Stitching the gaps in the Canadian public drug coverage patchwork? A review of provincial pharmacare policy changes from 2000 to 2010

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Introduction

Though they comprise the second largest component of health care costs in Canada, prescription drugs are not included in the basket of services covered by Canada's 'medicare' system (which, in fact, is comprised of thirteen independent provincial and territorial health insurance systems [1]). In exchange for federal contributions toward the cost of provincially-run health insurance programs, the Canada Health Act requires provincial governments to provide universal first-dollar public coverage for medically necessary hospital and physician services but not for prescription medicines used outside of hospital. As a result, provinces have independently developed public drug insurance programs for some population groups (primarily seniors and social assistance recipients) under various eligibility and patient cost sharing arrangements. The lack of national standards for these programs, as exist for hospital and physician services, has led to interprovincial disparities in public drug coverage, a large role for private financing of prescription drugs (via private insurance and out-of-pocket payments), and a significant number of Canadians who are under- or un-insured against the costs of needed medicines[2–4].

Concerns over Canadians falling through the gaps in this popularly described "patchwork" of drug benefits has led to repeated recommendations for the federal and provincial governments to act in cooperation to create national 'pharmacare' standards (e.g., via federal cost-sharing of pharmacare costs). While no new federal legislation has been enacted to do so, in recent years, federal and provincial governments have consistently articulated a shared policy goal in this area: to ensure no Canadian suffers undue financial hardship in accessing needed drug therapies [5–7]. It is possible that this shared policy goal has led to independent policy actions to "stitch the gaps" in provincial drug coverage and, consequently, to an implicit national standard for public drug coverage.

We aimed to describe recent changes and identify emergent trends in public insurance for outpatient prescription drugs in Canada. By tracking the characteristics of public drug benefit programs in Canada's ten provinces from 2000 to 2010, we sought to determine

Conflict of Interest

The authors have no conflicts of interest to declare.

which if any plan designs are emerging as a national standard and where the gaps in public coverage remain. We discuss the findings in terms of implications for progress toward national pharmacare in Canada.

Materials and Methods

To track pharmacare programs over time, we obtained information on the eligibility and benefit structure of provincial plans from 2000 to 2010 from historical editions of *Provincial Drug Benefit Programs*, a periodical published by the Canadian Pharmacists Association [8]. As required, we consulted provincial websites and government staff to confirm specific details. The ten-year study period was chosen to extend previous work by Groodendorst (2002) which described Canada's provincial drug benefit programs from their inception to 2000 [9].

Public drug benefit design in Canada consists of three major dimensions: eligibility, premiums, and patient cost-sharing mechanisms. Eligibility refers to who is covered under a program and may be based on age, income, or other factors. Many provinces have distinct drug benefit programs for different eligible populations. To ensure comparability of programs across provinces, we assessed premiums and cost-sharing mechanisms separately for three beneficiary groups: social assistance recipients, seniors (≥ 65), and the general (non-senior) population.

Premiums are fixed dollar amounts that must be paid (often monthly or annually) in order to receive coverage under a given plan: they are the "price" of coverage for eligible persons. Though a requirement of virtually all forms of private coverage (paid directly or through employer), premiums are less common for public drug plans which are more often financed through general government revenue.

For those covered under public drug benefit programs, three cost-sharing policies ultimately determine the expenses borne by the patient (or via supplementary private insurance): deductibles, co-payments/co-insurance, and out-of-pocket limits. Deductibles are the amounts that patients must pay out-of-pocket towards their prescriptions over a specific period (e.g. CAD\$100 per year) before drug costs become payable by the insurer (in this case, the government). Once a plan deductible is reached, patients often face additional cost-sharing for each prescription filled. Cost-sharing may take the form of a fixed co-payment (e.g. CAD\$2.00 per prescription) or co-insurance (e.g. 20% of the cost of each prescription). To ensure patient contributions are not excessive, insurance plans may also impose a maximum out-of-pocket limit set at a fixed dollar amount (e.g. CAD\$1,000 per year) or a certain percentage of income (e.g. 3% of annual household income), after which 100% of eligible drug costs are paid by the insurer.

Throughout the paper, we refer to a program as a "first-dollar" program when it involves no cost-sharing for eligible beneficiaries. We define "catastrophic" programs as those that involve sizeable deductibles (e.g., greater than expected average spending on prescription drugs). Deductibles under such plans are generally defined as a fixed dollar amount (e.g. CAD\$1,000 per year) or as a percentage of individual income that would reflect a similar

amount (e.g. 3% of household income). All dollar amounts presented are in Canadian dollars.

Although provincial formulary listings (the medicines that are covered by provincial drug programs) are an important point of comparison across public drug programs, this paper is primarily focused on assessing program eligibility and cost-sharing structures. The extent of variation in provincial formularies has been documented elsewhere [2, 10–12].

Results

Social Assistance Recipients

Figure 1 illustrates the general structure of provincial drug plans for social assistance recipients over the period of 2000 to 2010; detailed information on plan designs in 2000 and 2010 can be found in Appendix 1. As of 2000, four provinces provided first-dollar coverage for social assistance recipients: British Columbia, Manitoba, Prince Edward Island, and Newfoundland and Labrador. Five provinces required only a nominal co-payment (range CAD\$2.00 to CAD\$4.00): Alberta, Saskatchewan, Ontario, New Brunswick, and Nova Scotia. Quebec was the only province requiring a monthly deductible in addition to co-payments or co-insurance for welfare recipients (though patient cost-sharing was restricted to a monthly out-of-pocket limit of CAD\$16.67). Over the study period, drug benefits for this group went unchanged in all but two provinces: Alberta and Quebec eliminated patient cost-sharing and moved to first-dollar coverage in 2004 and 2007, respectively.

It appears that comprehensive drug coverage with minimal or no patient cost sharing represents the implicit national standard for social assistance recipients. Both recent changes in provincial plans for social assistance recipients were directed towards extending benefits by further reducing the level of patient cost sharing. Interprovincial variation in benefits is now minimal. As of 2010, six provinces provide first-dollar coverage for social assistance beneficiaries. Of the four provinces that include patient cost-sharing in their benefit design, namely, Ontario, Saskatchewan, New Brunswick and Nova Scotia, a low fixed dollar co-payment is required ranging from CAD\$2.00 to CAD\$5.00.

Seniors

Figure 2 illustrates the structure of provincial drug plans for seniors over the period of 2000 to 2010; detailed information on plan designs in 2000 and 2010 can be found in the Appendix 2. As of 2000, seven provinces offered seniors different extents of coverage depending on income: patient cost-sharing was means-tested in Ontario, Quebec, and Nova Scotia; and public coverage was offered solely for seniors below a certain income threshold in Saskatchewan, New Brunswick, and Newfoundland and Labrador. Three provinces offered universal, zero deductible coverage for seniors: British Columbia, Alberta, and PEI.

In most provinces there were no substantial reforms to senior's drug benefits over the past decade. Only Quebec and Saskatchewan made efforts to expand senior's coverage. In Quebec, extension of benefits was subtle and affected only a small proportion of the lowest income seniors. Cost-sharing was eliminated for low-income seniors receiving the maximum Guaranteed Income Supplement (GIS) benefit in 2005, and for those receiving 94% to 100%

of the maximum GIS benefit in 2007. In Saskatchewan, reforms to expand seniors' drug benefits were more substantial. In 2007, Saskatchewan introduced a universal senior's drug plan requiring no deductible and a CAD\$15 co-payment. This policy change reduced cost sharing considerably for lower income seniors by eliminating the semi-annual deductible and 35% co-insurance, while also extending coverage to higher income seniors who were previously ineligible for public drug benefits. However, a year later in 2008, a means test was introduced to retrench benefits for high income seniors not eligible for the old age tax credit (income greater than CAD\$75,380 in 2010).

In 2003, major changes to British Columbia's pharmacare had the effect of eliminating the province's drug plan that was specifically targeted for seniors. A universal, age-irrelevant income-based plan was implemented that provides "catastrophic" (i.e., high deductible) coverage for all but low-income households. To minimize the short-term impact of the policy change, those seniors who had been beneficiaries of the seniors' drug plan before 2003 received income-based coverage with lower deductibles than other residents. For all residents born after 1939, the British Columbia pharmacare plan was similar to that in Manitoba, where seniors have received the same benefits as the general population under the province's universal income-based plan since 1996.

Although provinces remain varied in their use of premiums and specific cost-sharing mechanisms, means-testing is now a standard feature of pharmacare for seniors in Canada. Only Alberta and PEI continue to offer universal, premium-free, no deductible seniors' coverage.

General Population

Figure 3 illustrates the general structure of provincial drug plans for general non-senior population over the period of 2000 to 2010; detailed information on plan designs in 2000 and 2010 can be found in Appendix 3. In 2000, the general non-senior population received some level of public coverage in all but the Atlantic Provinces. Three coverage models were present. First, in Alberta and Quebec, non-seniors unable to obtain private coverage were offered premium-based public insurance options (it is notable that group-based private insurance was mandatory for many employed residents of Quebec, e.g. those employed in medium to large firms). Second, in British Columbia, non-seniors were eligible for a fixed deductible catastrophic drug benefit. Third, Saskatchewan, Manitoba, and Ontario offered income-based catastrophic coverage with a deductible based on the proportion of household income spent out-of-pocket on prescription medicines.

All changes to general non-senior pharmacare plans that occurred from 2000 to 2010 represented moves towards the income-based catastrophic model. British Columbia's program shifted from a fixed deductible model to an income-based catastrophic scheme in 2003. This model was also introduced for non-seniors in Newfoundland in 2007 and Nova Scotia in 2008, two provinces which previously offered no coverage for the general population.

It appears that income-based catastrophic coverage – with high deductibles based on household income – has emerged as the national standard for public drug benefits for the

non-senior population (and in some cases, also for seniors). As of 2010, six provinces have embraced this model. Alberta and Quebec offer the only alternative model for non-seniors' pharmacare: premium-based public coverage exclusively for those without private insurance. New Brunswick and Prince Edward Island remain the only provinces without a public drug program for non-seniors.

Discussion

Despite recommendations at the national level and articulation of shared policy goals by provincial governments, expansion of pharmacare in Canada has not been widespread or momentous. This may, in part, reflect the evolving definition of what constitutes pharmacare "expansion" over the past decade. Though recommendations in the 1990s focused on the extension of medicare to include first-dollar coverage for prescription medicines, proposals over the past decade have increasingly shifted focus to catastrophic (or last-dollar) coverage [13–15].

Barriers to more ambitious reforms may partially explain the shift to a more incremental approach to drug benefit reforms in Canada. Among these barriers are the legacies of the historical exclusion of prescription medicines from Canada's health insurance scheme that have, over time, cumulatively added to the social, political, and economic costs of "big-bang" policy making in this area [16–18]. The first such barrier is financial. The total costs and long-term financial commitment (for both federal and provincial governments) that would be required under a first-dollar pharmacare scheme has been seen as an obstacle to reform since the 1960s, when the Hall Commission recommended Canada not proceed with pharmacare until prescription drug spending reaches a plateau [19]. This plateau, of course, has yet to occur, leaving Canada with a policy paradox and political stalemate: "no pharmacare without cost control, no cost control without pharmacare" [20]. The exclusion of prescription drugs from the public health insurance system in the 1960s also created a role for the private insurance industry, which is now a leading interest group with a "seat at the table" in the politics of Canadian health care. The existence of private insurance results not only in an opposing interest to reform; it may also reduce electoral incentives. While Canadians value public coverage for medical and hospital services to the extent that such coverage is considered a defining characteristic of Canadian identity, electoral motivation to expand medicare to include medically necessary prescription medicines appears absent [21]. This may be, in part, a function of the low salience of this issue for the majority of healthy, working Canadians, who nearly all have some form of coverage through employer-based private plans.

Canada's unique form of decentralized "power-separating" federalism also presents challenges for any national health care reform: enacting national standards for pharmacare requires consensus among all ten provinces and the federal government. While this institutional arrangement can be a source of policy innovation and learning within the health system, it also increases the number of vetoes within the policy process, facilitates blame avoidance between levels of government, and can ultimately act as a barrier to big-bang reforms [17, 22]

For politicians with short-term horizons, attempting to overcome existing barriers to large scale pharmacare reform – financial, political, and institutional – may come at a political cost that outweighs electoral incentives [16]. It is therefore not surprising that governments in Canada are embracing a model of pharmacare which is designed to provide coverage only for those with extraordinarily high drug costs. Income-based programs for non-seniors were introduced by three provinces in the 1990s, and three more from 2000 to 2010.

Newly introduced catastrophic programs do offer a public safety net for some populations that may previously have been under or uninsured for prescription medicines: for example, non-seniors in Newfoundland and Nova Scotia. However, one must carefully consider the extent to which these changes should be measured as progress towards ensuring Canadians do not face undue financial barriers in accessing needed medicines. Not all income-based programs are created equal and convergence on this model does not necessarily imply an important reduction in interprovincial disparities in public coverage (Table 1). For example, consider a couple with no children earning the median household income in Canada in 2008 (gross CAD\$75,880 [23]; net CAD\$56,800). For this household, the annual deductible under each provincial catastrophic program would represent out-of-pocket drug costs of approximately CAD\$1704 in British Columbia, CAD\$2054 in Ontario, CAD\$2580 in Saskatchewan, CAD\$3564 in Manitoba, CAD\$4260 in Newfoundland, and CAD\$8746 in Nova Scotia. Once a household has reached the catastrophic deductible, terms for co-payments/co-insurance and limits on total out-of-pocket payments vary widely across provinces and in some, may result in considerable additional patient contributions. Even among the various coverage levels offered, in no province could income-based pharmacare be defined as comprehensive public drug coverage. If faced with significant medical need, the majority of Canadian households would bear a substantial financial burden under the cost-sharing structure of existing plans. This finding is supported by previous studies that have analyzed cross-sectional survey data on household spending and found concerning levels of out-of-pocket spending and considerable variance across provinces and household age groups [3, 24].

The introduction of income-based catastrophic plans for non-seniors may also have important implications for the “basket” of drug plans offered by provincial governments. Our findings suggest that coverage for those on social assistance is not likely to be significantly affected; all provinces continue to provide comparable, near first-dollar coverage for the most vulnerable even after introducing income-based catastrophic plans. However, while seniors’ benefits were not affected by the introduction of coverage in some provinces, relatively comprehensive (near first-dollar) coverage for seniors in Manitoba and British Columbia was eliminated when those provinces implemented universal income-based coverage (in 1996 and 2003, respectively). Provinces that maintained coverage levels for seniors while introducing income-based plans for the general population introduced much less generous programs than Manitoba and British Columbia. Thus, over the past decade, a period characterized by governmental fiscal restraint [25], it appears that total public budget constraints may have been a determining factor in pharmacare expansion.

Implications for a National Pharmacare Program

While provinces may not explicitly engage in cross-jurisdictional policy learning when constructing drug benefit policies [26], parallel adoption of public drug plans with high, income-based deductibles suggests that the idea of catastrophic coverage has had diffusion effects across the provinces and may become an implicit national standard. The popularity of the idea of catastrophic drug coverage is not without explanation. Applying policy-making theory, it fits many of the criteria for “policy survival” [27]. First, implementation in several provinces has demonstrated the program’s technical feasibility (i.e. it is clear how such a program would work). Second, the implicit values of the program are deemed acceptable in the current political environment: it protects the most vulnerable but does not interfere with the establishment of a private insurance role [28]. Third, it eases policymaker’s anticipation of future constraints, namely rising drug costs (by limiting government’s role to payer of last resort) and an aging population (by shifting from age-based to income-based eligibility). Finally, support for public catastrophic coverage has been expressed via the policy statements of a number of key interests, including private insurers [29, 30], physicians [31], hospitals [32], pharmacists [33], and pharmaceutical companies [34].

With convergence towards income-based catastrophic coverage occurring on the provincial level, one might suspect that federal action to establish national standards for drug coverage is less pertinent. This is not the case. As discussed, given the wide variations in the extent of patient cost-sharing required, provincial policy convergence on income-based catastrophic pharmacare does not necessarily equate to an important reduction in intra- or inter-provincial disparities. Given the articulation of shared policy goals among provinces, the generosity of provincial pharmacare programs may reflect less on divergent ideological positions than varying provincial fiscal capacities. Thus, it is not necessarily only provincial political will to enact change on the regional level that is needed, but rather, a federal-provincial agreement on a fiscal transfer specifically for drug benefits with “strings attached” that can make meaningful expansion of coverage possible and consistent across provinces. Yielding federal spending power through conditional grants (rather than unconditional grants such as equalization payments or block health or social transfers), can allow provincial governments to expand coverage to a standard level beyond what could be achieved if the provinces pursue their policy goals independently. Potential renewal of the federal and provincial governments’ 10-Year Plan to Strengthen Health Care [35] in 2014 represents an institutionalized policy window within which such a conditional agreement could be forged.

Canadians should exercise caution when planning how pharmacare expansion will proceed. Incrementalists may see the establishment of national standards for catastrophic coverage as a necessary step towards a more comprehensive model. Yet theories of path dependency speak to the importance of the ‘first step’ [16]: establishing the government role as payer of last resort is likely to entrench the idea of last-dollar coverage and the institutions/policies that would support it, making later introduction of universal first-dollar coverage (and the potential for accompanying cost-control mechanisms) ever more difficult [36]. Indeed, the widespread provincial adoption of the catastrophic model indicates that the idea of last-dollar public drug coverage is already becoming institutionalized in the Canadian political landscape.

Conclusions

While changes in public drug benefits in Canada have been modest over the past decade, universal income-based catastrophic insurance appears to be emerging as an implicit national standard with implications for both non-senior and senior beneficiary groups. However, due to the nature and variation in patient cost sharing required under these programs, policy convergence on this model does not equate to substantial progress towards expanding coverage and reducing interprovincial disparities. The federal government ultimately needs to have a seat at (and money on) the pharmacare policy table if Canada is to move from a disparate patchwork to a harmonized quilt of public coverage for prescription medicines. Given that a comprehensive national pharmacare program has long been identified as a policy goal for Canada [13, 14, 19], the federal role might ideally be to take provinces further toward universal, first-dollar coverage than it appears they will go alone.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

This study was funded by a Canadian Institutes for Health Research/Health Canada Emerging Team Grant in Applied Health Services and Policy Research. Sponsors had no role in the project or in decisions to publish results. The authors thank the Canadian Pharmacists Association and Minsup Shim for assistance in obtaining Provincial Drug Benefits reports.

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Figure 1.

Cost sharing structure for social assistance beneficiaries by province, 2000–2010.

Notes:

AB: Co-payment of \$2.00 for the first three prescriptions per month was eliminated in May 2004.

QB: Deductibles and co-insurance for all welfare recipients were eliminated on July 1, 2007.

Figure 2.

Cost sharing structure for seniors (≥ 65) by province, 2000–2010.

Notes:

BC: Fair Pharmacare was introduced in May 2003, replacing both the Universal Plan (Plan E) and the Seniors Plan (Plan A).

SK: The Senior's Drug Plan was introduced on July 1, 2007. The plan required seniors to pay a \$15 co-payment for all drugs listed on the SK formulary. As of July 1, 2008, an income-based eligibility test was introduced. Only seniors with a reported income that is less than the limit for the federal age credit are eligible (individual net income less than \$75,480 in 2010).

QB: As of July 1, 2005, all patient cost sharing was removed for seniors receiving the maximum GIS. As of July 1, 2007, cost sharing was removed for seniors receiving 94 to 99% of the GIS.

NL: The 65Plus Plan covers only seniors eligible for both old age security and the GIS (individual net income less than \$15,888 required to qualify for the GIS in 2011). The universal catastrophic Assurance Plan was introduced on October 31, 2007.

= no coverage
= "catastrophic" coverage
= deductible + co-payment/co-insurance
= co-payment/co-insurance only
= "first-dollar" coverage (no cost-sharing)
<hr/>
= premiums
= cost-sharing differs by income <i>low band = lower incomes, high band = 'higher' incomes</i>

Figure 3.

Cost sharing structure for the general non-senior population by province, 2000–2010.

Notes:

BC: Fair Pharmacare was introduced in May 2003, replacing both the Universal Plan (Plan E) and the Seniors Plan (Plan A).

NS: Nova Scotia Family Pharmacare was introduced on March 1, 2008.

NL: The Assurance Plan was introduced on October 31, 2007.

Table 1

Structure of provincial income-based catastrophic public drug benefit programs as of December 2010.

Province	Household Income*	Deductible (% of income)	Co-Pay/ Co-Insurance	OOP Limit (% of income)
BC	<\$15,000	0%	30%	2%
	\$15,000–30,000	2.0%	30%	3%
	>\$30,000	3.0%	30%	4%
SK	All	3.4%	Up to 35%	None
MB	<\$15,000	2.7%	-	-
	\$15,000–39,999	3.8 - 4.3%	-	-
	\$40,000–74,999	4.6 - 4.9%	-	-
	>\$75,000	6.1%	-	-
ON	<\$15,000	2.0% [†]	\$2	None
	\$15,000–39,999	2.0 – 3.5%	\$2	None
	\$40,000–74,999	3.0 – 4.0%	\$2	None
	\$75,000–99,999	3.7 – 4.0%	\$2	None
	>=\$100,000	4.0%	\$2	None
NS	<\$15,000	1.0% [‡]	20%	6.0%
	\$15,000–39,999	1.5 – 4.0%	20%	6.5 – 12.0%
	\$40,000–74,999	4.5 – 12.5%	20%	14.0 – 25.5%
	\$75,000–98,000	13.0 – 19.5%	20%	26.0 – 34.5%
	>=\$98,000	20%	20%	35.0%
NFLD	<\$39,999	5.0%	-	-
	\$40,000–74,999	7.5%	-	-
	\$75,000–149,999	10.0%	-	-

Notes:

* Refers to net household income in BC, ON, and NFLD; refers to gross household income in SK, MB and NS. Income (or deductible) is adjusted for household size in ON, MB, NS, and SK.

[†] Reported deductibles for Ontario are approximate. Actual deductibles vary slightly within income bands according to household size and exact income.

[‡] Only 80% of the cost of an insured prescription drug is applied towards a household's payment of the annual deductible. Thus, reported deductibles are an underestimate of the actual proportion of income required to be spent on prescription medicines before only the 20% co-payment is required.