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

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

Marie-Pascale Pomey, Elisabeth Martin and Pierre-Gerlier Forest

July 2005

Table of Contents

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

In order to analyze the political factors that led to the policy decision to implement a public prescription drug insurance regime, we conducted 19 interviews with individuals who had either participated in the political process at the time or who were members of an organization involved in the process. We also reviewed the entire body of literature published on the question since the 1970's, focusing on various published reports on the question of prescription drugs as well as on those proposing reform to the regime of the time.

After presenting an overview of the insurance regime, we will analyze how the conception of the idea for the regime came about and the reasons for which it came to be put on the governmental agenda. We will also analyze the political choices that occurred as a result. An evaluation of the regime and an analysis of the reform will follow.

OVERVIEW OF QUEBEC'S PRESCRIPTION DRUG INSURANCE REGIME

Before the implementation of the prescription drug insurance regime, medication was provided to hospital patients free of charge. In certain cases, non-hospitalized patients also benefited from prescription drug coverage.

Firstly, individuals having access to group insurance plans through their employers were eligible for complete or partial reimbursement of prescription drug costs. Drugs covered, the amount of the premium and coverage of family members varied according to the insurance policy. In total, group insurance plans covered approximately 4 and a half million people.

Secondly, seniors over the age of 65 (as of 1975), welfare recipients and unemployment insurance recipients (as of 1970) received prescription drugs free of charge. For these cases, drugs were provided by the Régie de l'assurance maladie du Québec (RAMQ). As of 1992, seniors were required to contribute $2 towards costs.

Finally, in 1973, a decree known as the "Outpatient Circular" extended coverage for all prescription drugs to victims of certain serious illnesses (including victims of cystic fibrosis, cancer, severe psychiatric disorders, insipid diabetes, tuberculosis and hyperlipoproteinemia) when these patients were treated outside of a hospital. This decree allowed cancer patients, for example, to continue to obtain expensive medication outside of hospital stays.

January 1st, 1997, marked the beginning of a universal mixed prescription drug insurance regime (public and private). The regime is considered "universal" because it covers all Quebec residents and "mixed"

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

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

2- Membership in the public or a private regime was decided according to certain criteria and circumstances. Individuals already covered by a private plan provided by their employer as part of a group benefit were required to remain affiliated to that plan. Upon retirement, individuals could either switch to a public plan or remain with their private plan. In 95% of cases, they switched to the public plan; 5% continued private coverage with their employer. Individuals already covered by the public insurance plan, that is to say seniors and welfare recipients, continued their coverage under the public plan. All new clients (workers without access to a group insurance plan through their employment, the self-employed) were automatically included in the public plan: this group made up the plan's membership. The number of such new members was estimated at 1.2 million.

3- The prescription drugs covered by the prescription drug insurance regime were registered on a list drawn up by the *"Conseil consultatif de pharmacologie"*, a pharmacological advisory board. This list applies to persons covered by a private plan as well as to those covered by the RAMQ.

4- The regime is funded from three sources. Firstly, each members is required to pay a premium to the insurer. The amount of the premium is calculated as a function of the member's income, and varies from $0 to $521 per adult according to net family income for the period going from July 1, 2005, to June 30, 2006. For the period of July 1, 2004 to June 30, 2005, the amount of the yearly premium varied from $0 to $494. Secondly, the insured party must contribute to the cost of purchase of each prescription, paying both a deductible and a coinsurance payment that do not vary according to income but according to whether one is a plan member, a welfare recipient or senior. The deductible is "a fixed amount which makes up an initial portion of the cost of prescription drugs and is payable by the insured party upon purchase of covered prescription drugs". Under the public plan, the deductible is a monthly amount. Under most circumstances, the deductible is entirely paid when an individual fills out his or her first prescription in a given month. The coinsurance payment, or co-payment, is the percentage (or the portion) of the costs of medication that the insured party must pay once the deductible has been reached. In other words, when the cost of the medication exceeds that of the deductible, the insured party pays only a portion of the surplus. This portion is termed the coinsurance payment.

The percentage of the coinsurance payment required by the public regime is adjusted on July 1st of each year.

THE GOVERNEMENT AGENDA (AROUND 1992-1993)

An analysis of the published literature and of interviews conducted for this study shows that there was little interest prior to 1992 in the question of the implementation of a public prescription drug insurance regime. For example, there is no mention of such a plan in the report of the Rochon Commission in 1988, in the law on health and social services in 1991, or in the health and welfare policy (Politique de la santé et du bien-être) of 1992.

The issue of prescription drugs made its first real appearance around 1992-1993. The question was first brought up by means of the Outpatient Circular. Dating from 1973, this decree allowed victims of serious disease, when treated as outpatients, to continue to receive free medication as if they were still in hospital. The medication was provided to them free of charge by the hospital following their case.

For a number of years, however, the number of diseases for which medication was provided free of charge had been growing. At this time, two problems became evident. Firstly, more and more groups of patients were demanding that their disease be added to the list of diseases for which medication was covered under the plan. Secondly, the selection criteria for diseases making up the list had not been clearly defined. As a consequence, certain diseases were included and others were not, depending on the lobbying weight of the patients' associations and their ability to put pressure on the government. The result was a situation of untenable injustice that came to be known as the "loterie de maladies" ("disease lottery").

> "The real problem, the straw that broke the camel's back was the problem of unfairness. There was a kind of… patients' lobbying groups forming at that time. Because insurance coverage of prescription drugs was handled a bit like a lottery. If you picked the right disease, you had total coverage, because coverage was complete. Patients only paid a deductible of $2 to the institution when they received their medication. But if you had another disease, in some cases even a disease pathologically similar to the covered one, you had no coverage at all. The rules had in fact been made somewhat piecemeal…" (AM-17)

> "The attitude at the time focused on "disease". So what set things off was the name of the disease. It came to mean that a given disease was considered more expensive to treat, sadder, more tragic, than another. So a kind of judgment was taking place, that meant that treatment for some diseases was free or that the medication for those diseases was covered, whereas the same medication, in another situation, was not covered." (AM-11)

> "That was one of the problems. In my previous example, if – I don't know – let's say a person suffered from a genetic history of high cholesterol, the fact that he had that particular disease meant, at the time, that he had the right to free prescription drugs. But his neighbour, who suffered from high blood pressure, was diabetic, had cardiac insufficiency, was asthmatic, was diabetic and all that, whose medication cost even more, and whose income might be less – he didn't have the same right. So, there was --- it was discrimination…" (AM-03)

> "That was what Demers was describing, a kind of patchwork system. Instead of continuing to think along those terms, let's try something else, instead of continuing to focus on the disease as the criterion – a specific disease as the criterion for coverage, let's consider a criterion that's more fair or less unfair, like the capacity to pay." (AM-11)

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

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

> ”We were in the middle of … we still are, but I’d say that the evolution… the evolution in the science of prescription drugs was significant. Costs started to rise and many patients who didn’t have access to free medication via the Outpatient Circular now demanded that the ministry provide them access as well. In the meantime, hospital pharmacists had to serve those patients in addition to the usual patients without there necessarily being an increase in personnel or an increase in budgets.” (AM-14)

> ”All medication was free at the hospital, but from the moment you left the hospital, you lost your free medication. It was obviously worthwhile to get your doctor to commit you to hospital. It was crazy.” (AM-06)

The public discontent with respect to the Outpatient Circular was such that the minister of the time, Marc-Yvan Côté, went so far as to threaten to abolish the decree entirely.

> ”Well, like I said at the time… at the time, at a certain point, to address the problem of unfairness, we said… we said, “OK, we’ll just abolish the Outpatient Circular.” Which in my opinion was unrealistic. It was unrealistic because the institutions, the hospitals had always been a last resort in any event, so they were still there when the patients didn’t have a penny left, it was as if we were back in the 40’s, the 50’s, the 60’s, it really wasn’t anything new.” (AM-14)

> ”So the first political decision took place. It was in 1993, they decided to scrap the Outpatient Circular, because of the pressure to extend it, to extend it and on what criteria to choose a disease or a problem. It was a lottery… a lottery of disease.” (AM-07)

Other developments also played a role in convincing the government to consider the implementation of a prescription drug insurance regime. Firstly, the appearance of AIDS and the introduction on the market of especially expensive medication that could potentially save lives.

> ”But what also happened was triple therapy for AIDS, so that instead of taking one drug, they took three, which tripled costs and given that there were more people being treated for AIDS than there had been before, so it’s … Beforehand, people died, now they didn’t die anymore, which meant at least a thousand dollars’ worth of drugs per month, per person. So if you keep them from dying, well now it’s starting to cost you.” (AM-04)

Secondly, budgetary difficulties that had begun to affect social programs in the 1980’s sought a a solution in a shift toward ambulatory care. Such a shift was all the more interesting in that advances in technology, in particular the introduction of more powerful drugs, allowed treatment to take place in new ways. It was in fact no longer necessary to treat certain illnesses in the hospital:

> “To make a shift towards ambulatory care, to modernize the health system, a public prescription drug insurance regime was absolutely necessary, because outpatient care meant that hospital services were reduced, that the duration of hospital stays was reduced

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

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

> "In my view, the fact that it took place as quickly as it did, that it made it so quickly onto the political agenda, was because, like I was saying, the key was Mr. Rochon's strategy for the reform of the system. Without that, they could have …. A shift towards ambulatory care was only feasible if there was a change in prescription drug coverage. In his head, you couldn't have one without the other and that's why his hardest fight was to make sure that at least this condition was met, because if not, he wouldn't have been able to tell people: "Leave the hospitals. You'll get the same service in primary care, in the CLSC's, in doctors' offices", because there would still have remained the problem of no coverage of prescription drugs." (Am-06)

> "Yes, the new medication which was more expensive, plus the fact that it was good. Drugs are a kind of technology, technology that benefits human health. You get out of the hospital sooner, but you take more medication. There you are! All of that makes it expensive." (AM-07)

Lastly, it was clear that covering prescription drug costs for welfare recipients didn't encourage them to find work. Indeed, "it had become a major obstacle to people, as they say, getting off welfare" (AM-13): if they earned more income, they had to assume the cost of their medication. It was evident, too, that households allotted a large portion of the family budget to prescription drugs:

> "It was clear that medication had become… had become a heavy burden on households in Quebec, for families in Quebec, and what people were saying at the time, what they were arguing, was that we were making significant investment in diagnoses with top-of-the-line hospital equipment, we were investing… we were making significant investment in medical care, and the ultimate means of treatment was often pharmacotherapeutics. Patients were frequently unable to access to this service…" (AM-14)

It also became evident that there was no centralized record of the pharmacological history of patients and that there was inadequate continuity of care:

> "Major problems of coordination. Nobody was in a position to draw up a complete pharmacological history of the patient. The doctors, especially the family doctors or the patients' doctors, didn't have access to complete information about the patient's various medications. And they couldn't always count on the patient to… especially in cases of the mentally ill, to provide the information. So, there was that problem, a problem of continuity of care." (AM-17)

Finally, in 1992-1993, internal memos at the Ministry of Health and Social Services (MSSS) initiated the concept of a prescription drug coverage regime.

> "I'd say that there were internal memos. The concept first came about that way. Afterwards, committees were created, committees of civil servants." (AM-11)

THE DECISION-MAKING AGENDA (1993-1995)

It was thus that a liberal government, led by Daniel Johnson, created the Demers Committee in November 1993. The government of the day felt the need to put a prescription drug insurance regime into place but had no ideas on the means to do so. It was on this occasion and by this step that the government of Quebec implicitly recognized the existence of a problem of drug coverage for Quebecers. In fact, the mandate of the Demers Committee[1] was clear: "to suggest possible ways to improve fair access under the Outpatient Circular" (source: press release announcing the creating of a committee for the review of the decree – November 24, 1993).

The Demers Committee submitted its report in April 1994, revealing problems of flagrant inequity attributable to the Outpatient Circular. "Indeed, the existence of this decree can only be justified because the makeup of our social safety net is still incomplete" (p. 36). The report recommended eliminating a system of assistance in favour of a catastrophe- or emergency-type insurance system that would apply to the entire population: "Our proposal is more modest: it consists of extending to the entire population reasonable economic access to a list of prescription drugs, given that such access is necessary – but not sufficient – to continue to improve health for all." (p. 26)

Submission of the Demers Report was followed by an informal political consensus on the need to implement an alternative to the Outpatient Circular.

> "Well, I'd say that from the time they started to make committees, the Demers Committee, that meant, if you ask me, that there was a problem and they wanted to find a solution." (AM-11)

In order to go beyond the recommendations of the Demers Committee and to evaluate the feasibility of inaugurating a prescription drug regime, the new Minister of Health, Jean Rochon[2], of the Parti Québécois, appointed Reynald Gagnon to analyze the feasibility of introducing a basic universal prescription drug insurance regime in Quebec. The report was assigned to the RAMQ so that the RAMQ could realistically evaluate how it might administer such a regime.

It was thus on May 17, 1995, that the RAMQ submitted its internal report analyzing the possibility of introducing a universal public prescription drug insurance regime. Once again, the report identified the need to replace the actual system of prescription drug insurance. The report argued that the implementation of a universal regime was feasible. In terms of health and social equity, it was the best choice:

> "With respect to our greater goals in the matter of health, a universal prescription drug insurance regime is the best option for the population of Quebec in both the medium and the long term. It would promote fairer access to medication, it would promote the optimal use of medications and it would reduce the practice of having recourse to hospitalization and welfare in order to fund the cost of prescription drugs. The use of a regime limited to situations of great risk, such as a catastrophe-type regime, would encourage the shift towards ambulatory care and facilitate a transition from the existing system. Politically and financially, however, the stakes are high. To propose a universal public regime goes against the government's budgetary policy and the fact that the role of the state in the economy has been called into question. " (Rapport Gagnon, p. 88).

The report was clearly skeptical about the feasibility of the project in political and financial spheres. Insurers were important actors in the Quebec economy and some insurance companies were "home-

[1] Jocelyn Demers is head of the Department of hemato-oncology at Ste-Justine Hospital and is well known for his long-standing commitment to the cause of cancer, especially in children.
[2] Jean Rochon was named Minister of Health in September 1994.

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

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

During this time, other actors were also expressing dissatisfaction with the situation and proposing alternatives. Hospital directors, hospital pharmacists and the Hospital Association of Quebec denounced the financial burden borne by the institutions responsible for applying and implementing the Outpatient Circular at the same time as hospital budgets were being cut (AM-14, LA-01). Interest groups representing victims of chronic illness not covered by the Outpatient Circular also demanded change to the system (AM-09).

Other actors, in contrast, remained in favour of the status quo: in particular, private insurers who covered people whose risk was relatively low and who hoped to one day become important players in their own right within the Quebec health care system.

Still others, without being completely in favour of the existing state of affairs, did not support a change to the system either. Representatives of seniors resisted the change because seniors benefited from almost complete coverage of their medication costs. In addition, individuals whose illnesses were covered under the Outpatient Circular tended to resist a change. They knew what they would lose but not what they stood to gain.

The informal political and administrative decision to put in place a mixed system with member contributions took place after the submission of the Gagnon Report, but before the naming of the Castonguay Committee. At this time, significant budget pressures were weighing on the indebted public prescription drug system and the government needed "fresh funds".

> "But I think that in 1994 or 1995, the decision to do something, to divide the bill, had already been made, so we needed to figure out an acceptable political means or other way for the population to split the bill." (AM-04)
>
> (With respect to the mandate given to Mr. Castonguay by Mr. Rochon). "Look, he was probably…he had probably figured out his own kind of bottom line, as in, "Don't show up with free insurance for everyone. We can't afford it." (AM-11)

So it was that within three years, three reports were published consecutively, all addressing the question of introducing a prescription drug insurance regime. This series of reports was influenced by several factors:

1- Discontent with respect to the Outpatient Circular

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

2- The concern of the separatist government to find a more equitable system.

> ”Discrimination on the grounds of disease had become intolerable.” (AM-03)

3- The appointment of a minister with a degree in medicine and a specialization in public health.

4- The need to have coverage of prescription drugs in order to bring down hospitals costs and to promote the shift towards ambulatory care. Access to medication needed to follow patients out of the hospitals.

5- The government’s commitment to reach a zero deficit as soon as possible.

6- The accumulated deficit in the budget funding medication of welfare recipients and seniors.

7- Differing opinions within the government. Health Minister Rochon was in favour of a universal public system, while the president of the Treasury Board was in favour of a mixed public/private system.

Furthermore it can be said that putting the issue on the government’s agenda was the result of a strong political commitment to forward the prescription drug portfolio. The phenomenon was given impetus by the election of a separatist government that wanted the province to be the first to introduce this type of coverage, as well as by the presence at the Ministry of Health of a health minister very much aware of problems of public health who was also familiar with other systems of protection in the field of prescription drugs as a result of his experience at the World Health Organization. The minister had been successful in having prescription drug policy reform included in the electoral platform of the Parti Québécois for the 1994 campaign.

> “Ah!, well I think that Jean Rochon believed very much in social values, but he was made to deal with financial realities as well.” (AM-04)

> “It had to be sold as part of a greater project. And that’s how it was sold. So, I think that if there had only been the Outpatient Circular that didn’t work, well, there were its programs, etc., I’m not sure that it would have become a immediate priority for the government. There might have been some tweaking, some tinkering with the machinery, but it wouldn’t have become a new vision for society the way it did. Let’s say… let’s say that the timing was… the timing was right. Even though the timing was only right for Quebec. None of the other provinces came on board.” (AM-06)

> ”In the political process and the decision process, there was at that time Marc-Yvan Côté, there was Dr. Rochon. Jean Rochon who was the Minister of Health. It was he who… it was really he who carried the project. It was he who at a certain point said, ”Yes, look, let’s do it, it’s a good idea. ” The circumstances lent themselves well, there was, like he said, well informally the entire administration, that is to say the Premier, the Ministry of Finance, who were all aware of certain advantages in the immediate short term. ” (AM-07)

Putting the project on the political agenda took place at the same time as the Castonguay Commission studied several alternative scenarios supported by different pressure groups and actors within the health system. In all, four principle scenarios were on the table.

The first scenario consisted of introducing a *Universal Public Regime* with or without user contributions. This strictly public regime was to be funded by global taxes. It had been suggested by the Gagnon Report, which had retained it under certain conditions.

A universal public regime had the further support of consumer advocacy groups, health professionals such as pharmacists and individuals who leaned to the left on the political spectrum.

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

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

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

There were therefore three principal reasons for which this first scenario was all but impossible. Firstly, private insurance companies in Quebec represented an important interest group and were significant employers. Secondly, to antagonize community pharmacists was not good strategy. Their collaboration was crucial to the implementation of a new system. Thirdly, a purely public system would mean transferring the payment of premiums from companies onto individuals. The private sector was then paying $895 million in the way of prescription drug insurance premiums: covering these funds would mean increasing taxes, which was politically unacceptable.

> ”One scenario, of course, which had been on the table since the start, was an essentially nationalized prescription drug insurance system, whereby coverage would be provided by the Régie de l’assurance maladie for all of Quebec. It was eliminated by the Castonguay committee, which said: ”An important part of the population is already covered by private insurance. It works well. Plus, it’s an important industry.” And to nationalize that industry would have come at a cost to the government, a cost that the Castonguay committee evaluated at approximately 400 million dollars.” (AM-17)

> ”They brandished the private insurers, because they brandished job loss. They did the same thing as the pharmaceutical industry, they brandished job loss and the fact that it was too complicated because of negotiating with each employer.” (AM-04)

> ”It was one of the principal points. I think it came down to finances. You can’t kid yourself, it wasn’t the social debate, that was there just to sweeten the pill, but it was a dossier for me, it was financial, looking back that was what it was. It was financial because decisions about promoting optimal use of drugs and making sure that people had access to the medication they needed, take backseat to economic development and economic survival.” (AM-04)

> ”The pharmacists, I think they wanted to avoid a regime that was 100% public, because they price drugs differently for members of private plans and also because their professional fees were different for the privately insured.” (AM-04)

The second scenario consisted of the implementation of a *Universal Private Regime*. Private insurers would be called upon to ensure all Quebecers including seniors and recipients of social assistance.

This scenario was dismissed by insurers who did not wish to inherit all candidates for coverage, particularly the insolvent or those with significant medication costs. They were seriously doubtful of the likelihood of their receiving payment of the premium from unemployed individuals.

> ”The insurers, at that time, they weren’t particularly enthusiastic about the idea of inheriting clients that were on welfare, clients who were seniors or who didn’t have coverage, because first of all, these people didn’t have any money, plus how do you go about collecting the premium?” (AM-07)

> ”So the private insurers weren’t ready to become volunteers and philanthropists. So they said, “As for philanthropy, we’ll leave that to the government of Quebec, let the government take the most precarious clients, because they’re the most expensive, and we’ll take the rest.” (AM-04)

> ”When they were offered additional clients, when they were invited to discover another client base which were the 1 200 000 people estimated at the time, but after that it turned out to be 1.4 million, they turned it down. They said, ”No, we don’t want them.” In that sense, they were an important actor because they said ”No.” They were crucial in the sense that Minister Rochon then asked Mr. Dicaire, ”Could we take on this client base ourselves tomorrow morning?” (AM-07)

The third scenario consisted of implementating a *Catastrophe (Emergency) Regime*. The government would be in charge of covering the cost of medication for people whose health problems generated expenses greatly exceeding their capacity to pay. Over and above a given threshold, calculated as the total amount of medical expenses or as a percentage of income, the government would assume all costs of medication. This regime was comparable to that which already existed under the Outpatient Circular, but discrimination would be made according to income (capacity to pay) and not according to disease. For this reason, hospital pharmacists were opposed to this scenario. Seniors were more or less in favour, as were the Hospital Association of Quebec and the insurance companies.

The fourth and final scenario consisted of the implementation of a *Universal Mixed Public/Private Regime.* This regime allowed private insurers to coexist with a public insurer, the RAMQ. Individuals would be assigned membership in one of the two systems according to their employment status: individuals employed by large companies that already offered coverage would continue to be covered via their employers, while the rest would be covered by the public system. This scenario was strongly supported by the private insurers who nonetheless wished to limit this mixed system to a mixed catastrophe system. The implementation of a mixed system allowed them to keep their market share without having to take on new clients who might be “bad risks”. There was however some debate with respect to the clientele known as members. A segment of this population could in fact be an interesting clientele for private insurers; for that reason private insurers would have preferred that this population be permitted to choose between membership in a private plan or in the public plan. The Castonguay Report even suggested that the RAMQ and private insurers compete to cover this clientele, as a means to bringing down prices. After studying the numbers provided by the pharmaceutical industry, however, the government determined that it was better for the public system to cover all members, at least for the short and medium term.

> ”There was a whole world of the Quebec insurance industry that existed, that worked, that worked well, that was important for the economy in the province… to decide to go with a purely public system… for sure you’d kill a part of the insurance industry. It would surely have had… repercussions for the economy. Well. That was probably a consideration. There might have been a question of costs, that is to say that people might have believed

> that by going with a mixed system like that, it would be better for the costs of the program for the government." (AM-16)

In general the pharmaceutical industry was in favour of the most universal system possible. Still, the industry didn't want to have to compromise its ability to innovate. For that reason it opposed from the beginning a specific prescription drug policy that would have regulated medical prescriptions, by setting a standard price by therapeutic category, for example, or by allowing pharmacists to make substitutions for drugs.

> "But from the moment that there was a list of prescription drugs that was relatively extensive, that there weren't drastic policies about standard prices for drugs, for example, or a policy on required, comprehensive drug substitutions, from the moment that those policy ideas were allowed to drop, the pharmaceutical industry could continue to evolve**."** (AM-17)

THE POLICY CHOICE (1995-1996)

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

The arguments for a mixed public/private regime

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

1- The unique situation of the pharmaceutical industry in Quebec

Quebec is in a unique position compared to other provinces. Whereas generic drug producers are mostly situated in Ontario, the majority of head offices of large innovative pharmaceutical companies is located in Quebec. Historically, Quebec has always supported the pharmaceutical industry, making it a major employer of significant economic weight.

> ”But also, the pharmaceutical industry… Quebec is kind of special. It’s the most progressive province in terms of its prescription drug insurance regime, but it’s also the friendliest to the innovative pharmaceutical industry.” (AM-06)

The government had encouraged pharmaceutical companies to set up headquarters in Quebec by offering tax credits (federal and provincial), economic advantages and various subsidies. Other measures had also been put into place with a view to ”protecting” the original drug market: patent protection for 15 years and the absence of a policy to buy drugs at the lowest price. The pharmaceutical companies used all kinds of means to alter molecules in order to obtain patent extensions (patents are regulated at the federal level) and to have ”new” drugs included on the list. Quebec’s list of covered drugs was the most extensive of the provinces. This situation put the government of Quebec and the industry in an unusual balance of power. Medication may be a “good” in terms of health, but it is also an economic good and a source of employment in Quebec. Now, the pharmaceutical industry had the benefit of three lines into the government: the Ministry of Health and Social Services, the Ministry of Finance and the Ministry of Industry. The position and objectives of these ministries with respect to the pharmaceutical industry were often contradictory. In addition, the pharmaceutical industry had assumed an important role in the continued education of doctors by financing a number of training workshops.

2- The unique situation of private insurance companies in Quebec

A sizeable community of insurance companies is located within the territory of Quebec. Many insurance companies are based in Quebec and are part of the provincial identity. They also constitute an organized pressure group with major economic weight. Close to 90% of insurers belong to the *Canadian Life and Health Insurance Association.*

Group prescription drug insurance plans constituted an important market for insurance companies in the province. It was therefore important to protect this private market while also finding a way for the public system to continue to provide coverage for its regular, more vulnerable clients (seniors and the poor) in order to avoid any selection of bad risks. The project therefore envisioned the creation of a regime that would permit the co-existence of the private and public sectors.

If tt was politically and economically unthinkable to deprive private insurers of existing clients, it was similarly unthinkable to reduce the list of covered prescription drugs in order to bring down costs and reach goals of budget cutbacks. The impacts would have been too great for both the pharmaceutical industry and the population as a whole.

> ”But SSQ General Insurance and the Blue Cross, and all of them, they were companies that were very much entrenched in Quebec, they were Quebec companies. And they were companies that were very very active in the group insurance market, who knew that they would lose an important market if it were to become completely public, and I think that given that these were homegrown companies, the government acted very sensibly. It would kill … it would kill a good part of the insurance market… of private coverage in Quebec. So I think that, that there were considerable financial considerations…” (AM-14)

> ”So the big players in the insurance industry, which were SSQ General Insurance, which were the Groupe Desjardins, Industrial Alliance… all came before the parliamentary commission before Rochon, and they said, ”Think twice. Because what you are talking about, here, is to nationalize a whole sector, and there are companies in there, there are jobs that have to be protected, and that’s not going to happen at no cost to the government. The economic fallout will be major.” So, the government of course ran the numbers… looked at the numbers, and decided to keep a private system”. (AM-17)

> ”Of course. And the minister never tried to deny it. It’s that… that the private insurance industry, an industry that was active in Quebec, like it is in other provinces and in North America, so for him, there was no question… that he would deprive them of… of... that market, that role, that involvement.” (AM-11)

3- The economic motivation

The regime covering seniors and the poor was in debt. It was therefore important to replenish the coffers and attempt to make the system as self-financing and as inexpensive as possible. These were the motivations for the concept of a financial contribution by users and the inclusion of recipients known as ”members”. Choosing a mixed system meant that the costs would be shared by the public and the private sectors by means of a system that had already come to be known as a public-private partnership.

An additional concern had to do with the increase in costs of new medication for the treatment of new diseases. By introducing a mixed system requiring a contribution, thereby splitting the bill with the private sector and users, it remained possible to offer reasonable and fair coverage for all having to address the question of a specific policy respecting medications.

> ”What speeded up the process was that the introduction of an increased contribution at the time of purchase and of a premium payable by clients of the public system decreased the pressure on the public finances, because, of course, with respect to the hospitals, the pressure was building and so on, plus there was… even with respect to seniors, the poor, the upward spiral of costs had already begun. The introduction of a greater financial contribution, a premium, cut down on expenses.” (AM-07)

> ”So there were important budget considerations. The minister never denied it, everyone knew it.” (AM-11)

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

4- The question of equity

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

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

The goals of the government

By introducing this regime, the government hoped to attain three goals:

1. Providing fair and reasonable access to prescription drugs to all Quebecers.

The government wished to allow *reasonable* access to prescription drugs while retaining a measure of control. Accordingly, only drugs entered on the list of the Ministry of Health, upon the recommendations of the pharmacological consulting committee (now the Medication Council -- *le Conseil du médicament*) were covered. The government also wanted *equal* access to drugs, independent of income. In short, the government did not wish income to be an obstacle to drug consumption. The greater goal was to eliminate all discrimination based on age, gender and state of health. The government therefore wished *all Quebecers* to have the benefit of coverage. It had become evident that in order to obtain free medication, some individuals had chosen to be on public welfare.

2. Promoting the optimal use of medications.

At the beginning, Minister Rochon had wished to introduce a specific policy respecting medications at the same time as the implementation of the insurance regime, with a view to limiting the increase of costs. His desire to advance the project quickly, though, and to implement the regime as soon as possible, forced him to make significant concessions and specifically avoid antagonizing the pharmaceutical industry. For this reason little emphasis was made, in the end, on the implementation of a policy respecting medications. The only part retained was the role played by the pharmacological consulting committee, which established a list of covered prescription drugs for which the entry criteria were based on clinically proven effects.

3. Providing for the financial contribution of insured parties.

An important part of the reform was the modification of the public regime from one of public assistance to one of insurance/assistance (while retaining a component of pure assistance for the most needy) that provided for a premium that varied according to income as well as cost ceilings, coinsurance payments and premiums that were indexed. This modification to the regime allowed the introduction of a financial contribution by insured parties, in order that the system might be self-financing but also in order to pay off the deficit of the prior program, which had assumed the costs of medication for seniors and the poor. The plan covering seniors and the poor was in fact $240 million in debt. By adding a client base (the members), pooling of risks allowed for the replenishment of state coffers. The amount of the premium charged at the beginning of the regime in January 1997 was fixed at $175. In truth, even as the amount was fixed, the government knew full well that it was too low to adequately fund the regime. It was a means of selling the regime politically.

> "The first hurdle for the government in its attempt to square the circle was to determine a premium for those people. And that's where you have the prophecy of the private insurers

> who had told the government, ”You’re going to have a tough time selling this because you are trying to reconcile insurance and social assistance. ” And that’s where the government and Dr Rochon had their first real test about that: ”What do we... what do we set as a premium? Because if we set a premium based on… on… with the idea of actuarial logic, for insurance, then we’ll base it on current market premiums. ” These premiums were of course high because they covered clients who were on welfare, who were seniors. So right there the government had a difficult choice to make. It leaned on the side of social assistance, the social commitment of the government, by setting a relatively low premium, which at the time was $150. And by doing so, by setting its premium much lower than the market, it made the project much more attractive to the public.” (AM-17)

Implementing the regime

The subsequent implementation of the policy decision and specifically of Quebec Drug Insurance Act (“Loi 33”) was mostly left up to the RAMQ and its then-President and CEO, André Dicaire. In fact, the RAMQ acted as principal architect of the operational and logistical aspects of the regime, in close collaboration with community pharmacists. Together they had a period of 6 months to put together a new regime, the law having been passed in June 1996 and been slated to come partly into effect on August 1, 1996, and totally into effect on January 1, 1997: ”We had to put together a whole computer system, to get pharmacies online or in real time, it was done in six months.” (AM-13)

> ”We had very strong, very concrete support by the Régie de l’assurance maladie. The key figure was Mr. Dicaire. He really came on board for that project. And he came on board both for both strategy and organization. And you know, it’s tough to be against that kind of project.” (AM-06)

> ”But because the administration and political circles found it worth their while, there was a kind of speeding up… I’m not saying that they cut corners; things just got speeded up because everyone within the apparatus had something to gain. The health minister because the clients would be better off, the administration because of the increase in funds, the politician… just name them. To such an extent that at the time that the law was being made and being written, and getting passed and all that, it was crazy because it went very quickly.” (AM-07)

Amidst all the actors directly involved in these changes, the community pharmacists were front and center. They had to clear up the muddle created by the implementation of the regime and more particularly they found themselves having to explain the changes to the population. Seniors and for the poor were hurt by the changes because they went from paying almost nothing for medication to having to pay a co-payment and a premium. The government and the Ministry of Health were openly criticized for the lack of a communication strategy that would have explained changes to the system and the effects that the changes could have on people who had been covered in the past. Confronted with the distress of some individuals, some pharmacists even advanced them the cost of their medication.

> ”Because I want to say that the pharmacists were key actors. They might have been a little… and they say it themselves, let’s be clear about that, a little…, ”a little hurried along”, shall we say.” (AM-07)

> ”So the pharmacists were paying for the regime and they were sick and tired of paying for the regime, it was already a gamble and also people sometimes… people on welfare don’t always lead a stable life, they often have to move. So pharmacists wouldn’t see them again and they’d lose… they’d lose a lot of money and so…” (AM-04)

The policy on the sharing of costs was introduced in three stages: 1) the introduction, in August 1996, of a coinsurance payment of up to 25% of the total cost of prescription drugs, with a maximum contribution set

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

AN ASSESSMENT OF THE REGIME AND ITS FUTURE PROSPECTS

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

> "If we look at the goals of fair access and of equity, but if we want to be… if we want to be objective, I think that the regime achieved a part of its initial goals of fair access and equity. So, for me, that's a plus… I find that a plus. As I was saying, the arrival on the scene of the private sector with its requirements helped to achieve those goals, at least. Of course, from a financial and economic point of view, it's a catastrophe." (AM-14)

> "Everyone seemed to agree that it was a significant social accomplishment, one they wanted to keep, in fact that's the title of one of the reports evaluating the regime: *A Social Accomplishment to Protect (Un acquis social à preserver)*. So, at a basic level, the protection, the fair and reasonable access is a principle, just like health care, it's an accomplishment … In fact it's part of election platforms and so on, provincial elections … So the health care system, we want to keep it and, realistically, the politician who'd say tomorrow, let's terminate the prescription drug insurance plan, he would be very badly received. The advantages and the benefits that we get from it, everyone… I think there's a consensus on that. " (AM-07)

Principal difficulties

A certain number of problems have been identified thanks in part to the various reports commissioned on the issue (Tamblyn et al., 1999):

> "Listen, at that time, it had been a year and a half that the regime was in place. There were two major concerns. In a certain way there was the group of people… which had lived with the new regime for a year and a half, but which beforehand had been used to receiving their medication free of charge. This group was made of up welfare recipients and seniors, and they put a lot of pressure on the government to modify certain aspects of the regime. The other kind of concern that there was, which was more on the side of the government, was the exponential increase in costs, in the order of fifteen to twenty percent. Now, I don't know if you realize this, but this wasn't a regime of a hundred million dollars that was increasing by twenty per cent, it was a regime of more than a billion. So that made it … an expense, an enormous pressure on public finances. And that's, that's … we were seeing it. And at the time the regime was put into place, nobody thought that things would spiral like that. And a year and a half later, well I said nobody thought so… that's not right. Yes, there were people who had said right from the start that it was going to be more expensive than that. The insurance industry in particular said, "It's going to cost more than that. " But, well… the government didn't think, I don't think, that it would go so far, that the costs would spiral so far. So there were two basic concerns: the first more to do with social equity and the idea of… do we… are the poorest being properly treated? And the other was, "What do we do about this spiraling of costs?" First of all, the increase had to be understood, shored up, taken a look at, disclosed to the government itself, gotten a grasp on by saying, what do we do about this, where is this coming from, what's going on. Anyway. So those were the two major concerns of the study. And what came out of it was better coverage for welfare recipients who were truly unable to work." (AM-16)

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

1-Specific problems

The lack of a policy respecting medications

The implementation of the regime did not include a policy respecting medications, which meant that it has not been possible to regulate the optimal use of medications. No mechanisms are in place to evaluate the validity of medical prescriptions. Similarly, the amounts and the prices of drugs are not subject to regulation. In these matters, the best intentions of the Minister of Health and Social Services ran up against the pressure of the pharmaceutical industry on doctors and the resistance of the professional associations (the absence of restrictive incentives).

The financial impact on certain groups of individuals

The new regime requires beneficiaries to be responsible for a portion of the cost of their medication, a major departure from the prior situation with respect to individuals covered by the RAMQ. Prior to 1997, welfare recipients and seniors over 65 who had the right to the maximum federal guaranteed income supplement (GIS) received prescription drugs free of charge. Other seniors and their spouses made a contribution of $2 per prescription. Medication was entirely free once payment by these people reached a ceiling of $100 per year. Once the Quebec Drug Insurance Act ("Loi 33") took effect, though, these groups of individuals assumed a greater portion of their pharmaceutical expenses. The annual maximum contribution of welfare recipients and of seniors receiving the GIS went up to $200, that of seniors receiving partial GIS climbed to $500 and that of other beneficiaries went up to $750. In addition, insured parties pay an annual premium that ranges from $0 to $175. In contrast, prescription medication is provided free of charge to dependents of those covered by the RAMQ (children under 18, students aged 18 to 25, the handicapped).

> "Well, yes. Yes, yes. From the beginning, that was widely criticized, the fact that welfare recipients who had had access to free prescription drugs… some of them, anyway, had to pay, even if it wasn't a lot, just a portion. And also, of course, the senior population, seniors, who had had free medicine at age 65, are now required to contribute. You know, the seniors' lobby, it's a very well-organized lobby that's very powerful, and so the interest groups have been very demanding." (AM-16)

The complexity of the regime

The operation of the regime is very complex, which has obliged the government to make certain adjustments to the program (quarterly vs. monthly accounting procedures; purchasing at the beginning and at the end of the month). The collaboration of pharmacists was crucial to explain the regime to clients. Still today, many Quebecers are not aware that they are required to sign themselves up for public prescription drug insurance coverage.

Its effects on drug consumption and the health of beneficiaries

A study commissioned by the Ministry of Health and Social Services was assigned to Dr. Tamblyn (1999) in 1998/1999 in order to determine the effects of the new regime on the consumption of prescription drugs and to evaluate possible effects of the change in consumption on the health of individuals who had been covered under the previous regime.

Upon publication, the conclusions of the report caused a flurry. The report demonstrated firstly that the new policy of sharing costs had occasioned a decrease in the consumption of prescription drugs among seniors and the poor. In general, individuals who consumed the most medication (seniors, those with the least education and women), were the ones who most decreased their consumption of prescription drugs.

There was, furthermore, a significant increase in the frequency of undesirable events, doctors' visits and trips to the emergency room, attributable to a decrease in both necessary and not-as-necessary consumption of medication.

Problems in coordinating the consumption of medication in hospital and out of hospital

The fact that different mechanisms apply, according to whether the patient receives medication in or out of hospital, tends to encourage patient transfers out of hospital. Indeed because hospital budgets continue to be so tight, hospital tend to pass the bill for more expensive cases to other institutions:

> "If I'm up at the hospital, well then, I'm not eligible for the plan… for the prescription drug insurance plan, so I'm covered by hospital insurance. In any event, the way the ministry has interpreted this, is that as soon as the patient is in hospital, as soon as the drugs are received within the hospital walls, it's the hospital that has to pay. So that…that gives rise to…that gives rise to all kinds of hanky-panky in order to shuffle certain patients along. So, the institutions that don't want the patients… the expensive patients, the ones who consume expensive medication, well, they fix it so that the CLSC's will administer their drugs. I'm not saying that certain risks are deliberately overlooked, but sometime, the risk potential is stretched a bit." (AM-14)

2- Widespread problems

Funding

Quebec's public prescription drug insurance regime is chronically in debt. This problem is widespread in Canada and in other industrialized nations, and is common to public as well as private regimes.

Increases in the cost of prescription drugs

The price of prescription drugs increases significantly every year. The appearance on the market of new, so-called innovative and better-performing drugs significantly inflates the budget allocated to prescription drugs. It is the budget item that increases the most (13 to 14% increase per year). Furthermore, thanks to new molecules, certain groups of beneficiaries can now live longer and as a consequence they consume expensive medication for a longer period.

Increasingly aggressive pharmaceutical marketing

The lobbying expertise of the pharmaceutical industry vis-à-vis both the public and the government is increasingly organized and successful. It's all the more effective given the values of western society that comprise a yearning for immortality… or at least that are prepared to do anything in order to have access to the latest molecules that might possibly increase lifespan.

Limits of the regime

One of the principal criticisms that continued to surface in our interviews dealt with the duality of the public system, which provides social assistance at the same time as insurance coverage. These two concepts do not share the same financial bases, the same regulating process or the same social reasoning.

The public regime insures eligible parties, who are members of the program. The amount of the premium had initially been determined at a relatively low level in order to sell the concept politically. This allowed the government to show that a public program could provide the same coverage as private programs, at a lesser price. However, the amount of the premium had been under-estimated with respect to the real costs of the regime; furthermore, the coverage offered by the private sector usually included other products besides prescription drugs. Indeed, the private sector did not offer coverage for drugs alone, but sold "packages" that included other kinds of coverage.

> ”Private insurers didn’t offer prescription drug coverage as a single product. They always offered disability insurance, life insurance, long or short-term disability. It was always an insurance ‘package’.” (AM-17)

At the same time, the public system covers high-risk individuals who would otherwise have difficulty obtaining insurance. These include welfare recipients and seniors receiving the guaranteed income supplement. So these ”bad risks” all wound up in the public sector, and the ”good risks” in the private sector.

> ”So that made for a hybrid system, which was an attempt to square the circle, where on one hand, we were trying to insure the eligible, and on the other hand, we were trying to help out those who would no doubt not be insured by the private sector or who would have a hard time getting insurance. We’re talking about social welfare recipients and seniors, recipients of the guaranteed income supplement. And the hardest thing is that in an umbrella-type public-private regime like the one created in Quebec, those who aren’t insurable have been in the old programs of the Régie de l'assurance maladie since ‘73 and ‘78. So obviously the portion… the actuarial risk is much greater for the RAMQ than it is private insurers. ” (AM-17

The Future of the Regime

Many of those interviewed brought up the future of the prescription drug insurance regime. Indeed, given the fact that the public system provides social assistance and insurance at the same time, coupled with the fact that because of the provincial environment, there is no real possibility of addressing the regime’s chronic debt, several of those interviewed suggested that the regime is heading towards a so-called catastrophe regime.

Furthermore, the need for a serious policy respecting medications has been brought up a number of times. The current Minister of Health, Mr. Couillard, is working on such a policy and in December 2004 he announced a certain number of measures (*aller chercher le communiqué de Presse*).

> “The position of the pharmaceutical industry is that a prescription drug insurance regime can’t be seen as independent of the health care system as a whole. It’s really an integral part, a major, fundamental part of a given health care system. What emerges from Quebec’s experience, with all its problems, is that a universal group regime can have a positive effect on the overall cost of health care, by providing better access to medication. So Quebec’s experience has been positive in that it’s proved that it is important to invest in prescription drugs. The State has to manage its prescription drug insurance well and it has to limit the increase in costs. Because the increase in costs stems principally from an increase in consumption, it becomes necessary to intervene, to intervene intelligently, with respect to the consumption of drugs. And I think that the present government is trying to move toward that now. There are some good leads in the Quebec model. Partnership agreements have been in place for the past two years, they haven’t yet shown any results, but they are… they’re like the germ of a good idea, in that they have initiated a dialogue that aims to promote optimal use of medications. (AM-17)

ANALYSIS OF THE REFORM PROCESS

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

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

❖ **With respect to institutions**

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

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

The political decision was also made possible by the discontent inspired by the Outpatient Circular, the existence of which became increasingly difficult to defend on political and ethical terms because it did not allow for fairness among patients. The government provided free medication to victims of 6 specific diseases; at the same time, victims of other diseases, for which medication was just as expensive, had no access to free drugs. Discrimination on the basis of disease was therefore taking place and gave rise to pressure to extend coverage. For one thing, groups of non-covered patients wanted their treatment to be covered and for another, those already covered wanted access to the latest prescription drugs. In the meantime, the lack of transparency in the criteria used to include a disease in the decree was an ethical problem for the government. At the beginning, diseases covered by the decree had been selected according to the cost that patients had to pay in order to obtain medication. But this criterion quickly became difficult to justify. Firstly, new expensive medication for a number of diseases arrived on the market, resulting in significant expenses for patients. Secondly, this criterion did not take into account the case of victims of several diseases for whom the purchase of medication was more expensive than it was for those victims of diseases that were covered by the decree. Because of this, the decree acted as a "disease lottery". It was therefore necessary to rapidly replace the Outpatient Circular with a fairer regime. And once the abolishment of the decree was announced, the government had to act quickly because it could not leave patients without protection.

Furthermore, the decision had the opportunity to ripen, given the publication of numerous reports that led progressively to a proposal that became increasingly acceptable on political, social and financial terms. It was thus around 1992-1993 that the need to take action on prescription drug coverage in Quebec became part of the government agenda. In 1996, a number of parties were consequently in favour of the concept of introducing coverage for the risk of prescription drug expense. Even if details of coverage were the

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

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

❖ **With respect to various interests**

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

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

For elected officials, the implementation of prescription drug coverage quickly became an important electoral issue. In fact, the Parti Québécois even included it in its political platform. As already noted, the minister of health made it a personal priority and carried the project until the passing of the Quebec Drug Insurance Act (“Loi 33”). Nonetheless, there was no real consensus within the government on the form coverage should take and the minister of health quickly came up against the Treasury Board whose goal of eliminating of the deficit required the financial contribution of plan participants and consequently supported the implementation of a mixed system in order to avoid increasing taxes. In short, the advent of Jean Rochon, a doctor in the field of public health, as Health Minister, greatly contributed to the implementation of the reform: in fact, prescription drug insurance was one of his personal projects. Minister Rochon was very active in the social aspects of the reform, and he supported a universal public system. Nonetheless, he was made to accommodate certain financial and economic restrictions.

The economic conditions of the time accelerated the reform process in Quebec. In the 1990’s, Quebec continued to suffer after-effects of the recession of the late 1980’s. The reform took place towards the end of the 1990’s, at a time when the public finances of Quebec necessitated an immediate reduction of expenses, especially in the field of health care, in order to achieve a balanced budget and a zero deficit. The concept of requiring a financial contribution by plan users allowed for immediate mitigation of the pressure on public finances. Indeed, savings in the first year of the regime were estimated to reach the order of $240 million. Officials of the Ministry of Finance and of the Treasury Board insisted on the need to implement a mixed regime with financial contribution by members. The Treasury Board was very much in favour of the speedy implementation of such a regime because it would allow for short-term savings and would probably speed up elimination of the deficit. By the same token, the government was not in favour of introducing a public universal system because in order assume the $895 million in premiums then paid by the private sector, it would have to increase taxes. A mixed private/public regime was also expected to alleviate the pressure on the budgets of hospitals, which until then provided patients covered by the Outpatient Circular with expensive medication free of charge, despite the burden on their operating budgets. The implementation of the regime would transfer a portion of this financial burden onto the private sector.

Of the other actors, insurance companies played a pivotal role in the decision-making process. Indeed, the importance of their role in the system could not be ignored. It was politically unimaginable to separate them from a market in which they had participated for years past and which it itself was not in question.

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

The pharmaceutical community was divided. On one hand, hospital pharmacists supported the instatement of a universal public system and on the other hand, community pharmacists supported a mixed universal system. The first group argued in favour of increased solidarity and a better distribution of the workload and financial responsibility between hospitals and primary care providers. For the second group, financial incentives in the private sector and the wish to keep a certain independence, led them to support a regime with public as well as private aspects.

The pharmaceutical companies were in favour of the implementation of more generous coverage of prescription drugs. Their only concern related to their antipathy to constraints with respect to the price of the drugs, the right of substitution, prescription policies, etc.

❖ **With respect to ideas**

Prior to 1992, the problem of prescription drug coverage was little discussed. The Demers Report in 1992-1993 marked the beginning of a debate on the question. The issue was quickly put on the government agenda as a result of discontent with the Outpatient Circular as well as with a view to stabilizing hospital budgets, promoting the shift towards ambulatory care and eliminating the deficit.

Emphasis on the issue was also the result of the desire of the province of Quebec to distinguish itself from the other provinces and to prove its ability to innovate and take the lead on social issues. It was thus no accident that the reform took place under a separatist government.

> ”The concept really took off under the Liberals, and then Côté, I think, really wanted to move forward on it. Of course, then came the Parti Québécois, which was a party more on the left. So it’s obvious that the idea of offering coverage was more part of… more part of PQ thinking at the time. And it’s obvious too that despite the outcry among seniors, that politically, it was a good move politically. (…) The idea of values, you know, fairness, accessibility. They were … they were social democratic values. So, there was that. I think that politically, it was also a good move. I think that public opinion was in favour of the idea. And I think that for the separatist government, it was, once again, a way to show that they could do great things for Quebec. You have to remember that it really was a huge project at the time, the fact that we were the first province to have such a system, we’re still the only ones…” (AM-14)

Furthermore, the Rochon reform had as its cornerstone the implementation of a shift towards ambulatory care. But to put such a shift in place, it was necessary that individuals continue to benefit from the same advantages as before, whether they were treated within or without a hospital institution. In that way, the creation of a prescription drug insurance regime became the *sine qua non* of the success of the shift towards ambulatory care.

❖ **With respect to external events**

As we have already pointed out, little had been written on prescription drugs prior to 1992, while subsequently, numerous reports agreeing, in general, on the subject contributed to make instatement of the regime a realistic goal. The advent of the Parti Québécois in 1994 reinforced this possibility by its emphasis on fairness and its “social project” (“*projet de société*”). The financial constraints weighing on the government further encouraged the decision.

Lastly, the appearance of new diseases heightened consciousness of the need for a system of protection. The emergence of the AIDS crisis in the 1980’s, the rapid increase in reported cases and the development

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

CONCLUSION

That which can be retained from Quebec's experience covers a variety of points.

To begin with, Quebec's policy decision was based on a compromise between economic and social interests. There was a consensus as to the nature of the problem, but not all the actors favoured the same alternative to the status quo.

Furthermore, the timing was right. All the participants stood to gain: politicians (the opportunity to make a mark), the administration (the chance to reform an unwieldy system), public finances (the possibility to reduce significant public spending) and social welfare (the prospect of introducing a significant social asset for the well-being of the clientele).

Additionally, prescription drugs were used as a tool of reform to increase accessibility and promote effectiveness and efficiency within the system. This reform took place in a context of greater reform that transcended Quebec. Indeed, during the 1990's, a number of member-countries of the Organization for Economic Cooperation and Development (OECD) found themselves obliged to institute reform in their health care systems in order to reduce costs. These reforms were principally oriented towards decentralization and de-hospitalization, all within a context of bringing down costs and achieving a zero deficit.

Lastly, the experience of other provinces, particularly those with catastrophe regimes, served to legitimize and sell the project in Quebec. The experience of the other provinces was used as an example of counter-reform best to be avoided. The inadequate coverage and limited access of those regimes were decried and the regimes as a whole were presented as experiences not to emulate because of their inconsistency with the social-democratic values of Quebecers. Furthermore, the project in Quebec was held out as an authentic means of transforming the health care system.

In closing, we must ask ourselves whether the major funding problems that afflict the prescription drug insurance regime will catch up to the government, notwithstanding significant attachment to the social values that underpin the system. Could it be that the implementation of a public system will prove to be a mere interlude, one that will inevitably lead toward minimal catastrophe-type coverage (with respect to financing, the regime is, indeed, rapidly approaching a catastrophe)…

BIBLIOGRAPHY

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

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

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

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

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

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

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

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

Ministère de la Santé et des Services sociaux du Québec. 1999. *Évaluation du régime général d'assurance médicaments*. Québec : MSSS, 98 p.

Ministère de la Santé et des Services sociaux du Québec. 2002. *L'assurance médicaments : un acquis social à préserver*. Québec : MSSS, 45 p.

Ministère du Revenu du Québec. 2003. *L'assurance médicaments*. Québec : Ministère du revenu, 14 p.

Régie de l'assurance maladie du Québec. 2002. *Portrait évolutif du régime public d'assurance médicaments (version abrégée) 1998-1999-2000*. Québec : RAMQ, 115 p.

Reinharz, D.; Rousseau, L et Rheault, S. 1999. «La place du médicament dans le système de santé du Québec», dans Bégin, C.; Bergeron, P.; Forest P-G et Lemieux, V (sous la direction de). *Le système de santé québécois : un modèle en transformation.* Montréal : Presses de l'Université de Montréal, 439 p.

Santé Canada. 2001. L'assurance médicaments au Canada : Enjeux et options. Gouvernement du Canada : Santé Canada, 30 p.

Tamblyn, R. *et a*l., 1999. *Rapport d'évaluation de l'impact du régime général d'assurance médicaments : résumé*. Montréal : Université McGill/Université de Montréal/Université McMaster (CHEPA), USAGE, 28 p.

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

1970-1980-1990 :	Coverage of prescription drugs provided via the Outpatient Circular	○ Prescription drugs are free for victims of the following diseases : cystic fibrosis, cancer, severe psychiatric disorders, insipid diabetes, tuberculosis and hyperlipoproteinemia. ○ Medication is provided free of charge in hospital institutions.
1985 :	Advent of Premier Robert Bourassa (Quebec Liberals)	○ December 12, 1985 (replacing Pierre-Marc Johnson)
1989 :	Advent of Health Minister Marc-Yvan Côté (Quebec Liberals)	○ October 11, 1989 (replacing Thérèse Lavoie-Roux)
1991 :	Launching of the reform by Minister Marc-Yvan Côté (Quebec Liberals)	○ The minister identifies problems related to the Outpatient Circular (the decree is unfair because certain diseases are covered and others are not).
1992 :	Filing of the "*Rapport du Comité d'analyse de la consommation médicamenteuse des personnes âgées : rapport présenté à la Régie de l'assurance maladie du Québec*"	○ The report addresses the problem of possibly inappropriate prescriptions.
1993 :	Holding of the "*Colloque sur l'utilisation rationnelle des médicaments chez les personnes âgées*"	○ It is recommended to review the use of medications.
1993 :	Announcement of the abolition of the Outpatient Circular	○ The abolition is announced on November 11, 1993. ○ The announcement causes public outcry among patients covered by the decree. ○ On November 24, 1993, the Demers Committee is formed to review the decree.
1994 :	Advent of Premier Daniel Johnson (Quebec Liberals)	○ January 11, 1994 (replacing Robert Bourassa)
1994 :	Advent of Health Minister Lucienne Robillard (Quebec Liberals)	○ January 11, 1994 (replacing Marc-Yvan Côté)
1994 :	Filing of the Demers Report : *"De l'assistance à l'assurance : Rapport du comité de révision de la circulaire*	○ In April 1994 ○ The committee identifies all problems

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

	Tabling and passing of the Quebec Drug Insurance Act ("Loi 33"), and holding of a parliamentary commission	○ In the month of June ○ Law creating the prescription drug insurance regime. ○ The law created a committee for the review of the use of medications.
1997 :	The law takes effect	○ January 1, 1997
1998 :	Advent of Health Minister Pauline Marois (Parti Québécois)	○ December 15, 1998 (replacing Jean Rochon)
1998 :	Filing of the McGregor Report: "*Critères et processus de décision pour la couverture des médicaments coûteux au Québec : réflexions sur la situation actuelle et propositions de changement*"	○ In 1998 ○ The report reassesses the issue of the mandate of the pharmacological consulting committee of the time.
1999 :	Filing of the Tamblyn Report: "*Rapport d'évaluation de l'impact du régime général d'assurance-médicaments*"	○ In March, 1999 ○ The report determines that the new regime caused a decrease in the use of prescription drugs among seniors and the poor. ○ The new regime caused an increase in undesirable events, emergency room visits and doctors' visits. ○ In 1 year, the RAMQ saved between 16 and 17 million in funds previously spent on the drug expenses of welfare recipients.
1999 :	Filing of the Fillion Report: "*L'évaluation du régime général d'assurance-médicaments*"	○ December 15, 1999 ○ This evaluation had been planned for in the Quebec Drug Insurance Act (the regime was to be assessed after 3 years). ○ The regime had attained its goals, but certain challenges remained: the increase in costs, funding and the problem of optimal use.
2000 :	Filing of the report of the Doucet Committee: "*Les pistes de révision du régime général d'assurance-médicaments*"	○ The report reevaluates the proposals of the McGregor Report. ○ The report proposes to consolidate the committee for the review of the use of medications and the pharmacological consulting committee to create le Conseil du medicament (the Medication Council).
2000 - 2002	Reassessments of the regime	○ The reassessments introduced certain financial arrangements, in particular the reinstatement of free drugs for welfare recipients having a severely limited capacity for employment and monthly accounting for

		premiums and coinsurance payments (as opposed to quarterly accounting, which had created problems of cash flow). o Tuberculosis and STD medications are free to all.
2001 :	Advent of Premier Bernard Landry (Parti Québécois)	o March 8, 2001 (replacing Lucien Bouchard)
2001 :	Advent of Health Minister Rémy Trudel (Parti Québécois)	o March 8, 2001 (replacing Pauline Marois)
2001 :	Filing of the Montmarquette Report: "*Pour un régime d'assurance-médicaments équitable et viable*"	o In December 2001 o The report proposes to retain the mixed nature of the regime, obligatory registration and the financial participation of insured parties. o The report recommends more equal and transparent financing. o The report recommends a revision of the criteria for entry on the list of covered drugs. o The report recommends the creation of a mechanism for better monitoring of the use of medications.
2002 :	Advent of Health Minister François Legault (Parti Québécois)	o January 30, 2002 (replacing Rémi Trudel)
2002 :	Publication of the report "*L'assurance-médicaments : un acquis social à préserver*"	o In May, 2002 o The report proposes leads toward ensuring the continuity of the regime and proposes legislative changes that took place later that year. o "*L'assurance-médicaments : un acquis social à préserver* ": a document produced by the *Direction générale de la planification stratégique, évaluation et gestion de l'information* of the Ministry of Health and Social Services in collaboration with the RAMQ. The document facilitated the operation of the parliamentary commission on prescription drug insurance.
2002 :	Publication of the document "*Portrait évolutif du régime public d'assurances-médicaments 1998-1999-2000*" by the RAMQ	o In June, 2002 o The report identifies an increase in the average annual cost of prescription drugs per resident and of the average cost of prescriptions. o Prepared by the *Service de l'actuariat et des analyses économiques* of the RAMQ. This evaluation took place 5 years after the

		implementation of the regime. The goal was to describe the evolution of prescription drug consumption for the years 1998-1999-2000 for the clients of the public regime.
2002 :	Revision of the Quebec Drug Insurance Act ("Loi 33")	○ Creation of the *Conseil du Médicament* (Medication Council). ○ Increase in the premium (introduction of the principle of revising the amount of the premium on July 1 of each year)
2003 :	Advent of Premier Jean Charest (Quebec Liberals)	○ April 29, 2003 (replacing Bernard Landry)
2003 :	Advent of Health Minister Philippe Couillard (Quebec Liberals)	○ April 29, 2003 (replacing François Legault)
2004 :	Holding of the "*Symposium sur l'utilisation optimale du médicament*"	○ In May, 2004 ○ The sequels of the symposium produced a policy respecting medications in Quebec.
2004 :	Politique du médicament	○ On December 16th, Philippe Couillard announces that the draft document for the Politique du Médicament is now available. ○ Key actors will participate to consultations (public hearings) on the draft document in the spring and autumn of 2005.

ANNEX 2: LIST OF INTERVIEWS CONDUCTED

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

ANNEX 3: RESEARCH TEMPLATE

A CROSS-PROVINCIAL COMPARISON OF HEALTH CARE POLICY REFORM IN CANADA

RESEARCH TEMPLATE

prepared by

E. Martin & M-P Pomey

Please complete a copy of this table for each case study (summarizing the transcript data you have coded) and send it to the appropriate Case Study Coordinator, copying Aaron.

Province: Quebec

Case study: Drug plan

Category	Subcategory	Data
Institutions	Structures (esp. federal government and/or department or legislative committee mandates)	▪ Possibility for Quebec to come up with its own drug plan program. ▪ Health Minister (Jean Rochon) was directly involved in the elaboration of the program. ▪ The *Régie de l'assurance-maladie du Québec* was a key actor in the implementation [AM-13 + AM-16 drugQC].
	Policies (esp. specific domestic court decisions and/or international agreements)	▪ The existing program (*Circulaire Malades sur pied*) was very unpopular because it excluded large population segments (they were not covered). ▪ The Ministry of health started to do some thinking about a drug insurance plan in 1992-1993 (reflections were done inside the Ministry by civil servants) [AM-01 + AM-11 + AM-14 drugQC].
	Policy networks *(overlaps with Interests)*	▪ The population was interested in having a drug plan. ▪ The Health Minister (Jean Rochon) had the desire to put a plan in place. ▪ Looks like a clientele pluralist network with different insurance scenarios [AM-06 + AM-13 drugQC].
	Other	▪ Not mentioned by any participant
Interests	Societal interest groups	▪ The vulnerable groups (employment assistance claimant) wanted a public universal regime (without deductible & co-insurance) [AM-02 + AM-09 drugQC]. ▪ Elderly people: some of them were covered by a private insurance so they were more favourable toward

		a mixed regime [AM-02 + AM-12 drugQC]. ▪ Young workers were favourable to a drug plan [AM-06 drugQC]. ▪ Students tended to be against a drug plan [AM-07 drugQC]. ▪ Population segments covered by the *Circulaire Malades sur pied* wanted the status quo (maintain the existing program) [AM-03 + AM-11 drugQC].
	Policy entrepreneurs (including researchers)	▪ Researchers were asked to participate to numerous committees and commissions created since 1992. ▪ The conclusions of those research reports were supporting the creation of a drug plan. ▪ Numerous solutions were presented. The commissions and committees' recommendations tended to support either the universal drug plan or the mixed (public-private) approach. They tended to be less favourable towards the private drug plan scenario and the catastrophe-type of drug plan [AM-11 drugQC].
	Elected officials	▪ The creation of a drug plan was part of the electoral platform of the Parti Québécois [AM-16 drugQC]. ▪ The Health Minister (Jean Rochon) was involved in the development of the project. He wanted a universal regime but other members of the government did not agree (especially the Conseil du Trésor) [AM-04 drugQC]. ▪ Prime Minister/government were supporting a plan with a user's financial contribution. By combining an insurance principle (with financial contribution) and an assistance principle (without financial contribution), those paying a contribution could support the costs for those who did not. The government was not favourable towards a universal public regime because it would have to raise taxes [AM-01 + AM-07 drugQC]. ▪ Final decision was a government decision [AM-13 drugQC]. ▪ Underlying reasons were for cost control, not a primary driver, but definitely underlying [AM-07 drugQC].
	Civil servants	▪ The Conseil du Trésor /Ministry of finance was supporting a plan with user's financial contribution to pay for the deficit of the assistance portion of the plan (welfare recipients & elderly). Were not favorable towards a universal regime. Did not wanted to raise taxes [AM-04 + AM-16 drugQC].

	Other	▪ The private insurance companies were already offering coverage to large segments of the population. They wanted to be part of the drug insurance plan. They were not favourable towards a private regime (were not ready to cover all the population & and were not interested in covering vulnerable groups who are financially deprived) [AM-15 drugQC]. ▪ Health Minister Jean Rochon was coming back from working at WHO. He wanted to put in place a drug plan [AM-06 drugQC]. ▪ Community pharmacists were against a universal public regime. They were earning more professional fees by offering services to individuals covered by a private insurance plan [AM-08 + AM-10 drugQC]. ▪ Hospital pharmacists were favourable to a universal public regime. They were against the program *Circulaire Malades sur pied* because it brings extra work and is a burden on hospital's budgets [AM-08 + AM-14 drugQC]. ▪ *L'Association des hôpitaux du Québec* supported the arguments of the pharmacists [AM-14 + LA-01 drugQC]. ▪ Drug companies were favorable to a drug plan (any scenario) as long as it did not affect their privileges (especially pharmaceutical patent) [AM-17 drugQC]. ▪ The Ministry of Health was sceptical. They thought that the regime could not be implemented in 6 months [AM-07 drugQC].
Ideas	Knowledge / beliefs about what "is"	▪ Before 1992, the issue was not really discussed. It was brought to the attention by the Demers committee in 1992-1993 [AM-06 drugQC]. ▪ Between 1993-1995, the issue was put on the agenda rapidly because of the flaws of the *Circulaire Malades sur pied,* the desire to have a fair plan, the fact that Jean Rochon was convinced that a drug plan had to be implemented, to maintain the hospital budgets, to support the shift to ambulatory care and the desire to reach the zero deficit [AM-01 drugQC].
	Values / views about "what ought to be"	▪ Government hoping to achieve more equity throughout the system [AM-03 drugQC]. ▪ Government thought that a mixed drug plan could cover the deficit of the assistance portion of the plan (for welfare recipients and the elderly) [AM-04 drugQC]. ▪ The Ministry of Health thought that the idea of implementing a drug plan was in line with the social democrat values that the government was promoting

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