

Health Reform and Drug Policy in Alberta

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I. Introduction

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

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

Pertinent documents and public records (e.g., media, Hansard) were reviewed to establish the background for this case study. This was complemented with a number of semi-structured interviews with present and former government officials. The data was analyzed using a coding framework developed from the literature which focused on key

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

II. Background/Chronology

Total prescription drug costs in Canada have been growing rapidly in the last number of years, in the late 1990s surpassing physician fees as the second largest component of health spending (CIHI, 2005, p. 15). This increase in costs has placed a growing financial burden on both public benefit programs and private individuals. The latter are still responsible for bearing most of the costs; in Alberta in 2002, private payment accounted for 64.4% of all drug spending (CIHI, 2005, p. 15). Within this context, government must make choices about if, how and for whom to assume some of these costs through public subsidy.

The financial implications for Albertans were also affected by major reforms undertaken by the Klein government. One major development was regionalization, with its increased emphasis on shifting care from hospitals and other institutions to the community (where costs do not fall under the Canada Health Act and thus can be off-loaded to some extent from government budgets). Another thrust of government policy was to reduce the numbers of people on welfare. Changes initiated in 1993 reduced the numbers of Albertans on social assistance by 60% between 1993 and 1997 (Elton, Siepert, Azmier & Roach, 1997; Boessenkool, 2003). For many, this meant taking low-paying jobs without benefits, while giving up drug subsidies they would have previously received through the social assistance regime. The Canada West Foundation's 1997 survey of welfare leavers found that only 24% of those employed received extended health benefits from their job; 44% had no benefits of any kind (Elton, Siepert, Azmier & Roach, 1997). The 2001 MLA Committee to Review Low-Income Programs heard many submissions from the public that reinforced the idea that loss of health benefits was a major problem for poor Albertans trying to return to the workforce (MLA Committee, 2001).

Alberta was once among the innovators in pharmaceutical policy coverage. Drug benefits for social assistance recipients in Alberta have been provided since the early 1960s -- only BC and Manitoba had such programs at an earlier date. Starting in the 1970s, most provinces began to provide some support to other groups within their populations. During the last years of the Social Credit government, Alberta was first in Canada to introduce (in 1970) programs of government-funded pharmaceutical benefits for seniors, and for the general population through a voluntary program (Grootendorst, 2002).

However, only incremental changes in drug benefit policies have been pursued during the Klein 'revolution' and the extension of drug benefits has been limited to two relatively small and sympathetic groups: the terminally ill and the working poor.

Authority for Alberta's existing drug benefit programs is largely divided between Alberta Health and Wellness and Alberta Human Resources and Employment¹. These two departments oversee seven different prescription drug plans for Alberta residents. Alberta Health and Wellness provides three different programs. A voluntary and contributory drug program called *Non-Group Coverage* is available to all Albertans under the age of 65 years and their dependents. *Senior's coverage* is afforded to all Albertans 65 years of age and older and their dependents. *Palliative Care Drug Coverage* -- one focus of this case study -- has been available since 1999 for people diagnosed as being terminally ill in their final months of life and receiving their treatments at home. The Alberta Health Drug Benefit List (DBL) and the Palliative Care Drug Benefit Supplement outline the products which are available to those with coverage under these plans.

In 2003/04, these plans together covered 499,078 Albertans (Alberta Health and Wellness, 2004). The seniors group is by far the largest component of the population covered by these programs, accounting in 2003/04 for 73% of the total enrollment. Voluntary adult participants numbered around 133,779, or 27% of the total. The palliative care program had 743 discrete registrants, or approximately 0.15% of the total.

¹ The province has recently announced its intent to investigate the possibility of consolidating and managing its portfolio of drug subsidy programs under a single Ministry, presumably the department of health. This is despite the fact that there has previously been no compelling push for such a change.

Seniors accounted for 77% of the total cost of all prescriptions written in 2003/04, and 82% of the total number of prescriptions filled. The palliative care program funded 22,492 prescriptions (0.28% of all prescriptions) valued at \$1,314,904 – 0.22% of Alberta Health and Wellness' spending on prescription subsidization.

Four groups of recipients are eligible for coverage under programs managed by Alberta Human Resources and Employment. Persons receiving income support benefits under the program label *AlbertaWorks* (which in spring 2004 replaced the previous *Supports for Independence*, or welfare program and the *Alberta Widows' Pension* for low-income widows and widowers aged 55 to 64 and their dependents²) receive prescription drug coverage; so do those in receipt of *Assured Income for the Severely Handicapped*, (i.e., adults who have a permanent disability which severely affects their ability to earn a livelihood). Transitional coverage for adults leaving welfare has been offered since 2002 via the *Alberta Adult Health Benefit*. Finally, the *Alberta Child Health Benefit* program for children of low-income families – the other focus of this case study -- offers prescription drug coverage and other health benefits. Beneficiaries of this set of programs are covered for products on the DBL as well as on the AHRE Drug Benefit Supplement.

Because of this structural separation, the drug policy changes discussed in this case appear to have developed in two parallel tracks largely independent of one another. While there are some differences, both patterns share a common logic that reflects the role of institutions and interests, but particularly ideas and values. Conservative governments have consistently demonstrated an ideological bent against universal welfare programs, preferring instead to encourage personal responsibility while targeting specific discrete groups for carefully delimited support. The extension of benefits to palliative care patients flows from an emphasis on assisting supposedly needy and deserving members of the population, while the low-income child benefit has been framed as part of efforts to improve the labour force attachment of working families and propel their economic independence from government transfers.

² New applications for Alberta Widow's Pension were discontinued in April 2004, but those previously in receipt of such benefits would be maintained on that program until April 2006, at which time they would be rolled into the AlbertaWorks program.

Palliative Care Benefits

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

In October 1997, Alberta Health initiated the *Publicly Funded Drugs in Community Settings* project. This involved a consultation with RHAs and other health professionals (but not the public) about issues related to the delivery of home parenteral therapy and palliative home care. Some key concerns noted in the project report were inconsistencies between regions in eligibility and nature of services, patients’ access to these services potentially limited by the direct costs involved, and the concern that treatments were being dictated by the need to reduce patient cost rather than by the most effective and efficient method of delivery (C. A. MacDonald & Associates, 1998). No recommendations were provided.

Also in 1997, the government appointed MLA Dave Broda to head a Policy Advisory Committee on Long Term Care (hereafter the Broda Committee) to address some key issues and provide recommendations for the future. This committee consulted with provincial organizations in the continuing care field, held public meetings, and received briefs and submissions from over 1700 individuals and nearly 60 other organizations or groups (Alberta Health and Wellness, 1999c). In its *Summary of Consultations with Public, November 1998 to March 1999*, the Broda Committee notes that among recommended changes, “in-home intravenous therapy and palliative care drug programs need to be provided” (Alberta Health and Wellness, 1999b, p. 21). A palliative care drug benefit program was subsequently initiated as of February 1, 1999 with a \$3 million commitment. MLA Broda claimed partial credit for the change, stating during the debate on supply (Hansard, 1999, p. DSS39), “Some of the discussions we’ve had or discussion

papers we had given to the minister have already resulted in palliative care drugs that were implemented on February 1 of this year”.

The 1999 Health Summit also raised the issue of pharmaceutical coverage. The Health Summit consisted of a mixed group of key stakeholders chosen by the province and randomly selected Albertans. It was convened to provide advice and recommendations to the province about the health care system. The third recommendation in its final report was “Government should explore options for managing the growing costs of pharmaceuticals including the feasibility of expanding public coverage for pharmaceuticals” (Alberta Health and Wellness, 1999a, p. 33). No specific suggestions about the scope of such coverage were offered however.

Health Minister Jonson indicated how far down this road the province was willing to go when he stated (Hansard, April 15, 1999, p. 1043),

“There is located in [the Health Summit’s Final Report] a significant number of recommendations. There is a number that we are already acting upon, a number that in my personal opinion I think are worthy of support. The one with respect to pharmaceuticals is one that, in part, we are already acting upon in that in the current business plan of Alberta Health we are extending -- and I won’t go through the whole list -- pharmaceutical coverage for instance to palliative care patients that was not there before.

However, I would have to say, Mr. Speaker, that at least at this point in time I do not endorse in a very general way the idea of a pharmaceutical plan that is totally publicly funded. We do need to examine the experiences of other provinces. We do need to take the recommendations seriously. But I think there is a tremendous potential cost, and we have to balance that against its effectiveness and the ability of the health care system to pay.”

Pharmaceutical issues, with the exception of such cost saving measures as bulk purchasing, were largely absent from the province’s next major study on the future of health care and health reform, the Mazankowski Report (PACH, 2002).

The Alberta Child Health Benefit

The Alberta Child Health benefit was introduced in July 1998. This program includes coverage for optical and dental services, diabetic supplies, and emergency ambulance transportation, as well as premium-free prescription drugs. This program was the major initial allocation of funds made by the province in carrying out its portion of the federal-provincially agreed National Child Benefit (NCB).

Under the NCB, the federal government increased the amount of money it provided to low-income families with children through the Canada Child Tax Benefit. Provinces then had the opportunity to reduce their transfer payments to these families by an equivalent amount, so long as the savings were re-invested in other programs that provided benefits to these families. Each province had the flexibility to design the specific programs it would pursue.

Programs in five main areas have been developed: earned income supplements, child/day care initiatives, early childhood services and services for children at risk, supplemental health benefits, and other initiatives (NCB, 2005). Besides Alberta, Saskatchewan, PEI, Newfoundland and Labrador, and Yukon chose to offer some form of publicly-funded prescription drug coverage as part of their re-investment

The stated aim of Alberta's program was to ensure that families leaving social assistance would still have the opportunity to access benefits that had been provided through the welfare system. This meets the NCB objectives of addressing child poverty and 'increas[ing] attachment to the workforce'. It was initially estimated that 115,000 children would be eligible for these benefits (NCB, 1998); as of 2001/02, the province reported "approximately one-third of eligible families enrolled" under the program – 66,293 families in all (Alberta Human Resources and Employment, 2002). The 2003/04 spending of approximately \$21 million amounted to 2.7% of the department's spending on "People Investments" and about 1.9% of the total annual budget.

Table 1: Expenditures for Alberta Child Health Benefit, 1998-2004

| Fiscal Year | Budgeted for ACHB* | Spent* | No. of Beneficiaries* |
|-------------|--------------------|------------|-----------------------|
| 1998-99 | 12,400,000 | 3,298,000 | 37,873 |
| 1999-00 | 12,803,000 | 11,104,000 | 54,921 |
| 2000-01 | 14,666,000 | 16,271,000 | 62,311 |
| 2001-02 | 16,966,000 | 16,943,000 | 66,293 |
| 2002-03 | 19,266,000 | 18,579,000 | 68,272 |
| 2003-04 | 20,972,000 | 20,953,000 | 66,901 |

Note: These amounts include expenditures on other health benefits in addition to prescription drugs. The government's current accounting methods do not allow a more precise distinction among these program elements [P2].

*=Source: Family & Social Services Annual Report, 1998/99; Human Resources and Employment Annual Reports 1999/00 through 2003/04

Following its introduction, the ACHB program was expanded by

- Eliminating co-payments (January 1999), which previously ranged from 10-40% depending on family income³
- Making it sensitive to family size (families with more children were eligible for benefits while having higher net incomes)

In November 2002 a new program, the Alberta Adult Health Benefit, began. It extended coverage on the same terms as the ACHB to adult family members leaving welfare for the workforce (so long as families had incomes beneath the program's cut-off threshold). In fiscal year 2003/04, this program paid \$3.894 million in benefits to a monthly average of 1131 clients (up from an average of 628 in its first year of operation, 2002/03).

In spring 2004, several AHRE programs were reorganized under the brand of "Alberta Works." This includes the former Supports for Independence and job training programs. Clients on income support continue to receive drug coverage. This is continued

³ Deputy Minister Maria David-Evans suggested in testimony to supply committee that, with the first full year of funding in 99/00, plans were being developed to use additional resources either to raise the income cut-off or decrease cost-sharing. (Hansard 1998, DSS53).

transitionally for clients who have exited income support, through the Alberta Adult Health Benefit. These changes re-enforce the government's efforts to emphasize policies that reduce welfare caseloads and advance workforce attachment among low-income Albertans.

III. Analysis: Institutions, Interests, Ideas

Institutions

Federal-provincial negotiations were a crucial impetus for the child health benefit program [Email; P10]. However, as in most such negotiations in the current era, the provinces maintained the ability to shape the specific details of the program. As noted above, several possible uses of the funding were permitted, so long as they could be framed within the general goals. Palliative care, by contrast, was an initiative that came about through the province's own efforts. The background research and public consultations carried out by the Broda Committee led to a policy recommendation that was acted upon. There is little evidence that Alberta's policy choice was influenced by events or pressures from elsewhere in the country, though a palliative care plan developed earlier by Saskatchewan might have served as a model in some manner.

The health department had limited involvement in the negotiations around the NCB and on the decision to make health benefits the focus of Alberta's program; neither did department leaders push to obtain jurisdiction over it. Essentially, the Alberta Child Health Benefit is delivered by AHRE because AHW did not perceive it as a health program. This suggests that the decision makers within the department have not internalized a broad concept of the determinants of health as part of their mandate.

The challenges of delivering effective programming through department silos is also demonstrated by subsequent years experience in the ACHB, where any expansion of the program must compete with other departments' priorities (e.g., Children's Services and their responsibility for day care) when new money is available. While the tensions were

muted at first, the choice to spin off Children's Services into its own department created a competing voice around the cabinet table.

In both the palliative care and NCB cases, these new programs were shaped by pre-existing policy or program designs. The changes were non-controversial and could be implemented by the respective bureaucracies with relative ease. This demonstrates an incrementalist approach to policy by both the politicians and civil servants.

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The palliative care program was originally accompanied by a recommendation to expand coverage for home parenteral IV therapy. The latter was not carried forward.

Interviewees in part attribute this to it being a more complex policy to implement: it involved a broader range of health providers, such as hospital-based discharge planners [P2]. Respondents also linked the fate of parenteral IV therapy to changes in senior executive and/or the Minister. When new leadership came into the department, it saw other priorities as being more important. There was no longer any will to go forward with home parenteral IV therapy and its implementation stalled.

Interests

The absence of any strong external pressures, in the form of organized interests, makes it easy for such incremental changes to fall off the political and bureaucratic agendas. For neither policy choice do organized interests appear to have played a significant role. Relatively small numbers of beneficiaries and therefore small expenditures were involved in both cases, and neither the terminally ill nor the working poor had a strong history of organized and effective lobbying, though there are some professional or advocacy groups that claim to speak on behalf of these populations. Rather than hearing from any organized lobby effort, politicians and bureaucrats received letters and calls from individual physicians, patients, and their families.

The ACHB program was developed largely at the behest of the bureaucracy.

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The ACHB was designed following a modest province-wide consultation with a range of stakeholders; participants were selected by local AHRE offices. The process asked them to choose their preference among defined options, with health benefits being the overwhelming first choice. This kind of organized and controlled consultation is a standard bureaucratic approach and typifies Alberta's recent experience with Roundtables, Summits, and Symposia.

The case also reflects how strategic considerations affect how bureaucrats framed the issues.

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As another instance, the establishment of a program, even a somewhat limited one, could serve as a 'leg up' on potential competing demands in the future.

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The palliative care recommendation arose from the Broda report. Individual letters and stories from patients, providers, and family members would likely have been presented, but those involved do not recollect any organized pressure group or active campaign to have the specific policy proposal implemented. Policy development in this case was perhaps more open to research evidence being brought forward by the Secretariat; and since the Committee was led by an MLA and was strongly backed by the then-Minister, it gave the recommendations a very direct route to cabinet decision-making.

Ideas

The problem is understood in both instances in a fairly simple, straightforward and similar way. First, the personal costs are too high for people to do the appropriate thing, i.e., what *evidence* suggests ought to be done (receive palliative care at home; leave the welfare system for the workforce). The rational choices that individuals make in response to these incentives lead to less than optimal use of resources (people in hospital beds when they needn't be; people opting to stay on welfare rather than take employment). The evidence in this case seems to coincide well with both the 'common sense' view and the sentiments expressed by members of the public, as opposed to a policy area like private for-profit delivery of surgical services, where the evidence base is more ideologically contested.

The solutions were chosen to fit with pre-existing policy choices. In the case of the ACHB, it also had to be compatible with the framing of the issue arrived at through the F/P/T negotiations; provincial jurisdictions too had to be respected. Finally, there were financial limits on the kind of policy that would be feasible with the limited funds freed up through NCB.

Solutions also had to be compatible with the values/ideology of an Alberta Conservative government. For palliative care benefits, this meant retaining some element of personal responsibility (via co-payment). The limited extension of benefits to a small and well-defined group of sympathetic or 'deserving' persons is a pattern established when Alberta's first programs were designed and consistently continued since. The choice of beneficiaries can be described as a compassionate and morally virtuous action as well.

It was clear that the government had no interest in a universal approach to prescription drug coverage. Health Minister Halvar Jonson dismissed the Friends of Medicare's call for universal, premium free drug coverage: "we do not have any program or plan to introduce a universal, government-covered drug program. This is tremendously expensive. Once again, we are targeting the funds available to the areas of highest need, particularly those who have severe health conditions and those who have an inability to

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

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

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

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Government also shied away for ideological reasons from expanding day care services as a policy.].⁴

There seems to be a theme of ‘self-congratulation’ in some of the responses; that is, a feeling that “made in Alberta solutions”, Alberta’s programs in comparison to most other jurisdictions are equal or superior, which could be another criteria for judging solutions.

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A commissioned evaluation of the ACHB in 2001 suggested that the program was meeting its objectives and had good levels of client satisfaction (Nichols Applied Management, 2001). Where its effectiveness was questioned was around the matter of uptake. Since its inception, the program has never enrolled more than a fraction of the

⁴ Note how the province takes a similar stance in recent negotiations around national child care program.

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

IV. Conclusion

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

V. References

Available upon request from authors

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