

**Coping with Fiscal Crisis:  
Drug Plan Retrenchment in Saskatchewan  
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**Setting the stage – prescription drug insurance in Canada**

Access to prescription drugs in Canada is determined by a number of factors – in which province the person resides, employment status, age, and household income level. Though Canadians talk freely about the “universal” nature of the health care system, access to prescription drugs is not (for most Canadians) part of that universal system of care. And even in Quebec – to date the only province with a mandatory universal prescription drug insurance program – access is not “free” in the sense that access to doctor and hospital services are. That is, the cost of this insurance is not covered in its entirety through general revenue of the provincial governments.

Although the Hall Report (1964) that first called for a national health care insurance system advocated the inclusion of prescription drugs in its coverage, the Medical Care Act (1968) and the Canada Health Act (1985) both articulated a vision of health care centred on doctor and hospital services and left a number of medical services outside of Medicare’s orbit – dental care, eye care, home care, long-term care, etc. The rationale for the exclusion of these services from what has been termed the “core” of medicare or the original “medicare bargain” is rooted in the politics that surrounded the creation of medicare and in the nature of health care at the time of Medicare’s creation.

Opposition from some quarters – including from within the medical profession – pushed governments to be less ambitious in designing medicare than perhaps Medicare’s most ardent supporters would have liked. Doctor and hospital insurance was going to be hard enough to implement without widening its scope even further to include dentists,

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 development of medicare in Canada, made the “drug plan” a key collective bargaining issue such that comprehensive drug insurance (as well as dental insurance and other “extended health care” benefits) came to be seen an indicator of an individual having secured a good job. As the power of organized labour has declined and fewer Canadians

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 form of universal “pharmacare” program were floated from time to time, the issue never 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 pressure to contain these costs by limiting access either through deinsuring some classes of recipients or raising deductibles and co-payments. Yet as new drugs enter the marketplace governments are also under great pressure to add these drugs to the provincial drug formulary – which is the basis of most of the private and public drug insurance plans – which in turns drives up the cost of insurance plans.

But this is not necessarily a new problem for some provinces. Saskatchewan's plan, immediately after its inception in 1974, was one of the most generous plans in terms of having universal coverage for Saskatchewan residents. The *Prescription Drug Act* of 1974 laid the foundation for the program which included a fixed co-payment system: all

patients were charged a \$3.95 dispensing fee per prescription. Over time the plan grew to unsustainable cost levels and in 1987 changes were made in an attempt to offset increasing costs. Between 1987 and 1993 a number of incremental changes were made with the same goal. The exact numbers are outlined in Figure 1 below:

Year	Deductible (\$)			Co-Payment (%)		
	Regular Family	Senior Family	Single Senior	Regular Family	Senior Family	Single Senior
1987	125 (annual)	75 (annual)	50 (annual)	20	20	20
1991	125 (annual)	75 (annual)	50 (annual)	25	25	25
1992	190 (semi-annual)	75 (semi-annual)	50 (semi-annual)	35 to \$375 maximum, then 10.	35 to \$375 maximum, then 10.	35 to \$375 maximum, then 10.
1993*	850 (semi-annual)	850 (semi-annual)	850 (semi-annual)	35	35	35

\*In 1993, the drug plan changed so that anyone who does not qualify for special assistance must pay the above deductible and co-payment.

(Figure 1)

This project deals with the series of changes carried out between 1991 and 1993. In 1993, the drug plan saw a fundamental change as programs were incorporated to give more affordable coverage to lower-income beneficiaries. At this time, the Drug Plan also saw increased deductibles and co-payments for “regular” families and individuals that were deemed to be able to better afford prescription drugs. According to Saskatchewan’s Drug Plan and Extended Benefits Branch, 1993 was the year that:

- Families became eligible for the Special Support Program, where families and the Drug Plan share the cost of prescriptions if the cost for covered drugs exceeds 3.4% of the family income. The family co-payment for

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%.<sup>1</sup>

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 started toying with...deductibles to the point now...there basically is no deductible."<sup>2</sup>

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<sup>1</sup> Saskatchewan Health. "Annual Statistical Report: Drug Plan and Extended Benefits Branch." 2001-2002.

<sup>2</sup> 03DPSK.

One participant acknowledged that government saw a trend in the escalation of drug plan costs that would not cease if there was no action taken "and [they] felt that fiscally they weren't going to be able to afford the drug plan that they had in place. I think it was purely...cost, cost containment or cost management."<sup>3</sup>

Not only were the changes based on the escalating costs of the drug plan, but also the province was in a tight fiscal situation. To get the full picture, one must look at the historical context. The change of government in 1991 from the Conservative Party to the New Democratic Party (NDP) revealed that Saskatchewan had a large and almost unmanageable deficit. Saskatchewan also had a less-than-acceptable credit rating and was on the verge of admitting bankruptcy and needing to accept a federal government handout. "In fact when Roy Romanow took over in '91 the province was on the verge of bankruptcy, and the federal government was considering stepping in to save us from that fate. But through very-very tight budget measures, that was averted; we averted the ignominy of bankruptcy for a province which had never happened in Canada."<sup>4</sup> The tight budget measures included, along with other cuts, cuts to the drug plan in the area of thirty-two million dollars. The proposed drug plan cuts would produce significant enough savings to enable government to net thirty million dollars in savings per year out of a fifty million dollar goal.

While the health system at this time was undergoing major structural reform with the inception of health districts and a new, "wellness," approach to care, the drug plan changes were the only significant changes characterized almost completely as cost-driven measures.

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<sup>3</sup> 06DPSK.

<sup>4</sup> 08DPSK.\*

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.<sup>5</sup>

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 needed to realize savings for deficit reduction. Secondly if we were going to do that we had to protect low income families and we had to protect people who suffered catastrophic situations."<sup>6</sup>

Basically we try to keep our eye on the people that have the highest needs, the highest cost, and the lowest income are the people we want to make sure get their drugs. You don't want people to not take the drugs because they can't afford it; we never want that to be what you consider when you think about taking drugs.<sup>7</sup>

Furthermore, most middle-class Saskatchewan citizens have private drug coverage provided through their employer and are not in need of the provincial plan. This thinking was not only adhered to by the government of the day, but most interest groups also recognized the need to protect coverage for those who needed it most.

The emphasis on the poor and medically indigent stemmed from a knowledge that Saskatchewan's drug plan was one of the, if not the, most generous drug plan in the country at the time.

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<sup>5</sup> 05DPSK.

<sup>6</sup> 10DPSK.

<sup>7</sup> 08DPSK\*.



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.<sup>8</sup>

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 as...unreasonable."<sup>9</sup>

So towards these ends, government eventually created a plan that had programs for citizens who needed drugs but could not afford them such as the Special Support Program and plans for people on various Income Supplement programs. For the rest of population, who most likely had prescription drug coverage through their employer and did not need the provincial coverage, the plan was scaled back to the point of a rather large deductible.

And therefore there's coverage for folks who can't afford it. So you have sort of first dollar coverage for people on welfare and you have a very high level deductible for people who maybe can afford it. So there...I mean the decision to make changes and basically increase the level of the deductible was purely a fiscal decision, but the changes that were introduced were probably introduced to also improve the equity in the system on the assumption that it's not fair that everybody pay that much and therefore you need to protect the weakest, so to speak, or the poorest. So I think there was some effort to make it more equitable.<sup>10</sup>

### **How did this come about the way that it did?**

Even though the changes were agreed upon at the highest levels of government, one government official told us that proper decision-making procedures were following

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<sup>8</sup> 05DPSK.

<sup>9</sup> 05DPSK.

<sup>10</sup> 06DPSK.

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.<sup>11</sup>

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.<sup>12</sup>

One participant, a government official during the time of the changes, noted the process as this:

There was one Treasury Board session which we had in the CIC boardroom where Louise Simard, as the Minister of Health, presented a set of notes which she had in from of her arguing against all of these cutbacks that we're talking about. And this was a very heated moment and I must say I overreacted in my response and anger because we had already gone through the Treasury Board...and the whole routine was cabinet finalization at CIC, I actually asked (Duane) Adams (the Deputy Minister of Health) to come to our budget finalization, which he did/ And he underwent about three hours of cross-examination by me on all the arguments that couldn't take place, you could see where the relationships were.<sup>13</sup>

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<sup>11</sup> 07DPSK.

<sup>12</sup> 01DPSK.

<sup>13</sup> 07DPSK.

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.

It's very clear...that [being involved in policy is] not really a role that the government sees of [the formulary] committee. So, I mean, that's the way...the policy is that we're free at the meetings as part of our agenda to make comments on policy, make suggestions, and those are all taken back, but...it's the Health Minister's decision and it's not the Formulary Committee's<sup>14</sup> decision. Even on the inclusion of drugs into the formulary.<sup>15</sup>

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 destructive... Within caucus that minority became 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 our budgetary actions to caucus and every detail for three days, with slide shows and the like, at one point we couldn't even agree to a budget.<sup>16</sup>

### **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.<sup>17</sup> "A move away from the universality of it to basically the social benefits of the program...seemed consistent with the party in power at the time."<sup>18</sup> 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

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<sup>14</sup> The Formulary Committee's key responsibility is the creation of the annual Saskatchewan Formulary listing the drugs covered by the Pharmacare Plan which is then approved by the Minister of Health.

<sup>15</sup> 09DPSK.

<sup>16</sup> 07DPSK.

<sup>17</sup> 01DPSK.

<sup>18</sup> 01DPSK.

government recognized that something had to be done in terms of cost-saving measures, the necessity to cover needy populations outweighed any cost-cutting efforts.

I think the financial aspects were certainly there, you know, the fact that the drug costs were out of control and something needed to be done. You know the thing that I remember most about it was the actual...it was very prominent the fact that this was for...this was for the regular population and that there would be special things put in place for people who couldn't manage...weren't feeling comfortable with this co-payment. I mean, I think that's, you know, a PR thing, but I mean that was an important part of it too is that it...you know they were making provisions for people who...with high drug costs and low income and that sort of thing.<sup>19</sup>

Another reason suggested for the changes to the drug plan was the goal of optimal prescribing. While not a main factor in the decision-making machine, it was mentioned by some participants as a probable secondary reason as "we [were] not recognizing sort of optimal drug therapy as really an investment in health care rather than a drug driving the cost of the system."<sup>20</sup> To this end, the government set up a utilization committee to explore these issues and "how to more effectively increase the knowledge of patients and also the prescribing physicians about the costs as far as medications were concerned and about the various aspects so that... medications wouldn't be wasted and the best use"<sup>21</sup> would be considered.

One participant, a member of the Saskatchewan Medical Association (SMA) pointed out an interesting dynamic in the debate around coverage for one segment of the population versus another.

It seemed interesting to me...that on one day on the left hand they're saying absolutely must have first dollar coverage on doctor and hospital care because of the equity concerns etc, and nobody should go without that they can't pay etc, and a half hour later when we're talking about drugs

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<sup>19</sup> 09DPSK.

<sup>20</sup> 01DPSK.

<sup>21</sup> 02DPSK.

which keep people alive, no concern about a deductible and potential hardships.<sup>22</sup>

So I thought, and I still to this day find it interesting that at the same time that one can sort of ideologically defend first dollar coverage for doctor and hospital care, say there ought never to be, you know, sort of a user pay or deductibles or any kind of patient payment for doctor and hospital care those same people, many of them seemed to find no real difficulty with supporting for reasons of sustainability etc, a deductible, a fairly significant one, for drugs. Which one could argue is probably as important in keeping folks alive today as doctors.<sup>23</sup>

While government did set up various programs to aid with high costs of drugs for those who could not pay (such as the Special Support Program outlines above), the SMA was concerned about the apparent contradiction on the issue of universality. At the same time, the SMA has, historically, had a contentious relationship with medicare.

It was also apparent that the decision to cut the drug program was done with very little in the way of consultation outside of government. To the extent that the changes were driven inside the government by central agencies (i.e. Treasury Board and the Department of Finance), it was also done as part of a very traditional budget making process whereby few if any outside bodies were given an opportunity to weigh in on the issue. In retrospect, however, none of the stakeholder groups interviewed noted any particular objections to the changes that were made – recognizing the fiscal limitations of the government.

The limited opposition created by the SMA on this issue did not find support with other interests groups in the province. While no interest groups had a role in creating the policy, none came out with strong opposition. As one government official stated: "there is nothing that sticks out in my mind as a defining rally, a defining campaign in

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<sup>22</sup> 06DPSK.

<sup>23</sup> 06DPSK.

opposition to what we were doing."<sup>24</sup> 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."<sup>25</sup> The Pharmaceutical Association did not oppose such changes as they were very much in line with historical positions:

It was pretty consistent with our policy. Our...historically our position was a publicly funded, publicly administered drug insurance program in particular for those who need the drugs. And you know we...I guess 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.<sup>26</sup>

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 sort of almost first dollar coverage to a deductible, we didn't oppose...And the observation we made at the time was this. We said our sense was that the drug...the original drug plan with first 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

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<sup>24</sup> 07DPSK.

<sup>25</sup> 01DPSK.

<sup>26</sup> 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.<sup>27</sup>

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.<sup>28</sup>

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.

we had premiums under consideration at one point...and only 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.<sup>29</sup>

And then "the premium issue became a political issue amongst New Democrats and they...when they got wind that the government might be looking at premiums, the New 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."<sup>30</sup> One

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<sup>27</sup> 06DPSK.

<sup>28</sup> 05DPSK.

<sup>29</sup> 07DPSK.

<sup>30</sup> 10DPSK.

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

the general sense was because of increasing costs, what are the alternatives? What approaches can be used in order to...continue a drug program that is basically universal...And from that perspective I think there were various alternatives. They looked at what some of the other provinces were doing, they looked at some of the other countries I think, you know in a general sense and not in great detail. But I think when they came back with the okay we'll go a deductible and 35 percent co-payments that was a big...certainly a big decision to make. But that seemed to be the most effective way of at least providing for those people in greatest need and for the rest of us...it was help.<sup>31</sup>

### **Policy Outcomes**

In the overall scheme of things, the changes to the drug plan in the early 1990s really had little effect on the usage of prescription drugs. "I mean when the deductible system came in there was a...30 or 33 percent drop in prescription volume, but within weeks it came right back up to prechange levels and then it's continued to climb."<sup>32</sup> So while the changes created an initial drop, drug costs to the province have since surpassed 93 cost levels. This does beg the question of whether the cuts, proposed to save millions of dollars, actually achieved that goal.

What we saw...is that folks would find ways to get their drugs...There was a lot of different things happening out there. Most focused on the least cost options, you know, what can I do to get the cheapest drug therapy that's available out there. And so we saw...some shifts in terms of loyalty from the costly high dispensing fee pharmacies to some different pharmacies. And so there were little shifts you know.<sup>33</sup>

A Pharmacist in the province suggested that perhaps there were not that many changes in terms of covered population as one might think:

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<sup>31</sup> 02DPSK.

<sup>32</sup> 01DPSK.

<sup>33</sup> 01DPSK.



I'm sure that percentage of people that are getting benefits from the government are no different that they were forty years ago...if I remember 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 terms of drugs, whether it be through welfare...I don't know that that figure's really changed, but [it is] certainly more expensive.<sup>34</sup>

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 actually...made access to the low income, high drug costs kind of program."<sup>35</sup>

## **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 throughout the interviews was that the changes to the drug plan were, first and foremost, about reducing government expenditure in a fiscally perilous time.

The government of the day was newly elected, with few members of the caucus or cabinet with government experience. The fiscal situation of the province has been described as being "close to bankruptcy" as a result of unchecked spending by the previous administration and a general downturn in the economy of the nation as a whole. In this sense, the drug plan was an expensive program which in itself had been

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<sup>34</sup> 03DPSK.

<sup>35</sup> 09DPSK.

experiencing significant cost increases, which served to draw the attention of those forces within the government looking for areas where expenditures could be cut.

At the same time, given the manner in which prescription drugs are or are not integrated into the overall health care system, the government drug program may well have been an easier target for budget cutters. Insofar as the majority of middle class residents of the province had private drug insurance through their employers and the consumption of prescription drugs is highly skewed to specific populations, it is quite likely that the cuts to the program would not, in numerical terms, effect large numbers of people. Most residents would not be immediately affected by making the program less generous.

But the changes clearly posed something of a dilemma for the government. It inherited a fiscal crisis from the previous administration that it could not ignore and, like most social democratic governments in the country, would have been under significant scrutiny about its 'fiscal prudence'. Ironically, the province's fiscal problems were the result of the Conservative government's lack of expenditure control, whereas the Saskatchewan NDP has traditionally been relatively sound fiscal stewards for the province. For example, the Douglas government delayed implementation of full health insurance until the federal government's agreement to subsidize hospital insurance in 1957 freed up the necessary resources for the province to move into medical insurance.

But whatever the state of the province's finances, this was still a social democratic government with a commitment to protect the most vulnerable members of society. Hence the cuts were made with some consideration to mitigating the negative effects on those likely to be the hardest hit by the changes. Whether these were successful or not is

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.

While it can be seen as a ‘post-facto’ justification, there was a clear sense from 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 government’s commitment to universality within social spending was compromised within a specific social program in order to alleviate the pressure on the government’s finances. What the SMA characterized as a fundamental contradiction within the governing party’s philosophy, the government itself characterized 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 ran through much of the Romanow NDP’s nearly ten years in office. On the one hand, Saskatchewan’s economy was particularly vulnerable to forces beyond its control (e.g. 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, Romanow would consistently be confronted with the tension between what was ‘fiscally prudent’ and the party’s desire to expand social services and social protection. The government’s greatest challenge was finding some way of trying to do both.

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.