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 **Karen Philp,** during the first panel of AIMS "When Tea and Sympathy are not Enough" conference.

Dr. Karen Philp is responsible for the Canadian Diabetes Association's advocacy work as the National Director of Public Policy and Government Relations. Prior to her appointment in July 2003, Karen managed government relations for a number of non-governmental organizations, including the Canadian Cooperative Association, CUSO and the David Suzuki Foundation. From 1992 to 1996, Karen was a Senior Policy Officer with the U.K. Labour Party, responsible for development of the Party's public policies for Scotland which included health care, education, jobs, the economy, as well as the Scottish Parliament. Karen grew up in northern British Columbia, and studied at the University of Alberta and at Oxford University in the U.K.

Karen Philp:

Before I start I would like to let you know a little bit about the Canadian Diabetes Association.

We are national organization with over 45,000 members, including an additional 2,600 diabetes health care professionals, and 660 members who are endocrinologists, diabetes researchers, and physicians who are interested in diabetes. So we are more than just representing the 2-million Canadians who have diabetes. We also represent the interests of the health professionals who work with diabetes.

Today I want to talk a little bit about the epidemic of diabetes in Canada. Those with a family history of Type 2 diabetes are at highest risk. One in three children born in the year 2000 will have diabetes by the time they reach 65. That's quite a growth, and we are very concerned about the increase of Type 2 diabetes, in particular, because it is costing us more than $13-billion annually through our GDP and health care system.

We are very concerned about the impact of diabetes and other chronic diseases on the health care system and its ability to sustain itself. The Institute of Health Economics in Alberta has projected a 76% increase in the costs of health care by the year 2016. That's hospitalizations, and doesn't include things like post-operative surgeries or the medications you have to take at home.

Also, there's a personal suffering that happens with diabetes when one in two diabetic Canadians will ultimately have a heart attack. 80% of them, in fact, will die

from a heart attack or they'll develop kidney disease. Diabetes is a leading cause of kidney failure and kidney dialysis, and the leading cause of adult blindness.

So from our perspective, the situation is serious. And when we ask the people with diabetes what's the biggest problem they face they say it is the affordability and access to diabetes medications, devices and supplies. They need some help in order to manage the disease and reduce their risk of the complications.

When we started looking at the problem that they were facing we discovered startling variations in drug plan coverage and financial support levels for Canadians with diabetes. We looked, in particular, at the 17 listed diabetes medications. These have all been approved by Health Canada as safe and effective for people with diabetes.

There's evidence around the world that insulin glargine, for instance, can help certain people with certain types of diabetes that suffer hypo-glycemia at night. So there's a specific use for it. It's not necessarily first line, but there's a specific use, yet only Quebec lists it. P.E.I. in their last budget, moved five diabetes medications from the "not listed" to the "restricted" column, which for a small province like P.E.I. we really applaud. That took guts, and it is going to cost them a bit, and we are really pleased they did that. It also put Ontario at the bottom of the list for providing access to diabetes medications.

Members of the first panel at AIMS' When Tea and Sympathy are not Enough conference listen to Bryan Ferguson's presentation. Left to right: Brian Lee Crowle, Karen Philp, David Griller and Brian Ferguson.

People in British Columbia may not be paying for their medications, because there's a good plan in place to allow them to access it financially, but when they actually try to access the medications they do have difficulty accessing the full range of medications that the physician might prescribe. The financial barriers are still important for all Canadians, no matter where they live.

Yes, in Atlantic Canada, there are fewer people covered by the private plan, but when you add co-pay and all the other things that people have to pay in order to participate in a public plan you are going to see something really, really interesting.

We asked Brogans Research of Ottawa, who provide a lot of the analysis on pharmaceutical costs for Canadian governments – What's the cost for someone earning about $15,000 a year pre-tax? We went pre-tax, because it was a little less complicated to calculate. For a range of medications that their physician would prescribe, if they have Type 1 diabetes and have no complications, they are basically using insulin 3-4 times a day and require test strips and monitors. That's it. And we asked Brogans to cost it for us and this is the range of costs in each province.

We used an imaginary person called Janet, who earns $15,000 a year. Look at British Columbia, where someone earning $15,000 a year, pre-tax, is paying 2.7 percent of that income, or $395.85, to manage their diabetes. But in Atlantic Canada, the same person earning $15,000 a year faces a level of well over 20 percent of that income just to manage their diabetes. So we thought that was just amazingly and very telling of the challenge, financially, across the country.

What Janet pays

Jurisdiction	Annual out of pocket cost for prescribed medication & supplies	% of Janet's annual income
Newfoundland/Labrador	$ 3,639.33	25.1 %
Nova Scotia	$ 3,585.71	24.7 %
New Brunswick	$ 3,355.42	23.1 %
Prince Edward Island	$ 3,116.19	21.5 %
Alberta	$ 2,359.34	16.3 %
Saskatchewan	$ 1,451.04	10.0 %
Quebec	$ 962.85	6.6 %
Ontario	$ 948.27	6.5 %
Northwest Territories	$ 550.00	3.8 %
British Columbia	$ 395.85	2.7 %
Manitoba	$ 336.40	2.3 %
Yukon	$ 250.00	1.7 %
Nunavut	0	0 %
NIHB (federal)	0	0 %

We also did the calculation for someone earning $30,000 a year, with Type 2 diabetes being managed according to the clinical practice guidelines. The Canadian Diabetes Association issues clinical practice guidelines every three years that say what a person should be doing based on the scientific evidence as part of their management regime for diabetes. We looked at the cost of those drugs, not including costs for drugs like blood pressure medications, etc. This is just your oral medications and your test strips. You can again see the range of what people are paying across the country.

When we looked at that, we thought, let's survey our membership. We have 45,000 members; let's get FES Research to confirm we are getting an accurate picture. Our members are not necessarily reflective of the entire Canadian diabetic population. 90% of people with diabetes have Type 2, 10% have Type 1. Our membership is more like 40% of our members have Type 1, 60% have Type 2. So they are more

likely to be Type 1 diabetics. The survey of our members showed that 46% of them spent between $50-200 a month on medications and supplies. 28% of them are spending more than $200 per month, out of their pocket, and 1 in 4 reports that that they could not get their doctor recommended medications to manage diabetes because they couldn't afford the drugs or couldn't get them through their public or private insurance plan.

As a result of that our association decided we needed to get behind a call for a national catastrophic drug plan, for which all Canadians should be eligible. This is not just for people with diabetes, not just for people with chronic disease. It has to be for all Canadians, and it has to be at 3% of adjusted family income each year on medications prescribed by their physician. We are not advocating it be extended to drugs that are not prescribed, but we believe that all medications have to be covered if they were approved as safe and effective and for sale by Health Canada and the Patent Medicines Price Review Board. Why? Because we are growing increasingly concerned that those with money can afford to purchase the medications that the doctor prescribes, and therefore have better health outcomes. And those who can't afford it and rely on the public plans, primarily seniors, don't have access to the best medications and, therefore, don't have the best health outcomes. That is unfair.

We also recognize that Atlantic Canada does not have the population or tax base that would allow them to participate fully in a national catastrophic drug plan, without federal support. So we are advocating strongly to the federal government that they need to provide that financial support to Atlantic Canada.

We also wanted to look at what is happening across the country with other Canadians, and for that we did rely heavily on the work that Ken has produced for the Senator Kirby's committee. We met with Senator Kirby, and had worked a bit with Ken on pulling these slides together. You've already talked with Ken about this so you know the need is very serious, when people who are spending more than three percent of their income, are accounting for 66 percent of hospital drug costs ... out of hospital drug costs. That's a serious problem for them when trying to save for their retirement, for their kid's schooling, going off to university and such.

When we did our costing we were being very cautious, and we found that the cost, incrementally, would be pretty minimal, at less than 500-million. Canadians can afford it. The health care renewal agenda includes a proposal for a national catastrophic drug plan. The federal government surplus, and I know some people feel that it shouldn't be one, but there is surplus money between now and 2010/11 that could be allocated to a national catastrophic drug plan.

As a result, if we did invest in this we would end disparities in access to diabetes medications and supplies across the country. We'd ensure Canadians with diabetes, and other chronic diseases, like cancer and arthritis, could manage effectively and live healthier, more productive lives. We could reduce the risk of costly and long-term complications. 1 in 10 hospital admissions list diabetes as an underlying cause for that admission. People who have diabetes enter hospital more frequently, and they stay there longer. They are clogging up emergency wards; they are clogging up the wait list for heart surgeries. They are one of the challenges for health care renewal.

So if we are going to do anything about health care renewal and ensuring wait times will be reduced, we have to address it at the source. This includes ensuring that

people with diabetes don't develop those complications. There is evidence that supports that.

If you provide people with diabetes appropriate medications, as the Pitney-Bowes Company in the U.S. did when they expanded their formulary to cover all diabetes medications and test strips, you find their diabetes medications costs rose 7%, but overall their costs decreased 25%.

So we've got good evidence to support this idea that you can reduce the costly, long-term complications and reduce your drug budget at the same time. To give you some sense of what we've been doing, I participated in the federal election. We called for federal leadership and support for the creation of a national catastrophic drug plan. We had our volunteers across the country out there during the campaign. We got support from every single political party, including the Bloc Quebecois, which surprised us since we did not ask them, but they did send us a letter. We also wrote to all the ministers of health of each province and territory asking for their support for a national catastrophic drug plan and for our inclusion in the development of a national pharmaceutical strategy.

We are starting to get the responses to those letters back. We sent our letters in December; it is taken them until May to respond. It does appear that they coordinated their response because we've been told, in each of these letters we've been receiving that they are very concerned about a national catastrophic drug plan being established. The ministers say they are committed to ensuring one is put in place and organizations like the Canadian Diabetes Association can and will be involved in the development of the components for a national catastrophic drug plan. That gives us some support, and comfort.

Finally, we were invited to participate for the first time in the federal, provincial, territorial, national pharmaceutical strategy information session. The government laid out their work on the national pharmaceutical strategy and on the national catastrophic drug plan. They appear to be moving quite solidly towards a report going to the Ministers of Health at the end of June that includes components of principles and then options. The options appear to be maybe two or three different types, one based on Kirby, and one on Romanow, and one other.

We are also continuing to do our work. We have a national advocacy leadership forum 2006, on June 4th, in Ottawa. We bring together about 100 people from across Canada to train them on how to advocate appropriately and effectively. And then we have our “diabetes day on the hill” the next day, where we have individual meetings with M.P.'s and ministers in the morning, a lunch briefing with caucus members, the Conservatives, the Liberal caucus and the NDP, and we try to match our volunteers with their member of parliament to maximize our impact. On that day we are asking for our association's inclusion in the discussions around the national catastrophic drug plan, as well as the national pharmaceutical strategy.

We need to be involved with patient groups, and health care professionals need to be involved in whatever you develop, because if you don't develop something that has broad public support, it won't be sustainable, and it won't be effective. Thank you very much. (Applause.)