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Catastrophic Drug Coverage in Canada

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Abstract:

There is currently no nationwide catastrophic drug coverage in Canada, and this creates many inequities with regards to the costs and accessibility of out-of-hospital (outpatient) prescription drugs. This paper examines why catastrophic drug coverage needs to be addressed as well as implemented in order to improve the inequities in provincial drug plans and the continued non-coverage of outpatient prescription drugs. This paper used the recommendation of the 2002 Romanow Commission as a point of reference for the need to implement catastrophic drug coverage in Canada. Moreover, the 2003 First Ministers' Accord and 2004 First Ministers' Meeting are used to reveal the government's initiative to develop a Canadian catastrophic drug coverage policy that remains unaddressed and unimplemented to this day.

Keywords: catastrophic drug coverage, prescription drugs, Romanow Commission, First Ministers' Accord, First Ministers' Meeting

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Introduction

In Canada, there is a desperate need to address the lack of catastrophic drug coverage. Catastrophic drug coverage is a drug policy that extends prescription drug coverage to qualified Canadian individuals and families who have reached an unusually high level of out-of-pocket drug spending (Gagnon & Hébert, 2010). Such spending may be due to drug therapy for chronic illnesses and/or rare diseases. Catastrophic drug coverage as a healthcare system provision provides individuals access to medically necessary outpatient prescription medications, which can be extremely expensive to Canadians (Phillips, 2009). Without catastrophic drug coverage policy, individuals bear the risks of suffering financial burden and adversity resulting from high prescription costs (Phillips, 2009). There is also a risk of continued illness as a result of non-compliance with costly outpatient drug therapies (Lexchin, 2001).

Because prescription drugs play an increasingly important role in patients' illnesses, diseases, diagnoses, treatments, and cures (Romanow, 2002; Coombes, Morgan, Barer, & Pagliccia, 2004), the demand of prescription drugs in healthcare delivery has increased. As a result, expenditures on prescription drugs have been escalating expenditures on prescription drugs (Blomqvist & Xu, 2001). In 2009, the Health Council of Canada (HCC) reported that prescription drug costs have become quite a burden for Canadians. Compared to other western industrialized countries, Canadians pay more out-of-pocket for their prescription drugs. This can make it very difficult for patients to acquire medically necessary drug therapies due to the absence of universal drug coverage in the Canadian healthcare system (HCC, 2009; Romanow, 2002; Kapur & Basu, 2004; Gagnon & Hébert, 2012).

Three documents, namely, the Romanow Commission (2002), the First Ministers' Accord on Renewal (2003), and the First Ministers' Meeting on the Future of Health Care (2004) have provided recommendations and initiatives that address catastrophic drug coverage in Canada. These three documents aim to avert potential financial difficulties that prescription drugs impose on Canadians and to improve the overall sustainability of drug utilization within the healthcare system (Romanow, 2002; First Ministers' of Canada [FMoC], 2003; First Ministers' of Canada [FMoC], 2004). This paper examines why catastrophic drug coverage needs to be addressed in order to improve the issues of existing inequalities in provincial drug plans and the continued non-coverage of outpatient prescription drugs in Canada. Furthermore, this paper examines whether the recommendations from the 2002 Romanow Commission have been addressed by the initiatives developed during the 2003 First Ministers' Accord and 2004 First Ministers' Meeting.

Inequity in Prescription Drug Coverage

The costs of prescription drugs have been continually escalating at a rapid rate (Kapur & Basu, 2004). As prescription costs become a huge portion of healthcare system spending, individuals and governments will continue to experience financial dilemmas (FMoC, 2004). The Canadian Institute for Health Information (CIHI) (2012) reports that prescription drug spending is the second highest expenditure in the Canadian healthcare system with an average annual increase rate of 8.5 percent from 1985 to 2011. Canadians spent an estimated \$12.1 billion from public sector and \$15.1 billion from private sector on prescription drugs in 2011. These dollar values account for 37.6 percent and 47.2 percent of the total drug costs in Canada, respectively. Furthermore, out-of-pocket spending accounts for 15.2 percent (\$4.9 billion) of the private sector

expenditure (CIHI, 2012). The average per capita spending on prescription drugs is \$929—the public sector share is \$350 and the private sector share is \$438. Across all ten provinces, the public spending ranges from \$237 (British Columbia) to \$414 (Quebec), while in the three territories the range is from \$335 (Nunavut) to \$418 (Yukon). The private sector spending on prescription drugs is higher than public spending in all provinces except British Columbia (CIHI, 2012). This means that most of Canadians' spending on prescription drugs comes from out-of-pocket expense and/or insurance coverage. In such case, catastrophic drug coverage becomes an important policy initiative that enables all Canadians to have equitable access to medically necessary high-cost drugs regardless of their income, geographical location, and occupation (FMoC, 2003; FMoC, 2004; Romanow, 2002).

There is currently no universal drug coverage or national catastrophic drug coverage in Canada (Romanow, 2002; Phillips, 2009). Instead, a mix or “patchwork” model with private and public prescription drug coverage exists, which leaves a significant number of people without adequate access to medically necessary medications in the outpatient setting (Lexchin, 2001; Romanow, 2002; Law, Cheng, Dhalla, Heard, & Morgan, 2012). The existence of this model is driven by the perception and concern that public coverage of prescription drugs is a highly unsustainable endeavor for taxpayers to undertake (Gagnon and Hébert, 2012). As a result, the demand for private insurance access increases even if this entails overall higher costs for individuals (Gagnon and Hébert, 2012). This contributes to the continued increase in pharmaceutical costs and increasing inequity in prescription drugs, wherein the (in)accessibility of drug coverage depends on the individual's home and work location, as well as the individual's personal/family financial means (Gagnon & Hébert, 2012). These lead to the widening of already existing gaps and variations in prescription coverage across Canada (Morgan & Willison, 2004). The Romanow Commission (2002) has recognized these inequities in provincial and territorial prescription coverage; hence, the need to have nationwide catastrophic drug coverage was explicitly included and explained in the report.

Approximately 24 percent of Canadians have no drug coverage and about two-thirds of Canadian households have some form of out-of-pocket spending for prescription drugs (Law et al., 2012; Gagnon & Hébert, 2012). It is estimated that in the last 12 months, about 8 percent of Canadians who received prescription(s) from physicians did not fill, renew, or maintain their medications due to associated drug costs (Gagnon & Hébert, 2012). The recent study by Law and colleagues (2012) estimates that about one in ten Canadians do not adhere to their prescribed medications due to the variability of insurance coverage for prescription drugs. This variation and disparities in prescription drug costs, as explained in an earlier study by Kapur and Basu (2004), result in increased underinsurance of vulnerable population (discussed later).

All provinces and territories have special programs for individuals who are 65 and over, as well as welfare recipients (Gagnon & Hébert, 2012). However, the eligibility criteria for this vary widely across Canada (Demers, Melo, Jackevicius, Cox, Kalavrouiotis, Rinfret, Humphries, Johansen, Tu & Pilote, 2008). Demers & colleagues (2008) state that variations in provincial drug plans' reimbursement systems indicate that Canadian seniors have substantial support for drug costs but with varying differences across provinces. For example, in New Brunswick, coverage and reimbursement for seniors are not extended to high-income seniors, and low/high-income criteria are codified by provincial legislation (Phillips, 2009). In the same study, it was identified that non-seniors shoulder a significant part of the drugs cost even if there is drug plan

coverage available for them (Demers et al., 2008). Gagnon and Hébert (2012) explain that there are typically no cost deductibles to prescription drugs of individuals receiving welfare; however, there are co-payment costs per prescription with varying differences across provinces. For example, the prescription cost for social assistance recipients in most provinces is two dollars per prescription. Meanwhile, in Atlantic Canada, specifically in Newfoundland and Labrador, an individual may require a per prescription cost of up to five percent of their family income (Gagnon & Hébert, 2012). Therefore, it can be inferred that there is little attention given to vulnerable people, including the younger population and those on social assistance because of the minimal subsidy for drug costs incurred by these people.

The need for Canada to institute catastrophic drug coverage across the country is rooted by the concern that Canadians, wherever they may be living in the country, should be able to access needed prescription drugs without the risk of any financial adversity (Romanow, 2002; FMoC, 2003; FMoC, 2004). Access to prescription drugs should be based on patients' needs rather than the patients' ability to pay for the medications (FMoC, 2004). With the existing disparities in prescription drug coverage across Canada, it is imperative that catastrophic drug coverage is implemented. This ensures that Canadians' financial security is not threatened when they are struck with an illness. Moreover, catastrophic drug coverage would be able to provide Canadians with equitable access to medically necessary outpatient prescription drugs that are highly expensive.

Non-Coverage of Outpatient Prescription Drugs

Because of improvements in medical technologies and drug therapy, acute conditions that were once treated in hospital are now being treated at home (Phillips, 2009). However, the current mix of public and private drug coverage systems in Canada fails to recognize that these changes and improvements in medical practice have increased the use of prescription drugs in outpatient settings (Phillips, 2009). Currently, the provincial and territorial governments provide coverage for prescription drugs in hospital settings, but not in outpatient settings (Tamblyn, 2005; Anis, Guh, Lacaille, Marra, Rashidi, Li, & Esdaile, 2005). As such, the high costs of prescription medications can be financially problematic to patients who need medically necessary outpatient drug therapy, especially those who do not qualify for provincial drug plans or have sufficient coverage from private insurance (HCC, 2009).

There are several patient characteristics that hinder adherence to prescription drugs. Individuals with poor health, low income household, those with no insurance for prescription drug coverage, people who are below 65 years of age (Law et al., 2012), non senior women, middle-income workers, part-time workers and those without post secondary education are the most vulnerable to prescription non-adherence (Kapur & Basu, 2004). Similarly, younger Canadian population between the ages of 18 to 34 is particularly likely to suffer non-coverage or underinsurance due to their income and/or part-time job status (Phillips, 2009). Furthermore, low-income patients in general suffer from lack of adequate drug therapy (Law, Cheng, Dhalla, Heard & Morgan, 2012). According to Kapur and Basu (2005), various studies have proven that patients with insecure income tend to suffer from under-medication because they cannot afford private insurance or insurance costs (e.g. deductibles and co-payments). Therefore, the already poor state of the patient's health is worsened by the inability to access essential prescription medications. This is supported by another study where it was found that patient cost-sharing on prescription drugs results in fewer prescriptions filled, increased patient physician visits, and

increased hospital admissions (Anis, Guh, Lacaille, Marra, Rashidi, Li & Esdaile, 2005). When patients are asked to share the costs of their medication, they tend to reduce their use of prescriptions. In fact, some rely on hospital admissions to receive free medications (Tamblyn, 2005; Anis et al., 2005). According to Lexchin (2001), some patients opt not to fill their prescriptions due to lack of income. This seems reasonable and harmless for non-essential drugs; nevertheless, serious and adverse health risks could occur if essential prescription medication is ignored (Lexchin, 2001).

Tamblyn (2005) clarifies that even though there has been increased awareness of the need for outpatient drug coverage, the federal and provincial governments have yet to address the issue (Anis et al., 2005). With each provincial and territorial government having their own independently administered outpatient prescription subsidy plan, the coverage for outpatient prescription drugs remains to be varied in terms of who qualifies for coverage, portion of the drug cost covered, which drugs are covered, and what kind of cost-sharing is required (Romanow, 2002; Gagnon & Hébert, 2012). Therefore, Canadians who do not fit within the codified eligibility criteria within provincial and territorial prescription subsidy plan remain without drug coverage. When unforeseen illness and disability strikes, they are likely to suffer financial hardship because of high prescription costs. For example, if prescription coverage were offered only to low-income seniors, many middle income senior households would be left with limited or no coverage at all (Coombes et al., 2004). Hence, uninsured Canadians suffering serious chronic health conditions, such as those with diabetes and arthritis, become most vulnerable (HCC, 2009). These patients require maintenance medication outside the hospital settings, including conditions such as high blood pressure and asthma (Phillips, 2009). Thus, it is imperative that medically necessary prescription drugs are considered just as important as medically necessary hospital and physician services (Romanow, 2002).

Catastrophic Drug Coverage: Response from government

Having recognized that catastrophic drug coverage can revolutionize the Canadian health care system, the Romanow Commission (2002) recommended to the federal government a plan to institute a system of catastrophic drug transfer funding. This would provide additional funding for provinces and territories to widen their drug coverage and thus, narrow the disparities in the cost of prescription drugs across the nation (Romanow, 2002). Additionally, the First Ministers' Accord on Health Care Renewal (2003) then responded by developing the \$16 billion Health Reform Fund, which would include catastrophic drug coverage. The First Ministers' Accord (2003) promised that by the end of 2005/2006, "reasonable access" to catastrophic drug coverage would be provided to Canadians regardless of where they live. Moreover, the First Ministers' Accord, agreed to establish cooperation in promoting the best pharmaceutical practices that will provide Canadians with safe, effective, accessible, and cost-effective drugs (FMoC, 2003).

As a follow-up to the Accord, the First Ministers' Meeting for the Future of Health in Canada (2004) later established a National Pharmaceuticals Strategy. The Ministerial Task Force implemented this strategy, and it outlined the government's plan to initiate various improvements to the public delivery of pharmaceutical care, including catastrophic drug coverage. Tamblyn (2005) argues that even though the strategy is focused on providing affordable and accessible drug therapies, the National Pharmaceuticals Strategy failed in addressing the inequitable access to necessary prescription drugs across provinces (Anis et al., 2005). The out-of-hospital prescription drugs remain outside the scope of medically necessary

services. Therefore, very little impact on medication costs would be gained from the National Pharmaceutical Strategies as proposed by the First Ministers (Tamblyn, 2005; Anis et al., 2005).

The catastrophic drug coverage plan has yet to be assessed relative to its implementation costs, and there is still no certainty of actual implementation. In addition, the First Ministers' Accord (2003) has not addressed what "reasonable access" to catastrophic drug coverage entails (Coombes et al., 2004). In 2005, the National Pharmaceuticals Strategy had reaffirmed its intention to accelerate the work on catastrophic drug coverage—a strategy classified as short to medium term focus (HCC, 2009). In the September 2008 National Pharmaceutical Strategy meeting, the health ministers further reaffirmed that catastrophic drug coverage would be extended to all Canadians (Phillips, 2009). However, this reaffirmation remains unaddressed and unimplemented. According to Phillips (2009), the delay in progress is mainly due to the continued disagreement regarding cost sharing among provinces. Conversely, the responsibility of the federal government in the funding and establishment of minimum drug coverage standard should not be understated.

Currently in Ontario, there is an existing provincial catastrophic drug plan referred to as the Trillium Drug Program wherein individuals with higher prescription costs relative to income are provided access to prescription drug subsidy (Talaga & Brennan, 2008; Ministry of Health and Long-Term Care [MOHLTC], 2002). This drug benefit program pays for drugs listed in the provincial formulary, but it is only available to qualified individuals and requires patients to pay deductibles and co-payments (MOHLTC, 2002). The eligibility criteria to access this program require an individual to be a current resident of Ontario with a valid Ontario health insurance card. Moreover, the resident should not be covered by the Ontario Drug Benefit Program (ODB), which means that the individual must be younger than 65 years old, currently not receiving any social assistance such as the Ontario Disability Support Program, and/or does not reside in a long-term care facility or receiving home care services (MOHLTC, 2002). Lastly, the individual must not have any private health insurance coverage, or have an insurance that provides 100 percent coverage of the prescription costs. Those who qualify for the program share the cost of their prescription by paying an annual prescription cost called a deductible and co-payments that is the cost of each prescription (MOHLTC, 2002). These cost-sharing can amount to approximately four percent of household income and two dollars for each prescription, respectively. The Trillium Drug Program also includes the facilitated access drug coverage for HIV listed drugs and the Exceptional Access Program, which allows Ontario Drug Benefit qualified individuals to access medications not listed in the provincial formulary (MOHLTC, 2002). Other than Ontario, almost all other provincial and territorial governments have their own provincially administered catastrophic drug plan, except for the Yukon Territory, Prince Edward Island, and New Brunswick (Phillips, 2009). Nationwide catastrophic drug coverage implementation has yet to happen in Canada.

Conclusion

This paper argues that prescription drug coverage across Canada remains inequitable and inaccessible to many out-of-hospital patients; therefore, it is necessary that accessibility and equitability of prescription drugs are addressed through catastrophic drug coverage. By having catastrophic drug coverage available and accessible to every Canadian, there will be better health outcomes and potentially improvement in prescription costs. It is important that we critically look at the nationwide implementation of catastrophic drug coverage. Prescription drugs are

increasingly ingrained in the practice of medicine, and yet patients have been frustrated because of the continually escalating drug prices that are often being paid for out-of-pocket. In addition, catastrophic drug coverage will liberate Canadians from the worry of financial risks and adversity because of high prescription drug costs. However, to this day, catastrophic drug coverage remains to be implemented nationwide. If the provincial and territorial governments with the full cooperation of the federal government work towards overcoming bureaucracies and red-tape within the existing healthcare system, perhaps soon equitable and sustainable access to universal catastrophic prescription drug coverage will be realized. Nonetheless, we hope the First Ministers remain true to their words to have catastrophic drug coverage available to all Canadians.

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