Chapter 5
Department of Health and Wellness
Prescription Drug Program

Contents

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Background

5.1 The *Prescription Drug Payment Act* was proclaimed on October 1, 1975. It established the Prescription Drug Program to provide payment of entitled services required for preventive, diagnostic or therapeutic purposes, to eligible beneficiaries in the Province.

5.2 The Prescription Drug Program (PDP) is a program of the Department of Health and Wellness. During our audit fieldwork, PDP was a part of the Public Health and Medical Services Division. After we finished our fieldwork, the Department informed us that PDP is now part of the Institutional Services Division.

5.3 The PDP's purpose is to improve and maintain the well-being of the residents of New Brunswick by making available specified drugs to selected target groups. The PDP has a number of plans that identify the target groups eligible for prescription drug benefits. The beneficiary groups are:

1. New Brunswick residents aged 65 or older who receive Old Age Security/Guaranteed Income Supplement, or who qualify for benefits based on annual income.

2. Nursing home residents.

3. Clients of the Department of Family and Community Services who hold a valid health card for prescription drug coverage. These include recipients of financial assistance, adults living in a residential facility and children in care of the Minister of Family and Community Services.

4. Persons who have cystic fibrosis, are organ transplant recipients, have human growth hormone deficiency, are

HIV-positive, or have multiple sclerosis, and are registered with the PDP and deemed eligible for benefits.

5.4 Since 1975, the Department has contracted with Atlantic Blue Cross Care (which in March 2005 began operating as Medavie Blue Cross) to administer the Prescription Drug Program on a not-for-profit basis. Throughout this chapter, they will be referred to as the service provider or Blue Cross, as they are commonly known. In addition to administering the program, Blue Cross' role has been to process prescription drug claims from PDP beneficiaries. In 2003-04, Blue Cross billed the Department just over $ 2.3 million for its services.

5.5 During 2003-04, one in seven New Brunswickers were eligible beneficiaries of the PDP. Total expenditures for the program for that year were close to $114 million, a 42% increase since 2000-01. The 2004-08 Provincial Health Plan states that drug expenditures are the fastest growing component of health care costs in New Brunswick. The increasing amount of expenditures is the result of increases in both volume and cost. For instance, from 2000 to 2004, the average number of prescriptions per beneficiary increased 16% while the average cost per prescription increased by 29%. Offsetting this somewhat is the fact that the number of active beneficiaries decreased by 4% during this period.

5.6 In 2003, legislative auditors from a number of jurisdictions across Canada decided to conduct audits of drug programs in their jurisdictions, using a similar audit plan. This audit is a result of our participation in this joint effort. The reports from audits in other jurisdictions were issued in 2004 or 2005.

Scope

5.7 The objectives of this audit were:

To assess whether the Department of Health and Wellness has adequate procedures in place to manage the performance of the Prescription Drug Program;

To assess whether the Department has adequate procedures in place to ensure that the drug assessment process for formulary listing and the amount paid for drugs and pharmacy services are managed with due regard for cost effectiveness; and

To assess whether there is adequate reporting on the Prescription Drug Program's performance.

5.8 To further focus our audit efforts, we identified a number of audit criteria. Audit objectives and criteria were developed jointly by all participating legislative auditors to assist in the planning and performance of the prescription drug program audit. Some of these were modified for our own audit purposes. The audit objectives and criteria for this audit were discussed with the Department, which agreed that they were reasonable.

5.9 Our audit was performed in accordance with standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

Conclusions and results in brief

5.10 The Department does not have adequate procedures in place to manage the performance of the Prescription Drug Program. The program lacks a clear mission and measurable objectives. Although we found the Department is adequately monitoring the performance of the service provider, a number of other areas are in need of improvement. Information should be analyzed and acted upon. The Department has a significant amount of information available to it, yet no consistent, regular and systematic analysis is performed on the data. Finally, there are no standards for non-financial aspects of the program's performance.

5.11 The Department has adequate procedures to ensure the drug assessment process and the amount paid for drugs and dispensing fees are managed with due regard for cost effectiveness.

5.12 Reporting on goals, objectives, program relevance, achievement of plans and acceptance by client groups is not adequate. Reporting in these areas is necessary to provide sufficient effectiveness information to the members of the Legislative Assembly and the general public. However, the Department is reporting adequately on the financial performance of the Prescription Drug Program.

Program management

Program mission

5.13 Our first criterion was:

There should be a clear program mission for the Prescription Drug Program.

5.14 We reviewed the Medicare/Prescription Drug Program strategic plan dated 1999 (revised in 2002). This document outlines the

vision, mission, principles, values and goals of the Medicare/Prescription Drug Programs.

5.15 The mission states:

> *To fulfill our Vision, it is critical the Medicare/Prescription Drug Program team achieve acceptable results in the following areas:*
>
> 1. *Programs and services based on the needs of the population*
> 2. *Public satisfaction with programs and services*
> 3. *Cost effective and appropriate service delivery*
> 4. *Quality health information*
> 5. *Staff attitudes and morale*

5.16 A model mission statement is clear and concise. One common approach is to show the 3 W's - stating what you do, why you do it and for whom. It should illustrate what is the service unique to the program; who is the intended primary beneficiary or target group; and why the service is a benefit.

5.17 The PDP's mission statement does not state what they do, who the intended beneficiaries are and why the service is a benefit. It would be difficult to establish meaningful goals and objectives based on the current mission because these critical components are not there. Instead, the statement focuses on the team and not the program, and it does not mention the primary service the program provides. Our discussions with departmental staff indicate there are no plans to revisit the current mission in the near future.

5.18 Another deficiency of the current mission is that it addresses two distinct programs: Medicare and Prescription Drug. These programs do not serve the same beneficiaries. In addition, the structure of the PDP has changed since the mission was originally drafted, when the responsibility for both programs was in the hands of the same director. The current organizational chart available on the Department's website clearly shows that the responsibility for the two programs has been split between the Public Health and Medical Services Division (PDP) and the Planning and Medicare Services Division (Medicare). This change of structure is not reflected in the current mission. (Since the conclusion of our audit, departmental staff have informed us that PDP is now part of the Institutional Services and Prescription Drug Program Division, Medicare-Operations is part of the Administration and Finance Division and Medicare Services is part of the Planning and Medicare Services Division).

5.19 A clear program mission is the cornerstone required to develop well-defined and measurable objectives for a program. If at the onset a mission is not clear, many difficulties will arise with relation to the establishment of meaningful objectives, reporting, and performance management.

Conclusion

5.20 This criterion is not met. The joint mission does not reflect the primary activities of the program.

Recommendation

5.21 We recommended the Department establish a clear program mission for the Prescription Drug Program.

Objectives

5.22 Our second criterion was:

> *The objectives of the program should encompass the entire program mission. They should be well-defined, measurable, and periodically reviewed.*

5.23 The Medicare/Prescription Drug Program strategic plan identifies the following goals:

- Increase cost effective and appropriate case management.
- Increase public satisfaction with programs and services.
- Increase program sustainability.
- Maintain an environment that fosters positive staff attitudes and morale.
- Improve public and stakeholder attitudes and behaviours regarding health related services.
- Increase the use of quality information.

5.24 No objectives have been established for the Prescription Drug Program. Goals define the general results to be achieved, while objectives identify a specific result to be achieved over a specified period of time. Goals and objectives are important tools for setting program direction and achieving intended results. They also establish a basis for year-to-year comparison.

5.25 Having measurable objectives does not necessarily mean that an objective needs to be expressed as a single number. It can be expressed as meeting a specified range such as a scale of accomplishment (good, fair, poor), with the attributes of the scale being clearly defined.

5.26 Without specific objectives, the Department does not know its current standing with the goals, making it difficult to assess whether they are improving in an area or getting worse.

Conclusion

5.27 This criterion is not met. The Department has not established measurable objectives for the Prescription Drug Program.

Recommendation

5.28 We recommended the Department establish well-defined, measurable objectives for the program. They should be reviewed periodically to ensure they continue to be relevant.

Performance information

5.29 Our third criterion was:

Adequate performance information should be available to measure whether the program's mission and objectives are being achieved.

Information is available

5.30 During our audit, we found a significant amount of performance information available for analysis or review, and this information is collected on a regular basis. We found monthly financial reports concerning claims expense, amount of claims, and budget information on the administration of the program. We also found monthly performance reports on service levels by the service provider. And finally, we reviewed some of the statistical reports prepared by a program officer of PDP.

5.31 The statistical reports, prepared from data provided by the service provider, translate the data into a user friendly format of charts and graphs. These reports provide information on such areas as special authorization requests, overrides, beneficiary counts, utilization indicators by region and by drug groups, comparisons by plans, and top drug costs by year. The data can also be used to conduct more specific, ad hoc analysis.

5.32 Although this data is very informative, measurement of the program's performance is a difficult task due to the lack of objectives. That said, the financial information could be used to measure the general goals of cost-effective management and perhaps program sustainability. (In fact, we did find that cost-effective management of the program is being monitored regularly, and this is discussed later in this chapter.) It does not appear that the data can be used to measure other goals of the program, such as public satisfaction, staff attitudes and morale, or stakeholder attitudes toward health services.

Limited analysis performed

5.33 While reviewing the data produced by departmental staff, we became aware that the statistical reports are not being used to actively manage the program. No consistent, regular, systematic analysis is performed on the data. Some of the reports produced could be used to identify problem areas, or areas requiring further investigation. For example, the utilization indicator reports show utilization by physician

type (general practitioner or specialist) and by health region, including average number of prescriptions per beneficiary per year, average number of prescriptions filled per physician, cost per beneficiary, and cost per physician. Our review of these reports for 2003-04 indicated some interesting facts about prescription use in New Brunswick. For instance:

- The average cost per prescription was as high as $42.38 in one area and as low at $29.73 in another.

- Although rural physicians had a greater number of prescriptions per patient (23.3) than urban physicians (19.0), they had a lower average cost per prescription at $33.07 versus $38.36 for physicians in urban areas.

5.34 Although these facts pose intriguing questions for program managers, they currently remain unanswered. The program has some good information available to it, but it is not used to its full potential.

5.35 Analysis is performed when a specific issue arises or as required during a review of a drug for inclusion in the formulary. But there is limited regular review or analysis of this data. The Department may be missing opportunities for identifying problem areas or evaluating the effectiveness of the program. Departmental staff have indicated that there are no resources available to perform the type of analysis required. A staffing proposal prepared by departmental staff indicated that PDP has significantly fewer staff assigned than neighbouring jurisdictions. It shows that Nova Scotia has 11.5 positions for pharmacare while Newfoundland and Labrador has 10 positions. In comparison, PDP has 4.3 positions assigned, and one position, that of Health Infomatics Officer, has been vacant for several months.

Conclusion

5.36 This criterion is partially met. Although a significant amount of information is available, it is not used to its full potential. In other words, the information is not being analyzed and acted upon. Part of the problem lies with the lack of objectives, making it difficult to measure the achievement of the mission's goals. Another problem is a lack of resources to analyze the data collected, as comparisons to other jurisdictions and the current limited monitoring would indicate.

Recommendations

5.37 Once objectives have been established, we recommended the Department ensure the information collected is adequate to measure the performance with regard to the objectives.

5.38 We also recommended the Department monitor data and conduct analysis on a regular basis to ensure that problems and issues are identified.

Responsibility framework

5.39 Our fourth criterion was:

An adequate responsibility framework should be in place with the third party service provider to evaluate the effectiveness of its services.

5.40 The Department entered into a contract with the service provider in 1975. The contract identifies the duties of Blue Cross. This contract has limited reporting requirements and they all relate to financial reporting, such as the submission of a budget of estimated expenditures, monthly reports of payments made for entitled services and the submission of audited financial statements.

5.41 In recent years, the contract has been supplemented with Service Level Agreements. Service levels were established by the Department that require the service provider to perform at a certain level, or standard. Blue Cross must regularly report to the Department on its performance with regard to these service level standards. The service level standards cover the main aspects of administering the program, and are adhered to by Blue Cross. These additions have added accountability to the relationship between the Department and the service provider.

5.42 We sampled the reports for the calendar year 2004 to determine whether Blue Cross was reporting to the Department as required. We reviewed the standards and requirements, and assessed whether the Department was monitoring and evaluating the performance of the service provider. Our discussion is organized by the two main areas of financial reporting and service level reporting, and our results are summarized in Exhibit 5.1.

Exhibit 5.1
Reporting requirements and service level standards

Type of reporting	Requirement/Standard	Findings
Financial	Audited financial statements	Financial statements were submitted, although 11 months after year end in 2004.
	Monthly reports on all payments for services See note (1)	• A number of reports were submitted: – Administration expense analysis, including budget variance – Invoice from the service provider – Claims analysis – Reconciliation reports • All reports were submitted consistently each month.
	Budget of administration expenditures	Budget was submitted. See note (2).
Service level standard – Special Authorization Requests	• Standards: 5 standards for requests turnaround time and number of requests to be processed daily by staff • Reporting: weekly report required for 3 of the standards; 2 are by request only	• All reports that are required to be submitted were submitted. • Reports were complete. • Reports that are "by request only" were not requested during the period tested. • Monitoring of the standard is occurring. • For the majority of weeks of 2004, the standards were not met; however a reasonable explanation was provided, indicating evaluation of services was occurring.
Service level standard – Inquiry	• Standards: 5 standards for time to respond to an incoming call; responding to messages; calls to be handled daily. • Reporting: 2 reports produced on a weekly basis, 2 by request only	• All reports that are required to be submitted were submitted. • Reports were complete. • Reports that are "by request only" were not requested during the period tested. • Monitoring of the standard is occurring. • The standards were not fully met for the majority of weeks in 2004; however a reasonable explanation was provided.
Service level standard – Provider Audit	• Standards: 6 standards pertaining to number of on-site pharmacy audits to be performed each year; in-house claims verification. • Reporting: 7 reporting requirements consisting of monthly status reports.	• All reports that are required to be submitted were submitted. • Reports were complete. • Monitoring of the standard is occurring. • All standards for Provider Audit were met.

Notes:

(1) The contract does not specifically identify the reports to be submitted. In our analysis, we considered whether the reports addressed the payments for services made during the month.

(2) The budget document was signed by a program officer, indicating approval. Although the budget request was submitted prior to the commencement of the fiscal year, we could not determine when the budget was approved or approval was communicated to the service provider.

Conclusion

5.43 This criterion was met. Our discussions with departmental staff, as well as the review of the Service Level Agreements and reports provided to the Department, indicate that there is an adequate responsibility framework established with the service provider. Adequate standards have been established to monitor and evaluate the service provider, and monitoring by PDP is occurring.

Monitoring and evaluation of program performance

5.44 Our final two criteria for this objective addressed evaluating the performance of the Prescription Drug Program. They were:

> *The Department should have adequate standards to monitor and evaluate the Prescription Drug Program's performance; and*
>
> *There should be regular evaluation of key aspects of the program's performance and corrective action taken when necessary.*

5.45 In our 2004 Report, we had an extensive section discussing our government-wide survey of program evaluation in provincial departments. Our survey defined program evaluation as the systematic process of asking critical questions, collecting appropriate information, analyzing, interpreting and using the information in order to improve programs and be accountable for positive, equitable results and resources invested.

5.46 We noted that program evaluation can address:

- the needs of the target clients of a program (i.e. program relevance);
- the logic of the program's design;
- the efficiency and effectiveness with which program activities are being carried out and services delivered; and
- the extent to which the program has achieved its objectives (i.e. by focusing both on measurement of results and the degree to which those results can be attributed to the program).

5.47 Program evaluations can identify deficiencies in a program that may reduce the program's relevance, cost-effectiveness, and/or success in achieving its objectives. Such information is very important for decision-makers, and often not readily available. Information provided by program evaluations can also be used by senior management, legislators, and the public in holding decision-makers to account for the achievement of positive, equitable results with resources provided to them.

5.48 Despite the benefits of program evaluations, our Report observed a lack of formal program evaluation guidelines that specify standard departmental approaches to program evaluation. In the absence of guidelines, the two key factors in decision-making appear to be financial information and the degree of linkage between the program and departmental/government-wide strategic plans. This is not dissimilar for the Prescription Drug Program.

Limited evaluation of key aspects of performance

5.49 Departmental staff identified spending within budget as the key indicator of performance for the Prescription Drug Program. The Department does a good job of monitoring budget to actual. A review of budget-to-actual comparisons for the past four years shows that PDP has been making progressive improvements in remaining within budget, as displayed in Exhibit 5.2.

Exhibit 5.2
Budget-to-Actual comparisons

Year	Budget (000's)	Actual (000's)	Variance
2003-04	$ 115,549.0	$ 113,752.8	Under budget by 1.6%
2002-03	$ 102,549.0	$ 102,878.9	Over budget by 0.3%
2001-02	$ 90,135.0	$ 92,032.4	Over budget by 2%
2000-01	$ 72,426.0	$ 79,887.7	Over budget by 10.3%

5.50 Remaining within budget is the only area being measured. We agree that this is important. But it tells us simply that the program has spent the budget it was given, not whether the desired outcome was achieved.

5.51 There are other aspects of the Prescription Drug Program's performance that cannot be evaluated by financial performance information alone. Some examples come to mind when we consider the statements made in the mission, such as "programs ... based on the needs of the population" or "public satisfaction with programs". In a broader sense, the program is supporting the Department of Health and Wellness' commitment to the well-being of New Brunswickers and the program plays a part in the health status of New Brunswick residents.

5.52 The beneficiaries of the Prescription Drug Program are some of the most vulnerable citizens in the Province; they are individuals with low incomes, residents in nursing homes, children in care, adults with disabilities living in residential facilities, and other individuals with serious health problems. Seniors alone represent 50% of beneficiaries of the program. There is a need for the Department to evaluate the non-financial aspects of the performance of the Prescription Drug Program,

such as meeting the needs of the population, appropriate use of drugs, satisfaction with the program and services provided, access to drugs, and appropriate prescribing.

5.53 In order to do this, there is a need for additional standards to evaluate aspects of the program such as the program deliverables. For example, there is an eleven-month delay between the time a drug is recommended for benefit status and the time it is included in the formulary. This might provide an example of where a standard could be established for the program – the Department could determine what a reasonable delay should be, set a standard, and monitor the performance to determine whether the standard was met. Management would take corrective action where results required.

Monitoring the key components of costs

5.54 Although the Department closely monitors actual-to-budget for the PDP, this is not sufficient for ensuring cost-effectiveness. According to the Conference Board of Canada, drug prices and rates of utilization are the two major factors behind increased spending on prescription drugs.

5.55 When new drugs are substituted for older drugs, they are typically introduced at a higher cost than the products they displace, resulting in increased drug prices. Increased utilization is the result of a number of factors, including;

- an aging society (more likely to take medication);
- growing scope of pharmacotherapy (treatment, maintenance and prevention);
- more "consumer-driven" demand (internet access to information, direct-to-consumer advertising in the media); and
- more direct marketing to physicians by drug companies trying to establish the latest drug.[1]

5.56 According to departmental staff, there are two main ways to affect the growth in the program; one is to pay for the most cost-effective drugs and the other is to influence physician prescribing practices. We wanted to determine if the Department was monitoring drug utilization and prescribing practices.

Drug utilization

5.57 Monitoring of drug utilization is an important part of influencing costs. There is a drug usage report prepared by departmental staff, but as mentioned previously, limited analysis is performed on this data.

1. Source: *Understanding Health Care Cost Drivers and Escalators*, Conference Board of Canada, March 2004

5.58 The task of monitoring drug utilization by beneficiary has been assigned to the service provider, who conducts drug utilization reviews to identify cases where abnormal utilization may be the result of abuse or inappropriate use of the program. The objective of the review is to control, reduce or identify prescription drug usage which may be potentially harmful, by relying upon the cooperation of prescribers and providers to exercise their professional control responsibilities.

5.59 A monthly report produced by the service provider identifies beneficiaries who have met one of the criteria established by the Department to be an indication of a potential problem. Further investigation is conducted and can result in a letter being sent to the beneficiary's physician. The review process focuses on a number of drug classes, such as sedatives, narcotics, and antidepressants, when determining if a letter should be sent out. During 2004, the system identified 24,364 potential instances of abnormal usage. After further investigation, 1,906 letters were written to physicians. The response rate to these letters was just beginning to be recorded as of January 2005. The process will be improved by tracking this type of information, since it could be used to determine whether the intended result of the review was being achieved.

5.60 There could also be monitoring of utilization other than by beneficiary – for example, by region. Data currently collected by the Department shows that in 2003-04, the average number of prescriptions per beneficiary ranged from as low as 18 in some regions to as high as 29 in other regions during the same period. We found that the Department has made an attempt at this type of analysis for a particular drug group. In a joint initiative with the New Brunswick Medical Society, the Department provided physicians with a regional antibiotic prescribing profile. It compared consumption on antibacterials in each health region to the New Brunswick average as well as some leading countries in appropriate antimicrobial usage. The report was provided to physicians in 2002. We were pleased to see this initiative and encourage the PDP to continue in this vein.

Prescribing practices

5.61 Although the Department is monitoring some aspects of drug utilization, we did not find evidence of regular and consistent monitoring of prescribing practices, the other component required for influencing the growing costs of the program.

5.62 At one time, information bulletins were prepared when new drugs were added to the formulary – these bulletins described some of the differences between the new drug being added to the formulary and current benefits, and like information. This is no longer done. As

discussed earlier, the Department has distributed antibiotic prescribing profiles to physicians. The Department has also begun a pilot project where a tool was developed to provide physicians with provincial drug formulary information on handheld technology. The tool will enable physicians to access information on alternative drug options and their associated costs at the point of prescribing in order to make the most appropriate and cost-effective medication choices for their patients. These latest initiatives could be used for monitoring in the future.

5.63 The main tool currently used to influence prescribing is a special authorization process. This process restricts the coverage of certain drugs. For example, if a physician prescribes a drug for which there is a less expensive but equally effective alternative available, special authorization would be required in order for the beneficiary to be covered for the drug cost. The physician must send a written request describing why a particular drug is required. Of the 3,600 drugs listed in the formulary at 31 March 2004, 287 drugs (8% of the formulary) were restricted.

5.64 As mentioned previously, the Department is producing statistical reports on prescribing by health region and by physician type. An analysis of this type of data could assist in identifying unfavourable trends in prescribing practices. A report prepared by departmental staff, "Utilization Indicators by Physician Type by Health Region, Urban and Rural Areas" for 2003-04, highlighted a number of interesting points that may warrant further study:

- The area with the highest average number of prescriptions per beneficiary in New Brunswick (at 28.8 prescriptions) exceeded the lowest area (17.7 prescriptions) by 62%. Yet, there was only a 25% difference in average cost per beneficiary in these two regions.

- The report also indicated that beneficiaries in rural areas have on average 18% more prescriptions than those in urban areas. The average annual cost per beneficiary is also 6% higher in rural areas at $770.01 per beneficiary, compared to $727.77 per beneficiary in urban areas.

5.65 Another report, "Utilization by Health Region", provides additional and equally interesting information that could be examined:

- The highest regional increase (as a percentage) in the number of prescriptions from 1997-98 to 2002-03 was 50.45%. The lowest regional increase was 11.38% for the same period.

- The highest regional increase (as a percentage) in average annual number of prescriptions per beneficiary for the five-year period from 1997-98 to 2002-03 was 48.22%, and the lowest was 31.64%.

5.66 The PDP could analyze this and other information, but is not doing so due to a lack of resources. As a result the Department could be missing out on opportunities to identify areas where improvement is needed or where savings could be achieved.

Conclusion

5.67 The two criteria were partially met. There is monitoring and evaluation of the administrative aspects of the program, and whether or not the program remains within budget. Although remaining within budget is important to a program's performance, there are other important aspects which should be monitored and evaluated. The Department has not established standards for non-financial aspects of the program's performance. There is also a lack of evaluative information to monitor the goals of the program, which also impacts on the program's performance; there is no way of knowing whether the goals of the program are being achieved.

Recommendations

5.68 We recommended the Department identify the non-financial aspects of the Prescription Drug Program that affect performance, and accordingly establish standards to regularly monitor and evaluate the program's performance, and take corrective action as required.

5.69 We recommended the Department ensure the information required to evaluate the goals/objectives of the program is available.

5.70 We recommended the Department utilize the data it currently has to its fullest potential.

Departmental comments on program management

5.71 *As noted in the report, the Prescription Drug Program had been combined with Medicare, but these are now separate programs. This change in the organizational structure evolved over the past few years and became official in April 2004. The change in structure provides an opportunity to establish a separate mission, goals and objectives for the Prescription Drug Program.*

5.72 *With respect to data collection and analysis, this is performed in the course of regular operations. We agree that regular and systematic analysis of drug utilization data is necessary to identify potential utilization issues requiring action or further investigation. We will review the work requirements and identify the additional*

resources that would be necessary to ensure the data is used to its fullest potential.

Drug selection and cost

Drug assessment

5.73 Our first criterion was:

Drugs to be listed should be properly assessed to ensure they are cost-effective.

5.74 Drugs eligible for benefits under the Prescription Drug Program are listed in the New Brunswick Prescription Drug Formulary. During 2003-04, there were approximately 3,600 drugs listed in the formulary.

5.75 In 2002, the Atlantic Common Drug Review (ACDR) process was established to review new prescription drugs and provide listing recommendations to the Departments of Health in the four Atlantic provinces, improving the efficiency and quality of the process. A national Common Drug Review (CDR) was established in 2003, replacing some of the processes of the ACDR.

5.76 The national process covers all new drugs entering the market, while the Atlantic process looks only at drugs that have already been approved, but that have, for example, new strengths or uses. In both cases, expert committees conduct reviews and make listing recommendations. It is then up to the Minister of Health and Wellness to decide whether to include the drug on the New Brunswick PDP formulary.

Drugs are assessed for cost effectiveness

5.77 The evaluation of drugs includes a review of the drug's cost-effectiveness. No specific criteria have been established to evaluate cost-effectiveness, not unlike other jurisdictions in Canada.

5.78 Cost does, however, play an important role in drug reviews. We found evidence of the reviewer's consideration of whether the cost of therapy justifies the clinical and quality of life outcomes (in relation to a similar therapy already listed as a benefit). In New Brunswick, after a recommendation for inclusion is delivered from the Atlantic Common Drug Review process, the Ministerial approval document prepared by PDP for the Minister of Health and Wellness includes cost considerations such as cost per day of therapy, cost per year and budget impact (estimated annual cost or savings) for the Minister to consider when deciding whether to approve a drug as a benefit.

5.79 We reviewed the supporting documents for a sample of drugs recommended for inclusion in the formulary in 2002-03, and found that the process was functioning as described. The assessments were

thorough and complete. Our review also identified an elapsed time period of over eleven months between the time a drug was recommended for benefit status by the Atlantic Common Drug Review process and the time the drug was included in the New Brunswick formulary. In his December 2004 report, the Auditor General of Nova Scotia found a similar elapsed time in his jurisdiction. Our concern is that this could possibly lead to lost cost savings for the program or restrict beneficiary access to therapies covered by PDP since the beneficiary may not be able to afford the cost of the drug without PDP coverage.

Conclusion

5.80 This criterion was met. We found that drugs are assessed against many factors, including cost-effectiveness.

Regular review of formulary

5.81 Our second criterion was:

> *Drugs listed should be regularly evaluated to determine whether they should be retained, deleted or restricted in their use, and corrective action taken when necessary.*

5.82 There is no formal regular review process for drugs currently listed as benefits in the formulary. However, reviews do occur as a consequence of the review process involved when a new drug is examined – reviews require that the new drug be compared to drugs currently listed as benefits on the formulary. For example, this could indicate that the new drug is lower in cost, or has fewer side effects than the current benefit. Issues such as these could create a need to remove or restrict the use of a particular drug. A review would also occur if there was an issue related to a specific drug. For example, the drug Ciprofloxacin's status was changed from a regular benefit to requiring special authorization due to an increase in antibiotic resistance resulting from increased consumption. In this case, the drug is still available, but a beneficiary must meet specified criteria in order to be covered for this drug.

5.83 For other drugs currently listed as benefits in the formulary not otherwise identified for review, there is no regular review process. Departmental staff have indicated that the focus of the drug review process has been on new drugs submitted for review by manufacturers.

Conclusion

5.84 This criterion is met to the extent we consider it practical to do so. Drugs are reviewed as a result of the review process in place.

Acquisition of drugs and dispensing fees

5.85 Our final criterion for this objective was:

There should be policies and practices in place to ensure that listed drugs and dispensing fees are acquired at the lowest possible cost.

5.86 When a PDP beneficiary has their prescription filled, the pharmacy is reimbursed for the cost of the drug and receives a dispensing fee for each prescription filled. The dispensing fee paid is based on a ten-tier schedule of fees, based on the ingredient cost of the drug dispensed. These fees are generally negotiated and agreed to by the New Brunswick Pharmacists' Association and the Department; however, there has been no current signed agreement between these two parties since the last agreement expired in 1995. The fees currently paid have been in place since 2001.

Controlling drug costs

5.87 The Department does not purchase drugs directly from manufacturers or wholesalers; therefore, it seeks to control costs in other ways. The Department has implemented several means of influencing drug expenditures for the Prescription Drug Program:

1) Maximum Allowable Price (MAP)

   The Maximum Allowable Price (MAP) process establishes a price control between the original product and interchangeable generic brands. The MAP is based on the lowest manufacturer's price of the drug in a drug category.

2) Actual Acquisition Cost (AAC)

   Pharmacies buy the drugs that are dispensed to PDP beneficiaries, and the Department reimburses them via Blue Cross. The amount reimbursed is the amount the pharmacy actually paid for the drugs, unless MAP applies. When Blue Cross conducts an on-site pharmacy audit, they verify these amounts. In other words, pharmacies are not reimbursed for any mark-up on their acquisition cost.

3) Restricted drugs

   In order to receive certain drugs as benefits, special authorization must be obtained by the beneficiary. The beneficiary must meet the conditions or criteria established for the drug in order to receive coverage for the drug cost. Of the 3,600 drugs listed as benefits in the formulary, 287 require special authorization (8%). An example of a restricted drug is Travoprost, an eye drop used for the treatment of glaucoma. In this case, it is restricted to patients who have not been responsive to, or are intolerant of, other drugs.

Comparison to other jurisdictions

Drug costs

5.88 During our audit, we compared the price being paid in New Brunswick for a sample of drugs to what is paid in other jurisdictions. The sample consisted of the twenty most frequently prescribed drugs in Canada in 2002-03 as determined by IMS Health Canada. We compared New Brunswick to six other jurisdictions: federally funded programs (for example, National Defence, Veterans Affairs, RCMP), Nova Scotia, Manitoba, Saskatchewan, British Columbia and Newfoundland and Labrador.

5.89 We found that New Brunswick compared favourably to these jurisdictions. In fact, New Brunswick had the third lowest costs for this sample. Some of these jurisdictions use alternative methods for paying for drugs, such as standard price lists and contract pricing.

5.90 As another test of reasonableness, we compared the drug costs for the PDP with the costs incurred by hospitals in our Province for the same sample of drugs. Regional Health Authorities in New Brunswick belong to one of two national buying groups that negotiate prices with drug manufacturers. We contacted two health authorities, one belonging to each buying group, to determine if there were significant variances in the price paid for drugs. We found that, in total, PDP paid less than the health authorities for the drugs sampled.

Dispensing fees

5.91 We compared the dispensing fees paid in 2002-03 by PDP for the sample of drugs described in the previous section to the fees paid in other jurisdictions. Dispensing fees represent approximately 20% of total program expenditures. The jurisdictions we compared to New Brunswick PDP were Nova Scotia, Manitoba, Saskatchewan and British Columbia. Newfoundland and Labrador was excluded from our comparison because fees by drug sampled were not provided.

5.92 For the majority of the drugs sampled, PDP was slightly above the average dispensing fee of the jurisdictions examined. It should be noted, however, that some jurisdictions may pay an upcharge (a mark-up based on ingredient costs) in addition to the dispensing fee, which is not reflected in this analysis. Other jurisdictions, however, are paying less.

Conclusion

5.93 This criterion was met. PDP has established policies and practices that have allowed the program to obtain drugs and dispensing fees at the lowest possible cost considering the current program delivery model.

Reporting to the Legislative Assembly

Annual report policy

5.94 Our criterion was:

The reported information should meet the requirements of the Province's annual report policy.

5.95 The Province's annual report policy states that the objective of an annual report is to be the major accountability document by departments for the Legislative Assembly and the general public, serving as the key link between the objectives and plans of a department and the results obtained.

5.96 The annual report policy identifies the requirements concerning the content, format and timing of the report. Although the policy applies to the Department's entire annual report, some the requirements relate specifically to programs. For the years 2000-01 to 2003-04, we examined the section of the annual reports that addressed the Prescription Drug Program. Our findings are summarized in Exhibit 5.3.

5.97 During our review, we noted that although the Department identified achievement of budget as a key aspect of the program's performance, it is not highlighted in the narrative discussion of the program in the annual report, even though in 2003-04 PDP remained within its budget for the first time in several years.

5.98 As can be seen, the Department did not meet the annual report policy requirements in some key areas. The lack of information in these areas is cause for concern as they address issues of accountability.

5.99 The issue of not meeting the annual reports requirements is not unique to the Department of Health and Wellness. We continue to find shortcomings in this area in the annual reports of many government departments.

Exhibit 5.3
Summary of findings from review of annual reports

Annual report policy requirements that pertain to the PDP	Annual report (year) met requirement			
	2003-04	2002-03	2001-02	2000-01
1. Clear account of goals, objectives and performance indicators.	No	No	No	No
2. Extent to which a program continues to be relevant.	No	No	No	No
3. Department's performance in achieving its plans.	No	No	No	No
4. Acceptance by client groups.	No	No	No	No
5. Actual and budget information in summary form with narrative on variance analysis.	Yes	Yes	Yes	Yes
6. Clear and simple language.	Yes	Yes	Yes	Yes
7. Use of tables, charts and graphs.	Yes	Yes	Yes	Yes

Conclusion

5.100 This criterion is partially met. The Department's annual report met some of the requirements of the annual report policy, while others were not met.

Recommendation

5.101 We recommended the Department comply with the requirements of the annual report policy with respect to the content concerning the Prescription Drug Program.

Departmental comments on reporting to the Legislative Assembly

5.102 *We note that the Prescription Drug Program section of the annual report met some of the requirements of the annual report policy. We will review these requirements to ensure the other areas are addressed.*