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

10:45 Panel – Covering Atlantic Canada: Regional Dimension of Catastrophic Drug Coverage

This is the transcript of remarks made by John Abbot during the second panel of the AIMS "When Tea and Sympathy are not Enough" conference.

John Abbott is Deputy Minister of Health, Newfoundland & Labrador and brings a depth of experience and working knowledge of the provincial health care system. Abbott serves as the voluntary Chair of the Board of Trustees of the Health Care Corporation of St. John's and served on the Board of Trustees of the St. John's Nursing Home Board and as chair of the Hoyles-Escasoni Supervisory Committee. He has had a successful private management consulting practice that allowed him to undertake assignments in such diverse areas as the design and delivery of health care services, electronic service delivery, organizational analysis and general government services.

John Abbott:

What I want to speak to you about today is how the government recently has addressed this issue of catastrophic drug coverage to a certain degree, the role it is playing in the national debate, and hopefully contributing to a national solution. And I'm going to insert myself into some of this discussion as a sort of representative of what the government of Newfoundland and Labrador is trying to achieve.

There are many forces at play, when you are dealing with this issue. I was quite impressed with all the presentations, up to now, and I'm assuming the one to follow here, will also contribute. There is a consistency of information; there is a consistency of understanding, and there is a consistency of a shared solution to this issue. There is a series of national consultations for information sessions underway on the national pharmaceutical strategy that hopefully will pull in this same information and validate what government officials are working on.

Now when I became Deputy Minister of Health and Community Services, just about a year and a half ago, I was faced with lots of challenges in the health portfolio, but for me those challenges were opportunities to improve on the policies that government was dealing with at the time, as well developing and implementing some new program initiatives. The government had just announced the total restructuring of its health and community services sector where we started with 14 community boards, and reduced that number to four. We

wanted to invest in some new service delivery, to save money, and also wanted to focus on some other critical public policy initiatives. At the same time, we had a relatively new premier, who was engaged with the former prime minister in a battle of wits and political one-upmanship, but the end result has been a renewed Atlantic Accord, which is allowing the government of Newfoundland and Labrador to move ahead with some very significant social policy initiatives - one of which was drug coverage.

The other piece of this for me is getting reinserted into the world of intra-governmental relations in the health sector. And if there is a recipe for foot dragging, slowness of solution, and absence of resolve you will see it there. And one of the themes for us today, and in Atlantic Canada, is to keep your eye on the federal ball, and ask yourself what they are doing to solve this Atlantic Canadian problem. When you focus on that you get an appreciation of the challenge ahead.

I'm also on the Health Council of Canada as one of the two Newfoundland and Labrador representatives. It has a role to play in terms of addressing and reporting on the Health Accords, 2003 and 2004. But they also set up several working groups, one of which was on pharmaceuticals, so it too is sort of trying to track progress, and trying to look for solutions to move this item forward.

Just after I joined the department early in 2005, we were just in the throes of our budget process, our focus on allocating the Accord monies that were supplied largely, obviously, through the federal government based on the 2004 September Accord. And for us in Newfoundland that means roughly $50-55-million annually, and the government has steadfastly kept that allocation to the priorities identified in the Accord for new technology, new services, expanded services in certain areas, and focusing on the areas around wait times and the national pharmaceutical strategy.

We took some of that money and put it into our drug plan at that time but that was just to add some of the medications that obviously are found in most other jurisdictions. So we are constantly, and obviously, through advocacy and research, through CDR, and our Atlantic Advisory Expert Committee, looking at applying and adding new drugs to our formulary. We still have a fair way to go. But our drug plan, as of a year ago, was the best a minimalist plan could provide. We could say that. It was the least covered plans in terms of coverage for the population and for the drugs covered. We are focused, obviously, on people who are on income support and seniors who are on GIS. We had some elements that spoke to very specific drug classes or people who met other financial criteria. In fact, you would have to be on welfare, or close to it, to be eligible. That being said, we were covering approximately 100,000 people at that time.

Now it became very clear to me that our drug program was inadequate, that was no big mystery. Our Treasury Board colleagues and others were suggesting there should be ways to find savings in that program to re-apply to other health care priorities. I said, well, theoretically, yes, but practically, no. But we had undertaken some exercises in the department when I arrived to address that. Obviously, we have a lot of representations to

the minister, to the premier, to cabinet, and the department by various patient advocacy groups to talk about coverage. Each and every single one of those presentations, and discussions, and telephone calls, were legitimate, and legitimate in my mind, and certainly legitimate in the mind of the Minister.

The question is how you can respond to those very personal and real situations. We knew there were opportunities to re-design and add to the program. We certainly recognize the issue of using personal and family finances to support drug coverage, and the impact it has on the quality of life, health outcomes, and ability to work.

So we, a year or so ago, were working diligently with our provincial colleagues, territorial colleagues, with the federal government, with the view that maybe we would have a national catastrophic drug plan for the country. That's yet to happen. There is some frustration setting in, because we were putting a lot of energy into one exercise and realizing it wasn't going to produce results in the short term.

The interesting thing for me, as an observer, was the 2006 federal election, when there was very little national discussion on catastrophic drug coverage. The only party that really focused on it, that I could see, was the NDP, and I was surprised it did not play in our province. I don't know if it played in the Maritime Provinces, but it certainly didn't get much on the national agenda and, obviously, it is not showing up in the new federal government's agenda, to date.

The premiers met and discussed it in passing at their conference last year, and it was in a reference in their communiqué but they are, at this point, leaving it to their health ministers to forge a consensus. The federal, provincial and territorial ministers of health, in the previous federal administration, met last October, and there was some discussion around the catastrophic drug coverage and expensive drugs for rare diseases, largely driven by Fabre's. I would suggest that if Fabre's was not on the national agenda, we would not have been discussing that topic to the degree that we did.

The focus from the federal perspective was more on a common drug formulary than on catastrophic drug coverage. They tied the two together, but focused on the formulary piece, thinking provinces would be reluctant to go in that direction. On the contrary, the provinces do see the benefit of moving closer together on having the same drug coverage.
Now while all this was going on, the breakthrough from a Newfoundland perspective came from a totally different angle. The provincial cabinet last summer, in one of its think tank sessions, had a presentation on the issue of poverty and poverty reduction in Newfoundland and Labrador. The discussion was led by the Minister of Human Resources, Labour and Employment. There was some input from some of the other departments, but they focused on defining the problem, defining some solutions, and presenting potential options. Not

initiatives, just options. A working committee of officials was set up, and for me, that was what we were able to anchor, our immediate solution.

I was asked to attend one of the first meetings of the working committee. When asked if my Ministry had choices or initiatives to put on the table, I said catastrophic drug coverage. We need to expand the program. It fits within the policy objective in terms of poverty reduction. It allows people to re-deploy their finances to those other issues in their family lives that they need to spend their dollars on. And in some instances, our people who have drug coverage because they are on income support were indicating a deterrence of seeking employment because they would lose drug coverage. That's a very real concern. We had put in some programs to allow bridging of coverage, and we knew what the success rates were there. When on income support, drug coverage was per family was a certain dollar amount. When those people were at work, the drug coverage requirements were less. We were able to trap those savings.

We were also able to project costs for an expansion of the program. Initially we came up with an expansion of around $13-million. We thought, well, that's doable. After talking to our Department of Finance we revised our figures, and looked at the data more closely. The $13-million turned out to be $32-million to allow for doubling the coverage in our program. At that figure we feared we were dead in the water, but interestingly enough, the Minister of Finance came to our cause and had his officials work with us to make sure that we had both the numbers correct, and the design reasonably acceptable to cabinet. We presented our proposal. Interestingly enough, at the officials, ministerial, and the full cabinet level, this project was viewed as top priority. We went through various exercises, as this was the prime initiative for the strategy, yet to be announced formally, but fed into the budget discussions. The Premier and the Minister of Health were knowledgeable about the national pharmaceutical strategy discussions, but they said that's something we cannot wait for, but ideally our plan should dovetail with the national strategy that develops.

So what we've done is expanded coverage by roughly another 100,000 persons. We have an escalating co-pay, and I heard some of the discussions here this morning on program design and on something I think we will be continually looking at. We'll be able to cover families up to incomes of $30,000, adjusted based on the size of family and single individuals. We are at the program design stage now developing the logistics, and another win for us is that we had to open up a new office and there was discussion as to where said office will be located. That office will contribute to one of our communities that's hitting some economic hard times.

Our statistics show our average cost per client. It is in the $500-600/client range. It does escalate with age, but also de-escalates with income and employment. The part that we are now moving towards is further engagement with the federal government. The officials are working diligently on a proposal with several options put in place, but it is going to boil down to program design and funding issues.

Is the federal government prepared and willing to support this program? This jury is out. In Toronto this past weekend, there was a discussion. The federal minister would have preferred not to be engaged. We do not know where the prime minister is; we do not know where the federal government is collectively. So it is something that we all have to be conscious of moving forward.

As I said, our plan can be viewed as a bridge to a national plan. It is a start. It shows the government's commitment to a very pressing policy priority, and it is within our fiscal means to achieve it. But there are still and will continue to be many Newfoundlanders without the coverage that we feel is adequate.

In today's economy, good public policy is best served by ensuring that all Canadians have access to necessary prescription drug coverage. We need to ensure, at the same time, that only the right drugs are prescribed for the right clinical reasons. We can improve health outcomes with less drugs and at lower cost, but no consumer should be denied coverage because of income or employment status. In our case, we see a redesign allowing us to improve administrative efficiencies, because we had several departments involved in different aspects of drug coverage. We are now consolidating that for the benefit of the client.

We feel that our government has taken up the gauntlet and other governments in Atlantic Canada are facing similar challenges. The federal government has acknowledged a need and it is time that a comprehensive approach is adopted. I'm quite sure, and even more so then when I came in here this morning, that this conference can inform the ongoing regional and national discussions on catastrophic drug coverage. I would certainly ask that the presentations and findings from this conference be forwarded to all provincial and federal Ministers of Health. And really, what we need now is the federal political will to act, and we hope the federal government is listening. Thank you. (Applause)