Glen Abernethy

From: Gay Kennedy
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Cc: Doug Schauerte; Lee Selleck
Subject: CBC item re Supp Benefits from Tuesday AM

As requested this am
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CBC Special Report, Tuesday, May 18, 2010, 7:40 a.m.

JOSLYN OOSENBRUG, CBC: Well the government's plan to change the Supplementary Health Care Program is being billed as a bit of a Robin Hood scenario, clawing back existing drugs, dental and eye care benefits from wealthier seniors in order to provide more benefits to people on lower incomes. Some provinces have recently made similar changes to their drug coverage plans, also known as Pharmacare. Steve Morgan is a health policy analyst at the University of British Columbia's Centre for Health Service and Policy Research and he joins me on the line from Vancouver. Good morning.

MORGAN: Good morning.

CBC: Now the Northwest Territories of course is not the only jurisdiction to move towards an income test for supplementary health benefits. What can you tell me about the pressures the governments are facing to make these kinds of changes?

MORGAN: I think one of the first things to mention is that the major driver of these changes, and they've occurred in provinces like British Columbia and Manitoba and elsewhere in Canada, the major driver is that the aging of the population has a particular impact on extended benefits that are based on seniors' programs, and the impact is that as soon as the baby boomers cross the age of 65 they become beneficiaries of the public program. Although that does not really change the overall cost of the system, so for instance, the Pharmacare program, the overall spending on pharmaceuticals doesn't actually suddenly go up because of the aging of the population. The fact that there's a sudden increase in people over the age of 65 makes a lot of the spending suddenly become public liability rather than private liability. So the main difference here is that you have a period, which we're just about to set into, where a lot of people are going to suddenly become beneficiaries of the age-based programs and that's the pressures the governments across Canada are trying to grapple with. How do you deal with that in a way that is sustainable and equitable?

CBC: And that's it and our Health Minister has certainly been arguing that this is a matter of equity, taking from rich seniors who can afford to pay for the drugs and moving the benefits over to poorer people in the Territory. What have you learned through your research about income-based coverages? Does it actually make the system more equitable?

MORGAN: Well in a very narrow sense of distributional equity of how the money is spread around, income-based programs can improve equity in terms of this sort of Robin Hood like metaphor. Now I'll use the example of British Columbia, which actually transitioned from an age-based pharmaceutical benefit, an age-based Pharmacare program to an income-based Pharmacare program, which they call, quite intentionally, Fair Pharmacare in British Columbia. What we found, and we studied this program in detail actually for several years, we found that there is a Robin Hood like scenario and that is you do see a significant decrease in the benefits that are provided to relatively wealthy senior citizens and presumably they'll take that up by either

paying for their drugs out of pocket, or maybe by having private insurance if they're so lucky. What we did not find in British Columbia was a significant increase in the spending on non-seniors care. So B.C. government, when they put this in place, took more money away than they put back into the system. So it was a bit as though someone was skimming off of the top of the Robin Hood metaphor. So we didn't find it as great a potential equity benefit as one would hope for, but one of the things that we've found, which we think people have not anticipated when thinking through these programs, is the impact on the aged and particularly the people with chronic disease. When you have an income-based program people have to pay for their drug costs below their deductibles, which are often hundreds, if not thousands of dollars. For people with relatively serious chronic disease, they pay those hundreds or thousands of dollars every year because they can expect that they're going to have those diseases basically every year until they die. So what we found through some of our work in British Columbia that there's an unanticipated distributional consequence, which quite frankly is quite negative because it does have the implication of in effect taxing the sick.

CBC: Seniors here are asking the government to actually keep the existing coverage and just add in the lower income brackets that aren't covered. Now it seems in principle that that would cost more, we don't actually have the numbers of how much that could cost, but are there arguments to be made in favour of that approach?

MORGAN: Yeah I think there are. I mean this is something that Canada has struggled with for, to be honest, probably 60 years and that is how do we make Pharmacare more like our Medicare system, more like our insurance for hospital care and physician services, and that is how do we get a system where everyone would be covered with a reasonable degree of comprehensiveness. The Romano Commission in 2002 actually recommended to all provinces and to the Canadian government that the seniors' programs in the country remain as a basic infrastructure of our Pharmacare programs in this country and then we would have layers of additional coverage onto that. So the argument that people are making in the Northwest Territories is consistent with arguments being made by fairly prominent commissions of inquiry. The challenge is trying to find the commitments to raise the money to do that in a way that is politically acceptable.

CBC: And that is it. So what are the ways that governments can use to keep control of costs while maintaining broad coverage?

MORGAN: Well there's a few and some of them include, which will sound paradoxical, but expanding coverage so that you do cover the entire population provides an opportunity for the government to act as a bulk purchaser of medicines. There are countries around the world that actually exercise the power of a single payer to negotiate prices with manufacturers, and right now in the pharmaceutical industry we're entering what you might call the era of the generic drug, an overwhelming majority of the block buster drugs from the last 20 years are now either off patent or about to lose their patents and, therefore, they'll be available with generic competition. Countries around the world, the best example of which is New Zealand, have used generics to be able to drive down prices to literally pennies on the dollar relative to what brand name drugs cost. So if you have a big single payer you can exercise basically buying power, governments can negotiate prices and actually make a more sustainable program overall. It's a catch 22 though and I'll add this refrain, we've heard this a number of times through the Pharmacare debates in Canada probably dating back for at least 30 years, and the catch 22 is no Pharmacare without cost control, not cost control without Pharmacare. So it's a question of chicken and egg I suppose.

CBC: What about here in the Northwest Territories with the small population, is that a reasonable prospect?

MORGAN: You know, I think it's an important issue and challenge what the Northwest Territories represents for pharmaceutical policy in Canada and I say this as someone who spends a lot of time working with provincial, territorial and federal governments, as well as with some of the federal drug programs talking through what are the major policy challenges in Canada and the number one cross cutting theme is a need for collaboration and coordination of our programs. In some sense, only a few provinces can go it alone and there

are the obvious ones, places like Ontario and Quebec, perhaps British Columbia where you have four or more million people. The Northwest Territories with a very small population with it's very unique challenge with respect to both distribution and health issues that need to be addressed in terms of the reality of jurisdictional, whose paying for what kind of medicines for which patients, there needs to be a mechanism for coordination and collaboration for jurisdictions to be able to basically confront those challenges. So I guess in short what I'm saying is that there are significant political challenges. I don't envy actually the state of your Health Minister in trying to weigh these out in trying to figure out what's best for the population, but it would be possible, I think, for a region like the Northwest Territories to collaborate maybe with Saskatchewan or Manitoba on a strategy that could jointly address the pharmaceutical challenges that both the province and the territory face.

CBC: Doctor Morgan, some very interesting ideas. Thank you so much for joining us this morning.

MORGAN: You're quite welcome.

CBC: That's Doctor Steve Morgan. He's a health policy analyst with the Centre for Health Services and Policy Research at the University of British Columbia.