

Cost Impact Study

of a

National Pharmacare Program for Canada

September 2002

An Update to the 1997 Report

Palmer D'Angelo Consulting Inc. is a Canadian based consulting firm that conducts economic and policy research into the pricing and reimbursement of pharmaceuticals and biopharmaceuticals in Canada, the United States and Europe.

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HIGHLIGHTS

- Total prescription drug expenditures in 2001 are estimated to be \$12.3 billion with 45% (\$5.5 billion) funded by provincial drug plans.
- Private spending is calculated to have been just under \$6.8 billion, with private insurers accounting for almost \$3.7 billion and individuals (insured and uninsured) for \$3.1 billion.
- Approximately 10% of Canadians have no form of insurance whatsoever and must therefore pay for all their prescription medications. Their prescribed drug expenses account for about 6.4% of total prescription drug expenditures.
- Under a fully funded, comprehensive, publicly administered, national pharmacare program, public expenditure on prescribed drugs would increase by approximately \$8.1 billion.
- Other publicly administered pharmacare models (with typical levels of co-payments or with patients paying the dispensing fee) would entail increases in public expenditures ranging from \$4.6 billion to \$5.3 billion.
- A national pharmacare program with high annual deductibles and co-payments, designed to minimize cost by limiting coverage to those with high expenditures would increase individuals' expenditures by approximately 10.9% or \$338.6 million. On the other hand, public expenditures would decrease by 4.5%.
- Many of the current extended health care benefit plans may no longer be viable or premiums may have to be increased dramatically to make them viable if private drug plans are eliminated.
- Public/private plans have considerably less impact on the public purse than the public only plans. Public costs decrease by 1.5% or almost \$0.1 billion under a model similar to the current plan in Quebec while a model providing first dollar coverage increases public costs by almost \$3.5 billion.
- At the national level, perhaps the greatest need is to identify population groups that lack drug benefit coverage or that have inadequate coverage and propose ways in which coverage can be introduced or enhanced.

1.0 INTRODUCTION

The purpose of this study is to estimate the cost of funding a national pharmacare program in Canada. This research updates the previous study conducted in 1997 and considers additional aspects of a national pharmacare program, including an international overview and the roles existing Canadian agencies might play.

2.0 BACKGROUND

2.1 The Call for a National Pharmacare Program

Currently, Canadian seniors, individuals on social assistance and those residing in long-term care facilities have access to publicly funded prescription medicines. In addition, many provinces provide assistance to Canadians that spend a high proportion of their incomes on prescription drugs and may offer assistance for patients in certain disease groups (e.g., HIV/AIDS). There are also many working Canadians who receive prescription drug coverage through one of the various private insurers under an employer sponsored health plan. Some Canadians have no coverage at all. In general, almost all patients have to pay a certain proportion of their drug costs (outside of hospitals) which could result in considerable out-of-pocket expenses. Between 1991 and 2001, an average of 55%² of prescribed drug expenditures were funded by private payers (including non-government insurers and out-of-pocket spending by patients). Drugs provided in a hospital setting are considered medically necessary services under the Canada Health Act and are covered under provincial health plans. However, there is a growing shift toward outpatient treatment for many conditions which previously required hospitalization. Coverage provided for drugs prescribed on an outpatient basis varies from province to province. The gaps and inconsistencies in coverage under the present system have led many to call for the extension of public health insurance to include universal prescription drug coverage.

The Commission on the Future of Health Care in Canada (the “Romanow Commission”), launched on April 2001, has a mandate to:

...recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment.³

² National Health Expenditure Database; Canadian Institute for Health Information. For purposes of this study, Quebec's Drug Insurance Funds were treated as out-of-pocket expenses. National Health Expenditure Database; Canadian Institute for Health Information

³ <http://www.healthcarecommission.ca/default.asp?DN=cn=131.cn=7.cn=2.ou=Stories.ou=Suite247.o=HCC>; Commission on the Future of Health Care in Canada website

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The Commission is currently examining many aspects of the Canadian health care system. One of the issues it will be examining through “partner organizations” will be whether a national pharmacare program is needed and affordable (see appendix A).

It is anticipated that the review of this issue will consider the report of the National Forum on Health (February 1997) that recommended:

Because pharmaceuticals are medically necessary and public financing is the only reasonable way to promote universal access and to control costs, we believe Canada should take the necessary steps to include drugs as part of its publicly funded health care system.

That pharmaceutical payment policy in Canada be guided by the goals of:

- equity of access;
- improved prescribing appropriateness; and
- cost-containment;

and that to these ends the Canadian federal-provincial health insurance system move toward integration of prescription drugs as a fully funded component of publicly funded health care.⁴

In its report on the review of C-91, the House of Commons Standing Committee on Industry highlighted the testimony of numerous witnesses who endorse the findings of the National Forum on Health with regard to the establishment of a national pharmacare program. The Committee recommended that:

Because pharmaceutical products are medically necessary, the Committee believes steps should be taken to investigate the feasibility of a national pharmacare program. While the overwhelming majority of Canadians are presently covered by some form of public or private insurance, we must recognize the needs of those who are not. The Committee has heard the testimony of dozens of witnesses who cited the rising costs of pharmaceutical products and insisted that the Committee take action to follow the recommendations of the National Forum on Health.⁵

While the notion of a national pharmacare program may be desirable to many Canadians, its implementation would require the cooperation of the provinces. Moreover, according to the Canadian Institute for Health Information (CIHI), around 30% of prescription drug expenditures are funded through non-government insurance plans. Clearly, resistance to a publicly run national plan can be expected from private insurers and pharmacy benefit managers who now process claims and manage drug benefits for employer-sponsored plans. Finally, funding would have to be provided for such a program. This could be obtained from tax revenues, payroll taxes, premiums, deductibles and co-payments.

⁴ Canada Health Action: Building on the Legacy; Synthesis Reports and Issues Papers, National Forum on Health.

⁵ Review of Section 14 of the Patent Act Amendment Act 1992 (Chapter 2, Statutes of Canada, 1993); Fifth Report of the Standing Committee on Industry, April 1997.

2.2 Current Prescription Drug Expenditures

Drug costs are the fastest growing and second largest component of Canadian health expenditures, surpassing physician services in 1997 for the first time since the mid-1970s⁶. Each year the Canadian Institute for Health Information (CIHI) publishes estimates of drug expenditures from its National Health Expenditure Database. Total drug expenditure in 2001 was forecast by CIHI to be \$15.02 billion. However, this category not only includes prescription drugs but also non-prescription drugs and personal health supplies (e.g., bandages, condoms, etc.). In 2001, the share of prescribed drugs was estimated to have been \$12.3 billion or 79.1% of the total. The remaining \$3.25 billion is made up of non-prescribed or over-the-counter drugs (OTCs) and personal health supplies. Detailed information for 1995 to 1999 with CIHI forecasts for 2000 and 2001 at the aggregate level is shown in Table 2.1. It should be noted that CIHI data reflect retail consumption of pharmaceuticals and therefore the figures presented in this study will differ from the factory gate sales published by Statistics Canada, the Patented Medicine Prices Review Board (PMPRB) and IMS Canada. In particular, CIHI totals include wholesale and retail mark-ups as well as dispensing fees.

Table 2.1

Expenditure on Drugs by Type, by Source of Finance, and as a Share of Public, Private and Total Health Expenditures, Canada, 1995 – 2001

Year	Prescribed Drugs	Over the Counter Drugs	Personal Health Supplies	Total
\$ millions				
1995	7,295.60	1,389.40	1,314.20	9,999.20
1996	7,486.60	1,417.20	1,338.80	10,242.60
1997	8,400.30	1,469.90	1,407.60	11,277.80
1998	9,306.50	1,557.30	1,509.70	12,373.50
1999	10,106.80	1,640.70	1,575.20	13,322.60
2000 f	11,121.10	1,637.70	1,553.60	14,312.40
2001 f	12,303.10	1,665.50	1,581.20	15,549.80

source: Canadian Institute for Health Information (CIHI)

This study focuses on the \$12.3 billion of prescription drug costs and the impact a national pharmacare program would have on these expenditures.

⁶ Drug Prices and Cost Drivers 1990 –1997; F/P/T Task Force on Pharmaceutical Prices.

2.3 Who Pays for Drugs Now

With the exception of drugs dispensed for patients receiving hospital care, there is no national insurance program to ensure universal access for prescription medicines. Unlike hospital and medical care, which are publicly financed, multiple payers are involved in the financing of prescribed drugs, including federal, provincial and territorial governments, private insurers and individual consumers.

According to the Health Canada study, *Canadians' Access to Insurance for Prescription Medicines*, approximately 10% of Canadians have no form of insurance whatsoever and must therefore pay for all their prescription medications. About 52% are covered by private insurers either through employer-sponsored drug plans or individual drug insurance plans. The rest are covered by provincial plans. Currently, all provinces have plans that provide coverage to social assistance recipients, long-term care residents and seniors aged 65 and over (with the exception of Newfoundland and New Brunswick, which provide coverage to seniors only if they are Guaranteed Income Supplement recipients). Some provinces have plans that pay for prescription drugs required to treat patients with certain chronic diseases such as Ontario's Special Drugs Program. BC, Alberta, Saskatchewan, Manitoba and Quebec have plans that provide some sort of coverage for all their residents. Quebec's Prescription Drug Insurance Plan is unique in that it provides obligatory basic coverage for all Quebecers through a combination of public and private funding.

Most provinces require residents to contribute part of the cost by paying deductibles, co-payments or premiums. Some of these plans have very high deductibles which effectively exclude individuals with low drug costs. In BC, the annual deductible is \$1,000 for Plan E patients (see Appendix B for a detailed description of each of the provincial plans) with a 30% co-payment thereafter and an annual maximum individual contribution of \$2,000. Saskatchewan has recently changed its plan by replacing the \$850 semi-annual deductible with a new threshold based on drug costs as a percentage of income.⁷ A 35% co-payment is also required. In Ontario, deductibles and co-payments are lower, but benefits are limited to seniors, social assistance recipients and those with high drug costs relative to income. Seniors pay an annual deductible of \$100 along with a small co-payment per prescription while individuals with high drug costs pay an annual deductible of approximately 4% of their annual household net income. There are no deductibles in the Maritime provinces, while there may be co-payments and premiums.

⁷ On July 1, 2002, the semi-annual deductible in Saskatchewan was eliminated and replaced with a cost as a % of income based program, the Drug Plan for Special Support. As no claims experience based on the revised plan is available on which to build a new model, the earlier plan is used as the basis for Model 4 in this report.

Table 2.2

Prescription Drug Expenditure 2001*

	\$ millions	% distribution
Public Plan Expenditures (less co-pays and deductibles)	5,525.60	44.91%
Private Plan Expenditures (less co-pays and deductibles)	3,682.36	29.93%
Individuals		
Co-payments and Deductibles	2,104.06	17.10%
Uninsured Individuals	782.74	6.36%
Other Out-of-Pocket Expenses	208.24	1.69%
Total Rx Drug Costs	12,303.00	100.00%

* Forecast figures.

As illustrated in the table above, about 45% of total prescription drug costs are funded by provincial and federal drug plans. Private plans account for almost 30% of total prescription drug costs while individuals are responsible for the remaining 25%. Individuals' expenditures are a result of co-payments and deductibles, non-eligible expenses as well as a complete lack of insurance. Total co-payments and deductibles represent over 17% of total prescription drug costs. Public plan co-payments average about 25%⁸ of their total prescription drug expenditures while those of private plans are estimated to be about 8%⁹ of total prescription cost. Table 2.2 also illustrates our estimates of other out-of-pocket expenditures totaling almost 1.7% which include expenses for drugs not included on provincial or private formularies as well as for brand upgrades.

According to the Health Canada study, *Canadians' Access to Insurance for Prescription Medicines*, 10% of Canadians are not covered by prescription drug insurance. We have estimated that these individuals pay for approximately 6.4% of the total prescription drug costs in Canada. These figures are based on the assumption that these individuals are all under 65 years of age and would therefore have a lower than average annual per capita drug cost.

⁸ Survey of provincial drug benefit programs.

⁹ ESRx Essential Research

3.0 METHODS

3.1 Scope

The study quantifies the total and incremental costs to government of funding a national pharmacare program. The study does not consider the political feasibility or probability of a national program as these issues are beyond the scope of this study. However, the study considers a variety of models, some of which may be more attractive to the provinces than others. The study also considers the impact of a national pharmacare program on private payers and what role they could play under national pharmacare.

3.2 Assumptions

The basic assumption is that a national pharmacare program would meet all the criteria of the National Health Act:

- 1) universal
- 2) accessible
- 3) comprehensive
- 4) portable
- 5) publicly administered

For purposes of the analysis, it is assumed that all prescription drugs are “medically necessary” although in practice there may be some that are not (e.g., products for cosmetic use). Similarly, it assumes that non-prescription drugs are not “medically necessary” although some clearly are (e.g., insulin, pre-natal vitamins, iron therapy for anemia). These inconsistencies should not alter the overall conclusions of the study at the global level and to a large extent the inclusion of medically unnecessary prescription drugs should offset the exclusion of the medically necessary non-prescription drugs.

This study assumes that a publicly funded drug plan would cover all prescription drugs with few limitations. In practice, it is likely that some type of formulary or negative list would be implemented and that access to some drugs would be limited in an effort to control costs. This is the situation now under provincial plans. Any limitations on coverage under the public plan would mean that private extended health plans and individuals would still pay for some prescription drug costs.

It is assumed that generic substitution would continue to be mandated under national pharmacare for products that are considered interchangeable. Expenditures by hospitals on drugs are already covered under provincial health insurance programs and therefore these costs are not included in the analysis.

Some studies have indicated that consumption of prescription drugs decreases as a consequence of the introduction of co-payments and deductibles. We have assumed that the

reverse would also be true. For the purposes of this study it is assumed that a 10%¹⁰ increase in consumption will occur as a result of the removal of co-payments and deductibles. Likewise, offering insurance to individuals who have no coverage for prescription drugs will also result in a 10% increase in consumption. These figures are not inconsistent with studies that have evaluated the impact of drug plan cost sharing on consumption and utilization. For example Tamblyn et al., found that the introduction of cost sharing on the Quebec drug plan decreased utilization of essential drugs by 9% to 14% and non-essential drugs by 15% to 22%.

3.3 Data Limitations

The various models of a national pharmacare plan in this report are based on provincial drug program data from all provinces except Newfoundland and PEI. The total figures for current prescription drug expenditures were then estimated based on information provided by the Canadian Institute for Health Information (CIHI). CIHI does not provide provincial level insurance data due to confidentiality; hence, we estimated provincial level insurance and out-of-pocket expenditures based on the total private prescribed drug expenditures that CIHI does provide for each province. It should also be noted that CIHI numbers include expenditures from federal drug programs and the Workers' Compensation Board.

Since the provincial drug program information from the other provinces are based on calendar year 2001 figures while information from Alberta, Saskatchewan and Manitoba are for fiscal year April 2000 to March 2001, we estimated these three provinces' 2001 figures (calendar year) using data from the other provinces' previous fiscal years.

3.4 Information Sources

A brief one-page questionnaire was sent to all provinces requesting basic cost information regarding their provincial drug plans. This data is essential to determining the level of coverage in each province, the number of beneficiaries, co-payments and deductibles, as well as total drug plan payment and total program cost.

Other data sources include:

- Canadian Institute for Health Information
- Statistics Canada
- IMS Health
- Provincial Drug Plans / Ministries of Health
- ESRx Essential Research
- Health Canada
- OECD

¹⁰ Smith DG, "The effect of co-payments and generic substitution on the use and costs of prescription drugs", *Inquiry*, Summer 1993

4.0 FORMULATION OF THE MODEL

The first step was to build a complete-coverage model for Canada updating the basic model that was developed for the 1997 study. The current expenditures of each of the provincial plans¹¹ were examined and expanded to estimate the required expenditure for coverage of each province's population. This estimate takes into consideration, where available, current provincial expenditures by age and sex. Information on private insurers' expenditures were also included to the extent possible in an attempt to counteract the skewing effect of provincial expenditures which include, for the most part, only drug expenditures for seniors and those on social assistance.

Once the basic model was developed, it was possible to generate seven national pharmacare models starting with a fully funded public system. The other models were developed to show the impact in cost achieved by adjusting variables such as adding a deductible scheme, providing coverage of the drug component at the retail level only (i.e., pharmacist fee paid by the patient), and using both public and private insurers similar to Quebec.

The study also considers some of the models of "national" drug programs in place in other countries (e.g., UK, France, Sweden, Australia, etc.). In addition, the study takes into account some of the current initiatives underway by Health Canada and the FPT task forces such as the proposals for a common drug review and promotion of best practices in prescribing and utilization. Recommendations from provincial program reviews (e.g., Reference Drug Program in BC, Montmarquette Committee in Quebec) were taken into account in the analysis.

The following table outlines the framework of the basic model using the drug expenditures for 2001 as reported by CIHI. It is divided into four sections with the first providing breakdowns of drug costs and pharmacist fees, inclusive of co-payments and deductibles. The second section summarizes the estimates of co-payments and deductibles that were included in the public and private drug plan costs. Co-payments covered by private plans under the public only models are included in this section and not the first to avoid double counting. The third section provides the totals for drug costs and professional fees and the fourth section summarizes the sources of funds (public plan, private plan, individuals).

¹¹ Excludes Newfoundland and PEI.

Table 4.0
Basic Model. Prescription Drug Expenditures, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	6,001.7	48.8%
Pharmacist Fees	1,307.8	10.6%
Private Plan Rx Drug Costs		
Rx Drug Cost	3,442.2	28.0%
Pharmacist Fees	560.4	4.6%
Individuals with no coverage		
Rx Drug Cost	673.2	5.5%
Pharmacist Fees	109.6	0.9%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.5%
Pharmacist Fees	29.2	0.2%
Total	12,303.0	100.0%
II. Co-Payments & Deductibles		
Public Plans	1,783.9	14.5%
Private Plans	320.2	2.6%
Total	2,104.1	17.1%
III. Total Expenditures		
Total Rx Drug Costs	10,296.1	83.7%
Total Pharmacist Fees	2,006.9	16.3%
IV. Source of Funds		
Public Plans	5,525.6	44.9%
Private Plans	3,682.4	29.9%
Individuals	3,095.0	25.2%

Definition of terms:

- Rx Drug Costs – Drug material cost includes wholesale or retail mark-ups where applicable.
- Pharmacist Fees – Flat fees charged by the pharmacist for dispensing prescription medication.
- Co-Payments and Deductibles – Co-payments are the portion of the prescription cost the beneficiary has to pay when a prescription drug is purchased. Deductibles are the amount of covered expenses that must be incurred and paid for by the beneficiary before benefits become payable by the insurer.
- Other Out-of-Pocket Expenses – Include expenses for drugs ineligible for public or private drug benefit plans, brand upgrades or claims that were not submitted.

This basic model demonstrates that pharmacist fees in public plans represent a larger proportion of total prescription costs than in private plans. 2001 expenditure data provided by the provincial plans and private plan data provided by ESRx Essential Research, reveal that pharmacist fees account for 18% of total prescription costs of public plans and 14% of private plan prescription costs. These proportions are maintained throughout all the models.

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4.1 Model 1. Comprehensive Pharmacare

This model is the comprehensive, publicly funded, universal pharmacare model proposed by the National Forum on Health.

Assumptions:

- universal coverage, federally administered
- first dollar coverage (no deductibles or co-payments)
- removal of co-pays and deductibles increase consumption by 10% for those previously insured
- those previously uninsured increase consumption by 20%

Table 4.1 Model 1. Comprehensive Pharmacare, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	11,196.1	80.9%
Pharmacist Fees	2,439.7	17.6%
Private Plan Rx Cost		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.3%
Pharmacist Fees	29.2	0.2%
Total	13,844.0	100.0%
II. Co-Payments & Deductibles		
Public Plans	0.0	0.0%
Private Plans	0.0	0.0%
Total	0.0	0.0%
III. Total Expenditures		
Total Rx Drug Costs	11,375.1	82.2%
Total Pharmacist Fees	2,468.8	17.8%
IV. Source of Funds		
Public Plans	13,635.7	98.5%
Private Plans	0.0	0.0%
Individuals	208.2	1.5%

Results:

- ◆ Total expenditures increase by 12.53% (+ \$1,540 million)
- ◆ Public plan expenditures increase by 146.8% (+ \$8,110 million)
- ◆ Private plan expenditures decrease by 100% (- \$3,682 million)
- ◆ Expenditures by individuals decrease by 93.3% (- \$2,887 million)

4.2 Model 2. Public Only, Patient Pays the Dispensing Fee

This model is the same comprehensive, universal pharmacare model presented in Model 1 except in this scenario the patient pays the dispensing fee. Such a plan would allow the government to claim that it is offering first dollar coverage for drugs while maintaining the cost containment benefits of a co-payment.

Assumptions:

- universal coverage, publicly funded and administered
- first dollar coverage for drug cost only
- patient pays the dispensing fee, this fee becomes a defacto co-payment
- those previously uninsured increase consumption by 10%

Table 4.2
Model 2. Public Only, Patient Pays the Dispensing Fee, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	10,184.3	80.8%
Pharmacist Fees	2,219.2	17.6%
Private Plan Rx Drug Costs		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.4%
Pharmacist Fees	29.2	0.2%
Total	12,611.8	100.0%
II. Co-Payments & Deductibles		
Public Plans	2,219.2	17.6%
Private Plans	105.6	0.8%
Total	2,324.8	18.4%
III. Total Expenditures		
Total Rx Drug Costs	10,363.4	82.2%
Total Pharmacist Fees	2,248.4	17.8%
IV. Source of Funds		
Public Plans	10,184.3	80.8%
Private Plans	1,214.8	9.6%
Individuals	1,212.7	9.6%

Results:

- ◆ Total expenditures increase by 2.5% (+ \$309 million)
- ◆ Public plan expenditures increase by 84.3% (+ \$4,659 million)
- ◆ Private plan expenditures decrease by 67% (- \$2,468 million)
- ◆ Expenditures by individuals decrease by 60.8% (- \$1,882 million)

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4.3 Model 3. Public Only, Co-Payment of 12.51%

This model is similar to the existing provincial plan in Ontario in that deductibles and co-payments represent 12.51% of prescription costs.

Assumptions:

- universal coverage, publicly funded and administered
- deductibles and co-payments of 12.51%
- those previously uninsured increase consumption by 10%

Table 4.3

Model 3. Public Only, Co-payment of 12.51%, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	10,184.3	80.8%
Pharmacist Fees	2,219.2	17.6%
Private Plan Rx Drug Costs		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.4%
Pharmacist Fees	29.2	0.2%
Total	12,611.8	100.0%
II. Co-Payments & Deductibles		
Public Plans	1,551.2	12.3%
Private Plans	73.8	0.6%
Total	1,625.0	12.9%
III. Total Expenditures		
Total Rx Drug Costs	10,363.4	82.2%
Total Pharmacist Fees	2,248.4	17.8%
IV. Source of Funds		
Public Plans	10,852.4	86.0%
Private Plans	849.1	6.7%
Individuals	910.3	7.2%

Results:

- ◆ Total expenditures increase by 2.5% (+ \$309 million)
- ◆ Public plan expenditures increase by 96.4% (+ \$5,327 million)
- ◆ Private plan expenditures decrease by 77% (- \$2,833 million)
- ◆ Expenditures by individuals decrease by 70.6% (- \$2,185 million)

4.4 Model 4. Public Only, Large Co-Payment of 57.45%¹²

Universal coverage is provided, however, high annual deductibles exclude individuals with low drug costs. A co-payment per prescription further reduces public plan costs.

Assumptions:

- universal coverage, publicly funded and administered
- secondary coverage may be provided by private insurers¹³
- deductibles and co-payments of 57.45%
- those previously uninsured increase consumption by 10%

Table 4.4
Model 4. Public Only, Co-payment of 57.45%, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	10,184.3	80.8%
Pharmacist Fees	2,219.2	17.6%
Private Plan Rx Drug Costs		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.4%
Pharmacist Fees	29.2	0.2%
Total	12,611.8	100.0%
II. Co-Payments & Deductibles		
Public Plans	7,126.4	56.5%
Private Plans	339.2	2.7%
Total	7,465.6	59.2%
III. Total Expenditures		
Total Rx Drug Costs	10,363.4	82.2%
Total Pharmacist Fees	2,248.4	17.8%
IV. Source of Funds		
Public Plans	5,277.2	41.8%
Private Plans	3,901.0	30.9%
Individuals	3,433.6	27.2%

Results:

- ◆ Total expenditures increase by 2.5% (+ \$309 million)
- ◆ Public plan expenditures decrease by 4.5% (- \$248 million)
- ◆ Private plan expenditures increase by 5.9% (+ \$219 million)
- ◆ Expenditures by individuals increase by 10.9% (+ \$339 million)

¹² Calculated based on the Saskatchewan drug plan in effect in 2001 with an \$850 semi-annual deductible and 35% co-payment per Rx. In July 2002, Saskatchewan introduced a new eligibility formula based on drug expenses as a proportion of income.

¹³ Some people would have supplementary private insurance for expenses not covered under the public plan while others would have only public coverage and would pay for deductibles out-of-pocket.

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4.5 Model 5. Public & Private, Co-Payment of 33.74%

This model is similar to the current plan in Quebec in that obligatory basic coverage is provided for all its residents not covered under private plans.

Assumptions:

- universal coverage, publicly and privately administered
- public plan deductibles and co-payments of 33.74% (similar to Quebec)
- private plan co-payments are the same as in other models (8%)¹⁴
- those previously uninsured increase consumption by 10%

Table 4.5

Model 5. Public & Private, Co-payment of 33.74%, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	6,742.1	54.3%
Pharmacist Fees	1,469.1	11.8%
Private Plan Rx Drug Costs		
Rx Drug Cost	3,442.2	27.7%
Pharmacist Fees	560.4	4.5%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.4%
Pharmacist Fees	29.2	0.2%
Total	12,422.1	100.0%
II. Co-Payments & Deductibles		
Public Plans	2,770.5	22.3%
Private Plans	320.2	2.6%
Total	3,090.7	24.9%
III. Total Expenditures		
Total Rx Drug Costs	10,363.4	83.4%
Total Pharmacist Fees	2,058.7	16.6%
IV. Source of Funds		
Public Plans	5,440.8	43.8%
Private Plans	3,682.4	29.6%
Individuals	3,299.0	26.6%

Results:

- ◆ Total expenditures increase by 0.9% (+ \$119 million)
- ◆ Public plan expenditures decrease by 1.5% (- \$84 million)
- ◆ Private plan expenditures remain the same
- ◆ Expenditures by individuals increase by 6.6% (+ \$204 million)

¹⁴ In Quebec, private plans are required to meet minimum standards and co-payments cannot exceed those in the public plan. In reality, private plans usually set co-payments that are lower than the public plan.

4.6 Model 6. Public & Private, No Co-Payments

This model is similar to the model presented in Model 5, however, unlike Quebec, the model does not include a patient co-payment.

Assumptions:

- universal coverage, publicly and privately administered
- no deductibles and co-payments: removal of co-pays and deductibles increase consumption by 10% for those previously insured
- those previously uninsured increase consumption by 10%

Table 4.6
Model 6. Public & Private, No Co-payments, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	7,409.6	54.3%
Pharmacist Fees	1,614.6	11.8%
Private Plan Rx Drug Costs		
Rx Drug Cost	3,786.4	27.8%
Pharmacist Fees	616.4	4.5%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.3%
Pharmacist Fees	29.2	0.2%
Total	13,635.3	100.0%
II. Co-Payments & Deductibles		
Public Plans	0.0	0.0%
Private Plans	0.0	0.0%
Total	0.0	0.0%
III. Total Expenditures		
Total Rx Drug Costs	11,375.1	83.4%
Total Pharmacist Fees	2,260.1	16.6%
IV. Source of Funds		
Public Plans	9,024.2	66.2%
Private Plans	4,402.8	32.3%
Individuals	208.2	1.5%

Results:

- ◆ Total expenditures increase by 10.8% (+ \$1,332 million)
- ◆ Public plan expenditures increase by 63.3% (+ \$3,499 million)
- ◆ Private plan expenditures increase by 19.6% (+ \$720 million)
- ◆ Expenditures by individuals decrease by 93.3% (- \$2,887 million)

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4.7 Model 7. Public & Private, Patient Pays the Dispensing Fee

This model also achieves universal coverage by combining public and private plans. Under this model, insurers pay first dollar coverage for drugs but patients are required to pay the dispensing fees.

Assumptions:

- universal coverage, publicly and privately administered
- patient pays the dispensing fee under public and private plans
- those previously uninsured increase consumption by 10%

Table 4.7

Model 7. Public & Private, Patient Pays Dispensing Fee, 2001

	\$ millions	% of Total Expenditures
I. Drug Costs and Rx Fees		
Public Plan Rx Costs		
Rx Drug Cost	6,742.1	54.3%
Pharmacist Fees	1,469.1	11.8%
Private Plan Rx Drug Costs		
Rx Drug Cost	3,442.2	27.7%
Pharmacist Fees	560.4	4.5%
Individuals with no coverage		
Rx Drug Cost	0.0	0.0%
Pharmacist Fees	0.0	0.0%
Other Out-of-Pocket Expenses		
Rx Drug Cost	179.1	1.4%
Pharmacist Fees	29.2	0.2%
Total	12,422.1	100.0%
II. Co-Payments & Deductibles		
Public Plans	1,469.1	11.8%
Private Plans	560.4	4.5%
Total	2,029.5	16.3%
III. Total Expenditures		
Total Rx Drug Costs	10,363.4	83.4%
Total Pharmacist Fees	2,058.7	16.6%
IV. Source of Funds		
Public Plans	6,742.1	54.3%
Private Plans	3,442.2	27.7%
Individuals	2,237.7	18.0%

Results:

- ◆ Total expenditures increase by 0.9% (+ \$119 million)
- ◆ Public plan expenditures increase by 22% (+ \$1,216 million)
- ◆ Private plan expenditures decrease by 6.5% (- \$240 million)
- ◆ Expenditures by individuals decrease by 27.7% (- \$857 million)

5.0 COST IMPACT OF THE PHARMACARE MODELS

Table 5.1

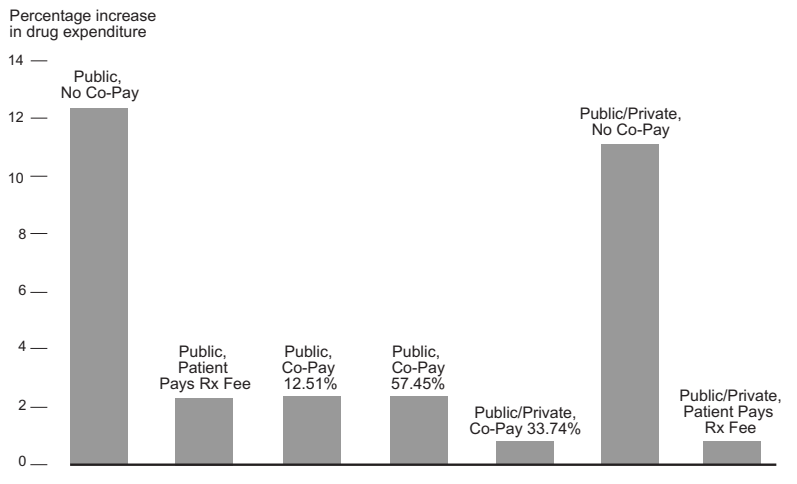
Cost Impact of Various Models of National Pharmacare

Pharmacare Model		Source of Funds			Total Impact
		Public	Private	Individual	
1. Public, No Co-Pay	\$M	8,110.12	-3,682.36	-2,886.80	1,540.95
	%	146.77	-100.00	-93.27	12.53
2. Public, Patient Pays Rx Fee	\$M	4,658.75	-2,467.57	-1,882.39	308.80
	%	84.31	-67.01	-60.82	2.51
3. Public, Co-Pay 12.51%	\$M	5,326.76	-2,833.24	-2,184.73	308.80
	%	96.40	-76.94	-70.59	2.51
4. Public, Co-Pay 57.45%	\$M	-248.43	218.62	338.61	308.80
	%	-4.50	5.94	10.94	2.51
5. Public/Private, Co-Pay 33.74%	\$M	-84.84	0.00	203.93	119.08
	%	-1.54	0.00	6.59	0.97
6. Public/Private, No Co-Pay	\$M	3,498.61	720.46	-2,886.80	1,332.27
	%	63.32	19.57	-93.27	10.83
7. Public/Private, Patient Pays Rx Fee	\$M	1,216.54	-240.15	-857.30	119.08
	%	22.02	-6.52	-27.70	0.97

Current drug expenditures would increase from 0.97% to 12.52% under the various national pharmacare models (Figure 1). Models 1 and 6 have the largest impact on total prescription costs. A publicly-funded pharmacare program providing first-dollar, universal coverage would require the highest increase in funding at \$1.5 billion, while another administered both publicly and privately with no co-payments would increase drug expenditures by 10.83% or

Figure 1

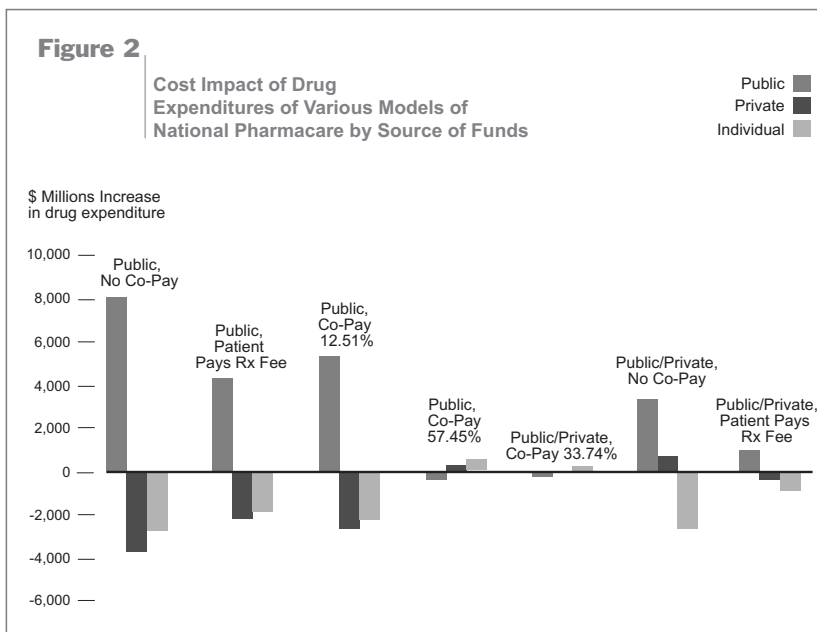
Cost Impact of Drug Expenditures of Various Models of National Pharmacare



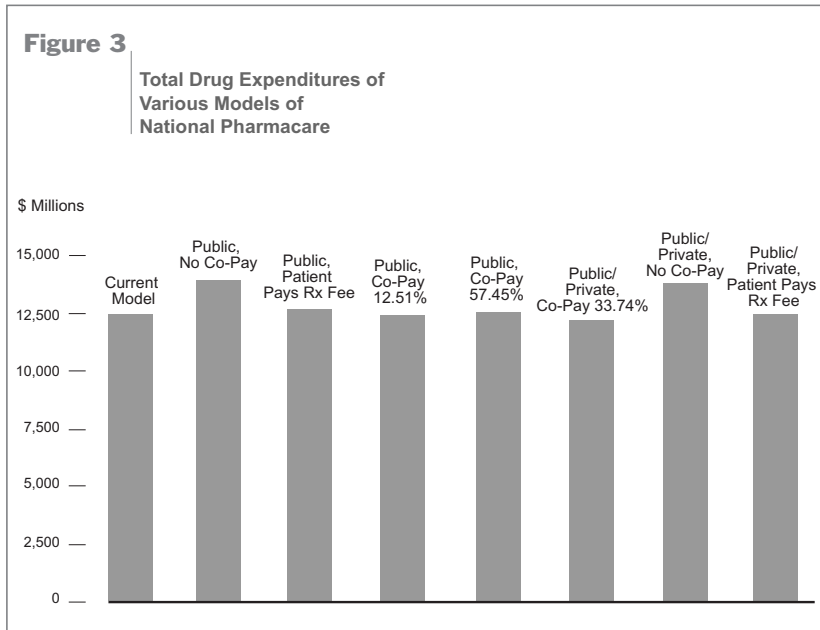
National Pharmicare Cost Impact Study 2002

\$1.3 billion. A public/private model where the patient pays the dispensing fee (the defacto co-payment) would have the smallest impact on total funding (0.97% or \$119 million).

Under a fully funded, publicly administered, national pharmacare program, government spending on prescribed drugs would increase by approximately 146.8% or \$8.1 billion (Figure 2). Accordingly, private spending would undergo the largest decrease under this model (\$3.6 billion) as a result of a dramatic shift in funding from the private sector to the public sector. Individuals' expenditures would also decrease considerably (almost \$2.9 billion) with the removal of deductibles and co-payments. On the other hand, a publicly administered, high co-payment plan would result in a decrease of public expenditures by 4.5% or \$248 million. Individuals would bear most of the impact with individuals' expenditures increasing by 10.9% or \$338 million.



A publicly funded national pharmacare program providing universal, first-dollar coverage would increase drug expenditures beyond current levels to a total cost of \$13.8 billion (Figure 3). A no co-payment program funded both publicly and privately would also have high drug expenditures totaling \$13.6 billion. Models 5 and 7, both publicly and privately administered, one with a co-payment of 33.74% and the other where the patient pays the dispensing fee, have the lowest total drug expenditures of all the pharmacare models at \$12.4 billion.



5.1 Impact of Public Only Plans (Models 1-3)

The first three publicly administered pharmacare models would entail increases ranging from 2.5% to 12.5% of current prescription drug costs. Model 1, providing universal first dollar coverage, would increase utilization such that there would be an increase in total prescription drug costs beyond current levels. Under this model, total prescription drug costs undergo the largest increase, with public expenditures rising by 146.8%, about \$8.1 billion. With the federal and provincial governments currently undertaking measures to contain Canada's increasing prescription drug costs, it is highly unlikely that such a significant increase in funding would be offered on an ongoing basis.

The Canadian Life and Health Insurance Association has indicated that the elimination of private drug plans could have a negative impact on all extended health care benefits as it is the drug plan portion that represents the lion's share of these benefits. Representatives of the CLHIA suggest that many of the current extended health care benefit plans would no longer be viable or premiums would have to be increased dramatically to make them viable.

5.2 Impact of Public Only, High Co-Payment Plan (Model 4)

Model 4 has large deductibles. Individuals would bear the costs until their drug costs reach the annual deductible. They would then be required to pay a co-payment for each claim submitted. The impact of this model is on the individuals' purse with individuals' expenditures increasing by 10.9%. Public expenditures would decrease by approximately \$248.4 million while private expenditures would increase by about \$218.6 million. Total prescription drug costs would increase by about 5.3% or \$653.2 million. Private plans would still be viable as many people would use extended health plans to supplement the high-deductible public plan.

While public sector costs are lowest under this model, some individuals who now are fully insured under public plans (such as many seniors and those on social assistance) could be faced with large out-of-pocket costs, which they could not afford. The objectives of accessibility and true universality are not achieved.

5.3 Impact of Public/Private Plans (Models 5-7)

With plans being administered both publicly and privately, the impact on the public purse under Models 5-7 is considerably less than that of the public only plans. Under a model similar to the current plan in Quebec, public costs decrease by 1.5% or \$84.8 million while a model providing first dollar coverage increases public costs by 63.3% or \$3.5 billion. While the previous model has one of the smallest impacts on public insurers, it does have one of the largest increases on individuals' prescription drug expenditures. Under the Quebec model, prescription drug costs for individuals increase by 6.6% or \$203.9 million. Of all models administered both publicly and privately, Model 6 is the only one that increases private insurers' share of current prescription drug costs. Premiums would have to be increased by almost 20% to offset the removal of deductibles and co-payments. This increase in premiums would undoubtedly be not as attractive to employers and their employees. This model also has one of the larger impacts on total funding, with total prescription drug costs increasing by 10.8% or over \$1.3 billion.

5.4 Impact of Plans with No Co-Payments (Models 1 & 6)

These two models have the largest impact on total prescription drug costs: 12.5% or \$1.5 billion for Model 1 and 10.8% or \$1.3 billion for Model 6. However, the increase is modest given the inelastic demand for pharmaceuticals (patients generally do not consume more of a prescription drug because it is cheaper). Predictably, individuals' costs decrease largely (93.3%) under these models as co-payments and deductibles are removed. The increase in consumers' consumption can be attributed to additional prescriptions that were previously not filled or written because of high co-payments or deductibles.

5.5 Impact of Plans with Co-Payments (Models 3, 4 & 5)

Models 3, 4 & 5, plans with co-payments, are based on existing drug programs in Ontario, Saskatchewan (program in effect up to July 2002) and Quebec, respectively. With most existing provincial drug plans already requiring co-payments and deductibles, these models have a modest impact on total prescription drug costs. However, as can be expected, the level of co-payments and the type of administration largely influences the effects on each group's expenditures. Under the Ontario-based model, private plans experience one of the larger decreases in prescription drug costs as a result of the low co-payment public plans. On the other hand, there is no impact on the private insurers' purse under the publicly and privately administered Quebec-based model.

5.6 Impact of Patient Paying the Dispensing Fee (Models 2 & 7)

With dispensing fees as the defacto co-payment, these models allow the government to claim to providing first-dollar coverage. Patients paying the prescription fee would contribute more in co-payments under the public model (Model 2), than under the model using Ontario's 12.5% co-payment: \$1.2 billion versus \$0.9 billion. Under the public/private model, patients paying the prescription fee contribute \$2.2 billion in co-payments versus almost \$3.3 billion under the model using Quebec's average co-payment of 33.74%. This approach encourages individuals to use pharmacies charging the lowest dispensing fees in order to reduce their out-of-pocket costs. However, it leaves the insurer with the responsibility to pay drug costs, which have been rising each year.

6.0 INTERNATIONAL PHARMACARE SCHEMES

6.1 France

Residents are covered by the national health insurance fund or *Caisse nationale d'assurance maladie* (CNAM), through the social security system, or *Sécurité sociale*.

Eligibility and Coverage

The CNAM is a mandatory health insurance that subsidizes pharmaceutical prices to almost all citizens (99%). About 80% of the population, composed of salaried and public sector workers, as well as their families, are covered through the main scheme, the *Régime Général*. However, most of this 80%, as well as the rest of the population, is covered by other supplementary sickness funds (*mutuelles*) and by private insurance.

About 100 life-saving and high-cost medicines have 'white barred price labels' and are given 100% reimbursement. These drugs include agents against diabetes, AIDS, cancer, chronic diseases, and hospital-only pharmaceuticals.

Deductibles, Co-payments and Professional Fees

The program has three levels of co-payment:

- white barred price labels – 0% for medicines that are used in life-threatening conditions, and/or are high-cost
- white price labels – 35% for medicines that do not qualify for either of the other two rates (i.e., antibiotics, drugs against certain infectious diseases)
- blue price labels – 65% for medicines mainly intended for non-serious conditions and disorders

Those who cannot afford their co-payments may receive regionally funded medical assistance. As well, patients are exempted from co-payments if they are suffering from one of **30** specified long-term diseases, or the '31st disease', i.e., another serious disease for which a special request has been made to and accepted by the *Sécurité Sociale*.

However, with almost 90% of the population covered through private insurers or the *mutuelles* that meet the co-payment liability listed above, most do not face any charge.

Pharmacists receive a fixed professional fee (forfeit) of FF3.50, as well as FF5.50 for **40** products with special status.

Cost Reimbursement

France has two lists of reimbursable drugs: one lists reimbursable drugs for sale by pharmacies (*liste de médicaments remboursables agréés aux assurés sociaux*), the other is a list for the public hospital sector (*liste des médicaments agréés aux collectivités*). Reimbursement status of drugs is granted by the Transparency Committee (*Commission de transparence*). The reimbursement price is negotiated by the Economic Pharmaceutical Committee (*Comité économique du médicament* or CEM).

The reimbursement rate of drugs in France is based on its main indication, rather than its efficacy or cost:

- 100% for life-saving or high-cost medicines (white barred price labels)
- 65% for drugs not included in either one of the other two groups (white price labels)
- 35% for drugs mainly used for non-serious conditions and disorders (blue price labels)

Wholesalers are allowed to add a mark-up of 10.74% on the ex-factory price of products below FF150 and 6% for products above FF150. Pharmacies are allowed to add a mark-up of 26.1% on the ex-factory price of products below FF150 and 10% for products above FF150.

A reduced VAT (*taxe sur la valeur ajoutée*) is added to all reimbursable medicines in France at a rate of 2.1%, compared to a standard rate of 20.6%.

6.2 Sweden

Sweden's Drug Benefit Scheme (DBS) is administered by the National Social Insurance Board (the *Riksförsäkringsverket* or RFV) and the social insurance offices. The RFV, a central government agency responsible for social insurance, reports to the Minister of Health and Social Affairs.

Eligibility and Coverage

The DBS is a universal social insurance scheme available to all residents of Sweden, including emergency patients from the EU/EEA countries and seven other countries. The DBS covers prescription drugs and some over-the-counter (OTC) products.

Deductibles, Co-payments and Professional Fees

A 'purchase cost maximization' system is used in Sweden, a cost reduction based on the total cost of reimbursable products purchased by the patient over a 12-month period:

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- 0% of the amount when the total cost is less than SEK900
- 50% of the amount when above SEK900 but less than SEK1,300
- 75% of the amount above SEK1,300 but less than SEK1,700
- 90% of the amount above SEK1,700 but less than SEK1,800
- 100% of the amount above SEK1,800

A nationwide database keeps track of each patient's pharmaceutical consumption expenditure. In 2000, Sweden had a national average per capita expenditure of SEK1,671.

Insulin-users are the only ones exempted from co-payments, their insulin costs are fully reimbursed.

Cost Reimbursement

In order for their products to be eligible for the DBS, companies must first apply for a reimbursement price from the RFV. The Division of Drug Affairs is the unit within the RFV responsible for setting the reimbursement price of pharmaceuticals.

- 0% of the amount when the total cost is less than SEK900
- 50% of the amount above SEK900 but less than SEK1,700
- 75% of the amount above SEK1,700 but less than SEK3,300
- 90% of the amount above SEK3,300 but less than SEK4,300
- 100% of the amount above SEK4,300

Sweden has no fixed wholesale margins, however, a 4.2% wholesaler mark-up is added on to the ex-factory price on average. Pharmacy mark-ups range from 7% for products costing more than SEK300 to 30% for products costing less than SEK34.25. These mark-ups are combined with a sliding scale of professional fees, starting from SEK18.00 for the cheapest products up to SEK32.70 for those that cost the most.

There is no tax (VAT) on prescribed pharmaceuticals in Sweden.

6.3 Australia

The Commonwealth Government's Pharmaceutical Benefits Scheme (PBS) is administered under the authority of Part VII of the National Health Act 1953 together with the National Health (Pharmaceutical Benefits) Regulations 1960 made under the act.

Eligibility and Coverage

The PBS provides universal coverage to all residents of Australia as well as visitors from countries with which Australia has a Reciprocal Health Care Agreement. These countries

include the UK (including Northern Ireland), Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands and Finland.

Deductibles, Co-payments and Professional Fees

General Patients – a maximum of \$22.40 for each prescription item. Once the eligible expenditure of a patient and/or their immediate family exceeds the 'safety net threshold' of \$686.40, they can apply for a Safety Net Concession Card and pay only \$3.60 per item for the rest of the calendar year.

Concession patients (low incomes and sickness beneficiaries) - a maximum of \$3.60 per prescription item. This co-payment is removed once their total eligible expenditure exceeds \$187.20 within a calendar year.

Patients may also pay brand premiums, therapeutic group premiums or special patient contributions which do not count toward the safety net thresholds.

Pharmacists receive a dispensing fee of \$4.58 for ready prepared items or \$6.49 for extemporaneously prepared items. There is also an additional \$0.89 fee for recording safety net expenditure on the Patient Record Form as well as an optional pharmacy charge of \$2.74 provided that the total charge does not exceed the patient co-payment. The latter fee may not count towards the Safety Net.

Cost Reimbursement

Prescription drugs covered by the PBS are listed on the Schedule for Pharmaceutical Benefits. The Pharmaceutical Benefits Advisory Committee reviews applications by companies to have their products included on the Schedule. According to the Department of Health and Ageing, 589 drug substances (generic drugs) are covered under the Scheme. These drugs are available in 1,458 forms and strengths and marketed as 2,459 different drug products (brands). The Pharmaceutical Benefits Pricing Authority reviews the prices of all products on the list annually.

The government reimburses any additional cost of drugs exceeding patient co-payments up to the dispensed price, excluding any delivery or after hours fee, brand or therapeutic group premium, or special patient contribution that may be applicable.

Australia uses a strict form of reference pricing wherein reimbursement prices for items in a particular sub-group (brand or therapeutic) are set on the basis of the lowest cost item. The therapeutic group may contain both patented and generic pharmaceuticals. If a higher-priced medicine is chosen, patients pay the difference on top of the usual patient contribution.

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Pharmacists are allowed to charge a mark-up of 10% on the price up to \$180, or \$18.00 on the price above \$180 up to \$450, or 4% on the price above \$450.

6.4 United Kingdom

The United Kingdom's National Health Service (NHS) is administered by the Department of Health under the authority of the *NHS Act* of 1946.

Eligibility and Coverage

The NHS is a national scheme with universal coverage for the whole population. This also includes coverage for patients with certain chronic disorders such as forms of hypo-adrenalism and hypopituitarism, diabetes insipidus and mellitus, hypoparathyroidism, epilepsy, etc.

Deductibles, Co-payments and Professional Fees

The NHS treatment is provided free of charge at the point of contact, therefore there is no need to reimburse patients. There is a fixed prescription fee, as of April 2001, of GBP6.10 per item for ambulatory patients.

The following patients (and their partners) are exempt from co-payments:

- children under 16 and all teenagers in full-time education or training;
- seniors aged 60 and over;
- pregnant women or those who have had children in the last 12 months and hold a current exemption certificate;
- families on supplementary benefits; and
- some patients with certain chronic disorders

The majority of NHS patients, therefore, receive their prescriptions at no cost. Non-exempt patients must pay a fixed amount toward the cost of medicines prescribed by their doctors. However, patients may also purchase pre-payment certificates, which would exempt them from paying any prescription charges during the period the certificates cover. In 1999/2000, an estimated 85% of prescription items were dispensed free of charge.

Cost Reimbursement

All prescription drugs that receive approval for marketing in the UK are automatically reimbursed in full, unless they are on the negative list. This list, known as Schedule ten or

the 'Black List', includes about 3,000 drugs and is administered by the Advisory Committee on NHS Drugs.

The NHS accounts for about 95% of the total pharmaceutical market in the UK and is, in effect, the only pharmaceutical market in the country. Reimbursement of prescription products is automatically carried out at the time of launch. No application or notification procedures apply.

Manufacturers of branded products are free to set prices as long as they are within the constraints of the Pharmaceutical Price Regulation Scheme. There are no taxes applied to drugs prescribed under the NHS.

6.5 Comparative Analysis

Regardless of the differences in the health care system of the countries covered in this study, most seek similar things from their health care such as reliability, accessibility, quality and cost-effectiveness. Yet, they have taken very different directions in pursuing their objectives. This study indicates that unlike Canada, which focuses public health care financing on doctors and hospitals, the UK, Australia, Sweden and France extend their health care much more into pharmaceuticals. All four countries provide much more extensive coverage for prescribed medicines than what is offered in Canada. The public share of total prescribed drug expenditures is also much higher in these countries than in Canada¹⁵. However, though these countries come close, none offer full coverage for the full cost of drugs to its residents.

Of the four countries included in this analysis, the United Kingdom has the most comprehensive pharmacare program. Its national scheme, the National Health Service (NHS) provides universal coverage for the whole population. The majority of NHS patients receive their prescriptions at no cost (no co-payments). This program is similar to Model 2 of this analysis, which is a publicly administered plan wherein the patient pays the dispensing fee. However, under the NHS, only ambulatory patients and patients who are not exempt from co-payments pay a fixed amount toward the cost of medicines prescribed by their doctors.

On the other hand, Sweden, which is considered to be one of the most socialized countries in Europe, requires user charges in the form of co-payments for its Drug Benefit Scheme (DBS). The DBS uses a "purchase cost maximization" system, a cost reduction based on the total cost of reimbursable products purchased by the patient over a 12-month period. It is community-rated in the sense that there is a single co-payment structure affecting all residents regardless of their health status. Model 3 of this analysis, which is a publicly administered plan with co-payments, closely resembles this scheme. Under the DBS, the maximum annual co-payment is SEK 1,800 or about \$275, after which patients are reimbursed 100% of their prescription costs.

7.0 CONCLUSION

It is evident from the analysis that a comprehensive national pharmacare system (Model 1) would result in a significant increase in public expenditures (more than \$8 billion) on pharmaceuticals. Much of this increase would in fact be cost shifting from private plans and individuals, however, there would also be an overall increase in expenditures (approximately 15%) due to the removal of the existing cost sharing arrangements that tend to moderate usage. Implementation of a national pharmacare scheme would likely result in other significant changes. For example the additional public expenditures would have to be funded in some manner (tax increases and/or reductions in other areas of programmed spending). Secondly, there would be ramifications for the private insurance market. Private drug plans are typically one component of extended health care benefits offered as employee benefits. Removing the drug plan portion from private insurers may increase the cost of offering the remaining benefits (dental, vision care, etc.). These additional costs would have to be weighed against the value or benefits a national pharmacare scheme might offer. Third, from a political perspective, health is a provincial jurisdiction and the implementation of national pharmacare would require the consent of all the provinces (history is not encouraging in this regard).

Generally, the benefits of implementing a national pharmacare scheme are seen as respecting the spirit and intent of Canadian Medicare by ensuring that all Canadians have access and coverage for prescription drugs through a publicly administered scheme. However, the evidence is that most Canadians have adequate access and coverage and that replacing private plans with a public scheme may offer little additional value but will involve significant structural and political costs. Indeed, when faced with this issue the province of Quebec decided to provide universal access by supplementing the private plans with public plan coverage rather than replacing them. Moreover, the public scheme established the minimum standards of coverage for all prescription plans in the province of Quebec. Even this approach resulted in important changes as well as winners and losers. Quebec introduced a system of “premiums” and co-insurance that had the net effect of increasing the cost for some claimants. Others enjoyed prescription drug coverage for the first time.

The question then, if a comprehensive scheme is not affordable or feasible, which model best fits the needs of Canadians. The models presented in this study offer a wide range of possibilities, however, the focus should be on the approaches that offer the greatest incremental access/coverage for Canadians that have no coverage or are under-insured while not adversely affecting those that currently enjoy good coverage through private drug plans. Moreover, just as there are important differences in the delivery of provincial health care systems, it is likely that each province will want to continue to provide drug benefits that best fit the needs of their population. At the national level, perhaps the greatest need is to identify population groups that lack drug benefit coverage or that have inadequate coverage and propose ways in which coverage can be introduced or enhanced.

Appendix A

Summary of Views on National Pharmacare

1.0 Romanow Commission: Four-Phase National Dialogue Strategy¹⁶

PHASE II: Public Consultations and Expert/Stakeholder Roundtables (March-June 2002)

Partnered Policy Debates

- To engage the expert stakeholder community in framing key health care issues and in exploring solutions to them, the Commission will partner with two or more health policy/advocacy groups. In selecting partners, care will be taken to ensure the requisite degree of balance across regions, perspectives and approaches.

The process will evolve in **three stages**:

In the **first stage**, the Commission partners will be tasked with developing a brief discussion document that frames a particular issue (see list of topics below), outlines 2-3 policy options and enumerates their “pros and cons”.

In the **second stage**, partner organizations will host an open-to-the-public policy debate moderated by an eminent Canadian on the options presented in the discussion document. Concurrent with this debate, the discussion document will be posted for feedback on both the partner and Commission web sites for a four-week period.

In the **third-stage**, the event moderator will provide a summary report on the debate highlighting areas of consensus/cleavage. The report will be posted on the Commission web site and will inform the Commission’s eventual recommendations.

Partner organizations will address the following topics:

- Waitlists/Timely Access to Care: What should be done?
- Health Human Resources: How can we maintain and grow capacity?
- The Canada Health Act: Beacon or lightning rod?
- Financing Health Care: How to Raise Revenues?
- Globalization: Threat or Opportunity?
- Medically Necessary: Who should decide what Medicare pays for?
- Home Care: Is a national strategy needed and affordable?
- **Pharmacare: Is a national strategy need[ed] and affordable?**
- Consumer Choice: Can it exist within a public system?
- Aboriginal Peoples Health: How can we do better?

The organizations participating in these activities, and the delivery dates for the discussion documents and public forums will be announced in late-January 2002.

¹⁶ Commission on the Future of Health Care in Canada, *Four-Phase National Dialogue Strategy*, January 2002. <http://www.healthcarecommission.ca/default.asp?DN=cn=277,cn=7,cn=2,ou=Stories,ou=Suite247,o=HCC>

2.0 Standing Senate Committee on Social Affairs, Science and Technology¹⁷

As a basis for Committee consultation and dialogue, four possible options for a national Pharmacare initiative are set out below, each offering a different focus and design.

8.9.2 A Comprehensive Public Program

A fully public national Pharmacare program could be financed by both the federal government and the provinces/territories either through increased CHST transfers or through a new cost-shared funding arrangement involving 25%, 50% or more in federal money. Such a program could provide first dollar coverage and therefore comply with the *Canada Health Act*. Or it could require user charges, in which case federal funding could be subject to a “revised” *Canada Health Act* or to a set of new conditions. This would be a “greenfield initiative”, replacing all current federal and provincial public drug insurance programs and would also likely make current private drug insurance plans largely redundant.

8.9.3 A Comprehensive Public/Private Initiative

Like Option 8.9.2, this initiative would focus on providing universal access to coverage for all drug expenses. However, it would do so through a partnership effort among the federal government, provincial governments and the private sector in order to expand the coverage that is currently offered under both public and private plans.

Federal cost-sharing could be provided to the provinces for the expansion of provincial drug program coverage. A special focus in this regard would be the Atlantic provinces, where there are currently no drug plans that are universally accessible. At the same time, however, equity would require providing federal assistance to those provinces which have already put in place broadly accessible programs. Such assistance could serve to encourage these latter provinces to maintain and even expand their coverage.

Recognizing that some provinces might not respond well to the cost-sharing incentives, and that therefore such programs might not reach the entire population, federal financial incentives could also be made available to private plans to encourage expansion of coverage to those who are currently uninsured and under-insured but still have some connection to the world of work (e.g., part-time workers, workers in transition between jobs, etc.).

Federal assistance to the provinces could be made subject to a number of conditions, including elimination of the major disincentives to private drug coverage posed by current provincial taxes on insurance premiums and retail sales taxes on supplementary health insurance premiums. It should be noted that Quebec used a hybrid public/private model to implement its Universal Drug Program, which has been in effect since 1997.

¹⁷ Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Volume Four: Issues and Options*, September 2001.

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8.9.4 Public/Private Initiative to Protect Against High Drug Expenses

Unlike Options 8.9.2 and 8.9.3, which seek to pay for all or virtually all prescription drug costs, this option would focus on ensuring that all Canadians are protected against undue financial hardship arising from high drug expenses. This option would focus on protecting Canadians, including those who now have private drug insurance coverage, from the type of catastrophic situations described in the example in the last paragraph of Section 8.9. As such, this option is a safety net option.

Like Option 8.9.3, this option would involve a shared effort among the federal government, provincial governments and the private sector to build upon and expand protection under provincial public plans and private plans against high drug expenses. Substantial federal cost-sharing would be available to universally accessible provincial programs that capped individual exposure to high drug costs at an appropriate limit. Such a limit might be a specified percentage of income (e.g., 4% or lower, as in some current programs) or a dollar amount (e.g., \$1000 per year).

As in the previous option, a special priority would be placed on inducing the Atlantic provinces to introduce provincial programs of this nature. However, cost-sharing would also be available for existing provincial drug insurance plans which already have this kind of protection.

Moreover, as in Option 8.9.3, recognizing that some provinces might not respond to the cost-sharing incentives and that hence such provincial public programs might not reach the entire population, federal financial assistance could be made available to private plans to induce them to cap the out-of-pocket expenses of individual plan members at a specified limit (e.g., \$1000/year). As under Option 8.9.3, the federal-provincial dimension could include conditions, such as the removal of the provincial tax disincentives on private drug insurance coverage.

Option 8.9.4 is likely to become increasingly important as drug costs rise and as high priced biotech drugs become an increasing part of drug utilization. There is a risk that such rising costs could cause some employers to discontinue prescription drug insurance plans. However, if employers knew that financial assistance would be made available from government once their plan had reached the limit of an employee's drug coverage, this might well persuade them to keep their existing drug plans.

8.9.5 Tax Initiative to Protect against High Drug Expenses

Like Option 8.9.4, this option would focus on capping an individual's exposure to high drug expenses. However, the tax system, rather than public and private drug insurance plans, would be the delivery mechanism.

Under this option, Canadians with expenses for "medically necessary" prescription drugs above some threshold (e.g., a percentage of income, probably in the range of 2% to 4%)

would receive a tax credit for the excess amount. This credit would reduce taxes otherwise payable (for higher income taxpayers) or be paid out as a refundable tax credit (for lower income earners owing no tax). It could be designed by modifying the current Medical Expenses Tax Credit or by introducing a new, separate tax credit. Such an option would require the development of an official drug formulary listing all the “medically necessary” drugs.

One drawback to this approach is the retrospective nature of tax filing – it only helps with last year’s high drug expense. This coverage could be rendered virtually irrelevant due to the prior death and/or prior personal insolvency of the intended beneficiary. This option would be more readily adaptable to meeting the needs of those with chronic high drug cost problems.

3.0 Canadian Pharmacy Coalition on Pharmacare¹⁸

The growth of our aging population and the increasing use of pharmaceuticals as a primary therapeutic intervention exacerbate the problem and increase the financial burden for provincial and private plans. The situation is acute and will only improve through a **joint effort by federal and provincial governments** to address the issues of access and affordability for all Canadians to the medications and pharmaceutical services they need.

It is with this in mind that, as representatives of pharmacy associations from across Canada, we are proposing a framework to begin to address the inequities in the current systems.

Our vision of a national Pharmacare program is an optimal drug therapy program available to all Canadians whatever their health, geographic, social and financial circumstances. Optimal drug therapy consists of the needed medication accompanied by a pharmacist’s cognitive services to make it a true therapeutic intervention.

Recommendations:¹⁹

- A National Pharmacare program should adhere to the CHA principles of public administration, comprehensiveness, universality, portability and accessibility. To ensure the program’s long-term sustainability, other principles, such as affordability, effectiveness and efficiency, need to be considered.
- We support the National Forum on Health’s recommendation for a National Pharmacare program and urge the federal government, in collaboration with the provinces, to set timelines and steps for implementing such a program.

¹⁸ Canadian Pharmacy Coalition on Pharmacare (CPCP), *Building Pharmacare: Expanding the Health Care Contract with Canadians*, November 1999.

¹⁹ These only highlight certain recommendations from CPCP’s report.

- Funding be provided to further develop and evaluate innovative pharmacy practice models. Such models should be evaluated in terms of the impact they may have on quality of patient care and cost effectiveness.
- Drug benefit plans develop and implement, in collaboration with pharmacy organizations, new methods of compensation to create incentives for innovative pharmacy services.

4.0 Quebec Task Force on the Feasibility of a Full Public Universal Plan (the Montmarquette Committee)²⁰

The committee's mandate was to make recommendations regarding the feasibility of a universal drug plan and to make suggestions with respect to the appropriate financial tools to ensure equity, economic efficacy and the capacity to maintain the integrity of the health system globally.

The recommendations are as follows:

Recommendation #1 – endorsed the public-private characteristics of the current Quebec drug benefit plan.

Recommendation #2 – proposed that the mandatory participation of all citizens be maintained.

Recommendation #3 – endorsed the concept of participant contributions, including premiums and co-insurance.

Recommendation #4 – suggested that more transparency and equity be built into the financing of the plan.

Recommendation #5 – proposed that steps be taken to facilitate data exchange between the revenue ministry and the *Régie d'assurance Maladie du Québec* (RAMQ) to ensure that the premiums are collected from people who are not covered through a private insurer.

Recommendation #6 – called for a review of drug selection criteria and a re-evaluation of the current pricing system.

²⁰ Jean-Yves Julien and Gerry Jeffcott, *Summary Report of the Quebec Task Force on the Feasibility of a Full Public Universal Drug Plan*, December 2001.

Recommendation #7 – proposed the creation of three new mechanisms to improve drug utilization, including:

- the creation of a fund, jointly financed by the government and the pharmaceutical industry, to track drug utilization better;
- the sponsorship of consensus conferences to develop recommended usages of certain medications (prescribing guidelines);
- the establishment of disease management programs.

5.0 Institute for Work & Health²¹

The integration of drug benefits with medicare will not come without costs to others besides some pharmaceutical manufacturers. Without being able to offer a drug plan as part of an extended benefits package, many businesses will lose an inducement for high-quality employees. And because a universal system will be substantially more efficient to administer, some jobs will become redundant in companies that have staff positions responsible for managing drug benefits. There are also questions of who would ultimately pay for a public drug benefit plan and exactly how comprehensive it would be. But a publicly administered drug plan will provide an opportunity to operate more effectively with fewer resources.

The costs to employers and employees, therefore, are relatively minor compared with what is to be gained in efficiency and equity from a universal, publicly administered pharmacare program. As prescription pharmaceutical costs approach the \$8 billion mark, the stakes rise in Canada's pharmacare debate and business leaders will play a pivotal role determining the direction and constitution of the policy.

6.0 The Institute for Research on Public Policy Task Force on Health Policy²²

Over the long-term, Canada must address pharmacare. Drug technology is a major driver of system change, including the scope of institutional care, the role of the consumer/patient, and the demand for healthcare services. Three key and inter-related issues have emerged that governments must deal with:

- Controlling drug costs and providing incentives for more appropriate drug use;
- Ensuring healthcare equity and access are not being eroded by drug cost-shifting to individuals; and,
- Harmonizing and strengthening the regulation of public interest.

²¹ Steve Morgan, *Pharmacare: The Pros and Cons for Business of Canada's National Drug Proposal*, Institute for Work & Health's first National Leadership Roundtable on Employee Health, April 1998.

²² IRPP Task Force on Health Policy, *Recommendations to First Ministers*, September 2000.

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In our view, the status quo can neither effectively contain drug costs nor prevent equity/access gaps from widening.

Significant organization issues will need to be overcome to implement a national approach to pharmacare. These issues include: addressing the compulsory retention of employer plans; a mechanism for regulatory-updated formularies based on best evidence; cost efficiency; and the appropriate cost burden on individuals. Quebec's experience provides important lessons for pursuing a national approach to a universal drug plan.

Attention should also be paid to how to ensure drug plans contribute to primary care reform objectives, in particular, to ensure physicians are more sensitive to the costs and benefits of the drugs available for use...

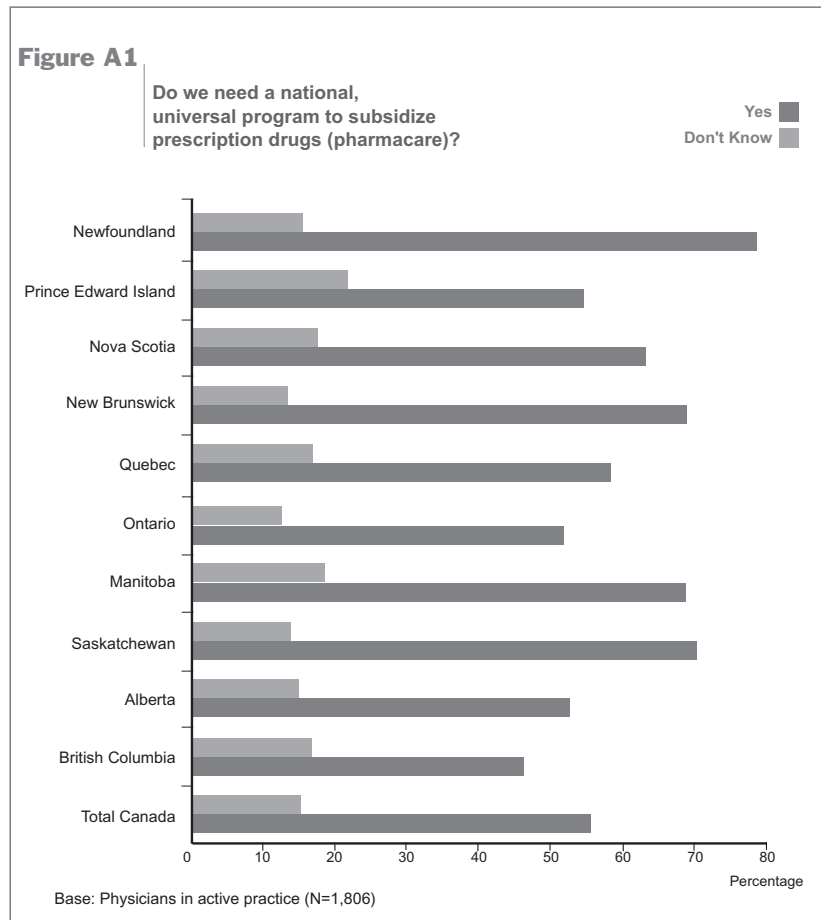
...Moving to a solely federal drug plan may prove too radical for the current state of federal-provincial relations. A second option would be the development of national standards to be accepted by each provincial drug plan. Chief among these standards would be universality. All Canadians would be covered.

7.0 Women's Health Clinic²³

Women's Health Clinic strongly supports a national pharmacare program, as a part of Medicare. Women's Health Clinic believes there is strong evidence that a national pharmacare program would reduce drug expenditures and increase health outcomes. Programs such as a national formulary, a system of reference-based pricing, and prohibition of direct to consumer advertising are critical components. Since the National Forum on Health there has been little action on this issue, which is of concern.

²³ Women's Health Clinic, *Women's Health Clinic Brief to the Standing Senate Committee on Social Affairs, Science and Technology*, November 2001.

8.0 2001 National Survey of Canadian Doctors²⁴



9.0 Canadian Pharmacists Association²⁵

Recommendations

1. Develop further collaboration among federal and provincial governments in matters of publicly funded drug programs.
2. Develop national standards to ensure equitable access to a core set of drugs for all Canadians.
3. Harmonize federal/provincial/territorial drug programs to develop national standards to ensure portability of drug benefits.

²⁴ The Medical Post 2001 National Survey of Doctors, September 2001.

²⁵ Canadian Pharmacists Association, *Submission to the Romanow Commission on the Future of Health Care in Canada*, October 2001.

4. Continue to create the building blocks necessary to establish a more universal and comprehensive approach to drug programs in Canada.
5. Harmonize drug programs intended for use in community settings with institutional formularies to ensure continuity of care.
6. Examine options with respect to taxation policy as a means of funding drug benefit programs.

10.0 New Democratic Party

The New Democratic Party believes that prescription drugs should be available to all Canadians equally on the basis of need and at the lowest cost. To that end, we urge the Commission on the Future of Health Care to recommend that the cost of prescription drugs be incorporated into the public health care system as part of a comprehensive approach to drug pricing...

...The New Democratic Party proposes a comprehensive national drug plan that would follow the five principles of the Canada Health Act. It would thus be universal, portable, comprehensive, accessible and publicly administered.

We are calling for coverage similar to current medicare practice – a single-payer first-dollar payment plan. Converting to a government-run plan means public costs will rise. The total amount Canadians will pay, however, will drop. When all the expected increases and decreases are balanced, drug industry expert Dr. Joel Lexchin estimates a net saving of \$650 million a year. Getting rid of duplication by administering only a single government plan could save \$110 million per year, according to Lexchin.²⁶

- Introduce a national Pharmacare plan in conjunction with measures to contain drug costs.

All Canadians should be able to benefit from advances in pharmaceutical science such as those which replace hospitalization and invasive treatments with drug therapy that can be administered at home or in the community. Yet the escalating cost burden of prescription drugs, which is now borne largely by individuals, poses a formidable obstacle to their coverage by universal health insurance. Introducing Pharmacare for all Canadians requires first containing the cost of prescription drugs.

New Democrats support a staged approach to introducing Pharmacare. The first stage should be a multifaceted national strategy to stabilize drug costs, including: reducing the 20 year protection for drug patents provided by the Drug Patent Act; using health information

²⁶ New Democratic Party, *Building Medicare for the Future, Submission of the Federal New Democratic Party Caucus to the Commission on the Future of Health Care in Canada*, December 2001.

systems to monitor physicians' prescribing practices; promoting best practices to change inappropriate prescribing practices; and building on British Columbia's Reference Based Drug Program to establish a national model for ensuring that the most cost effective drugs are prescribed for common medical conditions.

As drug costs are stabilized, the federal government should work with the provinces and territories to introduce a phased extension of Pharmacare programs to cover all Canadians with priority given to those with the greatest health and financial needs.

Universal Pharmacare will bring significant benefits for individuals and employers who now pay into extended health insurance plans with drug coverage. Just as Medicare now provides Canadian companies with a labour cost advantage over U.S. firms that pay hefty private health insurance premiums, so would a publicly funded and more cost-efficient Pharmacare program. Funding arrangements should take these benefits into account, with some offsetting adjustments to payroll, personal or corporate income taxes.²⁷

11.0 Liberal Party of Canada²⁸

The Health Action Plan also commits governments to work together on a range of other issues, such as the supply of doctors and nurses and the cost-effectiveness of prescription drugs. Shortages of doctors and nurses will be addressed by adding more trained personnel, putting an end to fierce competition between provinces to attract health care professionals. Greater collaboration in assessing the cost-effectiveness of prescription drugs will help Canadians make optimal use of pharmaceuticals and will enable governments to better control soaring drug costs.

12.0 Saskatchewan Commission on Medicare²⁹

Governments are wary of expanding Medicare to include prescription drugs. They are wary of establishing entitlements that create enormous demands on the treasury with little likelihood of controlling costs. Most government decision-makers recognize the fundamental injustice and illogic of current policies. But they view drugs as a Pandora's Box, their views coloured by a checkered past.

²⁷ New Democratic Party, *Health Care, Disease Prevention and Well-Being, Federal New Democratic Party Policy Paper*, August 1999.

²⁸ Liberal Party of Canada, *Opportunity for All, The Liberal Plan for the Future of Canada*, 2000.

²⁹ Saskatchewan Commission on Medicare, *Caring for Medicare, Sustaining a Quality System*, April 2001.

13.0 Canadian Health Coalition³⁰

Recommendations:

1. That the federal, provincial, and territorial governments proceed with the implementation of a universal public drug plan with first dollar coverage based on the recommendations of the National Forum on Health.
2. That a central purchasing agency be established to contract with Canadian pharmaceutical companies to supply generic copies of brand name drugs for non-commercial distribution as provided for in the TRIPS agreement of the WTO, through a national formulary.
3. That a national therapeutic products initiative be established, at arm's length from government and vested interest groups, to provide unbiased assessment of new and existing drug therapies, together with a strengthened adverse drug reaction reporting and to deliver the evidence to physicians, pharmacists and the public.
4. That a prohibition on direct-to-consumer advertisements of prescription drugs be strictly enforced, given the lack of evidence of health benefits and the serious potential to harm. Federal legislation should ban advertising, which includes both the product's name and indications for use, and ban cross-border direct-to-consumer advertising.

³⁰ Canadian Health Coalition, *Standing Together for Medicare: A Call to Care, A Submission to the Romanow Commission of the Future of Health Care in Canada*, November 2001.

Appendix B

Summary of Provincial Drug Plans

BRITISH COLUMBIA

British Columbia's Pharmacare, Home Oxygen Subsidy Program and HIV/AIDS Program are administered by the Ministry of Health under the authority of the Pharmacists and Pharmacy Operations Drug Scheduling Act (PPODS) and the PPODS Amendment Act.

Eligibility and Coverage

Residents of BC are eligible for Pharmacare benefits under one of the following categories:

- Plan A – seniors aged 65 and over;
- Plan B – permanent residents of licensed long-term care facilities;
- Plan C – individuals eligible for benefits through the Ministry for Social Development and Economic Security;
- Plan D – individuals registered with a provincial Cystic Fibrosis Clinic;
- Plan E – all other residents of the province under the age of 65 registered under the Medical Services Plan of B.C.;
- Plan F – children eligible for medical or full benefits through the At Home Program of the Ministry for Children and Families; and
- Plan G – clients eligible for benefits through mental health centres. The mental health centres determine eligibility.

Effective January 1, 2002, seniors coverage is separated into a regular plan and a Plan A for seniors receiving Premium Assistance from the Medical Services Plan (MSP) or B.C. Benefits from the Ministry of Human Resources (MHR).

Pharmacare's Home Oxygen Program provides assistance with the cost of oxygen and oxygen equipment for people who require respiratory assistance. The benefits of this program are limited to people in their private residences.

HIV-positive persons living in the province of B.C. receive their antiretroviral drugs free of charge when enrolled in the B.C. Centre for Excellence in HIV/AIDS.

Deductibles, Co-payments and Professional Fees

Plan A – seniors under regular Plan A must pay a maximum of \$25 towards the total cost of each prescription until the annual maximum payable of \$275 is reached. Those receiving MSP Premium Assistance or MHR Benefits must pay a maximum of \$10 towards the total cost of each prescription until the patient reaches the annual maximum payable of \$200. Once the annual maximum payable is reached (for both plans), Pharmacare covers all further expenses in the year.

Plan B, C, D, F & G – there are no deductibles or co-payments for residents eligible for benefits under these plans.

Plan E – effective January 2002, the annual deductible is \$1,000 for regular Plan E patients. When a family has reached the \$1,000 deductible, Pharmacare will continue to cover 70% of the cost of eligible benefits and dispensing fees. Once a family has paid \$2,000 as their portion, further eligible expenses in that year will be covered 100%.

For Plan E patients receiving MSP Premium Assistance, the deductible is \$800. When a family has paid \$800 as their portion, further eligible expenses in that year are covered 100%.

Cost Reimbursement

BC is the only province that does not have an established formulary of products eligible for coverage. Except for an exception list, B.C. covers all products, though not all are fully paid benefits under the Low Cost Acquisition Program and Reference Based Pricing.

The Low Cost Alternative Program limits Pharmacare to reimbursement for drug costs to the Actual Acquisition Cost of the average of lower cost alternatives. Pharmacare coverage under the Reference Drug Program is based on the cost of the reference drug or drugs in a therapeutic category. If the patient's drug cost is higher than the LCA price or the reference price, the claim will be reduced to the LCA price or reference price and the patient is required to pay the cost of the difference. Only the lower amount will count toward the family deductible of Plan E patients.

ALBERTA

Alberta's Blue Cross (Non-Group) and Palliative Care Drug Program are administered by Alberta Blue Cross under the authority of the Alberta Health Care Insurance Act and the Blue Cross Pharmacy Agreement.

Eligibility and Coverage

Beneficiaries of Alberta government-sponsored drug programs include:

- Alberta Blue Cross Non-Group Coverage (Group 1) – residents under the age of 65 and their dependents;
- Alberta Blue Cross Coverage for Seniors (Groups 66) – seniors aged 65 and over;
- Alberta Widows Pension Plan (Group 66A) – low income widows and widowers between the ages of 55-64;

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- Palliative Care Drug Program – residents who have been diagnosed as being palliative by a physician and are receiving treatments in their home;
- Alberta Child Health Benefit Program – for children under 18 living in families with low incomes;
- Alberta Health Special Drug Programs – cancer patients registered with the Alberta Cancer Board as well as Albertans who are HIV-positive; and
- MS Drug Coverage – patients with Multiple Sclerosis (MS) who meet a specific criteria.

The Special Drug Programs are also available through the Calgary Regional Health Authority, the Capital Health Authority, and the Alberta Cancer Board for the treatment of cystic fibrosis, growth hormone deficiency, HIV/AIDS and transplants.

Deductibles, Co-payments and Professional Fees

There are no deductibles in Alberta's drug programs. Residents must pay their Alberta Health Care Insurance premiums to be eligible for the Group 1 plan, while all other plans provide premium-free coverage. Premiums are \$41 per month for family coverage and \$20.50 per month for single coverage. Groups 1, 66 and 66A provide up to \$25,000 in coverage per subscriber in each benefit year. The programs cover 70% of the cost of prescription drugs, including insulin, while the subscriber pays 30% (to a maximum of \$25 for each drug prescribed). The Palliative Care Drug Program provides coverage similar to that provided by Groups 66 and 66A. The maximum out-of-pocket cost is \$1,000. There are no co-payments for the Alberta Child Health Benefit Program.

Cost Reimbursement

Drugs covered by Alberta's plans are listed on the Alberta Health and Wellness Drug Benefit List. The Alberta Health and Wellness Committee on Drug Evaluation and Therapeutics makes recommendations on the List while the Minister of Health and Wellness makes final decisions on listings and approvals of drug products. The Alberta Human Resources and Employment Drug Benefit Supplement defines drug coverage provided to Alberta Human Resources and Employment clients, Alberta Children's Services clients and Alberta Child Health Benefits recipients.

Where the Least Cost Alternative (LCA) price policy is followed, the Alberta government-sponsored drug programs will pay the Actual Acquisition Cost (AAC) of the drug material to a maximum of the LCA price. In addition, where the Maximum Allowable Cost (MAC) price policy is followed, the programs will pay the AAC of the drug material to a maximum of the MAC price. The MAC price is the maximum unit cost established for a specific drug product or a selected group of interchangeable drug products. If a patient chooses a higher priced interchangeable product subject to the LCA policy or a specific product subject to the MAC price policy, the patient will be responsible for any additional cost(s).

SASKATCHEWAN

The Saskatchewan Prescription Drug Plan, Saskatchewan Aids to Independent Living and Multi-Provincial HIV Assistance Program are administered by the Drug Plan and Extended Benefits Branch of Saskatchewan Health under the authority of the Saskatchewan Prescription Drug Act & Regulations.

Eligibility and Coverage

- Saskatchewan Prescription Drug Program – all residents of Saskatchewan with valid Saskatchewan Health Coverage unless they are covered by another federal or provincial government or non-government agency;
- Saskatchewan Aids to Independent Living – persons with cystic fibrosis and chronic end-stage renal disease, paraplegics, registered palliative care patients and residents with certain high-cost drugs, such as AIDS and transplant therapy; and
- Multi-Provincial HIV Assistance – persons who became infected with HIV through the Canadian blood system.

Certain drugs are approved for coverage under the Exception Drug Status (EDS) Program, upon review and recommendation of the Saskatchewan Formulary Committee (SFC). These drugs are subject to the same deductible and co-payment as the patient's Formulary drugs, with the exception of certain high cost drugs which are provided at no charge to the patient.

Deductibles, Co-payments and Professional Fees

Saskatchewan Prescription Drug Program:

- Seniors – Guaranteed Income Supplement (GIS) benefits recipients pay a semi-annual deductible of \$200 with a 35% co-payment thereafter if living in the community. The semi-annual deductible is \$100 with a 35% co-payment thereafter if residing in a special care home. Those receiving Saskatchewan Income Plan (SIP) benefits must pay a \$100 semi-annual deductible with a 35% co-payment thereafter.
- Recipients of Income Assistance – \$100 semi-annual deductible and a 35% co-payment. Adults on Family Health Benefits have a \$100 deductible while children do not pay anything.
- Saskatchewan Assistance Plan – \$2 per prescription. This fee is waived for certain adults and children under 18 years of age, as well as registrants on long-term medications.
- Special Support – the amount of assistance for which the beneficiary is eligible is determined on a case-by-case basis. A family that qualifies for Special Support may pay a co-payment based on the amount that the family drug costs exceed 3.4% of the adjusted combined family income (\$3,500 deducted for each dependent under the age of 18) from the most recent taxation year.
- Supplementary Health – Plan One beneficiaries pay a maximum of \$2.00 per prescription while Plan Two and Three beneficiaries receive benefits at no charge to them.

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- Drug Plan Emergency Assistance – level of assistance provided will be in accordance with the consumer's ability to pay and is offered only once in a lifetime.
- All Others – a deductible of \$850 semi-annually per person or family and a 35% co-payment per prescription.

On July 1, 2002, the \$850 semi-annual deductible was eliminated. Families who previously relied on the \$850 semi-annual deductible must apply to the Drug Plan for Special Support coverage if they wish to be assessed for assistance. Financial assistance will be available when an individual or family's prescription drug costs exceed 3.4 per cent of total family income.

Saskatchewan Aids to Independent Living and Multi-Provincial HIV Assistance – drug costs are fully covered

The maximum professional fee for prescription drugs is \$7.22.

In extremely rare cases where a person is not able to use a particular brand of product, the physician may request exemption from full payment of incremental cost when a specific brand of drug in an interchangeable category is found to be essential for a particular patient. There is no provision for 'blanket' exemptions; each request must be patient- and product-specific.

Cost Reimbursement

The Minister of Health compiles the Saskatchewan Formulary on the advice of the SFC. The SFC also looks at the clinical information provided by the Drug Quality Assessment Committee. The Drug Plan and Extended Benefits Branch (DPEBB) prepares, maintains and distributes the Saskatchewan Formulary.

The DPEBB requires drug manufacturers to provide guaranteed maximum prices for the Formulary period. The prices constitute the Maximum Allowable Cost the Drug Plan will allow for those products during the effective Formulary period.

The prescription cost is calculated by adding the acquisition cost of the drug material, the submitted mark-up and a dispensing fee (up to a maximum). The maximum mark-up allowance calculated on the prescription drug cost is:

- 30% for a drug cost up to \$6.30;
- 15% for a drug cost between \$6.31 and \$15.80; and
- 10% for a drug cost of \$15.81 and over (there is a \$20 maximum cap on pharmacy mark-up).

For urine-testing agents, the pharmacy receives acquisition cost along with the mark-up and a 50 per cent mark-up in place of the dispensing fee. For insulin, the pharmacy receives acquisition cost plus a negotiated mark-up.

MANITOBA

The Insured Benefits Branch of Manitoba Health administers Manitoba's Pharmacare Program and Personal Care Home Drug Program under the authority of The Prescription Drugs Cost Assistance Act and The Health Services Insurance Act & Regulations. Manitoba Family Services administers The Social Allowance Health Services (SAHS) Program under the authority of the Social Allowances Act.

Eligibility and Coverage

All Manitoba residents who make their home and are physically present in Manitoba at least six months in a calendar year are covered by its drug program.

- Pharmacare Program – all residents, regardless of age, whose income is seriously affected by high prescription drug costs. Applicants must meet all of the following criteria:
 - eligible for Manitoba health coverage;
 - prescriptions are not paid through other provincial or federal programs;
 - prescription costs are not fully covered by a private drug insurance program; and
 - eligible prescription drug costs exceed the Pharmacare deductible.
- Personal Care Home Drug Program – residents of personal care homes
- Social Allowance Health Services – clients who are enrolled in the Employment and Income Assistance (EIA) program.

Drugs for a number of medical conditions such as cancer, palliative care and organ transplants are provided through designated hospital programs.

Deductibles, Co-payments and Professional Fees

Pharmacare Program – deductibles are based on annual total family income: 2% for those with a total family income up to \$15,000 per year and 3% for those with a total family income greater than \$15,000 per year. Total family income may be reduced by \$3,000 for a spouse and for each dependent child under 18 years of age. A minimum \$100 deductible is applied to all clients. Beneficiaries receive 100% reimbursement once the deductibles have been reached.

Personal Care Home Drug Program and **Social Allowances Health Services** – no deductibles.

There are no co-payments under Manitoba's plan.

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Cost Reimbursement

The Manitoba Drug Benefits and Interchangeability Formulary is compiled with the advice of the Manitoba Drugs Standards and Therapeutics Committee, assisted by Manitoba Health staff and outside consultants. The Minister of Health gives the final approval for benefits under the Pharmacare drug benefit program. The Formulary lists benefits under the Pharmacare program and provides a list of interchangeable drugs.

The Personal Care Home Prescribing Guide lists those drugs that are preferred for use in personal care homes. Insured drug benefits under the Social Allowance Health Services program are listed in the Social Services Drug Program Benefits and Procedure Manual.

Manitoba Pharmacare will reimburse only up to the level of the lowest price in an interchangeable category for those interchangeable drugs that are Pharmacare benefits. Maximum Allowable Cost (MAC) is the primary basis for cost reimbursements. For personal care home patients, cost reimbursement is based on Actual Acquisition Cost (ACC).

ONTARIO

The Drug Programs Branch of the Ministry of Health and Long-Term Care administers the Ontario Drug Benefit (ODB) Program, the Trillium Drug Program and the Special Drugs Program. These programs are delivered under the authority of the Ontario Drug Benefit Act and the Drug Interchangeability and Dispensing Fee Act.

Eligibility and Coverage

Residents of Ontario who are valid members of the Ontario Health Insurance Plan (OHIP) are eligible for benefits under one of the following categories:

- ODB - 65 years of age or older;
 - residents of long-term care facilities;
 - residents of Homes for Special Care;
 - patients receiving professional services under the Home Care program;
 - Trillium Drug Program recipients; and
 - patients receiving social assistance (General Welfare or Family Benefits Assistance).
- Trillium Drug Program – patients with high costs in relation to their income;
 - patients whose private insurance does not cover 100% of prescription drug costs; and
 - patients who are not eligible for drug coverage under the ODB.

- Special Drugs Program – patients with one of the diseases or conditions covered;
 - applicants who meet the established clinical criteria; and/or
 - applicants approved by a designated centre/physician for a specific drug product.

The Special Drugs Program covers certain outpatient drugs used in the treatment of cystic fibrosis, thalassaemia, AIDS, end stage renal disease, Gaucher's disease, schizophrenia, children with growth failure and solid organ or bone marrow transplant recipients.

Specific Over-the-Counter (OTC) drug products are also covered by the ODB program and are listed in the Formulary.

In some cases where the only treatment available to improve a patient's health is not covered by the ODB program, a request for special coverage of the non-listed product can be made. This process is known as the Section 8 mechanism.

Deductibles, Co-payments and Professional Fees

ODB – single seniors (aged 65 or older) who have an annual income of \$16,018 or more and seniors in couples with a combined annual income of \$24,174 or more pay a \$100 deductible. After the deductible has been reached, they pay a maximum of \$6.11 toward the dispensing fee for each prescription. All other ODB beneficiaries pay up to \$2 for each prescription.

Trillium Drug Program – a deductible of approximately 4% of individual or household net income paid in four installments over the program year. Once the deductible has been paid, the patient may be asked to pay up to \$2 per prescription. Applicants who enroll into the program partway through the program year pay a prorated deductible. This deductible is based on the number of days left in the program year.

Special Drugs Program – this program has no deductibles or co-payments.

Patients who have drug products approved through the Section 8 mechanism must pay the same deductibles or co-payments as they would under the ODB or Trillium Drug Programs. However, the costs of non-ODB drugs will not normally count toward the Trillium deductible.

Pharmacists receive up to a maximum \$6.47 professional fee.

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Cost Reimbursement

The Drug Programs Branch of the Ministry of Health and Long-Term Care is responsible for the publication of the Ontario Drug Benefit Formulary/Comparative Drug Index (CDI). The Formulary was developed in consultation with the Ontario Drug Quality and Therapeutics Committee (DQTC). Only drug products that have received an NOC and a DIN from the federal government can be considered for listing in the Formulary. Submissions for listing made to the Ontario Ministry of Health are reviewed by the DQTC.

When both generic and brand name products are available, the ODB program pays the pharmacist for the lowest cost interchangeable generic product listed in the Formulary. The drug cost set out opposite the listed drug product in Part III of the Formulary/CDI is the Drug Benefit Price (DBP). Drug products listed in Part III are reimbursed at the listed DBP (or lowest DBP for an interchangeable category) plus a 10% mark-up plus the lesser of a pharmacy's posted usual and customary fee or the ODB dispensing fee, minus the applicable co-payment for every ODB prescription filled.

QUEBEC

Quebec's Prescription Drug Insurance Plan (la régime général d'assurance médicaments) is administered by the *Régie de l'assurance maladie du Québec* (RAMQ) under the authority of the *Loi sur L'assurance-médicaments et modifiant diverses dispositions législatives*.

Eligibility and Coverage

Quebec's Prescription Drug Insurance Plan provides obligatory basic coverage for all Quebecers. RAMQ covers the following persons and their children:

- persons without access to a group plan (the general category of persons covered);
- income security recipients and other holders of a *carte de réclamation* (claim slip);
- persons 65 years of age and over.

Deductibles, Co-payments and Professional Fees

Insured persons (except children) pay a deductible of \$8.33 of their drug cost every month. Annual premiums range from \$0 to \$385 and a required co-payment of 25% of the prescription cost. The monthly maximums for the co-payment system are:

- \$16.66 to a maximum annual contribution of \$200 for social assistance recipients receiving the Guaranteed Income Supplement (GIS);
- \$41.66 per month for seniors receiving partial GIS to a maximum of \$500 per year;
- \$62.49 per month to a maximum of \$750 per year for all others plus a \$25 deductible per quarter.

Beneficiary dependents, including children under 18, students between the ages of 18 and 25, and the handicapped receive their prescriptions free. Drugs used for the treatment of sexually transmitted diseases are also free of charge.

The following persons have had nothing to pay when purchasing prescription drugs since October 1, 1999:

- income security recipients with severe employment constraints; and
- persons 60 to 64 years of age with severe employment constraints who receive a spouse's allowance or a widow's allowance from Old Age Security and hold a *carnet de réclamation*.

Cost Reimbursement

Drugs whose cost is covered by the Basic Prescription Drug Insurance Plan are included on the List of Insured Medications (*Liste de médicaments*). The List is drawn up by the Minister of Health and Social Services in consultation with the Advisory Council of Pharmacology.

The prices indicated on the List of Medications are established according to the "guaranteed selling price" concept, in keeping with the manufacturer's commitment and in accordance with the method of establishing drug prices provided for in section 60 of the Act Respecting Prescription Drug Insurance. However, no price is indicated on the list for certain drugs, in which case the price payable is the pharmacist's actual acquisition price. Where the guaranteed selling price differs for sales to pharmacists and sales to wholesalers, the difference may not exceed 9% of the price submitted by the manufacturer.

The price paid by RAMQ is the price at which an accredited manufacturer or wholesaler sells the drug. This price is equal to the actual purchase price or, in certain cases, is the maximum price indicated on the list. For certain drugs that have appeared on the List for 15 years or more and that are produced by two or more manufacturers, the lowest price method is used to establish the price.

NEW BRUNSWICK

The New Brunswick Prescription Drug Program (PDP) is administered by Blue Cross of Atlantic Canada under the authority of the Prescription Drug Payment Act and Regulations.

Eligibility and Coverage

The PDP program, a payer of last resort, consists of 12 individual drug plans designed to meet the needs of specific groups:

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- Plan A (Seniors) – residents of the province 65 years of age and older; in receipt of Old Age Security/Guaranteed Income Supplement (GIS); or, who qualify for benefits based on annual income as follows:
 - single person, income not over \$17,198
 - combined income with spouse over 65, income not over \$26,955; combined income with spouse under 65, income not over \$32,390
- Plan B (Cystic Fibrosis) – persons with cystic fibrosis;
- Plan E (Family and Community Social Services) – persons in licensed residential facilities who are in receipt of financial assistance from the Department of Family & Community Social Services (FCSS) and hold a valid health card issued by FCSS;
- Plan F (Human Resources Development) – Family and Community Service clients;
- Plan G (Children in Care) – special needs children and children in care of the Minister of Family & Community Services;
- Plan H (Multiple Sclerosis) – individuals who have a valid NB Medicare Card and are in possession of a prescription written by a neurologist for the medications Avonex, Rebif, Betaseron or Copaxone;
- Plan R (Organ Transplant) – organ transplant recipients;
- Plan T (Human Growth Hormone) – individuals with growth hormone deficiency;
- Plan U (HIV) – persons who are HIV positive;
- Plan V (Nursing Home residents) – beneficiaries in registered nursing homes.

No person is eligible to receive benefits if the person has, or is covered by, any other contract or insurance plan.

Deductibles, Co-payments and Professional Fees

Plan A – co-pay of \$9.05 per prescription for GIS beneficiaries (annual maximum of \$250) and \$15 per prescription for income-tested beneficiaries;

Plan E – co-pay of \$4 per prescription up to a yearly maximum of \$250 per person.

Plan F – co-payment of \$4 per prescription for adults (18 and over) and \$2.00 for children (under 18 years) up to a yearly maximum of \$250 per family unit.

Plans G & V – no co-pays

Plan H – \$50 annual premium and co-payment amounts ranging from \$0 to 100% of the drug cost for each prescription. Co-payment is determined during the application process and is based on discretionary income.

Plans B, R, T and U – \$50 annual premium and a co-payment of 20% (maximum of \$20 per prescription) up to an annual ceiling of \$500 per family unit. Clients with a valid health card from HRD-DB are exempt from paying the annual registration fee and will have a co-pay to reflect Plan F.

Professional fees are based on a sliding scale from \$8.40 to \$160.

Cost Reimbursement

Drugs covered under the PDP are listed in the New Brunswick Prescription Drug Program Formulary. The Prescription Drug Program Advisory and Utilization Committee reviews and makes evidence-based recommendations to the Minister of Health and Wellness on the benefit status of drugs.

A Maximum Allowable Cost (MAC) for ingredients is payable directly to the dispensing pharmacy. The MAC is applicable to interchangeable products and some single source products where the maximum allowable price is published in a bulletin.

Pharmacy mark-ups were eliminated in 1996. The only other professional service covered by the PDP is for the dispensing of oral contraceptives (\$7.40) and the extemporaneous preparations that are reimbursed at 1.5 times the dispensing fee for the first two ingredient categories and at the listed dispensing fee for ingredient cost over \$200.

NOVA SCOTIA

Nova Scotia's Pharmacare program is administered by Maritime Medical Care under the authority of Health Services & Insurance Act and the Family Benefits Act.

Eligibility and Coverage

- Seniors' Pharmacare – offered to residents who are 65 years of age and older and who do not already have prescription drug coverage through a private insurance plan, Veterans Affairs Canada, or Indian and Inuit Health Services. The senior must also be registered under the Medical Services' Insurance (M.S.I.) Program. Program participation is optional. Privately insured seniors are ineligible for Pharmacare.
- Community Services Pharmacare – offered to residents and their dependents that are registered with the Social Assistance Program or the Family Benefits Program.

Additional coverage is extended to diabetics through the income-based Diabetic Assistance Pharmacare Program and to cancer patients through the Canadian Cancer Society Program, also an income-based program.

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Limited benefits are also available through special drug programs for residents with certain health conditions including cystic fibrosis, growth hormone deficiency, HIV/AIDS and organ transplants.

Deductibles, Co-payments and Professional Fees

Seniors' Pharmacare – annual premium of \$215 and a 33% co-payment (to a maximum of \$350 a year) with each prescription filled. Seniors in receipt of Guaranteed Income Supplement (GIS) do not pay the premium. Other low-income seniors are eligible to receive a tax credit of up to \$300 per year to refund the cost of the premium and the co-payments.

Community Services Pharmacare – a flat co-payment of \$5 per prescription. There is no co-pay for disabled persons.

There are no deductibles under Nova Scotia's Pharmacare program.

Cost Reimbursement

The Nova Scotia Formulary Management Committee approves listings of new drugs on the Nova Scotia Formulary. The Drugs and Therapeutics Committee is responsible for recommending to the Department of Health those products which will appear as interchangeable in the Formulary.

A Maximum Allowable Cost (MAC) program sets the maximum allowable price for each interchangeable drug category with benefit status, based on the lowest priced drug in the category. The additional cost of a higher priced brand (usually the brand name product) is paid by the patient who may, for one reason or another, choose such brand. In the documented adverse reaction to a particular brand, exceptions can be made to cover the cost of the brand product.

PRINCE EDWARD ISLAND

The Prince Edward Island government provides prescription drug coverage through the Drug Cost Assistance Plan (DCAP) and through special drug programs such as the Diabetes Oral and Insulin, Cystic Fibrosis, and Organ Transplant programs, among others. The DCAP is administered by the Department of Health and Social Services under the authority of the Drug Cost Assistance Act and the Welfare Assistance Act.

Eligibility and Coverage

- Drug Cost Assistance Plan – provides coverage to: persons under 18 years of age in temporary or permanent custody of the Director of Child Welfare (*Child-In-Care Program*); persons with diabetes eligible for PEI Medicare (*Diabetes Control Program*); families eligible for PEI Medicare, with one or more children under 18 years of age, and a total annual net family income of \$20,000 or less (*Family Health Benefit Program*); persons eligible for assistance as determined by the Welfare Assistance Act and Regulations (*Financial Assistance Program*); persons eligible for PEI Medicare, diagnosed with relapsing-remitting or secondary progressive multiple sclerosis (*MS Medications Program*); and, seniors 65 years of age or older and eligible for PEI Medicare (*Seniors DCAP*).
- Special drugs programs also provide prescription drug coverage to residents with AIDS/HIV, cystic fibrosis, chronic renal failure, growth hormone deficiency, meningitis, hairy cell leukemia, AIDS-related Kaposi's sarcoma, Non-A, Non-B/C hepatitis and basal cell carcinoma, rheumatic fever, STDs, TB, and organ or bone marrow transplants.

Deductibles, Co-payments and Professional Fees

Drug Cost Assistance Plan – seniors pay a professional fee of \$7 plus the first \$10 of the ingredient cost per prescription. Registered diabetics pay an \$8 charge for oral diabetes drugs and urine testing materials and \$8 per vial of insulin. Multiple Sclerosis Program clients pay an income-based portion of the drug cost plus the professional fee. Persons registered under the Family Health Benefit Program pay the first \$13.00 of the medication cost plus the professional fee for each prescription. Social assistance recipients pay no co-payment for prescriptions filled at government pharmacy or community pharmacies. There are no charges for those registered under the Children-In-Care Program.

100% coverage is provided for drugs registered under the special drugs program. There are no deductibles under PEI's drug program.

Cost Reimbursement

PEI's Drug Cost Assistance Formulary is compiled by the Minister of Health and Social Services with the advice of the PEI Pharmacy Advisory Committee.

Under the DCAP, seniors are responsible for paying \$8.00 towards the total cost of the drug ingredient and also for paying the pharmacist's professional fee. The government pays the balance of the ingredient cost that remains. This portion is paid directly to the pharmacy.

A Maximum Allowable Cost (MAC) list is published twice yearly for most categories of interchangeable products listed in the Formulary.

NEWFOUNDLAND

The Drug Programs Division of the Department of Health and Community Services administers the Newfoundland and Labrador Prescription Drug Program (NLPDP) under the authority of the Pharmaceutical Association Act of 1994.

Eligibility and Coverage

Eligible beneficiaries include senior citizens 65 years of age or older receiving Old Age Security and the Guaranteed Income Supplement (GIS). The NLPDP also covers the drug costs of social assistance recipients, and residents of nursing homes and/or long-term care facilities if they are eligible for the seniors' plan or social service plan. The program also provides coverage to eligible seniors or social service clients with cystic fibrosis, diabetes, cancer, HIV or organ transplantation.

Deductibles, Co-payments and Professional Fees

There are no deductibles under Newfoundland's drug plan. Patients pay dispensing and other professional services provided by the pharmacist. Social assistance recipients pay no co-payments; the Department of Health pays for the entire cost of the drug as well as a maximum of \$5 per prescription towards the dispensing fee.

Cost Reimbursement

The Newfoundland and Labrador Interchangeable Drug Products Formulary is compiled by the Minister of Health and Community Services with the advice of the Newfoundland Formulary Committee.

The Prescription Drug Program will pay the portion of the total prescription cost that includes the entire cost of the drug ingredients directly to the pharmacy. For drugs listed in the Formulary, the amount paid by the government will be the maximum of the lowest price listed in a category. Any difference between the lowest price product and any other product in a particular category is the responsibility of the patient and paid directly to the pharmacy. The patient is also responsible for payment of dispensing fees, the pharmacy's expenses and other professional services.

Appendix C

Methodological Notes

Methodological Notes

Each year, the Canadian Institute for Health Information (CIHI) publishes estimates of health expenditures from its National Health Expenditures Database. The expenditures are grouped into seven categories: hospitals, other institutions, physicians, other professionals, drugs, capital, and other health spending. A detailed breakdown is then provided, at the national and provincial levels, of prescribed and non-prescribed drug expenditures. CIHI figures include retail and wholesale mark-ups as well as dispensing fees.

Public Plan Expenditures

A brief one-page questionnaire was sent to all provinces requesting basic cost information regarding their provincial drug plans. This information included the level of coverage in each province, co-payments, deductibles, professional fees, drug ingredient cost, total drug plan payment and total program cost. The following table summarizes the results.

	\$ millions
Drug Material cost	\$4,913.76
Dispensing Fee	\$1,070.73
Total Prescription Cost	\$5,984.48
Deductibles and Co-payments	\$1,460.50
Total Drug Plan Payment	\$4,523.98
Drug Material Cost as a % of Prescription Cost	82.11%
Dispensing Fee as a % of Prescription Cost	17.89%
Deductibles and Co-pays as a % of Prescription Cost	24.40%

As survey results were only received from eight of the ten provinces, estimates were made for Newfoundland and PEI's public drug expenditures using data provided by CIHI. The total drug plan payment of \$4,524.2 million corresponds somewhat closely to the CIHI forecast public prescription drug expenditures of \$5,508.9³¹ million for 2001. The drug material costs, dispensing fees, deductibles and co-payments were adjusted accordingly so that the total drug plan payment corresponds to CIHI's forecast public prescribed drug expenditures for 2001. The following table outlines the adjusted expenditures.

³¹ Canadian Institute for Health Information, Drug Expenditures in Canada 1985 – 2001, April 2002. Note: This figure is based only on the public prescription drug expenditures of the ten provinces and not of the territories. It also includes prescription drug expenditures from federal drug programs and social security funds.

Table C2

Adjusted Distribution of Public Drug Expenditures

	\$ millions
Drug Material cost	\$6,001.67
Dispensing Fee	\$1,307.79
Total Prescription Cost	\$7,309.46
Deductibles and Co-payments	\$1,783.86
Total Drug Plan Payment	\$5,525.61
Drug Material Cost as a % of Prescription Cost	82.11%
Dispensing Fee as a % of Prescription Cost	17.89%
Deductibles and Co-pays as a % of Prescription Cost	24.40%

Private Expenditures

Private prescribed drug expenditures include costs incurred by:

- private insurance plans or third party payers that offer drug plan coverage as part of extended health care benefits to employers, unions, associations and other groups,
- individuals with no insurance, and
- insured individuals on products ineligible for benefits (brand upgrades and unlisted products) or on products that are eligible but for which claims were not filed.

It is estimated that about 10% of all Canadians are uninsured while about 52% are covered under private insurance plans. This study assumes that all members of private plans are under the age of 65 as all provincial drug programs offer some sort of coverage to seniors aged 65 and over. Since 87.4% of Canadians are under 65 years of age³², we know that the 52% of Canadians with private drug insurance represent 59.5%³³ of Canadians under 65.

In order to estimate the percentage of prescribed drug expenditures that are for people under 65, we have used figures from Saskatchewan Health. These figures, indicating that 55.6% of total prescription drug expenditures in the province are for those under 65 years of age, were then used to estimate total private plan payments. Based on information from ESI Canada, co-payments were estimated to be about 8% of total prescription cost while drug ingredient costs were 86% and dispensing fees 14%.

³² Health Canada.

³³ This may be higher than the actual number of people covered under private plans as there may be an overlap of patients who have coverage through employers and through individual drug plans.

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Table C3

Private Drug Plans

	\$ millions
Total Rx Drug Expenditures	\$12,303.0
% of Total Rx Drug Expenditures (under age 65)*	55.6%
Rx Drug Expenditures (under age 65)	\$6,840.8
% of Individuals with Private Plan Coverage (under 65)	59.5%
Private Plan Prescription Cost (after co-payments)	\$3,682.4
Private Plan Co-payment	8.0%
Private Plan Prescription Cost (before co-payments of 8%)	\$4,002.6
Co-payment of 8%	\$320.2
Drug Ingredient Cost (86% of prescription cost**)	\$3,442.2
Dispensing Fees (14% of prescription cost**)	\$560.4

* Saskatchewan Health Prescription Drug Expenditures *Annual Report 2001*

** ESI Canada

Prescribed drug expenditures by Canadians with no drug plan insurance are estimated using the same calculations as for private drug plan expenditures. Again, it is our assumption that all individuals with no insurance are under the age of 65. The 10% of Canadians with no insurance represent 11.4% of those under 65 years of age. Total prescription costs, proportions of drug ingredient costs and dispensing fees remain the same.

Table C4

Individuals with No Insurance

	% millions
Total Rx Drug Expenditures	\$12,303.0
% of Total Rx Drug Expenditures (under age 65)*	55.6%
Rx Drug Expenditures (under age 65)	\$6,840.8
% of Individuals with No Insurance (under 65)	11.4%
Prescription Cost	\$782.7
Drug Ingredient Cost (86% of prescription cost**)	\$673.2
Dispensing Fees (14% of prescription cost**)	\$109.6

* Saskatchewan Health Prescription Drug Expenditures
Annual Report 2001

** ESI Canada

The following table summarizes the deductibles and co-payments made by individuals under both public and private drug benefit plans.

Table C5

Co-payments and Deductibles Paid by Individuals

	\$ millions
Public Plan Co-payments and Deductibles (see Table C2)	\$1,783.9
Private Plan Co-payments	\$320.2
Total	\$2,104.1

Other out-of-pocket drug expenditures are based on CIHI's forecast data for out-of-pocket costs under private prescribed drug expenditures. This figure is calculated as a residual of CIHI's out-of-pocket costs after subtracting total drug expenditures of uninsured individuals. As mentioned earlier, this includes expenses for drugs ineligible for public or private drug benefit plans, brand upgrades or claims that were not submitted. Again, the same proportions of total prescription costs are used for drug ingredient costs and dispensing fees.

Table C6

Other Out-of-Pocket Expenditures

	\$ millions
Total Private Rx Drug Expenditures	\$6,777.4
Less: Private Plan Prescription Cost after co-payments (see Table C3)	\$3,682.4
Less: Uninsured Individuals Prescription Cost after co-payments (see Table C4)	\$782.7
Less: Co-payments and Deductibles Paid by Individuals	\$2,104.1
Prescription Costs	\$208.2
Drug Ingredient Cost (86% of prescription cost*)	\$179.1
Dispensing Fees (14% of prescription cost*)	\$29.2

* ESI Canada

The following table summarizes the expenditures by individuals.

Table C7

Distribution of Expenditures by Individuals

	\$ millions
Uninsured Individuals (see Table C4)	\$787.7
Co-payments and Deductibles Paid by Individuals (see Table C5)	\$2,104.1
Other Out-of-Pocket Expenditures (see Table C6)	\$208.2
Total Individual Expenditures	\$3,095.0

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National Pharmacare Provincial Drug Plans Survey

Please provide information for the year 2001 (or 2000, if 2001 not available) for the provincial drug plan. In addition, please indicate in the comments section, any remarks that might be useful in understanding the strengths, weaknesses and limitations of the data provided.

Drug Benefit Plan Summary Statistics				
	Over 65	Social Service	Other	Total
Eligible Beneficiaries				
Active Beneficiaries				
Number of Prescriptions				
Drug Material Cost (1)				
Dispensing Fee (2)				
Deductible/Co-payments (3)				
Total Drug Plan Payment (4)				
Program Administration Cost (5)				
Total Program Cost (6)				

Notes:

- (1) Includes wholesale & retail markups where applicable.
- (2) Dispensing or professional fees charged by the pharmacist.
- (3) Deductibles and co-payments paid by the beneficiary.
- (4) Drug plan payment is the total of the drug material cost and dispensing fee less deductibles, co-payments and prescription charges paid by the beneficiary to the pharmacy.
- (5) The cost of administering the drug benefit plan including public servant salaries, the cost of therapeutics committees, informatics support, etc.
- (6) The total cost to the province of the drug benefit plan.

What percentage of the province's population is not covered by the provincial drug benefit plan?

What percentage of the province's population is covered solely by private drug benefit plans?

What percentage of the province's population has coverage from both provincial and private benefit plans?

What percentage of the province's population has no drug coverage at all?

Additional comments:

Appendix D

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