When Tea and Sympathy are not Enough:
The Catastrophic Gap in Prescription Drug Coverage in Atlantic Canada

9:30 Panel — What Canada has Learned So Far about Catastrophic Drug Coverage

This is the transcript of remarks made by **Bryan Ferguson,** during the first panel of AIMS "When Tea and Sympathy are not Enough" conference.

Bryan Ferguson is a Partner and Vice President of Applied Management Consultants, a Fredericton-based health care consulting firm. He is a Fellow of the Canadian Institute of Management Consultants and a graduate of McGill and Queen's Universities. He has over 25 years consulting experience in strategic healthcare marketing and health policy. Bryan has spoken and published frequently on issues relating to drug insurance. He was one of the principal authors of the landmark study on access to drug insurance, "Canadians' Access to Insurance for Prescription Medicines – The Insured, The Uninsured and the Under-Insured", which laid much of the groundwork for analysis of needs in this area. He provided expert testimony and participated in panel discussions on Pharmacare for both the Kirby and Romanow Commissions.

Bryan Ferguson:

The topic that our panel was asked to talk about is what Canada has learned so far about catastrophic drug coverage, and so what I wanted to do was to talk about where we are going, about the NPS, the National Pharmaceutical Strategy, working toward a solution, and what the learnings have been there.

I want to talk very briefly about **Bill 102.** David Grueller mentioned it in his comments before, because it certainly has some impacts that we all have to think about in terms of costs on insurance and coverage in the country. Then I want to try to hopefully provide a bridge to some of the discussions later this morning and try to put this in the context of some key issues for Atlantic Canada. And then finally, sort of picking up on the comments that others have made, is there a made in Atlantic Canada solution?

We've often talked about the fact that nothing is going to move ahead unless we get some federal transfer, or we have some kind of federal money injected, and I think we need to look at this from the perspective of do we have the resources ourselves, or can we somehow use the resources that we have to solve some of the problems that have been well identified by the other speakers.

We are waiting eagerly at the end of June a progress report, at least, on the National

Pharmaceutical Strategy. And I just wanted to raise two or three of the points, because this is really the key initiative that's happening in the country right now – that will move the agenda forward, as far as catastrophic coverage is concerned, for the country.

It was created at the First Minister's meeting in September of 2004. There were nine elements included in the strategy. Two of them are related to coverage. One is specifically a task force or working group or committee on catastrophic drug coverage, talking about and developing plans for many of the issues we've talked about today. And secondly, there's another group that's working on an area known as access or was originally known in 2004, as access to breakthrough drugs, which I think now is being more commonly known by the name of acronym of expensive drugs for rare diseases. What will be interesting to see is the extent to which these two come together or get rolled together, but essentially, they're dealing with elements of the same problem.

As I mentioned, there is a deliverable of June 30th, 2006, for a report on all of the elements of the strategy and there are stake holder consultations currently underway. The key issues, I think, that the whole discussions are boiling down to are one of three types. There are design issues; there are funding issues; and probably the most important, or arguably the most important, are ultimately going to be the political issues.

Just to quickly touch on those. I think for the design issues there are a number of options being worked on and being laid out, but primarily it comes down to which is the model that the national catastrophic coverage program will follow. Will it be a last dollar type of coverage model, as they have in Ontario, or a first dollar model with high deductible similar to the programs that they operate in B.C., and Saskatchewan, and Manitoba? The issue that about definition of catastrophic will be based on percentage of income, based on some dollar threshold, or will it involve out-of-pocket cost, versus total costs. The funding issues, I think, are pretty clear.

The federal/provincial split of funds, certainly one of the issues that the provinces that are already there, or have made significant strides, want to see as part of that discussion is some compensation for those provinces that have already provided coverage and certainly the big one that affect all of us here is equalization. And for a national catastrophic plan, in the context of the whole federal/provincial agenda that's going to roll out over the next couple of years, related to equalization and transfer payments.

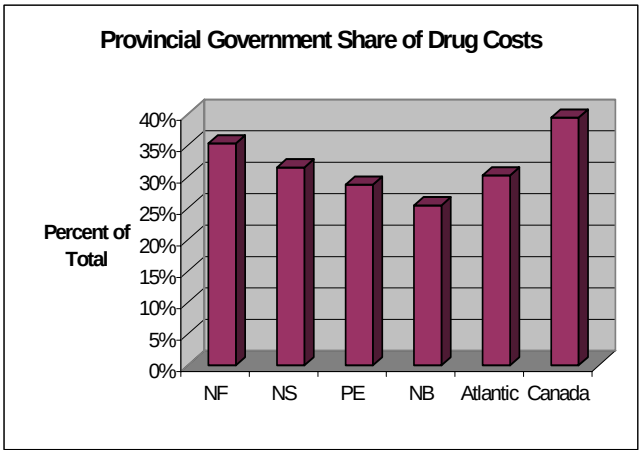
So that brings us to the political issues. We have a new federal government. This is clearly not one of their top priorities as they've identified in their own agenda, so we don't really know where the federal government is going to come down on this, and it is going to be very interesting to see when the report is tabled on the national pharmaceutical strategy exactly where the federal government will position itself, because we really haven't heard an awful lot up to this point about what their take is on the whole strategy.

Again, the transfer payments issue, we've certainly heard the comments of Premier McGinty in Ontario about his concerns and the fact that Ontario is not getting its fair shake and they want to have the whole transfer payment issue readdressed, and is this going to get caught up in that context.

And finally, while the key behind some kind of a national catastrophic program, as it is in other programs funded under the *Canada Health Act*, is the establishment of national standards and norms to which the provinces and territories run their programs, there is not a big appetite on the provincial level to commit themselves to that kind of a context.

Very quickly, I want to highlight a couple of things on *Bill 102.* This is a new piece of legislation that is tabled in Ontario that is going to put a lot of the emphasis on cost containment and actually move Ontario, I think, in exactly the opposite direction from where they need to go in terms of making more drugs available, making it more available on a timely basis. However, the one kind of bright light, in terms of some of the actions in Ontario, is that we should see very quickly a reduction in the price of generic drugs. We've artificially held the price of generic drugs fairly high in Canada, and Ontario has really been the driving force that's more or less established the pricing for generic drugs in Canada. So with both the reduction in prices, and quicker adoption of generics through the changes in the *Drug Interchangeability and Dispensing Fee Act*, in Ontario, we should actually see what I'm calling a drug dividend that some of the other provinces will benefit from as well.

So what does this bring us to, in terms of costs for Atlantic Canada? This graph shows the differences in the public/private share of funding, for drugs in Canada.



Source -
CIHI: Drug Expenditure in Canada 1985-2004

This is the SIHI Drug Expenditures in Canada Report for 2004, showing where provincial government drug expenditures are, as a percentage of total drug expenditures, in each of the four provinces, in Atlantic Canada, and in the other provinces in Canada as well. So you do see that we have this lag of about ten to 15 percentage points between the amount that our provincial governments or the provincial governments of Atlantic Canada are spending, relative to what the other provinces are spending in Canada.

I think another point that I would want to emphasize, in terms of where we see this going, is we do have to make this distinction between catastrophic insurance, and national Pharmacare. While I think there is a prevailing sense, or at least certainly a number of people in Ottawa, who feel that this is the opportunity to fix the mistake of the *Canada Health Act,* i.e. the drugs should never have been left out in the first place, back in 1964 or '65, and then in the subsequent amendments to the *Canada Health Act*, really, what the key issue that we need to focus on is that it is not about helping everyone with all their drug costs.

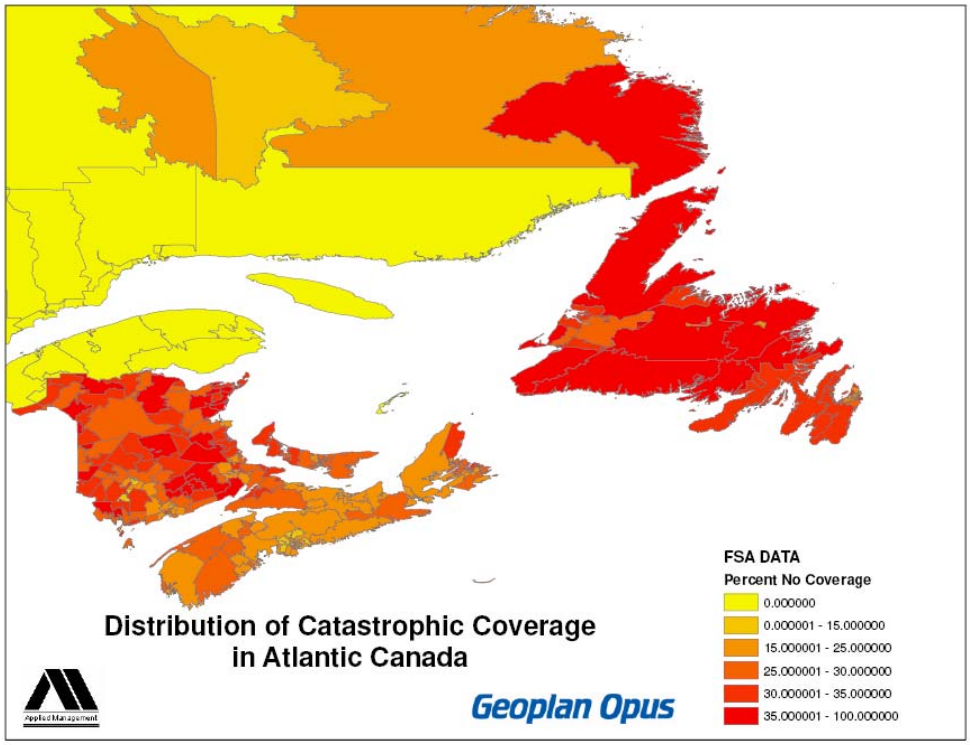
The emphasis should be on the chronic long-term illnesses and conditions that cause people significant financial hardships on an ongoing continuous basis. I think the other thing is that this is an opportunity to focus on priorities and needs, rather than on specific demographic age groups. Our initial forays into providing any kind of public insurance for drugs, the very first programs were programs aimed primarily at seniors so that all the senior population was included. While there's a close relationship between demographics and needs, there are many people who have significant needs that don't conveniently fit in to these identifiable demographic groups.

The next point is that not all drug plans are alike. This is getting back to the point about partial coverage versus full coverage. We still have significant co-payments, deductibles, and maximums that leave high out-of-pocket costs. Even though our coverage in Atlantic Canada certainly lags behind where we are in the rest of Canada, the prevailing model for co-payments is the region is co-insurance. Typically, sort of an 80/20 split. Eighty percent by the employer, 20 percent by the employee, so your costs continue to rise as your drug costs arise. And then finally there's the issue that exclusions of specific drugs in public and private plans, pass on the costs to other parts of the health system.

I think another issue that we have when we look at the situation in Canada, I've called it the unfair treatment of the prudent. We've designed a number of the plans in Atlantic Canada to work around people who have provided for their own drug insurance. For instance for retirees, who are paying for their own benefits are actually not only paying for their own benefits, but through taxation paying for other seniors in the province. Active employees get some or all of their premiums paid by employers with no tax consequences, but individuals buying non-group coverage pay with after-tax dollars, or indeed individuals who have no insurance who pay out-of-pocket are doing it all with after-tax dollars. So we have an unfairness from a taxation system as well as from a plan design perspective as well.

I also want to make the point that there are ... not only do we have Atlantic Canada being under represented or at least the situation with catastrophic coverage being poorer in Atlantic Canada than it is in the rest of the country, we have very significant intra-regional differences as well.

This is some mapping work that we've been doing, looking at rates of coverage for individuals in different parts of the Atlantic region. What you see is going from red being bad, if I can use the term, to yellow being good, the distribution of individuals in the country and their coverage. So this represents people who have no coverage of any kind for drugs in Atlantic Canada. And the areas that are red represent parts of the population when we have 35 percent or more of the people in those communities, without insurance. So you can see that the distribution kind of maps out, quite significantly, differently, in different parts of the region.



So the key point is that the lack of catastrophic coverage affects different regions in different ways. The lower the income the more disposable income goes towards drugs and less towards other goods and services. These tend to happen in the communities where the incomes are the lowest to start out with. And ultimately catastrophic coverage is about re-distribution of wealth within a province and shifting some of these private expenditures, to public expenditures. We are not talking, necessarily about redressing these problems with new money. It's redressing them through a shift in the “who pays” part of the equation.

The fact that we lag behind the rest of the country in our catastrophic program, has some significant impacts on the regional economy, as well. Costs of benefits for employees and retirees are higher. We have a higher rate of private coverage in Atlantic Canada than they do in the rest of the country. And to the extent this is not only an Atlantic Canada problem, but it is certainly an issue here as well. The arbitrary nature of government policy specifically with respect to de-listing and downloading has an impact on employers, who have to accommodate this, within their current business models.

So I'm going to leave you with five suggestions. These are just some things that hopefully we can concentrate some of our discussions on, as we move forward in the day.

First of all, we run most of our insurance programs based on first dollar coverage. The analogy that I like to use is that if you were buying insurance for a car that said, “Any time you have a flat, we'll fix it. Any time you run out of gas, we'll bring you some gas. Any time your windshield breaks, we'll put in a new windshield, but if someone steals your car, we are not there for you.” To a certain extent that's the way some of our programs are designed. So why not look at some re-design of both our public and our private health care insurance plans to put in higher deductibles and pay for some of these higher cost needs at the back end?

The second one is to try to address this issue of fairness. Could we require everyone without coverage to take catastrophic insurance, spread the risk across the entire population, but give them the same tax breaks on premiums as group plan members?

What about opportunities within the health care system itself for re-allocation? Some very good points have been made about the impact of investments early on at the appropriate points in the care spectrum which have large savings down the road, and we need to look at drugs in the perspective that we look at any other technology investment in health care. We've tended in the Atlantic region to look at putting priorities on MRI machines and other technology investments, neglecting to a certain extent investment in other areas of health care.

And it doesn't make sense to look at needs from a burden of illness perspective rather than demographics. Who are the ones who really have the greatest burden of illness, and can we fix those problems as opposed to just dealing with demographic groups as a whole?

And then finally can we reinvest the coming drug dividend, the one that I spoke of earlier, in catastrophic coverage, to help mitigate some of the cost impacts?

So that's the end of my presentation, and hopefully that's left some issues for discussion. Thank you.