RESEARCH REVIEW

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About This Issue:

According to the World Health Organization, an individual's socioeconomic status effects life expectancy and health outcomes throughout one's life. Poverty and income are powerful social determinants of health as it influences access to housing, food security, education, safety and a person's ability to participate in work and participate in community activities. May's Research Review focuses on issues related to health and the barriers experienced by Canada's low income, homeless or vulnerable population.

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Thank You to Our Volunteer Researchers & Writers:

Elise Broughton, Ben Lemphers, Isabelle Dena, Ryan Dexter, Hanna Nash and Albert Muhigi.

"The primary objective of Canadian health care policy is to protect, promote, and restore the physical and mental well-being of residents of Canada"

- Canadian Healthcare Act

Library of Parliament (2014). Current Issues in Mental Health in Canada: Homelessness and Accessing Housing (In Brief), Publication No. 2014-11-E
Reviewed by Elise Broughton, Volunteer Researcher and Writer

This publication examines the complex relationship between homelessness, access to housing, and mental health problems. In addition, this report discusses current initiatives and provides recommendations to address the challenges presented by mental health and core housing needs, which the authors argue is a social determinant of mental health (p.2).

As mental illness is often undiagnosed in the homeless population, the term 'mental health problem' is used to encompass both diagnosed mental illness and symptoms of poor mental health for the purposes of the discussion.

Poor mental health can be a barrier to obtaining adequate housing, while unmanaged symptoms may lead to unstable employment/finances and discrimination from employers and landlords. Conversely, unmet housing needs are associated with poor mental health outcomes such as high levels of stress, poor coping skills, self-harm, substance abuse, low self-esteem, and feelings of worthlessness and hopelessness while being overrepresented in areas of depression, anxiety, bipolar disorder, schizophrenia and post-traumatic stress disorder (p.2).

Chronic homelessness is more common in individuals with a concurrent disorder, such as substance abuse or mobility impairment, in addition to an existing mental health problem. Concurrent disorders can contribute to and result from mental health problems and/or homelessness. Health issues are exacerbated as vulnerable homeless population's tend to be underserved and marginalized and have limited access to health services (p.2).

Due to the multi-faceted nature of mental health and homelessness challenges, strategies exist at every level of government to address current needs for housing and mental health supports.

Although health services is a provincial jurisdiction, the federal government created the Mental Health Commission of Canada (MHCC) to address mental health. In 2011, the MHCC estimated that approximately 520,700 Canadians with mental health problems lacked adequate housing (p.4).

The MHCC has created recommendations relating to homelessness and mental health in Canada. In a 2011 report, the MHCC stated that approximately 25,000 supportive housing units and at least 100,000 social housing units are needed over the next decade in Canada given the few housing options available (p.4). Edmonton, for example, has the second lowest vacancy rate and the fourth highest monthly rent rates of all major cities in Canada (Edmonton Social Planning, 2015).

Key Facts about Mental Health

- All Canadians will be affected by mental illness, either directly or directly.
- 1 in 5 Canadians will directly experience a mental health illness at some point in their life.
- Mental illness affects people regardless of age, education, income or culture.
- Depression and youth suicide is a major health concern for government.
- Almost half of Canadians who suffer from mental illness do no seek treatment.
- Stigma is a leading barrier to seeking treatment.

Visit the Canadian Mental Health Association to learn more.

Visit the Mental Health Commission of Canada to access Canada's first mental health strategy.

Full report available at:

http://bit.ly/1k4KUHO

Barriers to accessing traditional 'housing ready' services, for example, require eligible individuals to have reached a certain level of stability/recovery prior to offering permanent housing placements, creating hurdles for many in need (p.4). Alternatively, the 'housing first' approach considers housing a basic human right that is fundamental to recovery from mental health problems and concurrent disorders; housing, along with recovery supports specific to individual needs, are provided. The latter strategy's demonstrated cost-effectiveness is due to reduction in health, social, and justice system services that are often utilized excessively and inappropriately by individuals who lack a stable housing situation.

In 2012, the MHCC released Canada's first mental health strategy, *Changing Direction, Changing Lives*. The strategy called for "increased access to housing for people living with mental health problem" and for "the expansion of programs that take a housing first approach" (p.5). Specific recommendation included:

1. Increase availability of safe, secure and affordable housing.
2. Expand housing first approaches
3. Change the poor living conditions that can affect mental health, such as overcrowding (p.6)

The MHCC has undertaken several initiatives to address homelessness and mental health, including the housing first "At Home/Chez Soi" pilot project which ran from 2009-2013. After the first 12 months, 73% of participants had stable housing, in contrast to the 30% who received conventional treatment. Due to its success, a renewal for the strategy was passed in the 2013/2014 budget. Similarly, funding was reaffirmed in 2014 for the Homelessness Partnering Strategy, which takes a housing first approach with emphasis on mental health.

Based on the success of housing first initiatives, the author concludes that while homelessness may lead to mental health problems, mental health problems do not have to lead to homelessness. There is a need for increased availability of suitable housing and recovery supports to this end.

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Edmonton Social Planning Council (2015). A Profile of Poverty in Edmonton.

Piat et al (2014). Pathways into Homelessness: Understanding how both Individual and Structural Factors Contribute to and Sustain Homelessness in Canada. Journal of Urban Studies.
Reviewed by Ben Lemphers, Volunteer Researcher and Writer

This article is a qualitative study authored by ten academics from universities across Canada. It is aimed at a scholarly audience. The study makes a valuable contribution to the study of homelessness as it uses a social ecological perspective, which considers the interplay between individual and structural factors leading to homelessness. In other words, there is an "emphasis on understanding the person" and their environment (Piat, 2014)

The authors identify individual risk factors leading to homelessness, including mental illness, substance abuse, family or relationship violence and trauma (p.3). Structural contributions to homelessness include transitions from foster care, institutional placement, and socio-political factors such as insufficient shelter benefits, lack of affordable housing stock, and discrimination (p.3)

The authors conducted interviews with 219 participants of the At Home/Chez Soi project, a Pan-Canadian Housing First strategy (Goering, 2014). The model prioritizes helping clients to acquire safe secure housing and providing them with comprehensive follow-up supports.

The sample used represents about 10 percent of the 2,234 participants in the larger At Home/Chez Soi project. Interviews were guided by the following research questions:

1. How do participants describe pathways into homelessness?
2. How do the participants make sense of continued homelessness, including barriers to exiting homelessness?

Key Findings

The study identifies four themes that emerged from participants' responses regarding the pathways and barriers to homelessness.

Theme 1 focused on individual factors. The majority of participants described concurrent personal issues and circumstances as the most significant factors leading to their homelessness. These included a combination: family violence, relationship problems, substance abuse, trauma, loss and mental health symptoms.

Notably, the authors cite a recent study finding that "formerly homeless individuals with mental illness had experienced an average of 8.8 adverse life events, including incarceration, suicidality, parental abandonment and the death of a mother" (Padgett, 2012). Such findings devalue the myth that homelessness results from a failing of personal responsibility.

Theme 2 focused on the transitions out of foster care and institutional settings as a cause of homelessness. Those in foster care often struggled with the difficulty of being isolated from family members or siblings. Numerous participants cited trauma stemming from physical, emotional and sexual abuse endured while in foster care. The aging out policy of foster care represented another common factor leading to homelessness as participants described a lack of supports and skills necessary for a successful transition to independent living.

Theme 3 identified a sense of entrenched barriers to exiting homelessness caused by structural factors. Lack of affordable housing options was a significant factor. Poverty severely limits access to housing, especially in cities with tight affordable rental markets.

When vacancy rates are low and demand for rental apartments is high, landlords can afford to be choosy. Vulnerable populations face discrimination based on race, reliance on social assistance and poor credit history, which make it difficult to secure housing.

Theme 4 revolves on structural factors such as those mentioned above but are intensified by individual risk factors. Participants reported substandard housing arrangements in communities with heavy drug activity as the only reliable shelter option.

Key Facts about Homelessness in Alberta

- Homeless individuals are more likely to experience mental health illness.
- For many, mental illness preceded homelessness
- Shortage of affordable housing, increasing rental fees and population growth are factors in creating homelessness.
- Edmonton and Calgary have the lowest vacancy rates in Canada.
- Calgary has the 3rd highest monthly rental rates, followed by Edmonton.
- Calgary's homeless count identified 3,533 homeless individuals in 2014, a 10.8% growth since 2012.
- Edmonton's homeless count identified 2,252 homeless individuals, in 2014 a 3.6% growth since 2012.
- Edmonton's 10 year Plan to End Homelessness reported 2,179 permanent homes secured for 2,909 people.

Full report Available at:

http://bit.ly/1LaPa1u

Notably, these living situations increase risky behaviours such as substance abuse due to frequent exposure and access to drugs. In Alberta, for example, insufficient welfare shelter benefits often provide individuals with little choice but to live in inner city neighbourhoods. Additionally, services for the marginalized people tend to be centralized in inner city communities, forcing individuals to spend time near addiction triggers.

Discussion

The study makes an original contribution to scholarship on the roots of homelessness through its social ecological approach, which considers interacting risk factors for homelessness in context. It also relies on a rigorous qualitative research methodology. To be sure, the themes the study identified as pathways into homelessness would likely come as no surprise to individuals who work with homeless populations. For policy change to happen, however, it is crucial to have the experiential knowledge of front line workers backed up by sound research.

Notably, the study relied on a very specific subset of housing first participants - those with a mental disorder meeting DSM-IV criteria. Further, 90.9% of participants interviewed had been hospitalized for a psychiatric problem for more than six months. This seems like a narrow sample for a study whose title suggests its findings represent the homeless in Canada as a whole.

The research reveals the importance of individual risk factors leading to homelessness, but also finds a role for policies to mitigate structural factors that increase individual risks and make exiting homelessness even more difficult. The authors stress the need for a well-funded forward-looking affordable housing strategy at both the national and provincial level.

In Alberta, the housing first principle is a key element of the Government of Alberta's and City of Edmonton's 10 year plans to end homelessness. There are 10 community agencies delivering Housing First in Edmonton. This is particularly important given the low vacancy rates in Edmonton (1.6%) during 2014 (CMHC, 2014)

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Marwah, S. (2014). Refugee Health Care Cuts in Canada: System Level Costs, Risks and Responses. Wellesley Institute.
Reviewed by Isabelle Dena, Volunteer Researcher and Writer

This report examines the Interim Federal Health (IFH) program which has provided health care for refugees since 1957. On June 30, 2012, amendments were introduced to the IFH program by the federal government under Bill C-31, which initiated broader immigration policy reforms (Marwah, 2014). The reforms introduced restrictions, in health care coverage based on an unequal three tier categorization for refugee claimants. The tiers include:

1. Expanded Health Coverage for government assisted refugees.
2. Healthcare coverage for refugee claimants and privately sponsored refugees.
3. Public Health and Safety Healthcare for claimants from Designated Countries of Origin (DCOs)

According to the author:

> "Strong evidence suggest that compared to other groups, refugees have poorer health due to their experience of displacement and the difficult resettlement process...In addition, settlement barriers to employment, language barriers and other social determinants of health create a situation where health is negatively impacted"

Citizenship and Immigration Canada (2014) describes DCOs as, "countries that do not normally produce refugees" and are considered "safe". The aim of the DCO policy is to deter abuse of the refugee system by people who come from countries that are considered safe."

This report focuses on the Public Safety Health Care coverage, "because this coverage stream is most restrictive in terms of access to health care services, such as medication and hospital facilities offered" (p. 4). In addition, health services and pharmaceuticals are limited to diseases posing a risk to public health or conditions posing a risk to the public.

A qualitative research study was conducted to demonstrate the impact of the Public Safety Health Care coverage. Therefore, this Research Review article will discuss the strengths and limitations of the report findings. Given the language, findings and recommendations, this paper was written for academics, researchers and policy makers. That said, the report should be of interest to community members and service organizations working with refugees as well as health advocates.

The study recruited 18 study participants from across Canada and collected data through interviews over a seven month period. Although diverse stakeholders were recruited, ranging from front line healthcare providers, to those in management positions, the study did not include the opinions of refugees themselves. It would have been valuable if feedback from the refugees themselves was obtained.

Key Facts about Refugee Healthcare

Application Guide can be found here: http://www.cic.gc.ca/english/information/applications/guides/5568ETOC.asp

Types of coverage and full requirements for eligibility can be found here: http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp

Additional Resource: Canadian Council for Refugee's Health Survey by Province and by Category (Feb 2015) Available here: http://ccrweb.ca/sites/ccrweb.ca/files/ccr-refugee-health-survey-public.pdf

Access full report here:

http://bit.ly/1K8M8GV

The author's findings indicated that reform led to "reduced and unequal access to healthcare for refugee groups" and has "impacted healthcare professionals ability to provide timely care to all refugees" (p.6). Completed findings were reported under the following five themes:

1. Administrative complexities to determined what diseases or conditions were covered and additional administrative tasks to confirm a patient's eligibility for coverage.
2. Reduced and unequal healthcare access to refugees who may have chronic or communicable health conditions that could pose a health risk to the public.
3. Turning away pregnant refugee claimants regardless of their medical coverage and making them sign waivers to pay fees in case their IFH coverage changes.
4. Putting health care providers in ethical dilemmas where some providers have turned away patients in need of medical care.
5. The shifting of health care costs; and service provider increased efforts to adjust with the complexities and demands of the IFH program cuts (Marwah, 2014).

According to the report, Quebec, Ontario, Manitoba, Alberta, Saskatchewan and Nova Scotia have taken steps to provide health care coverage to refugees not eligible and affected by the IFH cuts. Quebec is the leading province to provide provincial health care coverage to all refugees regardless of category. Ontario has the Ontario Temporary Health Program for refugee claimants who are not eligible for any coverage.

The findings show the negative effects caused by changes to the IFH program. These findings are also congruent with other recent articles written. For example, the Canadian Council for Refugees stated, "The cuts have also placed great stress on those struggling to serve them, notably health care providers and organizations serving refugees and migrants, who must improvise solutions for sick individuals" (CCR, July 2014).

In addition, the report underlines that the current IFH program is overly complex and confusing, leading to major obstacles in access to health care for refugees. In a recent survey of its members, the CCR heard that many refugees are having serious problems receiving essential health services for which they have IFH coverage, in part because of confusion over who and what is covered (CCR, December, 2014). The health care coverage for under insured and uninsured refugees is still an ongoing subject of discussion and debates as stakeholders attempt to find the best practice methods to ensure refugees have access to essential health services.

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Nicholas, D (N.D) The Experiences and Perceptions of Street-Involved Youth Regarding Emergency Department Services. Alberta Centre for Child, Family and Community Research.
Reviewed by Ryan Dexter, Volunteer Researcher and Writer

An estimated 650 street-involved youth live in Calgary and Edmonton, which represents approximately 11% and 13% of the homeless population in these cities (Nicholas). Street-involved youth are disproportionately at risk for poor health outcomes, and "necessarily access emergency department (ED) services for both emergency and primary care" (Nicholas, p. 2).

Specifically, street-involved youth constantly worry about basic survival needs, such as food, shelter, and safety. Additionally, street-involved youth are more likely to engage in risky behaviours such as legal and illegal substance use and unprotected sex (p.3). Further, they suffer from higher rates of injury, as well as post-traumatic stress disorder and learning disabilities. In addition, Nicholas reports that there is a "general malaise associated with persistent respiratory symptoms" (p. 4) that comes with being outdoors for prolonged periods of time, inadequate sleep and poor hygiene.

Alongside the daily health struggles there are structural barriers to adequate care, such as the lack of transportation and valid health insurance. Negative attitudes towards the street-involved youth are common. With these structural barriers in place, street-involved youth may wait until they are very sick to enter the emergency department or avoid going altogether.

Stemming from the knowledge about street-involved youth, health concerns, and the emergency department, Nicholas uses a community-based participatory action research (C-PAR) approach, which "recognizes community stakeholders as partners and co-researchers in all aspects of the research process" (p.6), to understand the relationship between street-involved youth and the emergency department. Further, grounded theory influenced the methodology of the study, as "Through focus groups, the experiences, interactions, processes, practices and systems of ED care for SI youth were theoretically examined" (Nicholas, p. 7). Specifically, street-involved youth between the ages of 15-26 in focus groups which met for approximately one hour, and were recorded accurately

Street-involved youth reported numerous reasons for going to the emergency department, such as intoxication, accidents, chronic health problems, violence and pregnancy. While some street-involved youth reported positive or neutral experiences in the emergency department, mostly the reaction to the emergency department was negative. On the positive side, some street-involved youth genuinely felt that health care professionals were there to support the youth by giving medication to the youth to avoid prescription costs; the youth also mentioned the cleanliness of the hospital and the food available were helpful.

On the negative side, however, street-involved youth reported long wait times which ranged from 1.5 to 2 hours (Nicholas, p. 11), even for individuals who had been sexually assaulted, which was felt to compromise personal dignity (Nicholas, p. 11). Overall, street-involved youth felt that the care being provided was not efficiently prioritized, especially for individuals who are marginalized and stigmatized.

Another repeated negative experience in the emergency department was the interaction between the street-involved youth and staff. Specifically, health care providers were described as "uncaring, impatient, judgmental, and lazy" (Nicholas, p. 13) with negative attitudes towards youth, which manifested as attempts to get street-involved youth out of the emergency department as soon as possible. Youth also interpreted staff responses as holding power or authority over the street-involved youth. Importantly, staff were intolerant concerning inappropriate language, even while one woman was giving birth (Nicholas, p. 13), which further contributed to the stigmatization of that woman being a "bad mother". As reported by the street-involved youth, the poor care and negative attitudes were a product of varying levels of stereotyping, prejudice and stigmatization.

Some of the youth reported they felt they received the same level of treatment as others, while most believed the care they received was substandard because of their status as street-involved. In this case, "youth felt multiple levels of stigma and marginalization related to attitudes and presumptions associated with their street involvement, lack of stable housing, young age, and in some cases, cultural background" (Nicholas, p. 15). Interestingly, youth reported that the level of care differed depending on who was with them in the emergency department. In general, it was reported that a poor experience in the emergency department made individuals less likely to enter care again.

Street-involved youth also reported "service gaps in the broader community" (Nicholas, p. 16). For example, long wait times meant not being able to access youth housing late at night. Also, lack of money made purchasing medication, and affording cost-related follow-up, difficult. Youth also noted that, when living on the street, it is difficult to keep safe personal belongings, such that important medical documents often went missing, interfering with their care. Transportation was also a difficulty for youth, as they were limited mostly to public transportation.

Given that street involved youth, to a large extent, do not have a voice, this research report is valuable as it collaborates with street-involved youth as research partners to better understand issues street-involved youth are facing. In this way, the research report is geared towards a wide audience, from professionals working with street-involved youth and health care practitioners to social policy experts and politicians. It is also valuable to the lay person who desires to aide his brothers and sisters in their everyday struggles.

Of note, however, is the implicit comparison between the levels of care received by non-street-involved populations and street-involved populations. This research report valuably focused on the reports of street-involved youth, but, to the degree that it does not include reports from non-street-involved populations, and specifically youth, there is a problem with knowing to what degree these issues are systematic for everyone. It is likely that most people have negative experiences in the emergency department, as waiting times and the prioritization of care is inefficient for all; however, this does not mean that street-involved youth do not experience more pronounced negativity in their visits to the emergency department, only that this study is not able to tease apart what is common for all and what is unique for the street-involved youth population.

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Barnes, S. (2014). Dealing with Urban Health Crisis: Responses to the Cuts to The Interim Federal Health Program. Wellesley Institute
By Hanna Nash, Volunteer Researcher and Writer

Universal health care is often touted as an integral facet of Canadian identity. However, changes to Canada's Interim Federal Health program (IFH) for refugees prevent many newcomers from accessing much-needed health care.. Steven Barnes' research into the policies of the federal government's revision of the Interim Federal Health program presents the predicted and unforeseen problems of the sudden changes resulting from this policy change. This research paper is written for academics and researchers although it has value for public community group's and government.

Barnes argues that a new urban health care crisis has emerged as a result of government health care cuts and a lack of focus on the health of refugees in Canada. As a result, those who have been affected are not likely to be able to financially compensate for the health care they do not qualify for and are therefore less able to maintain good health.

The changes to the IFH program were first introduced in April 2012 and were implemented on June 30, 2012. Critics were concerned by the abruptness of the alternations as well as the omission of any legislative pathways to address their concerns. While the previous IFH model allowed for refugees to have nearly the same basic health care provisions as most other Canadians, the changes to the IFH program place refuges into one of three categories.

The first of the three categories is the Public Health or Public Safety Health Care Coverage. This group is eligible to receive hospital, doctor, nursing, laboratory, diagnostic services, medications and vaccines services only in if the potential illness may pose a risk to public health and safety of others.

The provision of diagnosing a sickness before health care is paid for, is greatly criticized as refugees are less likely to seek health services if they are unsure of whether an unaffordable cost will follow if their diagnoses is not deemed a public health risk. These refugees are either rejected refugee claimants or are people from Designated Countries of Origin (DCOs).

DCOs are part of a list of countries the Canadian federal government has determined do not normally have refugees, such as European countries. As a result, the list of DCOs is harshly criticized, because being a refugee inherently means that you lack human security and basic human rights. Thus, a DCO should not exist since a creates a tiered system for refugee healthcare.

The second group of IFH program refugees includes those who qualify for Health Care Coverage. This group of refugees receive more health care as they meet more refugee qualifications, but are not given access to medications and vaccination unless they pose

Key Facts about Refugee Healthcare in Alberta

In addition to coverage based on federal program., Alberta provided

- Provincial insurance 2 weeks after arrival for GARs and privately sponsored refugees.

- Medication for chronic disease, dental and vision care for non-DCO claimants.

- Medication for pregnant women.

- Child health benefits

- Same benefits to claimants from DCO countries as non-DCO claimants.

Full report available here:

http://bit.ly/1VRYbon

a health risk to the public.

The last group of refugees fall under the category of Expanded Health Care Coverage. These refugees receive nearly the same amount of health care services provided under previous IFH program. These refugees are provided health care and benefits akin to Canadians who receive social assistance. Individuals in this category meet the qualifications of what Citizenship and Immigration Canada deem to be "genuine" refugees.

The full effect of cutting health care resources to refugees could not have been determined without using the Wesley Institute completing a Health Equity Impact Assessment (HEIA). The HEIA is a tool designed to assess the impact of the changes made to the IFH program. The Wesley Institute found that many problems development due to the changes made to the IFH program. The Institutes findings were very similar to the Refugee Health Outcome Monitoring and Evaluation System Tool (Refugee (HOMES) that Canadian doctors for Refugee Care used to determine the degree to which the changes impacted their services.

Some of the challenges resulting from the policy change include: refugees who have chronic conditions (that do not pose a threat to public health) are not able to afford medications; many refugees no longer have access to mental health care, which has significantly impacted their quality of life; children are more vulnerable to poor health as they are less likely to receive proper prenatal medical attention or early childhood medical care; emergency wait times were affected negatively and unexpectedly, such confusion surrounding the sudden changes prevented many refugees from accessing medical attention despite qualifying for care. This may affect our overall health system by increasing costs, increased use of acute care and longer wait times.

Critics of the reformed IFH program also cite the financial challenge provincial and territorial government must address, as unpaid health services bills are financially absorbed by these governments. Provinces such as Quebec and Ontario, who receive the greatest number of refugees, have created programs to compensate for the lack of health care available. While other provinces are slowly following suit, not all provinces are able to financially supply the same amount of health care. This in turn, creates a very uneven health care landscape across Canada.

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Dutt, M. (2014). Affordable Access to Medicines: A Prescription for Canada. Centre for Policy Alternatives.
Reviewed by Albert Muhigi, Volunteer Researcher and Writer

Affordable medication reduces the overall costs of the health system by preventing conditions from developing or progressing, thus reducing hospital stays and demands and pressure on resources. In spite of this, the federal government's inability to negotiate pharmaceutical prices on par with other developed countries means Canadians are paying more for their medicine.

As Dr. Monika Dutt's policy briefing series for the Canadian Centre for Policy Alternatives states, "bringing drug prices down to the OECD average could save Canadians $9.6 billion a year" (Dutt, pg 2) which reduces both public and household spending. This is particularly significant for low-income individuals and households.

Impact on health

Research indicates that one of the reasons patients are not adherent to their medications is because they are expensive (p.3). If the cost of these prescriptions are lowered, it would encourage patients to take their prescribed medications (p.3). On the other hand, non-adherence generates increase health costs because illnesses that are not being properly treated or managed lead to increase acute care (Sun Life Financial, 2014). An estimated $7-$9 billion of healthcare cost per year can be attributed to this cycle (p.3).

Low income people are primarily impacted by the cost of medication. Research suggests that fees as low as $10 per prescription increases the rate of non-adherence (p.3). Consequently, it is imperative that there is a strategy implemented to curb non-adherence as it not only improves overall health, but also decreases costs to our health system.

Challenges in addressing costs

In the past two decades, policymakers have had a difficult time controlling the cost of pharmaceuticals. A leading strategy used by provincial governments is to negotiate the cost of generic drugs as a fixed percentage of the brand name drug price (p.4). Although this controls the cost of some generic drugs, it also increases the cost for other generic drugs which were priced below the fixed percentage.

Key Facts about Pharmaceuticals in Alberta

- Alberta's Pharma Strategy was introduced in 2009.
- In 2009, 20% of Albertans were covered via government plan, 55% purchased private insurance and 25% lacked coverage.
- In 2012, the Alberta Government reduced the price of generic drugs from 75% to 45%.
- In 2013, generic reduced to 18% of brand named drugs.
- Alberta Health offers free medication during hospitalization.
- $12.30 dispensing fee in Alberta.
- 1 out of 4 Canadians without supplementary insurance cannot afford their prescription.
- Lack of national pharmacare leads to unequal access.
- Canadians pay 30% more than the OECD average for pharmaceuticals

Full report available here:

http://bit.ly/1ZDdqkl

Ultimately, because provincial and territorial governments utilize a unitary approach in pharmaceutical negotiations rather than a collective approach, bargaining powers are severely reduced. This has resulted in significant differences in drug costs across Canada (p.4).

However, since 2010 the Pan-Canadian Pricing Alliance has led to provincial cooperation which has increased provincial bargaining powers. As a result, Canadians have saved an estimated $230 million annually by reducing the cost of generic drugs to 18% of the brand name (p.4).

Dutt argues that compared to other developed countries using competitive bidding to tender generic drug contracts, Canada's model of managing generic prices based on a percentage of the brand name price is flawed since the strategy does not account for the real cost of production.

Dutt outlines four criteria points to succeed in reducing health care costs.

1. Increase interprovincial coordination as a tool to increase bargaining powers.
2. Reducing the high copayments, dispensing fees and deductibles.
3. Use a publically administered, not-for-profit, single-payer systems
4. Increase accessibility and reduce barriers to encourage adherence (p.6)

Discussion

Dutt's strategies on reducing the generic drug costs are feasible as other OECD countries have been successful in implementing competitive tendering which would achieve significant savings making drugs affordable to the patients. Making prescription medication affordable is important especially for low income earners as this would mean; fewer hospital admissions, low disease progression, a decrease in medical treatments and a decrease in total health care costs.

If the provinces of Canada worked together in bargaining the best price, there would be a better management of costs and prices of prescribed medications for Canadians. The government can work with private businesses by ensuring that there are no regulatory or financial barriers in the development of innovative approaches by the private sector.

Eliminating ancillary costs and setting regulations on how much overhead charges can be levied on patients could control the administrative costs. To reduce certain administrative costs, the government can reimburse pharmacy services such as dispensing and patient counselling fees (Competition Bureau, 2008).

Lastly the government can maximize access to health care by eliminating priority to certain age or income groups which will make a difference for low income earners as they would be able to afford medication at little or no cost.

References:

Dutt, Monika (2014). Affordable Access to Medicines: A Prescription for Canada. Centre for Policy Alternatives

About the Edmonton Social Planning

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The ESPC is an independent, non-profit, charitable organization. Our Focus is social research, particularly in the areas of low income and poverty.

We are dedicated to encouraging the adoption of equitable social policy, supporting the work of other organizations who are striving to improve the lives of Edmontonians, and educating the public regarding the social issues that impact them on a daily basis.

Our Vision

A healthy, just and inclusive community.

Our Mission

The Edmonton Social Planning Council provides leadership within the community by addressing and researching social issues, informing public discussion and influencing social policy.

Research Review Newsletter May 2015

The Edmonton Social Planning Council, in collaboration with our volunteers, strive to provide stakeholders and community members with up-to-date reviews on recently published social research reports.

Interested in volunteering for the ESPC or being added to our distribution list? Contact Manuel Escoto at manuele@ edmontonsocialplanning.ca

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Meet Ryan Dexter, ESPC Volunteer Researcher and Writer

Ryan Dexter was born in Calgary, but went to school in Sherwood Park, Alberta. He attended the University of Alberta and earned two B.A. degrees, the first in psychology and sociology, the second in philosophy and English literature.

Passionate about the well-being of others, Ryan worked as a front-line community worker, supporting adults with disabilities, youth with emotional and behavioural issues, and adults diagnosed with mental illnesses. Closer to home, Ryan helps support his brother with Down's syndrome, who inspired Ryan to engage in community work.

More recently, Ryan has worked to support the development of preschool children through his role as primary educator in a pre-kindergarten class at the YMCA. Concurrently, Ryan is also pursuing an M.A. degree at Athabasca University in adult education and community studies, with plans to engage more deeply in the non-profit world. As well, he is serving his second term as Vice-President of the AltView Foundation, a small community organization located in Sherwood Park, which serves the queer community, helping set up and run GSAs in schools in Alberta.

Ryan enjoys spending time relaxing at his family's cottage on St. Vincent Lake, is an avid reader and amateur painter and meditates regularly.