Fair Pharmacare?

A backgrounder on the government's changes to BC's Pharmacare program

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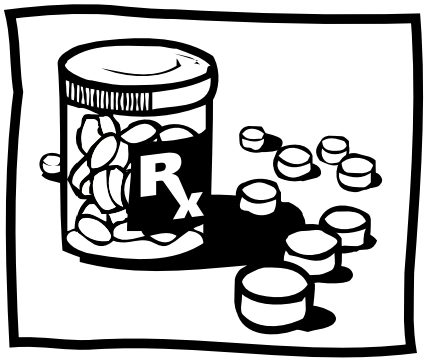
April 2003

THE BC GOVERNMENT'S RECENT RESTRUCTURING OF THE PHARMACARE PROGRAM has been presented as a "fair" solution to the problem of increasing drug costs. Pharmaceuticals have been consuming an ever larger proportion of the health budget, so the government is seeking to limit its role in paying for prescriptions.

The Pharmacare program used to cover 100 per cent of drug costs for BC seniors, regardless of income. Seniors did have to pay the dispensing fee charged by pharmacists, but after they had spent $200 on such fees, Pharmacare would also cover this cost. For non-seniors, the program had a deductible, covering a portion of costs only after a certain spending threshold had been passed. The Liberal government made interim changes to the Pharmacare program soon after assuming office, raising the deductible for nonseniors by $200 and increasing the maximum seniors had to pay to $275. In addition, seniors were now required to pay a portion of drug costs (up to $25 per prescription) up to the new maximum, not just dispensing fees. This move considerably increased seniors' up front costs, and means that more seniors are likely to reach the maximum.



The provincial government is now changing the program again, and in an even more dramatic fashion. Universal drug coverage for seniors is ending, and we are moving to a system where financial assistance for drugs is linked to the size of one's household income.

There are aspects of this change that do appear to be more "fair" than the old system. The government is correct in pointing out that there was an inherent unfairness in the fact that low-income nonsenior families could have potentially paid far more in drug costs than wealthy seniors under the previous plan. The recognition that those with fewer financial resources should pay less than those with more is a welcome recognition of the importance of the principal of progressivity in paying for social programs (in sharp contrast to the government's income tax cuts, which undermined this very principal).

But are the changes to the Pharmacare program the best way to achieve this principle? And furthermore, are these changes likely to actually reduce drug costs?

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Is the Plan Progressive?

Let's start with the principal of progressivity. The new plan attempts to achieve this by linking the family deductible (the threshold above which Pharmacare pays for a portion of drug costs) and the family maximum (after which 100 percent of drug costs are covered), to net family income. For non-seniors, and those who will become seniors after 2005, there are three income categories: less than $15,000, between $15,000 and $30,000, and over $30,000, with deductibles and family maximums higher as one moves up the income categories. Current seniors are given a substantially better deal—their family income categories are: less than $33,000, between $33,000 and $50,000, and over $50,000. In addition, within each income category, the family deductible and family maximum is lower for current seniors.

Given the strenuousness with which BC seniors have protested the move to a means tested Pharmacare program, giving *current* seniors a better deal makes sense politically, (although it still does not address seniors' main concerns). It is, however, a move away from progressivity insofar as it means that some with fewer financial resources will continue to pay more than others who are better off. The sharp break between those born before and after 1939 means that individuals born just a day apart will have substantially different benefits—one senior could potentially pay hundreds of dollars more each year.

Another odd feature of the plan that undermines progressivity is that, unlike the Medical Services Plan, "Fair Pharmacare" does not account for differences in family size when calculating family income. Thus a family of four with a combined income of $30,000 is treated the same as a single individual with the same income, despite the fact that a single individual is clearly financially better off than the family.

Finally, it is important to note that under both the new and old Pharmacare programs the amount one pays for prescriptions is not based solely on ability to pay (as in the case of medical treatments covered by MSP and paid for through the tax system), but rather *how sick one is*. Individuals and families with high drug costs continue to pay more than healthier British Columbians.

Shifting Costs

Do the Pharmacare changes really reduce drug costs? Well, from the perspective of the government, they should, at least in the short-term. The government is predicting that it will save $90 million a year from the changes to the Pharmacare program, largely because it will be paying for a much smaller overall share of senior British Colombians' drugs.

But the savings are not actually coming from a reduction in drug prices, or a decline in drug usage — they simply result from the fact that many individuals and families will now be paying a greater share of the cost of the prescriptions they use.

Some individuals, primarily lower-income non-senior families, will enjoy lower drug costs. The government claims that 84 percent of all BC families will pay the same or less for their prescription drugs under the new plan. Of course, the reason this figure is so high is that most British Columbians do not face drug costs high enough to qualify for assistance under either the old or the new plan. Of those who actually drew on the previous program, many will now be paying more.

Recall that before the current BC government started changing the program, the maximum amount any senior paid for prescription drugs was $200 in dispensing fees. Other British Colombians had a deductible of $800, after which Pharmacare paid 70 per cent of their drug costs up to a maximum of $2000. Once a family's costs exceeded $2000, the public plan covered 100 per cent of their drug costs.[1]

The table below outlines what this means in terms of prescription drug costs faced by British Columbians at different levels of family income under the old and new plans.

The table shows that differences in both deductible levels and family maximums between the old and new plans have implications for determining whether one wins or loses from the changes.

[1] The Pharmacare program has other plans for individuals with specific illnesses that have remained unchanged.

Costs Comparison of Old Pharmacare and "Fair Pharmacare" (in dollars)

Family Income	Old Deductible[1]	New Deductible	Difference in Deductible	Old Maximum	New Family Maximum	Difference in Maximum
Non-Seniors[2]						
10,000	600	0	600	2,000	200	1,800
15,000	600	0	600	2,000	300	1,700
20,000	600	400	200	2,000	600	1,400
25,000	800	500	300	2,000	750	1,250
30,000	800	600	200	2,000	900	1,100
35,000	800	1,050	-250	2,000	1,400	600
40,000	800	1,200	-400	2,000	1,600	400
45,000	800	1,350	-550	2,000	1,800	200
50,000	800	1,500	-700	2,000	2,000	0
55,000	800	1,650	-850	2,000	2,200	-200
60,000	800	1,800	-1,000	2,000	2,400	-400
65,000	800	1,950	-1,150	2,000	2,600	-600
70,000	800	2,100	-1,300	2,000	2,800	-800
Current Seniors						
10,000	0	0	0	200	125	75
15,000	0	0	0	200	188	13
20,000	0	0	0	200	250	-50
25,000	0	0	0	200	313	-113
30,000	0	0	0	200	375	-175
35,000	0	350	-350	200	700	-500
40,000	0	400	-400	200	800	-600
45,000	0	450	-450	200	900	-700
50,000	0	500	-500	200	1,000	-800
55,000	0	1,100	-1,100	200	1,650	-1,450
60,000	0	1,200	-1,200	200	1,800	-1,600
65,000	0	1,300	-1,300	200	1,950	-1,750
70,000	0	1,400	-1,400	200	2,100	-1,900

	Difference Between Current Senior and Nonsenior Deductibles	Difference Between Current Senior and Nonsenior Maximums
10,000	0	75
15,000	0	113
20,000	400	350
25,000	500	438
30,000	600	525
35,000	700	700
40,000	800	800
45,000	900	900
50,000	1,000	1,000
55,000	550	550
60,000	600	600
65,000	650	650
70,000	700	700

NOTES: While the government provides a table on its website to allow British Columbians to calculate their family deductibles and maximum costs as a percent of their net income, notes provided with the table reveal that the actual deductibles and family maximums do not correspond exactly to the percentages provided. However, no further information is made available.

[1] Income levels for deductible under the old Pharmacare system are based on qualifiying for premium assistance. The table uses the figures for a single individual. Families would have a higher income threshold for the same deductible level.

[2] This includes those who will turn 65 after 2005.

For those with drug costs that do not reach the maximum, it is the deductible level that matters most immediately, since Pharmacare does not provide any help with drug costs until this point is exceeded. If we look at the column labeled 'difference between new and old deductibles," for "others" (those who are not currently seniors), we see that the deductible is lower under the new plan at lower income levels. After around $33,000 of family income, however, the deductible becomes substantially higher. By $35,000 of family income, one must pay an additional $250 per year before receiving any financial help from Pharmacare.

The situation is worse for current seniors because they faced no deductible at all under the previous plan and because Pharmacare paid for 100 per cent of drug costs, leaving seniors responsible only for the dispensing fee charged by pharmacists. Many low-income seniors who do not face a deductible under the new plan *are still worse off* because they must now pay 30 per cent of the cost of drugs before they reach their maximum and receive full coverage. This 30 per cent share of drug costs is generally going to be higher than what they would have paid in dispensing fees under the old system.

Moreover, after reaching the $33,000 of family income, seniors now face a deductible, which quickly raises the ceiling of costs they must bear before receiving help from Pharmacare. A senior couple with combined income of $35,000, for example, must now spend $350 on drugs before receiving any help.

Changes in the family maximums, beyond which Pharmacare covers all drug costs, also mean that both seniors and non-seniors face different potential maximum costs under the new plan.

For those who are not yet seniors, the threshold beyond which one faces higher potential maximum costs is relatively high—$50,000. Of course, most non-seniors do not have high enough drug costs to reach the maximum under either plan—for non-seniors, it is the change in deductible level that is relevant for most people.

For current seniors, however, changes in the maximum cost for drugs are relevant. Under the old plan, seniors faced a maximum expenditure of $200 in dispensing fees before Pharmacare started paying for these fees as well as for the drugs themselves. Now, the maximum is based on family income. If we look at the column for difference in the new and old family maximum, we see that seniors start potentially facing a higher maximum cost for drugs at a family income of only $16,000. This, coupled with the fact that "Fair" Pharmacare requires seniors to pay 30 percent of their drug costs before they reach their maximum (rather than simply paying the dispensing fee), as well as the introduction of a deductible for middle-income and wealthier seniors, means that *most seniors will face higher costs.*

When we look at the columns comparing the deductibles and maximums for current seniors vs. others under the new plan, we also see that at any given income level, the difference between the deductible and maximum cost paid by those who are not yet seniors and current seniors is substantial.

False Economy?

Making Pharmacare coverage less generous for all but the poorest British Columbians clearly increases personal drug costs, while doing nothing to actually reduce overall drug expenditures. The resounding silence with which these changes have been greeted by pharmaceutical companies is telling in this respect—if they actually expected drug expenditures to decline, you can be sure that the companies would be objecting to the new policy on one ground or another.

But the policy change is more than simply a cost-shift—it also risks increasing overall health expenditures. Increased health costs can come about in a number of ways. First, by reducing the share of drug expenditures borne by the public system, we undermine our ability to collectively influence drug prices and control costs through the principle of therapeutic substitution (more on this later) and other means. Indeed, the fact that overall per capita drug expenditures (public and private combined) were the lowest in BC is likely tied to the fact that

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the provincial government used to pay for a greater share of drug costs than any other province and was thus able to implement more cost controls.

Another way that costs for public health care may increase is in higher acute care costs. The study by Robin Tamblyn et al. published in the January 2001 edition of the *Journal of the American Medical Association* looked at what happened when Québec raised the cost of prescriptions for those on social assistance and the elderly from a nominal $2 to 25 percent of the total cost per prescription. The study found that making these populations pay more for drugs meant that many simply went without. They got sicker, and costly emergency room visits rose.

In BC, people with low incomes who are not currently seniors are better off with the policy changes, so we would not expect them to be negatively affected. However, current seniors do face potentially higher costs at relatively low income levels. Moreover, the fact that the program itself is so much more complicated now, and requires seniors to actively register (and disclose income tax data) to receive benefits, increases the likelihood that some seniors will fall through the cracks. Some low income seniors may misunderstand the actual level of benefits to which they are entitled and curtail their drug purchases out of *fear* of the costs. Others may object to disclosing tax data. Still others may not understand that they *have* to register or how to do so until they find themselves at the Pharmacy unable to pay for their prescription.

Finally, it is worth noting that the changes to the program create massive new administrative costs because individuals must now register to receive Pharmacare benefits and their income must be verified every year with Revenue Canada.

The Alternative

Reforming the Pharmacare system to reduce costs and increase progressivity is an admirable goal. Drug costs are increasing rapidly, and we should try to do something about this. We should also strive to ensure that pharmaceuticals are treated the same as other necessary medical services so that income and ability to pay do not affect access. Unfortunately, the current changes do not make the system more cost-effective, and they also fall short on the issue of progressivity and fairness.

How can we do better? The key in terms of both equity and cost-efficiency is a universal Pharmacare program, funded through the tax system, that fully covers medically necessary pharmaceuticals the same way as other medically necessary treatments are covered.

Because our income tax system remains essentially progressive, a universal Pharmacare program funded through the tax system would ensure that everyone would have access to necessary drugs while sharing the costs of those drugs based on ability to pay—not on degree of ill health or birth date.

While a universal program would increase government expenditures, it could also reduce drug and dispensing costs so *overall* we would save money, even if the consumption of drugs increased somewhat. To achieve maximum cost efficiencies, this universal program should be national in scope, allowing the provinces to use their collective purchasing power to lower drug costs. For more details about the option of a national Pharmacare plan, including estimated costs and savings, see the CCPA publication "A National Pharmacare Plan: Combining Efficiency and Equity" by Dr. Joel Lexchin.

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We should also take steps to reduce money that is essentially wasted on drugs through the prescription of pharmaceuticals that are unnecessary, that are more expensive than equally effective alternatives, or that are not used because the patient cannot tolerate the side effects. We already have initiatives here in BC that can help address these problems, but they need to be promoted so that they will be more fully utilized.

The principle of therapeutic substitution determines that when there are therapeutically equivalent drugs to treat certain conditions, we should only pay for the drug with the lowest price. This principle is used in hospitals, and is also the basis for the reference-based pricing program, which has been found to be a success both clinically and economically. It would make sense to expand reference-based pricing where possible so that it can be applied to a broader range of ailments. A univeral Pharmacare program would also allow the principle of therapeutic substitution to have wider application.

Regular education of physicians about pharmaceuticals would also be helpful so they are not so reliant on marketing by drug manufacturers for information. This marketing encourages doctors to prescribe flashy and expensive new drugs that may be no better than older and cheaper alternatives [the curtailment of free samples and gifts to physicians from pharmaceutical companies would also make sense in this regard]. The therapeutics initiative at UBC provides a "gold standard" independent source of information on the clinical effectiveness of drugs, and is a resource that can and should be used more widely by physicians. The model of the North Shore community drug education program, where pharmacists visit physicians in their office with accurate information on drugs could also be usefully expanded.

Side effects are a problem with many drugs, and can lead to significant drug wastage as patients fill full prescriptions and then stop taking the drug after a few days if they cannot tolerate the side effects. In BC, we do have a trial prescription program whereby patients can buy small amounts of drugs to determine if they can tolerate them before filling their full prescription. Unfortunately, this program is not widely promoted or used. We should determine why this is the case, and make changes so that all patients may benefit from this sensible approach.

Rising drug costs are increasingly a problem for governments. Shifting more of these costs onto individuals and private insurers may improve the government's bottom line, but it does nothing to actually reduce the cost of drugs. There are things we can do to tackle this problem, but this requires more government involvement, not less. A universal Pharmacare program would not only improve equity in our health care system, it would also provide us with the collective muscle to achieve significant cost savings.

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