Health Reform and Drug Policy in Alberta

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I. Introduction

This case study is one of six being developed in Alberta as part of a cross-province study on the determinants of health reform in Canada. These cases collectively cover four policy categories: setting out governance and accountability arrangements, establishing financing arrangements, making program delivery arrangements, and defining program content (Lavis, Ross, Hurley et al, 2002). The case study around provincial drug benefits is an example of the fourth category, where the policy issues relate to who will receive a set of public benefits (in this case, subsidized coverage of prescription drug costs) under what terms and conditions. If we categorize the adoption of universal coverage by any Canadian province as the most dramatic departure from the status quo, then in this policy area during the last decade of health reform, Alberta has pursued only very limited and incremental change.

Two specific policy decisions were identified for study. These were the introduction of a Child Health Benefit program for children in low-income families in 1998, and the extension of government-paid drug benefits to palliative care patients in 1999. Thus, the research question for this case study was phrased as the following: Why did Alberta expand its prescription-drug plan to include palliative care patients and children in low-income families (and not adopt a universal plan)?

institutional, idea, and interest group variables, as well as important external events that may have impacted upon or shaped the policy making process.

II. Background/Chronology

Total prescription drug costs in Canada have been growing rapidly in the last number of years, in the late 1990s surpassing physician fees as the second largest component of health spending (CIHI, 2005, p. 15). This increase in costs has placed a growing financial burden on both public benefit programs and private individuals. The latter are still responsible for bearing most of the costs; in Alberta in 2002, private payment accounted

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Early attention by government to the question of drug coverage can perhaps be intimated from the December 1993 document, . Here it is stated that "Alberta Health will give funding priority to enhancing community-based palliative care services" (p.6) which included "improving access to pharmacy services, drugs and equipment" (p.5); all subject to existing resource constraints (Alberta Health, 1993). No specific plans or policy options were described however.

In October 1997, Alberta Health initiated the

project. This involved a consultation with RHAs and other health professionals (but not the public) about issues related to the delivery of home parenteral therapy and palliative home care. Some key concerns noted in the project report were inconsistencies between regions in eligibility and nature of services, patients' access to these services potentially limited by the direct costs involved, and the concern that treatments were being dictated by the need to reduce patient cost rather than by the most effective and efficient method of delivery (C. A. MacDonald & Associates, 1998). No recommendations were provided.

Also in 1997, the government appointed MLA Dave Broda to head a Policy Advisory Committee on Long Term Care (hereafter the Broda Committee) to address some key

transitionally for clients who have exited income support, through the Alberta Adult Health Benefit. These changes re-enforce the government's efforts to emphasize pol (s) -0.90 744.72 308E

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pay" (Hansard, February 24, 1999, p. 156). Subsequently, Jonson argues that there is no evidence a universal system such as that in Quebec would save the health system money, lower drug costs, or reduce the amount of pharmaceuticals prescribed (Hansard, March 1, 1999, p. 222).

Similarly, Lyle Oberg defended the ACHB as an appropriate step towards addressing child poverty by targeting discreet groups for assistance (Hansard, March 9, 1999, p. 405). "We recently brought in the child health benefit. That will directly benefit 138,000 children in this province. Our programs, when it comes to the child and family service authorities that the hon. minister is looking after, are geared towards helping these children that need help the most. That's what this government is about."

For ACHB, this also meant supporting low-income rather than welfare families.

families that would be eligible for benefits. This is a long-standing issue with health insurance programs aimed at a low-income audience; there is for instance a substantial US literature related to challenges and successes in enrollment children and youth in the 1997 State Child Health Insurance Program, or SCHIP (e.g., Morreales and English, 2003).

IV. Conclusion

In summary, recent Alberta developments in public prescription coverage have been driven most strongly by ideological factors. Conservative governments have consistently expressed opposition to universal programs. They emphasize individual responsibility, which can be demonstrated through the purchase of private coverage or by co-payments within public programs. Only select groups that are relatively sympathetic become the beneficiaries of public programs. The lack of strong interest group voices has meant that expansions in coverage proceed incrementally, as civil servants develop new services based upon existing models during periods when shifting political attention turns temporarily to the drug issue.