Message from the Assistant Deputy Minister
Pharmaceutical Services Division

The year 2006 brought continued progress on many of our key projects and the initiation of new endeavours. Much of our work has been evaluative in nature, with a focus on examining the robustness of current programs and policies. We also invested effort in examining our broader role in British Columbia's health care system and how we could most fully support the Ministry's vision of a health system that supports people to stay healthy and, when they are sick, provides high quality publicly funded health care services that meet their needs.

The result has been a refinement of our division's goals and objectives and the development of focused strategies to support optimal drug therapy for all British Columbians. In the coming year, our activity on this front will continue as we develop performance measures to help our division better assess its progress and to allow our stakeholders and the public to measure our success.

Realization of our goals has always depended on the commitment and enthusiasm of our staff and on the cooperation, interest, and support of our colleagues, stakeholders and the public. I would like to take this opportunity to thank all those whose energy and insight inform our work towards improved health outcomes for British Columbians.

Original signed by
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Assistant Deputy Minister
Pharmaceutical Services
Preface

This publication provides key statistical and financial information on the performance of the Pharmaceutical Services Division and the PharmaCare program for the year 2006.

Please note that the primary PharmaCare plan, Fair PharmaCare, is based on a calendar year. As a result, this report focuses primarily on the previous calendar year.

Comments? Suggestions?

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1. Highlights of the 2006 Year

In 2006, under the leadership of Assistant Deputy Minister, Bob Nakagawa, our division underwent a significant re-organization and expansion. The new division is in the process of establishing the capacity necessary to effectively manage the programs and services to advance the health of British Columbians by supporting optimal drug therapy.

Our division:

- Ensures that British Columbians enjoy an effective, balanced, and responsive PharmaCare program that includes a universal, income-based plan and specialty plans designed to address the needs of specific populations.
- Collaborates with other provincial agencies such as the BC Cancer Agency, Centre for Excellence in HIV/AIDS, BC Renal Agency and BC Transplant Society to support drug coverage for their patients.
- Provides leadership for the National Pharmaceuticals Strategy.
- Oversees the PharmaNet system, which provides an automated payment system and maintains drug utilization information.
- Plays a key role in the eHealth Program through its involvement in the eDrug project—which includes the enhanced PharmaNet-eRx system that will allow for electronic prescribing in the future.

Our growing team moved forward on several fronts in 2006. Here are just a few projects on which we focused our energies. Later sections of the report detail our progress on these and other activities.

1.1 Focusing our Energies

Our mission is advance the health of British Columbians by supporting optimal drug therapy. In doing so, we will contribute to the ministry’s vision of a health system that helps British Columbians to stay healthy and, when they are sick, provides high quality publicly-funded health care services that meet their needs.
Our pharmaceutical management strategy will directly influence drugs funded or provided through:

- BC PharmaCare Plans
- Provincial Health Services Authority (BC Cancer Agency, BC Renal Agency, BC Transplant Society),
- BC Centre for Excellence in HIV/AIDS
- Health authorities (acute care, residential care and public health).

It may also indirectly influence drugs funded by private insurers and individual British Columbians.

To fulfil our mission, we will focus on five areas critical to fair and equitable access to the most effective drug therapy for British Columbians:

Pharmaceutical Services Division's revitalized organizational structure aligns with these areas of focus.

*Please refer to Section 2.1 for more details on how each new branch within the division will serve the needs British Columbians.*
1.2 Alzheimer's Drug Therapy Initiative

In 2006, PharmaCare did not cover the cholinesterase inhibitor drugs—donepezil (Aricept®), galantamine (Reminyl®), or rivastigmine (Exelon®)—because there has been insufficient clinical evidence to demonstrate that these medications are effective treatments for Alzheimer’s disease.

The clinical trials included in the manufacturer’s submissions for coverage of these drugs have focused primarily on the drug’s capacity to improve cognitive abilities (for example, recall of dates and names) but have not adequately addressed whether the drug could help patients with day-to-day functioning (for instance, by helping them to remember to turn off appliances). There is, however, anecdotal evidence that the drugs may provide overall improvements in cognitive, physical and psycho-social functioning in some patients.

On July 5, 2006, we hosted a forum at which key stakeholders discussed and built consensus on issues related to the use of cholinesterase inhibitors, giving us their input and advice on how we might gather better data. Participants agreed that the best course of action would be to undertake a study that would determine which patients could potentially benefit from the use of these drugs.

The last half of 2006 and early 2007 was spent developing project plans to enable the recommended research to proceed. The resulting study, expected to last three years, will provide valuable information on which to base future formulary and public funding decisions while offering access to PharmaCare coverage of cholinesterase inhibitors for qualifying patients.

1.3 Provincial Initiatives

Hospital Access to PharmaNet

On December 5, 2006, we expanded PharmaNet access to authorized health professionals in hospitals and designated mental health facilities. By giving these professionals access to PharmaNet information on drugs dispensed to patients through community and hospital outpatient pharmacies, they will be able to make more informed decisions on appropriate care. This new service will be implemented in each health authority or facility depending on their internal priorities and plans and, over time, we expect all B.C. hospitals will have access to drug profiles within PharmaNet.

For more information on Hospital Access to PharmaNet, please visit www.health.gov.bc.ca/pharme/newsletter/hapinfosheet.pdf.
eHealth Program and the eDrug Project

In 2005, PharmaCare identified the vision and high level plan to improve the delivery of patient care in British Columbia by expanding the use of electronic medication information management to facilitate seamless care across all care settings. In 2006, PharmaCare, the eHealth Program and the eDrug Project began implementing the plan to meet this vision. The plan involves upgrading and enhancing the existing, well respected PharmaNet system and integrating its services with all eHealth electronic health record components.

The eDrug project will add new features to the PharmaNet system to further improve patient safety and health outcomes. One of the key enhancements will enable PharmaNet to accept electronic prescriptions from electronic medical record systems in physicians' offices, avoiding both handwriting legibility concerns and dosage calculation errors that can be associated with paper prescriptions. To mark this change, the enhanced system will have a new name—PharmaNet-eRx. “eRx” stands for electronic prescribing.

For more information on eHealth and the eDrug Project, please refer to Section 8.1.

1.4 National Initiatives

Ongoing National Initiatives

The B.C. Ministry of Health and Pharmaceutical Services Division continue to be actively involved in national organizations and initiatives that encourage cooperation between the federal government and provincial governments—such as the Canadian Agency for Drugs and Technologies, the Common Drug Review, the Canadian Optimal Medication Prescribing and Utilization Service and the National Prescription Drug Utilization Information System.

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 a Ministerial Task Force to develop and implement a National Pharmaceuticals Strategy (NPS). The federal and B.C. Ministers of Health co-chair the Task Force. In 2005, the BC NPS Secretariat was created to represent provincial and territorial interests and to lead and support the NPS in conjunction with the federal NPS Secretariat.
In September 2006, the NPS Progress Report was released. Designed as a snapshot of progress on the development and implementation of the Strategy to date, the Progress Report provides recommendations and next steps in the areas of catastrophic drug coverage, expensive drugs for rare diseases, a common national formulary, drug pricing and purchasing strategies, and ‘real world’ drug safety and effectiveness.

For more information, refer to Section 4.
2. Our New Division

In 2006, we built a robust human resources structure to support hiring in 2007.

Pharmaceutical Services Division was re-organized into five branches.

Working cooperatively, each branch will ensure excellence in a key component of our overall pharmaceutical strategy.

Bob Nakagawa
Assistant Deputy Minister
Pharmaceutical Services Division

Best Environment
Best Drugs
Best Prescribing
Best Policies
Best Deals

BC National Pharmaceuticals Strategy Secretariat
Drug Intelligence
Drug Use Optimization
Policy Outcomes, Evaluation and Research
Business Management, Supplier Relations and Systems
2.1 Our New Branches

BC National Pharmaceuticals Strategy (NPS) Secretariat

Creating the best environment means making sure that British Columbia operates in an environment of sound pharmaceutical policy.

We are working with our provincial, territorial and federal colleagues in addressing pharmaceutical policies of national importance. British Columbia is the lead provincial/territorial jurisdiction and the overall project co-lead (in conjunction with Health Canada) for this important undertaking.

Drug Intelligence Branch

As the cornerstone of western medicine, drug therapy is vital to the health of British Columbians. Drugs present a full spectrum of risks and benefits ranging from significant advancements that save lives to those that cause more harm than good when used inappropriately.

Our Drug Intelligence Branch will continue to ensure that British Columbians have access to PharmaCare coverage of the best drugs, by basing coverage decisions on a critical appraisal of the clinical evidence and, where appropriate, developing coverage criteria that ensures drugs are used in appropriate patient populations.

Drug Use Optimization Branch

Best prescribing means ensuring drug therapy is used in the most effective way. All prescribers—whether they be physicians, dentists, podiatrists, nurse practitioners, or midwives—need to know the range of choice in drugs available to treat their patients, the real-world risk and benefits associated with each drug and how to prescribe to achieve the most positive outcome for their patients. Patients need to be able to make informed decisions when a number of treatments are available.

The Drug Use Optimization Branch will review patterns of drug use and compare them with evidence-based best practices to design programs and initiatives that will facilitate improved patient outcomes in a fiscally-responsible manner. Educational programs and initiatives will target prescribers, other health care professionals, patients and/or the public.
**Policy Outcomes, Evaluation and Research Branch**

Financial support for publicly funded drug therapy in B.C. is provided through either PharmaCare (e.g., through various PharmaCare plans, funding for the B.C. Centre for Excellence in HIV/AIDS, etc.) or the Health Authorities (for example, chemotherapy drugs and drugs provided in acute care institutions). Delivering the best policies through good governance of drug availability, payment and use of drugs is essential to optimizing health outcomes.

Our Policy Outcomes, Evaluation and Research Branch is dedicated to excellence in evidence-based pharmaceutical policy for British Columbians. This branch guides the development, evaluation and research of pharmaceutical policies that support equitable, sustainable patient access to effective drug therapy. As we move forward with the divisional mandate, it is essential that we thoroughly and accurately research, measure, and report the affect that initiatives have on health outcomes.

This branch also supports other branches in our division, providing advice and assistance through economic analysis, research endeavours and communications coordination.

**Business Management, Supplier Relations and Systems Branch**

As a publicly-funded program, PharmaCare is committed to the wise use of taxpayer dollars. Our Business Management, Supplier Relations and Systems Branch will develop and implement strategies for publicly funded drugs to ensure B.C. gets the best deals on drug prices.

The price of drugs is dependent on both volume and price variables. Historically, PharmaCare has not actively negotiated drug prices with manufacturers. Drugs are purchased by pharmacies; PharmaCare is billed when they are dispensed. There is no price competition in the marketplace, other than through rebates and incentives provided to community pharmacies. In the Health Authorities, group purchasing organizations and hospitals have routinely issued competitive tenders to achieve significant savings.

Our Business Management, Supplier Relations and Systems Branch looks forward to actively pursuing better value for the public dollar.
3. Setting Our Course

3.1 Our Divisional Mission, Goals and Objectives

Our new division worked hard in 2006 to clarify its vision of the future, to develop a clear mission statement, and to identify specific goals and objectives. Guided by clear, shared goals, our division will be successful in achieving our mission.

Our vision....Excellence in drug therapy.

Our mission...Advance the health of British Columbians by supporting optimal drug therapy.

Goal 1 — Support citizens to have the best possible health

Objective 1 — Support patients in managing their own health

Objective 2 — Give health professionals access to objective and unbiased information regarding drugs and drug therapy.

Objective 3 — Ensure British Columbians have access to a comprehensive drug benefit program

Goal 2 — Develop the best pharmaceutical system in the world

Objective 1 — Secure the best drugs at the best prices

Objective 2 — Improve patient care and safety

Objective 3 — Create drug policies that are equitable, accountable, sustainable and meet the changing needs of British Columbians

Objective 4 — Maintain effective stakeholder engagement

Objective 5 — Enhance operational performance through continuous improvement

Goal 3 — Create the best place to work, with the best people

Objective 1 — Implement a divisional organizational structure and the human resources capacity to achieve the division's goals.

Objective 2 — A supportive, professional working environment that promotes teamwork and celebrates success.
3.2 Setting Targets and Measuring Our Progress

The primary divisional goals and objectives we established in 2006 provided a solid platform for work on a full divisional plan.

Our first priority was to secure appropriate staffing. Achieving our goals will depend on a skilled workforce operating in an innovative and accountable environment.

We will complete, and begin to implement, a full divisional plan in 2007 that:

- clearly identifies the risks and challenges of the coming years,
- includes objectives for each new branch,
- defines specific strategies for meeting our objectives, and
- sets meaningful performance measures against which British Columbians can measure our progress.

In the meantime, we will continue to inform our stakeholders and the public of our progress on specific projects and initiatives through stakeholder meetings, the PharmaCare Newsletter, our website and specific communication campaigns.
4. National Pharmaceuticals Strategy

The best environment for effective pharmaceutical therapy is one of well-considered and broadly implemented strategies and policies. In B.C., our work towards creating the best environment is focused first on policy issues of common national importance through our active participation in, and support of, the National Pharmaceuticals Strategy (NPS).

As provincial/territorial lead and co-chair with Health Canada on the NPS Ministerial Task Force, B.C. is working with its provincial and territorial colleagues to advance the priority areas of the National Pharmaceuticals Strategy. In September 2004, First Ministers identified nine priorities for the NPS, which were later further refined to five areas for short-to-medium term focus.

In September 2006, the NPS Progress Report, a snapshot of progress on developing and implementing the Strategy, was released. B.C. continues to lead the provincial and territorial interests and work with our federal counterparts to implement the report's recommendations and next steps in the five NPS priority areas:

1) **Catastrophic Drug Coverage (CDC):** Catastrophic drug coverage aims to address the undue financial hardship faced by Canadians in gaining access to needed drug therapy, regardless of where a person lives or works. Work on CDC has been directed toward defining “catastrophic” and identifying the general level of drug coverage necessary to protect Canadian families from undue financial hardship.

2) **Expensive Drugs for Rare Diseases (EDRDs):** EDRDs present a host of complex challenges to public health systems as these drugs are often introduced with limited evidence and efficacy (due to small patient populations) and can be prohibitively expensive. Historically, the number of EDRDs has been relatively low; however with scientific and technological advances, the number of treatments and identified affected patients is increasing. International practice and recent Canadian experience underscore the value for Canadian jurisdictions to work toward a structured framework that supports optimized decision-making in this area.
3) **COMMON NATIONAL FORMULARY:** There is variation in prescription drug coverage across the country. A national approach to formulary management would promote optimal use of drugs; reduce inequities across federal, provincial and territorial drug plans; achieve administrative efficiencies and support consistent, evidence-based decision-making.

The benefits of a collaborative, national approach have already been demonstrated by the Common Drug Review (CDR), a single process for reviewing new drugs and providing listing recommendations to participating public drug plans. As part of this work, the NPS is studying the feasibility of expanding the CDR.

*For more details on the drug review process, please see our information sheet at [www.health.gov.bc.ca/pharme/formulary/pdf/DRPInfoSheet.pdf](http://www.health.gov.bc.ca/pharme/formulary/pdf/DRPInfoSheet.pdf).*

4) **DRUG PRICING AND PURCHASING STRATEGIES:** The Canadian pharmaceuticals market is complex, with multiple players, competing incentives, priorities and interests. To date, there has been limited price or purchasing coordination among federal, provincial and territorial drug plans, and this lack of collaboration has meant that public plans may potentially under-utilize their significant purchasing power, resulting in an inability to achieve competitive prices. Work in the area of pricing and purchasing seeks to address these issues and, in doing so, contribute to the sustainability of public drug plans.

As part of this work, the Patented Medicine Prices Review Board (PMPRB) is monitoring and reporting on prices for non-patented prescription drugs both in Canada and internationally. These ongoing quarterly reports are now available, and help to identify and clarify differences in pricing between Canadian and international markets.

5) **REAL WORLD DRUG SAFETY AND EFFECTIVENESS:** Drugs approved by Health Canada are required to undergo rigorous pre-market clinical trials. However, evidence gathered only from controlled clinical trials in carefully selected patient groups cannot completely predict a drug’s safety and effectiveness in the real world (where the drug is used in different population groups at varying doses and for longer time periods). This information gap limits effective, evidence-based decision making and utilization. As such, work in the area of real world drug safety and effectiveness aims to develop a stronger system for gathering, interpreting and applying safety and effectiveness information.

*The NPS Progress Report is available at [www.nps-snpp.ca](http://www.nps-snpp.ca).*
5. Drug Intelligence

Effective drug therapy is vital to health of British Columbians. Drug products present a full spectrum of risks and benefits—appropriate drug therapy can save lives and improve quality of life; drugs used inappropriately can be ineffective or cause harm. And, of course, any chosen drug therapy must be "right" for an individual patient.

To secure access for British Columbians to drugs that offer true benefits in terms of health outcomes and to identify the circumstances under which treatment with a specific drug is appropriate, we need a strong Drug Intelligence Branch.

The branch, which includes our Formulary Management and Special Authority teams, will continue to manage and administer the provincial drug formulary—holding direct responsibility for the PharmaCare formulary and indirect responsibility for hospital formularies and drugs provided by publicly funded health care programs and agencies.

The branch will recommend additions, deletions and modifications to the PharmaCare formulary and develop special authority coverage criteria. It will also maintain and administer PharmaCare’s Special Authority program, which adjudicates requests for coverage based on pre-established criteria.

In conjunction with the Drug Use Optimization Branch, this branch will also serve as the drug knowledge information resource for the Ministry of Health, providing expert opinion and linking current research to the issues at hand. The branch will represent B.C. on the Advisory Committee on Pharmaceuticals for the Canadian Agency for Drugs and Technologies in Health.

It will plan and lead critical appraisals of health related literature and technical assessments to support evidence-based decision-making.
5.1 Formulary Management Unit

In 2006, we added 23 brand name and about 80 generic drugs to our formulary, providing pharmaceutical treatment options for a range of conditions including those shown below:

- Risk of myocardial infarction, stroke, death from cardiovascular causes
- Hypertension
- Reduction of elevated cholesterol levels in hyperlipidemic and dyslipidemic conditions
- Rheumatoid Arthritis
- Hyperprolactinemia
- Hypertension
- Hypothyroidism
- Major depressive disorder
- Mild to moderate active ulcerative colitis
- Acute migraine in adults
- Eczema and other dermatoses
- Hypothyroidism
- Rosacea
- Multiple sclerosis
- Growth hormone deficiency in children
- Prophylaxis and treatment of institutionalized individuals during outbreaks of influenza A or B
- Emergency treatment of severe allergic reactions
- Gastroesophageal reflux disease (GERD)

Changes to the PharmaCare formulary reflect current clinical and cost research. For instance, medications within a single “chemical sub-group” are often used to treat the same medical condition. An analysis of public funding for chemical sub-groups concluded that British Columbians and Nova Scotians have access to the greatest number of chemical sub-groups through their respective provincial drug plans.¹

Formulary Management Changes Resulting from our PharmaCare Program Review

Between April and November 2005, the division undertook a Formulary Management Review. The key objectives of the review were to re-engineer formulary management business processes and procedures to achieve greater efficiency, to maintain evidence-based decision-making and to integrate appropriate stakeholder engagement in the formulary management process.

The stakeholder consultations conducted during the review process, along with the recommendations resulting from the review and the follow-up feedback, highlighted support for three priority areas:

- Enhancing transparency—by enhancing the current review process to include greater input from clinicians and the public.

- Increasing and improving communications—by clearly communicating how the review process works, how the Drug Benefit Committee operates and what the roles and responsibilities of its members are, and by establishing a system for tracking and reporting the status of drug submission reviews and listing decisions.

- Achieving greater effectiveness and efficiency—by establishing a procedure for fast-tracking drug submissions.

We made notable progress on two of these priorities in 2006:

- **Working Towards an Expanded Drug Benefit Committee**—
  The Drug Benefit Committee is critical to a responsive, evidence-based provincial formulary. The committee—an independent advisory body of health and other professionals with expertise in drug therapy and drug evaluation—makes recommendations to the Pharmaceutical Services Division regarding the potential inclusion of drugs in the PharmaCare formulary. The approach is evidence-based and the advice reflects medical and scientific knowledge and current evidence-based clinical practice.

  In 2006, at the urging of our stakeholders, we assessed the feasibility of expanding the membership of our Drug Benefit Committee to include broader representation. Late in 2006, we resolved that the committee should have more robust representation and include members with expertise in general medical practice, medical specialties, geriatrics, medical ethics, clinical pharmacology/pharmacology, critical appraisal and health economics, and a public member.
In 2007, the Terms of Reference for the committee will be updated to reflect the expanded membership and Conflict of Interest Guidelines will be developed to ensure that the committee continues to meet the highest ethical standards.

With the Terms of Reference in place, Pharmaceutical Services Division will explore possible approaches to including public representation on the committee.

- **Drug Review Results Online**—In keeping with the priority areas identified in the formulary management review, in December 2006, we launched the new PharmaCare Drug Review Results website section to provide information on:
  - all drugs reviewed by the Common Drug Review and subsequently submitted to our division for consideration;
  - all drug reviews completed by our division on or after January 1, 2005; and
  - basic information on brand name drugs currently under review by our division and the Common Drug Review.

Information on reviews of generic drugs is not available on the website as these reviews are usually completed within six to eight weeks of receipt of a manufacturer’s submission.

We will continue working to make expanded information on drug review results available to all stakeholders, including the public.

To see our Drug Review Results Web page, visit [www.health.gov.bc.ca/pharme/formulary/index.html](http://www.health.gov.bc.ca/pharme/formulary/index.html).

## 5.2 Special Authorizations Unit

The Special Authorizations team implements the Drug Benefit Committee’s recommendations as approved by the Executive Director, Drug Intelligence.

In 2006, more than 500 Special Authority requests were processed each day. Most were handled by our Special Authority technicians and pharmacists. Practising physician specialists contracted to our division made recommendations on some of the more medically complex requests.

All routine requests met the stated performance targets:

- Urgent requests within one working day.
- Priority requests within two working days.
- Regular requests within ten working days.

In 2006, the Special Authority program benefited 250,000 patients.
6. Drug Use Optimization

Our division’s work does not end when a drug is available to the public. Developing a comprehensive formulary that meets the needs of B.C. residents is only one step towards effective drug therapy. Once a drug becomes available, how it is used determines its true therapeutic and cost value impact.

Real world use of a drug depends on the availability and accessibility of objective, unbiased information about the drug for use by prescribers, other health care professionals and their patients.

The Drug Use Optimization Branch will lead the development of safe medication practices in B.C. and guide and assist the development of safe medication systems across the continuum of care.

It will also help to educate prescribers, other health care professionals, patients and the public on the responsible use of drugs, why we cover what we cover, and how what we cover has improved health outcomes.

Plans for 2007/08 include explaining drug policy decisions in both professional and lay language on our website (in collaboration with the Drug Intelligence branch), increasing B.C.’s academic detailing capacity to offer province-wide services, participating in health fairs, continuing to support initiatives such as the “Do Bugs Need Drugs?” program, and developing a solid framework to evaluate programs and initiatives in terms of health outcomes.

Information Unit

The Information Unit will develop educational content such as websites, newsletters and other educational tools for health care professionals and patients. The unit will work closely with our Drug Intelligence Branch, the Education for Quality Improvement in Patient Care (EQIP) initiative, the Ministry of Health/BCMA Guidelines and Protocols Advisory Committee and the Canadian Optimal Medication Prescribing and Utilization Service.

For more information on EQIP, see Section 6.1.
Drug Use Optimization

Utilization Unit

The Utilization Unit will engage our stakeholders. This engagement will include academic detailing for health care professionals, working with advocacy and interest groups, participating in health fairs and developing new and more effective means of communicating with the public such as links with public schools and libraries, and support and advocacy groups.

Evaluation Unit

Our Evaluation Unit will analyze population data to identify target audiences for which educational materials are most critical and appropriate. This unit will also evaluate our policy-linked educational programs and initiatives in terms of cost-effectiveness, health outcomes, and/or user satisfaction.

6.1 Education for Quality Improvement in Patient Care (EQIP)

In late 2006, the B.C. Ministry of Health, the BC Medical Association and the University of British Columbia’s Continuing Professional Development-Knowledge Translation Division began work on a joint initiative to provide general practitioners with decision support tools for quality prescribing.

The EQIP Working Group also includes representatives of the College of Physicians and Surgeons of BC, the College of Pharmacists of BC and university researchers.

EQIP is slated to undertake its first mailing to general practitioners in 2007/08. The mailings will offer general practitioners multiple tools for assessing their prescribing of particular therapeutic classes of drugs and evidence-based tips to optimize these.
7. **Policy Outcomes, Evaluation and Research**

Sound policies that give fair access to pharmaceutical treatment to all provincial residents are crucial if we are to truly advance the health of British Columbians. Moreover, we are committed to providing a PharmaCare program that is responsive to changing demographics, that addresses the changing role of drug therapy in overall treatment protocols, and meets the challenge of new economic pressures.

A great deal of ongoing research and evaluation is required to keep pace with these changes. An excellent example is our review of coverage for patients with diabetes. PharmaCare provides universal and comprehensive coverage for diabetes. Nevertheless, as diabetes becomes more prevalent and as the range of products that support the health of those with the disease widens, careful re-evaluation of current policy and research into policy options is needed.

**Policy and Communications Unit**

Our Policy and Communications team leads the critical appraisal of health related literature and technical assessments to support program policy development. It works with all branches of our division to develop policy that is consistent with the division strategy. It evaluates the implications of national and international legislation, regulations and policies.

It also facilitates stakeholder engagement and feedback, develops short and long-term communications plans; researches and publishes documents such as the Annual Report, the PharmaCare Newsletter and the PharmaNet Bulletin; and maintains the PharmaCare program and policy content of the PharmaCare website.

**Economic Analysis Unit**

This unit evaluates current and emerging trends in public demand for pharmaceutical products, provides economic evaluation of drug listing options, develops health services investment and outcomes modeling, and supports data and information management.

The team liaises with the Patented Medicine Prices Review Board which establishes the maximum price that manufacturers can charge pharmacies for each drug and assesses the impact of existing and potential policies, provides budget forecasting and supports negotiation processes.
Research Unit

The Research team sets evidence-based research priorities relating to pharmaceutical outcomes and policies. It participates in the design of studies sponsored by Pharmaceutical Services Division and reviews the methods and results of research projects in progress.

As the division expands to meet its mandate, the branch must be prepared to support the evaluation of health outcomes resulting from new initiatives and to support evidence-based decision making.

7.1 Stakeholder Engagement

In 2005, our division introduced a formal stakeholder engagement process to provide a predictable, structured forum to facilitate collaboration and communication, garner stakeholder input, and address specific outstanding issues.

At the end of that year, we conducted a formal evaluation of the process to measure its value to stakeholders. The response from participants was favourable, with many participants commenting on the division's increased responsiveness and the greater sense of a collaborative approach.

We followed up in 2006, hosting scheduled, bi-annual, bilateral stakeholder engagement sessions with:

- Better PharmaCare Coalition
- BC Medical Association
- BC Pharmacy Association
- Canadian Association for Pharmacy Distribution Management
- Canadian Association of Chain Drug Stores
- Canada's Research Based Pharmaceutical Companies
- Canadian Generic Pharmaceutical Association
- College of Pharmacists of BC

We will also be hosting a multilateral session in the summer of 2007 to discuss the reorganization of the division with our stakeholders and to gather information on their current priorities and concerns.

7.2 Increase to Pharmacy Payments for Services to Residential Care Patients

PharmaCare pays pharmacies for dispensing drugs to patients in licensed residential care facilities. We increased the monthly capitation rate to $35 per occupied bed in 2006. This action recognizes the contemporary role pharmacists play in providing pharmaceutical services to residents of these care facilities.
7.3 Activity Based Costing Study

In March 2006, a partnership between the Ministry of Health, British Columbia Pharmacy Association and Canadian Association of Chain Drug Stores, initiated a study to investigate and determine the costs to pharmacies for dispensing medications and providing pharmaceutical services to the residents of British Columbia. An important objective was to develop cost estimates for dispensing services separate from the costs of delivering comprehensive pharmacy services.

The 47 pharmacies that volunteered to participate included chain, independent and franchise pharmacies.

The study was undertaken by AT Kearney Ltd. during the summer of 2006. AT Kearney Ltd. is an international management consulting company with offices located throughout the world.

The study provided valuable insights into pharmacy business and practices and indicated that the weighted average cost to dispense a prescription in B.C. was $8.02. This is $0.58 less than PSD’s maximum reimbursable dispensing fee of $8.60.

A copy of the study report is available in the Publications section of our website at [www.health.gov.bc.ca/pharme](http://www.health.gov.bc.ca/pharme).

7.4 Diabetes Coverage Policy Review

B.C.’s coverage policy for patients with diabetes, includes coverage of insulin and syringes, oral medications, and blood glucose monitoring strips for patients with insulin-dependent diabetes.

**PharmaCare expenditures for diabetes products have increased by 68% in the past seven years for a total cost in 2006 of $53.5 million. Coverage for glucose monitoring strips is our fourth highest product expenditure and is growing rapidly.**

A number of factors are fuelling this growth in costs: the incidence of diabetes is on the rise, the number of available treatments is expanding and many patients are purchasing larger quantities of monitoring strips.

The challenge we face is to develop a strategy that improves health outcomes and provides appropriate access to diabetes therapies—without jeopardizing sustainability of the program as a whole.

In 2006, we decided to pursue a diabetes policy review, beginning with a Spring 2007 stakeholder session. At that time, we will be asking stakeholders to consider ways in which our coverage policy can be optimized to best serve the health needs of B.C. residents and make sure that every dollar spent buys a true gain in health outcomes.
7.5 No-Charge Psychiatric Medication Plan Review

In July 2006, we began a detailed review of the No-Charge Psychiatric Medication Plan (Plan G).

This plan was introduced in 1998 to assist low-income individuals for whom the cost of psychiatric medications is a barrier to treatment and who, without medication, would suffer serious consequences, such as hospitalization. The plan provides 100% coverage for specific psychiatric prescription drugs and some adjunct medication.

Responsibility for the plan is shared by Pharmaceutical Services Division, Mental Health Services Centres within the B.C. health authorities, and the Ministry of Child and Family Development’s Child and Youth Mental Health Services Centres. Our division is responsible for plan policy, funding and management of services; Mental Health Service Centres administer the plan and determine patient eligibility.

Under current plan policy, patients must declare that they meet the income criteria for Medical Services Plan Premium Assistance and a physician must certify that the patient meets the clinical criteria. The Mental Health Services Centre then confirms client eligibility and submits the eligibility record to PharmaCare.

In 2006, we gathered comprehensive stakeholder input to inform our review. We were also mindful of the recommendations of the Auditor General of B.C. that we review the plan and the supporting policy framework to ensure consistency, and to ensure that the eligibility criteria for the plan are clear and that eligibility is being assessed in accordance with the criteria\(^2\). The review therefore included thorough assessment of the current plan eligibility criteria, the supporting policy and procedural framework, and the information technology concerns prompted by the pending retirement of the system currently used by Mental Health Services Centres to confirm financial eligibility. Drugs covered under the plan were not included in the review.

The review resulted in a number of options for increasing the clarity of the eligibility criteria, improving consistency in applying those criteria and responding to the retirement of the current technology used by service centres to confirm financial eligibility and communicate patient eligibility to PharmaCare.

\(^2\) Auditor General of B.C., 2005/06 report “Managing PharmaCare.”
In 2007, we will be collaborating with the Internal Audit and Advisory Services of the Office of the Comptroller General to ensure that proposed revisions to plan policy and procedures will be accountable and auditable. We will also be evaluating a variety of technological means for determining eligibility that are also accountable and auditable.

### 7.6 Harvard Medical School/University of Victoria Review of the PharmaCare Proton Pump Inhibitor Policy

When we introduced the preferential proton pump inhibitor policy in 2003, we committed to an external review on the impact of shifting prescribing to the less costly proton pump inhibitor, rabeprazole.

An independent academic review by Harvard Medical School and the University of Victoria was published in the April 2006 issue of the peer-reviewed journal, *Clinical Pharmacology and Therapeutics*.

The published report came to the following positive conclusions:

- Almost half of elderly users of proton pump inhibitors switched to rabeprazole.
- There was no increase in the rate of discontinuation of therapy with proton pump inhibitors, indicating that routine care was not interrupted.
- There was no increase in the rate of GI bleed or severe peptic ulcer disease leading to hospitalization, indicating that the policy is clinically safe.
- There was a 9% increase in visits to physicians coded as being related to Gastroesophageal Reflux Disease three months after the policy change, possibly due to increased follow-up of patients. The total rate of visits to physicians was unchanged.
- The policy produced substantial savings of at least $2.9 million in the senior population (patients 65 years or older) in the first six months of the policy.

As a result of this policy, PharmaCare saved an estimated $9 million across the entire patient population in 2006.
7.7 External Reviews—Fair PharmaCare Plan

When implementing the Fair PharmaCare plan, the Ministry of Health arranged for two independent evaluations of the plan. In 2006, the University of British Columbia's Centre for Health Services and Policy Research and Harvard University completed evaluations of the plan.

The study by British Columbia's Centre for Health Services examined PharmaNet records of prescriptions dispensed from 1996 to 2004. It assessed the impact that the co-payment policy for seniors (introduced in 2002) and the Fair PharmaCare plan (introduced in 2003) had on access to medicines, private and public expenditure, and the distribution of financial burden.

The findings—published in a series of reports in November 2006—indicated that the introduction of Fair PharmaCare met many of the intended policy goals such as maintaining access to drug therapy while ensuring financial sustainability. It also highlighted issues that we will need to consider when shaping future policy directions. Both internal and external reviews give us a clearer—and broader—appreciation of the impact of our policies on British Columbians.

Evaluations conducted by Harvard University focused on the affect the introduction of Fair PharmaCare had on B.C. seniors by looking at drug utilization changes, drug discontinuation rates, the rates of physician visits for specific diagnoses, and hospitalization rates. This valuable information on the effect that general PharmaCare program policy has on the use of specific groups of medications will help us to better understand the potential implications of policy options.

Pharmaceutical Services Division values the model of external independent academic research into its policies and procedural changes as a mechanism to attain valid and reliable evaluations of complex situations.

7.8 Internal Review—Fair PharmaCare Plan

Pharmaceutical Services Division has also examined the impacts of the Fair PharmaCare plan on British Columbian's ability to pay for medication. Before the Fair PharmaCare plan was launched in May 2003, many low-income families were paying more for their eligible drugs and medical supplies than individuals and families with higher incomes. The internal review we undertook in 2006 revealed that Fair PharmaCare lowered the drug costs of approximately 300,000 families in British Columbia annually.
8. **Business Management, Supplier Relations and Systems**

Every government makes a commitment to manage taxpayers' money well. Good management means delivering coverage of effective products and services at the lowest possible cost.

In our view, crucial components of good management include strong relationships with pharmacies and other suppliers of PharmaCare benefit products, coupled with robust technology to support services to patients.

This branch will ensure the best price possible for the best available products and services, leading the negotiations with drug manufacturers, wholesalers, pharmacies, pharmacists and others.

It will be responsible for the strategic direction of electronic information systems like PharmaNet, emerging eDrug initiatives, and management of agreements with third party service providers such as Health Insurance BC.

### 8.1 eHealth Program and the eDrug Project

The Ministry of Health’s eHealth Program is a major initiative funded by both the province and Canada Health Infoway to advance Canada’s electronic health record. eHealth’s long term goal is to make a secure and comprehensive provincial health record available to authorized health professionals across the province. B.C.’s eHealth Program will evolve over the next ten years and the projects underway now will build the foundation eHealth needs to enable a provincial electronic health record in B.C.

Throughout 2006, our division worked with the eDrug Project team to begin implementing the plan to meet the eDrug vision of expanding the use of electronic medication information management to facilitate seamless care across all care settings.

The work has benefited greatly from the input and involvement of key stakeholders including the College of Pharmacists of BC, the College of Physicians and Surgeons of BC, the College of Registered Nurses of BC, the BC Pharmacy Association, the BC Medical Association and B.C.’s six health authorities.
Enhancements to PharmaNet

The eDrug project will deliver key enhancements to PharmaNet that are critical to the delivery of eHealth and the provincial electronic health record. The enhanced system, PharmaNet-eRx, is designed to improve patient safety and health outcomes and will:

- Provide the foundation to allow physicians to electronically prescribe medications via their electronic medical record systems, thereby eliminating medication errors due to handwritten prescriptions.
- Provide comprehensive drug profiles including clinically relevant medication information from a patient's hospital stay as well as pertinent oncology and renal medications dispensed by provincial agencies.
- Provide seamless medication management tracking between acute care, residential care and community settings for physicians and pharmacists.
- Provide immediate online clinical and financial decision support tools to ensure patients receive affordable therapies that meet best practices.
- Enhance interaction between the provincial PharmaCare program and front line health care practitioners by using technology to significantly reduce administrative time in dealing with Special Authority coverage approvals.

Expanding Access to PharmaNet

PharmaNet access was available only to pharmacies until 1999, when access was expanded to include to B.C. Emergency Departments. In 2005, PharmaNet medication histories were made available to physicians in private practice, group practice and walk-in clinics through the Medical Practice Access to PharmaNet service.

In December 2006, Hospital Access to PharmaNet was introduced, giving authorized physicians access to patient medication profiles from a hospital or designated mental health facility. The patient information accessed through this service is similar to that already being used in many medical practices across the province.

For more information on Hospital Access to PharmaNet, please visit www.health.gov.bc.ca/pharme/newsletter/hapinfosheet.pdf.


The value of Medical Practice Access to PharmaNet in the delivery of patient care is evidenced by the number of medical practices (approximately 260 practices—including about 800 doctors) who signed up for the service by the end of 2006.
9. **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](http://www.health.gov.bc.ca)
- BC PharmaCare [www.health.gov.bc.ca/pharme](http://www.health.gov.bc.ca/pharme)
- BC eHealth [www.health.gov.bc.ca/ehealth/](http://www.health.gov.bc.ca/ehealth/)
- BC Mental Health and Addictions [www.health.gov.bc.ca/mhd](http://www.health.gov.bc.ca/mhd)
- Therapeutics Initiative [www.ti.ubc.ca](http://www.ti.ubc.ca)
- BC Centre for Excellence in HIV/AIDS [www.cfenet.ubc.ca](http://www.cfenet.ubc.ca)
- College of Pharmacists of BC [www.bcpharmacists.org](http://www.bcpharmacists.org)
- College of Physicians & Surgeons of BC [www.cpsbc.ca](http://www.cpsbc.ca)
- College of Dental Surgeons of BC [www.cdsbc.org](http://www.cdsbc.org)
- College of Midwives of BC [www.cmbc.bc.ca](http://www.cmbc.bc.ca)
- College of Registered Nurses of British Columbia [www.crnbc.ca](http://www.crnbc.ca)
- BC Pharmacy Association [www.bcpharmacy.ca](http://www.bcpharmacy.ca)
- BC Medical Association [www.bcma.org](http://www.bcma.org)
- BC Association of Podiatrists [www.foothealth.ca](http://www.foothealth.ca)

**Provincial websites**

Resources

- New Brunswick Prescription Drug Program  
- Prince Edward Island Health Services  
- Northwest Territories Health Programs  
  [www.hlthss.gov.nt.ca](http://www.hlthss.gov.nt.ca)
- Yukon Health & Social Services  
  [www.hss.gov.yk.ca](http://www.hss.gov.yk.ca)
- Government of Nunavut Health and Social Services  

Federal websites

- Health Canada  
  [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)
- Health Canada, Health Products and Food Branch  
  [www.hc-sc.gc.ca/hpfb-dgpsa](http://www.hc-sc.gc.ca/hpfb-dgpsa)
- Health Canada, Drug Product Database  
  [www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index_e.html](http://www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index_e.html)
- National Pharmaceuticals Strategy  
  [www.nps-snpp.ca](http://www.nps-snpp.ca)
- Canadian Health Network  
  [www.canadian-health-network.ca](http://www.canadian-health-network.ca)
- Canadian Institute for Health Information  
  [www.cihi.ca](http://www.cihi.ca)
- Patented Medicine Prices Review Board  
  [www.pmprb-cepmb.gc.ca](http://www.pmprb-cepmb.gc.ca)
- Canadian Agency for Drugs and Technologies in Health, Common Drug Review  
- Canadian Agency for Drugs and Technologies in Health, Canadian Optimal Medication Prescribing & Utilization Service  

Canadian association websites

- Canadian Pharmacists Association  
  [www.pharmacists.ca](http://www.pharmacists.ca)
- Canadian Medical Association  
  [www.cma.ca](http://www.cma.ca)
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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. Beginning in 2005, PharmaCare Trends was
superceded by the PharmaCare Annual Performance Report.

Citations:
This document must be cited as the source for any information extracted from it.
Suggested citation: PharmaCare Annual Performance Report 2006,

Comments and Inquiries: Please direct comments and inquiries to
pharma@gov.bc.ca or Policy Outcomes, Evaluation & Research Branch,
Pharmaceutical Services Division, Ministry of Health, P.O. Box 9652,
Victoria BC V8W 9P4.
Appendix A - PharmaCare Plans

A1. Fair PharmaCare (Plan I)

The Fair PharmaCare plan took effect May 1, 2003. It provides assistance to B.C. families based on their net income. Fair PharmaCare is the largest of the drug coverage plans under the B.C. PharmaCare program. Assistance for individuals is based on their annual net income. For families, the family’s level of assistance is based on the combined annual net income of both spouses.

A2. Permanent Residents of Licensed Residential Care Facilities (Plan B)

B.C. is one of three Canadian provinces that provide coverage of prescription medications for permanent residents of licensed residential 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 2006, approximately 24,000 care facility patients benefited from this coverage.

A3. 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 2006, Plan C expenditures represented just over 75.0% of the total expenditure for all specialty plans (i.e., plans other than Fair PharmaCare), providing coverage to approximately 146,000 residents.

B.C. is one of four provinces that do not require recipients of provincial income assistance to meet a deductible or make co-payments.

A4. Patients Registered with a Provincial Cystic Fibrosis Clinic (Plan D)

Since 1995, individuals with cystic fibrosis who register with a provincial Cystic Fibrosis Clinic have received coverage of eligible digestive enzymes. PharmaCare pays 100% of the drug cost (up to the maximum price recognized by PharmaCare) and the dispensing fee, up to the acceptable maximum.

In 2006, over 270 individuals with cystic fibrosis received coverage under this plan. Only four other provinces have designated plans for cystic fibrosis.
A5. 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 eligible drug cost are covered. In 2006, there were over 2,320 children eligible for this plan.

A6. No-Charge Psychiatric Medication Plan (Plan G)

In 2006, approximately 22,000 patients who were registered with a mental health services centre, and who demonstrated clinical and financial need, qualified for 100% coverage of the eligible cost of certain psychiatric medications. Mental health services centres determine individual patient eligibility.

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

A7. 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 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 simplified administration and brought the provision of palliative care benefits in line with other PharmaCare plans. Roughly 8,300 patients received coverage under this plan in 2006.

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

B1. Total Pharmaceutical Services Division Expenditures 2002-2006

The graph below depicts Pharmaceutical Services Division’s total expenditures, including all plan expenditures, additional pharmacist payments, and expenditures for the B.C. Centre for Excellence in HIV/AIDS (the anti-retroviral drugs it provides are funded directly by Pharmaceutical Services Division).

The graph does not include Ministry of Health expenditures for drugs administered in B.C. hospitals or through the B.C. Cancer Agency.

**Graph B.1—Total Pharmaceutical Services Division Expenditures 2002-2006**

<table>
<thead>
<tr>
<th>Year</th>
<th>Additional Pharmacy Expenditures</th>
<th>BC Centre for Excellence in HIV/AIDS</th>
<th>PharmaCare Plan Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$17.0</td>
<td>$36.8</td>
<td>$663.3</td>
</tr>
<tr>
<td>2003</td>
<td>$16.7</td>
<td>$37.9</td>
<td>$665.6</td>
</tr>
<tr>
<td>2004</td>
<td>$17.0</td>
<td>$47.2</td>
<td>$723.7</td>
</tr>
<tr>
<td>2005</td>
<td>$17.3</td>
<td>$58.7</td>
<td>$773.2</td>
</tr>
<tr>
<td>2006</td>
<td>$19.5</td>
<td>$65.3</td>
<td>$818.5</td>
</tr>
</tbody>
</table>

Figures exclude Pharmaceutical Services administration costs.

BC Centre for Excellence in HIV/AIDS figures are provided for fiscal year (e.g., 2002 = 2002/03, etc.).
Divisional expenditures are normally reported on a fiscal year basis. The expenditure amounts shown above have been estimated based on a calendar year.

**Plan Expenditures**

PharmaCare plan expenditures remained relatively level between 2002 and 2003. After the implementation of Fair PharmaCare, expenditures increased by 23.0% from $665.6 million in 2003 to $818.5 million in 2006. Fair PharmaCare (Plan I) dominates plan expenditures in 2006 at 63.4%. The B.C. Income Assistance Plan (Plan C) constitutes 27.9% of plan expenditures. Plan C and Plan I accounted for more than 90.0% of plan expenditures in 2006.

Plan coverage changes were introduced as a result of the significant expenditure increases from 1999 through 2001. Expenditure growth rates of up to 14.0% 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.
B.C. Centre for Excellence in HIV/AIDS Expenditures

Established in 1992, the B.C. Centre for Excellence in HIV/AIDS (the Centre) is Canada’s largest HIV/AIDS research and treatment facility. It provides support and treatment services for persons living with HIV.

HIV-infected individuals who are residents of B.C. and who have been determined to be eligible for health care services and benefits, receive all anti-HIV medications at no cost through the Centre’s drug treatment program as determined by the Centre’s Therapeutic Guidelines.

Since 2001, the Centre has received funding for its drug treatment program from PharmaCare. Funding for administration and research flows through the Provincial Health Services Authority.

- As of December 2006, approximately 7,993 British Columbians have enrolled in the program since its inception in 1992.
- The Centre's expenditures have increased by 77.4% from $36.8 million in 2002 to $65.3 million in 2006, with an increase of over 24.0% over the past two years.

Additional Pharmacy Expenditures

In addition to dispensing fees, PharmaCare makes payments to pharmacies through the following programs: Plan B (capitation fees), Methadone Maintenance Program (interaction fees), Special Services Fees (professional intervention fees), and the Rural Incentive Program (prescription subsidy).

- Additional pharmacy expenditures have increased by 14.6% from $17.0 million in 2002 to $19.5 million in 2006.
- Capitation fees have increased 15.5% from $6.9 million in 2002 to $8.0 million in 2006. The biggest increase was 23.3% from $6.5 million in 2005 to $8.0 million in 2006, due to an increase in the capitation fee amount.

---


2 Pharmacy participation in the interaction fee portion of this program is voluntary. As of May 1, 2001, pharmacies who participate receive an interaction fee ($7.70), in addition to the acquisition cost ($0.02/ml) and dispensing fee (currently $8.60), for each dispensing involving direct interaction with the patient. Pharmacies who do not participate in the interaction fee portion of the program are reimbursed for the acquisition cost and dispensing fee only.

3 In a “refusal to fill” situation, a pharmacist may choose not to dispense a prescription for reasons such as a drug-to-drug interaction, suspicion of multi-doctoring, etc. In these situations, PharmaCare may pay a professional intervention fee to a pharmacy if there has been a cost saving to PharmaCare as a result of a refusal to fill.

4 The Rural Incentive Program assists eligible pharmacies located in remote communities by paying a subsidy for each prescription dispensed. The subsidy is based on a sliding scale, with pharmacies that have lower volumes receiving larger subsidies per prescription.

5 Plan B capitation payments are paid based on the number of recognized beds the pharmacy has serviced in the past month.
Interaction fees have increased 16.2% from $9.2 million in 2002 to $10.7 million in 2006.

In 2006, 39,826 special services fees were paid, totalling $0.7 million of the additional pharmacy expenditures.

In 2006, prescription subsidies for the Rural Incentive Program totalled $0.9 million, which was a 55.0% increase from $0.6 million in 2005.
Appendix C - PharmaCare Plan Expenditures, 1999 to 2006

C1. Interpreting PharmaCare Data

The following data regarding costs, expenditures, and paid amounts refers only to PharmaCare plan expenditures (i.e., costs associated with Plans A, B, C, D, E, F, G, I and P). Therefore, data does not include claims expenditures for drugs provided through the B.C. Centre for Excellence in HIV/AIDS, or additional pharmacy expenditures, unless otherwise noted.

In addition, claims expenditures are based on claims submitted by community pharmacies, and do not include hospital pharmacy claims expenditures.

Subject to the rules of their PharmaCare plan, beneficiaries may be responsible for paying some of their prescription costs. Thus, the proceeding claims data refers only to claims in which PharmaCare contributed a portion of the cost.

Significant policy changes to PharmaCare Plans

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 Quality Note

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

Definitions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim(s)</td>
<td>A request to PharmaCare for payment of the cost of processing a prescription. For example, a prescription for a 90-days’ supply of medication, dispensed at 30-day intervals, would count as three claims.</td>
</tr>
<tr>
<td>Days’ Supply</td>
<td>The length of time a supply of medication dispensed will last based on the dosage prescribed (e.g., 60 tablets at a dosage of one tablet twice daily would equal a 30-day supply).</td>
</tr>
<tr>
<td>Dispensing fee/Professional fee</td>
<td>The fee a pharmacy charges to process a prescription.</td>
</tr>
<tr>
<td>Ingredient cost</td>
<td>A pharmacy’s actual acquisition cost for the drug ingredient(s) dispensed.</td>
</tr>
<tr>
<td>Ingredient cost paid / Professional fee paid / Total paid costs</td>
<td>Amounts paid by PharmaCare (i.e., excluding amounts paid by beneficiaries).</td>
</tr>
</tbody>
</table>
## C2. PharmaCare Plan Expenditure Tables

### Table C.1—Total Claims Expenditures: All Plans (A, B, C, D, E, F, G, I and P)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.850</td>
<td>0.881</td>
<td>0.916</td>
<td>0.816</td>
<td>0.902</td>
<td>0.829</td>
<td>0.817</td>
<td>0.802</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$455.107</td>
<td>$531.216</td>
<td>$606.213</td>
<td>$576.370</td>
<td>$563.072</td>
<td>$601.784</td>
<td>$639.444</td>
<td>$671.746</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$35.839</td>
<td>$41.003</td>
<td>$53.603</td>
<td>$86.925</td>
<td>$102.569</td>
<td>$121.899</td>
<td>$133.792</td>
<td>$146.793</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$490.946</td>
<td>$572.219</td>
<td>$659.816</td>
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<td>$665.641</td>
<td>$723.683</td>
<td>$773.236</td>
<td>$818.540</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>15.66</td>
<td>16.42</td>
<td>17.73</td>
<td>18.31</td>
<td>17.67</td>
<td>21.86</td>
<td>24.18</td>
<td>26.82</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$577.84</td>
<td>$649.69</td>
<td>$720.70</td>
<td>$812.65</td>
<td>$738.21</td>
<td>$872.61</td>
<td>$945.88</td>
<td>$1,020.79</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$2.69</td>
<td>$2.84</td>
<td>$3.30</td>
<td>$5.82</td>
<td>$6.44</td>
<td>$6.72</td>
<td>$6.77</td>
<td>$6.82</td>
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<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$34.22</td>
<td>$36.73</td>
<td>$37.34</td>
<td>$38.56</td>
<td>$35.33</td>
<td>$33.19</td>
<td>$32.35</td>
<td>$31.23</td>
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<tr>
<td>Avg total amount paid per claim</td>
<td>$36.91</td>
<td>$39.57</td>
<td>$40.65</td>
<td>$44.37</td>
<td>$41.77</td>
<td>$39.92</td>
<td>$39.12</td>
<td>$38.06</td>
</tr>
<tr>
<td>Avg days’ supply per claim</td>
<td>41.6</td>
<td>41.4</td>
<td>40.9</td>
<td>38.4</td>
<td>35.0</td>
<td>33.1</td>
<td>31.2</td>
<td>29.1</td>
</tr>
</tbody>
</table>

The Fair PharmaCare Plan (Plan I) was introduced May 1, 2003, replacing Plan A (Seniors Plan) and Plan E (Non-seniors Universal Plan). 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.

Figures have been updated to include payments for Plan P from 2001 onwards.
Table C.2—PharmaCare Claims Expenditures: Plan A (Seniors)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims (millions)</td>
<td>6.722</td>
<td>7.194</td>
<td>7.953</td>
<td>6.605</td>
<td>2.059</td>
</tr>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.430</td>
<td>0.439</td>
<td>0.450</td>
<td>0.413</td>
<td>0.364</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$263.953</td>
<td>$296.166</td>
<td>$341.017</td>
<td>$301.550</td>
<td>$93.689</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$6.705</td>
<td>$8.262</td>
<td>$11.323</td>
<td>$38.266</td>
<td>$10.885</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$270.658</td>
<td>$304.428</td>
<td>$352.340</td>
<td>$339.816</td>
<td>$104.574</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>15.65</td>
<td>16.39</td>
<td>17.68</td>
<td>15.98</td>
<td>5.66</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$629.93</td>
<td>$693.72</td>
<td>$783.19</td>
<td>$822.25</td>
<td>$287.52</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$1.00</td>
<td>$1.15</td>
<td>$1.42</td>
<td>$5.79</td>
<td>$5.29</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$39.27</td>
<td>$41.17</td>
<td>$42.88</td>
<td>$45.65</td>
<td>$45.50</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$40.26</td>
<td>$42.32</td>
<td>$44.30</td>
<td>$51.45</td>
<td>$50.78</td>
</tr>
<tr>
<td>Avg days’ supply per claim</td>
<td>53.4</td>
<td>53.7</td>
<td>53.6</td>
<td>53.5</td>
<td>52.4</td>
</tr>
</tbody>
</table>

Prior to 2001: Plan A beneficiaries (Seniors) received full coverage for all eligible drug and medical supply costs.Seniors paid the dispensing fee on all their prescriptions, until they reached their $200 annual maximum.

January 2002 to April 30, 2003: Seniors paid a maximum $25 towards the drug cost and dispensing fee for each prescription, until they reached a $275 annual maximum. Seniors on premium assistance paid a maximum $10 towards the drug cost and dispensing fee for each prescription, until they reached a $200 annual maximum.

May 1, 2003: Plan A was replaced by Plan I (Fair PharmaCare).
Table C.3—PharmaCare Claims Expenditures: Plan B (Permanent Residents of Licensed Residential Care Facilities)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims (millions)</td>
<td>1.103</td>
<td>1.119</td>
<td>1.165</td>
<td>1.188</td>
<td>1.191</td>
<td>1.290</td>
<td>1.519</td>
<td>1.819</td>
</tr>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.025</td>
<td>0.025</td>
<td>0.025</td>
<td>0.025</td>
<td>0.025</td>
<td>0.024</td>
<td>0.024</td>
<td>0.024</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>44.4</td>
<td>44.28</td>
<td>45.72</td>
<td>46.76</td>
<td>48.04</td>
<td>52.66</td>
<td>62.82</td>
<td>75.20</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$874.04</td>
<td>$952.95</td>
<td>$1,056.44</td>
<td>$1,153.14</td>
<td>$1,245.51</td>
<td>$1,265.54</td>
<td>$1,330.35</td>
<td>$1,357.93</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$19.69</td>
<td>$21.52</td>
<td>$23.11</td>
<td>$24.66</td>
<td>$25.93</td>
<td>$24.03</td>
<td>$21.18</td>
<td>$18.06</td>
</tr>
<tr>
<td>Avg days’ supply per claim</td>
<td>29.6</td>
<td>29.9</td>
<td>31.0</td>
<td>30.4</td>
<td>29.2</td>
<td>26.5</td>
<td>22.6</td>
<td>19.1</td>
</tr>
</tbody>
</table>

Plan B does not have a professional fee: pharmacies are paid a monthly capitation rate. This amount is not included in the above table; however, further information on capitation fees can be found in Graph B.1.

In 2006, PharmaCare changed its payment policy to pharmacies servicing Plan B patients. Before 2006, Plan B capitation payments were based on the number of recognized beds the pharmacy had serviced in the past month. As of January 1, 2006, the pharmacy monthly capitation rate was changed to $35 per patient registered for Plan B. However, the capitation rate has since returned to the previous bed model.

Changing the payment of capitation rates in 2006 resulted in a 23.0% increase in expenditures from $6.50 million in 2005 to $8.01 million in 2006.
### Table C.4—PharmaCare Claims Expenditures: Plan C (Recipients of B.C. Income Assistance)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.220</td>
<td>0.213</td>
<td>0.208</td>
<td>0.187</td>
<td>0.177</td>
<td>0.161</td>
<td>0.152</td>
<td>0.146</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$89.573</td>
<td>$110.172</td>
<td>$116.362</td>
<td>$120.326</td>
<td>$138.402</td>
<td>$153.037</td>
<td>$162.138</td>
<td>$168.907</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$20.834</td>
<td>$22.715</td>
<td>$29.634</td>
<td>$35.989</td>
<td>$43.359</td>
<td>$49.703</td>
<td>$54.011</td>
<td>$59.496</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$110.407</td>
<td>$132.887</td>
<td>$145.996</td>
<td>$156.315</td>
<td>$181.761</td>
<td>$202.739</td>
<td>$216.149</td>
<td>$228.403</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>16.42</td>
<td>18.57</td>
<td>21.67</td>
<td>26.01</td>
<td>30.62</td>
<td>37.69</td>
<td>43.03</td>
<td>49.05</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$502.85</td>
<td>$622.49</td>
<td>$702.69</td>
<td>$838.08</td>
<td>$1,024.60</td>
<td>$1,259.70</td>
<td>$1,420.57</td>
<td>$1,566.29</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$5.78</td>
<td>$5.73</td>
<td>$6.58</td>
<td>$7.42</td>
<td>$7.98</td>
<td>$8.19</td>
<td>$8.25</td>
<td>$8.32</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$24.85</td>
<td>$27.80</td>
<td>$25.85</td>
<td>$24.80</td>
<td>$25.48</td>
<td>$25.23</td>
<td>$24.76</td>
<td>$23.62</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$30.63</td>
<td>$33.53</td>
<td>$32.43</td>
<td>$32.22</td>
<td>$33.46</td>
<td>$33.42</td>
<td>$33.01</td>
<td>$31.93</td>
</tr>
<tr>
<td>Avg days' supply per claim</td>
<td>23.5</td>
<td>22.5</td>
<td>21.1</td>
<td>19.6</td>
<td>19.1</td>
<td>18.4</td>
<td>17.3</td>
<td>16.1</td>
</tr>
</tbody>
</table>
### Table C.5—PharmaCare Claims Expenditures: Plan D (Cystic Fibrosis)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims</td>
<td>1,469</td>
<td>1,347</td>
<td>1,419</td>
<td>1,418</td>
<td>1,371</td>
<td>1,516</td>
<td>1,553</td>
<td>1,552</td>
</tr>
<tr>
<td>Number of beneficiaries</td>
<td>263</td>
<td>265</td>
<td>262</td>
<td>252</td>
<td>257</td>
<td>267</td>
<td>274</td>
<td>277</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$0.677</td>
<td>$0.648</td>
<td>$0.690</td>
<td>$0.713</td>
<td>$0.730</td>
<td>$0.789</td>
<td>$0.821</td>
<td>$0.873</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$0.010</td>
<td>$0.009</td>
<td>$0.010</td>
<td>$0.010</td>
<td>$0.011</td>
<td>$0.012</td>
<td>$0.013</td>
<td>$0.013</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$0.687</td>
<td>$0.657</td>
<td>$0.700</td>
<td>$0.723</td>
<td>$0.740</td>
<td>$0.801</td>
<td>$0.833</td>
<td>$0.886</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>5.59</td>
<td>5.08</td>
<td>5.42</td>
<td>5.63</td>
<td>5.33</td>
<td>5.68</td>
<td>5.67</td>
<td>5.60</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$2,612.04</td>
<td>$2,478.53</td>
<td>$2,670.26</td>
<td>$2,869.90</td>
<td>$2,881.21</td>
<td>$3,000.00</td>
<td>$3,041.85</td>
<td>$3,199.64</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$6.48</td>
<td>$6.61</td>
<td>$6.74</td>
<td>$7.19</td>
<td>$7.78</td>
<td>$8.16</td>
<td>$8.30</td>
<td>$8.30</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$461.16</td>
<td>$481.00</td>
<td>$486.29</td>
<td>$502.83</td>
<td>$532.31</td>
<td>$520.21</td>
<td>$528.38</td>
<td>$562.77</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$467.64</td>
<td>$487.61</td>
<td>$493.03</td>
<td>$510.02</td>
<td>$540.09</td>
<td>$528.36</td>
<td>$536.68</td>
<td>$571.07</td>
</tr>
<tr>
<td>Avg days’ supply per claim</td>
<td>53.5</td>
<td>54.9</td>
<td>52.5</td>
<td>53.8</td>
<td>46.7</td>
<td>44.2</td>
<td>46.2</td>
<td>47.1</td>
</tr>
</tbody>
</table>
Table C.6—PharmaCare Claims Expenditures: Plan E (Universal)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims (millions)</td>
<td>1.704</td>
<td>1.984</td>
<td>2.295</td>
<td>1.885</td>
<td>0.117</td>
</tr>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.179</td>
<td>0.206</td>
<td>0.233</td>
<td>0.186</td>
<td>0.021</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$70.814</td>
<td>$90.189</td>
<td>$106.610</td>
<td>$105.792</td>
<td>$14.171</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$7.192</td>
<td>$8.671</td>
<td>$10.462</td>
<td>$9.614</td>
<td>$0.629</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$78.006</td>
<td>$98.860</td>
<td>$117.072</td>
<td>$115.406</td>
<td>$14.800</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>9.52</td>
<td>9.65</td>
<td>9.85</td>
<td>10.14</td>
<td>5.65</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$435.66</td>
<td>$480.76</td>
<td>$502.44</td>
<td>$620.34</td>
<td>$713.58</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$4.22</td>
<td>$4.37</td>
<td>$4.56</td>
<td>$5.10</td>
<td>$5.37</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$41.55</td>
<td>$45.45</td>
<td>$46.46</td>
<td>$56.11</td>
<td>$120.98</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$45.77</td>
<td>$49.82</td>
<td>$51.02</td>
<td>$61.21</td>
<td>$126.35</td>
</tr>
<tr>
<td>Avg days’ supply per claim</td>
<td>42.3</td>
<td>42.3</td>
<td>42.8</td>
<td>42.2</td>
<td>33.3</td>
</tr>
</tbody>
</table>

Prior to 2001: Plan E beneficiaries (Non-seniors) paid all their drug costs and dispensing fees until they reached an $800 annual family deductible. Once the deductible was met, non-seniors paid 30% of their drug costs until they reached an annual family maximum of $2,000. Once the annual maximum was met, PharmaCare covered 100% of all eligible drug costs for the rest of the year.

Non-seniors receiving Premium Assistance paid all their drug costs and dispensing fees until they reached a $600 annual family deductible. Once the deductible was met, PharmaCare covered 100% of all eligible drug costs for the rest of the year. Recipients whose annual net income was $20,000 or lower were eligible for Premium Assistance up until April 31, 2002. On May 1, 2002, the net income threshold was raised to $24,000.

January 2002 to April 30, 2003: Deductibles increased to $1,000 for non-seniors, and increased to $800 for non-seniors receiving Premium Assistance.

May 1, 2003: Plan E was replaced by Plan I (Fair PharmaCare).
Table C.7—PharmaCare Claims Expenditures: Plan F (At Home Children)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims</td>
<td>24,844</td>
<td>25,950</td>
<td>27,772</td>
<td>27,999</td>
<td>28,622</td>
<td>29,531</td>
<td>32,963</td>
<td>35,775</td>
</tr>
<tr>
<td>Number of beneficiaries</td>
<td>1,845</td>
<td>1,910</td>
<td>2,003</td>
<td>2,010</td>
<td>2,052</td>
<td>2,085</td>
<td>2,239</td>
<td>2,324</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$2.497</td>
<td>$2.669</td>
<td>$2.892</td>
<td>$3.066</td>
<td>$3.154</td>
<td>$3.440</td>
<td>$3.622</td>
<td>$3.830</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$0.157</td>
<td>$0.167</td>
<td>$0.184</td>
<td>$0.197</td>
<td>$0.217</td>
<td>$0.231</td>
<td>$0.260</td>
<td>$0.287</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$2.653</td>
<td>$2.836</td>
<td>$3.076</td>
<td>$3.263</td>
<td>$3.370</td>
<td>$3.670</td>
<td>$3.882</td>
<td>$4.117</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>13.47</td>
<td>13.59</td>
<td>13.87</td>
<td>13.93</td>
<td>13.95</td>
<td>14.16</td>
<td>14.72</td>
<td>15.39</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$1,438.18</td>
<td>$1,484.91</td>
<td>$1,535.91</td>
<td>$1,623.27</td>
<td>$1,642.51</td>
<td>$1,760.42</td>
<td>$1,733.74</td>
<td>$1,771.31</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$6.31</td>
<td>$6.44</td>
<td>$6.64</td>
<td>$7.04</td>
<td>$7.58</td>
<td>$7.81</td>
<td>$7.89</td>
<td>$8.02</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$100.49</td>
<td>$102.85</td>
<td>$104.13</td>
<td>$109.49</td>
<td>$110.18</td>
<td>$116.48</td>
<td>$109.87</td>
<td>$107.04</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$106.80</td>
<td>$109.29</td>
<td>$110.77</td>
<td>$116.53</td>
<td>$117.76</td>
<td>$124.29</td>
<td>$117.76</td>
<td>$115.07</td>
</tr>
<tr>
<td>Avg days' supply per claim</td>
<td>36.0</td>
<td>35.5</td>
<td>34.4</td>
<td>34.4</td>
<td>32.7</td>
<td>32.7</td>
<td>32.0</td>
<td>31.2</td>
</tr>
</tbody>
</table>
Table C.8—PharmaCare Claims Expenditures: Plan G (No-Charge Psychiatric Medication Plan)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims (millions)</td>
<td>0.140</td>
<td>0.174</td>
<td>0.214</td>
<td>0.260</td>
<td>0.319</td>
<td>0.365</td>
<td>0.418</td>
<td>0.463</td>
</tr>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.010</td>
<td>0.012</td>
<td>0.014</td>
<td>0.016</td>
<td>0.018</td>
<td>0.020</td>
<td>0.021</td>
<td>0.022</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$0.941</td>
<td>$1.179</td>
<td>$1.491</td>
<td>$1.929</td>
<td>$2.546</td>
<td>$2.988</td>
<td>$3.452</td>
<td>$3.864</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>14.45</td>
<td>14.83</td>
<td>15.67</td>
<td>16.37</td>
<td>17.28</td>
<td>18.33</td>
<td>19.82</td>
<td>21.19</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$701.59</td>
<td>$720.61</td>
<td>$775.87</td>
<td>$835.14</td>
<td>$890.47</td>
<td>$903.22</td>
<td>$950.23</td>
<td>$983.95</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$6.70</td>
<td>$6.77</td>
<td>$6.96</td>
<td>$7.42</td>
<td>$7.97</td>
<td>$8.19</td>
<td>$8.25</td>
<td>$8.35</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$41.86</td>
<td>$41.83</td>
<td>$42.56</td>
<td>$43.59</td>
<td>$43.55</td>
<td>$41.08</td>
<td>$39.69</td>
<td>$38.10</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$48.56</td>
<td>$48.60</td>
<td>$49.52</td>
<td>$51.01</td>
<td>$51.52</td>
<td>$49.27</td>
<td>$47.94</td>
<td>$46.44</td>
</tr>
<tr>
<td>Avg days' supply per claim</td>
<td>28.4</td>
<td>28.5</td>
<td>28.0</td>
<td>27.2</td>
<td>26.3</td>
<td>26.0</td>
<td>24.8</td>
<td>24.0</td>
</tr>
</tbody>
</table>
Table C.9—PharmaCare Claims Expenditures: Fair PharmaCare (Plan I)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims (millions)</td>
<td>6.614</td>
<td>10.163</td>
<td>10.999</td>
<td>11.751</td>
</tr>
<tr>
<td>Number of beneficiaries (millions)</td>
<td>0.613</td>
<td>0.643</td>
<td>0.637</td>
<td>0.626</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$262.373</td>
<td>$391.760</td>
<td>$415.575</td>
<td>$437.812</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$43.572</td>
<td>$67.242</td>
<td>$74.040</td>
<td>$80.796</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$305.945</td>
<td>$459.002</td>
<td>$489.616</td>
<td>$518.608</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>10.79</td>
<td>15.81</td>
<td>17.27</td>
<td>18.78</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$499.17</td>
<td>$714.26</td>
<td>$768.78</td>
<td>$829.03</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$6.59</td>
<td>$6.62</td>
<td>$6.73</td>
<td>$6.88</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$39.67</td>
<td>$38.55</td>
<td>$37.78</td>
<td>$37.26</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$46.26</td>
<td>$45.16</td>
<td>$44.51</td>
<td>$44.13</td>
</tr>
<tr>
<td>Avg days’ supply per claim</td>
<td>44.7</td>
<td>43.2</td>
<td>41.1</td>
<td>39.1</td>
</tr>
</tbody>
</table>

Fair PharmaCare was introduced May 1, 2003, replacing Plans A and E. Deductibles and annual maximum amounts are based on a family’s net annual income. Registrants born in or before 1939 are eligible for enhanced assistance.

Individuals and families registered for Fair PharmaCare pay full drug costs and dispensing fees until they reach their deductible. Once the deductible is met, PharmaCare pays 70% of eligible costs, until they reach their annual family maximum. Once the annual maximum is met, PharmaCare covers 100% of all eligible costs.

Individuals and families receiving Fair PharmaCare Enhanced Assistance pay full drug costs and dispensing fees until they reach their deductible. Once the deductible is met, PharmaCare pays 75.0% of eligible costs, until they reach their annual family maximum. Once the annual maximum is met, PharmaCare covers 100% of all eligible costs.

For more information on deductibles and annual family maximums, visit the PharmaCare website: [www.health.gov.bc.ca/pharme](http://www.health.gov.bc.ca/pharme).
### Table C.10—PharmaCare Claims Expenditures: Palliative Care (Plan P)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims</td>
<td>73,468</td>
<td>127,925</td>
<td>173,764</td>
<td>214,115</td>
<td>250,148</td>
<td>285,954</td>
</tr>
<tr>
<td>Number of beneficiaries</td>
<td>4,134</td>
<td>5,805</td>
<td>6,659</td>
<td>7,565</td>
<td>9,238</td>
<td>8,306</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$2.591</td>
<td>$4.263</td>
<td>$5.731</td>
<td>$6.754</td>
<td>$8.523</td>
<td>$9.841</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$0.497</td>
<td>$0.920</td>
<td>$1.350</td>
<td>$1.719</td>
<td>$2.024</td>
<td>$2.337</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$3.088</td>
<td>$5.183</td>
<td>$7.081</td>
<td>$8.472</td>
<td>$10.547</td>
<td>$12.178</td>
</tr>
<tr>
<td>Avg number of claims per beneficiary</td>
<td>17.77</td>
<td>22.04</td>
<td>26.09</td>
<td>28.30</td>
<td>27.08</td>
<td>34.43</td>
</tr>
<tr>
<td>Avg total paid cost per beneficiary</td>
<td>$746.99</td>
<td>$892.88</td>
<td>$1,063.32</td>
<td>$1,119.94</td>
<td>$1,141.66</td>
<td>$1,466.23</td>
</tr>
<tr>
<td>Avg professional fee paid per claim</td>
<td>$6.77</td>
<td>$7.19</td>
<td>$7.77</td>
<td>$8.03</td>
<td>$8.09</td>
<td>$8.17</td>
</tr>
<tr>
<td>Avg ingredient cost paid per claim</td>
<td>$35.26</td>
<td>$33.33</td>
<td>$32.98</td>
<td>$31.54</td>
<td>$34.07</td>
<td>$34.42</td>
</tr>
<tr>
<td>Avg total amount paid per claim</td>
<td>$42.03</td>
<td>$40.52</td>
<td>$40.75</td>
<td>$39.57</td>
<td>$42.16</td>
<td>$42.59</td>
</tr>
</tbody>
</table>

PharmaCare began reimbursing Plan P recipients on April 1, 2005.
Appendix D - PharmaCare Data

D1. PharmaCare Expenditures 2002 - 2006

Growth in PharmaCare Expenditures in British Columbia

From 2002 to 2006, total PharmaCare plan claims expenditures grew by 23.0%. This increase in costs results from a number of external pressures including:

- increase in the number of prescriptions per patient;
- introduction of newer and more expensive drugs (e.g., biologics and enzyme replacement therapies);
- an aging population;
- new 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
- increase in the price of generics.

From 2002 to 2006, the number of claims that received some level of PharmaCare coverage increased by 43.9% and the average number of claims per beneficiary increased by 46.5%. As the B.C. population ages, the average number of claims per beneficiary is expected to increase.

In comparison, population growth in the province during the same five-year period contributed to increased expenditures, but to a much lesser degree. Increasing drug utilization eclipses the 4.6% population growth, emphasizing the pressures on the PharmaCare program.

Table D.1—Comparison of PharmaCare claims expenditures for 2002, 2005 and 2006

<table>
<thead>
<tr>
<th></th>
<th>4 years ago (2002)</th>
<th>1 year ago (2005)</th>
<th>2006</th>
<th>1 year change</th>
<th>4 years change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of claims (millions)</td>
<td>14.948</td>
<td>19.767</td>
<td>21.508</td>
<td>8.8%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Beneficiaries (millions)</td>
<td>0.816</td>
<td>0.817</td>
<td>0.802</td>
<td>-1.9%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Avg. # of claims per beneficiary</td>
<td>18.31</td>
<td>24.18</td>
<td>26.82</td>
<td>10.9%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Ingredient cost paid (millions)</td>
<td>$576.370</td>
<td>$639.444</td>
<td>$671.746</td>
<td>5.1%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Professional fee paid (millions)</td>
<td>$86.925</td>
<td>$133.792</td>
<td>$146.793</td>
<td>9.7%</td>
<td>68.9%</td>
</tr>
<tr>
<td>Total amount paid (millions)</td>
<td>$663.295</td>
<td>$773.236</td>
<td>$818.540</td>
<td>5.9%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Avg. total amount paid per claim</td>
<td>$44.37</td>
<td>$39.12</td>
<td>$38.06</td>
<td>-2.7%</td>
<td>-14.2%</td>
</tr>
<tr>
<td>Total paid cost per beneficiary</td>
<td>$812.65</td>
<td>$945.88</td>
<td>$1,020.79</td>
<td>7.9%</td>
<td>25.6%</td>
</tr>
<tr>
<td>Total B.C. Population (millions)</td>
<td>4.115</td>
<td>4.256</td>
<td>4.303</td>
<td>1.1%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Dollar amounts refer to amounts paid by PharmaCare. Depending on coverage rules, beneficiaries may also pay a portion of the total drug cost. Data include Plan P claims expenditures. Population data from BC STATS (July 1).
D2. 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 receiving Health Canada coverage in 2006 | 6,212 |
| DINs receiving PharmaCare coverage in 2006 | 5,104 |
| Unique chemicals receiving Health Canada coverage in 2006 | 993 |
| Unique chemicals receiving PharmaCare coverage in 2006 | 700 |

Notes:
1. DINs approved by Health Canada for human use requiring prescription.
2. Includes only prescription drugs that had a payment by PharmaCare. Items receiving PharmaCare coverage may be full or partial benefits.
3. Numbers for Health Canada reflect prescription drugs only, whereas PharmaCare numbers include OTCs (over-the-counter, non-prescription drug) as well as prescription drugs.

D3. Formulary Expansion

In 2006, the PharmaCare formulary (i.e., the list of medicines that the PharmaCare program covers) was expanded to include an additional:

- 23 brand name drugs, and
- approximately 80 generic drugs.
D4. Top Ten Drugs in 2006

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 for which a portion of the cost was paid by PharmaCare.

**Table D.2— Top Ten Drugs by PharmaCare Expenditure 2006**

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Commonly used to treat</th>
<th>PharmaCare Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATORVASTATIN</td>
<td>High cholesterol</td>
<td>$45.4 million</td>
</tr>
<tr>
<td>RAMIPRIL</td>
<td>High blood pressure</td>
<td>$27.5 million</td>
</tr>
<tr>
<td>OLANZAPINE</td>
<td>Psychosis</td>
<td>$27.3 million</td>
</tr>
<tr>
<td>VENLAFAXINE</td>
<td>Depression</td>
<td>$19.3 million</td>
</tr>
<tr>
<td>INTERFERON BETA</td>
<td>Multiple sclerosis</td>
<td>$17.2 million</td>
</tr>
<tr>
<td>RABEPRAZOLE</td>
<td>(GI) Reflux disease</td>
<td>$16.7 million</td>
</tr>
<tr>
<td>QUETIAPINE FUMARATE</td>
<td>Psychosis</td>
<td>$15.3 million</td>
</tr>
<tr>
<td>GABAPENTIN</td>
<td>Pain control and nerve pain</td>
<td>$11.7 million</td>
</tr>
<tr>
<td>SIMVASTATIN</td>
<td>High cholesterol</td>
<td>$11.2 million</td>
</tr>
<tr>
<td>AMLODIPINE</td>
<td>High blood pressure</td>
<td>$11.1 million</td>
</tr>
</tbody>
</table>

**Table D.3— Top Ten Drugs by Number of PharmaCare Beneficiaries 2006**

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Commonly used to treat</th>
<th>Distinct Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACETAMINOPHEN WITH CODEINE 30MG</td>
<td>Pain and fever</td>
<td>134,000</td>
</tr>
<tr>
<td>RAMIPRIL</td>
<td>High blood pressure</td>
<td>117,000</td>
</tr>
<tr>
<td>AMOXICILLIN</td>
<td>Bacterial infection</td>
<td>111,500</td>
</tr>
<tr>
<td>ATORVASTATIN</td>
<td>High cholesterol</td>
<td>111,000</td>
</tr>
<tr>
<td>HYDROCHLOROTHIAZIDE</td>
<td>High blood pressure</td>
<td>105,000</td>
</tr>
<tr>
<td>LEVOthyroxine</td>
<td>Hypothyroidism</td>
<td>90,000</td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>Anxiety</td>
<td>77,000</td>
</tr>
<tr>
<td>SALBUTAMOL</td>
<td>Asthma and lung diseases</td>
<td>76,000</td>
</tr>
<tr>
<td>METFORMIN</td>
<td>Diabetes</td>
<td>75,000</td>
</tr>
<tr>
<td>CIPROFLOXACIN</td>
<td>Bacterial Infection</td>
<td>70,000</td>
</tr>
</tbody>
</table>

---

These indications are not approved by Health Canada.
D5. PharmaCare Beneficiaries

PharmaCare Beneficiaries 2006

A total of 801,866 provincial residents (18.6% of the entire B.C. population) received PharmaCare benefits in 2006.

The table below documents the number of PharmaCare beneficiaries in 2006 by five-year age groups, showing that the percentage of individuals receiving assistance from PharmaCare in 2006 increased with age. Nearly 95.0% of B.C. residents age 90+ received PharmaCare assistance in 2006.

Table D.4—PharmaCare Beneficiaries by Age Group 2006

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total BC Population*</th>
<th>Number of PharmaCare Beneficiaries</th>
<th>Percentage of Age Group Receiving Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4</td>
<td>205,755</td>
<td>13,045</td>
<td>6.3%</td>
</tr>
<tr>
<td>5 to 9</td>
<td>223,878</td>
<td>15,570</td>
<td>7.0%</td>
</tr>
<tr>
<td>10 to 14</td>
<td>257,818</td>
<td>16,321</td>
<td>6.3%</td>
</tr>
<tr>
<td>15 to 19</td>
<td>277,240</td>
<td>22,251</td>
<td>8.0%</td>
</tr>
<tr>
<td>20 to 24</td>
<td>306,752</td>
<td>29,428</td>
<td>9.6%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>286,341</td>
<td>31,838</td>
<td>11.1%</td>
</tr>
<tr>
<td>30 to 34</td>
<td>287,264</td>
<td>24,963</td>
<td>8.7%</td>
</tr>
<tr>
<td>35 to 39</td>
<td>316,351</td>
<td>27,711</td>
<td>8.8%</td>
</tr>
<tr>
<td>40 to 44</td>
<td>350,928</td>
<td>34,077</td>
<td>9.7%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>355,218</td>
<td>40,463</td>
<td>11.4%</td>
</tr>
<tr>
<td>50 to 54</td>
<td>326,543</td>
<td>44,192</td>
<td>13.5%</td>
</tr>
<tr>
<td>55 to 59</td>
<td>291,217</td>
<td>50,969</td>
<td>17.5%</td>
</tr>
<tr>
<td>60 to 64</td>
<td>214,606</td>
<td>59,304</td>
<td>27.6%</td>
</tr>
<tr>
<td>65 to 69</td>
<td>167,932</td>
<td>78,103</td>
<td>46.5%</td>
</tr>
<tr>
<td>70 to 74</td>
<td>143,408</td>
<td>91,508</td>
<td>63.8%</td>
</tr>
<tr>
<td>75 to 79</td>
<td>121,873</td>
<td>86,751</td>
<td>71.2%</td>
</tr>
<tr>
<td>80 to 84</td>
<td>90,517</td>
<td>66,586</td>
<td>73.6%</td>
</tr>
<tr>
<td>85 to 89</td>
<td>51,747</td>
<td>42,615</td>
<td>82.4%</td>
</tr>
<tr>
<td>90+</td>
<td>27,727</td>
<td>26,171</td>
<td>94.4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,303,115</td>
<td>801,866</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

*Population data from BC STATS (July 1, 2006).
PharmaCare Beneficiaries Compared to B.C. Population 2006

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

Graph D.1—PharmaCare Beneficiaries in 2006 Compared to B.C. Population
Average Annual PharmaCare Expenditures per Beneficiary by Age Group 2006

PharmaCare beneficiaries who are middle-aged (35 to 64 years) had the highest per-beneficiary expenditure in 2006; ranging from $1,430.63 for those aged 45 to 49 years to $1,099.14 for those aged 60 to 64 years.

PharmaCare beneficiaries who are seniors (65 years or older) had the second highest per-beneficiary expenditure in 2006; ranging from the highest average per-beneficiary expenditure at $1,122.50 for those aged 85 to 89 years and the lowest average per-beneficiary expenditure at $971.38 for those aged 65 to 69 years.

Middle-aged PharmaCare beneficiaries represent a smaller proportion of beneficiaries when compared to seniors in 2006. Of the province's total middle-aged population, 13.8% are PharmaCare beneficiaries whereas 65% of the province's seniors are PharmaCare beneficiaries.

Graph D.2—Average Annual PharmaCare Expenditure per Beneficiary by Age Group in 2006
D6. Drug Costs and Fees

Total Ingredient Costs and Dispensing Fees Paid, 2002-2006

The graph below plots total drug ingredient costs and total dispensing fees paid across all plans over the five-year period from 2002 to 2006.

The graph illustrates that the total amount PharmaCare paid in dispensing fees for all plans increased by 68.9%—from $86.9 million in 2002 to $146.8 million in 2006. The total amount PharmaCare paid in drug ingredient costs for all plans increased by 16.5%—from $576.4 million in 2002 to $671.7 million in 2006.

Graph D.3—Total Ingredient Costs and Dispensing Fees Paid by PharmaCare for All Plans: 2002 - 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Dispensing Fee Paid</th>
<th>Ingredient Cost Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$86.9</td>
<td>$576.4</td>
</tr>
<tr>
<td>2003</td>
<td>$102.6</td>
<td>$563.1</td>
</tr>
<tr>
<td>2004</td>
<td>$121.9</td>
<td>$601.8</td>
</tr>
<tr>
<td>2005</td>
<td>$133.8</td>
<td>$639.4</td>
</tr>
<tr>
<td>2006</td>
<td>$146.8</td>
<td>$671.7</td>
</tr>
</tbody>
</table>

Annual growth rates shown in box.
D7. Average Cost per Claim for all Plans, 2002 - 2006

The graph following shows the average PharmaCare payment per claim from 2002 to 2006. The average dispensing fee paid per claim has increased by 17.4%—from $5.82 in 2002 to $6.82 in 2006. The average paid ingredient cost per claim has decreased by 19.0%—from $38.56 in 2002 to $31.23 in 2006.

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.

Increases in the average dispensing fee paid per claim are likely due to increases in the dispensing fee charged by pharmacies; whereas, decreases in the average ingredient cost paid per claim are likely due to decrease in days’ supply.

The maximum dispensing fee paid by PharmaCare as of December 31, 2006, was $8.60.

Table D.5—Average Ingredient Cost and Dispensing Fee Paid by PharmaCare per Claim and Number of Claims for all Plans per Year, 2002 to 2006

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg dispensing fee per claim</th>
<th>Avg ingredient cost per claim</th>
<th>Number of claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$5.82</td>
<td>$38.56</td>
<td>14.95</td>
</tr>
<tr>
<td>2003</td>
<td>$6.44</td>
<td>$35.33</td>
<td>15.94</td>
</tr>
<tr>
<td>2004</td>
<td>$6.72</td>
<td>$33.19</td>
<td>18.13</td>
</tr>
<tr>
<td>2005</td>
<td>$6.77</td>
<td>$32.35</td>
<td>19.77</td>
</tr>
<tr>
<td>2006</td>
<td>$6.82</td>
<td>$31.23</td>
<td>21.51</td>
</tr>
</tbody>
</table>

Annual growth rates shown in box
D8. Data Bibliography

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

- Patented Medicine Prices Review Board (PMPRB)
- PharmaNet, BC Ministry of Health
- Ministry of Health 2006/07 – 2008/09 Service Plan