Coping with Fiscal Crisis:
Drug Plan Retrenchment in Saskatchewan

Tom McIntosh, Michael Ducie
And Courtney England

optometrists, long-term care facilities and a host of other services. And in the case of prescription drugs, it is probably fair to say that the lack of coverage for drugs taken outside of hospitals was not initially seen as terribly crucial simply because there were so few prescription drugs that were taken outside of hospitals.

That has clearly changed in recent decades. Where there were a handful of new drugs patented every year there are now hundreds of new medications every year. Catastrophic and chronic conditions that were untreatable in the past are now routinely treated with new drug therapies and the genetic revolution currently underway will only increase the number of drugs available. Drugs are increasingly being used as substitutions for other forms of care including surgical interventions. Where prescription drugs administered outside of hospital were a rarity in 1960s, Canadians now average 10 prescriptions per year per individual.

As drug therapies played an ever increasing role in medical care, access to drugs developed in an uneven manner across the country and through Canadian society. Provincial governments added drug insurance programs to their basket of health care services but almost always in a targeted or means-tested manner providing coverage for the elderly, for social assistance recipients and the disabled to varying degrees. The labour movement, whose growth in political and economic power coincided with the

work in unionized positions drug plans within collective agreements have become less generous and have been a key target of employers seeking concessions from employees.

The result is a patchwork of coverage across the country. If you live in a wealthier province there is a stronger likelihood that the government drug plan is more generous than those in poorer provinces. If you have a white-collar job or a unionized blue-collar job there is a greater likelihood that you have reasonably affordable drug insurance through your employer with relatively affordable co-payments or premiums. If you are a social assistance recipient, over 65 years of age or suffer from particular chronic illnesses that require particularly expensive drugs (being HIV positive) then, again, you likely have some level of coverage for necessary prescriptions. If you are a low to middle income individual working in a non-union job in a poorer province, then there is a greater likelihood that you cover all of your drug costs yourself.

In the decades that followed the creation of medicare, universal drug insurance was never, it seemed, at the centre of the health care debate. Though proposals for some had widespread popular support. The reasons are fairly obvious. In the 1970s and through most of the 1980s, the most vulnerable in the country were likely covered by public plans. Middle class Canadians had insurance through their employers. And while Canadians may average 10 prescriptions per year per man, woman and child, the reality is that the vast majority of Canadians take or need very few prescription drugs on a regular basis. Most pharmaceuticals are consumed by a relatively small proportion of the population. In short there was little perception of a great need for a comprehensive

pharmacare program because the patchwork of programs (both public and private) provided most Canadians with relatively comprehensive coverage.

But as the cost of pharmaceuticals has increased and their use has expanded exponentially, employers have made their provision of coverage less generous, private insurers have increased premiums and governments have restricted access for those previously covered. Both the Romanow Commission and the Kirby Report paid considerable attention to the future role of prescription drugs within the health care system, noting that the cost of both public and private insurance for drugs was rising at a rate that many would consider to be unsustainable. Although the provincial and territorial governments have attempted to make a national pharmacare program a key element in their negotiations with Ottawa, there has been little or no reported progress on a national strategy to deal with pharmaceuticals.

This leaves provincial governments in something of a bind. As the cost of public drug plans rise, there will be increased pressur

> each covered prescription is set based on the relation between family income and eligible drug cost.
>
> Family Income Plan recipients, Saskatchewan Income Plan recipients, and Guaranteed Income Supplement recipients in special care homes [received] a semi-annual deductible of $100 then a co-payment of 35%.
>
> All other Guaranteed Income Supplement recipients [received] a semi-annual deductible of $200 then a co-payment of 35%.[1]

This study seeks to understand why such changes were made and the decision-making process followed. The data to inform the study was gathered from written work as well as nine key informant interviews. The informants came from various groups within Saskatchewan including: the Saskatchewan Pharmaceutical Association, individual pharmacists, members of the Canadian Council for Accreditation of Pharmacy Programs, members of the College of Physicians and Surgeons of Saskatchewan, members of the Saskatchewan Medical Association, Elected Officials and employees of Regional Health Authorities.

How did the changes come about?

Most of the participants in this study pointed to fiscal reasons as the main factor for such fundamental change in the drug plan. While participants were fairly diverse in terms of their backgrounds, the fiscal imperative was seen as the main reason for change on which most could agree. "Every year of course the drug plan escalated at a rate beyond what they thought it should, as a percentage, and then all of a sudden they just

> And it was quite an extraordinary time in terms that I think people in the province being braced for the fact that there was going to have to be some hardship, if you like, and that the only hope was that the hardship would be, you know, not disproportionately visited on people who could least afford it. And so I think as a matter of general policy, for instance, the College of Physicians and Surgeons has been unequivocally on the side of the fact that we prefer that to the extent possible, services be publicly funded, publicly governed and that you know, you be very careful not to put in place barriers that disadvantage people who are least able to afford health services.[5]

This was a true dilemma for government: how to create significant savings through cuts to the drug plan while making sure that the poor and medically indigent were still covered through the provincial plan. As one senior government official described it: "First of all we

> And so I guess no one was terribly surprised when the crunch came in terms of drug benefits because that's a service that is pretty unevenly insured across the country, and at the time Saskatchewan had a substantially more generous plan than many other provinces. An so if you were going to have to make some cuts somewhere, I guess it was not surprising that it came in that area.[8]

So " this was projected as really sort of bringing Saskatchewan more into line with policies in other provinces. And of that basis it's pretty hard to characterize it

throughout the entire process. The process, as described by this official, originated with budget analysts.

> It started through the budget analysts by departments, and then it went to Treasury Board. The Treasury Board made its recommendations; I would be informed on a straight step-by-step basis. There'd be a little bit of kickback and a bit of slippage on some of the policies based on political necessities. You would go to Treasury board to Cabinet, to Cabinet would have its retreat as I've described it to CIC. There was full revelation right across the piece, including caucus.[11]

Many of our participants noted that these decisions were driven by Treasury Board and Finance, rather than by the Health Department.

> There'll be little doubt that the Treasury Board and Finance had a significant impact but again these are the soul, they're the decision-making part of government. It's almost like a ghost or phantom, they never talk to us, we never see them. We just hear about them in terms of well the Treasury Board analyst, you know, has told us this or wants this from us and we're you know, we're asking for some help. But other than that they're basically phantoms.[12]

One participant, a government

So this policy came down from Treasury Board and Finance and was agreed on in the higher levels of government. The Health Department was not heavily involved in the decisions, nor was the formulary committee.

> involved in policy is] not really a role that the government sees of [the formulary] committee. So, I mean, that's the
>
> make comments on policy, make suggestions, and those are all taken back,
>
> Committee's[14] decision. Even on the inclusion of drugs into the formulary.[15]
>
> It must be noted that:
>
> there was a small minority of ministers, primarily led by the minister of Health, who felt that dramatic changes to the Pharmacare plan or the introduction of premiums, for that matter even the closure of 52 hospitals, was bad policy in terms of health and was politically going to be very ecame much larger and the debates became much more vocal and heated, and the votes sharpened up and very close. Actually at one point the votes in caucus, because we gave all of out budgetary actions to caucus and every detail for three days, with slide shows and the even agree to a budget.[16]

Why did it come about in the way that it did?

One of the study participants, affiliated with the Saskatchewan pharmaceutical industry, offered that the changes came about as they did because of a hefty dose of political philosophy.[17] "A move away from the universality of it to basically the social [18] The NDP under Romanow felt strongly about insuring that those who needed drug coverage the most were the ones who received it. Many participants noted that while the

---

[14] listing the drugs covered by the Pharmacare Plan which is then approved by the Minister of Health.
[15] 09DPSK.
[16] 07DPSK.
[17] 01DPSK.
[18] 01DPSK.

opposition to what we were doing."[24] The Saskatchewan Pharmaceutical Association, who one would think would be heavily involved with such changes, was not: "we didn't have many details in terms of what government was actually going to do but our understanding was that we were taking government at their word that those who needed drugs, they would have coverage."[25] The Pharmaceutical Association did not oppose such changes as they were very much in line with historical positions:

> ally our position was a publicly funded, publicly administered drug insurance program in
>
> that context we saw the prior structure of the drug plan as a bit rich and a bit excessive but still supported it because it was consistent with our overall position being yes, those who needed coverage were getting it, but those who didn't need coverage were also getting it.[26]

Participants from health professional organizations, such as the SMA, the Saskatchewan Union of Nurses (SUN), and the College of Physicians and Surgeons (CPSS), did not express dissatisfaction with the drug plan changes. Although the SMA was concerned about patients falling through the cracks, the group was not in opposition to the changes as a whole.

> In terms of the feedback we'd be given at the time, of any, and I'm not sure there was any discussion of feedback, but there was no philosophical objection to having a deductible. It was understood that that probably was required too, in terms of affordability. The original change that went from
>
> the observation we made at the time was this. We said our sense was that st dollar coverage created unrealistic demands and expectations by the patients. So the scenario was this. A patient comes in to get their drugs, I write a script and in the original plan the patient says, is that the best drug Doc? And I'd say yes, of yes, this is a good one. Are you sure? Yes. And I'm going to give you

[24] 07DPSK.
[25] 01DPSK.
[26] 01DPSK.

> 20 to try and we'll see how they work. Well, you might as well give me 50 because you know, what the heck.[27]

So the SMA thinking was in line with the SPA in that the last plan was a bit excessive and this one prevented people from using unneeded drugs.

A participant with nursing affiliations did not make mention of any driving campaign by that group against the changes. The participant from the CPSS gave much the same impression:

> I don't recall any official concern raised by the College and primarily for the reason that I mentioned that there was a feeling, you know, that to some extent the hand of government was forced and it had to cut back to some extent, or at least moderate the growth in health expenditures. And this was projected as really sort of bringing Saskatchewan more into line with policies in other provinces. And on that basis it's pretty hard to characterize it as . . . unreasonable.[28]

It is interesting that some participants mentioned the vehement protection of first dollar coverage for primary care. At the time that deductibles were changed to higher amounts, there were alternative policies under consideration.

> y when it was leaked by somebody from the caucus that we had premiums on the plate, not variables but straight premiums on the table. And in the light of the deficit situation and the feedback, the kickback from the public and the party was so enormous that that was abandoned.[29]

And then "the premium issue became a political issue amongst New Democrats and Democrats created an issue and the government wasn't prepared to move forward with that initiative and so premiums were not implemented in that first budget."[30] One

[27] 06DPSK.
[28] 05DPSK.
[29] 07DPSK.
[30] 10DPSK.

participant, associated with the accreditation body for pharmacy programs argued that there really were no feasible alternatives:

> the general sense was because

> I'm sure that percentage of people that are getting benefits from the correctly when I first got involved with pharmacy something like 22 percent of the people in our province were getting some kind of benefit in figure's really changed, but [it is] certainly more expensive.[34]

Given that the purpose of these policy changes was to save money, it must be noted that there was no consensus amongst our participants as to whether this goal was achieved. A staff member for an RHA remarked: "I honestly don't know if they saved as much as they expected to save. There was certainly some savings and I know that we were very surprised at the total number of people that were eligible or had

[35]

Conclusion

In the final analysis the changes to the drug plan had little if anything to do with health care per se. Inside government the entire decision making process around these changes were made at the behest of the Department of Finance and Treasury Board with relatively minimal input from the Department of Health. The one constant refrain

a matter of some debate, but the intention of the government seems relatively clear from the evidence collected. Though these same measures are likely the cause for the lack of significant long term cuts in total drug spending.

-

those within the government at the time that there was little choice but to implement significant budget cuts if the province was to stave off bankruptcy. As such, the

within a specific social program in order to alleviate the pressure

finances. What the SMA characterized as a fundamental contradiction within the

it as a harsh reality of

governing in bad times. And there is at least some evidence that support for the decision, especially within the Department of Health, was less than whole-hearted.

In some ways, the decision to make cuts to the drug program although accomplished with little public or stakeholder outcry represents a common thread that

low prices for its agricultural and natural resources), while the government and more importantly the governing party had a commitment to expand and extend the social democratic policies that it had long advocated. Throughout his three terms in office,

iscally

What seems evident in this particular case is that the provincial drug program got caught in a kind of political cross-fire. It was an expensive program with rising costs in a time when government finances were particularly shaky. The impacts of the cuts could be relatively isolated especially from a middle class backed up by private drug insurance and key stakeholder organizations, especially those with strong links to the governing party, would be unlikely to raise strong objections. In such a climate, the program became a relatively easy way for the government to reduce expenditures while not tampering too greatly with the overall structure of the health care system.