



# Lessons from the Quebec Universal Prescription Drug Insurance Program

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## **Contents**

Executive summary /	iii
Introduction /	1
A universal drug insurance system /	2
Improved access and health outcomes /	6
Are prescription drug expenses out of control? /	10
The pernicious effects of cost containment policies /	15
Discussion and conclusion /	18
References /	20
About the author /	26
Acknowledgments /	26
Publishing information /	27
Supporting the Fraser Institute /	28
Purpose, funding, & independence /	28
About the Fraser Institute /	29
Editorial Advisory Board /	30



## Executive summary

The Quebec general drug insurance program (RGAM) was set up in 1997 with the objective of enabling all Quebecers to have “reasonable and fair access to the medication required by their state of health”. It is a mixed public-private and universal system, unique in Canada. The public plan “provides for a minimum level of coverage for the cost of pharmaceutical services and medications” for people 65 years of age or older and social assistance recipients. It also provides insurance coverage to individuals who are not eligible for a private group insurance plan with an employer.

Private insurers hence continue to play an important role in the drug insurance sector in Quebec. All persons who are eligible for coverage, either as a participant or as a dependent, under an eligible private group insurance plan are mandated to join it. Around 4.7 million people belong to a private group insurance plan, or about 57 percent of Quebec’s population. The coverage of a private group plan must be at least equivalent to that of the public plan and may be expanded to include drugs that are not part of it. This means that they can reimburse more products, more rapidly, at higher prices, and on more permissive terms. In actuality, most private insurance plans choose to provide more generous coverage to their members than the minimum standard set by the public plan.

Overall, while not perfect, the results achieved by the RGAM program in improving access to prescription drugs are generally positive when compared to those of other provinces. It is in Quebec that we now find the most generous coverage when comparing provincial public drug plans across the country. Whereas on average 25.6 percent of all medicines approved by Health Canada between 2008 and 2017 were listed on the drug formularies of other provincial public plans in June 2018, this proportion reached 33.4 percent in Quebec.

Public coverage in Quebec is not only more generous, but drug coverage approval is also faster than elsewhere in the country. Over the last 10 years, it took an average of 477 days for a drug approved by Health Canada to be added to the list of medications covered by the RGAM. In comparison, the average delay was 674 days for all public drug plans in Canada. Not only that, but patients generally have access to a wider range of prescription drugs

in Quebec, and prescribers may therefore have more options for them, due to the Quebec government's less restrictive formulary compared to those in the rest of the country. The list of medications covered by the public plan includes more than 8,000 prescription drug products, the most extensive in the country. In comparison, the number of pharmaceutical products listed on the Ontario Drug Benefit formulary is 4,400.

Researchers who have evaluated the RGAM program confirm that improvements in access to prescriptions drugs have been significant. Indeed, the expanded insurance coverage has facilitated access to the required medications and provided therapeutic benefits to a large portion of the previously uninsured population. Empirical evidence shows that it is first and foremost Quebecers with chronic and generally poorer health conditions who have benefited the most from Quebec's approach towards universal drug coverage, in terms of improved access to needed medications and better health outcomes.

The RGAM parameters also limit catastrophic drug expenditures for both public and private plans' beneficiaries, a unique feature in Canada. As a matter of fact, only a tiny fraction of households in Quebec (0.2 percent) must take on catastrophic pharmaceutical expenses over the course of a year. As well, Quebec is the province with the lowest percentage of patients saying that they do not fill prescriptions because of financial cost. In 2016, 3.7 percent of Quebecers said they did not fully adhere to their therapy because of costs, by far the lowest percentage in the country.

Although pharmaceutical expenditures have increased since the program was implemented, there has been a relative decrease in the use of other health services. This is consistent with the fact that some pharmacological therapies may have replaced hospitalizations and more expensive treatments elsewhere in the healthcare system. As a result, Quebec has the lowest total health spending per capita of any province in Canada.

Clearly, a mixed universal public-private system like the one in Quebec, partly based on mandated benefits, deserves more attention in the current discussions of a proposed reform of the pharmacare system in the country. Quebec's model limits the economic distortions usually associated with single-payer tax-financed provision of health and drug insurance. Perhaps more importantly, it preserves the ability of employers to offer more generous benefit plans than a single-payer public drug program, including arrangements that are more tailored to their employees' preferences.

## Introduction

In recent years, the issue of National Pharmacare has been at the forefront of public policy debates in Canada. Last year, the House of Commons Standing Committee on Health has looked into the matter and tabled a comprehensive report proposing the introduction of a single-payer universal drug plan in Canada (Casey et al., 2018). The federal government responded by creating the Advisory Council for the Implementation of National Pharmacare, led by former Ontario health minister Eric Hoskins, to evaluate the merits of reforming the actual public-private system (Hoskins et al., 2019). The conclusion of its report, released in June 2019, is also in line with the position of several advocacy groups that have been pushing over the past few years for the adoption of an entirely public national drug plan to replace the current mixed system (Gagnon, 2014; White, 2016).

In the context of these ongoing discussions pertaining to a proposed reform of the pharmacare system in Canada, few analysts and commentators have referred to the current public-private system in place in Quebec, except to criticize it. The Quebec experience can teach us valuable lessons about the costs and benefits of introducing a mandatory universal drug program.

This paper aims to provide an extensive description of the Quebec Prescription Drug Insurance Plan (RGAM), showing its strengths and weaknesses. The first section presents an overview of how the system works, describing its main objectives and characteristics. The second section looks at the major achievements of the program, especially in light of its goal of providing reasonable and fair access to required medications for all citizens in the province. The evolution of prescription drug spending since the implementation of the RGAM, in comparison to that of the rest of Canada, is examined in the third section. The fourth explains how recent emphasis on controlling pharmaceutical expenditures, although motivated by laudable intentions, has led to unintended effects that run counter to the initial objectives of the program. The paper concludes with a summary of the main lessons to be learned from the Quebec universal drug plan experience to date.

## A universal drug insurance system

The Quebec general drug insurance program (RGAM<sup>1</sup>) was set up in 1997 with the objective of enabling all Quebecers to have “reasonable and fair access to the medication required by their state of health” (Quebec, 2019). It is a mixed public-private and universal system, unique in Canada. The public plan “provides for a minimum level of coverage for the cost of pharmaceutical services and medications” for people 65 years of age or older and social assistance recipients. It also provides insurance coverage to individuals who are not eligible for a private group insurance plan with an employer (so-called “adherents”). This last group forms a little more than 50 percent of the people covered under the public plan. The children of persons registered in the public plan are also covered. Overall, about 3.6 million persons, or 43 percent of the Quebec population, are covered under the public plan.

Prior to the introduction of such a plan, there were several drug insurance and pharmacy programs for different segments of the population. The main public programs provided complete drug coverage to social welfare recipients and seniors aged 65 and over (Ferguson, 2018). Although more than 4.5 million Quebecers were covered by private drug plans provided through employment, about 1.5 million citizens (more than 20 percent of the population) did not have drug insurance coverage in the mid 1990s ([table 1](#)). There were discussions at the time about the federal government expanding the basket of medically required services covered under Medicare to include prescription drugs without deductibles and copayments, as was recommended in a public report following the National Forum on Health. According to Gagnon (2017), “Québec saw this eventuality as a threat since the federal government would then be imposing new uncontrollable expenses on the province without necessarily providing adequate funding.”

Hence, the Act Respecting Prescription Drug Insurance (the Act; Quebec 2019) did not create a single-payer plan when it came into effect in 1997. Rather, it created a legal framework governing private group insurance plans, alongside a public assistance program run by the Régie de l’assurance

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<sup>1</sup>. RGAM stands for Régime général d’assurance médicaments, or General Prescription Drug Insurance Plan.

**Table 1: Number of persons covered under a public or private drug insurance plan, Quebec, 1993 and 2017**

	1993	2017
<i>Public sector</i>		
Welfare recipients	720,000 (10.0%)	440,000 (5.4%)
Aged 65 and over	810,000 (11.3%)	1,360,000 (16.3%)
General population ("adherents")	—	1,820,000 (21.7%)
<i>Private sector</i>		
Privately insured	4,170,000 (57.9%)	4,680,000 (56.4%)
Uninsured	1,500,000 (20.8%)	—
<b>Total</b>	<b>7,200,000 (100.0%)</b>	<b>8,300,000 (100%)</b>

Sources: MSSS, 1995: 23; RAMQ, Oris Statistical Database.

maladie du Québec (RAMQ, the Quebec health insurance board) for those who did not have access to employer-provided insurance plans. Private insurers thus continue to play an important role in the drug insurance sector in Quebec. All persons who are eligible for coverage, either as a participant or as a dependent, under an eligible private group insurance plan are mandated to join it (Gagnon, 2017). According to the most recent data available, around 4.7 million people belong to a private group insurance plan, or about 57 percent of the actual Quebec population. These people, therefore, have the opportunity to access drug treatments that they would need to pay for out-of-pocket in the absence of insurance.

Of course, an employer can choose whether or not to offer group insurance to its employees. The same is true for a professional order or association with respect to its members. But if a private organization chooses to provide sickness benefits, dental, or a disability insurance plan to its employees, it must also include prescription drug coverage. It is interesting to note that the proportion of privately insured individuals in Quebec has remained relatively constant since the implementation of the RGAM, with between 56 and 58 percent of the total population covered by private insurance plans since 1997. This suggests that, contrary to what some commentators have claimed, the popularity of private group insurance plans is not declining (FCCQ, 2019).

In 2018–19, it is expected that government expenditures under the prescription drug insurance plan will amount to \$3.3 billion, plus patients' contributions totaling \$921 million. A little over 45 percent of this will be borne by the individuals covered under the public plan (in premiums, deductibles, and coinsurance), while Quebec taxpayers will bear the rest through general taxation (MSSS, 2019: 27). The private sector will account for a little over \$5 billion dollars of expenditures on prescription drugs (CIHI, 2018b).

Since July 2019, the maximum monthly (yearly) contribution for patients is set at \$93.08 (\$1,117) for adults aged 18 to 64 and for people 65 years and over who do not receive the Guaranteed Income Supplement (for lower incomes). Annual premiums vary between \$0 and \$636 depending on net family income. Social assistance recipients, low income seniors and people with serious disabilities receive full public drug insurance coverage free of charge. In total, about 900,000 Quebecers are covered in full by the public plan, with no direct contribution from them (26 percent of beneficiaries), and 1.4 million pay no annual premium (39 percent of beneficiaries), according to the most recent data available (**table 2**).

The Act also provides for a maximum annual contribution for persons covered under private plans, unlike the situation prevailing in the rest of Canada. The ceiling set must be equal to or lower than the limit in force for the public insurance plan. Only expenditures for prescription medications excluded from the public drug formulary are not subject to a cap on contributions. These RGAM parameters therefore limit catastrophic drug expenditures for both public and private plans' beneficiaries, a unique feature in Canada. As a matter of fact, Statistics Canada data show that only a tiny fraction of households in Quebec must take on catastrophic pharmaceutical expenses over the course of a year. Indeed, only 0.2 percent of households have to devote more than 9 percent of their budgets (except for large durables<sup>2</sup>) to the purchase of prescription drugs, the lowest percentage of all provinces (Caldbick et al., 2015).

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**2.** Vehicles and recreational vehicles.

**Table 2: Some characteristics of Quebec's universal drug program: number of individuals covered by the public plan and rates in effect as of July 2019 to June 2020**

Categories of insured	Number of individuals (2016)	Annual premium	Coinurance	Monthly deductible	Maximum contribution
Welfare recipients	458,011	None	None	None	None
Seniors receiving at least 94% of the Guaranteed income supplement	75,321	None	None	None	None
Seniors receiving up to 93% of Guaranteed Income Supplement	503,050	\$0 - \$636 depending on net family income	37% of the cost of covered drugs once the deductible is fully paid	\$21.75 for first purchases of the month	\$54.08 per month \$649 per year
Seniors receiving no Guaranteed income supplement	738,836	\$0 - \$636 depending on net family income	37% of the cost of covered drugs once the deductible is fully paid	\$21.75 for first purchases of the month	\$93.08 per month \$1,117 per year
General population	1,402,494	\$0 - \$636 depending on net family income	37% of the cost of covered drugs once the deductible is fully paid	\$21.75 for first purchases of the month	\$93.08 per month \$1,117 per year
Children of persons covered under the public plan	343,259	None	None	None	None
Children aged 18 to 25 attending school full time	53,350	None	None	None	None
Total	3,574,321	—	—	—	—

Source: RAMQ, 2019a.

## Improved access and health outcomes

The RAMQ's List of Medications (RAMQ, 2019b; the List) includes more than 8,000 prescription drug products. Determined by the Minister of Health, following the recommendations of the National Institute of Excellence in Health and Social Services (INESSS), this list is the most extensive in the country. In comparison, the number of pharmaceutical products listed on the Ontario Drug Benefit formulary is 4,400 (MOHLTC, 2019).

The recommendations of INESSS not to cover specific prescription drugs are regularly criticized in the media, with some groups judging the decision criteria to be discriminatory. Others are of the opinion that the list of covered medicines is already too wide and that a tightening of the criteria is necessary. Be that as it may, it is in Quebec that we now find the most generous coverage when comparing provincial public drug plans across the country. Whereas an average of 25.6 percent of all medicines approved by Health Canada between 2008 and 2017 were listed on the drug formularies of other provincial public plans in June 2018, this proportion reached 33.4 percent in Quebec (CHPI, 2018).

Public coverage in Quebec is not only more generous, but drug approval is also faster than elsewhere in the country (Grégoire et al., 2001; Gamble et al., 2011; Bremner et al., 2017). Over the last 10 years, it took an average of 477 days for a drug approved by Health Canada to be added to the list of medications covered by the RGAM. In comparison, the average delay was 674 days for all public drug plans in Canada (CHPI, 2018). Not only that, but patients generally have access to a wider range of prescription drugs in Quebec, and prescribers may therefore have more options for them, due to the Quebec government's less restrictive formulary compared to those in the rest of the country (Thanassoulis et al., 2009; Glass-Kastra et al., 2014).

The List also includes "exceptional medications" that the Minister of Health determines by regulation. In its Administrative Guide, RAMQ specifies that these prescription drugs are reimbursable on an exceptional basis for specific indications when the cheaper alternative medicines are, for different reasons, "not tolerated, ... contraindicated or have been rendered ineffective by the patient's clinical condition" (RAMQ, 2019b: 7). In 2017, it cost \$1.44 billion to cover these medicines for close to a million patients (RAMQ, Oris statistical database, table AM.13).

The public plan also provides coverage for so-called “exception patients,” under certain conditions, of prescription drugs not included on the List. This measure allows for the exceptional payment for any of these drugs, as well as the resulting pharmaceutical services that are provided by a pharmacist in specific circumstances, for example when dealing with a serious medical condition, when the physical or psychological functional impairment is immediate or foreseeable in the short term, or when it is required in the terminal phase of a fatal disease. Patients or their physicians must submit a request for exceptional coverage to RAMQ, which ultimately decides whether the reimbursement is authorized or not.

The List also sets out the conditions of coverage for other specific programs, including the Free Drug Program for the Treatment of Sexually Transmitted Diseases (STDs), the Free Drug Program for Chemoprophylaxis and the Treatment of Tuberculosis, the Program of free provision of the medication naloxone and certain supplies, and the Program for free universal access to voluntary medical termination of pregnancy (abortion pill) (RAMQ, n.d. a).

Private insurers active in Quebec have the obligation to include at a minimum the medications covered by the public plan, i.e., those appearing on the List of Medications (RAMQ, n.d. b). The Act also establishes the basic coverage required under the RGAM for a pharmacist executing or renewing a prescription, as well as the prescription drugs listed on the public drug plan’s formulary. The coverage of a private group plan must be at least equivalent to that of the public plan and may be expanded to include drugs that are not part of it. This means that they can reimburse more products, more rapidly, at higher prices, and on more permissive terms. In actuality, most private insurance plans choose to provide more generous coverage to their members than the minimum standard set by the public plan. The typical employer provided benefit plan covers between 10,000 and 12,000 prescription medications (CLHIA, 2018: 9), with lower copayments for patients.

Private insurance also confers benefits that go beyond the generosity of coverage to encompass other aspects. Private drug benefit plans are provided to promote employee health and productivity, and to attract and retain good candidates. Therefore, they generally offer more choice and flexibility than the public plan, and modalities that are designed in specific ways to achieve these goals. Indeed, private insurers generally put in place strategies aimed at optimizing expenses through targeted measures. For instance, many insurance companies have initiatives to raise client awareness regarding the true cost of drugs, and to promote a good adherence to medication therapies (e.g., Desjardins Insurance, n.d.).

In addition, since 1997, the Quebec Drug Insurance Pooling Corporation (2019) has allowed insurers to pool the risks associated with the drug plans they administer. Terms and conditions are established annually based on the

experience of the global Quebec market, and then submitted to the Minister of Health. By helping spread the risk over the entire industry, this pooling agreement makes it possible to act concretely in the face of the increased use and the high cost of certain specialized drugs.

Does the RGAM meet its initial expectations in terms of “reasonable and equitable access to the needed medications” for the whole population, the key objective on which it was originally built? Researchers who have evaluated the RGAM program confirm that improvements in access to prescriptions drugs have been significant. Indeed, the expanded insurance coverage has facilitated access to the required medications and provided therapeutic benefits to a large portion of the previously uninsured population. Empirical evidence shows that it is first and foremost Quebecers with chronic and generally poorer health conditions who have benefited the most from Quebec’s approach to universal drug coverage, in terms of improved access to needed medications and better health outcomes. As stated in a recent study published by economists at McMaster University:

A public drug program [like the one in Quebec] covering those who do not have private drug plans can improve access to medications, increase GP visits, and generate substantial health gains for the chronically ill and less healthy people. In the long run, this may lead to reduction in overall healthcare utilization. (Wang et al., 2015)

Other researchers have shown that access to medication does not vary with income in Quebec, as patients from disadvantaged neighborhoods are just as likely as those from better-off neighborhoods to have access to the required medications (Lauzier et al., 2018). There is also evidence that waivers of copayments for low-income people have favored adherence to drug therapies (Tamblyn et al., 2014). Hence, Quebec is the province with the lowest percentage of patients saying that they do not fill prescriptions because of financial cost ([table 3](#)). In 2016, 3 percent of older Quebecers were in this situation, according to an annual performance report of the Canadian Institute for Health Information, compared with 5 percent in Ontario and in Canada as a whole (CIHI, 2018c). According to another recent study published in the Canadian Medical Association Journal, 3.7 percent of Quebecers of all ages say they do not fully adhere to their therapy because of costs, by far the lowest percentage in the country (Law et al., 2018). Cost-related nonadherence for people with multiple chronic conditions is also much lower in Quebec (2.3 percent) than in any other province (Laba et al., forthcoming).

**Table 3: Cost-related non-adherence to prescription drugs, Quebec vs. other Canadian provinces**

	Weighted average cost-related non-adherence, general population (2016) <sup>1</sup>	Cost-related non-adherence, older population (2017) <sup>2</sup>	Weighted proportion with cost-related non-adherence in more than one chronic condition (2016) <sup>3</sup>	Percentage of the population who incurred 'catastrophic' drug expenses (2009) <sup>4</sup>
British Columbia	8.11%	8.9%	6.11%	0.9%
Alberta	5.73%	4.3%	3.61%	0.3%
Saskatchewan	5.69%	6.2%	3.51%	1.5%
Manitoba	5.51%	6.5%	6.07%	1.7%
Ontario	5.77%	4.8%	3.97%	0.5%
Quebec	3.70%	3.2%	2.28%	0.2%
New Brunswick	4.83%	4.9%	3.72%	1.2%
Nova Scotia	5.22%	4.1%	7.10%	1.4%
Prince Edward Island	6.08%	5.7%	3.09%	2.0%
Newfoundland & Labrador	4.51%	5.9%	5.61%	2.2%
Canada	5.53%	5.0%	4.03%	1.1%

Sources: 1. Law et al., 2018; 2. CIHI, 2018a; 3. Laba et al., 2019; 4. Caldbick et al., 2015.

## Are prescription drug expenses out of control?

Some analysts have argued that prescription drug expenditures in Quebec were similar to those in the rest of Canada before the implementation of the universal public-private drug insurance system in 1997, and that they have run out of control since then (Morgan et al., 2017). But pharmaceutical spending per capita has been increasing at a faster pace in Quebec than in the rest of Canada for at least the last 35 years (see figure 3). Contrary to what some believe, the rate of growth has slowed down considerably in the past fifteen years. Nonetheless, prescription drug expenses are higher in Quebec than in most other Canadian provinces, with the exception of New Brunswick (**table 4**).<sup>3</sup>

**Table 4: Total drug and health expenditures per capita, Canadian provinces, 2016**

Provinces	Prescription drug expenditures per capita (2016 \$)	Health care spending per capita (2016 \$)
British Columbia	\$799	\$6,194
Alberta	\$998	\$7,168
Saskatchewan	\$941	\$6,967
Manitoba	\$847	\$7,019
Ontario	\$1,096	\$6,199
Quebec	\$1,140	\$6,159
New Brunswick	\$1,194	\$6,471
Nova Scotia	\$1,129	\$6,839
Prince Edward Island	\$930	\$6,440
Newfoundland & Labrador	\$1,024	\$7,098

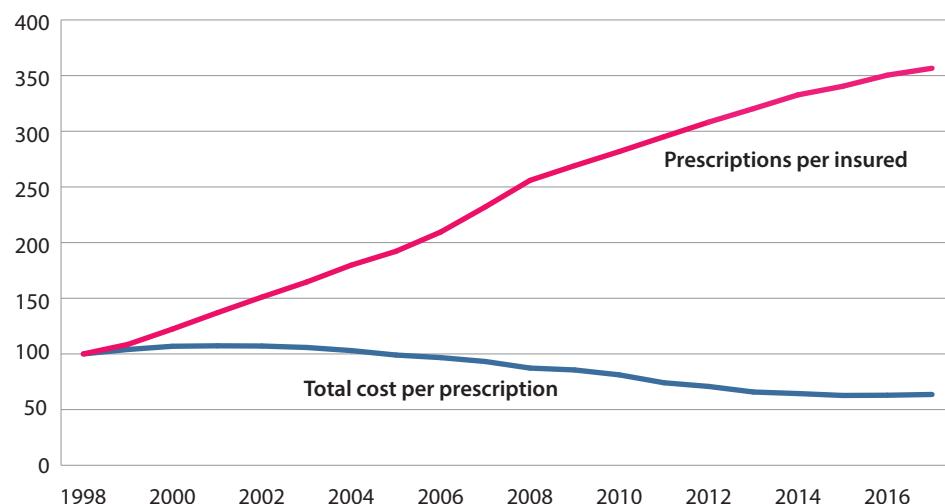
Source: CIHI, 2018b.

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3. Note that these drug spending comparisons don't take into account any confidential rebates obtained from drug manufacturers by private or public payers (CIHI, 2018c). In Quebec, the total annual rebates obtained by the government from patented medicine companies through product listing agreements (PLAs) amounted to \$222.3 million in 2017–18 (RAMQ, 2018: 110).

The factors responsible for higher drug expenditures in Quebec are multiple. Naturally, the introduction of a universal prescription drug plan has increased the number of prescriptions filled as a result of improved access. With the adoption of the RGAM in 1997, some 1.5 million people were able to benefit from drug insurance coverage they did not have before (MSSS, 1995: 23). In addition, the greater consumption of pharmaceuticals in Quebec may be explained in part by the faster aging of its population. While 11.1 percent of Quebecers were aged 65 and over in 1991, this proportion currently stands at 18.5 percent, the highest of all Canadian provinces (Statistics Canada, 2018).

Hence, the increase in spending on drugs and pharmaceutical services is more related to volume than to cost per prescription. As shown in **figure 1**, the total cost per prescription has decreased by more than 40 percent since 2000 in real terms, while the number of prescriptions per insured has more than tripled during this interval. The greater use of generic relative to patented drugs, combined with tighter controls on medicine prices and professional fees, have therefore provided significant savings to the Quebec public drug insurance plan. In other words, more people are now treated with medication, and some are taking more pills to treat their conditions, but these medicines on average cost less. This finding is consistent with the key cost drivers identified by a group of researchers in an analysis conducted a few years ago. It found that volume effects accounted for 80 percent of the difference in drug spending observed between Quebec and the rest of Canada (Smolina and Morgan, 2014).

**Figure 1: Change in the number of prescriptions per insured person and total cost per prescription, Québec Public Drug Insurance Plan, 1998 to 2017 (1998 = 100)**



Source: RAMQ, Oris database, table AM.04; author's calculations.

Another point worth considering is that Quebec has long wanted to encourage investments in the innovative pharmaceutical industry, by offering companies various advantages that were not found elsewhere in the country. The “BAP15-rule,” in effect until January 2013, according to which all first-to-market innovative drugs were to be covered at the initial price for 15 years, notably delayed the marketing of generic drugs in Quebec for a certain time compared to the rest of Canada (Ferguson, 2018). The public plan since then only pays for the lowest-price product (i.e., generic), unless the physician has specified “do not replace” on the patient’s prescription. Unsurprisingly, Quebec is now gradually catching-up the other provinces when it comes to the rate of utilization of generics.

The BAP15-rule, along with the less restrictive formulary, has had some positive results over time in terms of attracting pharmaceutical firms and investments to the province. In fact, since the late 1980s, Quebec has received more pharmaceutical R&D investment as a percentage of the population than any other Canadian province. Although these investments have declined recently, innovative companies have spent an average of \$400 million annually on R&D in Quebec over the last decade. The proportion of all Canadian R&D investments made by companies in Quebec reached nearly 40 percent in 2016, while the province represents 23 percent of Canada’s population. Close to 1,800 clinical trials are currently underway in Quebec (IMC, 2019: 38).

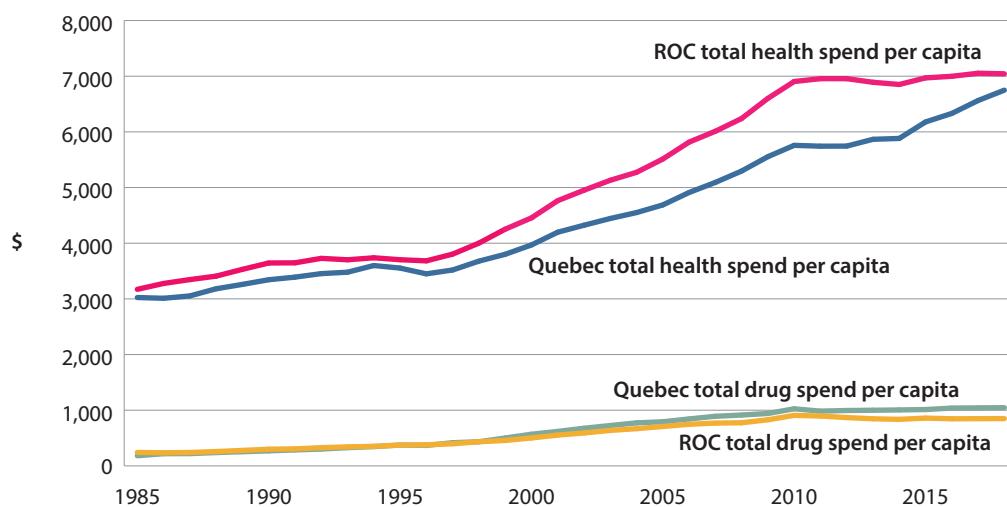
Quebec patients have also greatly benefited from increased access to these innovative medicines in terms of health outcomes. For instance, a group of researchers examined the effects of new drugs on the probability of survival of Quebecers aged 65 and over with cancer, cardiovascular disease, or asthma. Their results showed that the introduction of new drugs (marketed after 1995) was associated with a 51 percent reduction in mortality risk in the study population, compared with older drugs (Lichtenberg et al., 2009). This is in sharp contrast with the experience of other countries, notably New Zealand, where restricted access to new innovative drugs has led to poorer health outcomes (LeLorier and Rawson, 2007).

In addition, studies examining healthcare spending patterns at the provincial level in Canada have shown that higher prescription drug expenditures have led to decreases in the rate of growth of total health expenditures (Crémieux et al., 2007; Nauenberg, 2014). This is consistent with the notion that the prescription drug sector is a subset of the larger health care system, and that prescription drugs can substitute for other healthcare services and treatments. At the micro level, there is indeed evidence in Quebec that some pharmacological therapies have reduced the number of contact hours with health professionals and replaced hospitalizations and more expensive treatments elsewhere in the healthcare system (Dragomir et al., 2010; Leombruno et al., 2011). According to in-depth research conducted by economists Pierre-Yves Crémieux, Pierre Ouellette, and Patrick Petit:

The shift towards drugs and away from other types of spending has been most pronounced in Quebec and has resulted in slower growing hospital costs relative to other provinces and lower overall expenditures than would have occurred otherwise for a given health outcome. (Crémieux et al., 2007)

Not surprisingly, Quebec has the lowest total health spending per capita of any province in Canada. It should be noted that total per-capita health spending in the rest of Canada has surpassed that of Quebec ever since the introduction of the RGAM some 20 years ago ([figure 2](#)).

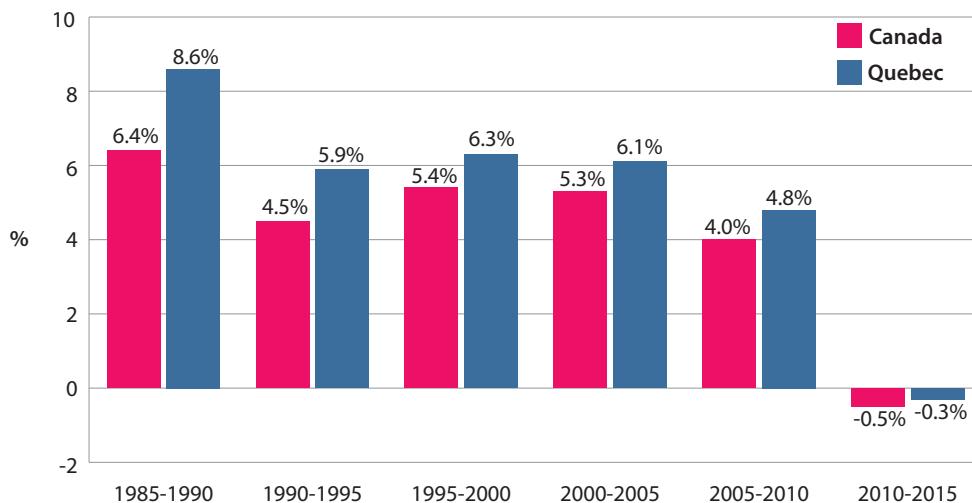
**Figure 2: Evolution of total health and drug expenditures per capita, Quebec and rest of Canada, 1985 to 2017 (real 2017 \$)**



Sources: Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2018; Statistics Canada, Consumer Price Index; author's calculations.

As figure 2 shows, since 2010, Quebec has been converging to the rest of Canada in terms of per-capita health spending. This is mainly due to the fact that the other provinces have tried even more to bend the prescription health spending curve in recent years. Also, there has been a steep slowdown in the growth of drug expenditures over the last decade, in Quebec as in the rest of Canada ([figure 3](#)). This trend is partly explained by the expiry of many patents but also because of government measures specifically aimed at curbing this growth. Since 2010, no other category of healthcare spending per capita has grown at a rate as low as that of drug expenditures, both in Quebec and across Canada. Taking into account inflation, drug spending per capita in Quebec has actually *decreased* by 0.3 percent on average each year from 2010 to 2015.

**Figure 3: Average annual growth rate of real drug expenditures per capita in Quebec and Canada, 1985–1990 to 2010–2015**



Sources: Canadian Institute for Health Information. National Health Expenditure Trends, 1975 to 2018; author's calculations.

Researchers who have recently examined the evolution of prescription drug expenditures in Quebec are surprised that expenditures did not increase more than they have given the circumstances and specificities of the province. They draw the following conclusion:

Our finding that expenditures increased in Quebec with expanded coverage is not surprising. In many ways, what is surprising is that it changed by so little. The most that annual per capita expenditures increased by at the provincial level was \$44.51 once we controlled for all the variables. (Wang and Devlin, 2016: 16–17)

## The pernicious effects of cost containment policies

As previously mentioned, the Quebec government has made many efforts to contain the growing costs of its public drug insurance program. The policies put in place have taken different forms: direct price controls, delayed or restricted reimbursement of new medicines, cost-effectiveness evaluation process, bulk-purchasing, generic substitution policy, etc. (Labrie, 2013). Quebec has also adopted the “best price granted to provincial plans” rule, according to which the guaranteed selling price of a generic must not exceed the lowest price of the same drug covered by any other provincial public plan in the rest of the country (Cambourieu et al., 2013: 11–12). Hence, significant price declines have occurred in recent years. Since 2007, the average price of generics has decreased by almost 60 percent in Canada and Quebec (40 percent more than the OECD countries), according to the federal Patented Medicine Prices Review Board (PMBRB, 2019). Since April 2018, the 67 most commonly used generic drugs are now sold at prices ranging from 10 to 18 percent of those of the equivalent brand name products (Canada’s Premiers, 2019).

It might seem legitimate to try to control costs in order to ensure the long-term sustainability of the system (Montmarquette, 2002). However, the measures put in place over time, whether in the form of increased user contributions or the regulatory compression of drug prices and pharmacist fees, have had adverse effects on the equity of access to medicines for patients. For instance, the number of cases of generic drug shortages has multiplied in recent years, in Quebec as in the rest of Canada, in parallel with the governments continued efforts at artificially lowering their prices. According to the Canadian drug shortage database, there were 2,129 instances of drug supply disruptions throughout the country in 2016–17, mostly of generics, and the problem seems to have worsened over the last decade (Videau et al., 2019).

In addition, the small increases in professional fees paid by the Quebec government to pharmacists for individuals covered under the public plan have had the effect of widening, at least for a certain time, the difference in the cost of prescriptions between publicly and privately insured individuals.

These differences seem to have stabilized over the past five years but remain in the range of 15–17 percent, according to reliable estimates. The origin of the problem unquestionably comes from fees set artificially low by the government for people covered under the public plan.

Indeed, professional fees paid by the government to pharmacists have not kept pace with the evolution of the pharmacy sector and the transformation of the profession, which has become more complex over time. In fact, RAMQ fees have been growing at a lower rate than inflation since 2002 ([figure 4](#)). As a result, the average fee paid by the government today (around \$9) is lower than the cost to the pharmacist of executing a regular prescription, which makes this portion of his/her business activities hardly profitable (Labrie and Frappier, 2016). Some pharmacies can only remain profitable by charging higher fees on prescriptions filled under private plans. Thus, the “lower cost” of public insurance is arguably, at least in part, an illusion created by hidden cross-subsidies from the private market.

In addition, few initiatives have been put forward to improve adherence to medications, even though the issue has been recognized for a long time. Several commentators have raised, quite rightly, the problems of poor adherence to drug therapies. A prescription that is not followed properly may lead to health problems and require unnecessary emergency room visits or even hospitalizations that could be avoided (Dragomir et al., 2010). Although this issue is not unique to Quebec, there are some reliable indications that work needs to be done in order to improve the situation (Assayag et al., 2013; Tamblyn et al., 2014). Cost-related non-adherence is systematically lower for privately insured individuals, who have to support lower copayments on average, than for those covered under the public plan (CSBE, 2015: 21; CSBE, 2017: 22).

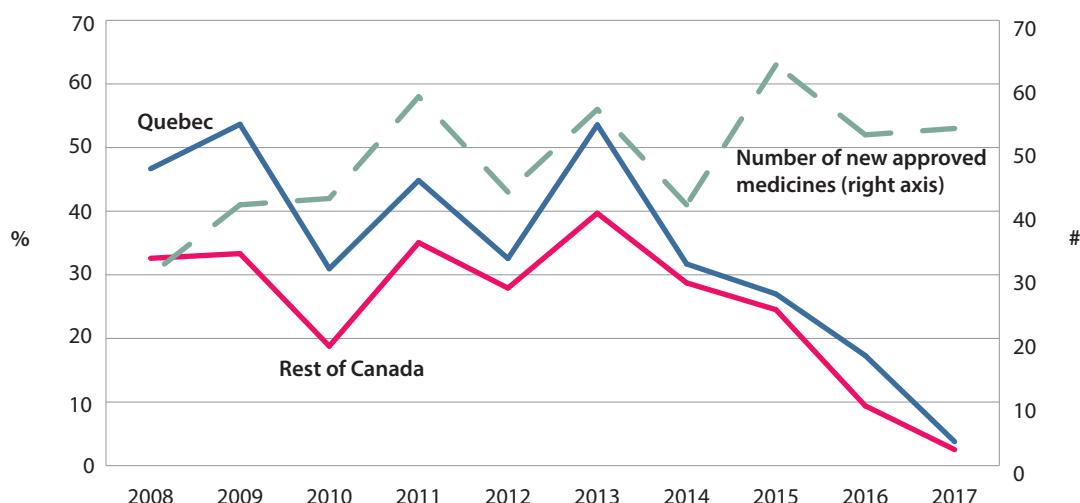
Finally, public drug coverage is not as generous as that of private plans, and the number of new medicines added to the public drug formulary in Quebec has decreased in recent years ([figure 5](#)). Public coverage delays have also lengthened recently, and it now takes a longer time for a new medicine approved by Health Canada to be included in Quebec’s List of Medications (CHPI, 2018; Salek et al., 2019). Unfortunately, the cost of delaying or rationing access to new innovative medicines, in terms of negative health outcomes, may well exceed the government’s budgetary savings (Sheehy et al., 2008).

**Figure 4: Total cost per prescription for persons insured under the public plan, Quebec, 1997 to 2017 (real 2017 dollars)**



Sources: RAMQ, ORIS statistical database, Table AM. 4; author's calculations.

**Figure 5: Proportion of new medicines covered by public plans in Quebec and the ROC among those approved by Health Canada, 2008 to 2017**



Sources: Canadian Health Policy Institute, 2019; author's calculations.

## Discussion and conclusion

In Canada, health care is offered in a highly decentralized context. There are 13 different health systems in the country, one for each province and territory. The federal government enacts some basic principles and rules for medically required services—enshrined in the Canada Health Act—but leaves the provinces some latitude to adopt different policies based on the needs of their respective populations.<sup>4</sup> Each province decides on its health budget based on its own fiscal capacity and priorities. Per-capita health expenditures reflect these distinct choices and differ greatly from province to province, from \$6,159 in Quebec to \$7,168 in Alberta.

Decentralization is based on the principle that a provincial government is better able to understand the specific needs and preferences of its population, as well as the means most likely to adequately address them. A decentralized system encourages the emergence of innovative policies in different provinces, which makes it possible to better assess what works or does not work. This decentralization has benefited Canadians in the area of healthcare, as researchers have shown (Rubio, 2011).

This decentralization context enables the Quebec prescription drug insurance model to provide relevant lessons for the rest of Canada. While not perfect, the results achieved by the RGAM in improving access to prescription drugs are generally positive when compared to those of other provinces. Although expenditures have increased since the program was implemented, there has been a relative decrease in the use of other health services and, consequently, a lower level of total health spending per capita in Quebec than in any other province in Canada.

However, the benefits of such a universal public-private system seem to have been ignored. In recent years, there has been increasing pressure on policymakers to introduce a fully public national drug plan. Some analysts and

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4. Contrary to popular belief, it is not federal legislation but rather provincial laws that regulate almost all of the public health care system in Canada. Political scientist Gerard W. Boychuk argues that the Canada Health Act may nevertheless constitute a barrier to healthcare reform in Canada, not because it is too restrictive but because of its lack of clarity that creates a political “negativity bias” against reform. See Boychuk (2012).

commentators have indeed argued that a single-payer system would facilitate cost controls by reducing administrative expenses and consolidating purchasing power (Wolfson and Morgan, 2018). However, as governments do not directly purchase drugs, the only way to increase their bargaining power is by threatening not to cover new approved medicines, unless their price is lowered. That kind of negotiating strategy is only effective insofar as the threat is enforced.<sup>5</sup> Hence, in a single-payer system, savings could only come at the price of increased rationing and a reduced access to needed medicines for patients.

Clearly, a mixed universal public-private system like the one in Quebec, partly based on mandated benefits, deserves more attention in the current discussions of a proposed reform of the pharmacare system in the country. Economists have shown that mandate-based reform is a relatively more efficient way to expand coverage than imposing a new income tax that workers would not link to receiving insurance (Kolstad and Kowalski, 2016). It avoids the economic and labor market distortions usually associated with tax-financed provision of health and drug insurance (Summers, 1989). Perhaps more importantly, it preserves the ability of employers to offer more generous benefit plans than a single-payer public drug program, including arrangements that are more tailored to their employees' preferences.

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5. Economists Sara Fisher Ellison and Christopher M. Snyder (2010) have shown that drug purchasing alliances can't obtain lower prices by increasing their size but rather by their ability to use restrictive drug formularies to induce supplier competition.

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