, there is a \$3500 deduction. Among the provinces with a graduated income-based structure similar to British Columbia’s, the catastrophic coverage patchwork is also evident. Whereas Newfoundland and Labrador establishes high thresholds at 5%, 7.5% and 10% of net annual household income, Manitoba’s graded scheme is comparatively lower at 2.69% to 6.08% of total household income.

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Similar to Saskatchewan, Manitoba Health adjusts for the number of dependents under the age of 18 by deducting \$3000 per child and a spouse (Phillips 2009).

CDC programs that adjust for the number of dependents account for the different levels of financial strains families face versus single-person households. The discrepancies in the breadth of coverage faced by individuals in different provinces highlight the independent health systems operating across Canada. Furthermore, it requires qualification of the term 'universal' when describing services outside of the CHA:

Except for New Brunswick and Prince Edward Island, all provinces provide a type of coverage available to all citizens. In most cases, such as in Saskatchewan, Ontario and Newfoundland, the deductible is so high that only people facing extremely high drug costs in relation to their income are truly eligible. For example, in Newfoundland, people earning \$40,000 must spend more than \$3,000 in medication each year to start being insured. In Alberta, people need to pay a premium of about \$720/year plus 35% of prescription costs afterwards (beginning in 2010). In regards to those facts, the real term to qualify those 'Universal' Plans should be 'insurance in case of disaster.'" (Canadian Hemophilia Society 2009).

To conclude, policy discussions of a Canadian CDC program and CDC schemes at the provincial level highlight the equity-efficiency tradeoff. The national debate involving the Romanow, Kirby and NPS reports reflects this via their different income threshold levels. The Fair Pharmacare reforms in British Columbia illustrate policy initiatives to maintain the balance with the aim of maximizing technical efficiency (improved health outcomes) with enhanced vertical equity (graduated catastrophic spending thresholds relative to income). Preference for universal CDC programs over targeted ones support awareness for the social determinants of health. Targeted initiatives grant less attention to the gradient in population health and do not address varying levels of health according to socioeconomic position. However, efforts to create a universal program to achieve greater equity for the general population have been in part at the expense of comprehensive coverage for seniors. This was evidenced by the greater cost-sharing arrangements introduced throughout Canada during the 1990s. Redistribution of existing funds, rather than procurement of additional ones, underpins the equity-efficiency balance.

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