BC PharmaCare

Annual Performance Report

2005

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BRITISH COLUMBIA
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A message from the Assistant Deputy Minister, Pharmaceutical Services, Ministry of Health

I am pleased to announce the publication of Pharmaceutical Services Division's Annual Performance Report for 2005.

This report, an expansion of the information previously published in *PharmaCare Trends*, provides background and updates on many of the projects and initiatives we consider vital to advancing evidence-based pharmaceutical policy in British Columbia and across Canada. It also highlights our progress with the ongoing work of delivering an effective, balanced, and responsive PharmaCare program.

Future performance reports will include updates on the growth of our division; the expansion of our role in provincial health care; and our cooperative endeavours with our provincial, territorial, and federal colleagues.

I am sure you will find the information in this report both interesting and useful. Your suggestions for topics for inclusion in subsequent versions are welcome. Please e-mail your comments to pharma@gov.bc.ca.

Original signed by
Bob Nakagawa, B.Sc. (Pharm.), ACPR, FCSHP
Assistant Deputy Minister
Pharmaceutical Services

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Preface

This publication, the first full annual performance report for PharmaCare (now the Pharmaceutical Services Division of the B.C. Ministry of Health), supercedes *PharmaCare Trends*.

In addition to the key statistical and financial information which was previously published in *PharmaCare Trends*, it offers comprehensive information on PharmaCare program performance for 2005.

Please note that the primary PharmaCare plan, Fair PharmaCare, is based on a calendar year. As a result, annual performance reports will focus primarily on the previous calendar year.

1. Highlights 2005

Ministry Goals

- *Improved health and wellness for British Columbians.*
- *High quality patient care.*
- *A sustainable, affordable health care system.*

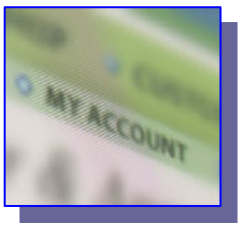
PharmaCare Mission

- *To provide British Columbians with a cost-effective and evidence-based universal drug program.*

In 2005, PharmaCare (now the Pharmaceutical Services Division) made notable advances towards a more responsive, efficient and effective drug program for British Columbians.

Here are just a few of the program enhancements and contributions to provincial and national undertakings PharmaCare made in 2005. More detailed information on these and other activities is provided in later sections of this publication.

Fair PharmaCare Monthly Deductible Payment Option (MDPO)



The implementation of the Fair PharmaCare plan in 2003 set the stage for improved coverage for B.C. families who need it most. On January 1, 2005, we strengthened our commitment to lower-income families and to families facing significant drug expenditures by introducing the MDPO.

For families whose drug expenditures regularly exceed their Fair PharmaCare deductible, this payment option offers a new tool for managing their prescription expenses. Under the option, families pay their deductible in monthly instalments and receive PharmaCare assistance with eligible prescription costs right away, effectively spreading their costs over the full course of the year.

Transfer of BC Palliative Care Drug Program

Since 2001, B.C. residents who wish to receive palliative care services at home could request the provincial government's assistance with the cost of palliative medications, medical supplies and medical equipment through the Ministry of Health's Home and Community Care Division.

On April 1, 2005, PharmaCare assumed full administration of the B.C. Palliative Care Benefits Program and full funding of the drug portion of the program.

In 2005, nearly 8,000 patients received benefits under the B.C. Palliative Care Drug Plan portion of the program. Expenditures per patient have been approximately $1100 per year.

The Palliative Care Benefits Program is available to B.C. residents of any age who wish to receive palliative care at home. Physicians assess a patient's medical eligibility for the program and submit an application on the patient's behalf.

Shifting responsibility for this program to PharmaCare simplified administration and brought the provision of palliative care benefits into line with other PharmaCare plans.

For more information, refer to Appendix A.

Expanded Formulary

Since 2003, when Canada's national Common Drug Review process began, many generic and brand name drugs have been added to the PharmaCare formulary (i.e., the list of medicines that the PharmaCare program covers). In 2005 alone, 30 brand name and approximately 300 generic drugs were added.

For more information PharmaCare benefits, please refer to Section 2.3.

For more information on the national and provincial drug review processes, refer to Section 5.

Program Review Implementation

The full program review undertaken in Fall 2003 resulted in two priority action items:

- **Supply Chain Project**—The PharmaCare-pharmacy supply chain is a complex system encompassing brand and generic drug manufacturers, drug wholesalers, distribution centres, and chain and independent pharmacies.

  During 2005, PharmaCare completed a preliminary analysis of the current PharmaCare-pharmacy supply chain and pharmacy remuneration model. This analysis paves the way for development of a new supply chain model that balances appropriate pharmacy remuneration with cost efficiency.

- **Formulary Management Review**—We reviewed our formulary management models and processes in 2005. The review included discussions with the public, health care professionals and drug manufacturers. As a direct result of the review, we increased the staffing in our Formulary Management Unit to ensure the necessary resources were in place to support re-engineered formulary management process.

  For more information on current and planned enhancements to the Formulary Management process, please refer to Section 5.3.

Stakeholder Engagement Process

In 2005, we implemented a structured process to provide key stakeholders with a voice as well as a venue for their concerns.

Regular bilateral meetings with stakeholders were scheduled.

On November 28, 2005, a multilateral stakeholder session was held to share the objectives for 2005/06 and to give stakeholders the opportunity to have an input into the 2006/07 planning process.

The response to our renewed commitment to involving and informing stakeholders has brought fresh perspectives and highlighted new potential avenues for developing a stronger program.

For more information, refer to Section 7.

Health Insurance BC

On April 1, 2005, Maximus BC began delivering the administrative operations of the Medical Services Plan and PharmaCare through Health Insurance BC (HIBC).

The primary objective in transferring administrative functions to HIBC was to improve the efficiency of services to the public.

Between April 1, 2005, and December 31, 2005, Health Insurance BC handled over 125,000 Fair PharmaCare enquiries, processed nearly 49,000 Fair PharmaCare registrations, and completed over 6,000 case reviews.

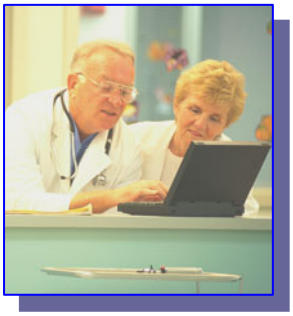
By the third quarter of 2005, HIBC was processing documents and applications within service level requirements—answering telephone enquiries from the public in an average time of less than three minutes, answering telephone enquiries from doctors and pharmacists, on average, within one minute—and had successfully maintained technology to ensure uninterrupted services.

Maintenance of the highest level of privacy protection for British Columbians was a key priority. In keeping with this goal, the government continues to own and control all information, to set all policy and to be accountable for the ultimate protection of the personal information of provincial residents.

PROVINCIAL INITIATIVES

EHEALTH DRUG STRATEGY–The provincial eHealth Drug Strategy defines the vision and requirements for improving delivery of care in B.C. by expanding the use of electronic medication management to facilitate seamless care across all care settings. Enhancements to PharmaNet are a key component of this strategy and of the development of Electronic Health Records for British Columbians.

Under the ministry's eDrug initiative, PharmaCare has taken two important steps towards electronic health records and electronic medication management (including electronic prescribing). We have laid the groundwork for enhanced content and scope of patient medication profiles on PharmaNet and have implemented provincewide Medical Practice Access to PharmaNet (MPAP):



- **MEDICAL PRACTICE ACCESS TO PHARMANET**: To improve patient care and safety, government made full access to PharmaNet medication histories available to physicians in private practice, group practice and walk-in clinics. The service became available provincewide on December 5, 2005, enabling authorized physicians to request a record of all medications dispensed to a patient.

  For more information, refer to Section 9.

GUIDELINES AND PROTOCOLS ADVISORY COMMITTEE (GPAC): PharmaCare contributes to the work of the GPAC, an advisory committee to the Medical Services Commission (MSC). Co-chaired by the British Columbia Medical Association and the Medical Services Plan, GPAC develops draft guidelines and protocols for external review and approves final guidelines and protocols for submission to the MSC for approval and adoption in B.C.

NATIONAL INITIATIVES

The B.C. Ministry of Health and PharmaCare have taken a strong and active role in national initiatives that encourage cooperation with the federal government, provincial governments and stakeholders. These cooperative undertakings promote better access to pharmaceutical treatment and the appropriate prescribing and use of prescription medication. Each is a critical step in the development of sustainable drug coverage programs in all provinces.

- **NATIONAL PHARMACEUTICALS STRATEGY (NPS)**: In September 2004, First Ministers directed Health Ministers to establish an NPS Ministerial Task Force. The federal and B.C. Ministers of Health co-chair the Task Force.

The NPS will examine and report on issues such as catastrophic drug coverage, expensive drugs for rare diseases, drug pricing and purchasing strategies, the possibility of a common national formulary and possible improvements in evaluation of drug safety and effectiveness.

For more information, refer to Section 8.

- **COMMON DRUG REVIEW (CDR)**: Launched in September 2003, the national CDR reviews the scientific evidence of the effectiveness of new drugs and makes coverage recommendations to provincial drug plans. The CDR helps provinces to identify effective drugs that represent the best value for money. All jurisdictions in Canada, except Québec, participate in the CDR. Three representatives from B.C. are current members of the CDR's Canadian Expert Drug Advisory Committee (CEDAC) which makes coverage recommendations to the provinces. The Executive Director of PharmaCare sits on CDR's cross-Canada Advisory Committee on Pharmaceuticals.

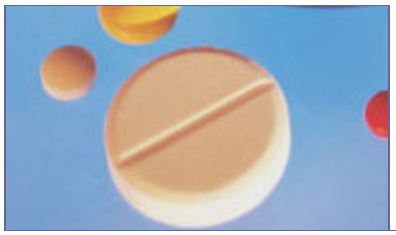
  For more information on the CDR, refer to Section 5.2.

- **CANADIAN OPTIMAL MEDICATION PRESCRIBING AND UTILIZATION SERVICE (COMPUS)**: COMPUS was launched by the Canadian Coordinating Office for Health Technology Assessment (now the Canadian Agency for Drugs and Technologies in Health) in 2004. It promotes and facilitates best practices in drug prescribing among health care providers and in drug use by consumers. A PharmaCare Senior Pharmacist sits on the cross-Canada Advisory Committee for COMPUS.

- **NATIONAL PRESCRIPTION DRUG UTILIZATION INFORMATION SYSTEM (NPDUIS)**—NPDUIS is a national database coupled with the analytical capacity to track and analyze the use of prescription drugs across Canada. It provides public drug plan managers with critical analyses of price, utilization, and cost trend information that helps them to make informed coverage decisions.

  The Senior Economist of PharmaCare is an active member of NPDUIS.

  For more information on senior PharmaCare staff, refer to Section 6.



2. PharmaCare Program Overview

PharmaCare is an integral part of British Columbia's health care infrastructure. Effective pharmaceutical treatment can prevent, cure, arrest or diminish the effects of many illnesses and conditions, easing the strain on the health care system as a whole and improving the quality of life of patients and their families.

PharmaCare assists B.C. residents in paying for prescription drugs and for designated medical supplies such as prosthetics, orthotics, ostomy supplies and diabetic supplies. Its formulary includes pharmaceutical treatments for a broad range of illnesses and conditions.

PharmaCare is one of Canada's most generous provincial drug programs. It is:

- one of only four provincial programs that provide universal catastrophic coverage to all its citizens.
- the only province with a no-charge psychiatric medication plan.
- one of only four provinces that do not require social assistance recipients to meet a deductible or make co-payments towards their drugs.
- one of the three provinces that provide no-deductible/ no-copayment coverage to individuals in residential care facilities.
- one of four provinces with a Cystic Fibrosis coverage plan.

British Columbians enjoy broad coverage of medications including:

- full coverage of drug administered to hospital in-patients,
- full coverage of chemotherapy and other drugs used in the treatment of cancer,
- full coverage of medications used to treat renal diseases,
- full coverage of anti-retroviral drugs for the treatment of HIV/AIDS, and
- special coverage for palliative care patients who choose to receive end-of-life care at home.

2.1 PharmaCare "Vital Stats"

19.8 million	Number of claims fully or partially funded by PharmaCare in 2005
1.27 million	Families registered for Fair PharmaCare by January 2005
$867 million	Total PharmaCare expenditures 2005/06 fiscal year

2.2 PharmaCare Plans

The Fair PharmaCare plan, introduced in 2003, provides B.C. residents with assistance based on financial need, rather than age or other factors.

Under the plan, all families have an annual deductible and a family maximum based on their income. Once they meet their deductible through the payments they make towards eligible prescriptions, PharmaCare begins contributing 70% towards their eligible prescription costs. When their payments for eligible costs reach their family maximum, PharmaCare contributes 100% to their eligible prescription costs for the rest of the calendar year.

By ensuring that no family pays more than 4% of their income towards their prescription drug costs, Fair PharmaCare insulates residents from potentially catastrophic drug costs.

PharmaCare also offers specialty plans for permanent residents of licensed long-term care facilities, those receiving income assistance from the Province, patients registered with a provincial Cystic Fibrosis Clinic, children eligible for medical or full financial assistance through the At Home Program of the Ministry of Children and Family Development, clients of mental health service centres and individuals who wish to receive palliative care at home.

2.3 PharmaCare Benefits

PharmaCare covers a wide range of products including:

- drugs prescribed by a physician, surgeon, dentist, midwife, nurse practitioner or podiatrist;
- insulin, needles, syringes and blood glucose monitoring strips for people with diabetes;
- digestive enzymes and nutritional supplements for people with Cystic Fibrosis;
- ostomy supplies;
- designated permanent prosthetic appliances; and
- children's orthotic devices (braces).

PharmaCare also funds antiretroviral drugs dispensed and managed through the B.C. Centre for Excellence in HIV/AIDS. Through the health authorities, the Ministry of Health funds medications for hospital in-patients and drugs distributed through the BC Cancer Agency, BC Renal Agency, BC Transplant Society and the BC Centre for Disease Control.

2005 - Top Ten Drugs

We are often asked which drugs are most commonly prescribed in B.C. Although all prescriptions filled at provincial community pharmacies are processed on PharmaNet, PharmaCare tracks only those prescriptions to which PharmaCare contributed a portion of the cost.

Top Ten Drugs by PharmaCare Expenditure

Generic Name	Commonly used to treat	PharmaCare Expenditure
ATORVASTATIN	High cholesterol	$ 43.3 million
OLANZAPINE	Psychosis	$ 26.5 million
RAMIPRIL	High blood pressure	$ 26.1 million
VENLAFAXINE	Depression	$ 17.3 million
INTERFERON BETA	Multiple sclerosis	$ 16.9 million
RABEPRAZOLE SODIUM	(GI) Reflux disease	$ 15.0 million
QUETIAPINE FUMARATE	Psychosis	$ 13.3 million
RISPERIDONE	Psychosis	$ 11.7 million
SIMVASTATIN	High cholesterol	$ 11.0 million
GABAPENTIN	Seizure	$ 10.2 million

Top Ten Drugs by number of PharmaCare Beneficiaries

Generic Name	Commonly used to treat	Distinct Beneficiaries
ACETAMINOPHEN WITH CODEINE 30 MG	Pain and Fever	139,000
AMOXICILLIN	Bacterial Infection	120,000
RAMIPRIL	High Blood Pressure	112,000
ATORVASTATIN	High Cholesterol	106,000
HYDROCHLOROTHIAZIDE	High Blood Pressure	103,000
LEVOTHYROXINE	Hypothyroidism	90,000
SALBUTAMOL	Asthma	79,000
LORAZEPAM	Anxiety	77,000
CIPROFLOXACIN	Bacterial Infection	71,000
METFORMIN	Diabetes	70,000

Benefit status

If included in the PharmaCare formulary, a drug is assigned a benefit status of full, partial or 'limited coverage':

- FULL BENEFITS are covered 100% within reasonable drug price limits set by PharmaCare.
- PARTIAL BENEFITS are covered up to a specific price limit under the Low Cost Alternative Program or Reference Drug Program. Under certain circumstances, a patient may qualify for full benefit coverage of a partial benefit through PharmaCare's Special Authority process.
- LIMITED COVERAGE DRUGS are drugs not normally regarded as first line therapies or drugs for which a more cost effective alternative exists. Limited Coverage drugs are PharmaCare benefits only for patients who meet certain Special Authority criteria. The criteria usually relate to their medical diagnosis and status or the outcome of previous treatments.

For more information on PharmaCare Special Authorities, refer to Section 5.4.

Actual coverage always depends on the rules of the individual's PharmaCare plan. For instance, if covered by Fair PharmaCare, an individual may need to meet a deductible before PharmaCare begins contributing to their prescription costs.

Maintaining affordable access

To control costs without sacrificing the range of pharmaceutical treatments covered, certain PharmaCare policies may reduce the amount PharmaCare contributes to a specific prescription:

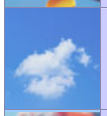
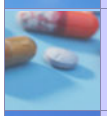
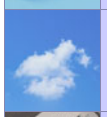
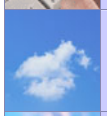
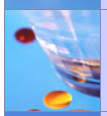
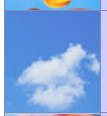
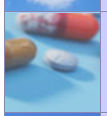
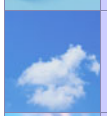
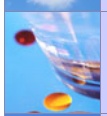
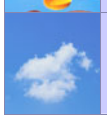
- REFERENCE DRUG PROGRAM: When a number of products contain different active ingredients but are in the same therapeutic class, PharmaCare promotes the use of the most cost-effective treatment through the Reference Drug Program.
- LOW COST ALTERNATIVE POLICY: When multiple medications contain the same active ingredient, PharmaCare promotes the use of the most cost-effective treatment through the Low Cost Alternative Program.
- MAXIMUM PRICING POLICY: The maximum amount a pharmacy can claim for drug cost when submitting claims for PharmaCare coverage is its Actual Acquisition Cost (AAC).

  To ensure claims reflect a reasonable AAC, there is a maximum price PharmaCare will recognize for each drug. This maximum is the manufacturer's catalogue price plus 7%.
- MAXIMUM DISPENSING FEE: The maximum dispensing fee recognized under PharmaCare in 2005 was $8.60.

If the cost of an eligible prescription exceeds the limit set under any the policies above, the patient may pay the balance of the cost and the balance of the cost will not count towards their Fair PharmaCare deductible.

2.4 Where We've Been—PharmaCare History

Since PharmaCare's inception in 1974, the Ministry of Health has delivered a high quality prescription drug coverage program responsive to the needs of British Columbians.

 1974	*B.C. PharmaCare Program introduced under the Ministry of Human Resources to provide coverage for seniors.*
 1977	*Universal drug coverage for B.C. residents introduced (as PharmaCare 'Plan E').*
 1987	*PharmaCare is transferred to the Ministry of Health.*
 1994	*The Low Cost Alternative Program is introduced to encourage the use of lower cost drugs.*
 1995	*PharmaNet, the provincewide network for prescription claim processing, is implemented.*
 1995	*Reference Drug Program is launched.*
 1997	*Emergency Room access to PharmaNet is launched.*
 2003	*Income-based Fair PharmaCare plan introduced ensuring resources are focused on those B.C. families who are most in need.*
 2005	*Monthly Deductible Payment Option introduced to help families distribute their expenses over the course of the year.*
 2005	*Health Insurance BC becomes the alternate service delivery provider for PharmaCare and Medical Services Plan operations.*
 2005	*PharmaCare takes leading role in development of the National Pharmaceuticals Strategy.*
 2005	*Medical Practice Access to PharmaNet implemented.*

Note that, in January 2006, the Pharmaceutical Services Division was formed. The division's mandate includes oversight for the PharmaCare program.

2.5 Where We're Going

Shifting demographics, exponential growth in the number of new drugs and drug formulations being developed, and increasing complexity in the pharmaceutical supply chain are just some of the pressing issues that continue to challenge Canada's provincial drug coverage programs.

However, unique opportunities also exist. Provincial governments can look forward to using technological advances and investments in cooperative ventures with other provinces, with health care providers and with stakeholders, to improve health outcomes for their citizens.

3. Health Sector Challenges

Across Canada, publicly funded drug coverage programs are seeking solutions to common issues that may impede their ability to provide reasonable access to drug therapy.

All provinces, whether individually or cooperatively, will need to respond to significant challenges in the coming years. These include:

- CHANGING DEMOGRAPHICS: British Columbia's population is expected to increase by approximately 45,000 in 2006 and by over 47,000 in 2007.[1]

  In its population projections for Canada for 2005-2031, Statistics Canada states that senior citizens may well outnumber children in Canada by 2015.

  Life expectancy is also increasing. In 2005, the median age at death was 79 years and by 2015, it will be 80.6 years.[2]

  With a larger population and a greater proportion of seniors, more residents are likely to require government assistance in paying for their prescriptions.

- INCREASE IN CHRONIC DISEASES: More people are living with chronic diseases such as diabetes and arthritis.

- INCREASE IN NEW DRUGS: An ever-expanding array of medications is becoming available on the Canadian market, usually at a higher cost than existing therapies. These drugs consist of new pharmaceutical treatments for known illnesses and conditions as well as additions to existing therapeutic classes of drugs.

- CHANGES IN APPROACH TO TREATMENT: More patients are being treated on an outpatient basis.

- INCREASED USE OF PHARMACEUTICAL TREATMENTS: More patients are being treated with medication, pharmaceutical therapies are being developed for illnesses and conditions previously treated by other means, and clinical trials are being conducted for more indications.

1 & 2 British Columbia-Level Population Projections, April 2005, BC Stats.

The number of PharmaCare beneficiaries has remained relatively constant, however, as shown below, in the period 1996 to 2005, the expenditures required to provide coverage for those beneficiaries has continued to grow.

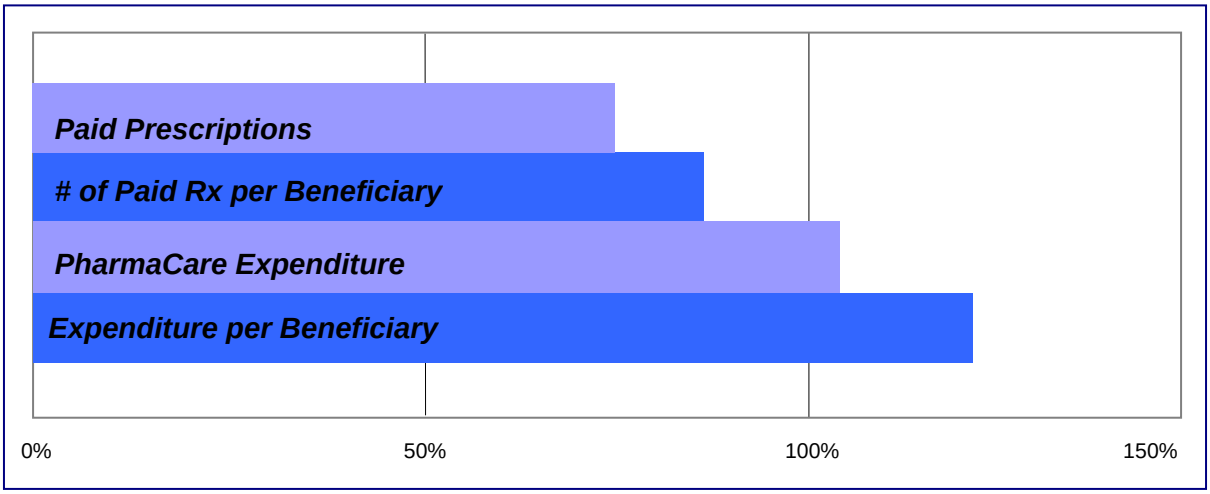


Figure 3-1 PharmaCare, Ten Years of Growth, 1996 to 2005

Getting value for money

B.C.'s relative success in controlling drug costs has been attributed to its rigorous evidence-based drug review process. Although we believe we have struck a reasonable balance by providing access to essential drugs while limiting public expenditures to only the most safe, effective, and cost-effective therapies, we recognize there are opportunities to improve our drug review process.

Over the past year, we added new staff and streamlined the drug review process. This had a positive impact on our ability to complete drug reviews. For example, PharmaCare finalized three times as many listing decisions in 2005 as it did in 2004.

Working with the provincial team

PharmaCare represents the largest portion of the Ministry of Health's expenditures for drugs. However, the ministry also funds:

- drug treatment in B.C. hospitals
- oncology drugs provided through the BC Cancer Agency
- transplant medications through the BC Transplant Society
- dialysis medications through the BC Renal Agency
- antiretroviral medications available through the BC Centre for Excellence in HIV/AIDS.

B.C. provides 100 per cent coverage of cancer drug therapy, transplant and dialysis medications, and antiretroviral drugs. Unlike some Canadian provinces, B.C. does not restrict coverage of these medications to a specific age or income group, nor does it require patients to make co-payments or pay a registration fee.

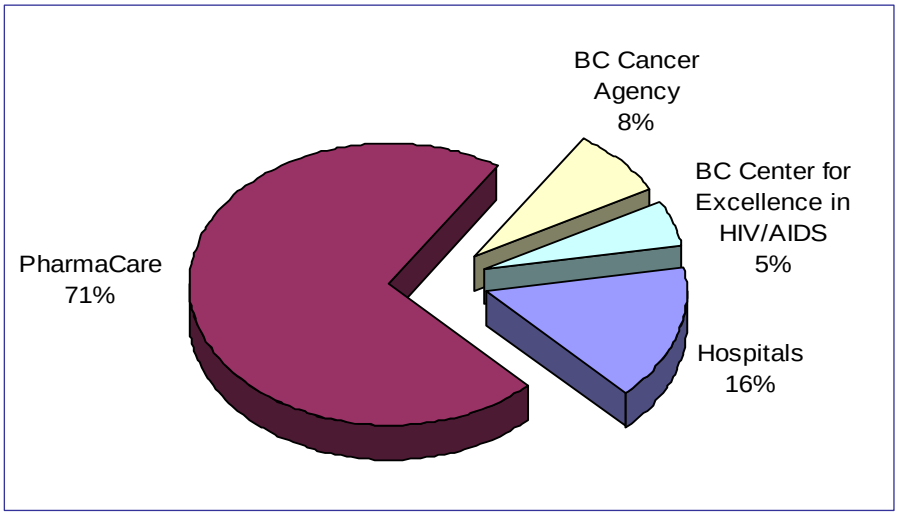


Figure 3-2 Pharmaceutical Spending by Source, 2005/06 Fiscal Year

By maintaining multiple avenues of coverage, the ministry is ensuring that British Columbians have broad access to pharmaceutical treatment.

4. PharmaCare Plans—Coverage

Expenditures for community pharmacy claims for all PharmaCare plans remained relatively level between 2001 and 2003 as a result of changes in plan coverage policies. However, as shown in the graph below, PharmaCare plan expenditures grew by 17.4% between 2003 and 2005.

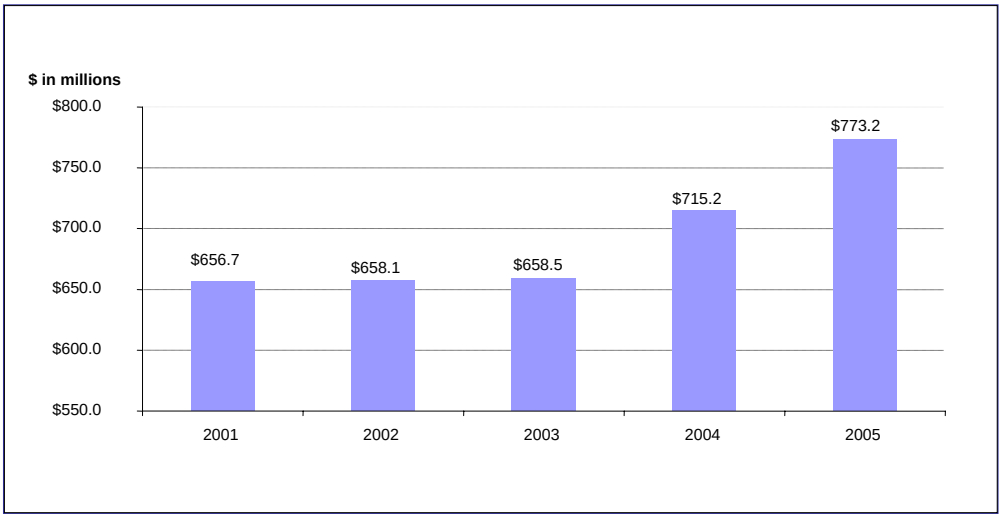


Figure 4-1 Plan Expenditures 2001 to 2005

4.1 Overview of Plan Expenditures in 2005

The following chart shows the percentage of overall 2005 expenditures attributable to each plan. As the chart indicates, over 90% of overall expenditures in 2005 were directed to the Fair PharmaCare and B.C. Income Assistance plans.

Please refer to Appendix A for descriptions of the specialty PharmaCare plans.

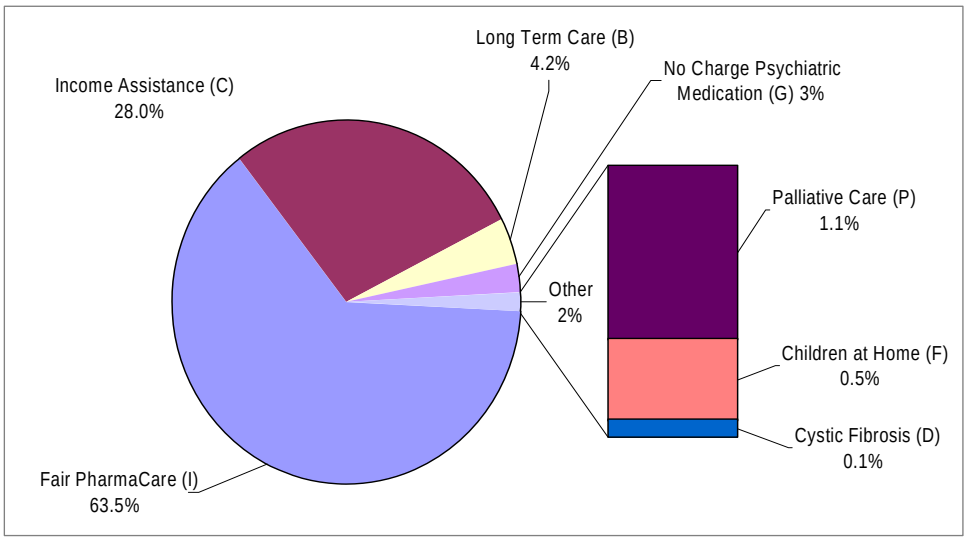


Figure 4-2 PharmaCare Expenditures by Plan

4.2 Fair PharmaCare—Assisting the Families Who Are Most in Need

As of January 2005, of a total of 2.2 million families in B.C., more than 1.27 million were registered for Fair PharmaCare. There were 637,000 individual British Columbians who received Fair PharmaCare assistance with their prescription costs.

B.C. introduced the Fair PharmaCare plan in 2003 as a more equitable way to assist British Columbians with their prescription drug costs. Because the plan bases a family's level of assistance on their combined annual net income, families with lower incomes receive more assistance.

Protection from catastrophic drug costs

B.C. is one of only four provinces that provides universal coverage, shielding its residents from catastrophic drug costs. No family in British Columbia pays more than four percent of their family net income towards eligible prescription drugs. All individuals who have resided in the province for more than three months and are enrolled with the Medical Services Plan of B.C.—whether or not they are registered for the Fair PharmaCare plan—are protected by a default deductible.

A 2004 publication comparing public drug plans across Canada concluded that "[c]omprehensive, tax-financed pharmacare models that limit out-of-pocket expenditures to a given percentage of income, such as those found in British Columbia, Saskatchewan, Manitoba and Ontario, provide the greatest protection against catastrophic prescription drug costs."[3]

[3] M.E. Coombes et al., "Who's the Fairest of Them All? Which Provincial Pharmacare Model would Best Protect Canadians against Catastrophic Drug Costs?" in Longwoods Review, 2:3, 2004. Pg.13.

How Fair PharmaCare works

To register, families complete a one-time registration process and sign a consent form allowing PharmaCare to verify their income information with the Canada Revenue Agency annually.

Each registered family is assigned an annual deductible and family maximum, which are calculated as a percentage of their annual family net income. Families with a net income of less than $15,000 are assigned a $0 deductible. PharmaCare immediately assists these families with their eligible drug costs. If a family that includes someone born in or before 1939 has a net income of less than $33,000, they do not have to meet a deductible.

Families with a deductible pay 100% of their drug costs until they reach their deductible. Fair PharmaCare deductibles range from 0% to 3% of family net income. Once the family's payments towards eligible prescriptions equals their deductible, PharmaCare pays the majority of the family's eligible drug costs for the rest of the year; the family is responsible for 25% (for families with one or more members born in 1939 or earlier) or 30% (for all other families) until they reach their maximum.

Once a family's out-of-pocket expenses (deductible plus co-payments) equal their family maximum, PharmaCare covers all their eligible prescription costs for the rest of the year. The family maximum ranges from 1.25% to 4% of family net income, depending on income level.

Enhanced Fair PharmaCare assistance is available for families that include one or more members born in 1939 or earlier.

Helping families to get their maximum level of assistance

Through the work of Health Insurance BC's Fair PharmaCare Registration Desk and Administrative Review Unit—and by taking advantage of programs like the Monthly Deductible Payment Option—B.C. families can access the maximum assistance available to them.

Fair PharmaCare Administrative Review Unit

The PharmaCare Administrative Review Unit at Health Insurance BC continues to help British Columbians access the maximum Fair PharmaCare assistance to which they are entitled.

In 2005, the Administrative Review Unit adjudicated over 8300 applications for income and case reviews. The income review process provides access to an adjusted level of assistance to families whose income has dropped 10% or more since the year on which their assistance was based. As Fair PharmaCare specialists, the Administrative Review Unit also helps new Canadian residents access the appropriate level of Fair PharmaCare assistance.

Fair PharmaCare Monthly Deductible Payment Option

2005 was the inaugural year of the Fair PharmaCare Monthly Deductible Payment Option. The option relieves financial pressure early in the calendar year by allowing families to pay an amount equal to their deductible in monthly instalments over the course of the year and receive PharmaCare's assistance with their eligible prescription costs from the start of the year.

Normally, these families would pay 100% of their prescription costs until their payments towards eligible costs reached their deductible. PharmaCare would then begin contributing to their eligible prescription costs. The need to pay the full cost of prescriptions early in the year presented cash flow difficulties for some families.

4.3 PharmaCare Specialty Plans

Although Fair PharmaCare provides coverage for the majority of British Columbians, some British Columbians have special prescription needs. These residents are served through PharmaCare's six specialty plans:

- Plan B—Permanent residents of licensed long-term care facilities
- Plan C—Recipients of provincial income assistance
- Plan D—Patients registered with a provincial Cystic Fibrosis Clinic
- Plan F—Children eligible through the At Home Program of the Ministry of Children and Family Development
- Plan G—No Charge Psychiatric Medication Plan
- Plan P—Palliative Care Drug Plan

Plan A (Seniors) and Plan E (Universal PharmaCare) were replaced by the Fair PharmaCare plan in May 2003.

For more information on these plans, please refer to Appendix A.

5. PharmaCare Benefits—Acting on the Evidence

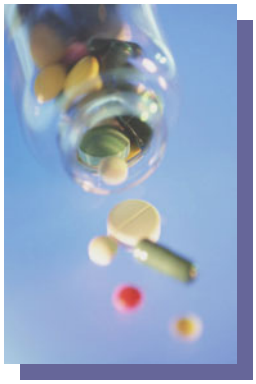
Prescription drugs play an increasingly prominent role in medical treatment. Not surprisingly, they are also the fastest-growing area of health system spending.

PharmaCare covers prescription therapy for the broadest possible range of illnesses and conditions.

5.1 New Drug Listings in 2005

In 2005, 30 brand name drugs and about 300 generic drugs were added to the PharmaCare formulary.

5.2 Overview—Drug Reviews in Canada



In recent years, the drug review process in Canada has changed.

On September 1, 2003, the national Common Drug Review (CDR) Directorate began accepting submissions from manufacturers for new chemical entities and new combination products. Once a drug has been reviewed by the CDR, the CDR also reviews any subsequent requests from the manufacturer regarding use of the drug for a new indication.

New indications and line extensions for existing drugs and new generic drugs are not reviewed by the CDR. Under these circumstances, a manufacturer would make a submission directly to a provincial drug coverage program.

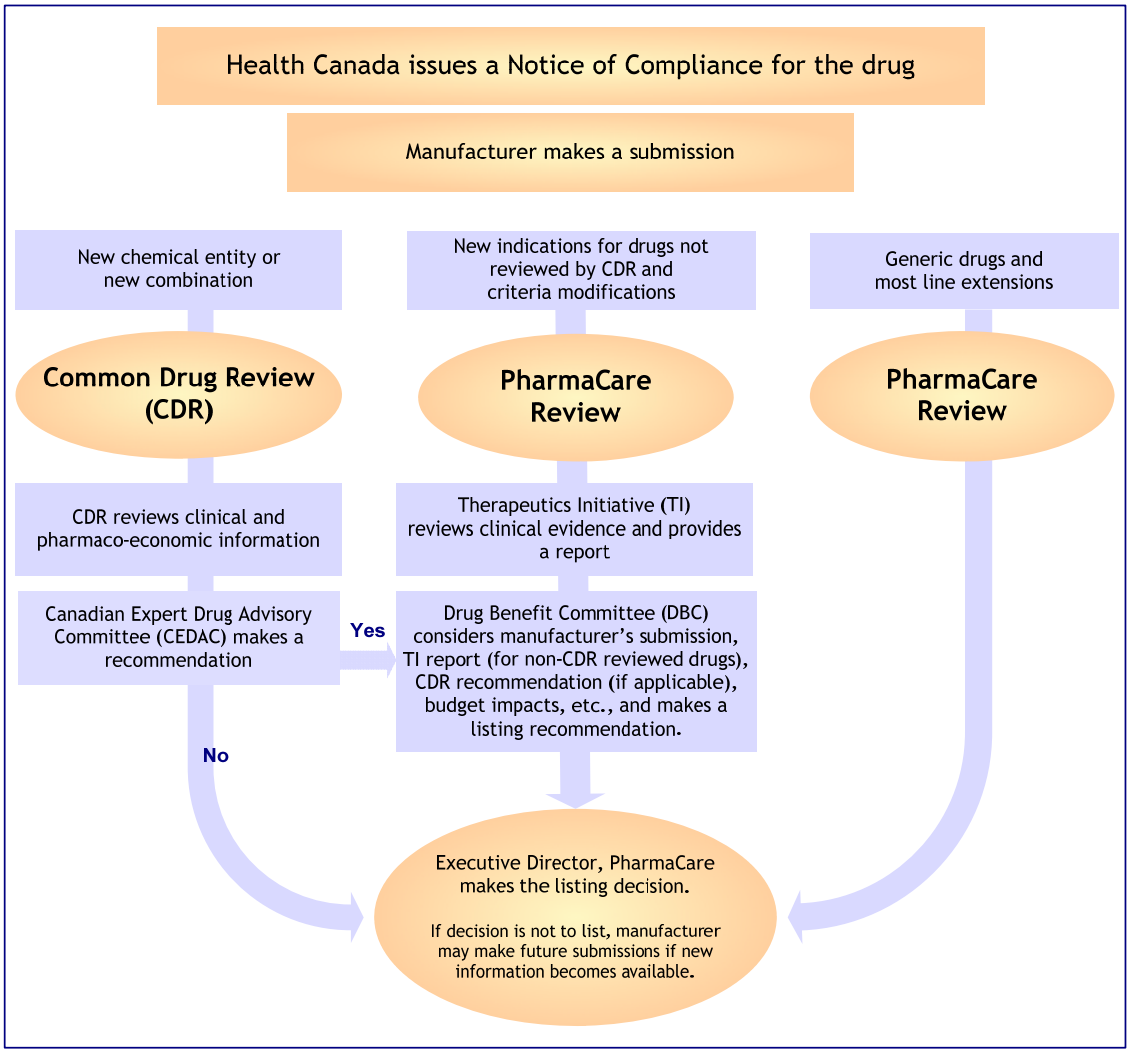


Figure 3-1 Drug Reviews in Canada and British Columbia

New chemical entities / new combination products

Once a manufacturer receives a Health Canada Notice of Compliance (NOC) for a new chemical entity or a new combination product, if they want to seek listing approval from federal, provincial or territorial drug programs, they submit information on the drug to the Common Drug Review (CDR) process. The CDR Directorate is housed at the Canadian Agency for Drugs and Technologies in Health.

The CDR conducts objective, rigorous reviews of the clinical and cost effectiveness of new drugs compared to the current standard of treatment and, through the Canadian Expert Drug Advisory Committee (CEDAC), provides provincial drug coverage plans with listing recommendations.

Participating publicly funded drug programs in Canada, including B.C. PharmaCare, consider CEDAC recommendations when making listing decisions on new drugs or new combination drugs. Each province makes a coverage decision based on the unique circumstances within its jurisdiction.

For more information on the CDR, visit their website at www.cadth.ca/index.php/en/cdr.

New indications/Modifications to current coverage

If a manufacturer wants to request coverage for a new indication of a drug that was introduced before the CDR was formed—or wants to request modification of the current PharmaCare coverage criteria for an existing drug—the manufacturer forwards a submission directly to PharmaCare.

In reviewing the submission, PharmaCare considers:

- The evaluation provided by the Therapeutics Initiative at the University of British Columbia. The TI provides a critical review of clinical trial evidence in drug submissions and the research findings from the current scientific literature but does not make recommendations regarding listings.

Therapeutics Initiative (TI)—Established in 1994 at the University of B.C. Department of Pharmacology and Therapeutics, the TI is an independent organization that provides health care professionals with up-to-date evidence-based information on rational drug therapy.

- A review of the manufacturer's drug submission and other evidence-based scientific information pertaining to the therapeutic advantages of new medications compared to current standards of treatment.
- Economic factors including budget considerations and the cost of new drugs compared to current standards of treatment.

New generic drugs/Line extensions

If, after receiving an NOC, a manufacturer wants to request listing of a new dosage formulation, a new strength of an existing drug or a new generic drug, they forward a submission directly to PharmaCare.

Reconsideration

If PharmaCare reviews a drug but does not approve coverage, a manufacturer can resubmit when new information becomes available.

5.3 PharmaCare Formulary Management

To maintain access to high quality, cost-effective patient care, our evidence-based policies must be supported by business processes that are effective, efficient and transparent.

In 2005, we worked diligently to streamline the process and reduce turnaround times. PharmaCare added staff to the Formulary Management Unit in 2005, substantially increasing its capacity. This enabled us to complete three times as many listing decisions as were completed in 2004.

Significant progress was made on turnaround times. By year's end, Formulary Management had processed 55 drug submissions and approved 30 new drugs (not including generics). This represented an substantial improvement from 2004 when 14 drug submissions were reviewed and five new drugs approved for coverage.

These advances are indications of the positive results of the full Program Review we undertook in 2003/04 to examine existing processes and identify opportunities for improving effectiveness and efficiency. The formulary management process—the process through which PharmaCare ensures that its decisions to list drugs are evidence-based and cost-effective—was one area that the program review highlighted for enhancement.

The Formulary Management review was initiated in April 2005. The final report was released in November 2005. The review, which included consultation with the public, health care professionals and drug manufacturers, pointed to three main priority areas: improving the effectiveness and efficiency of the Formulary Management process, increasing transparency, and improving communication.

5.4 Special Authority Coverage

The PharmaCare Special Authority coverage process works in concert with the Formulary Management process. It preserves access to specific drugs for patients with specific medical needs and to patients most likely to benefit from treatment with a particular drug.

In 2005, the PharmaCare program expended $205.9 million on special authority drugs for 2.3 million claims.

The Special Authority team received well over 10,000 requests per month in 2005 and processed all requests within its targeted turnaround times.

5.5 Funding for Expensive Drugs for Rare Diseases (EDRDs)

Funding for EDRDs is a difficult dilemma faced by all public drug programs. Nevertheless, measurable progress towards workable solutions was made in 2005.

Funding for EDRDs is not only an issue of cost, but of clinical evidence and ethics. Small patient populations make it difficult to gather sufficient clinical evidence. With little in the way of hard evidence, federal and provincial approval processes with differing evidentiary requirements may produce contradictory coverage recommendations.

There are also ethical considerations, especially if few treatments exist for a particular condition. Ethical considerations regarding coverage may be intensified in cases in which a pharmaceutical company has provided the drug to patients at no cost for a period prior to marketing.

The National Pharmaceuticals Strategy (NPS) began examining the issue of EDRDs in 2005. Work will continue on the development of an EDRD framework under the NPS.

5.6 Utilization Management—Supporting Appropriate Treatment

PharmaCare is establishing a new unit to develop and evaluate methods for promoting appropriate drug use.

Effective utilization management helps to ensure that: (a) drug therapy is fully utilized whenever its use can improve health outcomes; (b) drugs are not prescribed if a more effective non-pharmacological therapy is available and feasible; (c) patients consistently receive the right drug, at the right dose, for the right duration; and that (d) if more than one effective drug is available, the lower cost drug is prescribed.

Other benefits of utilization management include:

- REDUCED INCIDENCE OF ADVERSE REACTIONS: The fewer prescriptions a patient takes, the lower the chance that they will experience an adverse reaction or that one of their medications will interact negatively with another.
- BETTER BALANCE BETWEEN PHARMACOLOGICAL AND NON-PHARMACOLOGICAL INTERVENTIONS: The convenience of drug treatment should not overshadow the very real benefits of other forms of treatment—especially when those forms of treatment improve overall health outcomes, potentially reducing cost to the whole health care system.

- REDUCED COSTS FOR CONSUMERS AND PUBLICLY FUNDED DRUG PROGRAMS: By choosing the lowest cost product whenever more than one effective drug is available, consumers lower their prescription expenses. This also reduces the portion of the cost paid by their private health insurer and/or provincial drug program.

5.7 Funding for the British Columbia Centre for Disease Control (BCCDC) Anti-Microbial Strategy

As announced by the BCCDC on January 12, 2006, the Ministry of Health is providing the BCCDC with 1.4 million in funding over the next three years to coordinate an anti-microbial strategy.

The **Do Bugs Need Drugs?** program[4] aims to reduce the use of antibiotics by B.C. residents, thereby reducing the threat posed by antibiotic resistant bacterial infections.

In 2005, in collaboration with PharmaCare, the BCCDC used PharmaNet data to track out-patient consumption of antibiotics, then conducted a comparison between B.C. and European countries with similar tracking capabilities. The study revealed that B.C. consumes 50% more antibiotics per capita than countries like Denmark. Rising PharmaCare expenditures for antimicrobials—which exceeded $18 million in both 2003 and 2004—also indicate the extent of overuse in the province.

B.C. patients not only consumed greater quantities of antibiotics compared to northern European countries, they also consumed a higher proportion of newer and more expensive classes of antibiotics. For example, B.C. consumes 10 times more fluoroquinolones (e.g., levofloxacin, moxifloxacin, ciprofloxacin) than Denmark.

[4] The Do Bugs Need Drugs? program was developed by Dr. Edith Blondel-Hill along with other Alberta health care professionals and organizations.

Several Canadian provinces have already implemented community education programs to address the overuse of antibiotics. Similar programs in Europe are showing signs of slowing—or even reversing—the emergence of resistant organisms.

The Ministry of Health's decision to fund the anti-microbial strategy will help to stem the flow of funds expended on unnecessary antibiotic treatment and support public health by reducing the prevalence of resistant organisms.

In B.C., the Do Bugs Need Drugs program was made possible by a partnership between BC PharmaCare and the BCCDC, in cooperation with:

- B.C. Children's Hospital
- Provincial Health Services Authority
- Provincial Health Officer
- B.C. Ministry of Education
- College of Pharmacists of B.C.
- College of Physicians & Surgeons of B.C.
- College of Registered Nurses of B.C.
- B.C. Medical Association
- B.C. Pharmacy Association
- B.C. health authorities
- First Nation and Inuit Health Branch, Health Canada.

6. Building a Stronger Team

6.1 Executive Team in 2005

Assistant Deputy Minister, Medical & Pharmaceutical Services Branch *Stephen Brown*
Executive Director, PharmaCare *Suzanne Solven (Heather Davidson, A/Executive Director)*
Director, Policy Development & Management *Wendy Eyres*
Director, Business Management & Stakeholder Engagement *and later Executive Director, National Pharmaceuticals Strategy* *Andrew Van der Gugten*
Director, PharmaNet & Evaluation *Darlene Therrien*
Senior Pharmacist, Special Authorizations and Projects *Lynda Chiu*
Senior Pharmacist, Formulary Management *Darlene Arenson*

6.2 Divisional Teams in 2005

Policy Development and Management

Policy Development and Management conducts evaluative research, produces policy options and proposals on plan structures and payment policies, regularly assesses policy effectiveness, and conducts budget planning and economic analysis.

Special Authorization and Projects

This team processes and adjudicates a high volume of requests for PharmaCare Special Authority coverage of drugs included in the PharmaCare Limited Coverage Drug Program, Low Cost Alternative Program and Reference Drug Programs. The team consists of specially trained technicians and clerks who process the majority of requests and pharmacists who focus on the adjudication of complex requests.

Formulary Management

The Formulary Management team defines, implements, and maintains policies related to administering the PharmaCare formulary. It manages the PharmaCare brand and generic drug submission and review process, ensuring that drug coverage policies are based on clinical evidence of therapeutic effectiveness and economic evidence of cost-effectiveness.

PharmaNet and Evaluation

The new PharmaNet Policy and Evaluation Unit was established in the fall of 2005 to:

- support project management, policy development, implementation and evaluation for PharmaNet legislation and PharmaCare Pharmacy Participation Agreements;
- maintain a strong working relationship with Health Insurance BC, the ministry's contracted partner;
- respond to public enquiries and issues raised by stakeholders involving privacy issues, audits, overpayments by PharmaCare and other issues;
- liaise with key stakeholder groups; and
- play a key role in the eDrug initiative to enhance PharmaNet (see Section 9).

Business Management / Stakeholder Engagement Unit

In 2005, the Business Management/Stakeholder Engagement unit acted as an "internal" business management consulting body, leading the process of examining current business practices and operations in order to identify areas in which improvements could be realized. The unit also developed, coordinated, and facilitated the stakeholder engagement opportunities.

National Pharmaceuticals Strategy (NPS) Secretariat

The B.C. NPS Secretariat is the provincial/territorial co-lead on the NPS and, as such, represents the provinces and territories as the NPS is developed. The B.C. NPS Secretariat also provides the provincial/territorial strategic, logistical and coordination services for the NPS so that the goals and objectives of the NPS, as set out by First Ministers, can be achieved for Canadians.

7. PharmaCare and Stakeholders—Combining Strengths

PharmaCare stakeholders include patients and patient groups, community and hospital pharmacists, physicians, the College of Pharmacists of B.C., the College of Physicians and Surgeons of B.C., the B.C. Pharmacy Association, B.C. Medical Association, brand and generic pharmaceutical companies, wholesale distributors, and private health insurance companies.

Throughout the 2005/2006 fiscal year, PharmaCare strengthened its relationships with stakeholders. Regular bilateral meetings with individual organizations provided a forum for detailed discussions on concerns specific to each stakeholder group; multilateral meetings provided a broader view and revealed commonalities in the issues stakeholders wanted PharmaCare to consider in its strategic planning. Additionally, PharmaCare continued to converse regularly with individual pharmaceutical companies via hundreds of phone or face-to-face meetings.

Both bilateral and multilateral discussions highlighted the shared commitment to develop a PharmaCare program that is responsive to the realities of patient need.

7.1 Bilateral Meetings

In 2005, PharmaCare held bilateral meetings with the key stakeholders mentioned above.

Although ad hoc bilateral meetings with stakeholders had been the primary method of communication for many years, the 2005 meetings differed in that stakeholders could choose to schedule meetings for the entire year in advance, ensuring regular discussion of matters affecting their organization.

7.2 Multilateral Meeting

The 2005 multilateral meeting brought broader issues to the fore, acted as a conduit for overall stakeholder feedback, and gave both PharmaCare and stakeholders a chance to review the previous year, examine the lessons learned and discuss directions for the coming year.

8. Advancing the National Pharmaceuticals Strategy

As provincial/territorial lead and co-chair with Health Canada on the National Pharmaceuticals Strategy Ministerial Task Force, British Columbia is working with its provincial and territorial colleagues to determine priority areas for the National Pharmaceuticals Strategy (NPS) and identify what needs to be done and how. First Ministers have identified a number of priorities for the NPS. We are working with our provincial and territorial counterparts on the following five areas of concern:

1) **CATASTROPHIC DRUG COVERAGE**: Catastrophic drug coverage aims to address the issue of undue financial hardship faced by Canadians in gaining access to required drug therapies, regardless of where a person lives or works.

2) **EXPENSIVE DRUGS FOR RARE DISEASES (EDRDs)**: The NPS task force has been reviewing the issue of EDRDs and developing a national approach.

   At their annual meeting in October 2005, federal, provincial and territorial health ministers directed their officials to proceed with post market research studies for patients meeting treatment guidelines for two rare diseases. Ministers committed to undertake this research with manufacturers as quickly as possible.

3) **DRUG PRICING AND PURCHASING STRATEGIES**: To contribute to the sustainability of public drug programs, drug pricing and purchasing strategies need to be developed to:

   - accelerate access to non-patented drugs and achieve international parity of prices of non-patented drugs; and
   - pursue purchasing strategies to obtain best prices for prescription drugs and vaccines in Canada.

NPS officials are working with the Patented Medicine Prices Review Board (PMPRB) to monitor and report on prices for non-patented prescription drugs in Canada. The intention is to identify differences in pricing between Canadian and international markets.

4) **COMMON NATIONAL FORMULARY**: Currently the national Common Drug Review (CDR) process is used for new drug and new drug combinations only. The NPS task group is conducting an analysis of the feasibility of expanding the CDR. Such an expansion would potentially provide a national review process for all drugs approved for sale by Health Canada.

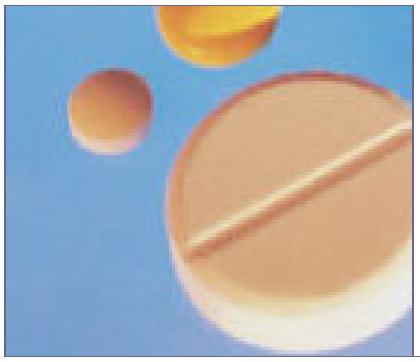
   For more information on the CDR process, please refer to Section 5.2.

   The NPS task group is looking at the commonalities and differences in drug provision across Canada to see if it is feasible to develop a full or partial national formulary.

5) **REAL WORLD DRUG SAFETY AND EFFECTIVENESS**: NPS officials hosted a national Working Conference in September 2005 to discuss ways to strengthen the evaluation of real world drug safety and effectiveness in Canada. The objective was to identify areas of consensus among stakeholders.

   Next steps are expected to focus on recommendations for improved pharmacosurveillance in Canada.

For more information, visit the NPS website at www.nps-snpp.ca.



9. Technology—Delivering Quality Information to Health Care Professionals

"… it is unrealistic to expect today's clinicians to operate in an environment originally implemented when there were but a few hundred pharmaceutical agents rather than the approximately 17,000 drugs now available.

Today's physicians can benefit from the support of technological tools and knowledge databases available at the point of care. Simply put, we must bring medication order entry into the 21st century."

Reinersten, J.L. 2000. "Let's Talk About Error: Leaders Should Take Responsibility for Mistakes."

eHealth is an overarching term used to describe a secure set of integrated information systems and processes that assist in the efficient delivery of high quality, coordinated health care.

A great deal of progress is being made in B.C. towards integrated information systems and electronic health records. These systems will eventually deliver more comprehensive and timely patient information to a broader range of health care professionals.

9.1 eHealth and Electronic Health Records

B.C. has taken a strong role in the effort to develop electronic health records (EHRs).

The framework for an EHR in British Columbia was formulated by the Health Chief Information Officer Council in 2003. The ultimate goal of the EHR framework is to assist in developing effective, client-focused, compatible information systems that support clinical decision-making, contribute to better health outcomes and enhance the security of patient information.

In November 2005, the Ministry of Health released the eHealth Strategic Framework, a document describing the strategic vision for eHealth and outlining the tangible deliverables and benefits expected over the next three years.

The provincial eDrug Project (eDrug) is one of the key clinical projects being implemented to support the eHealth Strategic Framework.

9.2 PharmaNet

Ten years ago, the B.C. Ministry of Health introduced PharmaNet, the computer network that links the province's community pharmacies, hospital pharmacies, emergency departments and medical practices to a common data-sharing network. B.C. was one of the first provinces to implement a network capable of processing all prescriptions dispensed in the province.

PharmaNet:

- provides electronic medication profiles for B.C. residents, giving authorized pharmacists and other authorized health care professionals access to comprehensive, up-to-the-minute information on all medications dispensed to a patient;
- alerts pharmacists to many possible drug interactions, verifies that the prescriber is licensed to prescribe the medication, and flags potential unintended duplications in drug therapy and drug allergies;
- is subject to strict privacy and security measures designed to prevent unauthorized access and protect the information in its databases;
- enables PharmaCare to pay its portion of a prescription's cost directly to the pharmacy making it unnecessary for BC residents to submit paper receipts for reimbursement;
- enables the province to reduce prescription fraud and safeguard individuals who might misuse prescription drugs by preventing duplicate prescriptions from being filled at different pharmacies.

In its 2002 report[5], the House of Commons Special Committee on Non-Medical Use of Drugs agreed that PharmaNet was "the most promising monitoring program currently available in Canada."

PharmaNet still leads the way, processing all prescriptions dispensed in B.C. community pharmacies whether or not the medication is a PharmaCare benefit. It promotes better quality of care for BC residents and provides valuable data for ensuring the effectiveness of PharmaCare programs and policies.

…British Columbia has implemented a provincewide PharmaNet system that records all prescriptions in the province. In one year, 7.9 million prescriptions out of a total of 35.3 million were flagged as potential problems. Twelve per cent of those flagged resulted in action to reduce harm to the patient."

Health Council of Canada, 2005 Report

[5] Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy, Interim Report of the Special Committee on Non-Medical Use of Drugs, December 2002.

Ten years after its introduction, PharmaNet continues to serve patients and pharmacists around the clock, 365 days a year.

9.3 Medical Practice Access to PharmaNet (MPAP)

Full access to PharmaNet medication histories for authorized physicians in medical practices became available provincewide on December 5, 2005. Authorized physicians can now request an up-to-date record of all medications dispensed to a patient and receive the information in a timely and secure manner. Expanding access to PharmaNet is part of the overall eDrug vision and strategy.

Strict privacy measures remain in place for PharmaNet—every access to it is logged and each user is individually identified. PharmaNet continues to comply with the province's Freedom of Information and Protection of Privacy Act. For MPAP, health care providers must obtain written consent from the patient to access their PharmaNet information.

PharmaCare is actively encouraging physicians to enroll for access to PharmaNet. Further information about medical practice registration is available on the Ministry of Health Data Access Services website at www.health.gov.bc.ca/ehealth/das/medpract.html.

9.4 How Will eDrug Affect PharmaNet?

Significant enhancements to PharmaNet will play a key role in the eHealth initiative. The eDrug project will augment PharmaNet's capabilities, allowing it to more fully support the work of pharmacists and physicians in a variety of clinical settings.

Improvements to PharmaNet will improve patient safety, enhance decision-making, improve coordination and delivery of care, and promote better cost management.

In addition to expanding access to medication profiles for authorized health care practitioners, an important enhancement to PharmaNet in support of the eHealth and eDrug is the implementation of electronic prescribing. This will eliminate problems associated with today's handwritten prescriptions such as fraud and legibility.

10. Mapping the Future

10.1 PharmaCare Reorganization

The past year brought significant decisions about PharmaCare's future organizational structure. Recognizing that pharmaceutical developments and demographic realities would place increasing demands on the ministry, additional resources were committed to support the research, planning, monitoring and reporting needed to protect PharmaCare's ability to deliver high quality services to clients.

To this end, in early 2006, the ministry created the new Pharmaceutical Services Division (PSD) and retained an Assistant Deputy Minister whose sole responsibility is the management of pharmaceutical-related programs and initiatives including PharmaCare and the BC National Pharmaceuticals Strategy Secretariat.

Bob Nakagawa, Assistant Deputy Minister, Pharmaceutical Services

Bob Nakagawa was formerly the Director of Pharmacy in the Fraser Health Authority. He has been the Director of Pharmacy and Director of Patient Care Services at Lions Gate Hospital and is a former Executive Director of the B.C. PharmaCare program. He has also chaired the Federal Pharmacy and Therapeutics Committee for Canada.

Bob is an expert in public drug plan management and has provided advice to federal, provincial and international governments. He has been a key participant in the development of new programs in Canada, including pharmacokinetic monitoring, academic detailing, medication management in the elderly, reference pricing and the Common Drug Review.

During his professional career, he has had extensive involvement with numerous professional organizations, committees and task forces, both at the provincial and national level. Bob has served as President of both the National and the B.C. branch of the Canadian Society of Hospital Pharmacists and the College of Pharmacists of B.C.

Bob has a pharmacy degree from UBC, a residency in hospital pharmacy from St. Paul's Hospital in Vancouver, is a Fellow of the CSHP and a Clinical Adjunct Professor at UBC.

10.2 Enhancing Our Strategic Planning

PSD is formalizing its strategic planning process. At the start of each year, PSD will develop a formal strategic plan outlining:

- objectives for the fiscal year;
- key steps to be taken towards those objectives; and
- benchmarks against which progress will be measured.

In setting objectives, PSD will consider the PharmaCare program mission, the Ministry of Health's Service Plan, the recommendations made in the Auditor General's report, and input from stakeholders.

10.3 Developing Meaningful Performance Measures

In 2005, we undertook to introduce a more formal performance measurement system specific to the PharmaCare program. Beginning in 2006, this system will tighten the focus of our efforts, enabling us to:

- monitor progress more accurately;
- adjust our strategy as necessary to meet the specific performance criteria; and
- communicate our progress to the public and other stakeholders in a concrete and tangible manner.

During the past year, PSD gathered baseline data on key program elements. In conjunction with drug utilization and population access data currently collected from PharmaNet, this data will allow us to develop meaningful performance measures for both our short and long-term objectives.

10.4 Developing an Annual Performance Report

In the past, the statistical publication *PharmaCare Trends* provided data on the PharmaCare program for health researchers, government officials and the public. It also included information on updated policies affecting drug coverage in B.C.

This publication—our first full annual performance report—supercedes *PharmaCare Trends*. In addition to the key statistical and financial information which would have previously been published in *PharmaCare Trends*, it offers comprehensive information on program performance for 2005.

Please note that, as the primary PharmaCare plan, Fair PharmaCare, is based on a calendar year, annual performance reports will necessarily focus primarily on the previous calendar year rather than the previous fiscal year.

11. Information Resources

The websites listed below may provide relevant information about drug programs and policies in B.C. and in Canada.

British Columbia websites

- BC Ministry of Health www.health.gov.bc.ca
- BC PharmaCare www.health.gov.bc.ca/pharme
- BC eHealth www.health.gov.bc.ca/ehealth/
- BC Mental Health and Addictions www.health.gov.bc.ca/mhd
- Therapeutics Initiative www.ti.ubc.ca
- BC Centre for Excellence in HIV/AIDS www.cfenet.ubc.ca
- College of Pharmacists of BC www.bcpharmacists.org
- College of Physicians & Surgeons of BC www.cpsbc.ca
- College of Dental Surgeons of BC www.cdsbc.org
- College of Midwives of BC www.cmbc.bc.ca
- College of Registered Nurses of British Columbia www.crnbc.ca
- BC Pharmacy Association www.bcpharmacy.ca
- BC Medical Association www.bcma.org
- BC Association of Podiatrists www.foothealth.ca

Provincial websites

- Alberta Health and Wellness www.health.gov.ab.ca/ahcip/ahcip_prescription.html
- Saskatchewan Health www.health.gov.sk.ca/ps_drug_plan.html
- Manitoba PharmaCare Program www.gov.mb.ca/health/PharmaCare/index.html

- Ontario Drug Benefit Program www.health.gov.on.ca/english/public/pub/drugs/odb.html
- Quebec Prescription Drug Insurance www.ramq.gouv.qc.ca/en/citoyens/assurancemedicaments/index.shtml
- Newfoundland & Labrador Prescription Drug Program www.gov.nf.ca/health/nlpdp
- Nova Scotia (health site) www.gov.ns.ca/health
- New Brunswick Prescription Drug Program www.gnb.ca/0212/en/index.htm
- Prince Edward Island –Health Services www.gov.pe.ca/hss/index.php3
- Northwest Territories Health Programs www.hlthss.gov.nt.ca
- Yukon Health & Social Services www.hss.gov.yk.ca
- Nunavut Territory Government Department of Health and Social Services www.gov.nu.ca/hsssite/hssmain.shtml

Federal websites

- Health Canada www.hc-sc.gc.ca
- Health Canada, Health Products and Food Branch www.hc-sc.gc.ca/hpfb-dgpsa
- Health Canada, Drug Product Database www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index_e.html
- National Pharmaceuticals Strategy www.nps-snpp.ca
- Canadian Health Network www.canadian-health-network.ca
- Canadian Institute for Health Information www.cihi.ca
- Patented Medicines Price Review Board www.pmprb-cepmb.gc.ca
- Canadian Agency for Drugs and Technologies in Health, Common Drug Review www.cadth.ca/index.php/en/cdr
- Canadian Agency for Drugs and Technologies in Health, Canadian Optimal Medication Prescribing & Utilization Service www.cadth.ca/index.php/en/compus

Canadian association websites

- Canadian Pharmacists Association www.pharmacists.ca
- Canadian Medical Association www.cma.ca

APPENDICES

Preface

These appendices provide most of the information previously made available in *PharmaCare Trends*, which was published by the B.C. Ministry of Health to provide information on the PharmaCare program to health researchers, government officials, and the public. Originally published in 1995, it was updated in 1997, 1998, 2000, 2002, and 2003.

Beginning with the 2005 report, *PharmaCare Trends* is being superceded by the *PharmaCare Annual Performance Report*.

PharmaCare Trends 2003 is available on the PharmaCare website at:
www.health.gov.bc.ca/pharme/publications.html

Acknowledgements:

The Ministry of Health and BC Stats provided data and material used in these appendices.

Citations:

This document must be cited as the source for any information extracted from it.

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Comments and Inquiries:

Please direct comments and inquiries to:
hlth.pcaretrends@gov.bc.ca

or

Policy Development and Management
Pharmaceutical Services Division
Ministry of Health
1515 Blanshard Street
Victoria BC V8W 3C8

Appendix A - PharmaCare Specialty Plans

In addition to the Fair PharmaCare plan (described in Section 4), PharmaCare offers six specialty plans:

A1. Permanent Residents of Licensed Long-Term Care Facilities (Plan B)

British Columbia is one of three Canadian provinces that provide coverage of prescription medications for permanent residents of licensed long-term care facilities. Long-term care patients are not required to meet a deductible or make co-payments and coverage is provided automatically beginning the first day the patient becomes a resident at a facility. In 2005, more than 24,000 care facility patients benefited from this coverage.

A2. Recipients of B.C. Income Assistance (Plan C)

PharmaCare coverage for 100% of eligible prescription costs has been available to recipients of B.C. income assistance from the Ministry of Human Resources since the 1970s. In 2003, when Fair PharmaCare was introduced, Plan C was expanded to include all seniors receiving income assistance.

Registration in Plan C is automatic and coverage remains in place until a person's income assistance ends, at which time they can register for coverage under the income-based Fair PharmaCare plan.

In 2005, Plan C expenditures represented 75% of the total expenditure for all specialty plans and more than 150,000 residents benefited from Plan C coverage.

PharmaCare is one of only four provincial plans that do not require recipients of social assistance to meet a deductible or make co-payments.

A3. Patients Registered with a Provincial Cystic Fibrosis Clinic (Plan D)

Since 1995, individuals with Cystic Fibrosis who register with a provincial Cystic Fibrosis Clinic receive coverage of eligible digestive enzymes. PharmaCare pays 100% of the drug cost (up to the maximum drug cost recognized by PharmaCare) and the dispensing fee, up to the acceptable maximum. Once eligibility under Plan D is in place, patients can receive coverage of other Cystic Fibrosis items, such as nutritional supplements and vitamins, under Plan C or Fair PharmaCare.

In 2005, just over 270 individuals received coverage under this plan. Only four other provinces have designated plans for cystic fibrosis.

A4. Children Eligible through the At Home Program of the Ministry of Children and Family Development (Plan F)

The At-Home Program provides community-based, family-style care for severely handicapped children age 18 or under who would otherwise become reliant on institutional care.

Plan F provides eligible benefits—at no charge—to children who are eligible for "full" or "medical only" benefits under the At Home Program. Both the dispensing fee and 100% of the drug cost of eligible benefits are covered, within acceptable maximums. In 2005, there were nearly 2,240 children eligible for this drug coverage plan.

A5. No Charge Psychiatric Medication Plan (Plan G)

In 2005, more than 21,000 patients who were registered with a mental health service centre and who demonstrated clinical and financial need qualified for PharmaCare coverage of certain psychiatric medications. Coverage is provided at no charge, within acceptable maximums. Mental health service centres determine individual patient eligibility.

B.C. PharmaCare is the only provincial drug program that has a plan dedicated to assisting mental health patients.

A6. Palliative Care Drug Plan (Plan P)

On April 1, 2005, PharmaCare took full responsibility for funding and administering the drug program portion of the B.C. Palliative Care Drug Benefit Program as the B.C. Palliative Care Drug Plan ("Plan P"). Local health authorities retained full responsibility for provision of medical supplies and equipment covered by the program.

All B.C. residents who are enrolled in the Medical Services Plan who meet the following criteria are eligible. Persons who:

- are living at home (defined as wherever the person is living, whether in their own home, with family or friends, or in a supportive living residence or hospice not covered under PharmaCare Plan B);
- have been diagnosed with a life-threatening illness or condition;
- have a life expectancy of up to six months; and
- consent to the focus of care being palliative rather than treatment aimed at cure.

The individual's physician determines their medical eligibility for palliative care benefits.

Shifting responsibility for this program to PharmaCare has simplified administration and brought the provision of palliative care benefits in line with other PharmaCare plans. Roughly 7,960 patients received coverage under this plan in 2005.

For more information on PharmaCare programs and policies, please visit our website at www.health.gov.bc.ca/pharme.

Appendix B - Expenditure Overview

B1. Interpreting PharmaCare Data

All data regarding costs, expenditures, and paid amounts refer only to the portion of the cost paid by PharmaCare. Similarly, references to numbers of prescriptions refer only to prescriptions to which PharmaCare contributed a portion of the cost.

Fair PharmaCare is based on annual net income. Data are therefore reported by calendar year in most instances.

Subject to the rules of their PharmaCare plan, beneficiaries may be responsible for paying some or all of their prescription costs.

Throughout the document, "plan expenditures" refers to expenditures as shown in the plan tables in Appendix Section B.2. "Total expenditures" includes plan expenditures and all other expenditures including funding for drugs provided through the BC Centre for Excellence in HIV/AIDS.

Payments and expenditures not included in the plan expenditure (Section B) data tables

This information is included in Section C4 for reference.

- Plan B capitation fees.
- Methadone interaction fees paid to pharmacies participating in the Methadone Maintenance Program.
- Special Services Fees.
- Rural Incentive Program subsidies.
- PharmaCare funding of anti-retroviral medications through the BC Centre for Excellence in HIV/AIDS.

Definitions

Rx	Prescription
Dispensing fee/ Professional fee	The fee a pharmacy charges to process a prescription.
Ingredient cost	A pharmacy's actual acquisition cost for the drug ingredient(s) dispensed.
Ingredient cost paid / Professional fee paid / Total paid costs	Amounts paid by PharmaCare (i.e., excluding amounts paid by beneficiaries).

Significant policy changes since 2002

The Fair PharmaCare plan was introduced May 1, 2003, replacing Plan A (Seniors) and Plan E (Universal). Since that date, seniors and non-seniors have been covered under the income-based Fair PharmaCare plan, resulting in a change in the deductible for some families.

Significant changes in plan coverage policies affecting PharmaCare expenditure data, such as the introduction of Fair PharmaCare, are noted in the relevant data tables.

Data source

Data were extracted from the Ministry of Health HNData Datamart and may not reconcile exactly with previous reports due to data quality improvements.

B2. PharmaCare Plan Expenditures, 1999 to 2005

The tables on the following pages provide a seven-year history of PharmaCare expenditures, both aggregate and per-plan. Dollar figures represent the total amounts PharmaCare paid for drug ingredients and dispensing fees per calendar year.

Table B.1— PharmaCare Traditional Plan Expenditures: Plans A, B, C, D, E, F, G and I, where applicable (excludes Plan P)

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	13.301	14.462	16.158	14.820	15.763	17.915	19.517
Number of beneficiaries (millions)	0.850	0.881	0.915	0.814	0.900	0.826	0.814
Ingredient cost paid (millions)	$455.107	$531.216	$603.618	$572.087	$557.313	$595.001	$630.881
Professional fee paid (millions)	$35.839	$41.003	$53.104	$86.005	$101.219	$120.176	$131.768
Total amount paid (millions)	$490.946	$572.219	$656.728	$658.092	$658.532	$715.177	$762.650
Avg number of Rx's per beneficiary	15.66	16.42	17.66	18.2	17.52	21.68	23.98
Avg total paid cost per beneficiary	$577.84	$649.69	$717.92	$808.05	$731.97	$865.56	$937.09
Avg professional fee paid per Rx	$2.69	$2.84	$3.29	$5.80	$6.42	$6.71	$6.75
Avg ingredient cost paid per Rx	$34.22	$36.73	$37.36	$38.60	$35.36	$33.21	$32.33
Avg total amount paid per Rx	$36.91	$39.57	$40.65	$44.41	$41.78	$39.92	$39.08

Table B.2—PharmaCare Expenditures: Plan A (Seniors)–Replaced by Fair PharmaCare (Plan I) on May 1, 2003

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	6.722	7.194	7.953	6.605	2.059	-	-
Number of beneficiaries (millions)	0.430	0.439	0.450	0.413	0.364	-	-
Ingredient cost paid (millions)	$263.953	$296.166	$341.017	$301.550	$93.689	-	-
Professional fee paid (millions)	$6.705	$8.262	$11.323	$38.266	$10.885	-	-
Total amount paid (millions)	$270.658	$304.428	$352.340	$339.816	$104.574	-	-
Avg number of Rx's per beneficiary	15.65	16.39	17.68	15.98	5.66	-	-
Avg total paid cost per beneficiary	$629.93	$693.72	$783.19	$822.25	$287.52	-	-
Avg professional fee paid per Rx	$1.00	$1.15	$1.42	$5.79	$5.29	-	-
Avg ingredient cost paid per Rx	$39.27	$41.17	$42.88	$45.65	$45.50	-	-
Avg total amount paid per Rx	$40.26	$42.32	$44.30	$51.45	$50.78	-	-

PharmaCare costs decreased in 2002 due to the Plan A deductibles introduced that year.

Rx = Prescription

Table B.3—PharmaCare Expenditures: Plan B (Permanent Residents of Licensed Long Term Care Facilities)

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	1.103	1.119	1.165	1.188	1.191	1.290	1.519
Number of beneficiaries (millions)	0.025	0.025	0.025	0.025	0.025	0.024	0.024
Ingredient cost paid (millions)	$21.719	$24.081	$26.928	$29.300	$30.877	$30.992	$32.160
Professional fee paid (millions)	-	-	-	-	-	-	-
Total amount paid (millions)	$21.719	$24.081	$26.928	$29.300	$30.877	$30.992	$32.160
Avg number of Rx's per beneficiary	44.4	44.28	45.72	46.76	48.04	52.66	52.1
Avg total paid cost per beneficiary	$874.04	$952.95	$1,056.44	$1,153.14	$1,245.51	$1,265.54	$1,330.31
Avg professional fee paid per Rx	-	-	-	-	-	-	-
Avg ingredient cost paid per Rx	$19.69	$21.52	$23.11	$24.66	$25.93	$24.03	$21.18

Plan B does not have a professional fee: pharmacies are paid a per-patient rate by PharmaCare on a monthly basis. This amount is not included in the above table.

Table B.4—PharmaCare Expenditures: Plan C (Recipients of B.C. Income Assistance)

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	3.605	3.964	4.501	4.851	5.432	6.066	6.547
Number of beneficiaries (millions)	0.220	0.213	0.208	0.187	0.177	0.161	0.152
Ingredient cost paid (millions)	$89.573	$110.172	$116.362	$120.326	$138.402	$153.037	$162.130
Professional fee paid (millions)	$20.834	$22.715	$29.634	$35.989	$43.359	$49.703	$54.010
Total amount paid (millions)	$110.407	$132.887	$145.996	$156.315	$181.761	$202.739	$216.140
Avg number of Rx's per beneficiary	16.42	18.57	21.67	26.01	30.62	37.69	43.03
Avg total paid cost per beneficiary	$502.85	$622.49	$702.69	$838.08	$1,024.60	$1,259.70	$1,420.61
Avg professional fee paid per Rx	$5.78	$5.73	$6.58	$7.42	$7.98	$8.19	$8.25
Avg ingredient cost paid per Rx	$24.85	$27.80	$25.85	$24.80	$25.48	$25.23	$24.76
Avg total amount paid per Rx	$30.63	$33.53	$32.43	$32.22	$33.46	$33.42	$33.01

There was a reduction in average prescription cost under Plan C from 2000 to 2001 due to changes to PharmaCare payments to pharmacies under the Methadone Maintenance Program.

Rx = Prescription

Table B.5—PharmaCare Expenditures: Plan D (Cystic Fibrosis)

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx	1,469	1,347	1,419	1,418	1,371	1,516	1,553
Number of beneficiaries	263	265	262	252	257	267	274
Ingredient cost paid (millions)	$0.677	$0.648	$0.690	$0.713	$0.730	$0.789	$0.821
Professional fee paid (millions)	$0.010	$0.009	$0.010	$0.010	$0.011	$0.012	$0.013
Total amount paid (millions)	$0.687	$0.657	$0.700	$0.723	$0.740	$0.801	$0.833
Avg number of Rx's per beneficiary	5.59	5.08	5.42	5.63	5.33	5.68	5.67
Avg total paid cost per beneficiary	$2,612.04	$2,478.53	$2,670.26	$2,869.90	$2,881.21	$3,000.00	$3,041.85
Avg professional fee paid per Rx	$6.48	$6.61	$6.74	$7.19	$7.78	$8.16	$8.30
Avg ingredient cost paid per Rx	$461.16	$481.00	$486.29	$502.83	$532.31	$520.21	$528.38
Avg total amount paid per Rx	$467.64	$487.61	$493.03	$510.02	$540.09	$528.36	$536.68

Table B.6—PharmaCare Expenditures: Plan E (Universal)—Replaced by Fair PharmaCare (Plan I) May 1, 2003

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	1.704	1.984	2.295	1.885	0.117	-	-
Number of beneficiaries (millions)	0.179	0.206	0.233	0.186	0.021	-	-
Ingredient cost paid (millions)	$70.814	$90.189	$106.610	$105.792	$14.171	-	-
Professional fee paid (millions)	$7.192	$8.671	$10.462	$9.614	$0.629	-	-
Total amount paid (millions)	$78.006	$98.860	$117.072	$115.406	$14.800	-	-
Avg number of Rx's per beneficiary	9.52	9.65	9.85	10.14	5.65	-	-
Avg total paid cost per beneficiary	$435.66	$480.76	$502.44	$620.34	$713.58	-	-
Avg professional fee paid per Rx	$4.22	$4.37	$4.56	$5.10	$5.37	-	-
Avg ingredient cost paid per Rx	$41.55	$45.45	$46.46	$56.11	$120.98	-	-
Avg total amount paid per Rx	$45.77	$49.82	$51.02	$61.21	$126.35	-	-

PharmaCare costs decreased in 2002 due to an increase in deductibles introduced that year.

Rx = Prescription

Table B.7—PharmaCare Expenditures: Plan F (At-Home Children)

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx	24,844	25,950	27,772	27,999	28,622	29,531	32,975
Number of beneficiaries	1,845	1,910	2,003	2,010	2,052	2,085	2,239
Ingredient cost paid (millions)	$2.497	$2.669	$2.892	$3.066	$3.154	$3.440	$3.623
Professional fee paid (millions)	$0.157	$0.167	$0.184	$0.197	$0.217	$0.231	$0.260
Total amount paid (millions)	$2.653	$2.836	$3.076	$3.263	$3.370	$3.670	$3.883
Avg number of Rx's per beneficiary	13.47	13.59	13.87	13.93	13.95	14.16	14.73
Avg total paid cost per beneficiary	$1,438.18	$1,484.91	$1,535.91	$1,623.27	$1,642.51	$1,760.42	$1,734.40
Avg professional fee paid per Rx	$6.31	$6.44	$6.64	$7.04	$7.58	$7.81	$7.89
Avg ingredient cost paid per Rx	$100.49	$102.85	$104.13	$109.49	$110.18	$116.48	$109.88
Avg total amount paid per Rx	$106.80	$109.29	$110.77	$116.53	$117.76	$124.29	$117.77

Table B.8—PharmaCare Expenditures: Plan G (No Charge Psychiatric Medication Plan)

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	0.140	0.174	0.214	0.260	0.319	0.365	0.418
Number of beneficiaries (millions)	0.010	0.012	0.014	0.016	0.018	0.020	0.021
Ingredient cost paid (millions)	$5.875	$7.291	$9.119	$11.340	$13.908	$14.984	$16.601
Professional fee paid (millions)	$0.941	$1.179	$1.491	$1.929	$2.546	$2.988	$3.452
Total amount paid (millions)	$6.816	$8.470	$10.610	$13.269	$16.454	$17.972	$20.053
Avg number of Rx's per beneficiary	14.45	14.83	15.67	16.37	17.28	18.33	19.82
Avg total paid cost per beneficiary	$701.59	$720.61	$775.87	$835.14	$890.47	$903.22	$950.06
Avg professional fee paid per Rx	$6.70	$6.77	$6.96	$7.42	$7.97	$8.19	$8.25
Avg ingredient cost paid per Rx	$41.86	$41.83	$42.56	$43.59	$43.55	$41.08	$39.69
Avg total amount paid per Rx	$48.56	$48.60	$49.52	$51.01	$51.52	$49.27	$47.94

Plan G was introduced in 1997.

Rx = Prescription

Table B.9—PharmaCare Expenditures: Fair PharmaCare (Plan I)—Introduced May 1, 2003

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	-	-	-	-	6.614	10.163	10.998
Number of beneficiaries (millions)	-	-	-	-	0.613	0.643	0.637
Ingredient cost paid (millions)	-	-	-	-	$262.373	$391.760	$415.546
Professional fee paid (millions)	-	-	-	-	$43.572	$67.242	$74.033
Total amount paid (millions)	-	-	-	-	$305.945	$459.002	$489.579
Avg number of Rx's per beneficiary	-	-	-	-	10.79	15.81	17.27
Avg total paid cost per beneficiary	-	-	-	-	$499.17	$714.26	$768.75
Avg professional fee paid per Rx	-	-	-	-	$6.59	$6.62	$6.73
Avg ingredient cost paid per Rx	-	-	-	-	$39.67	$38.55	$37.78
Avg total amount paid per Rx	-	-	-	-	$46.26	$45.16	$44.51

Table B.10—Total PharmaCare Expenditures: All Plans (A, B, C, D, E, F, G, I and P where applicable) - See Plan P description, following page.

Calendar Year	1999	2000	2001	2002	2003	2004	2005
Number of Rx (millions)	13.301	14.462	16.158	14.820	15.763	17.915	19.767
Number of beneficiaries (millions)	0.850	0.881	0.915	0.814	0.900	0.826	0.817
Ingredient cost paid (millions)	$455.107	$531.216	$603.618	$572.087	$557.313	$595.001	$639.404
Professional fee paid (millions)	$35.839	$41.003	$53.104	$86.005	$101.219	$120.176	$133.792
Total amount paid (millions)	$490.946	$572.219	$656.728	$658.092	$658.532	$715.177	$773.196
Avg number of Rx's per beneficiary	15.66	16.42	17.66	18.2	17.52	21.68	24.18
Avg total paid cost per beneficiary	$577.84	$649.69	$717.92	$808.05	$731.97	$865.56	$945.85
Avg professional fee paid per Rx	$2.69	$2.84	$3.29	$5.80	$6.42	$6.71	$6.77
Avg ingredient cost paid per Rx	$34.22	$36.73	$37.36	$38.60	$35.36	$33.21	$32.35
Avg total amount paid per Rx	$36.91	$39.57	$40.65	$44.41	$41.78	$39.92	$39.12

Rx = Prescription

Introduction of Plan P

In February 2001, the Ministry of Health introduced the Palliative Care Benefits Program. The program reduces financial barriers for B.C. residents who want to receive palliative care at home. The program has two components:

- coverage of specific palliative care drugs through PharmaCare (the B.C. Palliative Care Drug Plan), and
- provision of medical supplies and equipment through the local health authority.

On April 1, 2005, PharmaCare assumed full funding responsibility for the B.C. Palliative Care Drug Plan. The drug plan portion provides 100% coverage of drugs included in the unique formulary drawn up to include appropriate palliative care drugs. Some of these drugs are designated as "over-the-counter" drugs by Health Canada. Over-the-counter drugs do not require a medical prescription and are not included as benefits on PharmaCare's primary formulary. Individuals on Plan P are not required to meet a deductible.

Table B.1—Ministry of Health Expenditures: Plan P (Palliative Care)

Calendar Year	2001	2002	2003	2004	2005	April 1 – Dec 31 2005*
Number of Rx (millions)	0.073	0.128	0.174	0.214	0.250	0.194
Number of beneficiaries (millions)	0.004	0.006	0.007	0.008	0.009	0.008
Ingredient cost paid (millions)	$2.591	$4.263	$5.731	$6.754	$8.523	$6.770
Professional fee paid (millions)	$0.497	$0.920	$1.350	$1.719	$2.024	$1.567
Total amount paid (millions)	$3.088	$5.183	$7.081	$8.472	$10.547	$8.337
Average number of Rx per beneficiary	17.77	22.04	26.09	28.30	27.08	24.36
Average total paid cost per beneficiary	$746.99	$892.88	$1,063.32	$1,119.94	$1,141.66	$1,047.36
Average professional fee paid per Rx	$6.77	$7.19	$7.77	$8.03	$8.09	$8.08
Average ingredient cost paid per Rx	$35.26	$33.33	$32.98	$31.54	$34.07	$34.92
Average total amount paid per Rx	$42.03	$40.52	$40.75	$39.57	$42.16	$43.00

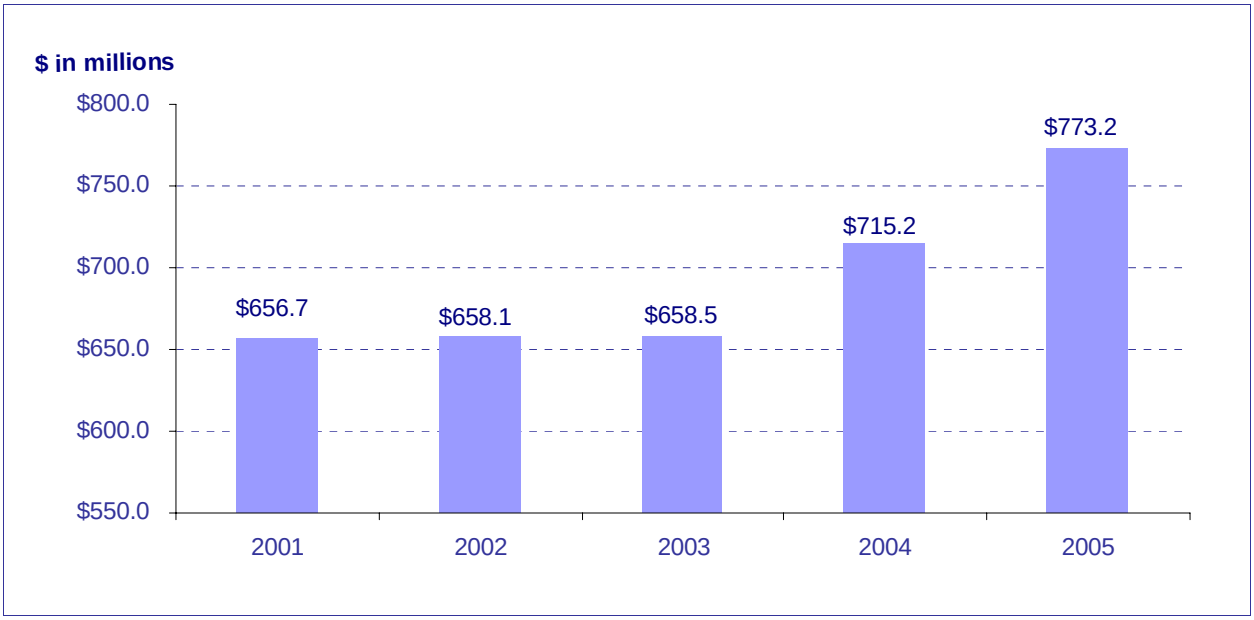
* Before April 1, 2005, the Ministry of Health, Home and Community Care Division, funded the plan. Funding responsibility was transferred to PharmaCare April 1, 2005, equivalent to this amount in 2005.

PharmaCare Expenditures for All Plans 2001-2005

The graph below depicts the "Total amount paid" for all PharmaCare plans combined. PharmaCare plan expenditures remained relatively level between 2001 and 2003 due to changes to plan coverage policies. Expenditures increased from $658.5 million in 2003 to $773.2 million in 2005.

Plan coverage changes were a result of the significant expenditure increases from 1999 through 2001. Expenditure growth rates of up to 14% per year were deemed unsustainable—policy changes, such as the introduction of Fair PharmaCare, were necessary to ensure the ministry could continue to offer financial assistance to those who needed it most.

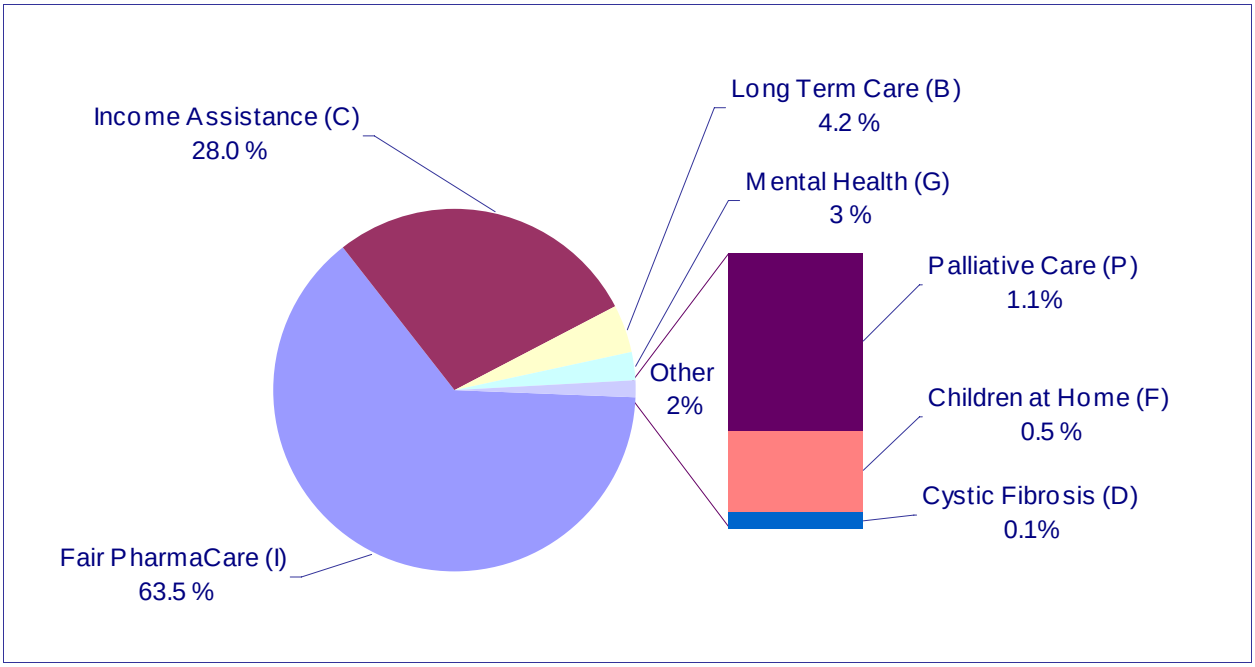
Graph B.1—Total PharmaCare Expenditures for All Plans 2001-2005



Note: Data for 2005 data includes costs for Plan P after April 1, 2005.

The chart below illustrates the contribution each plan made to PharmaCare's overall expenditures in 2005. Although it was in place only from May 1 to December 31, the Fair PharmaCare (Plan I) clearly dominated PharmaCare plan expenditures in 2005 at 63.5%. The Recipients of B.C. Income Assistance Plan (Plan C) constituted 28.0% of plan expenditures. Plan C and Plan I accounted for more than 90% of PharmaCare plan expenditures in 2005.

Graph B.2—PharmaCare Expenditures by Plan 2005



Appendix C - PharmaCare Data

C1. Number of Drugs Covered

PharmaCare is often asked how many drugs it covers. This number changes constantly as new drugs, and lower cost versions of existing drugs, are introduced to the market.

The number of drugs that are eligible for some degree of PharmaCare coverage can be expressed in two ways:

1. As distinct products by the Drug Identification Number (DIN) assigned by Health Canada.
2. By the active chemical ingredient in the drug.

The same active chemical ingredient may be made available in varying strengths or formulations and may be marketed by a number of different manufacturers. PharmaCare takes this into consideration by tracking its coverage of both the number of distinct products (DINs) and the number of unique chemical ingredients.

The number of unique chemicals indicates the variety of *treatments*; the number of DINs indicates the variety of individual *products*.

DINs in Canada in 2005[1]	22,000+
DINs receiving PharmaCare coverage in 2005[2]	5,048
Unique chemicals receiving PharmaCare coverage in 2005[3]	715

Notes:

[1] Health Canada assigns a DIN to many health products approved for sale in Canada including all prescription drugs, as well as over-the-counter products and drug store items such as toothpaste, natural health products, and vitamins.

[2] Includes only prescription drugs that had a payment by PharmaCare. Items receiving PharmaCare coverage may be full or partial benefits.

[3] Counts drugs by distinct chemical.

C2. PharmaCare Expenditures 2001 - 2005

Growth in PharmaCare Expenditures in British Columbia

From 2001 to 2005, total PharmaCare expenditures grew by 17.4%. This increase in costs results from a number of external pressures including:

- increase in the use of prescription drugs;
- introduction of newer and more expensive drugs (e.g., biologics and enzyme replacement therapies);
- an aging population;
- new clinical evidence (indications) and better treatment outcomes involving drug therapy;
- newly identified diseases and areas of pharmacology;
- changes in treatment modalities (i.e., shift to outpatient care);
- continued pressure for manufacturers to increase market share; and
- increases in the price of generics.

Between 2001 and 2005, the number of prescriptions filled by British Columbians that received some level of PharmaCare coverage increased by 22% and the average number of prescriptions per beneficiary increased by 36.9%. As the B.C. population ages, the demand for prescription medication is expected to increase.

In comparison, population growth in the province in the same five-year period contributed to increased expenditures, but to a much lesser degree. Increasing drug utilization eclipses the 3.9% population growth, emphasizing the pressures on the PharmaCare program.

Table C.1—Comparison of PharmaCare benefits for the calendar years 2001, 2004 and 2005

	4 years ago (2001)	1 year ago (2004)	2005	1 year change	4 years change
Number of Rx (millions)	16.158	17.915	19.767	10.34%	22.34%
Beneficiaries (millions)	0.915	0.826	0.817	-1.07%	-10.64%
Avg. # of Rx per beneficiary	17.66	21.68	24.18	11.53%	36.92%
Ingredient cost paid (millions)	$603.618	$595.001	$639.404	7.46%	5.93%
Professional fee paid (millions)	$53.104	$120.176	$133.792	11.33%	151.94%
Total amount paid (millions)	$656.728	$715.177	$773.196	8.11%	17.73%
Avg total amount paid per Rx	$40.65	$39.92	$39.12	-2.01%	-3.77%
Total paid cost per beneficiary	$717.92	$865.56	$945.85	9.28%	31.75%
Total B.C. Population (millions)	4.078	4.196	4.239	1.02%	3.94%

Dollar amounts refer to amounts paid by PharmaCare. Depending on individual plan rules, a beneficiary may also pay a portion of the total drug cost.

C3. PharmaCare Beneficiaries

PharmaCare Beneficiaries 2005

A total of 817,493 B.C. residents (19.3% of the entire B.C. population) received PharmaCare benefits in 2005.

The table below documents the number of PharmaCare beneficiaries in 2005 by five-year age groups, showing that the percentage of individuals receiving financial assistance from PharmaCare in 2005 increased with age. Nearly 94% of B.C. residents age 90+ received PharmaCare assistance in 2005.

Table C.2—PharmaCare Beneficiaries by Age Group 2005

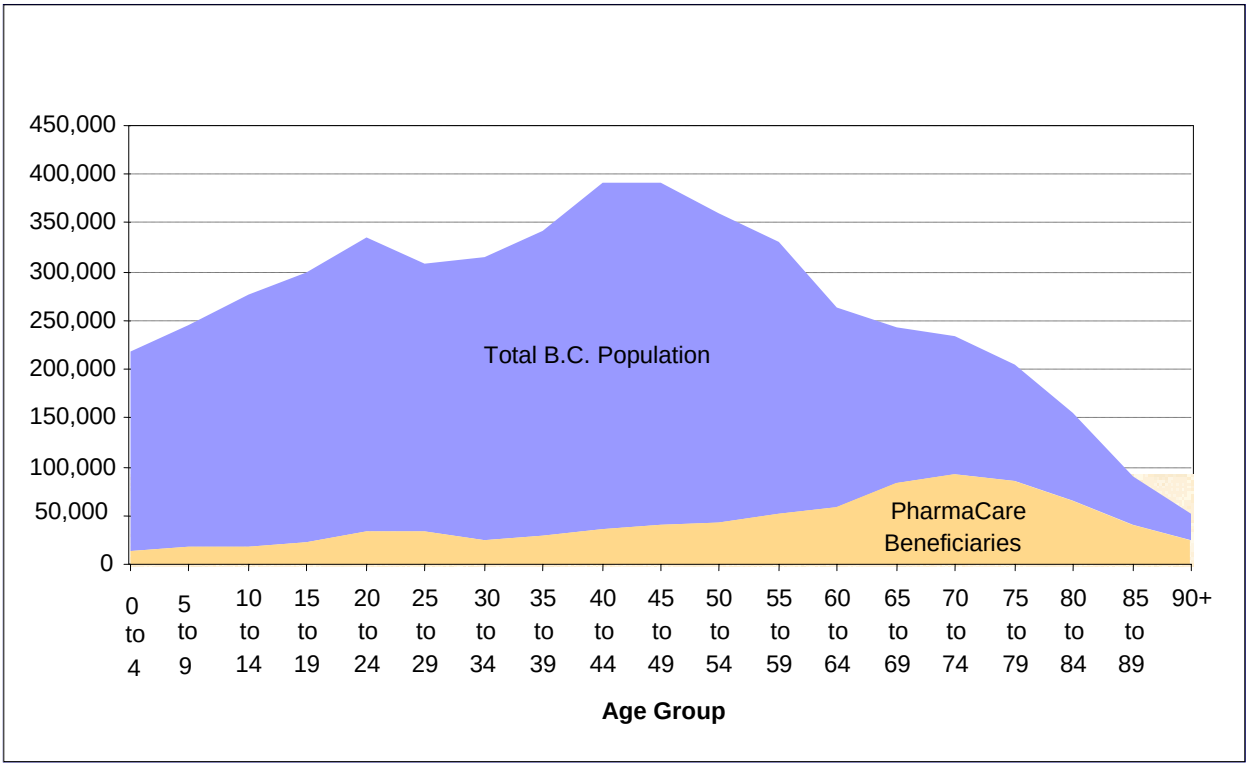
Age Group	Total BC Population*	# of PharmaCare Beneficiaries	% of Age Group Receiving Benefits
0 to 4	203,435	14,569	7.2%
5 to 9	228,540	17,778	7.8%
10 to 14	258,265	18,164	7.0%
15 to 19	276,376	23,323	8.4%
20 to 24	303,261	32,689	10.8%
25 to 29	275,358	32,791	11.9%
30 to 34	288,094	25,835	9.0%
35 to 39	312,887	29,103	9.3%
40 to 44	355,053	36,306	10.2%
45 to 49	349,492	41,061	11.7%
50 to 54	317,135	43,751	13.8%
55 to 59	277,563	52,206	18.8%
60 to 64	205,487	57,537	28.0%
65 to 69	161,771	82,189	50.8%
70 to 74	141,851	91,953	64.8%
75 to 79	119,351	86,370	72.4%
80 to 84	89,810	65,671	73.1%
85 to 89	48,269	40,793	84.5%
90+	27,066	25,375	93.8%
TOTAL	4,239,064	817,464	19.3%

*Population data from BC Stats

PharmaCare Beneficiaries Compared to B.C. Population 2005

The graph below depicts data from the preceding table, comparing the number of PharmaCare beneficiaries to B.C.'s total population by 5-year age groups.

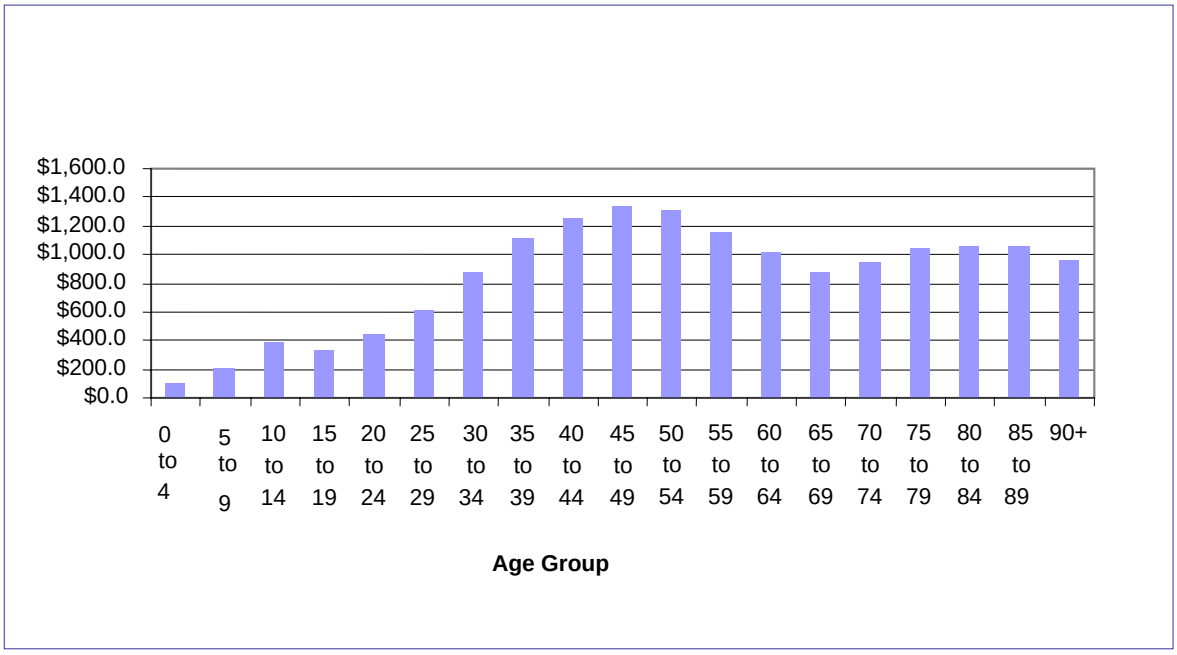
Graph C.1—PharmaCare Beneficiaries in 2005 Compared to B.C. Population



Average PharmaCare Expenditures per Beneficiary Age Group 2005

The age group with the highest per-beneficiary expenditure in 2005 were the 45-49 year olds, with an average $1,338.88 spent per beneficiary by PharmaCare. This age group represents 12% of the total B.C. population. The higher age groups have greater per capita costs because more B.C. residents receive PharmaCare benefits as their age increases.

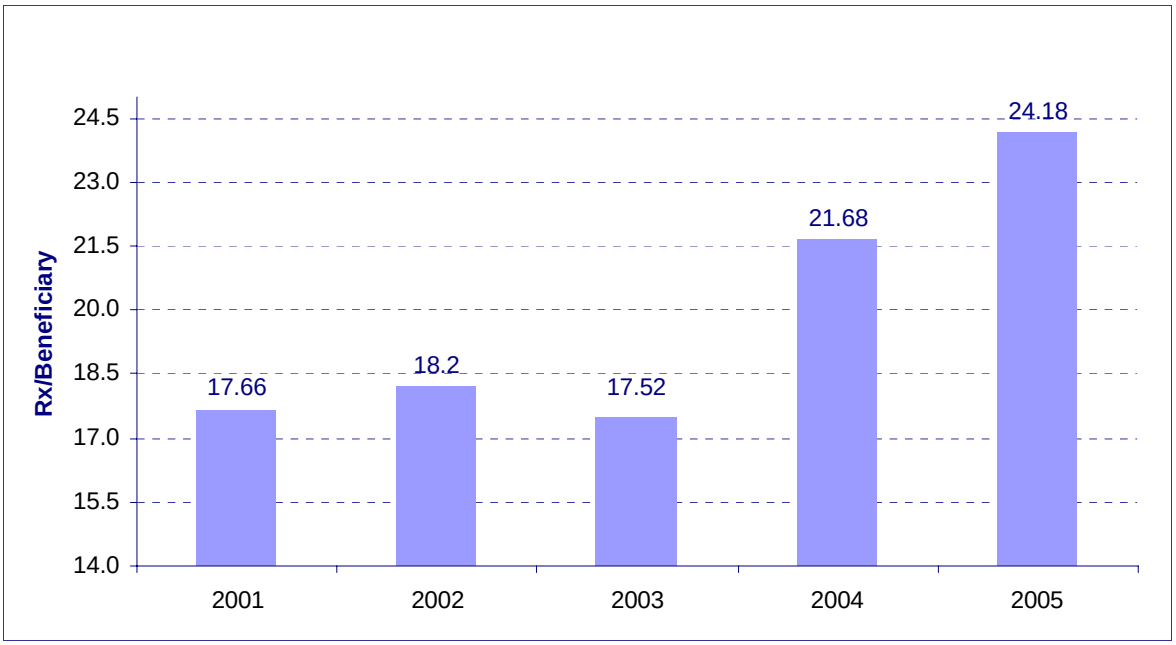
Graph C.2—Average PharmaCare Expenditure per Beneficiary Age Group in 2005



Average Number of Prescriptions per Beneficiary 1999-2002

The average number of PharmaCare-paid prescriptions per beneficiary rose from 15.7 prescriptions in 1999 to 24.1 prescriptions in 2005. Although the number of prescriptions per beneficiary declined by 4% from 2002 to 2003, total PharmaCare expenditures increased by almost $500,000 over the same period.

Graph C.3—Average Number of Prescriptions per Beneficiary



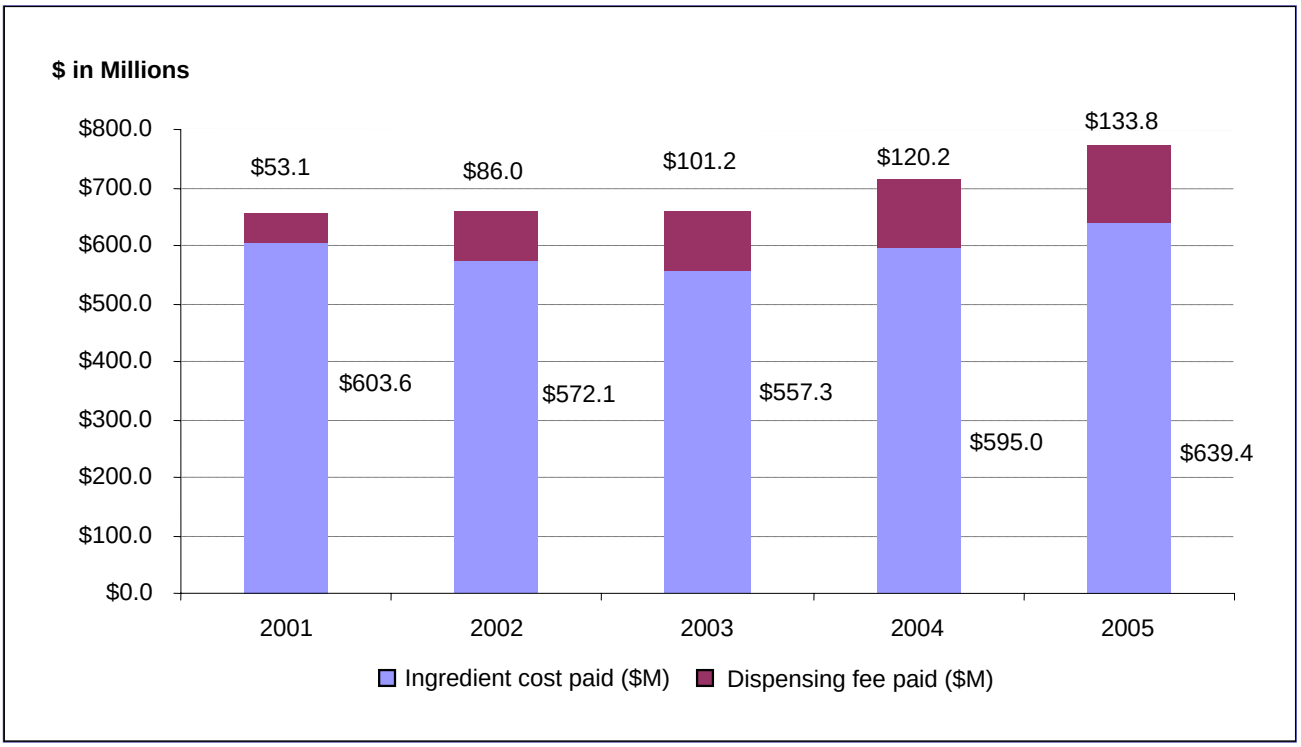
C4. Drug Costs and Fees

Total Ingredient Costs and Dispensing Fees Paid, 2001-2005

The graph below plots total drug ingredient costs and total dispensing fees paid across all plans over the five-year period from 2001 to 2005. The graph illustrates that:

- The total amount PharmaCare paid in dispensing fees increased almost three-fold, from $53.1 million to $133.8 million.
- A plan rule change for seniors resulted in a large increase between 2001 and 2002 (8.1% of expenditures in 2001 to 13.1% in 2002). Before 2002, there was no deductible requirement for seniors; they received 100% PharmaCare coverage of drug ingredient costs but were responsible for the first $200 in dispensing fees each year. In 2002, the plan was changed. Seniors were required to pay a set amount towards the total cost of each prescription—and both ingredient costs and dispensing fees counted towards a deductible.

Graph C.4—Total Ingredient Costs and Dispensing Fees Paid by PharmaCare: 2001 - 2005



Other PharmaCare Payments to Pharmacies

In addition to dispensing fees, PharmaCare makes payments to pharmacies through the following programs:

Table C.3—Additional Payments to Pharmacies, 2000 to 2005

		2000	2001	2002	2003	2004	2005
Program	Type of Payment	***($millions)***					
Service to permanent residents of licensed long-term care facilities	Capitation fees	$6.78	$6.86	$6.94	$6.87	$6.52	$6.50
Methadone Maintenance Program	Interaction fees	$4.15	$6.89	$9.22	$9.12	$9.74	$10.07
Special Services Fees*	-	$0.77	$0.86	$0.72	$0.65	$0.66	$0.65
Rural Incentive Program	Prescription subsidy	$0.15	$0.12	$0.13	$0.09	$0.07	$0.06
TOTAL		$11.84	$14.74	$17.00	$16.73	$16.99	$17.28

*38,698 special services fees were paid in 2005.

Average Cost per Prescription 2001 – 2005

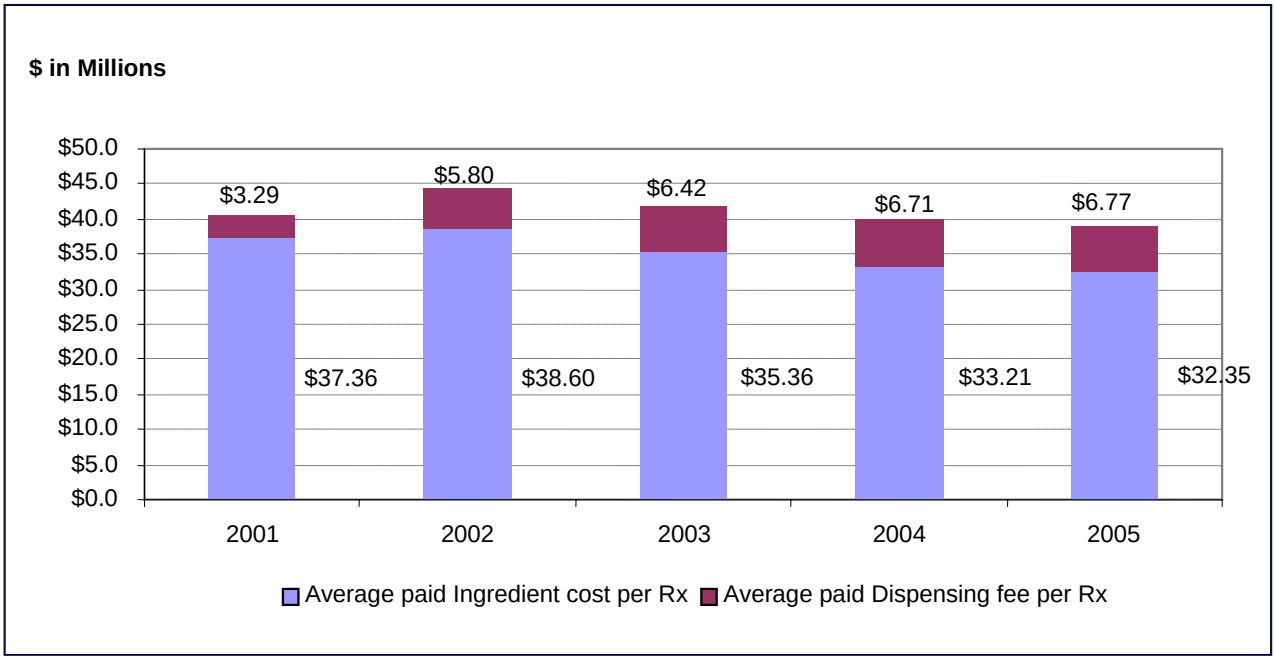
The graph following shows the average amount PharmaCare paid for prescriptions from 2000 to 2005. This cost has generally increased over the years. The decrease in total drug costs from 2003 to 2004 can be attributed to changes in PharmaCare deductibles introduced under Fair PharmaCare in May 2003.

PharmaCare sets a maximum dispensing fee it will cover per prescription. A pharmacy may charge any amount for the dispensing fee but must charge the same amount to all patients for all prescriptions dispensed. On prescriptions paid by PharmaCare, the patient pays any amount charged above the PharmaCare maximum dispensing fee.

The amount PharmaCare actually pays can range from $0 to the maximum accepted amount. Between 2001 and 2002, the average dispensing fee paid by PharmaCare per prescription increased from $3.29 to $5.80—largely due to the introduction of deductibles for seniors in 2002 but also, in part, due to increases in the dispensing fee charged by pharmacies.

The maximum dispensing fee paid by PharmaCare on December 31, 2005, was $8.60.

Table C.4—Average Ingredient Cost and Dispensing Fee Paid by PharmaCare per Prescription, 2001 to 2005



C5. Data Bibliography

Data used in this publication were drawn from a variety of sources, including those indicated below:

- PharmaCare Trends 2003 Update, BC Ministry of Health.
- PharmaNet, BC Ministry of Health.
- BC Stats, Ministry of Labour and Citizens' Services, Population Estimates for B.C., Canada and Other Provinces/Territories, British Columbia: 1971-2005 (Age and Sex, July 1).
- Ministry of Health 2006/07 – 2008/09 Service Plan.
- Ministry of Health Budget and Fiscal Plan – 2006/07 to 2008/09.