RESPONSE TO THE
NEW BRUNSWICK GOVERNMENT
CONSULTATION ON

# A Prescription Drug Plan for Uninsured New Brunswickers

*Nurses Association* OF NEW BRUNSWICK
*Association des infirmières et infirmiers* DU NOUVEAU-BRUNSWICK

***Nurses shaping nursing for healthy New Brunswickers.***

*The Nurses Association of New Brunswick (NANB) is the regulatory body and professional association for more than 9,400 registered nurses. The mission of NANB is to protect the public and to support nurses by promoting and maintaining standards for nursing education and practice, and by promoting healthy public policy*.

# Executive Summary

The Nurses Association of New Brunswick (NANB) commends the government for moving forward with a prescription drug plan for uninsured New Brunswickers and appreciates the opportunity to participate in this consultation process. As many as 33 percent of New Brunswickers have no private health care plan and at any one time, up to 11 percent of New Brunswick households are at risk of facing catastrophic drug costs. Research shows that approximately 10 percent of Canadians who receive a prescription medication report not filling a prescription, not renewing a prescription, or trying to make an existing prescription last longer. Lack of insurance coverage for drugs is directly related to this behaviour.

It is important that there is equitable access and fair distribution of the conditions required for good health. Those conditions are the social determinants of health and in this case, employment and income.

NANB believes that a prescription drug plan for uninsured New Brunswickers should be based on the following principles as agreed to by the National Pharmaceuticals Strategy (NPS)[1]:

- *Universal*
- *Transparency*
- *Equitable*
- *Evidence based*
- *Integrated*
- *Sustainable*

In addition, NANB believes the plan should include the principles of patient centredness and accountability.[2]

## NANB Recommendations:

1. A prescription drug plan for uninsured New Brunswickers should be voluntary.
2. New Brunswick cannot afford not to have a prescription drug plan for those without insurance. The financial sustainability of a prescription drug plan for uninsured New Brunswickers requires:
    - the involvement of employers (see recommendation 7);
    - comprehensive pharmaceutical policies that establish the requirement for (1) evidence of drug effectiveness, (2) drug pricing and purchasing, (3) individual patient health status, and (4) family size and financial need; and
    - continued pursuit of a national pharmaceutical strategy in collaboration with the federal government and other provincial/territorial governments.
3. A public prescription drug plan should not include copayments. The plan should include an annual deductible based on a variable percentage according to family size and net income. Once the yearly deductible is reached the insurance plan should then pay 100 percent of costs.
4. The plan should not have a premium.
5. There should be no restrictions for those with pre-existing medical conditions.
6. There should be no waiting period after enrolment.
7. Employer based drug plans should continue to play an integral role in New Brunswick. This public prescription drug plan should be for those who do not have existing prescription drug coverage. It will be important for the government to engage employer based drug plan providers throughout this process.

While the creation of a prescription drug insurance plan for those uninsured is important, the experience of other jurisdictions points to the need for a comprehensive pharmaceutical strategy in New Brunswick. For this insurance plan to be financially sustainable and effective, the NANB believes the plan must include robust policies that establish requirements for (1) evidence of drug effectiveness, (2) drug pricing and purchasing, (3) individual patient health status, and (4) family size and financial need.

# Introduction

The Nurses Association of New Brunswick (NANB) commends the government for moving forward with a prescription drug plan for uninsured New Brunswickers and appreciates the opportunity to participate in this consultation process.

NANB welcomes the government's initiative to introduce a prescription drug plan that will help New Brunswickers afford the medications they need without experiencing financial hardship or falling into poverty. As many as 33 percent of New Brunswickers have no private health care plan. Those who have a private health care plan may find their plan does not pay for new or expensive drugs and treatments.[3] At any point in time, up to 11 percent of New Brunswick households are at risk of facing catastrophic drug costs. New Brunswick is one of only two provinces in Canada without a catastrophic drug program or some type of program to financially assist those not insured (PEI is the other). Prescription drugs administered outside the hospital setting must be paid for by the individual, often a barrier to compliance with the prescribed therapeutic regime.

A very recent study in the Canadian Medical Association Journal found that nearly 1 in 10 Canadians who receive a prescription report cost related nonadherence either in the form of not filling a prescription, not renewing a prescription, or trying to make an existing prescription last longer.[4] Furthermore, they found that not having insurance coverage for prescription drugs, being in poor health, having a low household net income, being under the age of 65 years and living in British Columbia are associated with cost-related non-adherence. Two-thirds of Canadian households incur out-of-pocket expenses for prescription drugs each year.[5] These payments totalled $4.6 billion in 2010, or about 17.5 percent of total spending on prescription drugs.[6] One concern over these substantial out-of-pocket contributions is patients not adhering to necessary medications (i.e., they may not fill prescriptions, or they might skip doses) and thus worsening their health status, requiring an increase in health services resulting in overall increased system costs.

A 2005 study by Whelan, Cooke and Sketris is a case in point. These authors examined the impact of socio-economic and demographic factors on the utilization of smoking cessation medications in patients hospitalized with cardiovascular disease in Nova Scotia.[7] One estimate suggests that it costs the Nova Scotia healthcare system approximately $70 million per year in smoking-attributable costs.[8] It was found that both the presence of private drug insurance plans and less difficulty paying for basic needs were associated with higher use of smoking cessation medications. Their study confirms the findings of other studies that also found a link between higher income and social status (as determined by employment status, owning a home, and education) and the use of smoking cessation medications or of quitting.[9,10,11]

# NANB Perspective

NANB approaches this issue with a social justice lens. Social justice is "*the fair distribution of society's benefits, responsibilities and their consequences. It focuses on the relative position of one social group in relationship to others in society as well as on the root causes of disparities and what can be done to eliminate them*." (p.10).[12] One of the key components of a just society is equitable access and fair distribution of the conditions required for good health. Those conditions are linked to the social determinants of health and in this case, employment and income. Socio-economic circumstances have at least as much, and often more, influence on health status as do health-care services and personal health behaviours.[13]

As an organization we are also committed to evidence informed decision making and thus have developed our response based on this principle. We have examined the literature as well as the design of similar programs in other provinces and territories. New Brunswick can benefit from the experience of other jurisdictions who have implemented similar programs.

NANB believes that a prescription drug plan for uninsured New Brunswickers should be based on the following principles as agreed to by the National Pharmaceuticals Strategy (NPS)[14]:

- *Universal*
- *Transparency*
- *Equitable*
- *Evidence based*
- *Integrated*
- *Sustainable*

In addition, NANB believes the plan should include the principles of patient centredness and accountability.[15]

We also strongly encourage the government to develop and implement a robust evaluation framework that includes clear objectives, indicators, and measures both intended and unintended consequences.

We have organized our response to align with the seven questions posed by the Advisory Committee on Health Benefits as part of its consultation.

## NANB Recommendations:

### 1. Should all New Brunswickers be required to have a drug plan?

A prescription drug plan for uninsured New Brunswickers should be voluntary.

Background
Across Canada, all plans are voluntary with the exception of Quebec where jurisdictional legislation establishes the requirement that everyone is covered by a prescription drug plan.

### 2. How would we pay for what we need?

New Brunswick cannot afford not to have a prescription drug plan for those without insurance. The financial sustainability of a prescription drug plan for uninsured New Brunswickers requires:

- the involvement of employers (see recommendation 7);
- comprehensive pharmaceutical policies that establish the requirement for (1) evidence of drug effectiveness, (2) drug pricing and purchasing, (3) individual patient health status, and (4) family size and financial need; and
- continued pursuit of a national pharmaceutical strategy in collaboration with the federal government and other provincial/territorial governments.

Background
Several organizations such as the Canadian Centre for Policy Alternatives (CCPA) and the Canadian Health Coalition have called for a public drug insurance plan, proposing the creation of such a program would reverse the upward spiral of drug costs in Canada.[16,17] In the report written for CCPA, author Gagnon argues that universal pharmacare is a "*way to control costs through efficient pharmacoeconomic assessment of new drugs and by developing bargaining power when dealing with powerful transnational companies*"(p.5). Many countries, including France, the UK, Sweden, Australia and New Zealand have universal drug plans and as a result pay far less for drugs than Canada.[18]

The 2003 First Ministers' Accord on Health Care Renewal committed governments to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage by the end of 2005/06. The First Ministers also agreed that one of their priorities would be to collaboratively promote use of the best practices in prescribing medications. They also pledged to better manage the costs of all prescription medications, including generic medications, and to ensure that medications are safe, effective, and accessible in a timely and cost-effective fashion.[19]

The First Ministers recommended a National Pharmaceuticals Strategy (NPS) as part of their 10-Year Plan to Strengthen Health Care in 2004. The Accord stated that "*no Canadian should suffer undue financial hardship in accessing needed drug therapies. Affordable access to drugs is fundamental to equitable health outcomes for all our citizens*".[20]

In 2008, the provinces and territories signalled their intent to raise the profile of the NPS and to negotiate some elements of it with the federal government including the establishment of a national standard of pharmacare coverage for all Canadians. The proposed funding agreement would protect the flexibility and autonomy of provinces and territories to define programs for their populations ensure that prescription drug costs will not exceed 5 percent of the net income base for their respective populations, and recognize shared responsibility by allocating the cost of catastrophic drug coverage 50/ 50 between the federal government and the provinces/territories. They also noted that a nationwide approach to savings in pricing and purchasing is not realistic at this time, but that interprovincial collaborations should be separately pursued.[21]

Catastrophic drug coverage is the area within the NPS that has the broadest public support. Six percent of Canadian report spending more than $1000 (US) in the past year out-of-pocket on prescription drugs. In the UK, only 1 percent of consumers report spending more than $1000 in the past year on unreimbursed prescription drugs. In contrast, recent research found that nearly 1 in 10 Canadians who receive a prescription did not fill a prescription or had missed a dose of medicine because of cost.[22]

One of the major issues is that prescription medications are relatively more expensive in Canada than elsewhere. Canadians and their governments pay more for generic prescription medications compared to 11 other countries. Canada also pays more for patented and non-patented branded prescription medications than most other countries studied (except for Switzerland and the US).[23] While generic prescription drug prices dropped in all countries studied in 2005, Canada's prices dropped by only 0.3 percent compared to drops of between 1.2 percent (France) and 32.4 percent (UK). Similarly, for non-patented branded prescription drugs, Canada's prices rose by 3.4 percent whereas most other countries saw a drop in their prices. If Canadian prices had been kept in check and not exceeded international median prices in 2005, spending on non-patented prescription drugs could have been reduced by an estimated $1.47 billion in that year alone.[24] In addition, a report from the Competition Bureau states that Canadians could save up to $800 million a year if changes are made to the way private plans and provinces pay for generic drugs.[25]

According to the Canadian Health Coalition, Canadians pay 31 percent above the OECD average for brand-name drugs.[26]

The Standing Senate Committee on Social Affairs, Science and Technology of October 2002 called for the federal government to take over responsibility for 90 percent of prescription drug expenses that exceed a certain limit that qualifies them as catastrophic.[27]

According to the Canadian Health Coalition, the amount of prescription drug costs in Canada covered by the federal government is currently 2.7 percent.[28]

A commentary by Malcolm Maclure on an article by Vittorio Maio[29] and colleagues provides a detailed analysis of various drug insurance policies.[30] Maclure begins with a two-dimensional grid for classifying drug insurance policies. It shows two basic ideas, that (1) drug insurance should be for drugs that work, not for ineffective drugs, and (2) benefits should go to patients with greater needs, not to healthy people with little need. Maclure argues there is a spectrum of policies for directing drug benefits to patients with greater needs. He predicts that the best policies will be those that combine four types of information: (1) evidence of drug effectiveness, (2) relative prices for similar drugs, (3) individual patient health status, and (4) family financial need.

An outcome-based approach to prescription drug coverage was incorporated into British Columbia's public drug benefit plan. The inclusion for coverage of a given drug is determined on the basis of scientific evidence demonstrating a mortality or morbidity benefit. External researchers suggest that the policy has saved the provincial program "*approximately 14 percent of program costs without generating the adverse effects often associated with typical cost-cutting strategies*" (p. 1232).[31]

Pasquale et al state that "*for the vast majority of Quebecers, personal finances are no longer a barrier to prescription drugs, which, though unquestionably costly, are still seen by many experts as a relatively inexpensive means of preventing more serious health outcomes. In this sense, Quebec's move to simplify its program and reduce cost barriers for the poorest while retaining coverage for all residents has been successful*." (p.492)[32]

They note, however, that cost control remains a challenge for Quebec and similar programs in other provinces. The Quebec program has no mechanisms to monitor appropriate drug use or the volume of drug consumption citing a 2004 study of seniors in the Quebec City area found that the prescriptions of 54.7 percent of patients may have been inappropriate in regard to drug interactions, wrong duration or dosage, or simply the wrong drugs themselves. Meanwhile, Quebecers had the most prescriptions per capita of all Canadians in 2003 and "*purchased prescriptions for relatively more costly classes of drug within given broad therapeutic categories than did residents of the other provinces*" (p. 330).[33] The authors note that the introduction of a national formulary and price negotiations with drug companies are examples of measures that have been developed to counter rising drug costs worldwide. France is cited as cutting costs by reducing the use of antibiotics by 13 percent between 2002 and 2005 through public information campaigns.

According to Henry Mintzberg, one of the factors that kept comprehensive pharmaceutical policies from emerging thus far in Quebec is the power of the pharmaceutical industry and its influence on political processes.[34]

A 2009 study by Oremus et al suggest tax increases may be a palatable policy option to support unrestricted access to certain medications.[35] This study was conducted to assess Canadians' level of support for an increase in annual personal income taxes to fund a public program of unrestricted access to Alzheimer's Disease (AD) medications. Four out of five persons reported they would support a tax increase to fund unrestricted access to a hypothetical, new AD medication.

**3. What deductibles, copayments and maximums should the plan include? Should these vary by level of income? How?**

The public prescription drug plan should not include copayments. The plan should include an annual deductible based on a variable percentage according to family size and net income. Once the yearly deductible is reached the insurance plan then pays 100 percent of costs.

Background
The majority of similar prescription drug programs across Canada are based on a variable percentage according to family size and net income. The maximum, whether based on fixed or variable rate, ranges from 3 to 4.5 percent.

Numerous Canadian studies, including the Romanow Commission and the Kirby-LeBreton report, call on governments to make life-saving drugs universally accessible. The Kirby-LeBreton proposals call for "catastrophic" coverage of drug expenses greater than 3 percent of a family's income.[36]

The NPS recommended two options for determining access to catastrophic drug coverage:

Option 1: Variable percentage
- Based on drug costs exceeding a percentage of family income
- Proportion of income increases as family income increases
- A variable scale of 0/3/6/9 percent of family income with those families with an income below $20,000 being provided with a 0 percent threshold and a maximum of 9 percent at incomes of $90,000 and above.
-

Option 2: Fixed percentage
- Based on drug costs exceeding a fixed percentage of family income
- Fixed threshold set at 4.3 percent of family income

McLure, in his analysis of various drug strategies, describes deductibles and caps as the traditional approach of private insurers to cover only those who have paid their premiums and to pay only the amount of a claim that exceeds an annual deductible and falls below a limit or cap, such as a maximum monthly or annual claim.[37] Often there is also a fixed copayment for each prescription filled. He states this policy restricts claims and claimants, regardless of what drugs are used. It assumes that those claimants who exceed the deductible are generally sicker and needier than patients who have not reached the deductible. This assumption is often false, however, in that it is due to expensive new drugs used by fairly healthy claimants. There are less healthy patients who use cheap but effective drugs and do not reach their deductible.

A cap is based on the opposite assumption: the more drugs you are using, the more likely you are not to need one of them. To clinicians, a cap seems irrational: patients who exceed the cap are often much sicker and have a greater need for their drugs to be covered. McLure agrees with Maio and colleagues (2005) stating that the major problem with a cap on the number or cost of all medications is that patients sometimes stop taking essential medications after they have exceeded the cap and thus may suffer adverse health consequences and have to increase their use of other health services. However, he notes that whereas a cap on all drugs may cause a patient to stop taking an essential drug, a cap like maximum allowable cost for one drug class in which prices vary widely can result in little or no adverse health effects, according to studies funded by the British Columbia's Reference Drug Program (RDP). The most thorough evaluations have showed that when the policy was applied to two classes of antihypertensive medications, it caused switching to less expensive drugs but no increase in stopping drug use nor any sign of adverse health events.

The commentary by McLure illustrates how differential copayment policies employ different subsidies for different drug classes' counts. Such a policy uses drug evidence, prices, plus data on patients to set different copayments. He notes that one of the most common is a three-tier copayment system. For each prescription filled, the patient pays a low copayment (e.g., $10) for a generic drug, a moderate copayment (e.g., $20) for a preferred low cost brand, and a high copayment (e.g., $30) for a less preferable, more expensive drug. In some programs, a portion of the copayment counts toward the deductible. British Columbia's RDP is a differential copayment system. The effect is similar to that of the maximum allowable cost policy, but with no sudden change. The patient is sensitive to price differences at every level, and price sensitivity increases when going from generics to preferred brands to less-preferred brands. He adds that prior authorization is often used in conjunction with a maximum allowable cost policy such as in the case of British Columbia. In that province, more than 90 percent of physicians' requests for exemptions to the RDP are approved by PharmaCare, and yet the program still saves millions of dollars relative to that of other provinces in Canada.[38]

However, according to the Best Medicines Coalition, over the last five years, Norway and Sweden have abandoned their reference-pricing regime because the expected cost savings did not materialize. In Norway, a government-commissioned study by the ECON Centre for Economic Analysis found that reference based pricing had an adverse effect on appropriate prescribing and patient quality of life; according to the study, "*the reference pricing system increases the risk of incorrect use of medicines*." (p.41)[39] The report finds that patients have, in many cases, been forced to switch medicines to comply with reference-pricing regulations and doctors have been unduly burdened with navigating a system to determine which products are reference-priced, requiring special handling. Following the release of this report, the system in Norway was abandoned and replaced with one similar to that of Canada's recent system before "cost containment" policies were established.

According to a study by Tamblyn et al of the copayment model in Quebec, increased cost-sharing for prescription drugs had the desired effect of reducing the use of less essential drugs but also the unintended effect of reducing the use of drugs that are essential for disease management and prevention.[40] The results showed that the new policy of cost sharing had resulted in a lower consumption of prescription drugs by the poorest and the sickest, especially the mentally ill. The data also showed a significant increase in the rate of adverse event, these populations' frequency of doctors' visits, visits to the emergency room, and hospital admissions. The authors note that these effects are consistent with those reported by other authors in the evaluation of prescription reimbursement caps in US Medicaid programs. Quebec later changed its policy to address this.

A 2009 study by Dormuth et al examined the effects of prescription coinsurance and income-based deductibles on net health plan spending for older users of inhaled medications. [41] They analyzed the impact on health plan spending in British Columbia of a switch in public drug insurance from full coverage to a prescription copayment and then to income-based deductibles plus coinsurance (IBD) for residents 65 years of age or older who were dispensed inhaled steroids, beta2 agonists or anticholinergics on or after January 1996. Net health plan spending increased by $1.98 million per year during the copayment policy and $5.76 million per year during the first 10 months of the IBD policy. The net change in government spending was the sum of changes in spending for inhalers, physician visits, hospitalizations, and policy administration costs. Out-of-pocket spending by older patients increased 30 percent during the copayment policy and 59 percent during the IBD policy.

The authors conclude that British Columbia's experience indicates that cost containment focused on cost-shifting to patients may increase net expenditures for the treatment of some diseases.

The Canadian Pharmacists Association supports a variable income threshold model as being more equitable.

The Standing Senate Committee on Social Affairs, Science and Technology (2002) suggested that no Canadian should be obliged to pay out-of-pocket prescription drug expenses that exceed three per cent of family income. Although this figure can be used as a working standard of coverage, it should also be remembered that disincentives for adherence to drug therapy are created by deductibles of any kind. [42]

A report on the effect of the Saskatchewan Family Benefit Program shows that when user charges are reduced or removed, parents and children obtain health services they need, such as prescription drugs and optometric services.[43] The findings of this study emphasize the need for investing in programs that ensure affordable access to health services for all low-income people, regardless of their position in or out of the labour market. Over the long term these programs will enhance the health of adults and children living in low-income families. Better health among those living in low-income families will ultimately decrease the need for public expenditures on more costly and intensive health care.

**4. Should the plan have a premium? Should the premium vary by level of income? How?**

| |
|---|
| The plan should not have a premium. |

Background
More than 80 percent of similar provincial/territorial prescription drug programs in Canada do not have a premium.

Evidence in the previous section demonstrates that shifting costs to the patient is a disincentive for low-income individuals to adhere to prescription medications and may lead to increased costs to the system as a result of increased doctor's visits, emergency visits and hospitalizations.

**5. How should the plan deal with individuals who have pre-existing medical conditions?**

| |
|---|
| There should not be any restrictions for those with pre-existing medical conditions. |

Background
None of the other similar provincial/territorial prescription drug plans mention the issue of pre-existing medical conditions.

Individuals with pre-existing medical conditions are often the people most in need of financial assistance for prescription medications. In a 2007 international study, 6 percent of Canadian adults said that their families spent more than $1,000 in the past year out of their own pockets (not covered by insurance), a higher percentage of respondents than the other seven countries in the survey, except for the US.[44] In a 2008 international survey of adults described as "sicker" (those who experienced some specific health challenges), 11 percent of respondents said that their families spent more than $1,000 in the past year out of their own pockets (not covered by insurance). Many more Canadians with chronic conditions such as diabetes or arthritis had high drug costs: 17 percent of Canadian adults who have one chronic health condition and 21 percent who have two or more said they paid more than $1,000 a year out-of-pocket.[45]

The NPS proposed that any plan to provide catastrophic drug coverage should meet the criteria of universality: all Canadians are eligible.

**6. Should there be a waiting period after enrolment before benefits become available? How long?**

There should be no waiting period after enrolment.

Background
More than 90 percent of provinces/territories in Canada do not require a waiting period for similar prescription drug programs.

**7. How should employers be involved? Should they be required to continue their current drug plans? What happens if they don't?**

Employer based drug plans should continue to play an integral role in New Brunswick. This public prescription drug plan should be for those who do not have existing prescription drug coverage. It will be important for the government to engage employer based drug plan providers throughout this process.

Background
According to the Canadian Health Coalition, almost eight million Canadian workers and their spouses and dependents are covered by private drug insurance plans through their jobs, however these plans vary enormously and are lost if the worker quits or is laid off, and sometimes even when he or she retires. The organization argues that work-based drug plans provide limited benefits and little security and that administering thousands of different plans is expensive and inefficient. At the same time, almost 42 percent of Canadian workers do not get drug coverage through their jobs.

The Canadian Pharmacists Association supports the development of a national catastrophic drug plan integrated with existing drug plans wherever possible. They also believe that private payers have an important role in the long term sustainability of a catastrophic drug plan.[46]

The NPS proposed any plan to provide catastrophic drug coverage should be integrated with other public and private drug plans.

In Quebec, despite the differences among the private plans, all plans must meet certain requirements set out by provincial law. These are targeted at ensuring some parity between the employer based and public programs, thus removing incentives for individuals to switch from one program to another. For example, all must cover the drugs listed on Quebec's Drug Formulary which have been chosen on the recommendation of a pharmacological advisory board. Also, the law stipulates that beneficiaries may not be required to pay more than $881 per year for drug costs, including both deductibles and co-payments. Drug costs that exceed this amount must be assumed by the beneficiary's plan. Furthermore, the copayment required of a beneficiary after payment of the deductible may not surpass 29 percent of drug costs.[47]

## Conclusion

The creation of a prescription drug plan for uninsured residents of New Brunswick is fair and just. It has the potential to greatly improve the health status of New Brunswickers and reduce overall health system costs by promoting adherence to necessary medications thereby preventing health complications, unnecessary visits to family doctors and emergency departments, avoidable costly hospital admissions and improved quality of life for those individuals supported by this plan.

The design of such a drug plan is important and we trust you will find our contribution useful to your policy planning process. While the focus of this consultation was on the various attributes of such a plan, NANB wishes to emphasize that for the plan to be financially sustainable and effective, it needs to be complemented with other key pharmaceutical policies. Drug effectiveness, drug pricing and purchasing, individual health status and family size and financial need, as well as the contribution and impact of employer based drug plans are equally important to consider. Lessons learned from other governments in this area can help promote the success of our plan here, as well as a robust evaluation framework that examines both intended and unintended consequences.

## Notes

[1] Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy. (2006). *National Pharmaceuticals Strategy Progress Report*. Ottawa: Health Canada.
[2] Coalition for a Canadian Pharmaceutical Strategy. (2006). *Framework for a Canadian Pharmaceutical Strategy*. Ottawa: Author.
[3] Canadian Cancer Society. (2011). Catastrophic Drug Coverage. Retrieved from .http://www.cancer.ca/New%20Brunswick/How%20you%20can%20help/NB-Take%20action/Catastrophic%20Drug%20Coverage.aspx?sc_lang=en
[4] Law, M., Cheng, L., Dhalla, IA., Heard, D., & Morgan, SG. (2012). The effect of cost on adherence to prescription medications in Canada. *CMAJ*, 184(3).
[5] CANSIM Table 109-5012. (2009). Ottawa: Statistics Canada.
[6] Canadian Institute for Health Information. *Drug expenditure in Canada, 1985 to 2010*. Ottawa (ON): Author. 2010.
[7] Whelan, M., Cooke CA., Sketris, IS. (2005). The impact of socioeconomic and demographic factors on the utilization of smoking cessation medications in patients hospitalized with cardiovascular disease in Nova Scotia, Canada. *Journal of Clinical Pharmacy and Therapeutics*, 30, 165–171.
[8] Coleman, R. (2000). *The cost of tobacco in Nova Scotia*. Halifax, NS: Genuine Progress Index. Sponsored by Cancer Care Nova Scotia.
[9] Monso, E., Campbell, J., Tønnesen, P., Gustavsson, G., & Morera, J. (2001) Sociodemographic predictors of success in smoking intervention. *Tobacco Control*, 101, 65–69.
[10] Hymowitz, N., Cummings, KM., Hyland, A. et al. (1997). Predictors of smoking cessation in a cohort of adult smokers followed for five years. *Tobacco Control*, 6 (Suppl. 2), S57–S62.
[11] Osler, M., and Prescott, E. (1998) Psychosocial, behavioural and health determinants of successful smoking cessation: a longitudinal study of Danish adults. *Tobacco Control*, 7, 262–267.
[12] Canadian Nurses Association. (2010). *Social Justice … A means to an end, an end in itself*. Ottawa: Author.
[13] Canadian Nurses Association. (2009). *Determinants of Health*. Ottawa: Author.
[14] Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy. (2006). *National Pharmaceuticals Strategy Progress Report*. Ottawa: Health Canada.
[15] Coalition for a Canadian Pharmaceutical Strategy.(2006). *Framework for a Canadian Pharmaceutical Strategy*. Ottawa: Author.
[16] Gagnon, MA. (2010). *The Economic Case for Universal Pharmacare, Costs and Benefits of Publicly Funded Drug Coverage for all Canadians*. Ottawa: Canadian Centre for Policy Alternatives.
[17] Canadian Health Coalition. (nd). *Pharmacare Index*. Ottawa: Ottawa.
[18] Gagnon, MA. (2010). *The Economic Case for Universal Pharmacare, Costs and Benefits of Publicly Funded Drug Coverage for all Canadians*. Ottawa: Canadian Centre for Policy Alternatives.
[19] Canada. First Ministers' Meeting. (2003). *First Ministers' Accord on Health Care Renewal*. Ottawa: Health Canada.
[20] Canada. First Ministers' Meeting. (2004). *A 10-Year Plan to Strengthen Health Care*. Ottawa: Health Canada.
[21] Canadian Intergovernmental Conference Secretariat. (2008 September 4). *Annual Conference of Provincial-Territorial Ministers of Health. National Pharmaceuticals Strategy decision points*. [backgrounder].
[22] Law, M., Cheng, L., Dhalla, IA., Heard, D., & Morgan, SG. (2012). The effect of cost on adherence to prescription medications in Canada. *CMAJ*, 184(3).
[23] Patented Medicine Prices Review Board. (2006). *Non-patented Prescription Drug Prices Reporting: Canadian and Foreign Price Trends June 2006*. Ottawa: PMPRB.
[24] Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy. (2006). *National Pharmaceuticals Strategy Progress Report*. Ottawa: Health Canada.
[25] Competition Bureau. (2008). *Benefiting from Generic Drug Competition in Canada: The Way Forward*. Ottawa: Competition Bureau.
[26] Canadian Health Coalition. (nd). *Pharmacare Index*. Ottawa: Ottawa.

[27] The Standing Senate Committee on Social Affairs, Science and Technology. (October 2002). *The Health of Canadians – The Federal Role; Final Report, Volume 6.*
[28] Canadian Health Coalition. (nd). *Pharmacare Index*. Ottawa: Ottawa.
[29] Maio, V., L. Pizzi, A. Roumm, J. Clarke, N. Goldfarb, D. Nash, and D. Chess. (2005). Pharmacy Utilization and the Medicare Modernization Act. Milbank Quarterly 83(1):99–128.
[30] Maclure, M. (2005). Drug Insurance Utilization Management Policies and "Reference Pricing": An Illustrated Commentary on the Article by Vittorio Maio and Colleagues. The Milbank Quarterly, 83 (1); 131–147.
[31] Morgan, S., Bassett, K., & Mintzes, B. (2004). An Outcomes-Based Approach to Decisions about Drug Coverage Policies in British Columbia. *Psychiatric Services* 55(11):1230–32.
[32] Pascale Pomey, M., Gerlier Forest, P., Palley, H., & Martin, E. (2007). Public/Private Partnerships for Prescription Drug Coverage: Policy Formulation and Outcomes in Quebec's Universal Drug Insurance Program, with Comparisons to the Medicare Prescription Drug Program in the United States. *The Milbank Quarterly* 85(3); 469–498.
[33] Morgan, S., Bassett, K., & Mintzes, B. (2004). Outcomes-Based Drug Coverage in British Columbia. *Health Affairs* 23(3):269–76.
[34] Mintzberg, H. (2006). Patent Nonsense: Evidence Tells of an Industry Out of Social Control. *Canadian Medical Association Journal* 175(4):374–76.
[35] Oremus, M., Tarride, J., Clayton, N., & Raina, P. (2009). Support for a tax increase to provide unrestricted access to an Alzheimer's disease medication: a survey of the general public in Canada. *BMC Health Services Research*, 9:246.
[36] The Standing Senate Committee on Social Affairs, Science and Technology. (October 2002). *The Health of Canadians – The Federal Role; Final Report, Volume 6.*
[37] Maclure, M. (2005). Drug Insurance Utilization Management Policies and "Reference Pricing": An Illustrated Commentary on the Article by Vittorio Maio and Colleagues. *The Milbank Quarterly*, 83 (1); 131–147.
[38] Marshall, D.A., D.Willison, K. Sykora, N. Forde, M. Mamdani, P. Grootendorst, J. LeLorier, M. Maclure, S. Morgan, L.Warren, E. Rahme, &and P.R. Fortin. (2004). *Impact of Administrative Restrictions for Coxibs in Quebec (PQ), Ontario (ON) and British Columbia (BC).* Paper presented at the first annual meeting of the Canadian Association of Health Services and Policy Research, Montreal, May 26–28.
[39] ECON Centre for Economic Analysis. (2000). *Evaluation of the reference pricing system for medicines*. Prepared for the Norwegian Ministry of Health and Social Services.
[40] Tamblyn, R., Laprise, R., Hanley, J., Abrahamowicz, M., Scott, S., Mayo, N., et al. (2001). Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons. *JAMA* 285(4); 421-429.
[41] Dormuth, CR., Neumann, P., Maclure, M., Glynn, RJ., & Schneeweiss, S. (2009). Effects of prescription coinsurance and income-based deductibles on net health plan spending for older users of inhaled medications. *Medical Care*, May; 47(5): 508-16.
[42] The Campaign to Control Cancer. (2008). *Spinning the Wheel: The High Stakes Game of Catastrophic Drug Coverage for Canadians*. Toronto: Author.
[43] Saskatchewan Health and Saskatchewan Social Services. (2001). *Monitoring the Effect of Family Health Benefits for Low-Income Families in Saskatchewan*.
[44] The Commonwealth Fund. (2007). *The Commonwealth Fund 2007 International Health Policy Survey in Seven Countries*.
[45] The Commonwealth Fund. (2008). *The 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.*
[46] Canadian Pharmacists Association. (2008). *Catastrophic Drug Coverage Position Statement*. Ottawa: Author.
[47] Pascale Pomey, M., Gerlier Forest, P., Palley, H., & Martin, E. (2007). Public/Private Partnerships for Prescription Drug Coverage: Policy Formulation and Outcomes in Quebec's Universal Drug Insurance Program, with Comparisons to the Medicare Prescription Drug Program in the United States. *The Milbank Quarterly* 85(3); 469–498