

Public/Private Partnerships for Prescription Drug Coverage: Policy Formulation and Outcomes in Quebec's Universal Drug Insurance Program, with Comparisons to the Medicare Prescription Drug Program in the United States

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In January 1997, the government of Quebec, Canada, implemented a public/private prescription drug program that covered the entire population of the province. Under this program, the public sector collaborates with private insurers to protect all Quebecers from the high cost of drugs. This article outlines the principal features and history of the Quebec plan and draws parallels between the factors that led to its emergence and those that led to the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) in the United States. It also discusses the challenges and similarities of both programs and analyzes Quebec's ten years of experience to identify adjustments that may help U.S. policymakers optimize the MMA.

Keywords: Health care reform, drug insurance, Quebec, Medicare.

DESPITE THE UNITED STATES' POSITION AS THE OECD's highest health care spender, and Canada's also higher-than-average spending (Organization for Economic

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Co-Operation and Development 2006), both countries have struggled to ensure that their citizens have affordable and equitable access to prescription drugs. Confronted by often significant discrepancies in access, prescription drug policies in both Canada and the United States have tried to create programs that make access less contingent on individual circumstances. They also have sought ways to make access more transparent, given the plethora of drug benefit plans available at varying costs in both states and provinces. Finally, aggressive marketing by a strong and profitable drug industry has helped make drugs the fastest-rising health expenditure in both Canada and the United States. As a result, policies have tried to find a balance between limiting costs and continuing to support domestic pharmaceutical companies.

This article examines how the Canadian province of Quebec has addressed these issues over ten years of experience with a universal private/public prescription drug insurance program. In complex social systems such as health care, cross-national policy learning is notoriously difficult (Marmor, Freeman, and Okma 2005). In Quebec, however, where evaluations and adjustments accompanied the implementation of the new drug insurance program from the beginning, decision makers succeeded in adapting an innovative new policy in order to better meet program goals of equitable access, a healthy and innovative domestic pharmaceutical industry, and cost containment. For this reason, we believe that an account of Quebec's experience may provide perspective and ideas to American policymakers trying to optimize Medicare's new Part D prescription drug insurance benefit as legislated by the Medicare Prescription Drug, Improvement and Modernization Act (MMA).

We begin with a brief history of Quebec's drug insurance program. This history is part of a larger study comparing health care policy reform across several Canadian provinces (see acknowledgments) and was based on nineteen interviews with key individuals involved in the development of Quebec's program. Using Kingdon's concept of "windows of opportunity" for policy reform (1995), we then discuss the factors that led to the adoption of Quebec's drug policy in 1997 and the MMA in 2003 and show that despite significant differences between the two contexts, both programs resulted from a similar constellation of events and interests at comparable junctures in time. Finally, we consider some of the challenges that have faced Quebec over the first ten years of its program, namely, the complexity of the regime, the heavy burden of users' contributions, and the lack of a comprehensive pharmaceutical

policy. In responding to these challenges, which face the MMA in the United States as well, policymakers in Quebec made adjustments that reflect constraints specific to Quebec but may nonetheless help inform policymakers confronting similar issues in the MMA. We also outline solutions tested elsewhere that could help address the principal problems facing both programs.

Overview of Quebec's Prescription Drug Insurance Program

Key Features

Except when administered in hospitals, prescription drugs have been excluded from the basket of services covered under Canada's "single-payer" universal health care system since its creation in the 1960s. As a result, Canada's provinces have addressed problems of access to prescription drugs by creating their own programs. Quebec's prescription drug insurance program was implemented on January 1, 1997, following thirty years of patchwork measures aimed at covering the poorest and frailest of the province's residents. Under this program, all residents of Quebec are required by law to have drug insurance coverage. Depending on their employment status, they must be covered by either a private insurer or Quebec's public health insurance agency, the Régie de l'assurance maladie du Québec (RAMQ). In 2006, the public portion of the regime covered 3.2 million Quebecers. Another 4.4 million residents were covered by private policies, usually group plans made available by employers or professional associations.

Coverage by Quebec's private-sector insurers varies from plan to plan. Most private plans offer prescription drug coverage alongside other benefits, such as paramedical services and consultations with specific health professionals. Despite the differences among the private plans, however, all plans must meet certain requirements set out by provincial law. For example, all must cover the drugs listed on Quebec's Drug Formulary. This formulary lists more than five thousand prescription drugs chosen by the Ministry of Health on the recommendation of a pharmacological advisory board. Similarly, the law stipulates that beneficiaries may not be required to pay more than C\$881 per year for drug costs, including both deductibles and co-payments. Drug costs that exceed this amount must be assumed by the beneficiary's plan. Furthermore, the co-payment

required of a beneficiary after payment of the deductible may not surpass 29 percent of drug costs.

Administered by the RAMQ, Quebec's public drug insurance plan is open to seniors, employment assistance (welfare) recipients, and persons without access to a private plan. It also covers beneficiaries' dependent children. Seniors receiving the Guaranteed Income Supplement (GIS) are exempt from paying the plan's premium, as are the socially assisted and all children. All other public plan beneficiaries pay "user fees" (premiums, deductibles, and co-payments) adjusted to income. The Ministry of Revenue collects the premium yearly, with the filing of income tax returns. The current annual premium ranges from C\$0 to C\$538 per adult, depending on net family income. Table 1 compares the key features of Quebec's plan with key features of Medicare Part D in order to identify some of the differences and similarities between the two programs.

Costs

Drug expenditures by Quebec's public drug insurance program grew from C\$832 million in 1997 to C\$2.38 billion in 2005, an increase of 286 percent over nine years. Only a small part of these increases can be attributed to an increase in the number of beneficiaries (the covered population grew by less than 3 percent in that period) or to the aging of the population (the number of covered seniors rose by 6.5 percent). Rather, the addition of new drugs to the provincial formulary, reflecting the introduction of new and expensive medication, helped swell the number of filled prescriptions by 217 percent. At the same time, the average cost of a prescription rose by 21 percent, and the average length of prescriptions grew as well (Canadian Institute for Health Information 2006; RAMQ 2006).

Quebec's public plan participants spent C\$287 million on deductibles and co-payments for their prescriptions in 1997, compared with C\$555 million in 2005, for a cost increase of 193 percent. These figures indicate that the share of prescription drug costs financed by the RAMQ versus those financed by user fees rose from 74 percent in 1997 to 81 percent in 2005. This rise reflects the program's evolution toward lower user fee requirements for poorer segments of the covered population. Beneficiaries' premium payments totaled \$661 million in 2006 and accounted for only 27 percent of RAMQ's revenues. Instead, the balance of RAMQ's revenues came from general taxes.

TABLE 1
Key Features of Quebec's Program Compared with Medicare Part D

	The Quebec Plan	Medicare Part D
Role of government	The RAMQ, a public agency, insures all Quebecers who do not have access to private group insurance, including seniors, welfare recipients, and dependents of those insured.	There is no public insurer. Federal legislation regulates user fee limits and other plan provisions; a federal agency (the CMS) approves insurers eligible to provide coverage.
Role of private plans	Private plans provide group coverage to the employees of participating companies, institutions, associations, etc.	Beneficiaries must choose among stand-alone prescription plans, Health Maintenance Organization (HMO) plans, and Preferred Provider Organization (PPO) plans.
Financing of benefits	The public plan is financed by general taxes and user fees (premiums, deductibles and co-pays); private plans are financed by user fees and employer contributions.	General tax revenues and user fees payable to drug insurance plans.
Eligibility for government-subsidized coverage	The public plan exempts the socially assisted, low-income seniors, and children from payment of the premium; some are also exempted from co-pays and deductibles.	Some beneficiaries have reduced co-pays, do not pay a deductible, and are covered for the coverage gap. Eligibility is determined by a stringent income-and-asset test.
Nature of coverage (voluntary/mandatory)	Mandatory for all residents of the province. All those eligible for private group insurance must register; all others must register for the public plan.	This plan is voluntary for most Medicare beneficiaries (seniors over 65 and some disabled persons) but is mandatory for individuals eligible for both Medicare and Medicaid.

(Continued)

TABLE 1—*Continued*

	The Quebec Plan	Medicare Part D
Drug spending controls	The 1994 price freeze on formulary drugs was revoked in 2007. Prior authorization is required for certain drugs, but the Quebec formulary is considered very extensive. There is no mandated step therapy, generic substitution, or quantity limits.	There are no controls at the federal level. Instead, plans are expected to compete by negotiating lower drug prices and using utilization management tools (formularies, prior authorization, quantity limits, step therapy, and generic substitution).
Limits for out-of-pocket spending	The maximum annual premium is C\$538/adult for public plan beneficiaries (premiums are not regulated for private plan beneficiaries). Maximum annual co-pays plus deductibles for beneficiaries of both private and public plans are C\$881/adult.	There is no maximum premium, but the 2007 average annual amount is estimated to be US\$328. After paying US\$3,850 out of pocket, the user pays only 5% of costs for the rest of the year.
Drug formularies	At a minimum, all insurers must cover the more than 5,000 drugs listed on Quebec's drug formulary.	There is no national formulary, but all plans are required to cover at least two drugs in each therapeutic category and class. Many, if not most, plans have their own formularies.

It is interesting to compare Quebec's drug spending with that of the other Canadian provinces, none of which has mandatory universal coverage or has so many innovative pharmaceutical companies located in their territory. Indeed, the RAMQ's per capita drug expenses were the highest of all Canadian drug programs in 2002, and in 2005 these expenditures

accounted for 20 percent of the province's total health spending, versus 17.5 percent of total health spending across the country. In explanation, Steve Morgan points to the fact that Quebecers "used more prescription drugs, used a more expensive mix of products and paid more per unit purchased than did residents of the other provinces" (2004, p. 330). Furthermore, Quebec's proportion of brand-name drug purchases was almost 20 percent higher than these proportions in the rest of Canada (61 percent of drug purchases in Quebec were brand-name drugs versus 51 percent for the rest of Canada; see IMS Health Canada 2007). The proportion of drug expenses paid by the public plan, as opposed to the proportion paid by private plans, also was higher in Quebec than in other Canadian provinces. The RAMQ paid for 43.9 percent of all drug expenditures in 2005 versus an average of 38.3 percent for all Canadian public drug plans. Furthermore, when Quebec's program began, only 36 percent of all drug costs were paid by the RAMQ, whereas the proportion of the population covered by the public plan was the same as it is now (43 percent in 1997 and 42 percent in 2005). Quebec's higher costs may be attributable to user fees that often are lower in Quebec than elsewhere in Canada, the fact that Quebec's population is slightly older than the Canadian average (Statistics Canada 2006), and Quebec's relative speed in approving new drugs for inclusion on the provincial formulary.

In an effort to contain drug costs, Quebec has implemented several aggressive policies. Quebec's non-increasing price policy of 1994 limited costs by freezing the amount paid for drugs on the provincial formulary at 1994 levels. This policy was in place for thirteen years before being revoked in February 2007. The province also requires that pharmaceutical companies sell formulary drugs at the lowest prices available throughout Canada. In one case, Quebec removed thirty-seven products from its formulary after the manufacturer was found to have sold one of its products at a lower price in the province of Saskatchewan (Hollis and Law 2004). These cost-containment policies have been offset, however, by Quebec's fifteen-year rule, according to which newly approved drugs are fully covered for fifteen years after being included in the formulary, even if the patent expires and a less expensive generic version becomes available in the interim. To justify this policy, Quebec's minister of economic development recently pointed out that the provincial pharmaceutical industry directly employs some 18,600 Quebecers (Ministère de la Santé et des Services Sociaux 2007).

The History of the Quebec Regime's Implementation

Quebec's drug insurance program was created after many years of debate on Quebec's political scene. It is necessary to turn back to the 1970s in order to understand how the problem was defined over time and how a shift in the political status quo in 1996 opened a "window of opportunity" that led to the adoption of today's program.

1970–1992: Patchwork Coverage

Since 1962, when the Quebec Hospital Insurance Plan established free public access to hospital services in Quebec, medication has been provided to hospital patients free of charge (Reinharz, Rousseau, and Rheault 1999). In some cases, outpatients also benefited from free coverage. By the mid-1970s, therefore, drug costs were fully covered for recipients of social assistance and seniors eligible for the maximum federal guaranteed income supplement (GIS). Other seniors contributed C\$2 per prescription, up to a ceiling of C\$100 per year. In 1973, Quebec's "Outpatient Circular" extended coverage to patients with certain serious illnesses when treated outside a hospital. This allowed cancer patients, for example, to obtain expensive medication free of charge outside their hospital stays. Individuals who had access to private group insurance plans through employment were also eligible for reimbursement of prescription drug costs, but the drugs covered, the amount of the premium, and the nature of coverage varied according to the insurance policy. In all, group insurance plans (both public and private) covered approximately 4.5 million people out of a provincial population of 6.1 million in 1973.

1992–1995: Evaluating the Options

By 1992, access to prescription drugs had become an important political issue. More and more patient advocacy groups were demanding that their disease be added to the Outpatient Circular's restricted list of diseases for which medication was provided free of charge. With no selection criteria for listing diseases, the inclusion of a particular disease in the circular depended largely on the lobbying efforts of the relevant patients' group. The ensuing "disease lottery" gave rise to situations of flagrant

inequality, publicized by frequent news coverage of patients unable to afford expensive medication because their disease was not covered by the circular. Furthermore, in an era of spending cuts and hospital downsizing, the Ministry of Health and Social Services wished to encourage a shift toward ambulatory care. In order for the program to take root, medication had to be made available to outpatients free of charge. For that reason, in addition to addressing problems of inequity, creating a prescription drug insurance regime was considered the sine qua non of a successful shift to ambulatory care.

Successive provincial administrations (first the Quebec Liberal Party and then the Parti Québécois) commissioned three reports in as many years with the goal of creating a prescription drug insurance program that would improve equity of access to medication within affordable limits. Claude Castonguay, the health minister under the ruling Quebec Liberal Party from 1970 to 1973 and a leading private-sector insurance executive, oversaw the last of these reports, in which the authors identified a choice of four scenarios (Québec, Comité d'experts sur l'assurance-médicaments 1996).

The *first scenario* consisted of a “universal public regime” with or without users’ contributions. This strictly public regime was to be funded by general tax revenues and some user fees and had the support of large segments of the public. Health professionals, including hospital pharmacists and the Parti Québécois’ health minister, Jean Rochon, also supported a universal public regime, believing that a state-run program was the best means of ensuring equity. Nonetheless, three large factors made it all but impossible. First, private insurance companies opposed it on the grounds that they would lose clients. Private insurers were and still are significant employers in Quebec and represent an important interest group. Second, private pharmacists resisted it because it threatened the two-tiered system in which they charged higher prices for medication and higher dispensing fees to private plan beneficiaries than they did to beneficiaries with public coverage. Because pharmacists were in direct contact with the public and the government counted on them to explain the new system of coverage to their clients, antagonizing the pharmacists would have been dangerous. Third, a purely public system would have meant transferring the payment of premiums from companies to individuals, a move that would have alienated the public.

The *second scenario* consisted of a “universal private regime.” Private insurers would be called on to insure all Quebecers, including seniors and

the socially assisted. The insurers refused this scenario on the grounds that many of these clients, estimated to be between 1.2 million and 1.4 million people, were either financially unstable or likely to have high medication costs.

The *third scenario* was a “catastrophic drug coverage regime.” The government would cover the cost of medication for people whose health problems generated expenses that greatly exceeded their capacity to pay. Over and above a given threshold, calculated as either total medical expenses or a percentage of income, the government would assume all costs of medication. This regime was comparable to what already existed under the Outpatient Circular, but coverage would be determined according to income and not according to disease. Having witnessed firsthand the injustice caused by incomplete drug coverage under the circular, hospital pharmacists protested that this scenario would not resolve the problem of inequity. Seniors’ groups and the Quebec Hospital Association did not reject it outright, however, and insurance companies were willing to participate on the grounds that it would allow them to retain clients for noncatastrophic benefits.

The *fourth scenario* consisted of a “universal mixed (public/private) regime.” This regime allowed private insurers to coexist with Quebec’s Health Insurance Board, the RAMQ. Employment status (employed, socially assisted, retired, or dependent) would be the basis on which individuals were assigned membership in either the public or a private plan. This scenario was supported by the private insurers, who could thus keep their market share without having to take on “bad risks.” The pharmaceutical industry also was in favor of the most universal system possible, that is, the system that would cover the greatest number of people. Invoking the cost of research and development, however, the pharmaceutical lobby insisted on excluding any measures that would regulate drug prices or allow pharmacists to make generic substitutions.

1995–1996: A Compromise Decision

The Castonguay report was published in March 1996. Shortly thereafter, the government of Quebec, acting on circumstances that we will discuss later, announced its decision to implement the fourth scenario, a universal mixed regime.

The United States also considered various ways of adding a prescription drug benefit to Medicare that date well before the defeat of President

Bill Clinton's Health Security Act in 1994 (Marmor 2000). While not all of these approaches were based on "White Paper"-type publications such as the Castonguay report, they had a common goal of more equitable access to drugs and better control of public costs without cutting too deeply into pharmaceutical industry profits. Their principal differences lay in the extent of their user fees, the role they proposed to assign to private plans versus traditional fee-for-service Medicare, and the scope of subsidies they planned to offer to low-income beneficiaries (Oliver, Lee, and Lipton 2004).

Windows of Opportunity for Reform in Quebec and in the United States

Notwithstanding the political, ideological, economic, and social differences between the two cases, both Quebec and the United States addressed the issue of access to prescription drugs through legislative means at a time when analogous factors opened windows of opportunity for reform. In this section and table 2, we contrast the factors that led to the respective adoption of both programs.

In the United States, numerous unsuccessful Democratic and Republican initiatives to reform Medicare over the years bear witness to the fact that "consensus that a problem exists implies no agreement whatsoever on solutions" (Oberlander 2003, pp. W3-391 to W3-404). Moreover, the United States' two principal political parties have different views of health care, which have repeatedly thwarted initiatives to effect profound change. The Republicans, who are inclined to be proponents of what Columbia University health policy specialist Sherry Glied terms the "marketist" view (1997, p. 26), see health as a good like any other, best serviced by a free market. The "medicalist" Democrats, in contrast, tend to prefer a government-financed system of national health insurance. This long-standing impasse was broken to some extent in 2002 when the Republicans found themselves in control of the White House and Congress for the first time since the 1950s and President George W. Bush decided to invest heavily in a publicly funded prescription drug program "in order to take that issue away from Democrats in his 2004 re-election campaign" (Oliver, Lee, and Lipton 2004, p. 334). At the same time, the dramatic rise in both public and private drug spending—alongside accusations that drug manufacturers were grossly

TABLE 2
Factors Leading to the Adoption of Quebec's Policy and the MMA

	Quebec's Policy	The MMA
Cost of drugs	The emergence of increasingly expensive drugs, including those for AIDS, left more people unable to meet costs.	Drugs are an ever-growing financial burden for seniors without coverage. Also, Medicare revealed in 2001 that it had paid US\$6.5 billion in selected covered drugs at prices between two and ten times higher than those advertised to doctors.
Public resistance to tax increases	The continuing aftereffects of the recession of the late 1980s favored a public/private system funded by user fees and employer contributions rather than a public system funded by taxes.	President Bush had just made massive tax cuts: increasing taxes was not consistent with Republican philosophy. With the expiration of the "pay-as-you-go" provisions of the Budget Enforcement Act, however, new expenses could now be added to the federal deficit.
Discontent with the status quo	There was widespread agreement that the Outpatient Circular was unfair and needed to be replaced.	Besides long-standing discontent, new charges of corruption by pharmaceutical companies (overcharging Medicare, extending patents with me-too drugs) gave greater urgency to the problem.
Pharmaceutical industry	An important employer in Quebec, the pharmaceutical industry ensured that price controls and utilization management tools (generic substitution, step therapy, etc.) were excluded from the new program.	A key employer in many states and a major lobbyist, the pharmaceutical industry saw the advantages of an expanded market for subsidized drugs but opposed government administration of benefits, legalized drug importation, and cost-control measures such as program-wide negotiations on the price of pharmaceuticals.

(Continued)

TABLE 2—Continued

	Quebec's Policy	The MMA
Insurance industry	Important employers and often "homegrown" companies, insurers opposed a purely public system that would eliminate their market. They also opposed a purely private system that would require them to insure the elderly.	The insurance industry favored the publicly subsidized purchase of private coverage by Medicare beneficiaries. It also supported US\$14 billion in increased payments to managed care plans in the Medicare Advantage program, part of the MMA package.
Private pharmacists	Private pharmacists favor a two-tier system in which fees charged to private plans could exceed those charged to the public plan.	Private pharmacists favored the exclusion of a national formulary and the introduction of the MMA's Medication Therapy Management Program, provided by paid pharmacists.
Seniors' lobby	Many seniors' groups opposed the new regime because it introduced user fees for seniors.	Possibly influenced by insurance revenues, the American Association of Retired People (AARP) largely supported the MMA. Other groups were opposed (the National Committee to Preserve Social Security and Medicare, CPSSM).
Government solvency and choice of financing	The PQ administration had adopted a zero-deficit policy; a new public/private program was a means of erasing old program debt with new contributions.	Bush's tax cuts, the war in Iraq, and a sluggish economy eliminated budget surpluses. Congress and the White House agreed in advance to limit spending to within US\$400 billion over ten years, making it necessary to add a coverage gap to the new benefit.

(Continued)

TABLE 2—*Continued*

	Quebec's Policy	The MMA
Political situation	The governing party (PQ) wanted to implement large-scale reform in the wake of defeat of the referendum. The opposition (Quebec Liberal Party) had also favored prescription drug coverage in prior elections.	The GOP controlled both Congress and the White House for the first time since the 1950s. Passage of drug coverage legislation would help neutralize the Democratic Party's historical ownership of this issue in preparation for the 2004 elections. Many Democrats voted in favor after Republicans agreed to increased subsidies for the poorest.
Agreement on the nature of coverage	Much-publicized inequities resulting from the selectivity of the Outpatient Circular helped forge consensus on the need for universal coverage.	"Concessions" rather than "consensus": subsidies for the poorest (drug discount cards in 2005/6, lower user fees as of 2006) were offset by a substantial coverage gap (the "doughnut hole") and other user fees.

Sources: Hurley and Morgan 2004; Oliver, Lee, and Lipton 2004.

overcharging Medicare beneficiaries and taking other questionable measures to increase their profits—had given a new sense of urgency to the problem. For a short time, it looked as though the Republicans' desire to follow up on their success with voters had momentarily superseded their market-oriented ideology. Ultimately, however, the MMA's reliance on private-sector competition as a means of controlling drug costs stood as testimony to enduring Republican values.

While the Parti Québécois (PQ) has historically promoted a stronger role for government in the province's economic affairs than has the Quebec Liberal Party, the ideological split between the two main parties is less marked than in the United States, and the "marketist" versus the "medicalist" dichotomy is less pronounced. Both parties supported the

need for a provincial prescription drug plan in the 1994 elections, and indeed in 1995 the Parti Québécois' new health minister, Jean Rochon, appointed the Quebec Liberal Party's former health minister, Claude Castonguay, to head the task force responsible for recommending scenarios for the proposed program. Nonetheless, an unexpected political event also helped open a window of opportunity for reform in Quebec. In October 1995, the PQ government of the day lost a provincial referendum on Quebec's separation from Canada by only slightly more than 1 percent in a vote in which 94 percent of eligible voters participated. Wanting to build on this unprecedented show of support for separation, the party's signature issue, the PQ took up the implementation of an extensive universal prescription drug program as a new argument for a fundamental element of separatist ideology: Quebec's distinctiveness vis-à-vis other provinces (no other province had comprehensive drug coverage at that time). Furthermore, the PQ had to move quickly, for at the federal level, the National Forum on Health was preparing to submit recommendations in favor of a new, national prescription drug insurance program that would have added drug coverage to the basket of publicly funded medical services throughout Canada (Canada Health Action 1997).

In both the United States and Quebec, windows of opportunity opened at a time when policy streams appeared to have developed solutions at "a tolerable cost" (Kingdon 1995, p. 138), at least at a tolerable political cost. In fact, the financial costs of both programs were deliberately underestimated. In the case of Quebec, the Ministry of Finance and the Treasury Board were committed to balancing the budget and eliminating chronic fiscal deficits. Adopting a purely public drug insurance system would have meant raising taxes to cover the C\$895 million in premiums then paid by the private sector to private insurance plans. A mixed regime with user contributions, however, represented savings of around C\$240 million in the first year alone, on what had been the publicly funded drug costs of seniors, the socially assisted, and those whose drugs were covered by the Outpatient Circular. Furthermore, the program that had been funding those costs was in debt, and the injection of funds from a new, mixed program would absorb the balance due. The only obstacle left was political opposition to the high long-term costs of the public portion of the proposed program. The solution was to manipulate the forecasts.

The Bush administration's proposal also claimed to have a tolerable price tag. At a net cost of US\$395 billion over ten years, the reform

package barely slipped in under the US\$400 billion limit set by the Senate (Oliver, Lee, and Lipton 2004, p. 321). The chief actuary at the Centers for Medicare and Medicaid Services later revealed, however, that his office had been ordered to withhold from Congress its estimates of much higher costs (Foster 2004). Not surprisingly, a few weeks after the legislation was passed, the administration announced that the costs of the program had been reevaluated at US\$534 billion (Pear 2005a).

In both cases, the choice of policy reflected the interests of powerful players in the political stream. Private insurance companies in Quebec were an important constituency, and their resistance to covering retirees (because of their higher drug costs) was one of the reasons that Quebec decided on a mixed model. This was the same reason that Medicare was created in the United States. Pharmacists also were important stakeholders in both systems and wished to retain their lucrative private-sector clients. Finally, the MMA's prohibition of federal negotiations of drug prices with pharmaceutical manufacturers created a "huge business opportunity" for pharmacy benefit managers (Atlas 2004), who by 2005 were managing roughly 70 percent of the more than \$170 billion of retail prescriptions sold in the United States (URAC 2006) and, on numerous occasions over the years, had faced charges of pocketing drug rebates rather than passing them onto consumers or drug plans.

The pharmaceutical industry weighed in on the final decision as well. Fifty percent of Canada's pharmaceutical investments are made in Quebec. Furthermore, the Canadian headquarters of several of the world's largest multinational pharmaceutical companies (Pfizer, Merck Frosst, and Bristol-Myers Squibb, among others) are located in Montreal. The imposition of a purely public drug insurance system, therefore, risked economic fallout for the province. As a result, Quebec policymakers crafted a policy that steered clear of regulating the price of drugs. The exertion of similar pressures by American pharmaceutical companies in the United States helps explain why the MMA also pursued a policy that did not regulate drug pricing (Angell 2005).

In the United States, the clout of the pharmaceutical industry is also strongly related to the interface between money and political influence in American politics. In the 2003/2004 election cycle alone, the contributions of pharmaceutical and health products to federal campaigns—not including their funds to state and local party committees—amounted to US\$17.9 million (Center for Responsive Politics 2004). Drug companies spent another \$155 million lobbying the federal government between January 2005 and June 2006 (Center for Public Integrity 2007). Of the

1,291 lobbyists listed as representing pharmaceutical corporations and their trade groups in 2004, some 52 percent were former federal officials (Center for Public Integrity 2005). One of the most visible such lobbyists is Representative Billy Tauzin, Republican from Louisiana. Shortly after the MMA was passed, Tauzin stepped down from his post as chairman of the House Energy and Commerce Committee, which regulates the pharmaceutical industry, to become the president and CEO of the Pharmaceutical Research and Manufacturers of America (PhRMA). Commenting on the event, Joan Claybrook, the president of Public Citizen, noted: "It is a sad commentary on politics in Washington that a member of Congress who pushed through a major piece of legislation benefiting the drug industry gets the job leading the industry" (Welch 2004, p. 4B).

Another key element in securing passage of the MMA was the support of the leadership of the American Association of Retired People (AARP). The 35-million-member AARP has historically been considered an organization representative of elderly stakeholders and a strong Democratic ally, and its last-minute decision to support the MMA despite strong Democratic opposition came as a shock to many. Critics accused AARP of supporting the legislation at the expense of lower-income seniors and the disabled (Russell Chaddock 2003) and linked the move to financial interests: between 1998 and 2002, AARP received 30 percent of its income (US\$608 million) from insurance-related sources (Drinkard and Welch 2003).

In both the United States and Quebec, then, a number of factors allowed for the adoption of innovative policies regarding prescription drugs. Later we shall see that Quebec adapted its policy over the following decade to better meet the program's goals. The goal of cost containment, however, continues to elude policymakers in the province.

Constraints and Challenges: Parallels with the United States

In 1975, political scientist Giandomenico Majone argued that policy change should be based on feasibility rather than optimality. Policy-making would be more responsible and have a better chance of success, he wrote, if it were founded on the scrupulous consideration of social, political, economic, and other constraints, rather than on theoretical arguments about what was most desirable. Twenty years later, Yale's

eminent health policy specialist Theodore Marmor reframed the issue in terms of the importance of an execution strategy, arguing that “we need to move beyond our preconceptions of plans to realistic forecasts of their implementation” (1994, p. 216).

In order to implement Quebec’s public/private drug insurance program successfully, policymakers have made a number of adjustments that reflect various constraints. In this section, we outline the principal challenges that have faced Quebec’s regime over the past decade and discuss Quebec’s responses. These challenges mirror those predicted for the MMA: program complexity, the heavy burden of user contributions, and the lack of a pharmaceutical policy based on efficiency or cost/benefit.

Complexity of the Regime

When the new regime took effect in 1997, Quebecers were confronted with a complex payment structure. The elderly were especially confused by the three elements of their payments (premiums, monthly deductibles, and co-payments), which varied according to the member’s age and employment status. The government’s lack of a communication strategy quickly became a problem, as pharmacists were left to explain the new system to a public often upset at learning that its portion of medication costs had just increased. Later, problems with accounting procedures became apparent when administrators realized that a loophole allowed beneficiaries to avoid paying several months’ worth of deductibles by stockpiling drugs. Ten years later, marginal changes have largely addressed these problems, but many Quebecers are still unaware that they have to sign up for public prescription drug insurance coverage.

The widespread misunderstanding of a complex program has also caused difficulty in the United States. After the MMA was passed, for example, policymakers were perplexed at low enrollment in the drug discount card program, which provided beneficiaries with up to US\$600 in free drugs per year in 2004 and 2005. Research later revealed, however, that only 24 percent of eligible low-income beneficiaries even knew about the benefit (Kaiser Family Foundation/Harvard School of Public Health 2004). This confusion is hardly surprising. Robert Pear of the *New York Times* wrote in 2005 that not only program beneficiaries but “Medicare officials were also confused” (Pear 2005b).

The enormous number of options under the MMA has made the system even more complex. Hanoch and Rice (2006) showed that in Los

Angeles County, the MMA offered eighty-five plans for users to choose from. Iyengar and Jiang asserted that when there is too wide a range of choice, consumers' "ability to choose is disabled, decision quality diminishes, and both financial and subjective well-being may be sacrificed" (2005, p. 22). In other words, it is likely that the MMA's complexity could cause seniors to make poor choices or even avoid making choices altogether, with deleterious consequences. Indeed, the data seem to bear this out: a 2007 Kaiser Family Foundation report pointed out that more than 10 percent of the Medicare population (between 4 million and 5 million people) still had no prescription drug coverage, despite qualifying under Part D. Furthermore, a study of Part D beneficiaries by the same foundation in 2006 confirmed that a majority of those interviewed felt overwhelmed and anxious by the magnitude of information provided them. Sixty percent wanted Medicare to select a handful of plans that met certain standards, so that seniors would have an easier time making their choice.

Several solutions to the problem of complexity in the MMA have been proposed. As the beneficiaries just cited seem to suggest, one such solution would be to reduce the number of insurers from which beneficiaries must choose. Another would be to have the government act as a plan broker for beneficiaries, just as many U.S. employers do for their employees. Yet another option would be to standardize HMO benefits, much as Quebec has standardized private plan benefits, in order to make comparisons easier. Requiring Part D plans to cover at least a predetermined list of drugs, for example, would mean less discrepancy among the various plans, enabling consumers to make a clearer and more informed choice. Providing effective decision support systems tailored to the elderly could also help. Under the MMA, sponsors of private plans are required to staff call centers that give beneficiaries the information they need to make an intelligent choice of plan. A study by the U.S. Government Accountability Office, however, found that only 34 percent of calls to such centers received accurate and complete information (2006).

The Heavy Burden of User Contributions

Quebec's regime requires beneficiaries to be responsible for a portion of their medication costs. For many individuals, this has been a departure from past practice. Before 1997, welfare recipients and seniors over age sixty-five who collected the maximum federal guaranteed income

supplement (GIS) received prescription drugs free of charge. Other seniors contributed C\$2 per prescription up to a ceiling of C\$100 per year. Under the new regime, however, user costs increased markedly: between 1995 and 1998, welfare recipients' average annual contribution rose from C\$0 to C\$81 and that of seniors went from C\$49 to C\$240.

However outrageous to certain Quebecers, though, these increases must seem marginal to Medicare beneficiaries, for whom financial costs under Part D are much more daunting. Approximately 20 percent of Medicare's 42 million beneficiaries are eligible for low-income subsidies that feature generous benefits with minimal co-payments or low coinsurance rates. But in 2006, the first year of the program, some 25 percent of beneficiaries are estimated to have spent more under the MMA than they would have spent in the absence of the legislation, for an average increase of US\$492 per beneficiary (Mays et al. 2004). Typical beneficiaries with high but not catastrophic drug spending were expected to have annual out-of-pocket prescription drug costs of around US\$3,600, or 12.6 percent of income, and drug costs for an elderly couple could easily approach 20 percent of their household income (Stuart et al. 2005). Furthermore, the MMA gap in prescription drug cost coverage (the "doughnut hole") is estimated to have affected between 3.8 million and 5.8 million beneficiaries in 2006 (Haislmaier 2005). Left alone to face up to US\$3,500 in out-of-pocket drug costs in addition to their premium payments, these individuals, of whom 850,000 have incomes below 200 percent of the federal poverty guideline (Price Waterhouse Coopers 2006), are among those with the most serious health problems.

Shortly after implementing its new program, Quebec commissioned a study of the impact of the higher personal cost of medication on the health of seniors and welfare recipients. The results showed that the new policy of cost sharing had resulted in a lower consumption of prescription drugs by the poorest and the sickest, especially the mentally ill. The data also showed a significant increase in these populations' frequency of doctors' visits, visits to the emergency room, and hospital admissions (Tamblyn et al. 2001). The RAND Health Insurance Experiment, published in the United States in 1984, found similar results: cost sharing had had a negative health impact on poor people with certain health conditions (Brook et al. 1984). Vittorio Maio and colleagues' review of the literature on the health effects of cost-sharing mechanisms further confirms that cost-sharing policies could have "adverse, unintended effects" for Part D enrollees (Maio et al. 2005, p. 123).

A solution to the negative effects of user costs on the poorest was adopted in Quebec in 1999 when the province passed a law exempting those unfit for work from all contribution requirements.¹ In July 2007, this exemption will be extended to another 280,000 low-income beneficiaries, bringing to 1 million the number of Quebecers with free access to drugs (Pratte 2007). In the United States, decreasing the amount of financial contributions asked of low- and middle-income seniors by expanding eligibility for sliding-scale premiums or exempting a greater part of the population from user fees might not only avoid negative health outcomes but also save money on hospital admissions and doctors' bills (Health Policy Alternatives 2003).

The Lack of a Comprehensive Pharmaceutical Policy

Quebec's difficulty in meeting spiraling drug costs is undoubtedly the program's most persistent challenge. In the first six years of the Quebec program, government spending on prescription drugs rose by an average of 15 percent per year (Santé et Services sociaux du Québec 2004, p. v), slightly more than the average per capita spending increases of 14 percent per year in the United States between 1998 and 2003 (Strunk and Ginsburg 2003). While a slightly older population needing more drugs and the greater availability of expensive end-of-life medication accounts for part of this phenomenon, the absence of measures promoting the optimal use of drugs also played a role. The Quebec program has no mechanisms to monitor appropriate drug use or the volume of drug consumption. Indeed, a 2004 study of seniors in the Quebec City area found that the prescriptions of 54.7 percent of patients may have been inappropriate in regard to drug interactions, wrong duration or dosage, or simply the wrong drugs themselves (Rancourt et al. 2004). Meanwhile, Quebecers had the most prescriptions per capita of all Canadians in 2003 and "purchased prescriptions for relatively more costly classes of drug within given broad therapeutic categories than did residents of the other provinces" (Morgan 2004, p. 330). In fact, while pharmacists in Quebec have long had the right to substitute generics for prescribed drugs unless the doctor specifies otherwise, therapeutic substitution (the substitution of a chemically different drug from the same therapeutic class) has been conspicuously absent from the public debate, despite known cost advantages to the public payer.

In counterpart, the MMA, also influenced by the drug industry, explicitly prohibited the federal government from establishing a drug formulary (Pear 2006) and using its purchasing power to negotiate better drug prices (Oliver, Lee, and Lipton 2004, p. 320), even though the Veterans Administration does both. The decision to ban negotiations was controversial and has not become more popular with time. A recent Kaiser Family Foundation report found that 67 percent of seniors surveyed strongly supported enabling the government to negotiate with drug companies for lower drug prices (2006b). On January 12, 2007, the new Democratic majority in the U.S. House of Representatives fulfilled electoral promises and passed a bill requiring the government to negotiate lower prices for Medicare beneficiaries. On April 20, however, Republican senators blocked a parallel bill.

The introduction of a national formulary and price negotiations with drug companies, however, are but two of a number of measures that have been developed to counter rising drug costs worldwide. An alternative strategy was adopted by the Canadian province of British Columbia (B.C.) in 1995, when an outcomes-based approach to prescription drug coverage was incorporated into the province's public drug benefit plan (Morgan, Bassett, and Mintzes 2004b). Under this approach, the inclusion for coverage of a given drug is determined on the basis of scientific evidence demonstrating a mortality or morbidity benefit. External researchers suggest that the policy has saved the provincial program "approximately 14 percent of program costs without generating the adverse effects often associated with typical cost-cutting strategies" (Morgan, Bassett, and Mintzes 2004a, p. 1232). A similar approach has been suggested by the Drug Effectiveness Review Project in the United States, which points out that federal funding of an independent clearinghouse for evidence-based drug reviews could help plan administrators make better decisions about what drugs to cover (and possibly streamline their choices for greater savings) without necessarily reopening the controversial question of a national formulary (see <http://www.ohsu.edu/drugeffectiveness/description/index.htm>; accessed June 15, 2007).

Another way to control costs is conducting public information campaigns such as the one that helped France reduce the use of antibiotics by 13 percent between 2002 and 2005 (L'expansion.com 2005).

Programs to educate the public about the cost and relative merit of different drugs have also been successful. Accordingly, a program like the MMA's Medication Therapy Management Service (MTMS), in which pharmacists and case managers work with patients to optimize drug use, could make a valuable contribution.

Neither of these last two possibilities, however, has been actively pursued in Quebec, despite the growth of drug costs in the province. Indeed, the province's long-awaited pharmaceutical policy, released in February 2007, revoked the non-increasing drug price policy of 1994 after pharmaceutical companies threatened to withdraw their products from the market. The policy promised instead to save money by imposing new price ceilings on reimbursements for generic drugs, amounting to 60 percent of the price of the name-brand drug for the first generic substitute and 54 percent for the second substitute and those that followed (Ministère de la Santé et des Services Sociaux 2007). The policy made no attempt to catch up to the rest of Canada by increasing its use of less expensive generics, and the fifteen-year patent protection rule remained untouched.

As stated earlier, the number of Quebecers exempt from all user contributions will rise to 1 million in July 2007. Given the provincial population of 7.5 million inhabitants in 2006, this figure brings to 13 percent the number of Quebecers who will soon have entirely free access to drugs. While annual increases in the costs of the public program have dropped in recent years, reaching only 6.1 percent in 2006 after an all-time high of 21.9 percent in 2000, drug costs still hit C\$2.58 billion in 2006 and accounted for 20 percent of Quebec's health care costs in 2005. For these reasons, the lack of more aggressive cost-containment measures is alarming.

In a recent article, the distinguished management author Henry Mintzberg questioned the rationale for high brand-name drug prices in the current market (2006). Referring to the 30 percent return on equity earned by the five biggest U.S.-based drugmakers between 1998 and 2000, Mintzberg claimed that governmental grants of monopolies in the form of patent protection, and not research and development costs, are what allow pharmaceutical companies to charge "what the market will bear." "Unfortunately," wrote Mintzberg, "what the market will bear is not necessarily what the ill can afford" (2006, p. 376). In the long term, it may not be what governments can afford, either.

Conclusion

During the 1990s, a number of member countries of the Organization for Economic Cooperation and Development (OECD) were confronted by the need to reform their health care systems in order to reduce costs. These reforms were principally oriented toward decentralization and de-hospitalization with a view to bringing down costs and eliminating government deficits. Negative side effects, however, led policymakers to look for ways to help the new regimes reconcile quality and cost-control objectives. It was in this context that Quebec's prescription drug insurance reform took place. While successful on many counts, the program continues to search for solutions, particularly with respect to cost containment. Indeed, some experts question the program's long-term survival in its current form.

Those involved in the implementation of the MMA in the United States face other challenges. The new prescription drug benefit is undoubtedly an improvement for many Americans. According to a recent Kaiser Family Foundation survey, 52 percent of those surveyed reported saving money with the new program (2006b). Another study estimated that approximately 9 million Medicare beneficiaries will have received financial help for their drug costs under Part D in 2006 (Kaiser Family Foundation 2006a). For many others, however, the results are disappointing. Eight percent of the sample surveyed reported having spent "a lot more" with Part D than they had spent without it, and another 6 percent reported having spent "more." Many of these are poorer individuals who must struggle alone to meet high co-payments because they do not meet the means tests of the law and therefore do not qualify for subsidies. In addition, more than a year into the new program, an estimated 4.4 million Medicare beneficiaries (10 percent of the Medicare population) still had no drug coverage at all (Kaiser Family Foundation 2007).

Despite its imperfections, Quebec's model of universal prescription drug insurance, provided within a public-private partnership, has succeeded on one crucial count. The drastic inequalities in access to drugs so condemned by the media in the mid-1990s are a thing of the past. For the vast majority of Quebecers, personal finances are no longer a barrier to prescription drugs, which, though unquestionably costly, are still seen by many experts as a relatively inexpensive means of preventing more serious health outcomes. In this sense, Quebec's move to simplify its

program and reduce cost barriers for the poorest while retaining coverage for all residents has been successful.

Cost control remains the weak link in Quebec's system and is also at the root of the current dilemma in the United States. Differences in politics, ideology, and government notwithstanding, policy constraints that were not dissimilar have in both cases resulted in the absence of pharmaceutical policies that address pricing and manage utilization fairly and efficiently over the long term.

In the article quoted earlier, Henry Mintzberg identified some of the factors that have kept comprehensive pharmaceutical policies from emerging thus far. It is his opinion that "because of the power of the industry and its influence on political processes," the situation will continue "until concerned citizens gather the energy to change it" (2006, p. 376). Stanford economist Victor Fuchs and E.J. Emanuel (2005) also believe in the possibility of reform despite existing constraints and evoke the prospect of a national health crisis (like a flu pandemic), a major war, or a "confluence of forces" as catalysts that could help achieve it.

Such a confluence resulted in the coverage of the entire population of Quebec in 1997, in a program that was the first of its kind in Canada. Another confluence brought improved prescription drug coverage to many older and disabled Americans in 2006. With so much already achieved, cross-national policy learning may be one of the tools that will allow both programs to progress even further, so that Quebecers and Americans alike can enjoy the positive health benefits of prescription drug programs that balance the goals of equitable access, a healthy and innovative pharmaceutical industry, and cost containment.

Endnote

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