A Cross -Provincial Comparison
of Health Care Policy Reform in Canada

MAKING DECISIONS ABOUT PRESCRIPTIONS DRUGS IN QUEBEC: IMPLEMENTING THE PUBLIC PRESCRIPTION DRUG INSURANCE REGIME IN 1996-1997

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Quebec"s public prescription drug insurance regime was inaugurated in June 1996. The province had, however, been weighing its policy on prescription drugs since the 1970"s, when it had put into place a decree known as the Outpatient Circular. The Outpatient Circular allowed victims of serious disease to continue to obtain free prescription drugs after having completed hospital treatment. It quickly became evident, however, that the decree was flawed by a lack of transparency in the criteria used to determine the diseases for which medication would be provided free of charge. Following the publication of a number of reports looking into the issue, in June 1996 the separatist government ended up deciding to implement a public prescription drug insurance regime. The advent of a new separatist premier dedicated to eliminating the deficit and the presence of a health minister actively committed to the field of public health were two decisive elements in the instauration of the regime.

because it allows for the co-existence of private insurers together with a public insurer (the Régie de l"assurance maladie du Québec - RAMQ). This regime was established by the Quebec Drug Insurance Act (la Loi sur l"assurance-médicaments – “Loi 33”), passed by Parliament in June 1996. It was based on 4 principal elements.

1- Independently of all other considerations, there exists a legal obligation for all Quebecers, as well as for all residents of the province, to have health insurance coverage. Coverage can be provided privately or by the RAMQ.

2- Membership in the public or a private regime was decided according to certain criteria and circumstances. Individuals already covered by a private plan provided by their employer as part of a group benefit were required to remain affiliated to that plan. Upon retirement, individuals could either switch to a public plan or remain with their private plan

> "Those patients who weren't covered, like victims of multiple sclerosis, and who had… for whom the new medication was extremely costly, they were saying, "I deserve free medication just like victims of cystic fibrosis." In a nutshell, I remember it as a time when everyone was looking out for himself." (AM-11)

There was also significant pressure on hospital budgets. Indeed, hospitals were required to provide their patients with medication free of charge, but their budgets were not adjusted accordingly. The addition of a disease on the list of diseases for which medication was covered thus strained a fixed budget. In addition, no account was taken of the work performed by hospital pharmacists for the outpatient clientele:

to the bare minimum. So convalescence was taking place outside of the hospital setting. Convalescence was taking place outside of hospitals, and patients needed the continued support of medication. " (AM-16)

"So, there were people without any insurance. They were in the hospital. Their medication was free. When they left the hospital, they no longer had access to medication, which of course slowed down the shift towards ambulatory care. So the plan allowed us to eliminate the problem of unfairness, it made medication more accessible to the population as a whole and it promoted an increase in outpatient care." (AM-03)

"In my view, the fact that it took place as quickly as it did, that it made it so quickly onto the political agenda, was because, like I was saying, the key was Mr. Rochon"s strategy for the reform of the system. Without that, they could have …. A shift towards ambulatory care was only feasible if there was a change in prescription drug coverage. In his head, you couldn"t have one without the other and that"th

THE DECISION-MAKING AGENDA (1993-1995)

It was thus that a liberal government, led by Daniel Johnson, created the Demers Committee in November 1993. The government of the day felt the need to put a prescription drug insurance regime into place but had no ideas on the means to do so. It was on this occasion and by this step that the government of

grown". They would not appreciate losing market share. Furthermore, the report underlined the need to simultaneously introduce a system to monitor and verify the optimal use of prescription drugs in order to ensure the viability of the regime. In the end, the conclusions of the report can be summarized thus: "This type of regime can be introduced in Quebec if we agree to the necessary changes as well as to the application of specific parameters and a rigorous monitoring system" (Gagnon Report 1995, p. 89).

Following the submission of this internal report, Health Minister Rochon asked an expert committee on prescription drug insurance, headed by Claude Castonguay, ex-Minister of Health under the Liberals (1970-1973), to study details of the implementation of a prescription drug insurance regime. Indeed, from this stage forward, the health minister was convinced of the need for a regime that would function as an insurance plan requiring a contribution by users. However, he continued to support a purely public regime (AM-13).

During this time, other actors were also expressing dissatisfaction with the situation and proposing alternatives. Hospital directors, hospital pharmacists and the Hospital Association of Quebec denounced

”The infamous Outpatient Circular, which had been the straw that broke the camel"s back in… in… in the string of events that led to the adoption of a general plan… of the general plan, the universal drug insurance regime of 1997.” (AM-17)

> "Well of course at the beginning we were more in favour of a regime that was completely… a completely public plan. The public… if you ask me, the public has always shown an ability to grasp the concept of equal access... in any event, that's my personal opinion … we could talk about quality, but with respect to… with respect to access, guaranteeing equal access to all citizens, the government was a better distributor, so to speak. So at the Association, our first proposal was a regime that was completely public. All the more so since it avoided the transfer of bad risks …" (AM-14)

At the beginning, a purely public plan was the preference of Health Minister Rochon. In fact, the majority of the clientele (unions, interest groups representing recipients of social assistance, interest groups representing seniors, etc.) demanded a universal public program financed by global taxes. They believed that responsibility for such a program should reside with the state in order to ensure as much equity as possible between individuals. Nonetheless, welfare recipients and some seniors' groups opposed the introduction of the payment of a coinsurance and a premium. In fact, the situation of seniors was not clear: some were in favour of a mixed public/private system because they already had private coverage. Younger workers tended to favour a mixed system because the majority of them did not have coverage. Students, in contrast, were more reticent, resisting compulsory registration because they were rarely sick and bought little medication as a rule.

Private insurers were formally opposed a purely public plan, as were community pharmacists. Private insurers saw themselves deprived of existing clients. As for community pharmacists, they wished to retain a certain negotiating power vis-à-vis the government and not just the RAMQ. They also wanted the guarantee of a two-tiered system in which the prices of medication and pharmacists' fees were not the

THE POLICY CHOICE (1995-1996)

As soon as the Castonguay report was published in March 1996, the government announced that it would go ahead with the implementation of a universal mixed private/public regime. In record time, the government introduced a public bill to Parliament in June. The speed of the response can be principally attributed to Health Minister Jean Rochon for whom the project was a priority.

The arguments for a mixed public/pr ivate regime

We have already explored a number of the differing opinions expressed during the course of the parliamentary commission that took place at this time. It is therefore important to understand the reasons for which the government of Quebec finally decided in favour of a mixed public/private prescription drug insurance regime rather than a catastrophe regime as most other Canadian provinces had done. Much of the answer resides in the unique situation of pharmaceutical companies and of insurance companies in Quebec. It was necessary for the government to protect the advances of these industries and the rapport already established with them, while simultaneously promoting a relationship of partnership rather than one of confrontation. For that reason we can conclude that the final decision was the product of a compromise that arose from negotiations between the interests of insurers and the government.

1- The unique situation of the pharmaceutical industry in Quebec

Quebec is in a unique position compared to other provinces. Whereas generic drug producers are mostly situated in Ontario, the majority

Group prescription drug insurance plans constituted an important market for insurance companies in the province. It was therefore important to protect this private market while also finding a way for the public system to continue to provide coverage for its regular, more vulnerable clients (seniors and the poor) in

Finally, the third and most important argument was the desire of the government of Quebec to achieve a zero deficit and bring public spending back into balance.

4- The question of equity

Changes in the ways individuals were being cared for, allowing them to be treated as outpatients thanks to new pharmacological molecules, made it important to complete the public health safety system to the extent possible. The implementation of a regime covering the entire population thus became the final patch sewn on the quilt of health care coverage in the province. Consequently, the regime became an integral part of the social welfare system, alongside public access to hospitals and public health care.

The plan also addressed problems of discrimination in the public as well as the private sector. In the private sector, some plan members were denied coverage because of health problems (the medication for their treatment was too expensive). In the public sector, such discrimination on the basis of disease had become unjustifiable.

who had told the government, "You're going to have a tough time selling this because you are trying to reconcile insurance and social assistance. " And that's where the government and Dr Rochon had their first real test about that: "What do we... what do we set as a premium? Because if we set a premium based on… on… with the idea of actuarial logic, for insurance, then we'll base it on current market premiums. " These premiums were of course high because they covered clients who were on welfare, who were seniors. So right there the government had a difficult choice to make. It leaned on the side of social assistance, the social commitment of the government, by setting a

at $83.33, $208.33 and $310.50 according to the insurance policy, over a period of 5 months; 2) the addition in January 1997 of a $25 deductible and the readjustment of contributions ceilings at $50, $125 and $187.50, over a period of 3 months (a fiscal quarter); 3) the reduction of the premium to $8.33 per month and the calculation of maximum contributions set at $16.67, $41.66 and $62.50 on a monthly basis. Some of the severely mentally ill were able to benefit from this latter adjustment as of August 1996.

AN ASSESSMENT OF THE REGIME AND ITS FUTURE PROSPECTS

To begin with, it"s important to underline that one of the regime"s initial goals, that of permitting better access to prescription drugs for all Quebecers, has been successfully reached. Furthermore, the current regime is one of Canada"s most generous. Nonetheless, significant criticism of the regime persists, particularly with respect to the fact that it has failed to adequately control costs. Private insurers and the AHQ (Quebec"s Hospital Association) in particular are pessimistic about the current situation.

Some problems are common to all prescription drug insurance regimes while others are specific to the Quebec program.

1-Specific problems

The lack of a policy respecting medications

The implementation of the regime did not include a policy respecting medications, which meant that it has not been possible to regulate the optimal use of medications. No mechanisms are in place to evaluate the validity of medical prescriptions.

There was, furthermore, a significant increase in the frequency of undesirable events, doctors" visits and

ANALYSIS OF THE REFORM PROCESS

Analysis of the reform process that gave rise to the implementation of the prescription drug regime in Quebec highlights a unique situation. The policy decision and the implementation of the regime took less than a year and Quebec continues to be the only province (with the possible exception of British Columbia) to have a non-catastrophe regime today. It is therefore important to attempt to understand the reasons for which the reform took place so quickly.

The rapidity of the reform was, in fact, the result of the convergence of several favourable conditions relative to the political, social, and financial context of the time, as well as to the ways services were organized.

With respect to institutions

To begin with, the implementation of universal coverage in Quebec is directly linked to the advent of Health Minister Jean Rochon, who was actively concerned by questions of public health and equal access to care. His advent allowed the ministry to make progress in this area at a time when significant concern regarding equal access to prescription drugs had been surfacing for a number of years.

Indeed, it is important to emphasize the existence at the time of a strong political consensus on the need to address the dossier of prescription drugs. It was an issue for the Parti Québécois (PQ) as well as for the Quebec Liberal Party (QLP). For the PQ, though, the concept put forward by Rochon to promote fairer coverage for prescription drugs made rapid progress within the party and especially with Mr. Parizeau. In short, Rochon convinced both the political milieu and the party to take on the project, allowing the PQ (a leftist, social democratic party) to include the project in its platform from the beginning of its mandate. For the PQ, it became a social mission, a part of its identity. By the time that the party gained power, therefore, the PQ was already convinced that implementing such a regime was consistent with the progressive social values espoused by the party. This position had been made clear in the various reports produced on the question in the 1990"s.

The political decision was also made possible by the discontent inspired by the Outpatient Circular, the existence of which became increasingng (fr-CA)>BDC BTnt sioe

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subject of disagreement, the fact that coverage should be universal was a matter of consensus. For that reason, we can characterize the situation as a “clientele pluralist network”.

Finally, with respect to the implementation of the new insurance, the RAMQ played a pivotal role in allowing the reform to take place in record time without excessive public inconvenience.

With respect to various interests

A detailed look at various interest groups and their proposals reveals important discrepancies of opinion that went beyond the consensus to implement the measure. On one hand were social and leftist groups that advocated an exclusively public system in order that the system be principally oriented towards the principles of assistance and social solidarity, rather than towards the principle of insurance. On the other hand were the insurers and the community pharmacists in favour of a mixed system that would preserve to some extent the status quo as it pertained to their own prerogatives and interests. Furthermore, with respect to the generosity of coverage, even if the government dismissed the possibility of a catastrophe regime out of hand, a catastrophe regime had the support of a certain number of actors (insurers, the QHA, certain seniors" associations, the self-employed, students).

Among ”policy entrepreneurs”, researchers in the field participated widely by means of the many commissions and committees formed. As a whole, their opinions were largely uniform: they supported the establishment of coverage for the risk of prescription drug expense. On the whole, two scenarios were retained: the implementation of a mixed regime and the implementation of a public regime. The implementation of a strictly private regime was quickly rejected. The most politically acceptable scenario emerged with the passage of time.

For elected officials, the implementation of prescription drug coverage quickly became an important

The separatist government would have been hard put to go against this constituency because of its economic weight with respect to jobs, as well as with respect to public opinion, given that a number of insurers were homegrown companies. From the beginning, the insurers expressed their desire to continue to participate in the prescription drug regime: although they rejected the proposal of a strictly public system, they were open to a mixed regime, especially one with a component of greater consumer choice that would be restricted to catastrophe-type coverage.

of costly but effective treatment forced the government to rapidly address the question of medication and to define its position on social protection. The development of new molecules that were increasingly efficient in the treatment of certain diseases was changing public perception of prescription drugs. Finally, prescription drugs were being increasingly considered as an essential and indispensable form of technology to which the population as a whole should have a right.

BIBLIOGRAPHY

Boudreau, Christian. 2003. «La dialectique de la surveillance et le nouveau régime d‟assurance médicaments au Québec», *Administration Publique du Canada*, 46(2), p. 202-217.

Boudreau, Christian. 2003. *Surveillance et gestion des médicaments au Québec.* Université Laval : thèse de doctorat en sciences de l‟administration, 310 p.

Comité d‟experts sur l‟assurance médicaments. *L'assurance médicaments : des voies de solution*. Québec : Comité d‟experts sur l‟assurance médicaments, 198 p.

Comité de révision de la circulaire «Malades sur pied». 1994. *De l'assistance à l'assurance*. Québec : MSSS, 50 p.

Comité sur la pertinence et la faisabilité d‟un régime universel public d‟assurance médicaments au Québec. 2001. *Pour un régime d'assurance médicaments équitable et viable*. Québec : Comité sur la pertinence et la faisabilité d‟un régime universel public d‟assurance médicaments au Québec, 67 p.

Gouvernement du Québec. *Loi sur l'assurance médicaments*, L.R.Q., chapitre A-29.01. Québec, Éditeur officiel du Québec.

Ministère de la Santé et des Services sociaux du Québec. 1995. *Mise en place d'un régime universel de base d'assurance médicaments au Québec : analyse de la faisabilité*. Québec : MSSS, 89 p.

Ministère de la Santé et des Services sociaux du Québec. 2000. *Les pistes de révision du régime général d'assurance médicaments*. Québec : MSSS, 98 p.

Ministère de la Santé et des Services sociaux du Québec. 1999. *Évaluation du régime général* [illegible]

ANNEX 1: CHRONOLOGY OF THE PRINCIPAL POLICY DECISIONS ABOUT QUEBEC'S PRESCRIPTION DRUG REGIME IN THE LAST DECADE

1970-1980-1990 : Coverage of prescription drugs

	Malades sur pied“	related to the Outpatient Circular. The committee proposes exchanging a regime of assistance for one of insurance.
1994 :	Advent of Premier Jacques Parizeau (Parti Québécois)	September 26, 1994 (replacing Daniel Johnson)
1994 :	Advent of Health Minister Jean Rochon (Parti Québécois)	September 26, 1994 (replacing Lucienne Robillard)
1995 :	Filing of the Gagnon Report: “*Mise en place d’un régime universel de base d’assurance-médicaments au Québec : Analyse de la faisabilité*“	Internal report of the RAMQ filed on May 17, 1995. The report studies the possibility of implementing a public universal prescription drug insurance regime. The report establishes that significant changes to the current system of reimbursement of prescription drugs seem inevitable. The report contends that the project is potentially feasible: in terms of health care, a universal regime is the best choice. In political and economic terms, the challenges are significant. The monitoring and optimal use of medications are pre-requisites for the viability of the regime. ”This type of regime can be introduced in Quebec if we agree to the necessary changes as well as to the application of specific parameters and a rigourous monitoring system” (p. 89).
	Naming of the Castonguay Committee	September 8, 1995 Jean Rochon gives Castonguay the mandate to make proposals for the creation of a prescription drug insurance regime.
1996 :	Advent of Premier Lucien Bouchard (Parti Québécois)	January 29, 1996 (replacing Jacques Parizeau)
1996 :	Filing of the Castonguay Report “*L’assurance-médicaments : des voies de solution*“	March 15,1996 A voluminous report which makes several recommendations. Castonguay proposes to preserve the accomplishments of the private sector. The report proposes that the RAMQ retain its usual clients (seniors and the poor).

	Tabling and passing of the Quebec Drug Insurance Act (“Loi 33”), and holding of a parliamentary commission	In the month of June Law creating the prescription drug insurance regime. The law created a committee for the review of the use of medications.
1997 :	The law takes effect	January 1, 1997
1998 :	Advent of Health Minister Pauline Marois (Parti Québécois)	December 15, 1998 (replacing Jean Rochon)
1998 :	Filing of the McGregor Report: “*Critères et processus de décision pour la couverture des médicaments coûteux au Québec : réflexions sur la situation actuelle et propositions de changement*“	In 1998 The report reassesses the issue of the mandate of the pharmacological consulting committee of the time.
1999 :	Filing of the Tamblyn Report: “*Rapport d’évaluation de l’impact du régime général d’assurance-médicaments*“	In March, 1999 The report determines that the new regime caused a decrease in the use of prescription drugs among seniors and the poor. The new regime caused an increase in undesirable events, emergency room visits and doctors" visits. In 1 year, the RAMQ saved between 16 and 17 million in funds previously spent on the drug expenses of welfare recipients.
1999 :	Filing of the Fillion Report: “*L’évaluation du régime général d’assurance-médicaments*“	December 15, 1999 This evaluation had been planned for in the Quebec Drug Insurance Act (the regime was to be assessed after 3 years). The regime had attained its goals, but certain challenges remained: the increase in costs, funding and the problem of optimal use.
2000 :	Filing of the report of the Doucet Committee: “	

Quebec

Quebec –

ANNEX 2: LIST OF INTERVIEWS CONDUCTED

AM-01	University professor
AM-02	University professor
AM-03	Pharmaceutical industry
AM-04	Conseil du medicament
AM-05	Conseil du médicament
AM-06	Ministry of Health
AM-07	Régie de l"assurance-maladie du Québec
AM-08	Pharmacists
AM-09	Social groups
AM-10	Pharmacists
AM-11	Ministry of health
AM-12	Social groups
AM-13	Ministry of health
AM-14	Social groups
AM-15	Insurers
AM-16	Ministry of health
AM-17	Pharmaceutical industry

Quebec

		a mixed regime [AM-02 + AM-12 drugQC]. Young workers were favourable to a drug plan [AM-06 drugQC]. Students tended to be against a drug plan [AM-07 drugQC]. Population segments covered by the *Circulaire Malades sur pied* wanted the status quo (maintain the existing program) [AM-03 + AM-11 drugQC].
	Policy entrepreneurs (including researchers)	Researchers were asked to participate to numerous committees and commissions created since 1992. The conclusions of those research reports were supporting the creation of a drug plan. Numerous solutions were presented. The commissions and committees" recommendations tended to support either the universal drug plan or the mixed (public-private) approach. They tended to be less favourable towards the private drug plan scenario and the catastrophe-type of drug plan [AM-11 drugQC].

	Other		The private insurance companies were already offering coverage to large segments of the population. They wanted to be part of the drug insurance plan. They were not favourable towards a private regime (were not ready to cover all the population & and were not interested in covering vulnerable groups who are financially deprived) [AM-15 drugQC]. Health Minister Jean Rochon was coming back from working at WHO. He wanted to put in place a drug plan [AM-06 drugQC]. Community pharmacists were against a universal public regime. They were earning more professional fees by offering services to individuals covered by a private insurance plan [AM-08 + AM-10 drugQC]. Hospital pharmacists were favourable to a universal public regime. They were against the program *Circulaire Malades sur pied* because it brings extra work and is a burden on hospital"s budgets [AM-08 + AM-14 drugQC]. *L'Association des hôpitaux du Québec* supported the arguments of the pharmacists [AM-14 + LA-01 drugQC]. Drug companies were favorable to a drug plan (any scenario) as long as it did not affect their privileges (especially pharmaceutical patent) [AM-17 drugQC]. The Ministry of Health was sceptical. They thought that the regime could not be implemented in 6 months [AM-07 drugQC].
Ideas	Knowledge / beliefs about what "is"		Before 1992, the issue was not really discussed. It was brought to the attention by the Demers committee in 1992-1993 [AM-06 drugQC]. *f* Between 1993-1995, the issue was put on the agenda rapidly because of the flaws of the *Circulaire Malades sur pied,* the desire to have a fair plan, the fact that Jean Rochon was convinced that a drug plan had to be implemented, to maintain the hospital budgets, to support the shift to ambulatory care and the desire to reach the zeroreW*nBT231t21 4231.0(t)-4(he4] TJETQq

		[AM-06 drugQC].
	Combined (e.g., commission recommendations)	Lots of committees and commissions were put in place to document the idea of a drug plan [AM-11 drugQC].
	Other	Allows Quebec to differentiate itself from the other provinces [AM-15 + AM-16 drugQC].
External events	Release of major report (e.g., commission)	Numerous reports
	Political change (e.g., election, cabinet shuffle) – provincial and national	Arrival of the Parti Québécois in 1994 [AM-06 drugQC].
	Economic change (e.g., recession)	The zero deficit policy. The need to cover the deficit of the assistance portion of the plan [AM-13 drugQC].
	Technological change (e.g., MRI scans)	The development of new expensive drugs [AM-05 drugQC].
	New disease (e.g., SARS)	AIDS crisis. Treatment is costly [AM-06 drugQC].
	Media coverage (e.g., deaths on the waiting list)	Criticism of the *Circulaire Malades sur pied* [AM-09 + AM-14 drugQC].
	Other	Not mentioned by any participant.