RESEARCH PAPER

Income-Based Drug Coverage in British Columbia: Towards an Understanding of the Policy

Un régime d'assurance-médicaments fondé sur le revenu en Colombie-Britannique : Vers une compréhension de la politique

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Abstract

Background and Objectives: In May 2003, the government of British Columbia adopted income-based pharmacare, replacing an age-based drug benefits program. Income-based pharmacare has been proposed as a national model for Canada. Prior to

evaluating the policy impact of the change, we sought to understand classic elements of the policy process: the problem that prompted the policy change, the objectives to be met, the choice of policy instruments and potential measures of success or failure.
Methods: We conducted interviews with decision-makers in British Columbia shortly after the policy was introduced. We used purposive sampling to target individuals specifically involved with BC pharmacare policy, including current or former government employees, government ministers and the leader of the opposition party. Seventeen of 24 invited subjects participated.
Results: Participants identified primary and secondary problems that required remedy through policy change: financial pressures and equity issues. Financial pressures were framed in the context of budgetary constraints on the BC PharmaCare Program, with reduction in public spending cited as the primary policy objective. Participants also indicated that it was important to minimize potential harm from any program change and, ideally, to improve access for low-income families.
Discussion: Income-based pharmacare in British Columbia appears to be the result of a two-stage policy-making process. Budgets were set by pan-ministerial actions of the provincial government. In turn, these budgetary measures constrained policy design at the ministerial level. Income-based coverage was BC PharmaCare's choice among options that would meet budget expectations. Success or failure of the policy would be gauged by (a) meeting budget targets, (b) maintaining or increasing access to medicines and (c) improving financial equity.

Résumé

Contexte et objectifs : En mai 2003, le gouvernement de la Colombie-Britannique a instauré un régime d'assurance-médicaments fondé sur le revenu pour remplacer un régime fondé sur l'âge. L'assurance-médicaments fondée sur le revenu a été proposé comme un modèle national pour le Canada. Avant d'évaluer l'incidence de ce changement de politique, nous avons cherché à comprendre les éléments classiques du processus d'élaboration de politiques : le problème qui a mené au changement de politique, les objectifs visés, le choix des instruments et les mesures potentielles du succès ou de l'échec.
Méthodes : Nous avons mené des entrevues avec des décideurs de la Colombie-Britannique peu après l'adoption de la politique. Nous avons utilisé un échantillonnage fonctionnel pour cibler les personnes travaillant spécifiquement dans le domaine des politiques d'assurance-médicaments en C.-B., y compris des fonctionnaires anciens et actuels, des ministres du gouvernement et le chef du parti de l'opposition. Dix-sept des 24 sujets invités ont accepté de participer à l'exercice.
Résultats : Les participants ont mentionné des problèmes primaires et secondaires qui devaient être rectifiés au moyen de changements aux politiques : les pressions financières et les questions d'équité. Les pressions financières s'inscrivaient dans le contexte

des contraintes budgétaires placées sur le programme d'assurance-médicaments de la C.-B. et la réduction des dépenses publiques était citée comme le principal objectif visé par les politiques. Les participants ont également indiqué qu'il était important de minimiser les torts potentiels que peut causer tout changement au programme et, idéalement, d'améliorer l'accès pour les familles à faible revenu.

Discussion : L'assurance-médicaments fondée sur le revenu en Colombie-Britannique semble être le résultat d'un processus d'élaboration de politiques à deux étapes. Les budgets ont été établis suite à des mesures globales prises par le gouvernement provincial. En retour, ces mesures budgétaires ont restreint l'élaboration des politiques à l'échelon ministériel. Parmi les options qui permettraient de respecter les attentes budgétaires, les responsables du régime d'assurance-médicaments de la C.-B. ont opté pour une couverture fondée sur le revenu. Le succès ou l'échec de la politique serait évalué en fonction des critères suivants : (a) l'atteinte des objectifs budgétaires, (b) un accès égal ou amélioré aux médicaments et (c) une meilleure équité financière.

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At over $20 billion and growing by more than 10% a year, prescription drug expenditures are the second largest and fastest-growing component of healthcare spending in Canada (CIHI 2006). Public coverage for these expenses varies considerably across and within provinces (Grootendorst et al. 2003; Coombes et al. 2004). The share of total drug costs borne by public plans also varies, from approximately 32% in New Brunswick to approximately 51% in Manitoba (and Quebec, if one counts premium-based social insurance run by government) (CIHI 2006). Coverage within most provinces depends on age and, in some instances, income. The fragmentation of Canadian pharmacare programs contrasts starkly with the universality of public insurance programs for medical and hospital services. It creates challenges for cost control, disparities in access to needed treatments, and financial inequities. These factors have provoked several high-profile calls for a national approach to pharmacare, one that would establish uniform standards of coverage for all provinces (Canada 1998, 2002a,b).

In February 2003, the First Ministers' Accord on Health Care Renewal committed provinces to pursue a first-ever national standard for outpatient pharmacare: "to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage" (Health Canada 2003). This course of action was restated in 2004 when the First Ministers' Ten-Year Plan to Strengthen Health Care put catastrophic drug coverage among the priority elements of Canada's National Pharmaceuticals Strategy (Health Canada 2004). Despite clear intent for reform in this area, a standard for "catastrophic coverage" has yet to be determined.

The lack of a standard for coverage is due in part to the paucity of empirical

evidence on which to base a choice among alternative pharmacare models. Comparable data regarding the effects of different pharmacare systems existing across Canada are too sparse to allow for meaningful inference. Policy making can, however, be informed by assessing changes in pharmacare within jurisdictions. To inform policy and planning at the provincial and national level, we present a coordinated set of analyses of a significant change in British Columbia: the adoption of an income-based model of universal pharmacare. Called Fair PharmaCare, policy makers have proposed this as a potential national model (Joyce 2004).

In this introductory paper, we review the change in BC policy. We also report on a series of interviews with policy makers that helped us understand classic elements of the policy: the problem that prompted a policy change, the objectives to be met through policy change, the choice of policy instruments, and potential measures of policy success or failure (Pal 2001). This review provides the foundation for the evaluations that follow. In the accompanying papers, we provide empirical analyses of three dimensions of Fair PharmaCare: (1) its impact on trends in drug expenditures and their determinants (Morgan and Yan 2006); (2) its impact on access to commonly used medicines (Caetano et al. 2006); and (3) its impact on the distribution of financial burden (Hanley et al. 2006). Because of the nature of the policy change – from an age-related to an income-based program – all of our analyses assess impacts across age and income strata. Finally, we conclude with a paper on policy "consistency" in British Columbia, and highlight emerging issues to be considered by Canadians as we search for a national pharmacare model (Morgan et al., page 115).

The research presented in this series of papers was funded through a peer-reviewed operating grant from the Canadian Institutes of Health Research. Data were provided by the BC Ministry of Health and analyzed at the UBC Centre for Health Services and Policy Research. All investigations were approved by the Behavioural Research Ethics Board at the University of British Columbia.

Fair PharmaCare in British Columbia

Through a sequence of two policy reforms, the BC PharmaCare Program underwent a major transformation between 2001 and 2003. BC PharmaCare circa 2001 could be characterized as a mixed pharmacare model, involving relatively comprehensive coverage for social assistance recipients and seniors, and fixed-deductible catastrophic coverage for all others. It had the following features:

- social assistance recipients received 100% coverage for all prescription drug costs (including dispensing fees);
- seniors received 100% coverage for the ingredient cost of prescription drugs, but

were required to pay for pharmacists' dispensing fees up to an annual maximum of $200;
- low-income non-seniors received 100% coverage for prescription drug costs exceeding a deductible of $800; and
- other non-seniors received 70% coverage for drug costs exceeding $1,000, with a maximum total private payment (first $1,000 plus 30% co-payments) of $2,000.

This combination of comprehensive coverage for seniors and social assistance recipients, and fixed-deductible coverage of catastrophic costs for all other residents, resembled the national standard for pharmacare programs proposed by the Romanow Commission (Romanow 2002) as well as drug programs in several other provinces (CPA 2002).

As a temporary measure to reduce public expenditure in 2002, the BC government introduced a co-payment on drug purchases by seniors. Low-income seniors were required to pay the first $10 towards the total cost (including dispensing fee) of each prescription until they had paid $200 out of pocket, after which BC PharmaCare covered 100% of costs. All other seniors were required to pay the first $25 towards the total cost of each prescription until they had paid $275 out of pocket, after which BC PharmaCare paid 100% of costs.

On May 1, 2003, the seniors' plan and the universal catastrophic plan were combined into the Fair PharmaCare Program (British Columbia 2003). Benefit rates under this new program will eventually become purely income-based for all residents, regardless of age. During a transitional period, however, seniors born on or before December 31, 1939 receive slightly more generous benefits for themselves and their spouses. The specific terms of coverage are illustrated in Table 1.

Interviews with Policy Makers

To better understand the rationale for the change towards an income-based program, we interviewed decision-makers shortly after the policy was introduced. This knowledge would assist us in two important ways. First and foremost, a better understanding of the policy-making process would help us design and produce a more relevant empirical evaluation of the policy's impact. Second, documenting the rationale behind this major change would advance theories and understanding of policy making in this sector. This latter goal also facilitates analysis of the "policy consistency" of the BC Fair PharmaCare Program as it was implemented. This is the degree to which the goals set for the policy change are consistent with the problems that motivated policy change and the degree to which the policy chosen meets the goals. These objectives could jointly be met by structuring our analysis of the policy-making process around the conceptual framework of the "policy cycle" (Pal 2001; Howlett and Ramesh 2003).

TABLE 1. Terms of Fair PharmaCare Program

	ENHANCED ASSISTANCE FOR SENIORS BORN IN 1939 OR EARLIER		
Family Income	**Family Deductible**	**Co-Payment**	**Maximum Family Contribution**
Less than $33,000	0	25%	1.25% of gross household income
$33,000 to $50,000	1% of gross household income	25%	2% of gross household income
Over $50,000	2% of gross household income	25%	3% of gross household income
	ALL OTHER FAMILIES		
Family Income	**Family Deductible**	**Co-Payment**	**Maximum Family Contribution**
Less than $15,000	0	30%	2% of gross household income
$15,000 to $30,000	2% of gross household income	30%	3% of gross household income
Over $30,000	3% of gross household income	30%	4% of gross household income

Source: Adapted from BC Ministry of Health 2003b.

The adapted version of the policy cycle explored in our interviews contained the four conceptual categories illustrated in Figure 1: problem, objective, choice and evaluation.

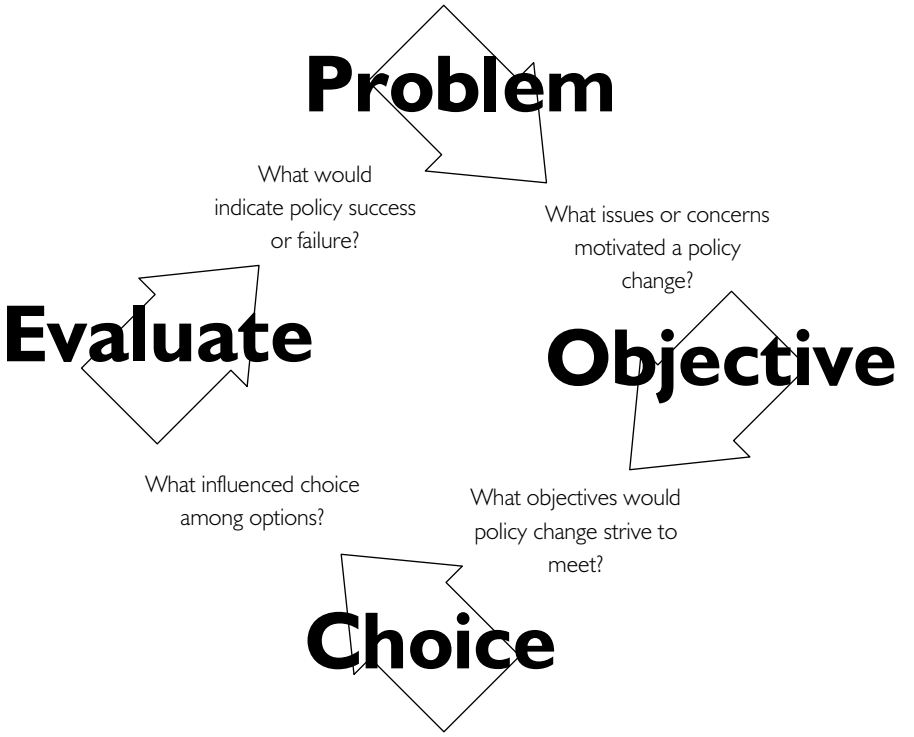
Problem

If policy is a "… course of action or inaction taken by public authorities to address a given problem or set of related problems" (Pal 2001), then the first stage in public policy making is problem recognition and definition. Problem recognition occurs when an indicator suggests *something* is wrong. Problem definition requires some indication of *what* is wrong or, more specifically, what led to the problem. We therefore sought to understand decision-makers' perspectives on what issues or concerns motivated the change in the BC PharmaCare Program.

Objectives

Public policy can seldom directly eliminate a problem; rather, it must use the resources and powers of public agencies to influence the behaviour of different actors in society

FIGURE 1. Conceptual framework for interviews: The policy cycle



in a manner that remedies the problem—for example, by addressing and reversing the specific factors that led to the problem. In engaging the resources and powers of public agencies, policies (or policy makers) aim to achieve certain objectives. The selection of these objectives helps to determine what behaviours of which actors in society to influence; logically consistent policy would aim to alter behaviours in ways that achieve the objectives. We therefore sought to understand the objectives that a change in the BC PharmaCare Program would strive to meet.

Choice

In order to meet the objectives of a policy, decision-makers must select, from among various policy instruments, the means by which public agencies will attempt to achieve goals. A number of factors may influence the choice of instrument. Various forms of evidence regarding effectiveness may be considered, such as experiences of other jurisdictions and results of research studies. Local values, priorities and interests will also affect the choice of policy instruments. We sought to understand what options were considered for changes to the BC PharmaCare Program and what factors influenced the choice of income-based pharmacare.

Evaluation

After a problem has been defined, objectives set and instruments chosen, policy makers (or other actors in the policy arena) may choose to evaluate the policy in practice. This could include a variety of types of investigation. Because one of our objectives was to help structure a policy evaluation, we specifically sought to understand decision-makers' perspectives on what would indicate policy success or failure.

Interview Methods

We used purposive sampling: interviews were sought with individuals who had specific experience with BC PharmaCare policy. This included current or former government employees involved in pharmacare policy, government ministers involved with health policy and a representative of the opposition party (at the time of the interviews, the governing party held 77 of 79 seats in the legislative assembly). Participation from political, executive, managerial and staff levels was sought to ensure the sample incorporated a range of policy perspectives. With input from a director of policy within government, we established a list of 27 potential interview participants.

Of the 27 potential subjects, three were inaccessible (e.g., on extended vacation or leave). Of the 24 subjects invited to participate, three did not reply and four declined to participate. In total, 17 subjects agreed to an interview, representing a 71% participation rate. Participation rates by political, executive, managerial and analyst levels were 38%, 80%, 83% and 100%, respectively.

To bolster confidentiality and rapport, typed field notes (rather than tape recordings) were used to compile interview responses, and wherever possible, the interviews were conducted in person at the participant's place of work. A total of 15 face-to-face interviews and two telephone interviews were conducted during July 2003. Two researchers (MC and SM) jointly conducted all interviews, which ranged in length from 20 to 55 minutes. Interviews were based on semi-structured questions (Appendix 1) designed with the four main conceptual categories in mind: (1) the problem that motivated the policy change, (2) the objective for the new policy, (3) factors that influenced choice among policy options and (4) evaluation criteria that would indicate policy success or failure. At the end of each interview, field notes were reviewed and checked for accuracy by both interviewers. Each researcher independently analyzed and coded the content of the individual field notes, followed by thematic analysis across the set of interviews.

Interviews were conducted two months after the launch of Fair PharmaCare. It might have been preferable to conduct interviews prior to policy implementation, but constraints on policy makers' time during such a significant policy reform rendered that option impracticable. A two-month lag ensured that participants could readily recall the decision-making processes leading up to the policy change while (a) allow-

ing them to schedule and participate in interviews comfortably and (b) giving them some time to reflect on the policy change that had just occurred. The study received approval from UBC's Behavioural Research Ethics Board.

Interview Findings

Problem definition

Participants consistently identified two problems that required remedy through policy change. The first concerned financial pressures facing the BC PharmaCare Program. The second concerned perceptions of the program's fairness or equity.

All participants stated that uncontrolled growth in government spending on pharmaceuticals was the primary problem that made policy change necessary. They noted that BC PharmaCare had experienced double-digit cost growth for many years and that it accounted for a rapidly growing share of the health budget. Several participants recalled that the provincial treasury had scrutinized the increasing expenditures for almost two decades. These recollections are substantiated by government documents (British Columbia 2003a). Throughout the 1990s, BC PharmaCare's budget increased by a rate of almost 14% a year; at over $720 million in 2002/03, it accounted for over 7% of the Ministry of Health's total operating expenses. Moreover, as some participants pointed out, PharmaCare was entirely a provincial liability because the federal government did not support outpatient pharmaceutical costs through cost-sharing arrangements such as the Canada Health Transfer – which is targeted for insured services under the *Canada Health Act* (Canada 2002a).

As the participants went on to define the problem in detail – to provide some notion of what caused the fiscal pressures and therefore what might be done to address them – their definitions differed by their role within the policy- and decision-making process. Participants at executive and political levels of government framed the problem in its broadest sense: BC PharmaCare was said to be "unsustainable" as it had been configured. It was noted that a major influx of eligible beneficiaries under the seniors' drug benefits plan would occur when the "baby boomer" generation reached 65 years of age. Irrespective of other causes of cost pressures within the BC PharmaCare Program, this was believed to threaten the sustainability of comprehensive public subsidy for seniors' drug costs. Furthermore, several interviewees noted that public expectations of the healthcare system, including BC PharmaCare, were virtually insatiable, and past attempts at managing the sources of cost growth within the system had met with limited success and significant opposition. These interviewees concluded that financial responsibility was needed for users of the system. Yet, this suggestion was inconsistent with concerns – expressed by many respondents, including those advocating more financial responsibility – that increased user charges may have negative

impacts on access to necessary medicines, as shown in studies conducted in Canada and the United States (Soumerai et al. 1987; Tamblyn et al. 2001).

Whereas participants at higher levels of government provided detailed descriptions of threats to the sustainability of the BC PharmaCare Program, decision-makers at lower levels of the organizational structure provided a simple portrait of what made policy change essential: a three-year "freeze" had been imposed on the budget for the Ministry of Health. Early estimates suggested that the budget freeze necessitated change capable of reducing government spending on BC PharmaCare by as much as 43% compared to trends over the three-year period. Several interviewees concluded that the BC PharmaCare Program therefore had to be redesigned, quickly and dramatically.

The distinct definitions of the problem at different levels of government appeared to reflect policy makers' and decision-makers' separate roles. Policy makers – those who set the broad course of government policy and are ultimately accountable to the public – viewed the BC PharmaCare Program within the broader framework of the newly elected government's objective to reduce both taxes and government spending while maintaining a balanced budget (British Columbia 2001). From this overarching view of government objectives, the BC PharmaCare Program was perceived as unsustainable, and constraints were therefore imposed on it. While executive-level civil servants hold positions and influence that lie somewhere between the extremes, decision-makers within the government structure have a different responsibility in the policy process. They were tasked with identifying program terms that would be consistent with the broader policy framework set by policy makers. They therefore took the budgetary freeze as an exogenous constraint on policy and planning. Given the budgetary freeze, policy reforms that would increase program spending were "not an option" for decision-makers tasked with program design.

The second motivation for BC PharmaCare reform identified by participants was the perception that the age-based entitlement of the old program was fundamentally unfair or inequitable. It was argued that the seniors' drug benefits plan diverted considerable public resources towards the drug costs of individuals who might otherwise be able to afford to pay for their medications. Under the age-based entitlement, many non-senior families with modest or low incomes were not eligible for comprehensive drug benefits. Political-level participants in our interviews recalled phone calls from constituents who were young, single parents struggling to pay drug bills under the old program. Managers within governments relayed how they would "feel like hell" when working poor families would call to say that they could not afford the cost of their drugs and had to decide between food or medicine. Those providing such anecdotes suggested that an unfair burden was created by the $800 or $1,000 deductible for non-seniors who do not qualify for social assistance. Terms of coverage under Fair PharmaCare would be more generous for non-senior families whose gross household income was less than $30,000.

Another anecdote was consistently used to explain how the old system was perhaps unduly generous to wealthy seniors. While participants did not specifically define what they meant by a "wealthy senior," they commonly cited the fact that Jimmy Pattison, British Columbia's wealthiest resident (with an estimated worth of $3.5 billion), was a beneficiary of public drug subsidies under the age-based BC PharmaCare Program. Participants saw him as someone who did not need the subsidy and, if not for the automatic entitlement under the old program, would not likely claim a public subsidy for his drug purchases. The fact that multiple participants at all levels of government singled out this well-known British Columbian made it clear that this illustrative anecdote had become culturally ingrained within government. Participants appeared unanimous in the contention that people with higher incomes, and thus a higher ability to pay, should make a greater *direct* financial contribution towards their prescription drug costs, regardless of whether they are seniors. (We add the emphasis on "*direct* financial contribution" because, of course, wealthy individuals like Jimmy Pattison make much larger *indirect* contributions to public subsidies for drugs through their taxes.)

Policy objectives

When participants were asked what they perceived to be the objectives of the new policy, not surprisingly, their response was to reduce BC PharmaCare spending and to improve fairness. Reduction in program spending was cited as the primary objective by all but two senior respondents. The secondary objective – to improve fairness or equity under the BC PharmaCare Program – had several dimensions.

Most participants described the goal of improving fairness in terms of improving the allocation of subsidies by basing eligibility for PharmaCare subsidies on ability to pay, rather than age. Such financial equity was not, however, to be achieved at the expense of imposing "catastrophic" prescription drug costs on any one family. It was specifically mentioned that an informal goal of the policy was to try to ensure no household would be required to pay more than 4% of its annual income for prescription drugs. The rationale provided for this particular percentage was that it was similar to the guidelines used in an existing report (Applied Management et al. 2000).

Many participants went on to explain how the goal of improved financial equity would also improve equity in access to medicines. If greater subsidy could be provided to lower-income families, the plan would make prescription drugs more affordable for those families. Participants considered a "good policy" to be one that achieved the maximum population health impact for the investment in prescription drug subsidy while simultaneously improving financial equity.

When discussing the goals of improved fairness and access to medicines, participants emphasized the need for equal access to the program itself. This objective was

top-of-mind for many interview participants. The Fair PharmaCare Program that had been adopted required registration in order for the government to collect and verify income information used in the calculation of a family's income-based deductible. Failure to register would result in minimum subsidy for a household. Participants therefore believed fairness and access required that all potential beneficiaries be given all reasonable opportunities to participate in the new program.

Choice

When asked about factors that influenced which policy options were considered, almost all participants noted that the idea of income testing of BC PharmaCare programs had been considered for over a decade. They referred to one of the first reports submitted by the BC PharmaCare Review Panel in 1993, which supported an income-tested program (British Columbia 1993). They noted that this report sparked development of numerous (estimated at over 40) income-testing proposals, which were brought to various levels of government over the years. Participants reasoned that this long intra-governmental history made an income-based program a natural policy choice. Participants also suggested that an income-tested program was the only policy option that could generate the scale of savings required by the freeze imposed on the health budget.

When it was clear that an income-tested program was the only policy option consistent with the budget constraints imposed at the pan-ministerial level, the decision-making process shifted from selection of a suitable policy option to refining its design. Though technically simple, the process involved one of the core struggles of policy making: who gets what share of available public resources? Analysts within the government simulated dozens of scenarios to examine the family types that would fare better or worse under different terms of benefit. These were then presented and debated within various levels of government, including meetings of the executive and caucus. The stories that were recounted to us were ones in which individuals at all levels of government provided suggestions about how proposed terms of coverage could be made "more fair" by adjusting allocations so that particular groups would receive more public subsidy. Such iteration between different views of what would be "most fair" is certainly understandable given that equity is a construct that is in the eye of the beholder (Stone 2002).

Participants also explained that it was important that program change minimize harm and, ideally, maximize benefits in terms of access to necessary medicines. According to participants, a study by Tamblyn and colleagues (2001) was particularly influential because it raised awareness of adverse consequences that could arise from a reduction in public drug benefits. The study, which evaluated changes to Quebec's pharmacare policies in 1997, found that the increased cost sharing for low-income seniors was followed by reduced use of essential drugs and adverse health outcomes.

Participants recalled that the government therefore wanted to ensure that the new BC PharmaCare plan continued to protect low-income seniors, while trying to increase access to essential medicines for non-seniors.

Evaluation

When asked about markers of policy success or failure, responses were consistent with the problem definition and delineation of policy goals. All but three respondents suggested the first objective of a policy evaluation would be to ensure that it met goals with respect to government spending. Many also added that contained government expenditures should be evaluated against changes in overall spending that might occur because of the new policy. Participants proposed that the increased financial accountability of senior households might alter the choices they make with respect to drug purchases. Specifically, the new policy might increase price sensitivity and thereby encourage patients to select lower-cost options for their treatments. Because one of the policy goals was to ensure ongoing access to medicines, we were told that an evaluation should determine whether changes in expenditure trends stem from changes in access to medicines or from changes in the cost of drugs.

Access was defined as an important measure of the policy impact. Given the consideration paid to the potential adverse effects of reduced public spending in this sector, just over half of the interview participants suggested that an evaluation should track potential reductions and improvements in access to medicines. Middle- and lower-income seniors were viewed as being particularly at risk, while middle- and lower-income non-seniors might gain from an income-based program.

Finally, participants indicated that financial equity would be an important indicator of the success of the policy. Participants suggested that the key determinant of the fairness of the program was whether there was a more equitable distribution of private drug expenditure relative to income. Many interviewees were candid about the desire to determine whether the government "got it right" the first time, or whether adjustments to terms of coverage by income level might be necessary. One participant shared the concern that the total financial equity of the system needed to be accounted for because income testing might not be fair for middle- and high-income earners who, as a result of their incomes, pay more (in taxes) towards the program and receive less from it.

Conclusions

The decision-makers who participated in our interviews were remarkably candid about the recent program change. They consistently identified two main problems that prompted the policy shift: financial pressures on the BC PharmaCare Program and the perceived inequity of seniors' age-based entitlement to generous subsidies. The most

notable variance in responses concerned how participants defined the financial pressures on the existing system. Participants who held the roles of policy makers – those at the executive and political levels of government – described financial pressures in terms of the sustainability of the program, often within the context of broader pressures on healthcare spending and government finances. Managers and analysts perceived the challenges posed by growing drug costs and demographic change, but defined the cause for policy change as constraints imposed by a three-year budget freeze.

Differences in how the policy problem was defined reflect, in our view, different stages in the policy-making process. The imposition of a three-year budget freeze on the Ministry of Health must be viewed as a pan-ministerial course of action set by the government because it was consistent with (indeed, even less severe than) cuts applied across government. This would be seen as an exogenous policy decision from the perspective of managers within the Ministry of Health. Thus, decision-making within the BC PharmaCare Program would become one of defining the terms of coverage for a new program that would potentially address other policy problems and strive to achieve other objectives while meeting budget targets.

Interview participants also identified the unfair allocation of subsidies arising from the age-based entitlement of the old BC PharmaCare Program as a principal problem to be addressed. Participants juxtaposed anecdotes about young families struggling to afford medicines against that of billionaire Jimmy Pattison's receiving a generous public subsidy for his medicine purchases. They consistently concluded that it was time for the wealthy to begin taking greater responsibility for the cost of their drugs.

The identified objectives for the policy change included reducing program spending. Participants also identified a number of dimensions of fairness and equity that were targets for improvement. They described financial equity in relation to households contributing to their drug costs according to their ability to pay (not age). Participants also described equity in terms of access to medicines. Decision-makers were particularly mindful of potential reductions in access to medicines that could occur when drug benefits are reduced. They stated that the policy change should attempt to minimize such harms while striving to improve access to necessary medicines for low-income non-seniors' households.

Finally, participants stated that policy success or failure would be indicated by measures consistent with the policy objectives. Were costs controlled for the public program? Would patients make more cost-effective choices? Did the plan's design protect seniors from potentially adverse impacts while improving access to medicines for non-seniors? Did the allocation of public subsidy become more equitable in terms of reducing disparities in private drug costs relative to incomes? Our analyses in the papers that follow set out to use population-based, person-specific data to quantify the impact of the new policy on these three dimensions: costs, access and equity.

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Appendix 1: Interview Guide

Preamble

The recent revisions to British Columbia's PharmaCare Program represent a significant policy change in pharmacare history. We are interested in documenting the change by capturing the various perspectives of the many people involved in redesigning and implementing the new program. We are also interested in the evolution of these changes. As you may know, our research team has been asked to conduct an evaluation of the new program. We feel that by understanding your perspective, we can make our evaluation more relevant to you. Do you have any questions before we begin?

Semi-structured questions: not to be asked verbatim, but used as a guide for interviews.

1. Background:
   i) Let's start at the beginning. Please tell me about how you first came to be involved in the Fair PharmaCare project.
   ii) Please tell me about your position prior to becoming involved in the BC PharmaCare project.
   iii) What were your roles and responsibilities on the project team?
   iv) What was your level of involvement in formulating the changes to BC PharmaCare?
2. Motives for Policy Change:
   i) I would like to begin with some questions dealing with the challenges that motivated the BC PharmaCare policy change.
   ii) From your perspective, what were the key issues or concerns that motivated the policy change?
3. Objectives for New Policy:
   i) When implementing the policy change, the government would have had a

number of specific objectives for Fair PharmaCare to strive to meet. Can you please describe these objectives?

ii) What would you consider to be the main objective?

4. Policy Selection:
   i) Were there any influential national or international documents / reports / studies / experiences that you referred to when deciding between various policy options?
   ii) What would you say was the main challenge in selecting the appropriate policy option?
5. Evaluating Fair PharmaCare:
   i) What aspects of the program do you feel should be considered when evaluating the program's performance? (e.g., enrollment)
   ii) What do you consider important ways to measure the impact of the Fair PharmaCare Program?
   iii) What level of performance do you feel should be reached for the program to be considered successful?
   iv) What would you say was the main challenge facing the implementers of the Fair PharmaCare Program?
   v) Managing the province's increasing drug costs is an extremely complex issue, and unfortunately, there is no one panacea or cure-all that can address all of these problems. Do you feel there might have been a better way to achieve the same objective? What outstanding issues do you anticipate requiring other new policy initiatives? What do you feel remains to be addressed?

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