THE QUEBEC EXPERIENCE: LESSONS TO BE LEARNED

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Quebec's "General Drug Insurance Program" was enacted in June 1996, to take effect on July 1st, 1997. It was conceived as a private/public partnership this meaning in effect two parallel drug plans, one a set of private drug benefits under group insurance plans sponsored by employers for some 57% of the Quebec population. The other a segmented public plan for the rest. However, coverage by one means or another was made compulsory. The public plan provides for financial contributions from users with a number of exemptions and caps but is financed from the public treasury to the tune of over 80% of its total costs.

The main justification given for the creation of this "General" drug program, was the provision of coverage for drugs to at least 1.2 million people (styled as "adhérents" or subscribers) broadly speaking "in the labour force" or living on its margin and not otherwise able to access an employer-supported drug benefits plan (i.e. the self-employed, small business people together with their employees, the unemployed and social assistance recipients able to work, students…). This component of the general plan and the plan as a whole were explained (and still are by the government to this day) as providing equitable access to drug benefits to all.

That component of the new Quebec drug regime is indeed the only major innovation brought about by the 1996 legislation. Only marginal changes were brought about for employer-funded drug plans (They have to use the same drug formulary as the public plan and cover spouses and children) or to the government sponsored benefits for seniors and severely handicapped people.

The segmented public plan provides for an annual premium (set since July 1st 2002 at $422.) a contribution of 27.4% of the cost of any drug but of 100% for the first dollar in a month up to a monthly deductible; all that subject to an annual cap. Various exemptions from the premium, the 27.4% contribution and different levels of caps apply to various groups.

Several revisions have been made to the original plan in its short five-year history because of rapidly escalating costs, in excess of 18% per annum on average. Public hearings were held in 2000 about options for modifications put forward by government and a study commission (Chaired by economist Claude Montmarquette) reported in 2001.

APPROACH

This paper will attempt to assess experience with the Quebec drug plan from the following three vantage points:

- How successful is the plan in bringing about equity of access to all groups of users?

- Is the plan viable given the rapid cost escalation it has experienced?

- What is the relationship between the drug plan and the health care system?

Any assessment of the Quebec Drug Plan is hindered by the unavailability of statistics about the characteristics of users or beneficiaries in terms of their distribution by income classes or according to their drug consumption profiles etc. The Quebec *Regie de l'Assurance-maladie* that administers the public plan publishes only global figures on user numbers by plan segment and their respective total costs. One test that the Quebec plan fails is that of public accountability.

THE QUEBEC DRUG PLAN AND EQUITABLE ACCESS

The one rationale for the 1996 law that instituted Quebec's drug plan heavily underscored at the time and still always mentioned is that of providing "equitable access" to drugs to all Quebec residents. Any systematic assessment of how well this objective is met requires a definition of equity. This is done here by reference to the well known and probably uncontroversial concepts of horizontal (treating all individuals in the same income class equally) and vertical equity (treating different individuals in different income classes in some direct proportion to their respective income classes)[1]. The latter concept is particularly apt given the contributory features of the Quebec plan.

1. The treatment of dependent children. One segment of the public plan, that destined to "Adhérents" (or "subscribers"), provides for an exemption from the deductible as well as the 27.4% contribution or fee with regard to the purchase of drugs prescribed for children. The annual subscription is, furthermore a flat amount unrelated to the presence of children. The cost of this subsidy coming in effect from the consolidated revenue fund was in 2001/2002 $45.5 Million (or 8.8 % of the segment's total cost) for the almost 900,000 subscribers and some 300,000 children[2].

On the other hand, families with dependent children covered by employer-sponsored plans receive no such subsidy. They number over 4 Million people and possibly about a million children. The assumption made by the government seems to be that beneficiaries of employer-sponsored plan are better off than the subscribers to the public plan. It is impossible with available data to confirm or falsify this assumption, however it should be noted that the subsidy given to subscribers is not income-related and that there must be among families covered by private group insurance many that are no better off than many subscribers to the public plan. The private plans often impose an employee contribution that is higher when dependents are present. Those families therefore end up paying more for their own coverage, do not get the subsidy and contribute through their taxes to finance a subsidy that goes in part to families that are in some cases better off than they are themselves. Groups that favor a move to a totally public drug plan have raised this

[1] These concepts have been developed for, and extensively used in, the study of public finance and taxation. They are based on the premise that it is useful to look at the impact of tax and public expenditures, including social programs, by analyzing their differential consequences on individuals and families at different levels of income.

[2] Through an accounting sleight-of-hand this subsidy is officially described as coming from the Drug Plan Account financed from subscriptions. This however is misleading since most of the subscription recorded into the funds come from seniors whose benefits are paid directly from the Consolidated revenue Fund and not from that account. True "adhérents" pay in only $127 Million for expenditures of $390M.

situation. It is also indirectly mentioned by Quebec "Protecteur du Citoyen"[3] as contributing factors in making the employee premiums to employer-sponsored plans unaffordable for some employees with the possibility that they withdraw from those plans and subscribe to the public plan as "subscribers" to benefit from the large subsidy involved.

This source of obvious inequitable treatment could only be remedied through a substantial redesign of the subscriber segment of the public plan so as to make it more similar to private plans and, perhaps, some additional constraints on private plans. For instance it could be done by modulating annual subscriptions to the public plan to reflect the presence of children and ensuring that richer subscribers subsidize poorer ones in the context of a more genuine self-financing of that segment of the public plan. Private plans could also be required to provide some minimum internal redistribution of the burden in favor of lower income employees. The feasibility of any of these changes is impossible to assess given the unavailability of public information on the various groups covered.

2. Low income bracket relief. The Quebec Drug Plan operates according to different rules for "subscribers" than it does for seniors (people over 65 years of age). Seniors with low incomes benefit from an income related rebate in the contribution required of them, the monthly deductible as well as the monthly cap on drug expenditure. The relevant provisions are shown in the following table, as they stand since July 1st 2002:

CATEGORY	MONTHLY DEDUCTIBLE	COINSURANCE	MONTHLY LIMIT	PREMIUM
Seniors with max. GIS	$8.33	25%	$16.66	NIL
Seniors with Some GIS	$9.13	27.4%	$45.67	NIL to $290[4]
Seniors with No GIS	$9.13	27.4%	$68.50	$290 to $422
Subscribers	$9.13	27.4%	$68.50	NIL to $422.

As can be seen, all subscribers are assumed to have an annual income in excess of $17,961, which is the high income cut off point for the GIS for an individual over 65. A significant percentage of the 1_ Million subscribers, with an average income of around $23,500, must be less well off than some seniors who benefit from a lower monthly cap and lower coinsurance. Income distribution data for this group is not available.

Interestingly, subscribers here are assumed to be "too rich" (compared with the better off seniors), to qualify for an income-related subsidy. However, the same group of subscribers was considered "too poor"

[3] Le Protecteur du Citoyen "Au-dela de l'argent l'équité", commentaires sur les pistes de revision du régime général d'assurance médicaments, février 2000, especially p.4 and 19.

[4] The amount is income-related in each bracket. It is calculated at a 4% rate on the excess over the threshold amount of $11,461. for a single person and $17,961. for a couple, for the first $5,000. and 6 % on income beyond that first tranche. The amounts indicated in the table are for a single person.

(compared with beneficiaries of private plans) to absorb the cost of graduated premiums needed to finance free drugs for their dependent children.

The granting of an income-related relief to seniors that is denied to subscribers at the same level of income constitutes the second departure from horizontal equity in the Quebec drug plan. The discriminatory treatment of subscribers seems related to age alone.

3. Discontinuity in the contribution scale for seniors. The Quebec *Protecteur du Citoyen* noted that the ceiling applied to coinsurance and deductible jumps from $200 per annum to (now) $548 per annum as soon as a senior receives any income beyond federal old age security. Some seniors that may receive only a token amount from, say, the Quebec Pension Plan, see their ceiling increase by more than this amount.[5]

The patchwork nature of the Quebec drug plan lies behind these and other disparities between the various segments. When it was set up, private plans were in existence that for obvious financial reasons the Government did not want to overturn at a huge cost to itself. Some 57% of Quebec residents are insured for drugs by a private plan; 43% by one of the several segments of the public plan at a cost to the provincial Treasury in 2001-2002 of $2,182 M$. With regard to seniors, a pattern had already been set for a number of years, including its income-related features that were in essence carried over to the new system. Provisions for income support recipients also have a long history. The only new segment of the program therefore consisted in the one targeted at "subscribers".

Because Quebec's General Drug Plan discriminates among plan beneficiaries according to their employment status (whether they work or not for a firm that has a private plan) and their age, shows that the claim made on its behalf that it implements a concept of equity is severely flawed. This failure is no accident either: how can a plan claiming to be general reconcile the two extremes: private plan beneficiaries receiving no subsidy whatever on the one hand and disabled persons and seniors receiving massive subsidies on the other hand while a group in the middle are treated differently but without regard to their income levels? It is only in light of a tautological definition of equity (equity is whatever the plan does) that such a scheme can be termed equitable. The true rationale for covering subscribers is found in an efficiency argument. As soon as social assistance recipients see their drug needs explicitly covered, there soon comes a recognition that some heavily subsidized drug plan must be made much more widely available and without an income test or claw-back in order to avoid creating a poverty and dependency trap. Quebec has taken a similar approach by creating a child day care program with a flat user fee of $5 per day, irrespective of income. This was probably done, in both cases to avoid the criticism that otherwise some low-income families would confront an effective tax and claw-back rate in excess of 100%.

We cannot leave a discussion of the equitable character of the plan without alluding to its compulsory nature. This feature is, I believe, unique to the Quebec plan[6]. The Montmarquette study briefly discussed it in terms of adverse self-selection alleging that only higher risk indiduals would pay a premium at a cost to the rest.[7] This argument would only make sense if the mutuality element was a lot stronger than it is: at

[5] *Le protecteur du citoyen*, op.cit., p.19
[6] Santé Canada « L'Assurance-médicaments au Canada : enjeux et options » Document de travail 01-01 Septembre 2001.
[7] Op.cit., p29-30.

over 80% of the cost assumed by taxpayers, even those refusing to join a voluntary plan would contribute to that extent through their taxes[8].

FINANCIAL VIABILITY

The Montmarquette study group underlined the rapid increase in the total gross cost of the public program since its inception:

SEGMENTS	1997	1998	1999	2000	AVERAGE ANNUAL INCRREASE
Employment Assistance recipients	$231.3M	$264.6M	$304.3M	$356.0M	15.5 %
Seniors	$648.2M	$724.2M	$830.9M	$986.0M	15.0 %
Subscribers	$239.9M	$303.0M	$363.2M	$430.1M	21.5 %
Total costs	$1,119.4M	$1,291.8M	$1,498.4M	$1,772.2M	16.5 %
Annual increase	-	15.4 %	16.0 %	18.3 %	

Comparable increases in total gross costs were 19.9% in 2001 and almost 19% in 2002[9].

The first four years of the program therefore saw aggregate costs increase cumulatively by almost 60% and the process does not appear to reach a plateau any time soon. The average 16.5 % average annual increase must be compared to the anticipated 7% constant dollar annual growth projected in one of the early studies that paved the way for the introduction of the 1996 legislation[10].In 2002, the Quebec government official projection to 2005-2006 is for total costs to increase at an average rate of 15,7%[11].

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[8] Any insurance program, public or private offers individuals an exchange: on the one hand total liability vis-à-vis an uncertain adverse event versus on the other hand the certainty of having to pay compensation for the actualisation of this risk for some members of the insured group of which this individual is a member and therefore to pay that cost averaged out over the entire group plus management fees. As a result of the risk being thus mutualised a large but uncertain loss is exchanged for a small but certain cost. Anything that alters this exchange rate between risk and premium, such as a subsidy received or paid out reduces proportionately this mutualisation. This happens when a risk is more finely defined, for instance when it became evident that smokers had a different life expectancy from non smokers; or when 18 to 25 year old males driving red sports cars had systematically more road accidents than mature drivers in sedans. In both cases insurance rates were adjusted to reflect a new partitioning of the insurable population, avoid the cross subsidisation and thereby restore the balance between the two terms of the exchange. In public insurance programs when the public treasury subsidises benefits, the relationship between costs and benefits is weakened, mutuality is destroyed proportionately and the "insurance" program become more and more an income transfer program. Adverse self selection undermines the mutuality principle and can be opposed on that basis. But when is turning down a subsidy a problem? The answer is probably never especially when the one turning it down is a taxpayer whose taxes help fund the subsidy!

[9] Québec, Régie de l'Assurance-maladie, Statistiques annuelles, 2000, p. 181 and « Le régime général d!assurance-médicaments, Rapport d'activité, 2001-2002. The reporting base in the two documents are not strictly comparable.

[10] The "Castonguay" study "L'Assurance médicaments – Des voies de solution" Ministe
ère de la Santé et des services et sociaux" Gouvernement du Québec, 1996, 198 pages.

[11] "L'Assurance-medicaments: un acquis social a préserver" Ministère de la Santé et des Services sociaux, Gouvernement du Québec, mai 2002 p.11. The Montmarquette study estimates future growth at between 17 and 18% for the same period., (op.cit. page 22.) a modest estimate given what emerged in 2001 and 2002.

An increasing share of that total cost is borne by the public Treasury as opposed to the various user charges in the form of annual premiums and contributions. The share of those charges over the first four years is shown below:

	1997	1998	1999	2000
Deductibles	10.4 %	8.6 %	7.6 %	6.3 %
Coinsurance	15.2 %	14.8 %	14.3 %	13.5 %
Total	25.6 %	23.4 %	21.9 %	19.8 %

The picture is clear and the trend unmistakable: more than a drug plan, the Quebec program is an income transfer mechanism that heavily and increasingly subsidizes drug consumption. The mutuality element is small and getting smaller.

The origins of the increase in total gross costs over the first four years of the plan's existence provide an interesting insight into the dynamics underlying the program. The number of people insurer grew, on average by 2.2 % annually, that is to say faster than the overall population increase. It is unclear whether this is due to improving compliance for the first years of a program that is supposed to cover 100 % of those not covered by employer-sponsored plans. Another possibility is a progressive erosion of coverage under private, employer-sponsored plans given the large subsidy offered to subscribers to the public plan[12]. For its part, the cost per participant increased by 14 % annually, with most of this due to an increased number of prescriptions per user, namely a 8.5 % average annual increase[13] and "only" a 5 % increase in the average cost per prescription. This later increase, according to the Montmarquette study [14], "is in large part due to the arrival on the market of new drugs, such as Celebrex® and Vioxx® and to widespread adoption of other drugs for which generic alternatives are unavailable, such as Lipitor®, Mevacor®, Pravachol® etc".

This rapid and unexpected increase in cost has been a source of embarrassment to the government, all the more so as it was the current government that introduced the program and therefore could not blame its predecessor for bad planning. It had to increase premiums for the first time on July 1st 2000 from $175. to $ 350; then the following year from $350 to $385. and a last (?) time in 2002 from $350 to $422. This last increase was accompanied by increases in the coinsurance percentage from 25 % to 27.4 % and the monthly deductible from $8.33 to $9.13. All these 2002 increments represent an increase in user charge of 9.6 % in a year for which the anticipated (or rather budgeted) increase in costs amounts to 14.6 %. This clearly means that the trend to a gradual shrinking of user charges as a percentage of total costs will continue.[15]

[12] This has not been publicly discussed. However the latter hypothesis seems to find some support in the fact that, year after year, the rate of increase in the number of users of the public plan has accelerated instead of tailing off.

[13] This statistic keeps increasing from year to year, going from 9.7,10.2,13.0and 14.1% from1997 t0 2001.

[14] Op.cit. Pages 19 and 20.

[15] All the latter changes together with selected illustrations of their impacts can be found in the May 2002 white paper "L'assurance médicaments : un acquis social à préserver".

All this raises obvious questions as to the viability of the plan in its present configuration. This, of course is not on the public agenda as such but there is a degree of obfuscation about the true nature of the challenge that will in time lead to significant change. Some of this obfuscation is found in the convoluted accounting of the cost of the program. There is a "Fonds de l'assurance médicaments" whose raison d'être seems to be to hide the immediate cost of the subscriber segment of the program in an account that improbably attempts to describe that segment as self supporting from user charges by including on the income side charges contributed by seniors whereas they receive no benefit from the account.

A more substantial harbinger of change is to be found in a decision announced in May 2002, to "broaden the criteria" used in adding new drugs to the Quebec drug formulary. This expression used in official pronouncements offer a wonderful example of "newspeak" since this exercise in "broadening" is intended to result in a narrowing of the drug formulary since by adding criteria not at present considered, some drugs that qualified in the past will not qualify for insertion in the future. The present formulary, with over 4,000 drugs listed is very extensive in both absolute and comparative terms. The concept of limiting the drug list according to the adequacy of the evidence of effectiveness and cost effectiveness had been mooted two years previously in two commissioned reports[16] and submitted to public consultation[17]. In May 2002, the Government finally seems to have resolved to implement a policy that would restrict the formulary by taking into consideration "socio-economic factors" to refuse to list some drugs that threaten society's ability to pay.

While this may eventually be important, this recent announcement (together with a vague program of utilization review) continues the obfuscation since the Government writes into its current year forecast a $90M expenditure reduction that would supposedly result from these moves in their first year of implementation

Generous public programs that rapidly exceed the appetite of governments to finance them tend to end up with more or less explicit forms of rationing. The Quebec drug plan seems to be on its way in that direction.

PHARMACARE IN THE CONTEXT OF AN OPTIMAL HEALTH SYSTEM

There seems to have been unstated assumptions in the original design of the Quebec drug plan, namely that:

- More medication is optimal medication; and
- Self-monitoring of medication is optimal.

It is well known that patient and physicians already have, even in the absence of a drug plan, many incentives to (over) utilize medication. Side effects, contraindications and interactions are little understood and poorly documented (or even not documented at all). They are factors in hospitalization. Further more, compliance with prescribed dosage and duration is low and as a result waste is significant and, in the case of antibiotics, positively harmful in the long term.

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[16] The initial discussion goes back to 1998, McGegor, Maurice (collaboration R. Jacob) "Critères et processus de décision pour la couverture des médicaments coûteux au Québec : réflexions sur la situation actuelle et propositions de changement" Québec, 25 pages plus appendices. It was followed in 1999 by Doucet *et al.*, Rapport du Comite sur les questions relatives au processus de décision pour la couverture des médicaments": Québec, Ministère de la Santé et des services sociaux, 15 pages and appendices.

[17] Gouvernement du Québec "les pistes de révision" p.10-12.

To this cocktail of concerns, the introduction of a drug plan conceived strictly, as the Quebec plan is, as a financial measure to remove income- and price-related impediments to drug use, is bound to have a powerful effect and add to those concerns. The increase in the number of prescriptions per user so far testifies to that.

The rhetoric surrounding the drug plan is that liberal access to drugs support the functioning of the health care system in the following ways:

- By reducing the need for expensive treatments and even hospitalization by facilitating preventative action that relies on drugs;
- By facilitating early discharge of in-patients that could otherwise remain in institutional settings to benefit from free drugs in those settings.

Unfortunately, there is little evidence that these arguments and their implications are true. In a companion paper to the present one by Mark Stabile , it is shown that the first statement is almost certainly not true[18] . With regard to the second one, it should be obvious that a stand-alone drug plan is a second best approach to achieve these benefits. Studies of many prevention programs show that if prevention efforts are to be successful, a structured approach is necessary. Patients suffering from persistent hypertension, diabetes or any other permanent condition can benefit from medication but also require competent and organized follow-up. They will occasionally suffer from transient infections etc and drug interaction must be professionally monitored. The same holds true *a fortiori* for psychiatric patients or HIV patients. The present inability of our health system to provide (except before the drug plan in part for the latter categories) free medication on an outpatient basis is what must be corrected rather than the silo approach of providing free or heavily subsidized drugs outside the proper context[19].

The early-discharge benefit is also dubious. Hospital formularies, while more restrictive than the present Quebec formulary overall, include nevertheless controlled drugs that play an essential role in pain management. Because of legal restrictions on their use, these drugs cannot be available outside a context of institutional control and delivery.

Here again, a policy of early discharge has been intensely promoted in the context of budget cuts to the mainstream health system while the resources to develop community support and home care have been neglected. A structured approach to provide continuity of care even after early discharge could conceivably remove this obstacle to high quality pain management while meeting legal restrictions on the management of controlled drugs. This is something that a freestanding drug plan will never be able to do. This is particularly significant for patients discharged into the community for palliative care. As it is a stand-alone drug plan can easily become one more excuse to simply "dump" patients rather than address the issue of continuity of care.

Finally, the existence of a drug plan divorced from the mainstream health system is the temptation of game playing. With severely constrained budgets, hospitals are tempted to tighten up either their formularies or to

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[18] Mark Stabile « The Effects of Private Insurance on Utilization ». In that paper the author shows that drug insurance increases the probability of using any doctors' services by 4% especially among lower income people. There is no reason to believe that these results would be different for public drug insurance.

[19] The importance of the potential contribution of a structured environment for drug prescription and dispensation is well illustrated in a companion paper dy Dr Robyn Tamblyn.

manage its use more sparingly by encouraging patients to obtain from the subsidized drug plan medication to be administered to in-patients.

A research report by Dr R. Tamblyn and associates at McGill University on the impact of the Quebec Drug Plan, published in 1999, attracted a lot of attention.[20]The study highlighted the impact in terms of a reduced consumption of drugs following the introduction of the Drug plan that introduced increased financial contributions on employment assistance recipients (mostly mentally ill patients) and seniors receiving the maximum GIS. As one would expect, drug usage was curtailed but what the study showed was that in a good number of "incidents", the rationing or interruption of medication led to increased number of medical consultations, visits to emergency departments or even re-admissions. As a result the plan was amended, mainly by doing away with deductible and coinsurance payments for severely handicapped recipients. This rapping of the knuckles probably intimidated Government from pursuing the initial objective of keeping user charges a stable proportion of costs as aggressively as it had once thought possible.

The Tamblyn study had been mandated by the Minister of Health. It addressed the impact of the drug plan (and the changes it effected from the previous situation). It was not conceived as a comparative evaluation of the Drug plan and other possible approaches to drug availability. Given the well-known sensitivity of drug usage to prices and insurance coverage[21], any regime must be evaluated from the dual perspective of avoiding the error of inducing excessive and detrimental drug use on the one hand and avoiding underutilization on the other hand. Other approaches, including some that would better integrate drug availability into the mainstream health services delivery system and that would distinguish between essential and merely useful drugs could be imagined that might conceivably better address the double trade-off than either the current drug plan or any pre-existent set of measures.

CONCLUSIONS

The Quebec drug plan has had a short but turbulent existence. It has been studied, criticized and modified several times. The most significant disappointment concerns the rapid cost escalation that has far outstripped initial forecasts. Yet, this inflating cost of the program is apparently nothing that sets the Quebec program apart from other public or private drug plans. The level of drug prices in Canada is notoriously lower than in other countries, such as the USA; consequently not much store has been put on efforts to reduce that level further[22] . This in any case could only result in a once-for-all saving with the rising cost trend thereafter continuing to assert itself. Moreover more aggressive use of mandatory substitution or adoption of a lowest price reimbursement policy would have no impact on the newest drugs that account for a substantial part of incremental consumption and, of course, of the upward creep in average prescription costs.

These considerations give a fatalistic tone to many analyses of the problem: drugs are important, society deems it important to ensure access to them irrespective of price or income barriers and drug discovery and development ensure that the cost implications will continue to soar indefinitely.

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[20] Tamblyn, R. *et al.*, « Evaluation de l'impact du régime général d'assurance –médicaments », Université McGill, Université de Montréal, Université McMaster (CHEPA) USAGE, mars 1999.

[21] In the Quebec context, this was documented when the drug plan was introduced in a report prepared for the Health ministry in Rheault, S., "La gestion des coûts des médicaments –Evaluation des interventions gouvernementales québecoises et canadiennes" MSSS, avril1998.

[22] The Rheault study credits the Canadian Patented Medicines Price Review Board for its effectiveness in this regard (*op.cit.*, pages 47-51). See on this organization a paper given at this IRPP Conference by Robert Elgie M.D.

This is not to say that anyone considers the plan perfect. For instance, in response to conflicting pressures, the plan has tended to become increasingly complex. Pharmacists who carry the burden of explaining those complexities to - and collecting the coinsurance payments from - uncomprehending recipients have particularly criticized this aspect of the plan. Monthly caps on private contributions can be in part avoided by bunching drug purchases into a single month for longer-term requirements and so on. Whether these irritants are corrected or not will not affect the viability of the plan.

The purpose of the incremental change to drug coverage introduced by the Quebec government in 1997 was misrepresented. Rather than any attempt to improve "equity", the creation of the public plan segment for subscribers reflects concerns about the efficiency of the labor market. Income support programs especially when they include explicit coverage of special needs such as drugs, risk creating welfare dependence or a "poverty trap". When coverage is extended to other neighboring groups and scaled back as income increases, the resulting tax-back rates for a number of parallel benefits can add up to close to 100% or even more of incremental income. The solution to this problem is very expensive since it requires removing the income test or to adopt a tax-back rate that ensures that some subsidized benefits will be available at relatively high income levels.

Needless to say, Quebec's Drug Plan was never explained by Government in those terms. It is easier but misleading, to account for that plan as en effort to provide equity of access to health care than as an extension and a consequence of social assistance. As long as drugs are considered distinct and even separate from the rest of the health care system, an approach such as that adopted by the Quebec government is inescapable.

Rather, it is the "big picture" issues of the escalating total cost and of optimal drug use that are bound to emerge sooner or later as determining factor for a drastic revision. It is ironic to observe that although Quebec developed its drug plan totally outside the frame of reference of the Canada Health Act with its five "principles", it has nevertheless, in its claim to universality, public administration (standards are mandated even for private plans) and comprehensiveness adhered quite closely to that pattern! It may be, here as in other part of the health system, that it is the attempt at comprehensive coverage that a fundamental mistake has been made[23]. Heavily subsidized, even free drugs, may be entirely appropriate (and cost effective) for genuinely essential drugs of proven effectiveness delivered in the appropriate context of professional monitoring and continuing care and professional responsibility for outcomes. Other drugs may also be subsidized but not necessarily at over 80 %. Yet other drugs, including the so-called life-style drugs might be better left out of a public scheme altogether.

Selective coverage can be anchored on a number of significant dichotomies that have been suggested in academic inputs to the evaluation of the Drug plan such as the distinctions made by McGregor between cost efficient and non cost efficient drugs; experimental and established drugs; large ticket drugs and minor drugs. The distinction made in the Tamblyn study are also of interest, namely between essential drugs and episodic ones…Such classifications and cross-classifications, especially if joined to an integrated approach to drug prescription and follow-up shall inevitable be found in the solution set to an otherwise intractable problem.

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[23] This author has challenged the principle of comprehensiveness in a forthcoming IRRP Policy paper entitled "Why comprehensiveness is a dream".

The most important lesson to be learned from the Quebec experience with its drug plan is not to take that route. The motivating factor for this conference is the notion that the Federal government might be moved to institute some kind of National Drug Plan with uniform standards across the country and, moreover, a Plan that would be distinct and separate from its putative role the present hospital and medical services core of the Canadian Health system. For some, the model for such a National plan is the Quebec plan. That would be a grievous mistake. Such a National Plan, just as the Quebec plan, would not be financially viable: an $8 Billion plan growing exponentially at between 18 and 19% annually would cripple the National finances. Moreover, at a time when at least rhetorical emphasis is so often placed on evidence-based decision-making and concern for outcomes, this would represent a leap into the unknown. Drugs are just one very important tool of the health system: nothing in terms of access or quality of care is gained by segregating that tool into a program of its own. On the contrary, a great opportunity is lost.