

NATIONAL STANDARDS AS VIEWED BY A PROGRAM MANAGER

LINDA TENNANT

Former Director, Drug Programs Branch, The Ontario Ministry of Health and Long Term Care

Towards a National Strategy on Drug Insurance: Challenges and Priorities

Publicly funded health services in Canada are broadly described by the Canada Health Act (CHA); however, the Act does not cover drugs that are prescribed and dispensed in a non-hospital or community setting. Publicly funded benefit plans or programs for such community drugs exist at the discretion of each province or territory and are not part of federal/provincial/territorial cost sharing arrangements.

A wide range of provincial, territorial and federal drug programs, as well as private drug plans, has been developed over time. A mix of private and public plans is found in all jurisdictions in Canada. While the programs have many similar or common features, there are also considerable disparities. These disparities result in inequities in who is covered, the amount of cost sharing by beneficiaries, and the level of benefits provided.

As more and more drug treatment options become available, emerging scientific evidence supports more active treatment of many conditions, and the health care system moves to more services in a community setting, drugs consume an increasing share of private and public health care costs. In most jurisdictions, the perceived need to manage the rate of growth in costs in order to sustain programs has led to changes in program eligibility and the benefits provided and further changes are anticipated. Other stakeholders view such changes as further restrictions that are being imposed on access to necessary medications.

Establishing a consensus on the need for national standards and what those standards might be presents a major challenge, given the multiple stakeholder involvement and interest in community drug programs, and widely divergent views. Assuming that consensus can be reached, implementation will also present issues.

The most difficult questions to be resolved will center on the level of benefits to be provided, the associated costs and how programs are to be funded. Provincial and territorial governments are voicing concerns about the sustainability of existing programs, given the high rate of growth and escalating demands. Governments face multiple demands for additional funds for other health services as well as services such as education.

Many private insurers are also voicing concerns about the rate of growth in drug program costs.

In recent years, a dominant feature of federal, provincial, territorial discussions on health care has been provincial and territorial allegations of a substantial reduction in the federal funding contribution. Placing a national strategy on drug insurance on the federal/provincial/territorial agenda will require bold leadership as well as a willingness to participate in the discussions by all governments.

General

Private drug plans are frequently available through employers or may be obtained through private insurance arrangements. Generally, private plans provide coverage for a broad range of prescription drugs commonly used in conditions treated in a community or non hospital setting for the employee, spouse and children. Private plans may require cost sharing in the form of a co-payment or may have a maximum amount of benefits allowable per year or for the term of the employment. Under the Quebec scheme, private plans must provide a minimum standard of coverage, as set by the government, for both public and private plans.

Public plans are available in all provinces and territories and for certain groups covered by the federal government, including First Nations and veterans. Historically, public plans were developed to cover specific groups in the population many of whom have limited means, are without private insurance and have high drug costs in relation to their incomes. The groups include: seniors, those on social assistance, those in long term care facilities, and people with certain clinical conditions for which the associated medication costs were high. The total cost and average cost per recipient of public plans is considerably higher than those for private plans.

In discussing national standards for community drug programs, the five principles of the Canada Health Act can be used as a starting point to measure current services and make recommendations for the future, given ongoing public support for these principles. The Act states that health services must be: universal; accessible; comprehensive; portable; and publicly administered.

Universality

Under the CHA, universality means that one hundred percent of the insured residents of a province or territory must be entitled to the insured services on uniform terms and conditions.

Many provinces and territories have extended the coverage available under public plans to anyone within their geographic boundaries who qualifies; in this way, they can be termed “universal”. That is, those not covered under private insurance may apply for coverage under the public plan and drug coverage is available to anyone who meets eligibility qualifications, such as a residency requirement. The following plans are universal: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Yukon and the North West Territories

Other jurisdictions do not have universal plans using this definition: New Brunswick, Nova Scotia, Newfoundland, and Prince Edward Island.

As a result, some Canadians do not have access to public or private drug insurance if private insurance is beyond their means. In addition, because of the independent historical development of the various plans, beneficiaries of public and private plans are not covered under uniform terms and conditions. As already stated, considerable disparity exists across the country.

Accessibility

The Canada Health Act principle for accessibility specifically precludes user charges which are common to what is likely the majority of community drug programs.

All provinces and territories have some form of cost sharing for some but not all beneficiaries. The definition of cost sharing here includes: premiums; deductibles (either standard or graduated based on income); and co-payments. Most jurisdictions have different levels of cost sharing according to income level or disease state and cost sharing by the beneficiary is frequently held to a maximum amount.

Similarly, the majority of private drug plans have some form of cost sharing. Again, there is wide diversity across such plans.

Comprehensiveness

The Canada Health Act refers here to “insured services”. For drug programs, comprehensiveness can be used to refer to the list of medications available as benefits, usually known as a program’s drug formulary.

Private and public drug programs cover an extensive array of prescription medications but they do not cover all drugs on the market and may restrict access to certain medications to those who meet specific clinical criteria.

Historically, each province and territory has, for the most part, used local experts to provide advice on whether or not a drug should be covered based on a determination of clinical and cost effectiveness. A local decision on funding is made subsequently. A drug may be a benefit of a public plan in one jurisdiction and not in another, over the short or long term.

With the introduction this year of the Common Drug Review (CDR) process, which all jurisdictions except Quebec have agreed to use at this time, it is hoped that there will eventually be one clinical and cost effectiveness review to be considered by all public plans. The decision on funding will, however, remain with each jurisdiction which will take into account local conditions such as the funding impact or other local circumstances in deciding whether or not to reimburse a drug.

All public plans have a form of limited benefit status or special authorization. The restrictions are usually applied to drugs that expert reviews consider to be clinically beneficial and cost effective in a specific population group, and/or there are other less costly drugs available for that condition.

Some products may have general or unrestricted benefit status in one plan and be restricted in another, or may not be a benefit. While there is usually an awareness of the status of provincial and territorial decisions on new products, the full extent of the disparity across plans is not known as this has not been the subject of study. It is known that the number of drugs being given limited benefit status, or not being reimbursed, is increasing.

The Quebec government has established a minimum level of benefits for both public and private plans in that province.

Public plans also show some variation in the amount in which the same drug product or a group of drugs is reimbursed. For example, a public plan may set a maximum amount of reimbursement for a category of drugs and the patient can elect to pay the difference if a more costly product is selected. Another common feature is that most plans have restrictions on the amount paid on generic or multiple source products.

While private plans may more comprehensive lists of benefits, many now have restricted formularies. As with public plans, private plans are experiencing a substantial annual growth rate and many are expressing concerns about the future sustainability of their programs in their current form.

Portable

Since community drug plans are at the discretion of individual provinces and territories or are a condition of employment, they are not portable from one jurisdiction to another, unless an employee is transferred within the country by the same employer. Thus, individuals and families may find themselves responsible for payment of drug costs incurred while traveling within Canada or moving from one employer or one jurisdiction to another. Even if there is no gap in coverage periods, there may be differences in the level of benefits provided by two different plans.

Public Administration

The Canada Health Act requires that provincial and territorial health insurance plans be administered and operated on a non profit basis by a public authority, responsible to those governments and subject to audit.

Obviously, the wide array of existing programs which is administered by the private and public sectors do not meet this condition. As community drug programs are not cost shared by the federal government, program specific terms and conditions have been arranged according to the needs of each program manager and payer. All publicly funded programs are managed by and responsible to a public authority and are subject to audit; however, some of the day to day operations (e.g., claims processing) may be carried out under a contract with a private agency.

Overview

Community drug programs, as they exist presently, do not meet some or all of the five principles of the Canada Health Act as examined here, to a greater or lesser degree.

Given public support for these principles, they are being used here as a suggested guide in any discussion on establishing national standards for drug programs.

As has been stated, the most pressing issue raised in the discussion is likely to be whether the introduction of national standards will increase costs and how the increase in costs will be met. All jurisdictions are expressing serious concerns about the sustainability of existing programs and the current level of benefits provided.

Concerns are also being voiced over "cost shifting", that is, a transfer of costs from the public to the private sector, or vice versa, as various program changes are introduced. This concern will arise in any discussion of national standards.

Given the plethora of drug plans already in place, the involvement of both the private and public sector, and program managers' concerns on the financial sustainability of existing programs, a more realistic approach to establishing national standards may be to first deal with public plans and introduce certain basic conditions, in order to reduce the most serious disparities in the public sphere.

The Quebec experience in introducing common or minimum standards for public and private drug programs in that province would provide a useful guide for the same discussion in other jurisdictions.

The following are suggested as essential, basic principles:

1. Drug benefits should be available to everyone who is entitled to health insurance and the cost of medications should not be a deterrent in accessing treatment.
2. Benefits should be based on medical necessity and clinical and cost effectiveness.

1. Drug benefits should be available to everyone (universality) and the cost of medications should not be a deterrent in accessing treatment (accessibility)

Drug insurance should be available to everyone within each provincial and territorial jurisdiction who meets residency requirements and does not have private insurance. The terms of coverage should be coordinated with those for general health services in order to deal with some of the issues on portability.

An extension of program benefits would be required in some jurisdictions for segments of the population not already covered, as a consequence.

The cost of medication in relation to income should not be a deterrent to accessing treatment for low income individuals and families, or those with high drug costs in relation to their income.

Ensuring that cost is not a deterrent to accessing treatment means an examination of existing cost sharing schemes. Given the multiplicity of schemes now in place, the challenge of establishing some basic conditions, e.g., a minimum or zero level of cost sharing for those least able to afford it or an income based system with common terms, cannot be underestimated. This is not to suggest that basic terms and conditions should not be established or are undesirable; rather, it is to point out that a major commitment and considerable effort will be involved. Again, in light of governments' concerns on the growing costs of existing programs, it will be difficult to engage provinces and territories in such a discussion if the outcome is additional financial pressures.

2. Benefits should be based on medical necessity and clinical and cost effectiveness

Programs will reimburse products that are shown by scientific evidence to be clinically efficacious and cost effective when compared with other drugs or other treatments for the same condition.

This is considered to be a continuation of the current practice of provincial, territorial and federal drug plans' use of internal and external experts to assess and make recommendations on formulary benefits. The introduction of the Common Drug Review for use by all public plans has already been mentioned.

The determination of benefits to be provided and the amounts to be reimbursed are crucial to managing community drug programs and providing quality care at the most reasonable price or cost. It is highly unlikely that any public or private plan will agree to an open formulary which includes most or all drugs available on the market. Given the wide range of products and prices, and the associated costs, restricted lists of benefits and limits on the amounts to be reimbursed are inevitable.

The establishment of a “national” or basic list of benefits that all programs should include will present a major challenge; but not one that is insurmountable. It is not necessary that each and every drug be included in all formularies, especially at the outset, rather that one or more products for any one condition should be reimbursed. The goal is not that all beneficiaries have access to all products but that all beneficiaries have access to medically necessary treatment.

It is acknowledged that the interpretation of medical necessity is, in and of itself, controversial in some cases and that expert opinion on scientific evidence and cost effectiveness can conflict. In addition, as evidence continues to evolve, opinions change. These circumstances are common to other health care services and are not restricted to drugs. Differences in opinion are inevitable and will continue to be debated as they arise.

As has been mentioned, existing programs use a range of management approaches which include:

- Restricted formularies
- Special authorization or limited use for certain drugs
- Maximum prices for generic drugs
- Reimbursement of the lowest cost alternative on the formulary and reference based pricing
- Bulk purchasing or standing offer contracts
- Written agreements with manufacturers

The introduction of national standards should not inhibit specific management initiatives in each jurisdiction as long as such initiatives do not compromise the standards. Such initiatives can offer opportunities to look at alternative management approaches that can improve services and benefit other programs.

Conclusion

The approach used here to examine national standards for drug programs builds on the system now in place, which includes a wide variety of private and public plans. In order to ensure that all Canadians have equal access to a range of medically necessary benefits, the starting point in the discussion should be the coordination of basic or broad terms and conditions for public plans. A subsequent step would be the extension of these terms and conditions to private plans.

The federal, provincial and territorial governments cooperate in a number of initiatives on pharmaceutical care through the existing federal/provincial/territorial standing committees which report to the Deputy Ministers of Health. It is equally important to continue to develop and implement national approaches to initiatives which help to improve prescribing practices and the quality of care.