Prescription Drug Reform in Newfoundland and Labrador: Reform or Lack of Reform?

Stephen Tomblin and Jeff Braun-Jackson

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In 2004, total spending for prescription drugs in Canada was $19.3 billion, of which $1.3 billion were medications dispensed in hospitals. From 1985 to 2004, prescription drug spending increased a whopping 692 percent, from $2.6 billion to $18 billion. Canadians now spend more money on drugs than on physician services.[1]

A key question is what accounts for the huge increase in spending on prescription drugs in Canada? There are no simple or easy answers as researchers and academics struggle to better understand the dynamics of drug costs. Drivers of inflated costs include increased usage of prescription drugs as a result of innovation; the introduction of new diseases which require treatment; an aging population; the continued substitution of newer and more expensive drugs for older ones and changes in the methods of health care delivery whereby emphasis is placed on prevention rather than in-hospital stays.[2] The per person spending on drugs across the country varies by region and the differences among provincial drug subsidy programs. The per person average for Canada is $681 while in Newfoundland and Labrador, the equivalent figure is $669.66. As well, a fraction of the population consumes the majority of prescription drugs. Approximately five percent of the population consumes 40 percent of all drug spending in the country. These individuals tend to be chronically ill and use a large number of health services.[3] Costs continue to escalate forcing governments to consider how to fund drug coverage for the most vulnerable citizens in the population.

Another consideration is that several of new therapies marketed by pharmaceutical companies are prohibitively expensive and may not necessarily be any better for treating illness than an older and more established drug. In a study released in late summer 2005, Dr. Stephen Morgan at the Centre for Health Services and Policy Research at the University of British Columbia, 80 percent of the increase in drug spending in British Columbia between 1996 and 2003 was "explained by the use of new, patented drug products that did not offer substantial improvements on less expensive alternatives available before 1990."[4] Those of us who consume drugs are targeted by advertising paid for by pharmaceutical companies touting the latest benefits of new therapies for heart disease, cholesterol, arthritis and the like. The reality is that many of these new therapies are not effective and end up costing billions of dollars in out of pocket expenses.

The purpose of this paper is to report our team's findings with respect to the case study of prescription drug reform in Newfoundland and Labrador. The first part of the paper will provide a brief overview of the provincial drug plan in place and the province's participation in the Atlantic Drug Formulary Program. The next three sections will outline our informants' responses to questions focusing on the government agenda, the decision agenda and policy choice as to why the province has not made formal legislative and institutional changes to encourage prescription drug reform. As will be evident, key

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[1] . André Picard, "'New' Drugs Too Often Offer Little New," Globe and Mail, September 8, 2005, p. A21.
[2] . André Picard, "Experts Question if Burgeoning Drug Costs Worth Swallowing," Globe and Mail, April 6, 2005, p. A13.
[3] . André Picard, "Tiny Minority Consumes Lion's Share of Medication Dollars," Globe and Mail, April 6, 2005, p. A 13.
[4] . Quoted in André Picard, "'New' Drugs Too Often Offer Little New," Globe and Mail, September 8, 2005, p. A 21.

drivers of drug reform in Newfoundland and Labrador are the mass media and advocacy groups. These have generally met with limited success due largely to the province's lack of fiscal resources and state capacity to deal with such problems. Within a cabinet-parliamentary system that also features an executive-dominated form of federalism, these external influences or voices (unless well organized and linked to public opinion) may in the end, have limited opportunities to shape the public agenda. There is little evidence that critics have been well organized or able to challenge the status quo in a coherent or effective way. Divisions over age, income, region, disease, federal, provincial programs and jurisdictional responsibilities have all added to the building of a very complex system of power-sharing that is not easily understand let alone maneuvered by critics or political competitors.

Overview of Newfoundland and Labrador's Drug Program

The province administers a plan known as the Newfoundland and Labrador Prescription Drug Program. This comprises three separate components: (1) the Income Support Program; (2) the Senior Citizens Drug Subsidy Program and Ostomy Subsidy Program and (3) the Special Needs Program. The Income Support Program provides prescription drug coverage for those residents in receipt of social assistance as well as those who qualify for drug benefits because of the high cost of medication. The government provides 100 percent of the drug ingredient costs, up to a ten percent mark-up where drug ingredient costs exceed $30 and a maximum dispensing fee of $6.50. In 1996 the government capped coverage for dispensing fees at $3.50 for social assistance recipients. These individuals must pay the difference for higher dispensing fees charged at their local pharmacies. The Senior Citizens Drug Subsidy Plan provides benefits to residents aged 65 and over who are receiving the Guaranteed Income Supplement from the federal government. Those residents over the age of 65 with limited residency, in Canada and who have not qualified for Old Age Security may apply for drug benefits by writing the Deputy Minister of Health and Community Services. This plan covers the full cost of the drug ingredient. However, drugs listed in the Newfoundland Interchangeable Drug Products Formulary will be paid to the maximum lowest price listed in a category. Any difference in the cost between the lowest priced and any other product in the category is paid for by the patient. The following items are excluded as benefits under the Plan:

- Over the counter non-prescription drugs;
- Prescription cough syrups;
- Drugs used in habituation or addiction;
- Delivery, postal or C.O.D. charges;
- Any insured service for which the resident is entitled to benefits under the Department of Veteran Affairs, Worker's Compensation or other legislation;
- Single doses of injectibles or other medications provided or administered by a doctor or dentist in the course of a home or office visit;
- Appliances, prosthetics, first aid supplies and dressings;
- Dietary supplements and food products;
- Cosmetics, soaps, dental and beauty aids and

- Charges in excess of the defined ingredient cost for drug benefits.[5]

Related to the Senior Citizens' Subsidy is the Ostomy Subsidy Program. This program is designed to subsidize the cost of certain ostomy supplies. Eligibility is based on being at least 65 years of age or older and in receipt of drug card provided under the Senior Citizens' Drug Program. Under the Ostomy Subsidy Program, government will reimburse eligible seniors for 75 percent of the retail cost of items under benefit. Covered benefits include:

- skin barriers;
- adhesive disks and gaskets;
- powders, cleansers and deodorants;
- all colostomy, iliostomy and urinary pouches;
- night drainage kits and
- irrigation equipment.

The Special Needs Programs provide universal coverage for patients with cystic fibrosis and growth hormone. Universal coverage is also given to Food Bank clients; however, clients must apply for coverage under the Department of Human Resources and Employment once they reach their 18th birthday. The program also provides 100 percent coverage for identified benefits (disease-related prescription drugs, enzymes, foods, medical supplies and equipment) supplied through the Health Sciences Central Supply and Pharmacy. In May, 2000, the Minister of Human Resources and Employment announced the extension of drug card benefits to single persons and families without children who move from social assistance to the paid work force. The Minister noted that "for many clients, the loss of health benefits is a disincentive to taking employment".[6] Families with children receive drug card benefits for six months when they leave social assistance.

The main debates over drugs in the province concern the addition of new medications to the drug formulary. National associations representing diseases such as diabetes, arthritis and Alzheimer's have been lobbying government to have certain new drugs covered under the plan for both seniors and the indigent[7]. The reality is that Newfoundland and

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[5] . Government of Newfoundland and Labrador. Department of Health and Community Services, *Overview of the Newfoundland and Labrador Prescription Drug Program*. www.gov.nf.ca/health/nlpdp/overview.htm

[6]. Ingrid Botting. *Health Care Restructuring and Privatization from Women's Perspective in Newfoundland and Labrador*. St. John's: Coasts Under Stress Project. July, 2000: 43.

[7] . Several examples abound. A provincial government employee diagnosed with MS in 2002 attended a pre-budget consultation meeting in January, 2005 to personally lobby Finance Minister Loyola Sullivan to include certain pharmaceutical drugs under the province's drug formulary for treatment of MS. Newfoundland and Labrador is the only province in Canada that has a monetary requirement for MS medication; if in receipt of social assistance, the drug costs are paid for by the province. In order to be covered under the province's drug subsidy program, you cannot have more than $500 in savings. The cost of the MS drug Copaxone is $14, 800 per annum. In early spring of 2005, a family from Plate Cove,

Labrador is the poor cousin in our study since the province provides no universal drug coverage to residents other than those groups identified above. For drug coverage, change has been slow to evolve. Prescription drug coverage lacks universality and is provided only for the most vulnerable groups in the population. It is very much a needs-based approach, but the needs are framed by politic competition/debate and not according to some embedded framework. While some innovations have recently been announced for providing drug cards to individuals and families coming off social assistance and entering the work force, few low income workers have access to drug and health coverage for prescriptions, dental work and other medical services.

A recent innovation is the province's participation in the Atlantic Drug Formulary. This is a program where the four Atlantic provinces cooperate and collaborate to share resources to review new drug therapies coming onto the market. However, the program does not mandate that each province adopt a common set of drug benefits. In other words, New Brunswick may approve a drug therapy as part of its provincial formulary that will be paid by government but the same drug may not be added to the formulary in Nova Scotia. One of our informants described how the program works:

"The Atlantic premiers in the late 1990s around 2000, thereabouts, were looking at health care. A lot of collaborative work in one of the areas they targeted was pharmaceuticals because of the rising cost issue, and asked if we [the policy people] would formalize the structure for reviewing new drug therapies that came to market. And we did that, and that's when the Atlantic Common Drug Review Process began its formal work. With that came the establishment of an Atlantic Expert Advisory Committee composed of physicians and pharmacists. So when new drugs came to the market, they would undergo one review and we would look at the clinical and the economic data surrounding them. It would go the Expert Advisory Committee, which had representatives from the four provinces and which the government division, such as mine, had an observer from each province and recommendations would come to that group, back individually to each province. There have been some differences in terms of implementing the decisions, and that's come down to different fiscal circumstances in the four provinces."[8]

Put simply, the experiment in intergovernmental relations has not really changed anything in a substantive way. The Atlantic Canadian initiative continues to rely upon old provincial structures and processes, and is very pragmatic in approach. The primary objective seems to be to working together in defining and dealing with common problems - but without jeopardizing the status quo. Old lines and traditional governance systems in the health care system continue to matter and work against efforts to promote fundamental restructuring.

Bonavista Bay, lobbied the province to include new therapies for Alzheimer's disease under the provincial drug formulary. The previous Liberal government of Roger Grimes had promised to include the drugs in the formulary during the 2003 provincial election. The current government rejected that policy. Such is life in Newfoundland and Labrador. See Will Hilliard, "Women With MS Asks Minister to Adjust Province's Drug Plan," The Telegram, January 16, 2005, p. A3 and Deana Stokes Sullivan, "Family Discouraged by Drug Decision," The Telegram, March 29, 2005, p. A1, A2.

[8] . Respondent 6.

Prescription Drug Reform: the Government Agenda

The issue of prescription drug reform has periodically appeared on the provincial government's radar screen since the late 1980s in part because of federal efforts to introduce a pharmacare program or due to lobbying by specific advocacy groups and the mass media. The province does not have a universal drug program but a rather one that is targeted to specific groups within the population. While interest in having a universal drug program is present, our informants are unanimous in saying that it would never become a reality on the ground without fundamental changes in governance that would simplify reality, make it possible to understand and work across organization boundaries and divisions within both the state and society. Problems or obstacles to reform identified include a lack of consensus about what constitutes catastrophic care; the issue of equity in providing for catastrophic care; the historical exclusion of pharmaceuticals from the Medicare bargain (hence no integrated governance or institutional system to promote a common approach to problem definition) and the reluctance of the federal government to assist the province in providing broader drug coverage to more people.

The issue of universal drug coverage and reform was made visible following the release of the Romanow and Kirby reports on Canada's health system. In particular, the federal government has been negotiating with the provinces and territories to establish a pharmacare plan that would assist in providing drugs for catastrophic health care.

However, Ottawa's financial contribution is inadequate to cover the costs of extending catastrophic drug coverage to all individuals in Newfoundland and Labrador. Currently under the province's targeted drug plan, approximately 110,000 persons are provided catastrophic coverage at a cost of $114 million (fiscal year 2005). This represents twenty percent of the population. This group consumes approximately 40 percent of all the prescription drugs purchased across the province.[9] Another informant stated that "I can tell you that the amount of money coming in a federal transfer as part of the health accord will not come anywhere close to us extending coverage to the entire population - certainly not to the level that I think the population would expect and in their mind what a catastrophic program, a universal program would look like."[10] Our informant expanded upon the lack of federal financing to pay for broadening catastrophic drug coverage noting that much more consultation needs to occur before a common definition and understanding of such care can be achieved: "So if we're looking at trying to come to some common threshold of what would the national definition be of a universal or catastrophic program, there's a lot of consultation that has to occur. But for us to move in any direction beyond the people, there are a lot of financial issues for the province at the moment."[11]

Even without federal funding, the province has neither been able to provide universal coverage nor targeted coverage for all new drug therapies introduced. An informant remarked "we [the government] didn't make it universal because of the horrendous cost

[9]. Figures quoted by Respondent 7.
[10]. Respondent 6.
[11]. Respondent 6.

in doing so and really that's where it starts and stops. There's other subsidiary reasons about what should be the role of government; but, basically, the costs of the existing targeted program are unmanageable and there's no consideration of going beyond that."[12]

From this perspective, the effort to construct or reconstruct common perceptions or views of the problem or reality struggled over the question of feasibility of such a framework or response. The extent to which outside pressure and critics have been unorganized and competitive has added little steam in the quest for reform and much to the concerns of the provincial government about the dangers of increasing costs and changing citizen expectations. These became front and centre. In fact, with so many competitive state-societal divisions in play with changes in fiscal federalism and various problems associated with the collapse of the fishery, it was difficult developing a common vision and agenda. It was a period when there was not much trust between levels of government and little incentive to work together in promoting common objectives and a mental map.

A related theme concerns equity in drug coverage with respect to new therapies. In a targeted drug plan, certain new therapies may be excluded because of their prohibitive costs even though they may be an improvement in treatment for patients. In Newfoundland and Labrador, particular "champions" have emerged to lobby government to include specific therapies in the formulary for individuals who either can not afford them or for those persons whose private drug plans do not cover any or all of the costs.

Recently, groups such as the Alzheimer's Society, the Arthritis Society, and the Cancer Society have gone public in order to persuade the province to pay for the cost of specific therapies beneficial to patients. These groups usually rely on the mass media to publicize cases where patients are needlessly suffering because they can not afford the necessary therapy. However, the issue of equity becomes salient because it is impossible for government to fund all therapies requested. In the most recent provincial budget (March 21, 2005), government announced it would fund new arthritis therapies but not those for Alzheimer's disease. An informant commented that "why would you choose one disease over another? That's a fair argument, and then I would have to look at that with respect to what would make one disease more significant than another? To the person who has that disease, that is the significant issue for them. I would think that government would look at designing a program that has that equity in balance in that you treat all individuals equally irrespective of what type or nature, extent or cost of their disease."[13] Besides specific disease-advocacy groups, low-income persons and lower middle-class persons who lack private drug coverage continue to lobby government for reform. However, these individuals and groups lack the funding, the tools and the knowledge to go public and persuade policy-makers and citizens to come on board and support their positions with respect to drug reform. Comparable to mental health patients in the contest over waiting list reform, these power differentials work against integrated universal, province-centred policy reforms.

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[12] . Respondent 5.
[13] . Respondent 6.

Another issue that is significant is that pharmaceuticals were not part of the original Medicare bargain. Thus, there was never any discussion to have a national plan in place to cover the cost of prescription drugs for Canadians. As an informant suggested, "in 1957 when Medicare was introduced, we thought the two biggest problems in this country were hospital services and physicians; and if we could ensure that Canadians had equitable access regardless of their financial means to hospitals and to physicians, that we would be protecting the Canadian citizens."[14] Ideas relating to drug reform have informed some of the debates in Newfoundland and Labrador but without adequate financial resources, the ability of the province to expand its already poor drug coverage is not present. Nor is there incentive to adopt such an approach. One of our informants noted that "in the 1980s we started to have discussions about pharmacare - about the need to address this. The National Forum on Health was the first national body, which did very good work but weren't listened to for all kinds of reasons - but they did very good work that Romanow pretty much replicated, but was listened to. They talked about the need for both home care and pharmacare to be funded."[15]

In Newfoundland and Labrador, universal pharmaceutical drug coverage is not likely to become reality even with the new found oil and natural gas wealth negotiated by Premier Williams in the Atlantic Accord. The costs of such a reform are simply too much to bare in a province with a limited fiscal capacity. Additions of therapies to the provincial drug formulary are based on evidence of effectiveness but also are dependent on the efforts of individuals and groups to catch the attention of policy-makers and the public. For the most part, people appear to be much more concerned about Health Human Resources issues. Part of this might have to do with the nature of health care delivery. Everyone needs doctors, nurses and technicians - these are resources that appeal to all citizens, and every region, drug group, and class. Even though drugs are a bigger expenditure item, and hence financial problem, it is a policy field that is more complicated and makes it difficult to make sense of and respond in a coherent manner. This applies to both pressure groups and governments too. When drug reform appears on the government's radar, it does so because of national ideas, reports and commissions or as a result of media coverage of the plight of a patient suffering needlessly because she or he lacks access to a new and improved therapy. In Newfoundland, it tends to drop off just as quickly since there are no coalitions, champions, political resources, ideas, incentives or institutional support to sustain it and move it to the next level.

Prescription Drug Reform: the Decision Agenda

As indicated above, prescription drug reform generally appears on the radar screen when a national report is issued. Most of our informants were quick to note that drug reform became more visible in the wake of the Romanow and Kirby reports. However, as much as everyone supports the idea of extending prescription drug coverage to the entire population regardless of income, no government has ever formally adopted such a position. Informants note that opposing universal coverage is "arguing against motherhood and apple pie. So in terms of perspective, I guess everyone would say, if we

[14]. Respondent 3.
[15]. Respondent 3.

could afford it, yes, why would we not move in this direction; but unfortunately, money is an issue and we don't have a bottomless pit or dish here in our province, so the perspective was more of exploration."[16] Another respondent remarked that "The government's overwhelming problem is its inability to balance the budget, and this [prescription drug coverage] is a program with explosive growth; and it's been very, very difficult to contemplate expanding."[17] In a similar vein, there was mention of attempting to rein in drug costs by putting pressure on pharmaceutical companies. One informant suggested that "control is a big issue because the companies who create the drugs have incredible control on the population's thought process around effectiveness of those medications. The very fact they're expensive is an indication of that. And the thing is this is open-ended. You can control the number of hospitals you fund and you can control the number of doctors you allow to be licensed but you really can't control the amount of drugs that you're willing to cover."[18]

The individuals and groups that were responsible for bringing the issue to government's attention are the same as for the government agenda. In Newfoundland and Labrador, this would include disease-advocacy groups (Arthritis Society, MS Society, Alzheimer's Society), community groups (Coalition Against Poverty, Community Services Council, Provincial Advisory Council on the Status of Women), the political opposition (especially the provincial New Democratic Party) and low-income persons. While sympathetic, governments did not formally institute reform other than to add therapies to the formulary for those receiving social assistance or who are senior citizens. For some therapies, groups and individuals benefited from having physicians on side. Physicians are effective lobbyists because they can verify the importance of a particular drug for a patient's recovery and ultimate well-being. One informant stated "some groups might be [more successful] because they have the physicians behind them."[19]

One final issue for the province concerns funding, especially from the federal government, with respect to pharmacare programs. Provincial governments have been wary of participating in national programs if Ottawa is not willing to pay its share of the costs. An informant wrily remarked:

"If the federal government were going to bring in a pharmacare program, we'd say, okay, the first thing you have to do cost share whatever the cost sharing is going to be. So if it's going to be 50/50, that gives the current government of the day $55 million that they decide whether they add on drugs for 55 million dollars extra, or maybe the $55 million might go over for wait lists. It might go into home care. It might go into something else. It might go into nutrition, education programs, preventative programs; but the feds would always say - and this is where they push and this was a bit of Romanow too - the people wanted to know where the money was. This is this Health Council. That if we're going to give you [the province] money, we want to see some improvement; and our view here was, listen pal, we've been carrying the ticket for this for a long time so if you're going to

[16]. Respondent 6.
[17]. Respondent 5.
[18]. Respondent 3.
[19]. Respondent 10.

come for the first time ever with some money for pharmacare, the first thing we do is we offset some of our own cost in our current program and then we decide alone whether or not we expand the program."[20]

Federalism exercises a significant role with respect to cost-sharing on proposed programs such as pharmacare. What has occurred in the decision realm is for policy-makers to tinker ever so modestly with the existing targeted drug program. An informant remarked, "how could we possibly modify our current program so that we may be able to cast the net a little wider? Maybe we can't go all the way; but perhaps we can pull in a few more people without a tremendous financial burden on the province. So it was exploration - let's look at see. Let's look at what potential definitions there are for catastrophic [drug coverage]. Let's look at what potential models there are in place in some of the provinces that have a more expanded population that they cover, and let's see what it would potentially cost us."[21] The decision to reform drug coverage in Newfoundland and Labrador has been sporadic and is stimulated by national attention to the issue and group and individual lobbying for expanding the types of therapies covered by the provincial formulary. On the other hand, given the lack of resources and concerns that the drivers to increase expenditures on drugs and bring about reforms may either be politically motivated at the national level, or the result of drug companies trying to achieve even higher profits has undermined the drive for renewing governance and introducing reforms at the provincial decision-making level.

Prescription Drug Reform: Policy Choice

The kinds of policy choices made by the provincial government with respect to drug reform are largely focused on sustaining the current targeted program. Instead of trying to expand the number of people covered, policy-makers have opted to keep the existing level of drug coverage stable for those who are most vulnerable. As an informant remarked, "if we have a program that we're already struggling with do you not put it [additional resources] in strengthening your current program and providing better coverage to the people that we're already servicing or do you take a program that's already struggling and put your extra finances into covering more people. I guess that's a difficult policy, for sure."[22] The government has opted for this approach by making changes to the therapies covered for the reasons enumerated above.

The policy choices made by decision-makers in Newfoundland and Labrador come down to money; more specifically, the lack of fiscal capacity. The number of new therapies have multiplied exponentially so that no government can possibly pay for all drugs coming onto the market. An informant stated that "the single biggest problem for prescription drug programs right now in this province and many others is that there are not enough funds to provide coverage for all of the new drugs that are coming at us day

[20]. Respondent 4.
[21]. Respondent 6.
[22]. Respondent 6.

by day; and until that's resolved, it's difficult to make a decision such as this in terms of expansion. I guess the first hurdle is economics."[23]

Another consideration with respect to policy choice is which groups and individuals should be covered with respect to prescription drugs. In Newfoundland and Labrador, the poor and seniors are covered but not necessarily those individuals who may work for minimum wage or part-time. While governments have been cognizant of the plight of such persons, a formal decision has never been made to provide drug coverage. However, this does not mean government is not experimenting with new models. As an informant notes, "I'm bringing forth a few models for an expansion [of the targeted drug plan] and that is specifically, I think, in the direction of the catastrophic drug plan discussed at the First Premiers Conference and so there are two or three models for expansion, and this particular one which will include a working definition of that. And expansion of the senior's plan - more like a premium type model similar to what Nova Scotia has[24]. Seniors who [have] retired and do not have a retirement drug [plan] can access this."[25] As well, the provincial health research agency has been examining differing models of drug coverage based on a premium scheme where low-income persons could purchase drug coverage. This has yet to be formalized by government.[26] The dilemma for government can be summed up thus: "the most vulnerable get served and the most powerful get served (chuckle). It's the poor crew in the middle who get caught over and over again."[27]

There is a political dimension to policy choice in that people expect government to deal with problems now rather than later. Politicians operate on four year cycles ever mindful of re-election. What this means is that long-term reform is impossible to achieve. Fewer prescriptions could be written if the population health indicators of Newfoundlanders and Labradorians were markedly better. An informant remarked "as soon as you look at the early intervention and prevention schemes, knowing that the payoff is sometimes a generation down the road and you've got to dedicate millions of dollars a year to it for it to be effective, and that's millions of dollars a year that your current population who are now voting for you are saying, but I'm waiting for my heart surgery."[28] This is the paradox of reform; more money for health prevention and promotion would have long-term benefits for both the population and the provincial treasury but citizens and politicians simultaneously want a quick fix. The political payoff is with the quick fix rather than long-term planning. One area of reform undermines another. One other paradox is that the drug companies themselves have lobbied the provincial government for expanding coverage: "the pharmaceutical companies advocated for a universal program. They weren't intense on it; but, they would argue that the health benefits in the economy, the health benefits in the society would turn into economic benefits from

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[23]. Respondent 6.
[24]. In Nova Scotia, the seniors' pharmacare program requires a co-payment of 33 percent of the cost of the prescription between a minimum of $3 and a maximum of $30 with the maximum co-payment amount set at $350. See Deana Stokes Sullivan, "Drug Spending Up: Report," The Telegram, April 6, 2005, p. A3.
[25]. Respondent 8.
[26]. Respondent 8 mentioned this point during the interview.
[27]. Respondent 3.
[28]. Respondent 4.

people missing less work, generating more taxes and using the health services less often."[29] The costs, of course, are too prohibitive for government to contemplate.

Newfoundland and Labrador does appear to be more interested in adopting a more preventive and health promotion model of health. Whether this is simply rhetoric only time will tell but such a vision of health will make it more not less difficult to focus on old bio-medical solutions or reforms.

Conclusion

Prescription drug reform in Newfoundland and Labrador is a "no go" case. There have not been any formal institutional or legislative acts with respect to the province's targeted drug plan. Reform, when it has occurred, has been incremental, reactive rather than proactive, and forced on government as a result of national commissions and reports and internally by the mass media on behalf of disease-advocacy groups. The lack of fiscal capacity in the province makes formal reform impossible. There are far more serious problems with the provincial health system (wait lists and Health Human Resource recruitment and maintenance) that require immediate attention. Individuals and groups will keep trying to persuade policy-makers to add specific therapies to the provincial drug formulary that may be of benefit to them. As an informant noted, "the fiscal capacity, pure and simple is not there."[30]

[29]. Respondent 5.
[30]. Respondent 9.

APPENDIX 1 CODING REPORT FOR PRESCRIPTION DRUG REFORM IN NEWFOUNDLAND AND LABRADOR

1. IDEAS
    - access to drugs
    - alternative funding models for drug coverage
    - catastrophic drug plans
    - change and reform
    - collaboration among stakeholders
    - coalitions of groups driving reform
    - political culture
    - equity
    - fairness
    - ideas about reform
    - important features of reform
    - information for reform
    - market ideas and reform
    - needs of individuals
    - pharmacare plans
    - reform policy
    - priority of drug reforms
    - reform
    - drug coverage
    - universal drug plans
    - quality of data used to study reform
    - quality of evidence
    - drug therapies

2.INTERESTS
    - advocacy on behalf of marginalized groups
    - anti-poverty groups
    - associations targeting reform
    - cancer groups
    - cardiac groups

- community groups
- diabetes groups
- doctors
- drug companies
- elderly groups
- fiscal interests in reform
- funding and reform
- groups
- health system
- human resources
- interest in reform
- lobby
- lobbying
- low income groups
- media
- MS groups
- patients' interests
- opposition parties
- poor
- pressure for reform
- senior interests
- social services
- subsidies
- visible minorities
- welfare

3. EXTERNAL EVENTS
    - Health Accord
    - Alberta reforms
    - Canada
    - Federalism
    - Kirby Report
    - Ontario reforms
    - Romanow Reports
    - external reports

4. INSTITUTIONS
    - agenda setting
    - health boards
    - health budgets
    - Cabinet decisions
    - control over reform
    - Department of Health
    - government
    - hospitals

- informal change
- medical bodies
- Ministers/Deputy Ministers
- Money
- nurses
- physicians
- region/regionalization
- resources
- tension
- Treasury Board

APPENDIX 2 PRESCRIPTION DRUG REFORM CODING TABLES

NOTES ON TABLES AND METHODOLOGY

The terms employed for the tables are drawn from the coding report found in Appendix 1. Codes were devised based on the template from 21 October 2003 (revised) and the report distributed to the research team by John Lavis (23 November 2004). Tables are listed numerically as follows: prefix 1 are ideas; prefix 2, interests; prefix 3, external factors and prefix 4, institutions. The percentage figure in the column "# of mentions" refers to the percentage of all text units analyzed that the concept represents. For our case, there were a total of 1644 text units employed in the analysis.

TABLE 1.1 ACCESS TO PRESCRIPTION DRUG COVERAGE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	7.7
4	Politician	3	23.1
5	Civil Servant	0	0
6	Civil Servant	3	23.1
8	Civil Servant	5	38.5
9	Interest Group	0	0
10	Health Professional	1	7.7
TOTAL		13 (0.8%)	100.1

TABLE 1.2 CATASTROPHIC DRUG PLANS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	9.1
6	Civil Servant	8	72.7
8	Civil Servant	2	18.2
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		11 (0.7%)	100

TABLE 1.3 CHANGE AND REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	40
5	Civil Servant	0	0
6	Civil Servant	3	60
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		5 (0.3%)	100

TABLE 1.4 COALITIONS OF GROUPS DRIVING REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	50
6	Civil Servant	1	50
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.1%)	100

TABLE 1.5 POLITICAL CULTURE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 1.6 EQUITY IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	2	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.1%)	100

TABLE 1.7 IDEAS AROUND FAIRNESS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	2	66.7
8	Civil Servant	1	33.3
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		3 (0.2%)	100

TABLE 1.8 QUALITY OF DATA USED FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	33.3
8	Civil Servant	2	66.7
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		3 (0.2%)	100

TABLE 1.9 QUALITY OF EVIDENCE TO GENERATE IDEAS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	33.3
5	Civil Servant	1	11.1
6	Civil Servant	1	11.1
8	Civil Servant	4	44.4
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		9 (0.55%)	99.9

TABLE 1.10 DRUG THERAPIES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	33.3
5	Civil Servant	1	11.1
6	Civil Servant	5	55.5
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		9 (0.55%)	99.9

TABLE 1.11 IMPORTANCE OF REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	4	80
4	Politician	0	0
5	Civil Servant	1	20
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		5 (0.3%)	100

TABLE 1.12 INFORMATION ABOUT REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	50
8	Civil Servant	1	50
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.12%)	100

TABLE 1.13 MARKET IDEAS ABOUT REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	25
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	3	75
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		4 (0.24%)	100

TABLE 1.14 IDEAS ABOUT NEED

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	3	42.9
4	Politician	1	14.3
5	Civil Servant	0	0
6	Civil Servant	1	14.3
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	2	28.6
TOTAL		7 (0.43%)	100.1

TABLE 1.15 IDEAS ABOUT PHARMACARE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	9	60
4	Politician	6	40
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		15 (0.91%)	100

TABLE 1.16 PRIORITY OF IDEAS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	60
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	2	40
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		5 (0.3%)	100

TABLE 1.17 REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	3	75
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	1	25
10	Health Professional	0	0
TOTAL		4 (0.24%)	100

TABLE 1.18 TECHNOLOGY AND REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	50
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	1	50
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.12%)	100

TABLE 1.19 DRUG COVERAGE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	9	25.7
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	18	51.4
8	Civil Servant	6	17.1
9	Interest Group	0	0
10	Health Professional	2	5.7
TOTAL		35 (2.13%)	99.9

TABLE 1.20 UNIVERSAL DRUG COVERAGE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	6.7
4	Politician	0	0
5	Civil Servant	5	16.7
6	Civil Servant	15	50
8	Civil Servant	5	16.7
9	Interest Group	0	0
10	Health Professional	3	10
TOTAL		30 (1.82%)	100.1

TABLE 2.1 ADVOCACY FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	16.7
6	Civil Servant	5	83.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		6 (0.36%)	100

TABLE 2.2 ADVOCACY ASSOCIATIONS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	25
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	3	75
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		4 (0.24%)	100

TABLE 2.3 INTERESTS OF CANCER ASSOCIATION

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	16.7
4	Politician	1	16.7
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	2	33.3
9	Interest Group	0	0
10	Health Professional	2	33.3
TOTAL		6 (0.36%)	100

TABLE 2.4 INTERESTS OF COMMUNITY GROUPS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	100
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 2.5 INTERESTS OF DOCTORS IN DRUG REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	3	60
4	Politician	1	20
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	20
TOTAL		5 (0.3%)	100

TABLE 2.6 INTERESTS OF DRUG COMPANIES IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	66.7
4	Politician	1	33.3
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		3 (0.18%)	100

TABLE 2.7 INTERESTS OF ELDERLY PERSONS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	4	57.1
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	2	28.6
8	Civil Servant	0	0
9	Interest Group	1	14.3
10	Health Professional	0	0
TOTAL		7 (0.43%)	100

TABLE 2.8 FISCAL INTERESTS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	50
8	Civil Servant	1	50
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.24%)	100

TABLE 2.9 FUNDING FOR DRUG REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	20
5	Civil Servant	0	0
6	Civil Servant	3	30
8	Civil Servant	5	50
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		10 (0.61%)	100

TABLE 2.10 INTERESTS OF GROUPS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	100
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 2.11 INTEREST IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	2	28.6
4	Politician	4	57.1
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	1	14.3
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		7 (0.43%)	100

TABLE 2.12 LOBBYING FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	4	33.3
5	Civil Servant	0	0
6	Civil Servant	3	25
8	Civil Servant	3	25
9	Interest Group	2	16.7
10	Health Professional	0	0
TOTAL		12 (0.73%)	100

TABLE 2.13 INTERESTS OF LOW-INCOME PERSONS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	33.3
6	Civil Servant	1	16.7
8	Civil Servant	2	33.3
9	Interest Group	1	16.7
10	Health Professional	0	0
TOTAL		6 (0.37%)	100

TABLE 2.14 INTEREST OF MEDIA IN DRUG REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	33.3
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	2	66.7
10	Health Professional	0	0
TOTAL		3 (0.19%)	100

TABLE 2.15 INTERESTS OF MS PATIENTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	0	0
4	Politician	2	25
5	Civil Servant	0	0
6	Civil Servant	4	50
8	Civil Servant	2	25
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		8 (0.49%)	100

TABLE 2.16 INTERESTS OF PATIENTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	33.3
4	Politician	2	33.3
5	Civil Servant	0	0
6	Civil Servant	1	16.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	16.7
TOTAL		6 (0.36%)	100

TABLE 2.17 OPPOSITION TO DRUG REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	66.7
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	1	33.3
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		3 (0.18%)	100

TABLE 2.18 INTERESTS OF POOR PERSONS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	1	14.3
9	Interest Group	0	0
10	Health Professional	6	85.7
TOTAL		7 (0.43%)	100

TABLE 2.19 PRESSURE FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	0	0
4	Politician	2	20
5	Civil Servant	0	0
6	Civil Servant	4	40
8	Civil Servant	4	40
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		10 (0.61%)	100

TABLE 2.20 DRUG SUBSIDIES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 2.21 INTERESTS OF INDIVIDUALS ON WELFARE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	100
TOTAL		1 (0.06%)	100

TABLE 3.1 HEALTH ACCORD

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	11.1
6	Civil Servant	7	77.7
8	Civil Servant	1	11.1
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		9 (0.55%)	99.9

TABLE 3.2 ALBERTA REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	0	0
4	Politician	1	33.3
5	Civil Servant	1	33.3
6	Civil Servant	0	0
8	Civil Servant	1	33.4
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		3 (0.18%)	100

TABLE 3.3 CANADA

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	9	69.2
5	Civil Servant	0	0
6	Civil Servant	1	7.7
8	Civil Servant	3	23.1
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		13 (0.8%)	100

TABLE 3.4 KIRBY REPORT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	2	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.12%)	100

TABLE 3.5 ONTARIO REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	100
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.12%)	100

TABLE 3.6 ROMANOW REPORT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	20
5	Civil Servant	0	0
6	Civil Servant	8	80
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		10 (0.6%)	100

TABLE 3.7 EXTERNAL REPORTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	25
5	Civil Servant	0	0
6	Civil Servant	3	75
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		4 (0.24%)	100

TABLE 4.1 REGIONAL HEALTH BOARDS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	1	100
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 4.2 HEALTH BUDGETS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	27.3
5	Civil Servant	1	9.1
6	Civil Servant	1	9.1
8	Civil Servant	6	54.5
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		11 (0.67%)	100

TABLE 4.3 CONTROL OVER DRUG COSTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	14	87.5
4	Politician	1	6.25
5	Civil Servant	1	6.25
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		16 (0.97%)	100

TABLE 4.4 DEPARTMENT OF HEALTH

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 4.5 GOVERNMENT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	11	39.3
4	Politician	8	28.6
5	Civil Servant	3	10.7
6	Civil Servant	5	17.8
8	Civil Servant	1	3.6
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		28 (1.7%)	100

TABLE 4.6 HOSPITALS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	8	88.9
4	Politician	1	11.1
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		9 (0.55%)	100

TABLE 4.7 INFORMAL CHANGE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 4.8 MEDICAL BODIES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	100
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.12%)	100

TABLE 4.9 MONEY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	3	10.3
4	Politician	8	27.6
5	Civil Servant	4	13.8
6	Civil Servant	5	17.2
8	Civil Servant	5	17.2
9	Interest Group	0	0
10	Health Professional	4	13.8
TOTAL		29 (1.8%)	99.9

TABLE 4.10 NURSES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		1 (0.06%)	100

TABLE 4.11 PHYSICIANS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	4	57.1
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	1	14.3
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	2	28.6
TOTAL		7 (0.43%)	100

TABLE 4.12 REGION/REGIONALIZATION

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	66.7
5	Civil Servant	0	0
6	Civil Servant	1	33.3
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		3 (0.18%)	100

TABLE 4.13 RESOURCES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	5	100
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		5 (0.3%)	100

TABLE 4.14 TENSIONS AMONG DECISION-MAKERS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	100
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		2 (0.12%)	100

TABLE 4.15 TREASURY BOARD

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS

3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
6	Civil Servant	0	0
8	Civil Servant	4	100
9	Interest Group	0	0
10	Health Professional	0	0
TOTAL		4 (0.24%)	100