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A PRESCRIPTION FOR CANADA?**

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Quebec's Drug Insurance Plan: A Prescription For Canada?

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In the wake of the National Forum on Health's recommendation that Canada extend public health insurance to include universal Pharmacare, stakeholders are scrambling to shape what might become. Though this has been the topic of some discussion in the past,¹ the Forum's endorsement of the idea has brought it to the fore. One proposed model of universal pharmaceutical insurance is the recently implemented prescription drug insurance plan of Quebec.

The Quebec Plan:

The act pertaining to pharmaceutical insurance in Quebec (Bill 33)² went into effect in two stages. The first stage began on August 1, 1996. For the first five months of the prescription drug insurance plan, the only substantial change was increased user-charges for beneficiaries of existing programs—seniors and persons on social assistance. Increased participation of eligible residents in private and public drug plans was not mandated until January 1, 1997, when every resident of Quebec was required to obtain insurance coverage for all medicines on the government's *Liste de médicaments*. The coverage purchased must meet standards, set out in Bill 33, that far surpass insurance for 'catastrophic drug costs' available universally in provinces such as British Columbia, Saskatchewan and Ontario.

The prescription drug insurance plan outlined in Bill 33 is not a public drug benefits program. It is a 'compulsory insurance plan' with government administration of contracts for populations that private insurance companies were unwilling to insure at acceptable costs. Private insurance companies will only insure residents who are eligible for group coverage by way of their current or former occupation (e.g., professional guilds) or via employee benefit plans. Eligible residents *must* purchase at least basic drug coverage through private markets. Moreover, they must also purchase coverage for their children,³ persons suffering from a functional impairment who are domiciled with them, and their spouse. It is a legal obligation for eligible residents to insure through the private markets. The only exception to this rule is the elderly, who may choose whether to insure privately (if eligible) or to insure through the publicly administered plan.

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All individuals not otherwise eligible for private insurance are required to purchase coverage through the public insurance plan. The public plan is administered by the Régie de l'assurance-maladie du Québec (RAMQ). The cohort covered by the RAMQ is broken into segments, depending on the age and income of the recipient. In broad terms, these segments are the elderly, social assistance recipients, and those who do not qualify for private, group insurance. (These groups are described in greater detail in table 1.)

Bill 33 significantly altered the form of coverage received by the elderly and those on social assistance—the primary beneficiaries of RAMQ coverage before 1997. The government embraced a user-pay mandate for both new members of the RAMQ plan *and* previous recipients of government drug benefits. Prior to August, 1996, RAMQ provided drugs free of charge to persons on social assistance and subject to a \$2.00 co-payment for senior citizens. Under the new law, the basic coverage provided by RAMQ operates as a traditional third-party insurance contract—involving premia, deductibles and coinsurance. The major difference between the private and public plans is that those purchasing insurance from the RAMQ have higher needs (on average) and fewer means (on average); hence *some* members of the RAMQ plan have subsidized premiums.

Basic Coverage: The basic plan, which private and public providers of prescription drug insurance are required to meet or exceed, provides coverage for products on the *Liste de médicaments*. Annual premiums for the basic plan are \$175. The deductible, which is the amount of drug costs that must be fully borne by the consumer before any insurance 'benefits' kick in, is \$25 per quarter (or \$100 annually). After the deductible is exceeded, the insurer begins to pay benefits and patients are charged a coinsurance rate equal to 25 percent of drug costs. Finally, once the total contribution from the patient (*excluding premiums*) has reached a maximum contribution limit of \$750 in any year, the full cost of drugs for the remainder of that year must be born by the insurance plan.

RAMQ Plans: Premiums, deductibles and contribution limits differ across the populations covered by RAMQ. Table 1 outlines how the terms of the RAMQ plans differ according to income and age of the plan member. The coverage offered to the elderly and those not eligible for private insurance just meets the minimum standards for 'basic coverage.' Coverage offered to (very-) low-income residents (young and old) exceeds these terms, providing more 'assistance' so to speak. Key differences include the premium exemptions for social assistance recipients and children, and the graduated annual contribution limits depending on income level. Similarities between groups include the \$100 deductible and the constant co-insurance rate of 25 percent, which apply to all groups except children.

The minister of revenue collects premiums from RAMQ beneficiaries along with their income taxes. Due to pressures from groups representing consumers, the RAMQ has opted to administer the deductibles and contribution limits on a monthly basis, as opposed to the quarterly basis required by law.⁴ For example, persons covered with the *basic* RAMQ plan are responsible for the first \$8.33 of drugs purchased each month and 25 percent of costs until their out-of-pocket costs for the month have reached \$62.49—after which they pay nothing—until, of course, the next month. To facilitate administration and to reduce the beneficiaries' financial burden, the RAMQ program is administered on a computer network that keeps track of the monthly contributions of its members. The network automatically calculates the proportion of costs payable by government and credits this to the pharmacy. Thus, consumers covered under the government plan pay only their share of the costs (i.e., they needn't pay the full costs and submit bills for reimbursement).

Private Plans: Private insurance contracts must also meet the minimum standards of basic coverage outlined in Bill 33 (see table 1). However, premium levels, co-payments and deductibles may be negotiated by the insurer and the group sponsoring the plan. There are no explicit criteria for comparing the requirements of the basic plan to the terms of private plans involving higher premiums with lower co-payments, smaller deductibles, and/or more extensive coverage. Private drug plans may tabulate deductibles and contribution limits on an annual basis, and they may require beneficiaries to pay the full cost of their drugs and submit receipts for eligible reimbursement.⁵

Bill 33 also contains a rule which stipulates that no individual or group may offer benefits for accident, illness or invalidity without also offering drug coverage at least equal to the basic plan. This provision makes it impossible for employers or groups to drop the pharmaceutical component of their 'extended benefits packages' without also dropping all other benefits. The intent of this clause is to limit the population for which RAMQ will be responsible. In practice, it gives the private insurance industry a captive market made up of employers who now must offer drug benefits or no benefits at all. However, the elderly are an important exception to this rule. Private plans may offer other extended benefits for group members over 65 years of age who opt to obtain their pharmaceutical benefits through the RAMQ insurance plan.⁶

Table 1: Description of Groups and Terms of Coverage Under RAMQ

Group Description	Premium	Deductible	Co-insurance	Contribution Limit
Children: Aged 0-17, and full-time students aged 18-26 having no spouse.	0	0	0	0
Persons over 65 years of age who are not members of a group plan and who are receiving the FULL Guaranteed Income Supplement under the Old Age Security Act.	Scaled by Income 0\$ to \$175	\$100	25%	\$200
Persons over 65 years of age who are not members of a group plan and who are receiving a PARTIAL Guaranteed Income Supplement under the Old Age Security Act.	Scaled by Income 0\$ to \$175	\$100	25%	\$500
Persons over 65 years of age who are not members of a group plan and who are NOT receiving the Guaranteed Income Supplement under the Old Age Security Act.	Scaled by Income 0\$ to \$175	\$100	25%	\$750
Recipients of social assistance under the Last Resort Assistance Plan.	\$0	\$100	25%	\$200
Persons over 60 years of age who hold a valid booklet from the Minister of Income Security.	\$0	\$100	25%	\$200
All other persons who are not eligible for group insurance plans and whom no person is required to ensure coverage for under section 18 of the Act.	Scaled by Income 0\$ to \$175	\$100	25%	\$750
Private Group Insurance Plans	Negotiated	Negotiated	Not more than 25%	Not more than \$750

Source: Bill 33 Sections 15 and 28, and RAMQ (1997)

Where did the Quebec plan come from?

To understand the prescription drug insurance plan of Quebec, it is useful to see how it emerged. The evolution of the Quebec plan goes back to 1993, when the government announced plans to end the 'Malades sur pied' circular, a program that provided drugs for persons with specific illnesses.⁷ Under the now defunct program, the government dispensed drugs from hospital pharmacies to residents with AIDS, cystic fibrosis, cancer and certain other conditions. Due to the public outcry surrounding this program's potential demise, the Quebec government established a committee (the Demers committee), in November 1993, to examine possible alternatives. After reviewing the costs of the public drug benefits programs and noting the wide discrepancies in coverage between residents of Quebec, it was concluded that what the province needed was not more assistance, but more insurance. The Demers committee felt that partial solutions to the access problem—that is, more assistance—would be inadequate, and recommended that the government investigate ways of implementing universal pharmaceutical insurance.

To pursue the ostensible objective of mending the 'gaping holes' in the patchwork of pharmaceutical insurance that characterized Quebec at the time, the Minister of Health and Social Services, Jean Rochon, set up the Committee of Experts on Drug Insurance in September 1995. The committee, chaired by Claude Castonguay, was given the 'one priority' mandate to find a way to insure all Quebecers for the cost of their medications while reducing government expenditures.⁸ There appeared to be little concern for researching Pharmacare policies that might lead to improved prescribing and lower costs to the system as a whole. Although reported on by the Castonguay committee, such issues were to be addressed *after* universal insurance coverage was achieved. And, while insuring the uninsured was the ostensible purpose of Quebec's prescription drug insurance plan, the Castonguay report makes it clear that the reduction in government expenditures was the ultimate objective. The following quotes helped to establish that fact:

The objective of our report is to reconcile social policy objectives with the hard economic reality, in a context based on partnership between the public and private sectors. p.4. [bold in original]

... the primary objective of the drug insurance plan must be to guarantee that all Quebecers have reasonable and equitable access to the drugs required by their state of health within the limits set by government's financial framework. p.52. [bold in original]

In the current fiscal and budgetary context, the Committee feels that the cost to the government of a drug insurance plan must be below the current level of public expenditure. Furthermore, this constraint must

apply not only in the first year of the plan but also in subsequent years. The fact that drug expenditures will continue to increase at a rate that may be more rapid than that of government revenue must be taken into account. Accordingly, this dimension of the question implies a level of net public expenditure [government expenditures less premium revenue] below the current level. p.56. [bold in original]

The Quebec government's focus on the 1.2 million Quebecers without pharmaceutical insurance was surpassed only by its focus on controlling not the cost of the system, but the cost to government.

The hard economic realities referred to by the Castonguay committee surely included some political realities as well—ones that are unique to the province of Quebec. Quebec is the Canadian home to a disproportionately large share of multinational pharmaceutical companies, securing it about 45 percent of Canada's pharmaceutical R&D; and Quebec based insurance companies represent about 50 percent of the group health insurance market in the province. To threaten the continued prosperity of these two industries would have serious political repercussions. Consistent with this, the committee consulted with only those stakeholders that had interests in a mixed system of public and private insurance for pharmaceuticals. Specifically, they consulted with representatives from the pharmaceutical industry, insurance industry, benefits consulting industry, health professional associations and government offices. Conspicuous in its absence was consultation with consumer groups or those representing the employers and employees who pay for private insurance.

The selective nature of their consultations and the economic and political limits placed on their objective appear to have biased the assumption and conclusions of the Castonguay committee. Throughout several key chapters, there is a dearth of unbiased evidence. There are only 20 research citations in the 8 chapters on drug costs, current policies, objectives, plan design, the formulary and price list, information systems, non-compliance, and drug use review: 10 of these are government publications and 5 are reports sponsored by the pharmaceutical industry. Only in the chapter on which the Castonguay committee had the least influence, training and information, does one find several citations of academic literature—8 to be precise. Many of the committee's conclusions, drawn from scant evidence, are contentious. For example, the Castonguay committee strongly supports user-charges for medicines, discourages restricted formularies and reference pricing, and claims that the price of new drugs is now under control due to the efforts of the Patented Medicine Prices Review Board.⁹ Furthermore, the cost-impact analysis performed by the Castonguay committee was based on fundamentally flawed logic. The

committee held the assumption that all forms of financing universal coverage will cost the same amount (\$1.939 billion to be exact). This overlooks two significant factors: first, universal public administration of Pharmacare aligns the incentives and opportunities to implement real improvements in the cost-effectiveness of drug use (discussed below); second, administration costs in the private sector are two to three times as high as those in the public sector.

Shortly after the publication of the Castonguay report in June 1996, the Quebec government drafted and pushed Bill 33 through National Assembly.¹⁰ Though the bill resembled one of the options presented in the Castonguay report, it went even further to reduce the governments' financial contribution to the plan. When the Bill was announced, Rochon boasted that it would save the government \$200 million.¹¹ The government was not quick to boast that most of these 'savings' would, in fact, become a financial burden on the elderly and the poor—which explains why the bill was immediately denounced by groups representing the elderly,¹² the impoverished,¹³ those with HIV,¹⁴ persons with mental illnesses,¹⁵ and even the provincial ombudsman.¹⁶

Characterizing the Quebec Plan:

Public policies are supposed to be designed to meet the objective set out by government. With its pharmaceutical insurance policy, the government of Quebec clearly wished to reduce public spending, insure all residents, and maintain a favorable position with pharmaceutical manufacturers and insurance companies. Bill 33 was crafted to meet these objectives, and has been heralded as a success by government, the insurance industry and pharmaceutical companies. However, the Quebec government's pursuit of these objectives came at the cost of other potential priorities for Pharmacare. Objectives that conflict with the government's primary goals—some in ways less obvious than others—include ensuring access to pharmacotherapy based on needs, not ability to pay; controlling the total cost of pharmaceutical care; and progressively redistributing across groups with different health status and incomes.

The Quebec government chose an insurance mechanism with mixed private and public administration as the Pharmacare policy for achieving its goals. After all, insuring the uninsured while reducing public expenditures was the 'one priority objective' for the Quebec plan. The ostensible purpose of this was to ensure equitable access to needed medicines. However, some of the consequences of choosing an insurance mechanism with a mixed administration may interfere with both access and equity. In the long run, the mechanism set into law with Bill 33 may even jeopardize the reduction of public spending.

Access: An often cited reason for insuring the entire population is the fact that a segment of the population ‘falls through the cracks’ between private drug coverage and public drug benefits plans. This may be a concern because evidence suggests that persons with low incomes may be at risk of inequitable access to medicines due to financial barriers. A smaller proportion of people with low incomes have pharmaceutical insurance than persons with higher incomes; and as a percentage of income, low income families pay more out-of-pocket for their prescriptions than do families with higher incomes.¹⁷ Insurance may remove some of these barriers by spreading risks across individuals who face the random chance of potentially unaffordable drug costs. It could do this by pooling premia collected *ex-ante* and redistributing wealth (to those who end up suffering a loss) *ex-post*. But the story is not that simple.

Competitive markets for insurance can prosper provided that risk status is observable, such that consumers can be charged a premium equal to their expected losses (plus an administration cost), and (of course) that there is sufficient demand for insurance in the first place. In such perfectly competitive insurance markets, firms can charge ‘actuarially fair’ premiums that reflect an individual’s risk status. An individual’s risk status for pharmaceutical needs may be reasonably predicted by their age, sex, and medical history. Unfortunately for some people, an actuarially fair premium may represent a financial burden that is too great to afford—a problem that will be greatest for the elderly and the chronically ill whose ‘actuarially fair’ premiums would reflect their high average drug use. That is, financial barriers to access can exist *ex-ante* just as they do *ex-post*. If such barriers existed, market based insurance as a mechanism for ‘ensuring access’ to pharmaceuticals will fail.

To get around this problem (and others), private insurance companies sell insurance to distinct groups of individuals (e.g., employees of a company), the members of which must pay a ‘community rate’ for pooling risks amongst themselves. A community rate reflects the average risk status of members in the group. Because this rate is charged to all members of the group, it will be higher than the actuarially fair rate that would apply for some members and lower than that of other members. That is, a group rate will involve a degree of health-related cross-subsidy from the relatively healthy to the relatively unhealthy members of the group. In private markets, groups are selected to be relatively homogenous in terms of age, health status (typically indicated by their employment) and income. This makes it easier for companies to set the community rate and, by keeping the health-related cross-subsidy to a minimum, it encourages the relatively healthy members of the group to voluntarily participate in the plan. Too much variation in health status spoils

the pot, because the healthy members may find it in their interest to seek insurance on their own or not at all. Moreover, premiums for some well identified and relatively homogeneous groups may represent a barrier to access just as with individual insurance contracts. For rather obvious reasons, insurance companies do not try to sell pharmaceutical insurance to groups made up of individuals who are elderly, ill, or poor. Therefore, to ensure universal insurance coverage, government must pick up those individuals and groups that private markets leave uninsured—which is exactly what happened in Quebec.

The potential for health-related cross-subsidy is diminished by the fact that fragmentation between private and public insurance occurs along the lines of health status. The fee structure in Bill 33's basic plan are essentially a 'community rate' for the entire adult population of Quebec. Roughly speaking, the terms of the basic plan cover the needs of any group with 'average' drug needs per adult beneficiary in the neighbourhood of \$300.¹⁸ Under these terms, the government could have profitably sold the basic insurance plan to the entire Quebec population, even after administration costs are factored in. Differences in average drug needs across all age cohorts would have been pooled in one universal plan—implying a fairly substantial health-related cross-subsidy financed through premia. Such pooling, however, is not possible when the private sector insures the healthiest and wealthiest segment of population—for whom the national average drug costs per life covered are in the neighbourhood of \$130.¹⁹ In fact, Bill 33 permits Quebec's private sector to off-load their high-cost, elderly beneficiaries onto the RAMQ plan.²⁰ Encouraging older group members to opt out will reduce the total costs of the private drug plan, thereby reducing the premiums for younger group members (or increasing profits earned by the administrators). In this way, private plans avoid pooling risks between young and old, which inevitably involves a health-related cross-subsidy. The cost of the health-related subsidy for the elderly does not disappear, it just gets off-loaded onto the public sector.

Terms of coverage: Health related subsidies were also greatly diminished through the required user-contributions of RAMQ beneficiaries. Coverage under the RAMQ drug now involves contributions that are of a risk-pooling nature (the premia discussed above) and of a user-pay nature. User charges only apply to those who use drugs, and those who use drugs most often are typically those who are least healthy. Therefore, user-contributions necessarily reduce the potential health-related cross-subsidy in the system, regardless of how it is financed. The reduction in cross-subsidy will be proportional to the user charge. Deductibles and coinsurance payments are motivated as utilization control mechanisms. Whether user-charges achieve their ostensible purpose is questionable.

Some theorists and policy researchers, such as the Castonguay committee, believe that lowering the cost of drugs will induce over-use. In technical terms, they believe that insurance causes people to consume more and more drugs, to the point where the marginal cost of a drug to society would exceed its marginal benefit to the patient—the ‘moral hazard’ problem in health insurance theory. User-charges are said to help curb the excessive drug use that might result from insurance. But it is not that simple. First, this line of reasoning requires that patients have sufficient information about their illness and alternative treatments—not to mention the ability to process that information in a ‘rational’ way—such that they may decide when their prescription drugs are worth the costs or not. A number of studies have showed that, faced with co-payments, patients tend to reduce their use of both essential and non-essential drugs.²¹ As a result of changes in patients decisions induced by co-payments, downstream health costs can increase significantly. This is probably not what policy makers have in mind when they think of ‘rational decision-making,’ but it should not come as a surprise. By the very definition of a prescription drug, it is the physician who ‘makes the call’ as to whether a drug is medically necessary or not. Physicians are given the license to do so specifically because they have the necessary training to make these decisions. A second critical assumption behind a user-charge policy is that the decision-making process will not be perversely affected by the consumer’s ability-to-pay for prescription drugs—regardless of their medical knowledge. Research from the US has shown that even low co-payments can have drastically negative impacts on utilization of medicines by the mentally ill, the elderly and those on social assistance.²² This, too, should not come as a surprise. Insurance is often motivated as a removal of barriers to access. For some consumers, any cost of prescription drugs may be a barrier to access, yet no research has been conducted to determine how large a group such consumers represent.

The basic plan under Bill 33 also includes an annual deductible that diminishes the potential for health- and income-related subsidies. As mentioned above, the deductible is the annual (or monthly) amount which a patient must pay out-of-pocket before any benefits kick in. While at first glance deductibles may appear to prevent patients from over-using medicines, it is clear that overuse is a problem that is marked by large, not small, drug costs. Moreover, the monthly deductible under the RAMQ plan is \$8.33 and the average dispensing fee (*not* including ingredient costs) is \$7.00, and patients could game the system by stacking their prescriptions up in any given month, making the RAMQ deductible of questionable merit in this regard. On the other hand, deductibles may be a relic of a paper-driven private insurance system. Traditionally, processing claims sent into insurance

companies involved 'lumpy' administrative costs, and the use of a deductible ensures that administrative effort is not wasted processing minor claims. In recent years, government drug plans in many provinces, including Quebec, have installed networks for on-line, real-time claims processing and reimbursement at the point of purchase. These systems have made the marginal cost of processing claims infinitesimal, thereby invalidating the 'lumpy processing costs' rationale for deductibles. Finally, deductibles might also be rationalized in a risk-pooling sense. It may be justified to have a deductible if insurance was to protect people against only large losses—a form of 'catastrophic' coverage. At moderate levels, the deductible effectively increases the average premia; only, its incidence is concentrated among those who actually need drugs, nullifying its potential for health-related cross-subsidy in comparison to an equivalent premium increase. And, as mentioned above, the mixed administration of Quebec's prescription drug insurance plan mitigates the potential for premium- and deductible-driven subsidies for the relatively unhealthy.

Equity: Another form of subsidy that the prescription drug insurance plan of Quebec altered significantly is the income-related subsidy. The changes in the structure of the benefits provided under the RAMQ, and the compulsory nature of private plan membership had one primary effect: to shift costs from the government onto consumers. This was consistent with the objective of reducing government's net contribution to drug benefits without threatening the incomes of pharmaceutical manufacturers. Due to this cost shifting, Bill 33 not only diminished the extent of the income-related subsidy, but made its financing more regressive than it was prior to 1997. Traditionally, income-related Pharmacare subsidies have manifest themselves in the free provision of drug benefits for social assistance recipients, financed through general revenues. Within Quebec's new system, the income-related subsidy is achieved through reduced premiums and contribution limits—in effect, the government sells insurance to some beneficiaries at prices below the community rate. However, as discussed above, the basic plan still involves significant user contributions that reduce the total magnitude of the redistributive component. And, designed like a typical third-party insurance plan, a large portion of subsidy under the Quebec plan is supposed to be financed through premia.

Table 2 shows cost estimates from the *Federation nationale des associations de consommateurs du Quebec*. This table lists the contribution levels from government and different consumer groups under the old and the new pharmaceutical insurance schemes in Quebec. According to these estimates, the government will save more than the \$200 million announced with the new plan, while elderly and poor consumers will pay \$400 million more, and private plan membership will pay almost \$50 million more. Preliminary data

Table 2: Changes in financial contributions by category of the insured

Group	Prior to Bill 33 (\$'millions)	After Bill 33 (\$'millions)	Change (\$'millions)
Social Assistance Recipients	0	90	90
The Elderly	42	375	333
Previously Un-Insured	193	203	10
Previously Insured	783	821	38
Government	922	551	(371)
Total	\$1,940.00	\$2,040.00	\$100.00

Source: Federation nationale des associations de consommateurs du Quebec

from RAMQ confirm that \$225 million dollars have been shifted from government to consumer via the new user-contributions under the RAMQ plans.²³ The reduction in tax-financed expenditure makes the system less progressive.

Even a universal 'community rate' premium is less progressive than tax financing. This is because tax financing involves an element of progressivity, whereas a premium (under a universal plan) is uniform across incomes. Due to the mix of public and private administration, however, the distribution of premia under the Quebec plan is even less progressive than a universal, premium based plan. The reason for this is analogous to the diminished health-related subsidy under mixed administration: beneficiaries of private plans are generally wealthier, as well as healthier, than those of the RAMQ plan. To the extent that middle- to low-income members of the RAMQ plan are paying for health- and income-related subsidies through their premia, the system becomes more regressive. For example, previously uninsured Quebecers who are now required to join the RAMQ plan have average annual drug costs of approximately \$152—far less than the costs necessary to justify the \$175 premium, \$100 deductible and 25 percent coinsurance.²⁴ Thus, people in this cohort—whose incomes vary widely—are paying for a portion of RAMQ's health- and income-related subsidies through their premia. Premia paid to private insurance plans do not cross-subsidize in this manner. Excess revenues in the private sector are profits; as such, they stay in the private sector. The only way in which private plan beneficiaries contribute to the social assistance component of the drug insurance is through their taxes. Due to the fact that net government expenditure has fallen by over \$200 million dollars and is supposed to continue falling, the tax financed portion of the program will erode over time, and progressivity along with it.

Total costs and cost growth: The Quebec government set out to reduce net public expenditures on pharmaceuticals. By attempting to achieve this through a compulsory in-

insurance system with private and public administration, the long-term prospects of government savings may be threatened. Total expenditures will necessarily increase in the short-term, and long-term expenditures may out-grow consumers' and employers' willingness to sponsor the system. And, as populations age and the nature of the work-force changes, the size of the cohort that the government must sell insurance to is going to rise, not fall.

In the short term, the Quebec plan involves duplication of a number of administrative services. The cost savings of central administration of insurance plans are well known and are one of the justifications for a single administrator of a universal plan. Administering plans and processing claims requires certain fixed costs—bricks and mortar, computer systems, personnel—with low variable costs. Private insurance companies do not have access to the same advantages that public administrators have, such as networks for billing and tracking pharmaceutical records along side with medical and diagnostic records—a necessary tool for moving pharmaceutical care into the 21st century. Public administrators can also tie revenue collection onto the taxation function of government—whether the program is tax financed or premium based, as in Quebec. In addition to the cost of administration, private for-profit insurance companies must charge a premium such that they can offer a suitable return to their share-holders. The difference in administration costs between multiple private and centralized public administration are not mere percentages, but orders of magnitude. In June 1996, the Quebec government estimated that their administrative costs for a universal drug plan would be 3.7 percent of the program expenses, less than one-half of the private insurers' estimate.²⁵ Such administration cost differences—which are on the conservative side for a universal system—would translate into a system-wide difference of more than \$70 million dollars per year in the province of Quebec.

One must also consider the cost of complying with competing insurance plans' procedures and regulations which are borne by pharmacists and physicians. These costs would be less significant under a plan wherein the competing firms could agree on standardized claims processing and regulations (such as generic substitution). However, arriving at agreement among competing insurance companies will involve additional costs of negotiation—costs that will eventually be passed on to consumers. There are also significant bargaining costs borne by professional associations, pension funds, employers and unions when determining the cost of their drug plans and the levels of benefits associated with them. This is not to say that government plans are without these costs, but that they would be significantly reduced through universal public administration—as evidenced by comparisons of the Canadian and US health care systems. Even large corporations who are major drug plan sponsors, such as those represented by the Employer Committee on Health

Care in Ontario,²⁶ have voiced interest in a publicly administered universal Pharmacare program because it would place the burden of managing drug benefits in the hands of Ministries of Health who have the in-house expertise to do so.²⁷

In the long term, the multiple-payer environment established by the Quebec pharmaceutical insurance plan will hinder the ability to control system-wide costs and prescribing patterns. Only government has control over the entire range of policies—regulatory, educational and economic—for promoting cost-effective pharmaceutical care. A single payer will also have the greatest ability to implement purchasing power through systems such as price regulation, generic substitution or reference pricing. If such systems are applied selectively by competing drug plans, the system-wide savings or changes in prescribing will be mitigated. Moreover, sponsors of private plans may not be fully committed to managing the costs of their plans (which is a costly endeavor, the incentive for which is weakened by tax expenditure subsidies). A mix of private and public benefits providers allows for policies that, in absence of integrated approaches to cost control, result in the perpetual shifting of costs from one payer to another—often ending in the consumer's lap. The Quebec government made it clear that it no longer wants to participate in this cost-shifting game by developing policies that ensure costs to the government shrink "...not only in the first year of the plan but also in subsequent years."²⁸ On the other hand, employers and consumer groups are already dismayed at the increased cost of pharmaceuticals under the new plan. It may be the case that these groups will lobby government to take responsibility for managing all pharmaceutical costs in Quebec, rather than perpetually off-loading this responsibility to the private sector.

Is this a model for Canada?

There are many objectives that might be pursued by implementing universal pharmaceutical insurance. Some of these include improving access to medically necessary drugs; pooling risk across groups of different risk status; financing care in a progressive manner; applying systematic approaches to improving prescribing; integrating incentives across health services; and controlling drug costs through monopsony purchasing power. As with universal health insurance in Canada, the aims of protecting the vulnerable while controlling the total costs of the system are not necessarily, in conflict. Achieving these goals will depend on the type of system adopted.

The Quebec government appears to have been remarkably successful in achieving its goals of reducing public expenditures, insuring the entire population, and maintaining favour with the pharmaceutical and insurance industries. It is not clear whether the new

plan has guaranteed equal access based on needs, rather than ability-to-pay. Moreover, from the perspective of total costs, it is quite clear that the Quebec government headed in the wrong direction. International experience with medical insurance provides ample evidence to support a single payer model for achieving total-cost control while ensuring equitable access to high-quality care. Furthermore, a universal Pharmacare program in conjunction with existing Medicare can allow for integration of incentives to monitor the impact of utilization and cost controls across health care sectors (e.g., from hospitals to physicians services to pharmaceuticals) With government finance and administration of universal Pharmacare, incentives and opportunities align for increasing efficiency by 'breaking down the silos' between hospital, medical and pharmaceutical programs that otherwise impede the efficient allocation of scarce resources. There are sufficient similarities between the Quebec prescription drug insurance plan and health insurance in the US to give us the confidence to use American experience as a guide to what is likely to transpire in Quebec (and in any other province that chooses to follow the Quebec path). Compulsory insurance plans with a mix of private and public administration are akin to throwing good money after bad, in the hopes that it will somehow make access more equitable, improve pharmaceutical utilization, and reduce overall costs. Unless policy makers' primary objective is to minimize the costs to government without controlling the total costs of the system, a pharmaceutical insurance policy such as the Quebec plan is not advised. There is sufficient evidence to conclude that, in comparison to a universal Pharmacare program with public administration, the Quebec plan is inefficient, inequitable, and will cost Quebecers billions of dollars in the years to come.

As federal and provincial governments look for a better Pharmacare model, they should reflect on all potential objectives. Achieving many goals will require dramatic changes in how pharmaceuticals are financed and delivered. A publicly administered universal Pharmacare program has enormous support, in the literature on health care and pharmaceutical policy and in the minds of Canadians. In an era where government programs face declining budgets, change will not be easy. But with leadership that perceives the needs of society and has the foresight to find the means of meeting those needs, Canada may be headed toward a Pharmacare solution on par with our Medicare system.

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For an 'average' recipient of coverage under a plan with a \$175 premium, \$100 deductible and 25% co-payment, annual drug expenses of \$333 would be revenue neutral:

$$\$333(\text{total costs}) - \$100(\text{deductible}) = \$233(\text{costs to be split between patient and plan})$$

$$\$233 * .75(\text{percent paid by plan}) = \$175 (\text{cost to plan}) = \$175 (\text{premium})$$

Taking into account the \$750 contribution limit, which occurs when an individual's expenses exceed \$2,700 per year, is impossible to do without data on the distribution of drug costs per benefici-

ary. Thus, \$300 is an approximation of the break-even cost in light of the contribution limit. The \$300 estimate allows two percent of the population to have \$6,000 in annual drug costs, while the remainder of the population had expenses equal to \$195. In light of the fact that the Quebec government has continued to fund the cost of drugs to treat sexually transmitted diseases and cancer through other programs, this appears to be a reasonable estimate.

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