Government of Saskatchewan

Annual Statistical Report 2005-06

Saskatchewan Health

Drug Plan and Extended Benefits Branch

Preface

This document is a statistical supplement to the Annual Report of Saskatchewan Health for the fiscal year 2005-06. It contains statistical data concerning the programs administered by the Drug Plan and Extended Benefits Branch, including the Drug Plan, Supplementary Health Program, Family Health Benefits and Saskatchewan Aids to Independent Living.

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Drug Plan & Extended Benefits Branch

The Drug Plan and Extended Benefits Branch was formed on April 1, 1996 by amalgamating the Drug Plan program, the Supplementary Health program, the Saskatchewan Aids to Independent Living program, and the Income testing for Special Care Homes.

MISSION STATEMENT

Drug Plan and Extended Benefits Branch provides benefits to the eligible Saskatchewan population by:

- promoting optimal, cost-effective drug therapy and extended benefits
- subsidizing qualifying residents and
- facilitating the use of the database

The following kinds of activities contribute to achieving the Mission:

- leading policy development on Drug Plan, SAIL, Supplementary Health and Family Health Benefits related issues
- providing Drug Plan benefits to the eligible Saskatchewan population
- providing non-insured health benefits to residents nominated for Supplementary Health benefits by the Department of Community Resources, and for residents receiving Family Health Benefits
- providing Saskatchewan Aids to Independent Living (SAIL) Program benefits to eligible residents
- administering, on behalf of Health Regions, income-tested resident charges for residents of Special Care Homes
- providing case management services in appropriate areas
- improving program delivery and accountability to the public and the Legislature through trends analysis and annual statistical reports
- providing funds for various initiatives that encourage appropriate use of drugs, e.g. RxFiles Academic Detailing Program
- using the claims paid database for various studies to promote appropriate use of drugs

Eligibility for Coverage

Drug Plan

Eligible
All Saskatchewan residents with valid Saskatchewan Health coverage unless coverage is provided by another federal or provincial government or non-government agency.

Active beneficiaries
A resident of Saskatchewan who received an eligible prescription.

Not Eligible
Beneficiaries eligible under the First Nations and Inuit Health Branch of Health Canada, Department of Veteran Affairs, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation, and inmates of a federal penitentiary.

Supplementary Health

Eligible
People nominated for coverage by the Department of Community Resources (eg. persons receiving social assistance), inmates of provincial correctional institutions, nominated seniors in special care homes or hospitals whose incomes are below the Saskatchewan Income Plan level.

Family Health Benefits

Eligible
Families who receive the Saskatchewan Child Benefit and/or the Saskatchewan Employment Supplement.

Saskatchewan Aids to Independent Living (SAIL)

Eligible
People with long term disabilities or illnesses, which leave them unable to function fully, may receive specialized benefits to help them achieve more independent and active lifestyles.

Saskatchewan residents with valid Saskatchewan Health coverage.

Not Eligible
Beneficiaries eligible under departments or agencies of the Government of Canada, the Workers' Compensation Board and Saskatchewan Government Insurance.

Highlights for 2005-06

Drug Plan

- One in every four families that received a prescription received a financial benefit.

- At June 30, 2005 a total of 917,731 individuals, representing approximately 529,028 family units were eligible to receive Drug Plan benefits.

- A total of 638,637 individual beneficiaries representing 448,005 family units, purchased eligible prescriptions. This represents 69.6% of eligible individuals.

- Tendering of certain high volume interchangeable drug groups helped to keep Formulary drug prices low. Estimated savings for Saskatchewan residents and the Drug Plan in 2005-06 were approximately $13.4 M.

- Terminally ill patients covered under the Palliative Care Program received 94,337 prescriptions at no charge. The Drug Plan payment for Palliative Care totalled $4.6 million.

- **The Special Support Program:**
  - helped 63,143 families (65% were senior families).
  - provided benefits in the amount of $115.1 million.
  - dispensed an average of 41.7 prescriptions to each active beneficiary.
  - dispensed an average of 59.4 prescriptions to each family unit.
  - assisted on average 67.3% of the total prescription costs.

- **Active beneficiaries exempt from being income-tested:**
  - helped 56,120 families.
  - provided benefits of $54.3 million.
  - dispensed an average of 15.3 prescriptions to each active beneficiary.
  - dispensed an average of 19.5 prescriptions to each family unit.
  - assisted on average 98.9% of the total prescription costs.

- **Active beneficiaries receiving income supplements and not income-tested:**
  - provided benefits of $11.8 million.
  - dispensed an average of 9.5 prescriptions to each active beneficiary.
  - dispensed an average of 13.7 prescriptions to each family unit.
  - assisted on average 7.9% of the total prescription costs.

- **Drug claims processed for Formulary and Exception Drug Status drugs:**
  - processed 9.4 million prescriptions during April 1/05 to March 31/06.
  - provided benefits in the amount of $181.3 million.
  - average drug acquisition cost per prescription was $30.01.
  - average mark-up paid to pharmacies was $2.86.
  - average dispensing fee paid to pharmacies was $7.20.

Supplementary Health

- The average number of eligible beneficiaries under the program was 40,708.
- Net payments for the program were $14.75 million during the fiscal 12-month period.
- Program expenditures per eligible beneficiary rose from $222.52 in 1999-00 to $362.36 in 2005-06. These figures do not include Formulary Drugs (covered by the Drug Plan).

Family Health Benefit Program

- The average number of eligible beneficiaries under the program in 2005-06 was 62,452 (26,691 adults and 35,761 children). This is an increase of 828 beneficiaries from the previous year. The number of eligible families was 21,418.
- Net payments for the program were $4.44 million from April 1, 2005 to March 31, 2006. This is an increase of $17,121 from the previous year. These figures do not include Formulary Drugs (covered by the Drug Plan).

Saskatchewan Aids to Independent Living (SAIL)

- Net payments during the 12-month period were $2.50 million for Orthopaedic services and $3.71 million for Special Needs Equipment.
- The SAIL Oxygen program was changed in 1996-97 to provide benefits according to medical criteria. The program cost in 2005-06 was $9.06 million.
- Net payments for approved beneficiaries were $8.03 million for non-formulary drugs and $0.94 million for ostomy supplies.
- A total 4,576 orthopaedic issues were made in 2005-06, a slight decrease from the previous year. The number of repairs was 3,118, a slight increase from the previous year.
- A total 22,924 wheelchairs and other special needs equipment aids were loaned to beneficiaries in 2005-06, an increase over the previous year.

The Drug Plan

Background

- Enabling legislation for the Drug Plan, The Prescription Drugs Act, was assented to on May 10, 1974.

- The Drug Plan began providing benefits on September 1, 1975. A review process was established to recommend which drugs should be covered under the Drug Plan. The actual acquisition cost plus a dispensing fee comprised the total cost of a Formulary drug. During the first full year, $14.9 million was paid in benefits; the average prescription cost was $6.04; and the average consumer share was $1.96 per prescription.

- On July 1, 1987, a mark-up on the cost of a drug was added. Mark-up was calculated on the acquisition cost before the dispensing fee was added.

- On July 1, 1987, the Drug Plan was changed from a fixed co-payment coverage program to a basic deductible* and percentage co-payment program. Those residents entitled to special health benefits were exempted.

- On July 1, 1987, Palliative Care coverage was introduced.

- On January 1, 1989, Point of Sale terminals were installed for each pharmacy to submit claims information electronically for adjudication on-line real time.

- On January 1, 1989, eligible drugs purchased anywhere in Canada by all eligible Saskatchewan residents became a benefit.

- On March 8, 1991, beneficiaries in Special Care Homes who previously paid a maximum $3.95 for each prescription, became part of the deductible plan.

- On July 1, 1991, the coverage policy for drugs in an interchangeable group was changed. The actual acquisition cost of every product in the interchangeable group is covered only up to lowest listed price in the group.

- In October 1997, implemented a Managed Care Fee for community-based pharmacies that provide monitoring, supervision and other required activities to administer the Methadone Program.

- In December 1997, the Task Force on High Cost Drugs was appointed to determine improvements that would be appropriate to the way government evaluates new pharmaceuticals such as bringing greater transparency to the process; review the implications of providing new drugs in the scope of the Saskatchewan Prescription Drug Plan; and identify actions Saskatchewan should take at the federal, provincial and territorial level, including approaches to a National Pharmacare Program.

- In August 1999, implemented a Trial Prescription Program.

- In 2000, the Prescription Drug Plan, in partnership with the Saskatoon Health District implemented the RxFiles Academic Detailing Program as an educational program aimed at assisting physicians in selecting the most appropriate and cost-effective drug therapy for their patients. This program is an extension of the Community Drug Utilization Program, established in 1997 as a pilot project in the district.

- In July 2002, the Income-based program was implemented to replace the $850 semi-annual deductible.

- On July 1, 2004 the Maximum Allowable Cost policy was implemented with one group of drugs, the Proton Pump Inhibitors. Under this policy, the price of the most cost effective drugs is used as a guide to set the maximum price the Drug Plan will cover for other similar drugs used to treat the same condition.

- On September 15, 2004, following a legislative change, the Drug Plan began collecting information on all prescriptions dispensed from community pharmacies, including those that are not benefits of the Drug Plan. This more complete information was an important building block for the Pharmaceutical Information Program (PIP).

- The Medication Viewer phase of PIP began October 24, 2005 with a pre-production rollout to selected sites to validate production processes. Full production rollout began in March 2006, extending the medication profile viewer to pharmacies, emergency rooms, physician clinics, long-term care and home care facilities as they were equipped and trained. The PIP viewer provides authorized health care professionals with confidential, shared access to patient medication histories to help improve drug therapy for Saskatchewan residents.

* Refers to ***History of Deductibles***.

History of Deductibles:

- **July 1, 1987**
  - Annual deductible of $125 (regular family), then a co-payment of 20%.
  - Annual deductible of $75 (senior family), then a co-payment of 20%.
  - Annual deductible of $50 (single senior), then a co-payment of 20%.

- **March 8, 1991**
  - Annual deductibles as above (1987), then a co-payment of 25%.
  - Residents of Special Care Homes became part of the deductible program.

- **May 19, 1992**
  - Semi-annual deductible of $190 (regular family), then a co-payment of 35% to a $375 maximum, then 10% co-payment.
  - Single Senior and Senior family deductibles at 1987 level but became semi-annual, with a co-payment of 35% to a $375 maximum, then 10% co-payment.

- **March 19, 1993**
  - Families became eligible for the Special Support program, where families and the Drug Plan share the cost of prescriptions if the cost for covered drugs exceeds 3.4% of the family income. The family co-payment for each covered prescription is set based on the relation between family income and eligible drug cost.
  - Family Income Plan recipients, Saskatchewan Income Plan recipients, and Guaranteed Income Supplement recipients in special care homes, a semi-annual deductible of $100 then a co-payment of 35%.
  - All other Guaranteed Income Supplement recipients, a semi-annual deductible of $200 then a co-payment of 35%.
  - All other family units subject to a deductible and not approved for Special Support, a semi-annual deductible of $850, then a co-payment of 35%.

- **December 1, 1997**
  - The $50,000 family income cap for the Special Support program was removed.

- **August 1, 1998**
  - The Family Health Benefits program was introduced to replace the Family Income Plan. The program provides adults with a semi-annual deductible of $100 then a co-payment of 35%, and children no charge.

- **July 1, 2002**
  - The Income-based program replaced the semi-annual deductible of $850 that began in 1993.

OBJECTIVES

The Drug Plan has been established to:

- provide coverage to Saskatchewan residents for quality pharmaceutical products of proven therapeutic effectiveness;
- reduce the direct cost of prescription drugs to Saskatchewan residents;
- reduce the cost of drug materials;
- encourage the rational use of prescription drugs.

Table 1 - Prescription Use & Drug Plan Payment

Type of Beneficiary	Active Beneficiaries [1]	Number of Prescriptions [2]	%	Total Drug Plan Payment [3]	%
April 2005 - March 2006					
Saskatchewan Assistance Plan Recipients					
-Prescription Charge Subsidized, (Plan One)	17,420	301,221	3.2	$ 13,915,735	7.7
-Prescription Charge Fully Covered					
Special Drugs for Plan One	1,807	39,140	0.4	1,393,669	0.8
Plan One Dependents to Age 18	7,399	36,525	0.4	1,013,991	0.6
Plans Two and Three	10,345	362,553	3.9	14,268,856	7.9
Special Beneficiaries					
-Paraplegics	1,272	43,223	0.5	1,754,620	1.0
-Cystic Fibrosis	86	2,749	0.0	707,727	0.4
-Chronic Renal Disease	840	63,485	0.7	5,187,644	2.9
-Others for Certain Drugs [4]	4,347	47,712	0.5	8,400,124	4.6
Family Health Benefits					
-Children	25,043	103,840	1.1	3,092,718	1.7
-Adults	17,584	116,116	1.2	1,234,497	0.7
Palliative Care	2,789	94,337	1.0	4,611,503	2.5
Emergency Assistance	171	979	0.0	27,258	0.0
Special Support	89,987	3,753,601	40.1	115,096,857	63.5
Income Supplement Recipients					
-Saskatchewan Income Plan	4,683	112,941	1.2	1,894,150	1.0
-Guaranteed Income Supplement					
Special Care Home	1,854	75,072	0.8	1,229,980	0.7
Community	18,852	393,520	4.2	5,038,629	2.8
Other Drug Plan Beneficiaries	434,158	3,817,857	40.8	2,420,536	1.3
Total	638,637	9,364,871	100.0	$ 181,288,493	100.0

1 Active Beneficiaries are more than in other tables as a beneficiary can appear in more than one type in the same year.

2 Refers to Formulary and Exception Drug Status drugs.

3 Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee, less the portion paid by consumers; i.e. deductibles, co-payments, prescription charges and the full cost if not income tested.

4 Prescriptions for certain drugs have been restated to show under Special Beneficiaries to conform with co-payments policies established when approving coverage of new high cost MS drugs.

Types of Drug Plan Coverage

1. Saskatchewan Assistance Plan Coverage

Residents receiving benefits through the Saskatchewan Assistance Plan (SAP) are entitled to Drug Plan benefits at a reduced charge, or at no charge depending on their level of coverage. Deductibles are waived for these beneficiaries.

a. Plan One

Plan One beneficiaries 18 years or older are entitled to receive insulin, oral hypoglycemics, injectable vitamin B12, allergenic extracts, oral contraceptives and some products used in megavitamin therapy at no charge. These beneficiaries pay a reduced charge, to a maximum of $2.00, for all Formulary and approved Exception Drug Status drugs.

Dependents under 18 years of age are entitled to receive the above benefits at no charge.

b. Plan Two

Beneficiaries receiving Plan Two coverage are entitled to receive the same benefits as Plan One patients at no charge.

Plan One beneficiaries requiring several Formulary drugs on a regular basis can be considered for "Plan Two" drug coverage. Plan Two drug coverage may be initiated by contacting the Drug Plan. The request can be made by the patient or a health professional (i.e. physician, social worker).

c. Plan Three

Plan Three beneficiaries are entitled to receive all Formulary drugs and certain non-Formulary drugs at no charge.

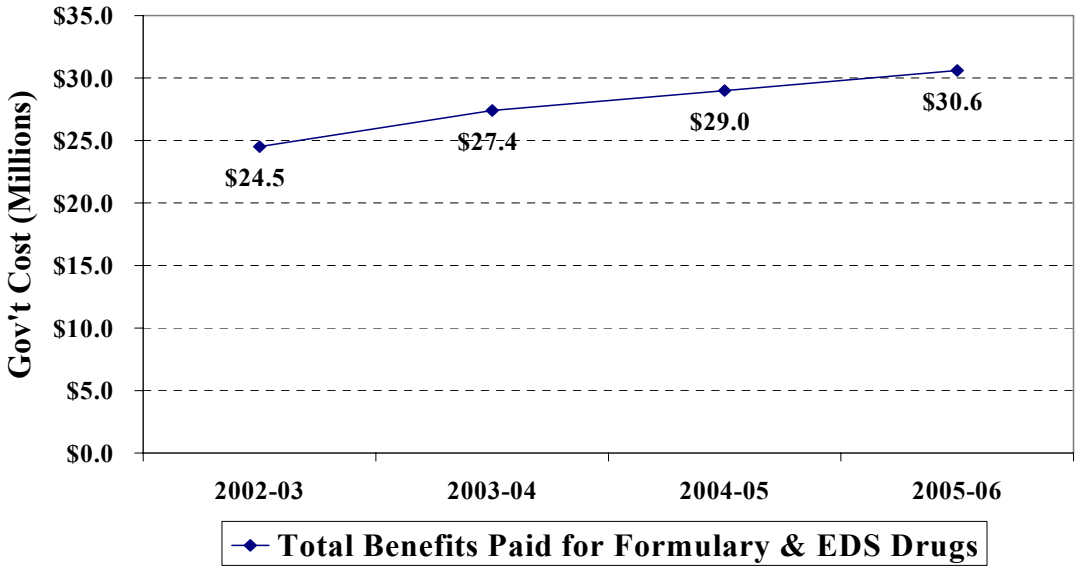
The Supplementary Health program covers the cost of certain non-Formulary drugs as well as the cost of megavitamins and allergenic extracts for Plan One and Plan Two beneficiaries.

Plan Three beneficiaries are residents receiving supplementary assistance who live in Special-Care homes licensed under *The Housing and Special-Care Homes Act*, Approved Homes licensed under *The Mental Health Act*, wards of the province and inmates of provincial correctional institutions.

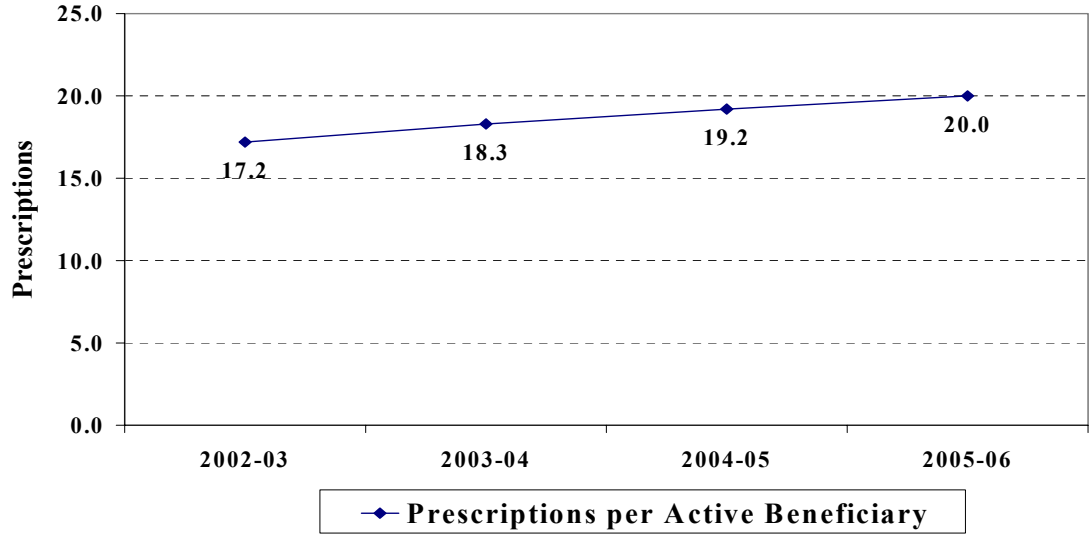
Saskatchewan Assistance Plan Coverage (Continued)

	2002-03	2003-04	2004-05	2005-06
Number of SAP Active Beneficiaries	39,586	38,693	37,565	36,971

Saskatchewan Assistance Plan Drug Coverage



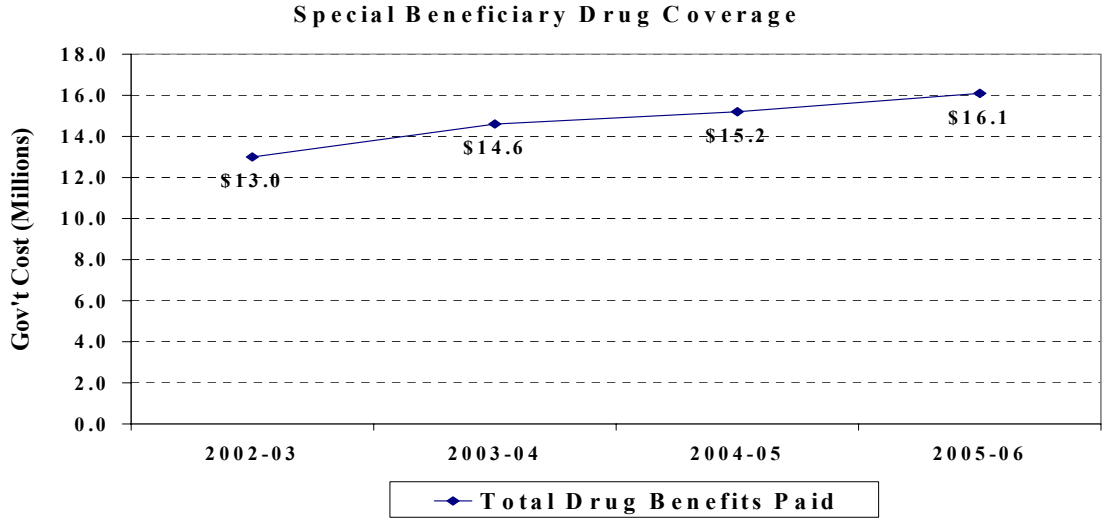
Saskatchewan Assistance Plan Drug Coverage

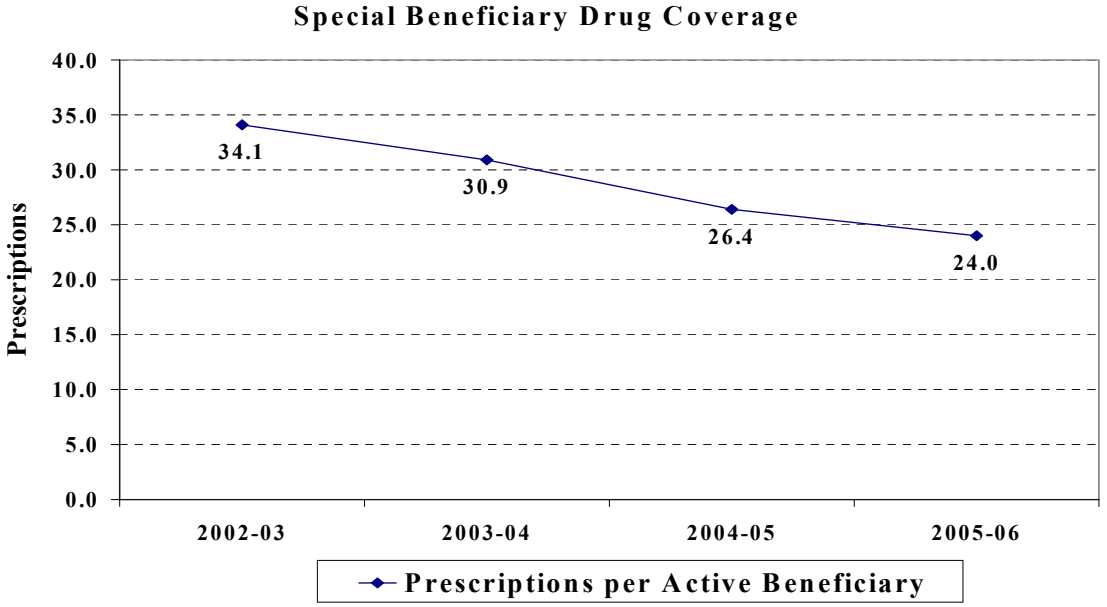


2. Special Beneficiaries

Special Beneficiaries include persons approved for coverage under the paraplegic program, cystic fibrosis program, chronic end-stage renal disease program, and users of certain no charge high cost drugs, depending on their coverage. These beneficiaries may be entitled to receive certain non-Formulary drugs, Exception Drug Status drugs, or all prescribed Formulary drugs at no charge under the Drug Plan.

	2002-03	2003-04	2004-05	2005-06
Number of Active Beneficiaries	3,912	4,647	5,632	6,545



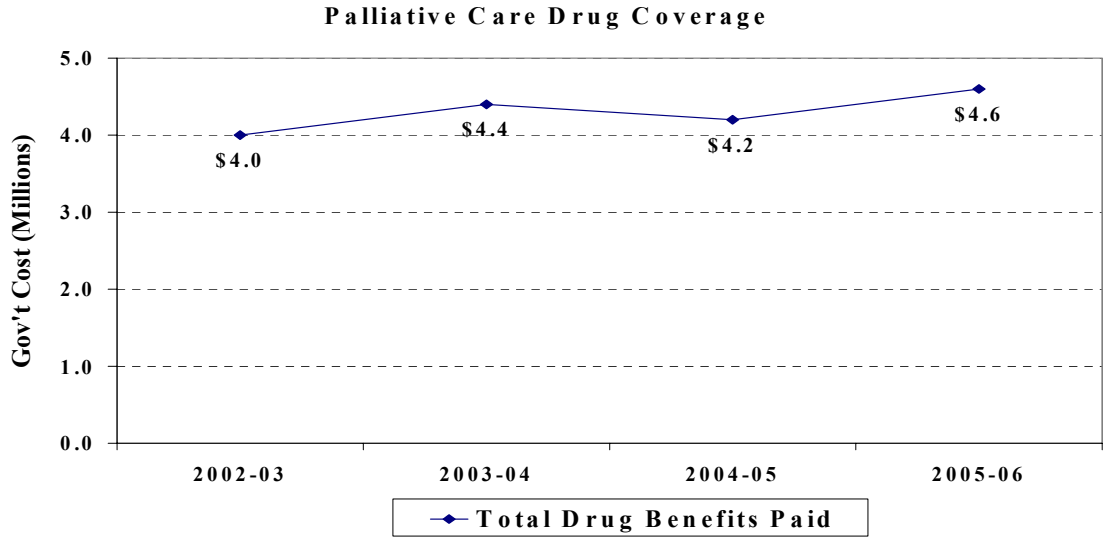


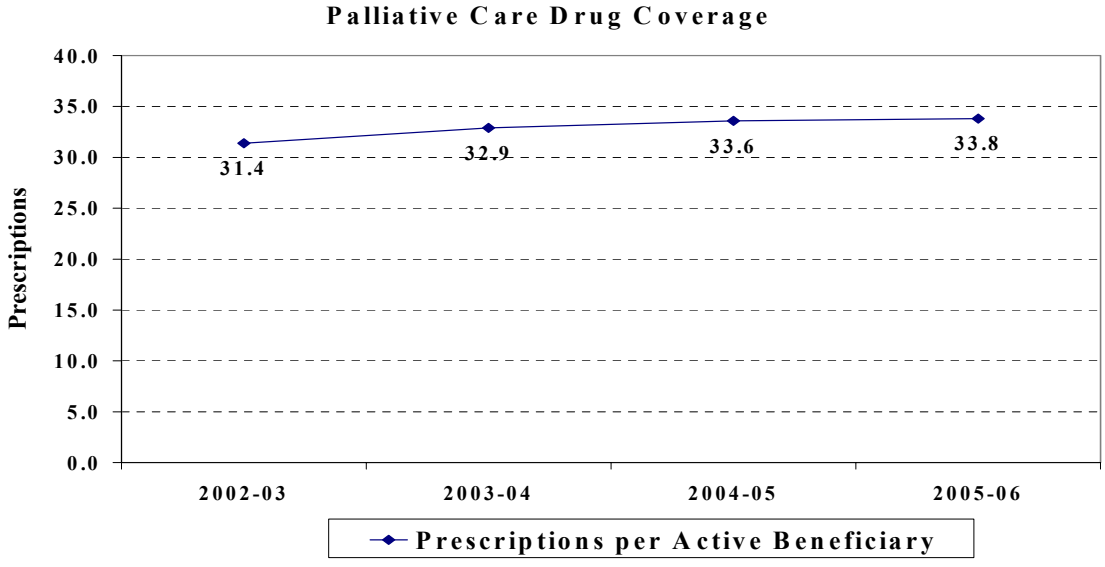
3. Palliative Care Coverage

Persons in late stages of terminal illness are entitled to receive at no cost:

- regular Formulary drugs;
- Exception Drug Status drugs where prior approval has been granted;
- most laxatives.

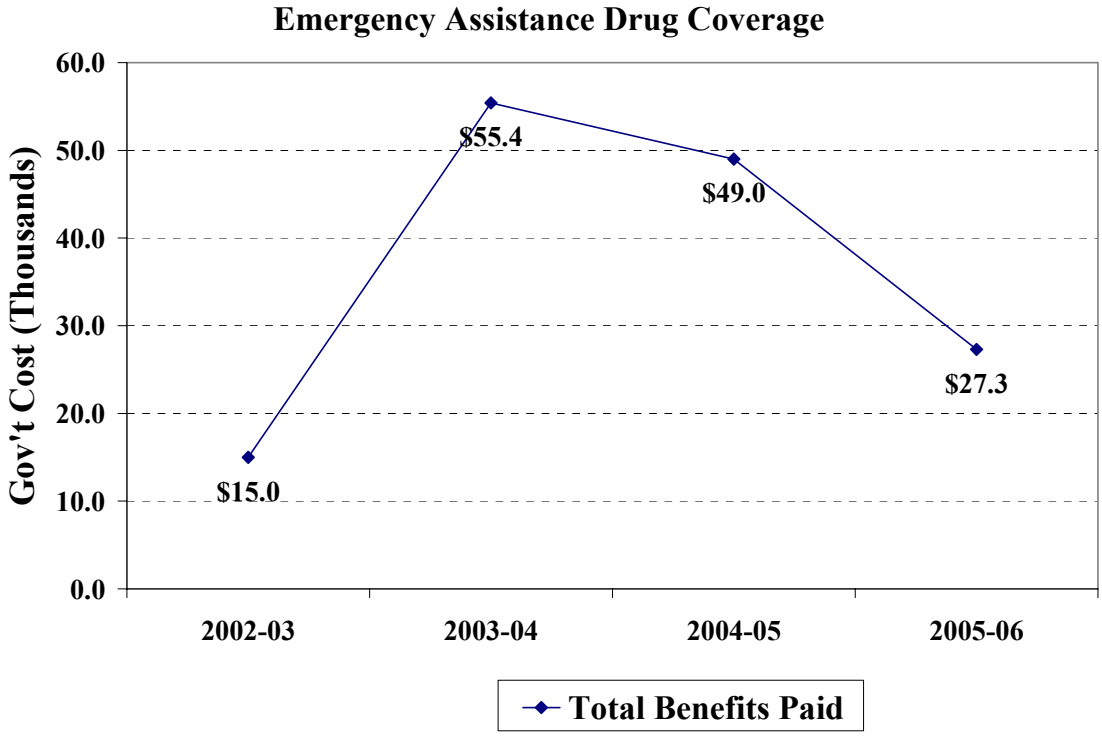
	2002-03	2003-04	2004-05	2005-06
Number of Active Beneficiaries	2,605	2,664	2,647	2,789





4. Emergency Assistance

Residents who require immediate treatment with covered prescription drugs and who are unable to cover the cost, may access emergency assistance. An eligible beneficiary may obtain a limited supply of covered prescription drug(s) at a reduced cost. The level of assistance provided will be in accordance with the consumer's ability to pay. Emergency assistance is available on one occasion, after which the beneficiary is then encouraged to apply for Special Support.



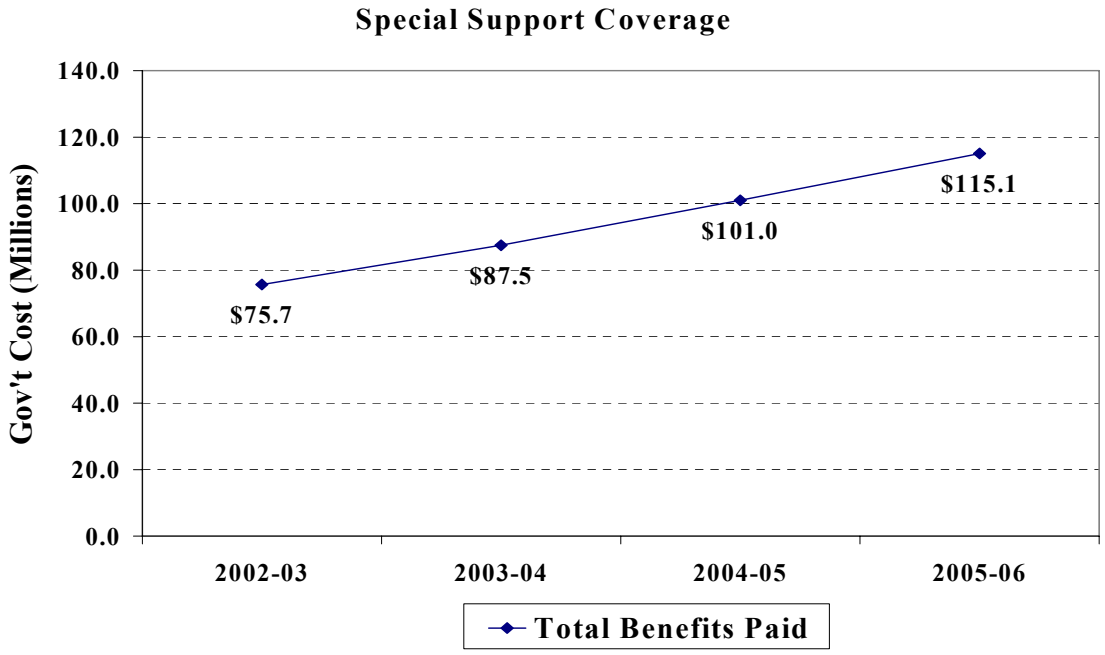
5. Income-based program - Special Support Coverage

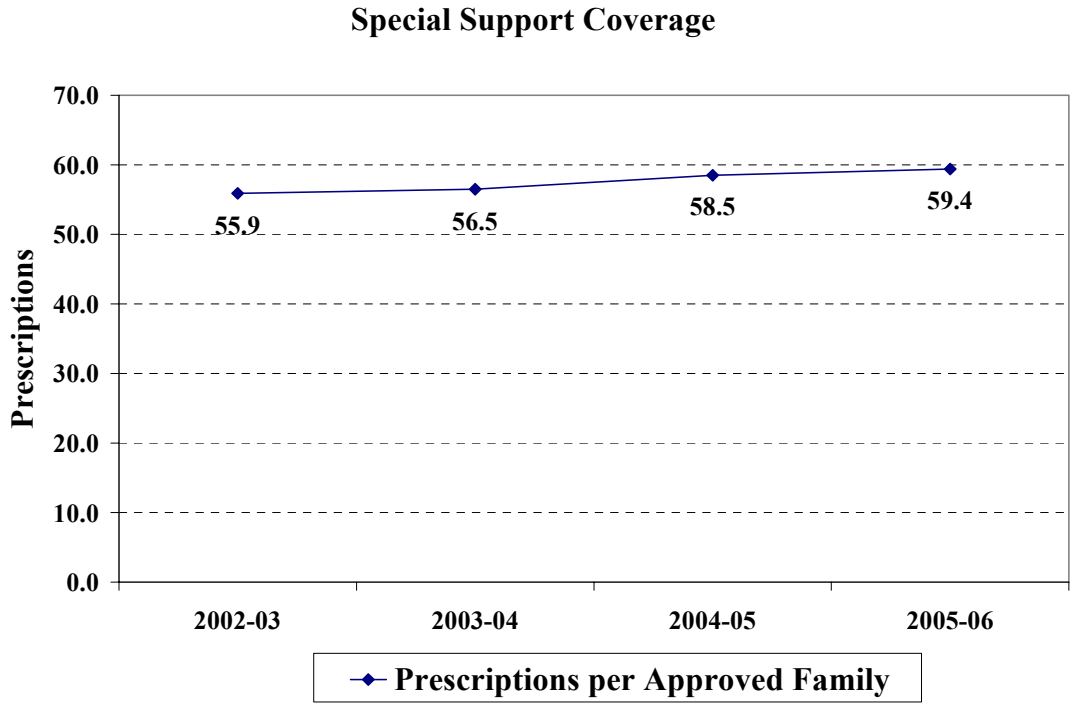
The Special Support program helps **those families whose drug costs are high in relation to their income**. If the annual drug costs exceed 3.4% of the family adjusted income (income after adjusting for the number of dependents), the family is eligible for Special Support benefits. Residents must apply for the Special Support Program as the Drug Plan does not have access to the required income information.

If a family is eligible for Special Support, the family and the Drug Plan share the prescription cost. The family co-payment is calculated using drug costs and adjusted family income.

Income-based program - Special Support Coverage (Continued)

	2002-03	2003-04	2004-05	2005-06
Number of Approved Special Support Families	48,455	52,854	56,374	63,143



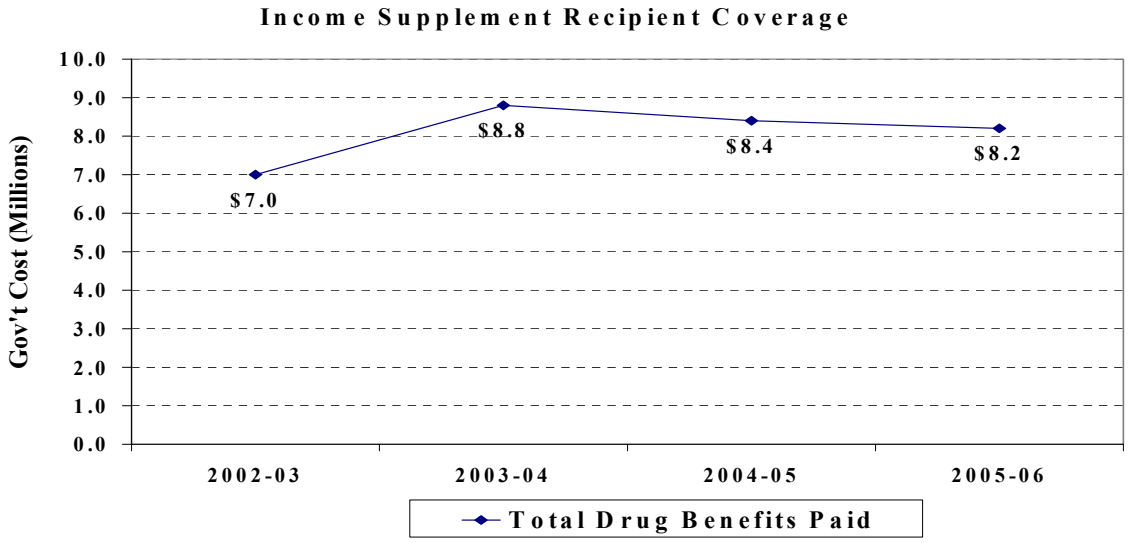


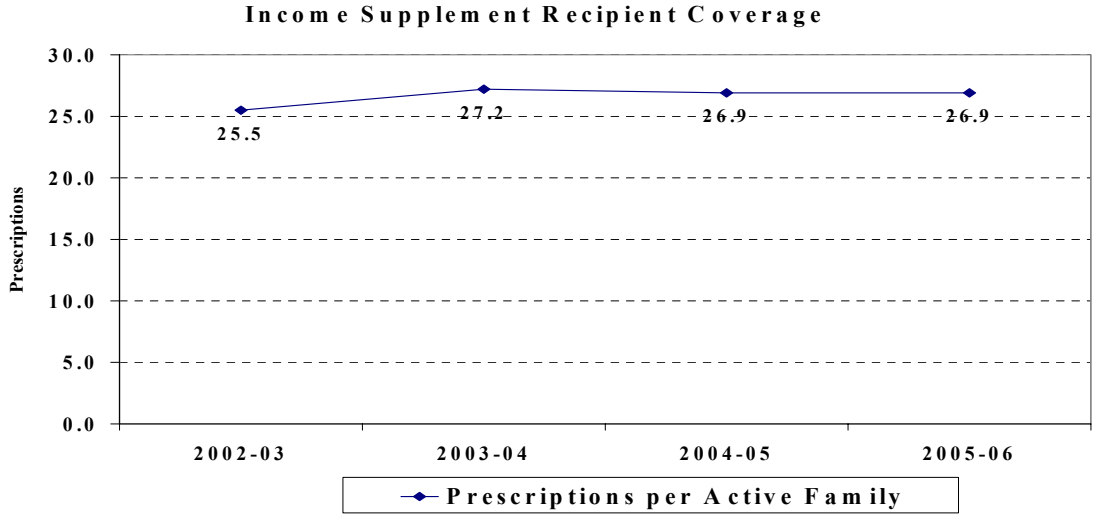
6. Income Supplement Recipients

Single seniors and senior families receiving the Saskatchewan Income Supplement (SIP) or receiving the federal Guaranteed Income Supplement (GIS) and residing in a nursing home have a $100 semi-annual deductible. Other single seniors and senior families receiving GIS have a $200 semi-annual deductible. The number of active families continues to decline as more income supplement families begin to incur high drug costs, and apply for Special Support. Other seniors who have higher incomes paid the full cost of their prescriptions up to the regular $850 semi-annual deductible until June 30, 2002. Starting July 1, 2002, these seniors became eligible for benefits under the income based program.

Note: Families approved for Family Health Benefits are not included in this chart.

	2002-03	2003-04	2004-05	2005-06
Number of Active Families	23,284	23,088	22,331	21,649





Family Health Benefit Program

Effective August 1, 1998, families who received the Saskatchewan Child Benefit, and/or the Saskatchewan Employment Supplement were eligible for the Family Health Benefits Program.

Comprehensive Supplementary Health Benefits became available to children under the age of 18 who qualified (dental, optical, Formulary drugs, medical supplies and appliances and ambulance services).

Partial benefits became available for adults in qualifying families (eye examinations, chiropractic co-payments, $100 semi-annual Family Drug Plan deductible with a 35% consumer co-payment thereafter).

	2002-03	2003-04	2004-05	2005-06
Number of Active Children Beneficiaries	24,471	23,558	23,973	25,043
Average Number of Prescriptions per Child	3.8	4.0	4.0	4.1
Cost of the Program	$2.4M	$2.6M	$2.8M	$3.1M

	2002-03	2003-04	2004-05	2005-06
Number of Active Adult Beneficiaries	17,430	16,553	17,682	17,584
Average Number of Prescriptions per Adult	6.1	6.4	6.6	6.6
Cost of the Program	$1.0 M	$1.1 M	$1.2M	$1.2M

Note: Not included in the above chart is the program cost for Active Adults approved for Special Support. This program cost $2,217,378 in 2004-05 and $2,707,938 in 2005-06.

Drugs Covered by the Drug Plan

With the exception of insulin, blood testing agents and urine testing agents, syringes, needles, lancets, and swabs used by patients with diabetes, a prescription is required from a licensed prescriber for all drugs eligible for coverage under the Drug Plan.

The Formulary

The Drug Plan and Extended Benefits Branch prepares, maintains, and distributes the Saskatchewan Formulary. The Formulary is a listing of therapeutically effective drugs of proven high quality that have been approved for coverage under the Drug Plan.

Drugs listed in the Formulary are periodically reviewed and additions and deletions are recommended when necessary. Revised editions of the Formulary are published yearly in July, followed up with updates approximately every quarter. The goal of the Formulary is to list a range and variety of drugs that will enable prescribers to select an effective course of therapy for most patients. The July 2005 Saskatchewan Formulary lists 2,917 Formulary drug products and 681 published Exception Drug Status products.

Exception Drug Status

Certain drugs are reviewed and recommended by the Saskatchewan Formulary Committee for coverage under Exception Drug Status (EDS). All recommendations must be approved by the Minister of Health. The drugs usually fall into one of the following categories:

1. The drug is ordinarily administered only to hospital in-patients but is being administered outside of a hospital because of unusual circumstances.

2. The drug is not ordinarily prescribed or administered in Saskatchewan, but is being prescribed because it is required in the diagnosis or treatment of an illness, disability, or condition rarely found in Saskatchewan.

3. The drug is infrequently used since therapeutic alternatives listed in the Formulary are usually effective, but are contraindicated or found to be ineffective due to the clinical condition of the patient.

4. The drug has been deleted from the Formulary but is required by patients previously stabilized on the drug.

5. The drug has potential for use in other than approved indications.

6. The drug has potential for the development of widespread inappropriate use.

7. The drug is more expensive than listed alternatives and offers an advantage in only a limited number of indications.

Most drugs approved for Exception Drug Status coverage are subject to the same co-payment as the patient's Formulary drugs.

Over-the-Counter Products

Over-the-counter (OTC) products are generally not included as benefits under the Drug Plan.

Saskatchewan Formulary Process

Product Selection

The Minister of Health relies on the recommendations of two expert committees; the Drug Quality Assessment Committee, and the Saskatchewan Formulary Committee in order to decide which products will be listed as benefits under the Drug Plan.

The Drug Plan and Extended Benefits Branch provides resources and staff support to the Committees in the review of products for listing in the Saskatchewan Formulary. This support includes forecasting drug costs and preparing use/cost analysis reports.

Saskatchewan is participating in the national Common Drug Review (CDR) which is managed by the Canadian Agency for Drugs and Technologies in Health (CADTH). The CDR provides participating federal, provincial and territorial drug benefit plans with a systematic review of the available clinical evidence, a critique of manufacturer-submitted pharmacoeconomic studies and a formulary listing recommendation made by the Canadian Expert Drug Advisory Committee (CEDAC).

Note: The Drug Review process described below is in transition and will be changing to reflect the CDR process.

- **Drug Quality Assessment Committee**

  The Drug Quality Assessment Committee (DQAC) is appointed by the Minister of Health to:

  - evaluate manufacturer submissions for consideration for coverage of new drugs and report its findings to the Saskatchewan Formulary Committee.

  - review available manufacturing documentation including clinical documents, reports of scientific studies and published literature.

  - evaluate comparative bioavailability studies and/or comparative clinical studies to determine compliance with accepted standards for interchangeability.

Saskatchewan Formulary Committee

The Saskatchewan Formulary Committee (SFC), appointed by the Minister of Health, has the following functions:

- recommends to the Minister of Health additions and deletions to the Saskatchewan Formulary. The SFC considers economic information including utilization patterns as well as the clinical assessment of the DQAC.

- provides advice in compiling and maintaining the Saskatchewan Formulary.

- identifies those products which are "interchangeable". Interchangeable products are different brands of the same drug that are equivalent in therapeutic effectiveness and quality.

- reviews recommendations on new drug products from CEDAC.

- re-evaluates listed products based on new information about use, efficacy and cost.

Product Interchangeability and Pricing

One function of the Saskatchewan Formulary Committee is to identify interchangeable drug groups. Interchangeable products are different brands of the same drug with the same strength and dosage form that are equivalent in therapeutic effectiveness and quality. The Formulary lists two types of interchangeable drug groups; Low Cost Alternative, and Standing Offer Contract.

- **Low Cost Alternative**

  In order to ensure price stability for the Formulary period, the Drug Plan and Extended Benefits Branch requires drug manufacturers to provide guaranteed maximum prices for the period. The prices constitute the maximum price that the Drug Plan will allow for those products during the effective Formulary period.

  Any drug in a Low Cost Alternative interchangeable group can be used to fill a prescription. The drug cost component in the approved prescription price is the actual acquisition cost of the drug up to the lowest price listed in the Formulary within that interchangeable group.

- **Standing Offer Contract (SOC)**

  The Drug Plan tenders the drugs in certain interchangeable groups to obtain the lowest possible price. An accepted tender, called SOC, requires the manufacturer to guarantee delivery of the specific drug to pharmacies through approved distributors at the contracted price. In return, the manufacturer's product will be used almost exclusively. This tender process saved an estimated $13.4M in 2005-06 for beneficiaries and government combined.

  Only the accepted tendered drug can be used to fill a prescription in an SOC interchangeable group. If a prescription is ordered as "no substitution" for any brand other than the SOC brand listed, the Drug Plan will cover the actual acquisition cost up to the listed SOC unit price. The difference in acquisition cost between the brand dispensed and the cost covered by the Drug Plan is the responsibility of the consumer.

- **"No Substitution" Prescription Drug Coverage**

  It is recognized that extremely rare cases may exist in which a person is not able to use a particular brand of product. In such cases, the physician may request exemption from full payment of incremental cost when a specific brand of drug in an interchangeable category is found to be essential for a particular patient. There is no provision for "blanket" exemptions. Each request must be patient and product specific.

- **Maximum Allowable Cost (MAC)**

MAC is a policy to encourage cost-effective prescribing without compromising the health of Saskatchewan residents. Under this policy, the price of the most cost effective drug(s) is used as a guide to set the maximum price the Drug Plan will cover for other similar drugs used to treat the same condition.

Under this policy, residents do not have to switch medications. They have the option of continuing to take the higher-priced prescription drug and paying the difference in cost over the MAC.

The policy was implemented in Saskatchewan on July 1, 2004 with one group of drugs, the Proton Pump Inhibitors (PPIs). These drugs are covered under the Exception Drug Status program and are used to treat various gastrointestinal disorders. The policy was implemented in a staged approach and when fully implemented (after June 30, 2005) is estimated to result in government savings of over $1M annually.

Encouraging Appropriate Drug Use

The Drug Plan uses a number of activities to encourage appropriate use of drugs:

- Use of the claims processing system to perform various edit and assessment checks.

- Use of Exception Drug Status coverage where drugs are only intended for use in certain circumstances. e.g. products intended for second line use.

- Use of the Maximum Allowable Cost policy to encourage cost effective prescribing.

- Provides funding support for:

  a) The College of Medicine Drug Evaluation Support - Roving Professorship Program to assist in the drug review process, to provide expert opinions on an ad hoc basis, and to deliver drug information to promote the optimal use of pharmaceuticals in the province.

  b) The College of Pharmacy & Nutrition Drug Information Services provides a province-wide drug information service for health professionals and consumers.

  c) The Triplicate Prescription Program operated by the College of Physicians and Surgeons, a two part written prescription to monitor prescribing for a select panel of prescription drugs with intent to reduce abuse and diversion.

  d) The RxFiles Academic Detailing Program operated by the Saskatoon Regional Health Authority as an educational program aimed at assisting physicians in selecting the most appropriate and cost-effective drug therapy for their patients.

- The Trial Prescription Program, started as a joint project with the Saskatchewan College of Pharmacists, and later came under the Drug Plan. The pharmacist is encouraged to dispense a seven to ten day supply for the initial prescription of certain drugs, monitor the effect on the patient and if the outcomes are positive, dispense the full prescription as directed by the physician. There is no additional cost to the resident for this service.

- The Pharmaceutical Information Program (PIP) has been developed to provide authorized health care professionals with confidential access to patient medication records. PIP will enhance patient safety by helping physicians and other health care providers select the best medication, avoid drug interactions, and avoid duplications of therapy. PIP will be extended in future phases to include information entered directly by health care providers, such as allergy information, and prescriptions entered electronically by prescribers.

Pharmacy Claims Processing

An on-line computer network transmits prescription information from the pharmacy to the central computer where it is checked against stored data to determine whether it can be approved for payment. Checking includes: is the drug a benefit, does the beneficiary have health coverage and the type, is the quantity dispensed within appropriate levels, is the number of prescriptions for the beneficiary within limits, is the prescription a duplicate or possible duplicate of another dispensed prescription, is the prescriber authorized, are the unit costs within limits. The prescription claim is adjudicated and cost information is then transmitted back to the pharmacy, detailing the consumer share and Drug Plan share.

- **Pharmacy Reimbursements**

  At March 31, 2006, there were 368 pharmacies providing Drug Plan eligible services.

  According to the agreement between Saskatchewan Health and pharmacy proprietors, the prescription cost is calculated by adding the acquisition cost of the drug material, the submitted mark-up and dispensing fee (up to a maximum).

  The maximum dispensing fee was increased to $8.21 on December 1, 2005. From September 1, 2003 to November 30, 2005, the maximum dispensing fee was $7.97. The maximum mark-up allowance calculated on the prescription drug cost is: 30% for drug cost up to $6.30, 15% for drug cost between $6.31 and $15.80, 10% for drug cost of $15.81 to $200.00, and a maximum mark-up of $20.00 for drug cost over $200.00.

  For urine-testing agents the pharmacy receives acquisition cost along with the mark-up and a 50% mark-up in place of the dispensing fee. For insulin, the pharmacy receives acquisition cost plus a negotiated mark-up. For diabetic supplies, (syringes, needles, lancets and swabs) the pharmacy receives actual acquisition cost plus a mark-up not to exceed 50%. The tiered mark-up and dispensing fee do not apply for diabetic supplies.

- **Prescription Quantities**

  The Drug Plan places no limitation on the quantities of drugs that may be prescribed. Prescribers shall exercise their professional judgment in determining the course and duration of treatment for their patients. However, in most cases, the Drug Plan will not pay benefits or credit deductibles for more than a 3 month supply of a drug at one time.

  The pharmacist may charge one dispensing fee for each prescription for most drugs listed in the Formulary. The pharmacist is entitled to charge a dispensing fee for each 34 day supply, however, the Pharmacy Agreement does not prohibit the pharmacist from dispensing more than a 34 day supply for one fee. The Pharmacy Agreement also contains a list of 2 month and 100 day maintenance drugs. Once a patient's therapy is stable, prescribing and dispensing of these drugs should be in quantities of 2 months or 100 days, unless there are unusual circumstances that require different quantities.

Formulary and EDS Drug Utilization 2005-06

At June 30, 2005, a total of 917,731 individuals, representing approximately 529,028 family units were eligible to receive Drug Plan benefits.

A total of 638,637 individual beneficiaries representing 448,005 family units, purchased eligible prescriptions. This represents 69.6% of eligible individuals.

1. Overall 2005-06 Utilization

Figure 1 compares active Drug Plan beneficiaries to the eligible population and shows the percentage of total prescriptions dispensed to each age group. This shows that the 65+ age group is 15.8% of the eligible population, represents 21.0% of Drug Plan active beneficiaries, and receive 46.8% of all prescriptions.

Table 2 presents prescription drug utilization by age and sex of the beneficiary. It also shows that drug utilization increases with age, with the larger increases beginning at age 45.

Figure 1
Prescriptions Dispensed by Age Groups, Eligible and Active Beneficiaries

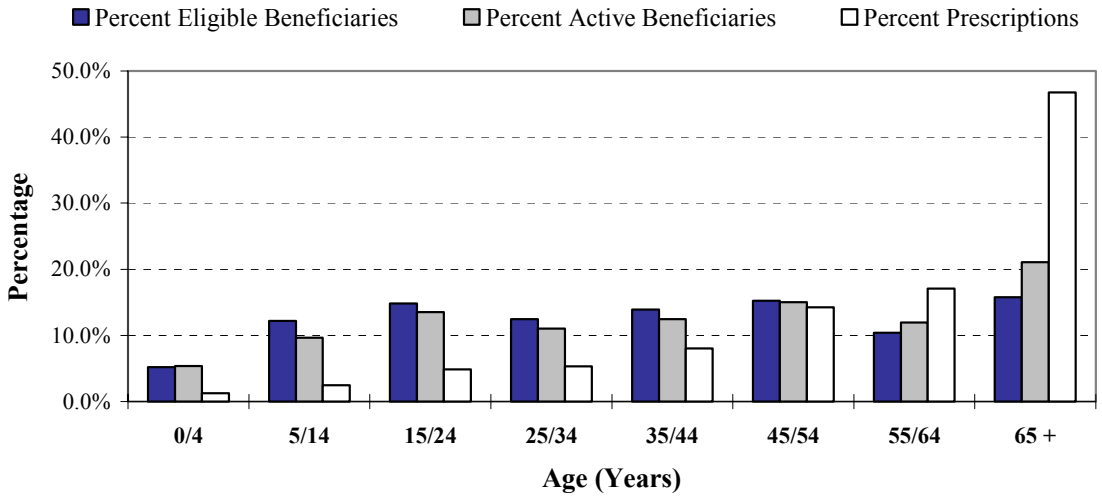


Table 2
Prescription Drug Utilization by Age and Sex of Active Beneficiary

Age of Consumer [1]	Active Beneficiaries	Number of Prescriptions [2]	Drug Material Cost [3]	Dispensing Fee [4]	Total Drug Plan Payment [5]
April 2005 - March 2006 (as submitted for all prescriptions to all beneficiaries)					
Male					
0 - 4	17,835	63,131	$ 842,944	$ 465,219	$ 561,904
5 - 14	31,243	125,655	3,329,653	907,390	2,157,916
15 - 24	34,945	153,628	5,220,935	1,077,936	3,031,178
25 - 34	27,547	166,812	6,374,276	1,197,857	4,115,835
35 - 44	34,283	310,475	13,020,957	2,262,996	8,151,695
45 - 54	44,154	597,839	23,841,089	4,334,142	11,963,520
55 - 64	36,202	752,376	27,943,889	5,329,894	13,676,008
65 - 74	28,376	789,447	26,595,060	5,501,279	15,117,602
75 - 84	20,713	689,193	20,956,004	4,944,338	13,155,024
85 and over	6,832	240,713	6,203,490	1,806,061	4,376,983
Male Total	282,130	3,889,269	$ 134,328,299	$ 27,827,112	$ 76,307,664
Female					
0 - 4	16,331	52,695	$ 609,779	$ 389,027	$ 454,819
5 - 14	30,461	103,873	2,691,138	751,379	1,868,367
15 - 24	51,369	302,109	8,493,940	2,174,869	3,563,227
25 - 34	42,980	332,471	11,102,453	2,368,794	5,583,094
35 - 44	45,145	441,615	17,084,807	3,171,077	9,701,635
45 - 54	51,758	736,933	27,990,075	5,280,451	14,749,548
55 - 64	39,983	845,771	29,165,672	5,990,162	16,213,488
65 - 74	31,932	902,205	28,489,264	6,385,035	18,012,489
75 - 84	29,446	1,054,112	30,471,166	7,738,482	20,896,957
85 and over	17,102	703,818	17,449,475	5,352,471	13,937,205
Female Total	356,507	5,475,602	$ 173,547,770	$ 39,601,745	$ 104,980,829
Both Sexes					
0 - 4	34,166	115,826	$ 1,452,723	$ 854,245	$ 1,016,723
5 - 14	61,704	229,528	6,020,791	1,658,770	4,026,283
15 - 24	86,314	455,737	13,714,876	3,252,805	6,594,405
25 - 34	70,527	499,283	17,476,730	3,566,651	9,698,929
35 - 44	79,428	752,090	30,105,764	5,434,073	17,853,330
45 - 54	95,912	1,334,772	51,831,164	9,614,593	26,713,068
55 - 64	76,185	1,598,147	57,109,561	11,320,056	29,889,497
65 - 74	60,308	1,691,652	55,084,324	11,886,313	33,130,090
75 - 84	50,159	1,743,305	51,427,170	12,682,820	34,051,980
85 and over	23,934	944,531	23,652,966	7,158,532	18,314,188
Grand Total	638,637	9,364,871	$ 307,876,069	$ 67,428,857	$ 181,288,493

1 Age of beneficiary as at March 31, 2005.

2 Refers to Formulary and Exception Drug Status drugs.

3 Includes mark-up on drug acquisition cost.

4 The Dispensing fee charged by pharmacy for the prescriptions dispensed.

5 Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee; less portion paid by consumers; such as deductibles, co-payments, prescription charges and the full cost if not income tested.

2. 2005-06 Utilization by Type of Beneficiary

Drug Plan benefits are directed at families with low incomes, families with high drug costs and those with a combination of the two. Table 3 summarizes the beneficiaries into five main groups:

1. beneficiaries approved for an Income-based Special Support co-payment;
2. beneficiaries exempt from paying a co-payment, some of which are on Saskatchewan Assistance Plan (SAP), Saskatchewan Aids to Independent Living (SAIL) beneficiaries, palliative care, or those who receive certain high cost drugs grandfathered at 100%;
3. beneficiaries approved for Family Health Benefits;
4. beneficiaries approved for Income Supplement under Saskatchewan Income Plan (SIP), and Guaranteed Income Supplement (GIS);
5. other Drug Plan beneficiaries.

Table 3
Prescription Drug Utilization by Over/Under 65

April 2005 - March 2006

Type of Beneficiary	Active Beneficiaries	Number of Prescriptions [1]	Payment Patient Paid	Average Cost to Patient	Drug Plan Payment [2]	Average Cost to Drug Plan
Beneficiaries approved under Income-based Special Support Program						
Under 65	36,731	1,166,203	$ 22,962,184	$ 625.14	$ 47,826,300	$ 1,302.07
65 and over	53,256	2,587,398	33,056,027	620.70	67,270,557	1,263.15
Sub-Total	89,987	3,753,601	$ 56,018,211	$ 622.51	$ 115,096,857	$ 1,279.04
Beneficiaries exempt from paying a Deductible (e.g. SAP, SAIL, Palliative Care)						
Under 65	41,156	804,295	$ 606,240	$ 14.73	$ 41,712,253	$ 1,013.52
65 and over	5,149	186,650	18,505	3.59	9,541,615	1,853.10
Sub-Total	46,305	990,945	$ 624,745	$ 13.49	$ 51,253,868	$ 1,106.88
Beneficiaries receiving Family Health Benefits (excludes prescriptions under Special Support)						
Under 65	42,571	218,861	$ 2,330,426	$ 54.74	$ 4,311,646	$ 101.28
65 and over	56	1,095	18,325	327.23	15,569	278.02
Sub-Total	42,627	219,956	$ 2,348,751	$ 55.10	$ 4,327,215	$ 101.51
Beneficiaries receiving Income Supplements (SIP & GIS not covered under Special Support)						
Under 65	1,869	28,498	$ 589,082	$ 315.19	$ 334,276	$ 178.85
65 and over	23,520	553,035	9,572,119	406.98	7,828,483	332.84
Sub-Total	25,389	581,533	$ 10,161,201	$ 400.22	$ 8,162,759	$ 321.51
Other Drug Plan Beneficiaries (families whose Income Supplement coverage or special support benefits ended by fiscal year end)						
Under 65	381,909	2,767,526	$ 91,106,547	$ 238.56	$ 1,607,759	$ 4.21
65 and over	52,420	1,051,310	33,730,915	643.47	840,035	16.03
Sub-Total	434,329	3,818,836	$ 124,837,462	$ 287.43	$ 2,447,794	$ 5.64
Grand Total	638,637	9,364,871	$ 193,990,369		$ 181,288,493	

1 Refers to Formulary and Exception Drug Status drugs.

2 Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee, less the portion paid by consumers; such as deductibles, co-payments, prescription charges and the full cost if not income tested.

3. 2005-06 Utilization by Families

Tables 4, 5, and 6 show the breakdown of prescription utilization, family cost, and government cost for all families using one or more prescriptions in the fiscal year by three categories of families:

1. Families that applied for Special Support and were granted a reduced co-payment because their annual drug costs exceeded 3.4% of their annual family income;

2. Families exempt from a co-payment program. (e.g. some Saskatchewan Assistance Plan families, SAIL beneficiaries, Palliative Care, children of families approved for Family Health Benefits);

3. Families Receiving Income Supplements, and not income-tested. Families included in this table are:

    - Those that have a $100 semi-annual deductible because they are adults of families approved for Family Health Benefits (FHB), single seniors and senior families receiving the Saskatchewan Income Supplement (SIP), or those receiving the federal Guaranteed Income Supplement (GIS) and residing in a nursing home.

    - Those that have a $200 semi-annual deductible because they receive GIS.

    - Those that paid the full cost of prescriptions who did not apply for the income-based Special Support Program.

In 'Families Approved under the Special Support Program' (Table 4), 63,143 families who had high drug costs in relation to their income received $115 million in benefits, which equals an average payment of $1,822.80 per family, an increase of 1.7% over the previous year.

In 'Prescription Cost to Families Exempt from being Income Tested' (Table 5), the average payment on behalf of each active family was $968.40, an increase of 2.8% over the previous year.

In 'Prescription Cost to Families Receiving Income Supplements, and Not Income Tested' (Table 6), the average payment on behalf of each active family was $36.03.

Table 4

Prescription Cost to Families Approved Under Special Support Program

April 2005 - March 2006

Cost to Family Unit	Number of Family Units	Number of Prescriptions [1]	Drug Material Cost [2]	Approved Prescription Cost	Net Family Payments [3]	Total Drug Plan Payment [4]
$ 00.01 - 25.00	1,398	16,838	$ 541,839	$ 664,465	$ 6,457	$ 658,009
25.01 - 50.00	672	14,024	517,428	617,681	24,663	593,018
50.01 - 75.00	626	14,239	514,263	617,466	39,248	578,218
75.01 - 100.00	596	13,282	507,515	603,128	51,827	551,302
100.01 - 125.00	579	13,647	520,953	620,594	65,010	555,584
125.01 - 150.00	626	16,265	571,937	691,290	85,993	605,297
150.01 - 175.00	605	16,978	673,389	796,705	98,255	698,450
175.01 - 200.00	641	20,085	979,872	1,126,337	120,004	1,006,333
200.01 - 250.00	1,403	46,207	1,789,807	2,126,218	316,663	1,809,555
250.01 - 300.00	1,849	67,865	2,503,382	3,002,585	510,657	2,491,928
300.01 - 350.00	2,272	93,817	3,105,534	3,795,898	741,398	3,054,500
350.01 - 400.00	2,887	132,620	4,180,548	5,159,308	1,085,611	4,073,697
400.01 - 450.00	3,601	181,364	5,677,654	7,028,808	1,530,589	5,498,220
450.01 - 500.00	3,567	191,899	6,084,215	7,510,338	1,692,503	5,817,836
500.01 - 600.00	6,058	341,439	11,152,711	13,676,225	3,319,058	10,357,167
600.01 - 725.00	5,972	363,195	12,301,669	14,968,877	3,944,773	11,024,105
725.01 - 850.00	4,991	328,520	11,113,377	13,521,446	3,921,523	9,599,923
850.01 - 1000.00	4,712	332,406	11,795,692	14,187,165	4,344,677	9,842,488
1000.01 - 1250.00	5,967	428,506	16,135,155	19,191,620	6,670,820	12,520,799
1250.01 - and over	14,121	1,120,405	53,364,310	61,208,913	27,448,483	33,760,430
All	63,143	3,753,601	$ 144,031,250	$ 171,115,068	$ 56,018,211	$ 115,096,857

1 Refers to Formulary and Exception Drug Status drugs.

2 Includes mark-up on drug acquisition cost.

3 Net Family Payments is the total cost paid by families granted a reduced co-payment.

4 Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee; less portion paid by consumers; such as deductibles, co-payments, prescription charges and the full cost if not income tested.

Table 5
Prescription Cost to Families Exempt from being Income-tested

April 2005 - March 2006

Cost to Family Unit	Number of Family Units	Number of Prescriptions[1]	Drug Material Cost [2]	Approved Prescription Cost	Net Family Payments [3]	Total Drug Plan Payment [4]
$ NIL	37,632	671,494	$ 31,554,768	$ 36,651,228	$ -	$ 36,651,228
00.01 - 25.00	11,426	100,651	2,657,566	3,421,543	101,557	3,319,985
25.01 - 50.00	3,036	76,416	2,836,865	3,418,922	110,768	3,308,154
50.01 - 75.00	1,528	58,930	2,252,781	2,707,112	94,836	2,612,276
75.01 - 100.00	1,003	52,764	2,106,117	2,516,037	87,054	2,428,983
100.01 - 125.00	520	34,310	1,362,547	1,643,562	58,267	1,585,296
125.01 - 150.00	388	30,848	1,208,862	1,455,682	53,192	1,402,490
150.01 - 175.00	207	19,266	720,920	870,207	33,519	836,688
175.01 - 200.00	121	13,122	486,697	591,294	22,604	568,690
200.01 - 250.00	136	17,732	647,752	788,321	30,096	758,225
250.01 - 300.00	62	9,464	378,144	449,131	16,780	432,351
300.01 - 350.00	22	4,015	173,306	203,288	7,088	196,200
350.01 and over	39	5,773	213,333	255,344	9,324	246,021
All	56,120	1,094,785	$ 46,599,659	$ 54,971,670	$ 625,084	$ 54,346,586

1 Refers to Formulary and Exception Drug Status drugs.

2 Includes mark-up on drug acquisition cost.

3 Refers to the maximum $2 per prescription charge paid by the family.

4 Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee; less portion paid by consumers; such as deductibles, co-payments, prescription charges and the full cost if not income tested.

Table 6

Prescription Cost to Families Receiving Income Supplements, and Not Income-Tested [5]

April 2005 - March 2006

Cost to Family Unit	Number of Family Units	Number of Prescriptions[1]	Drug Material Cost [2]	Approved Prescription Cost	Net Family Payments [3]	Total Drug Plan Payment [4]
$ 00.01 - 25.00	43,884	48,599	$ 281,892	$ 630,229	$ 614,127	$ 16,102
25.01 - 50.00	36,333	79,526	765,436	1,342,177	1,319,403	22,773
50.01 - 75.00	23,417	79,667	902,541	1,477,230	1,449,333	27,897
75.01 - 100.00	17,253	78,082	972,757	1,532,176	1,500,176	32,000
100.01 - 125.00	14,494	78,645	1,105,061	1,669,719	1,621,915	47,804
125.01 - 150.00	12,167	77,883	1,167,854	1,721,203	1,670,526	50,677
150.01 - 175.00	10,727	77,814	1,247,920	1,797,682	1,740,574	57,107
175.01 - 200.00	9,968	80,297	1,383,754	1,946,086	1,867,107	78,979
200.01 - 250.00	18,838	172,394	3,213,090	4,427,101	4,231,694	195,407
250.01 - 300.00	15,198	166,955	3,218,915	4,404,590	4,158,845	245,746
300.01 - 350.00	11,844	154,431	3,045,569	4,139,019	3,836,090	302,928
350.01 - 400.00	9,896	144,415	3,020,857	4,042,961	3,707,002	335,960
400.01 - 450.00	8,608	139,113	3,059,541	4,043,594	3,654,861	388,733
450.01 - 500.00	7,838	139,142	3,172,687	4,153,224	3,718,113	435,112
500.01 - 600.00	13,974	276,333	6,675,406	8,641,407	7,659,863	981,544
600.01 - 725.00	13,638	318,372	8,045,877	10,312,059	8,999,409	1,312,650
725.01 - 850.00	10,708	284,367	7,638,194	9,658,408	8,406,792	1,251,615
850.01 - 1000.00	10,161	304,668	8,529,092	10,690,114	9,368,587	1,321,529
1000.01 - 1250.00	12,390	422,564	12,530,997	15,518,843	13,835,282	1,683,561
1250.01 - and over	27,406	1,393,218	47,268,350	57,070,391	54,013,465	3,056,926
All	328,742	4,516,485	$ 117,245,789	$ 149,218,211	$ 137,373,162	$ 11,845,050

1 Refers to Formulary and Exception Drug Status drugs.

2 Includes mark-up on drug acquisition cost.

3 Net Family Payments is the full cost of prescriptions for those families who are not income-tested, and is the net cost to an Income Supplement family for the total of the deductible and the family co-payment once the deductible has been met.

4 Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee; less portion paid by consumers; such as deductibles, co-payments, prescription charges and the full cost if not income tested.

5 Includes beneficiaries covered under the semi-annual Income Supplement deductibles, and those families who are not income-tested to receive benefits

4. 2005-06 Utilization by Pharmacologic - Therapeutic Classification

Table 7 shows prescription volume and Drug Plan expenditures by Pharmacologic - Therapeutic Classification. Four categories; Central Nervous System (CNS) Drugs, Cardiovascular Drugs, Hormones and Substitutes and Anti-Infectives, accounted for 69.0% of all prescriptions and 57.6% of the Drug Plan payment.

Table 7
Prescriptions by Pharmacologic - Therapeutic Classification

Pharmacologic - Therapeutic Classification [1]	Number of Prescriptions [2]	Drug Material Cost [3]	Total Drug Plan Payment
April 2005 - March 2006			
As submitted for all beneficiaries			
8:00 Anti-Infectives	692,269	$ 11,886,668	$ 6,794,751
10:00 Antineoplastic agents	835	127,660	104,890
12:00 Autonomic Drugs	301,281	10,168,889	6,609,767
20:00 Blood Formation and Coagulation	218,165	9,547,260	7,351,620
24:00 Cardiovascular Drugs	2,736,693	98,611,144	44,989,486
28:00 Central Nervous System Drugs	1,875,368	59,794,964	39,416,972
36:00 Diagnostic Agents	129,339	9,827,671	5,385,438
40:00 Electrolytic, Caloric, and Water Balance	525,307	2,546,300	3,082,372
48:00 Cough Preparations	366	163,512	163,404
52:00 Eye, Ear, Nose and Throat Preparations	306,854	7,739,621	3,104,682
56:00 Gastrointestinal Drugs	479,656	18,112,035	11,088,448
60:00 Gold Compounds	270	13,008	7,360
64:00 Metal Antagonists	313	100,479	94,425
68:00 Hormones and Substitutes	1,132,470	27,309,577	13,204,359
84:00 Skin and Mucous Membrane Preparations	273,494	6,040,308	2,317,169
86:00 Spasmolytics	47,823	1,030,465	806,681
88:00 Vitamins	79,673	237,382	395,550
92:00 Unclassified and others	564,695	44,619,125	36,371,121
Total	9,364,871	$ 307,876,069	$ 181,288,493

1 The drug classification system used is that of the American Hospital Formulary Service

2 Refers to Formulary and Exception Drug Status drugs.

3 Includes Mark-up on drug acquisition cost.

Figure 2 shows the Table 7 prescription volume by Pharmacologic – Therapeutic Classification.

Figure 2
Prescription Volume by Pharmacologic - Therapeutic Classification

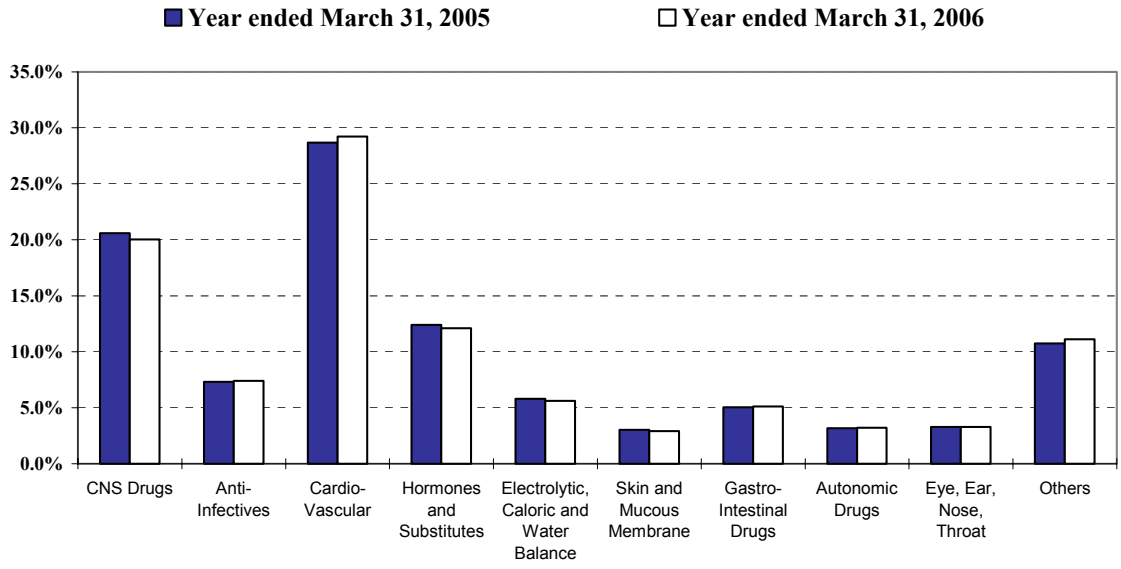


Table 8 & 9

Table 10

Table 10 – Page 2

Table 10 – Page 3

2005-2006 Utilization Trends

1. Cost to Beneficiaries

Trend information from Table 11 for the past four years shows that the number of active beneficiaries has remained fairly constant while the number of prescriptions and total prescription cost is increasing.

	Active Beneficiaries	Number of Prescriptions	Total Cost of Prescriptions	Total Drug Plan Payment
1995-96	633,333	5,798,090	$157,194,207	$ 59,492,033
1996-97	626,953	5,996,106	$162,165,923	$ 61,863,705
1997-98	620,258	6,261,167	$171,208,698	$ 65,199,190
1998-99	633,020	6,622,455	$189,003,078	$ 75,892,289
1999-00	633,259	7,014,580	$204,982,067	$ 85,368,696
2000-01	633,698	7,534,187	$232,474,567	$ 98,907,678
2001-02	629,090	7,979,826	$261,413,126	$114,865,694
2002-03	620,866	8,350,855	$297,844,480	$132,274,241
2003-04	623,914	8,641,855	$327,787,913	$149,163,934
2004-05	625,924	8,919,090	$346,752,834	$164,410,108
2005-06	638,637	9,364,871	$375,304,926	$181,288,493

Table 11 was prepared to highlight three factors that might contribute to the increased growth: number of prescriptions per beneficiary; average prescription cost; and cost of prescriptions per beneficiary.

In Table 11, the total cost of prescriptions per active beneficiary has grown an average of 11.9% between 2003-04 and 2005-06 for all beneficiaries. The range of increases, based on age, was 6.3% to 13.4%.

The cost of prescriptions per beneficiary increased for all age groups from both an increased average prescription cost and increased number of prescriptions per beneficiary.

TABLE 11

2. Costs by Therapeutic Classification

Table 12 shows the cost of drugs covered by the Drug Plan by therapeutic classification.

During the three-year period from 2003-04 to 2005-06, the total cost of all prescriptions increased from 1.8% to 26.1% for the following reasons:

- Autonomic Drugs increased the most due to a combination of a 14.4% increase in average prescription cost and a 10.2% increase in the number of prescriptions.

- The next greatest increase was for Cardiovascular Drugs due to a combination of a 14.4% increase in the number of prescriptions and a 5.2% increase in average prescription cost.

- Diagnostic Agents showed an increase of 18.8% as a result of a 14.1% increase in the number of prescriptions and an increase in average prescription cost of 4.1%.

- Eye, Ear, Nose, and Throat Preparations showed an increase of 16.9% in total prescription cost as well as an increase of 8.6% in average prescription cost and a 7.6% increase in the number of prescriptions.

- The total prescription cost of Anti-Infectives increased by 12.8% as a result of a 5.0% increase in the number of prescriptions and a 7.4% increase in the average prescription cost.

- The total prescription cost of Hormones and Substitutes increased by 10.6% as a result of a 8.8% increase in average prescription costs and a 1.7% increase in the number of prescriptions.

- Skin & Mucous Membrane Preparations increased by 4.9% due to both an increase in the number of prescriptions and the average prescription cost of 0.5% and 4.4% respectively.

- Central Nervous System Drugs showed an increase of 4.4% due to a 4.1% increase in the number of prescriptions and a 0.3% increase in the average prescription cost.

- Electrolytic, Caloric and Water Balance showed a 3.3% increase in total prescription cost and a 5.7% increase in average prescription cost while showing a decrease in number of prescriptions.

- Gastrointestinal Drugs showed a 1.8% increase in total prescription cost and a 11.7% increase in the number of prescriptions while showing a 8.9% decrease in average prescription cost.

Table 12

Table 13

Supplementary Health and Family Health Benefits

BACKGROUND

- On April 1, 1966 the Saskatchewan Assistance Plan was instituted. Several categories of beneficiaries under the Medical Services Division were combined into one program with the basis of need becoming the criteria to determine eligibility.

- On September 1, 1968 coverage for refractions was moved to the Saskatchewan Medical Care Insurance.

- On September 1, 1975 payment responsibility of formulary drugs and of prosthetic and orthotic appliances for Social Assistance beneficiaries was taken over by the Saskatchewan Prescription Drug Plan and by the Saskatchewan Aids to Independent Living respectively.

- On July 1, 1981 program eligibility was expanded to include benefits for non-recipients of Social Assistance receiving level 2, 3,and 4 Special Care Home or long term hospital care where incomes are at or below the Saskatchewan Income Plan level.

- On May 1, 1984 responsibility for emergency medical transportation costs by road ambulance and Saskatchewan Government air ambulance for Supplementary Health beneficiaries was transferred from the Department of Social Services.

- On June 1, 1992 eye examinations were added to coverage for Supplementary Health beneficiaries over the age of 17, and for adults receiving the Family Income Plan and the Saskatchewan Income Plan supplements.

- On September 8, 1992 services of chiropractors became fully covered for Supplementary Health, Family Income Plan and Saskatchewan Income Plan beneficiaries.

- On June 30, 1993 Supplementary Health began providing dental coverage for children in families that received the Family Income Plan supplement.

- On May 1, 1997 began providing all Supplementary Health Benefits for children in Family Income Plan families.

- On August 1, 1998 began providing Family Health Benefits for families who received the Saskatchewan Child Benefit and/or the Saskatchewan Employment Supplement. Family Income Plan recipients became part of Family Health Benefits.

OBJECTIVES

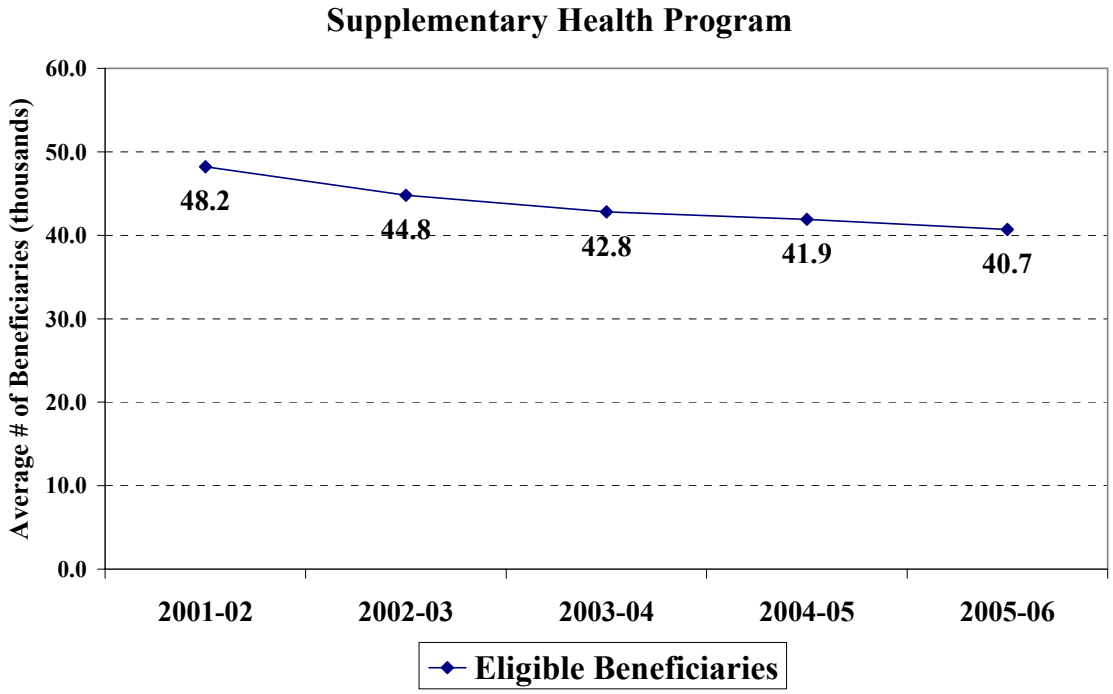
To provide for payment of accounts for non-insured health services to people nominated for coverage by the Department of Community Resources.

ELIGIBLE BENEFICIARIES

The Supplementary Health program provides benefits for the following types of beneficiaries:

- Supplementary Health beneficiaries:
  - Saskatchewan Assistance Plan recipients nominated by the Department of Community Resources.
  - Government Wards
  - Inmates of correctional institutions.
  - Nominated persons 65 years and older who are in special care homes or hospitals and whose income is at or below the Saskatchewan Income Plan level.

- The Family Health Benefits Program provides benefits for families with at least one child under the age of eighteen who may be receiving the Saskatchewan Child Benefit, the Saskatchewan Employment Supplement or the National Child Benefit.



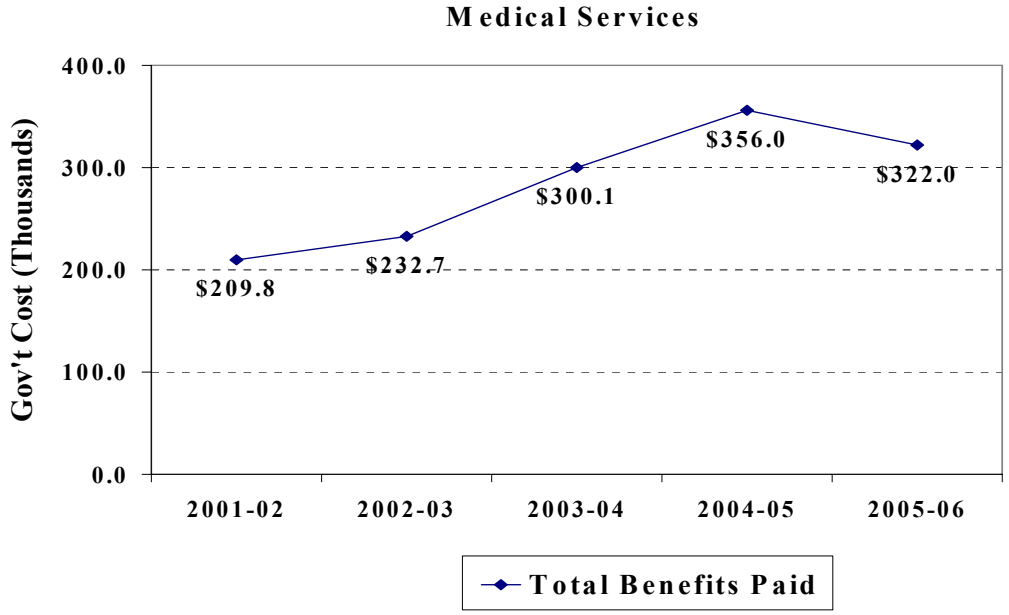
The above chart shows on average, 40,708 persons receiving full Supplementary Health benefits. Families receiving Family Health Benefits or SIP income supplements receive only partial Supplementary Health benefits and are not included in the numbers above.

During 2005-06, the average number of families eligible for Family Health Benefits was 21,418. This includes 26,691 adults and 35,761 children.

Table 14

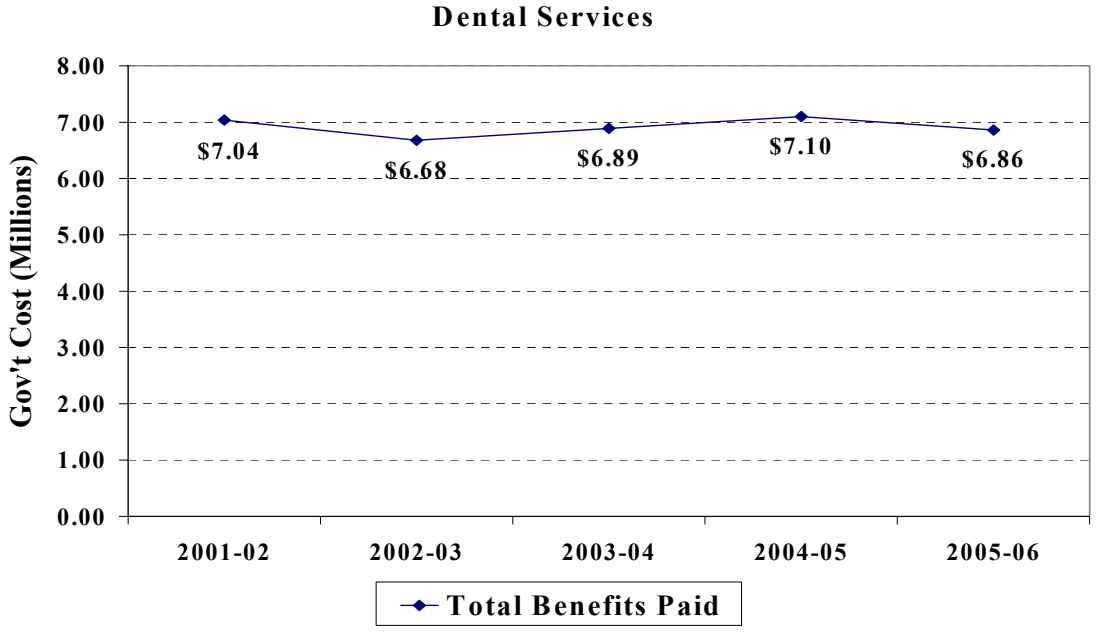
1. Medical Services

Supplementary Health and Family Health Benefits pays the cost for non-insured third party medical examinations and reports requested by the Department of Community Resources. These examinations are to determine the level of required nursing care, rehabilitation potential and employability.



2. Dental Services

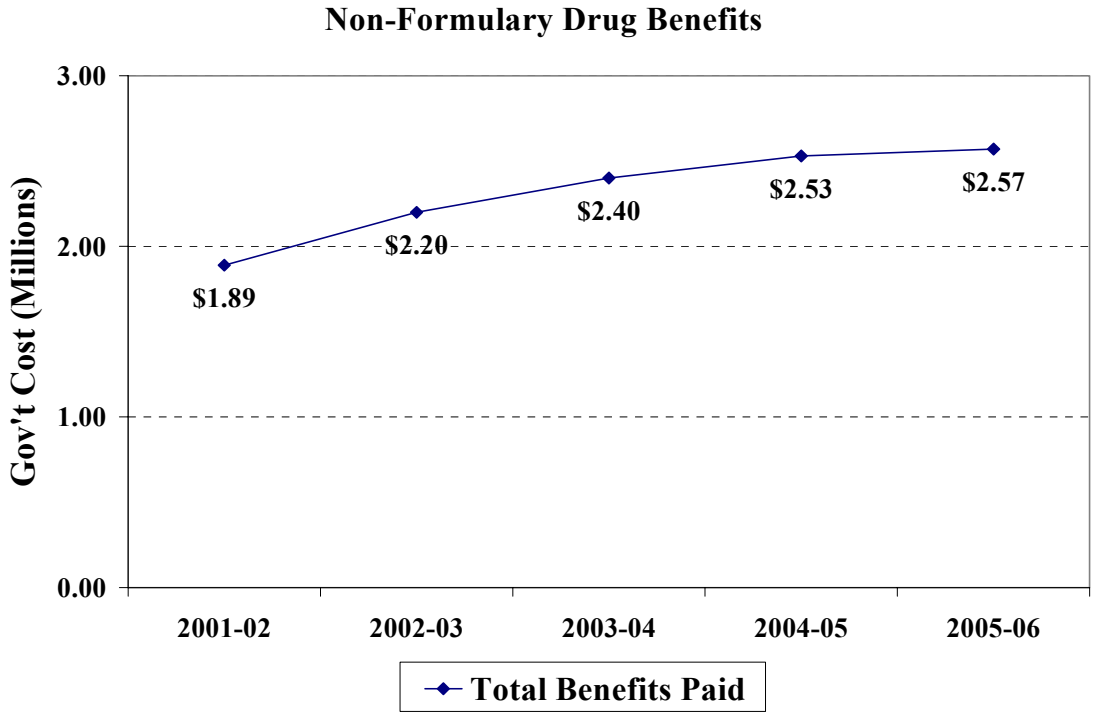
Coverage includes preventive, restorative, exodontic, and prosthetic dentistry for eligible beneficiaries. Only children are eligible for Family Health Benefits coverage.



3. Non-Formulary Drug Benefits

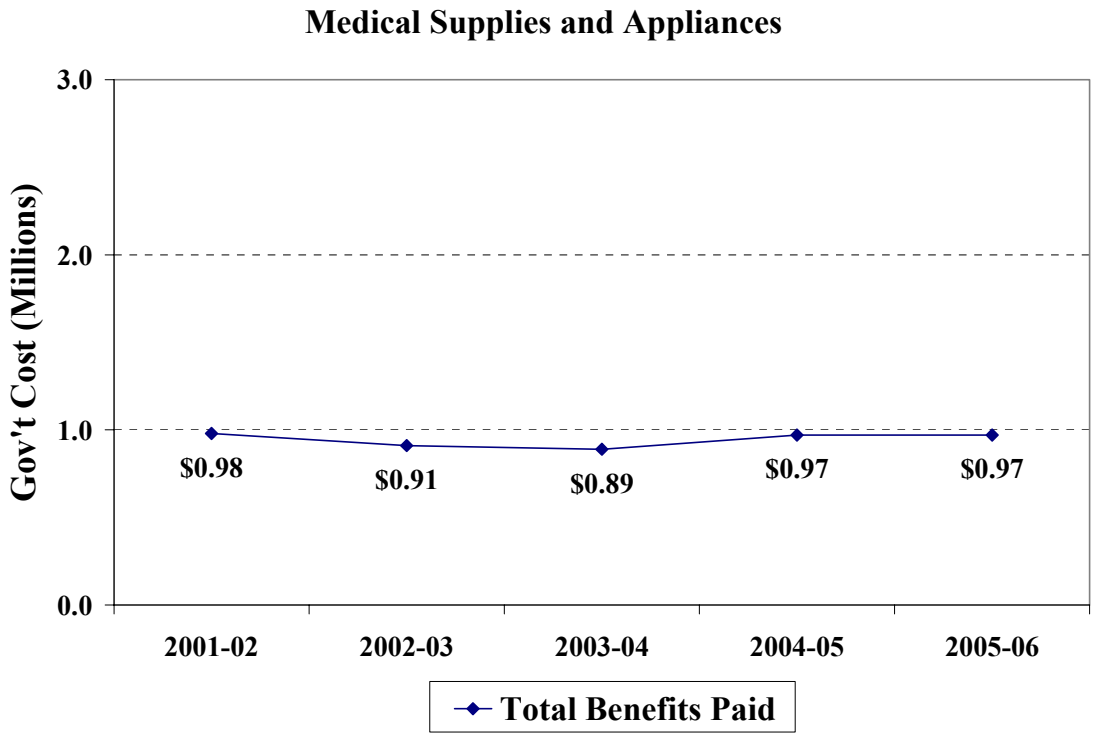
Supplementary Health provides certain non-Formulary drugs without charge for Plan Three residents in nursing and approved community homes, government wards and provincial correctional centre inmates. Formulary and non-Formulary drug benefits for the different levels of Social Assistance Plan coverage are outlined earlier in the report on page 9.

Coverage may also be granted in unusual circumstances for Plan One and Two beneficiaries where drug requirements are not met by Formulary drugs or products approved under Exception Drug Status.



4. Medical Supplies and Appliances

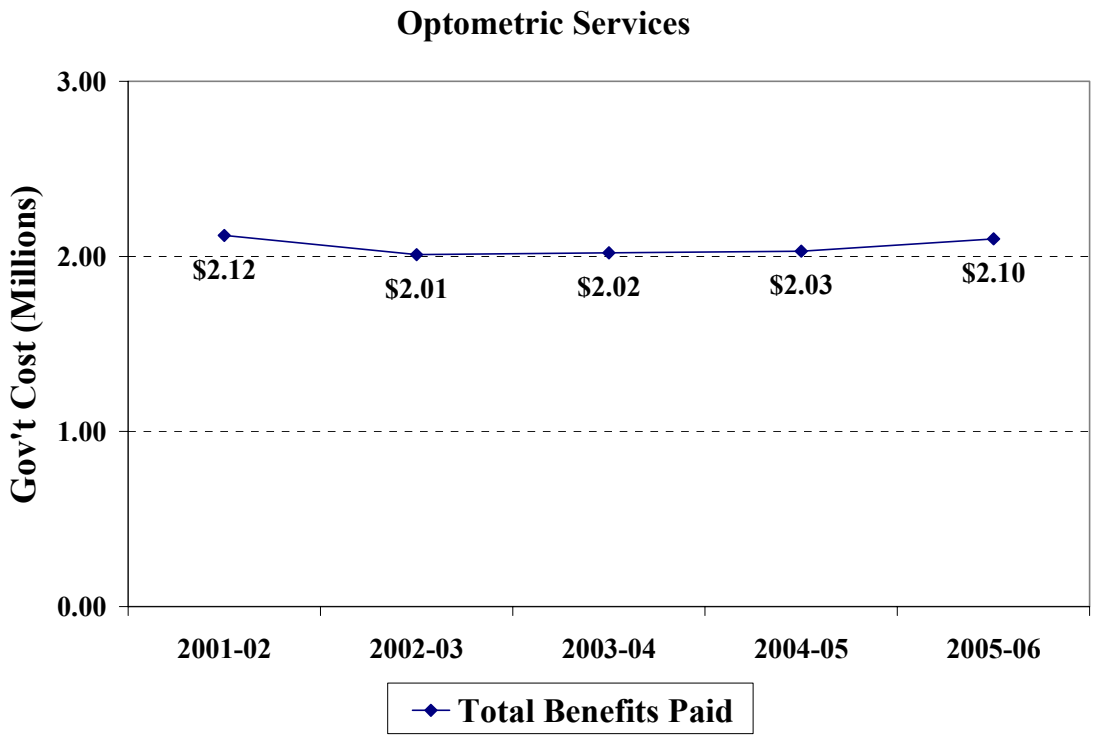
Supplementary Health and Family Health Benefits covers the full cost of most medical supplies and appliances prescribed by a physician for covered beneficiaries.



5. Optometric Services

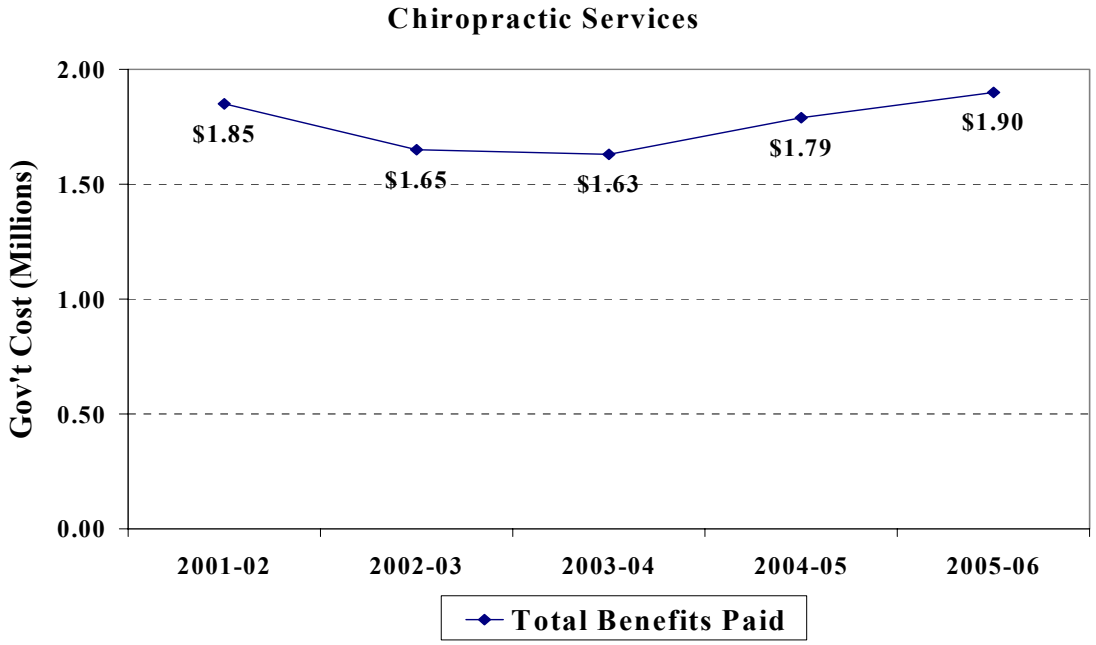
Eyeglasses are covered for Supplementary Health beneficiaries and children of families approved for Family Health Benefits, whether provided by an optometrist or ophthalmic dispensary. Payment is made on the basis of laboratory costs plus a dispensing fee. Fees are paid according to negotiated payment schedules. There is an upper limit on the amount paid for eyeglass frames.

The cost of eye examinations is covered for all Supplementary Health beneficiaries age 18 and over. Children are covered on a universal basis by the Medical Services Branch.



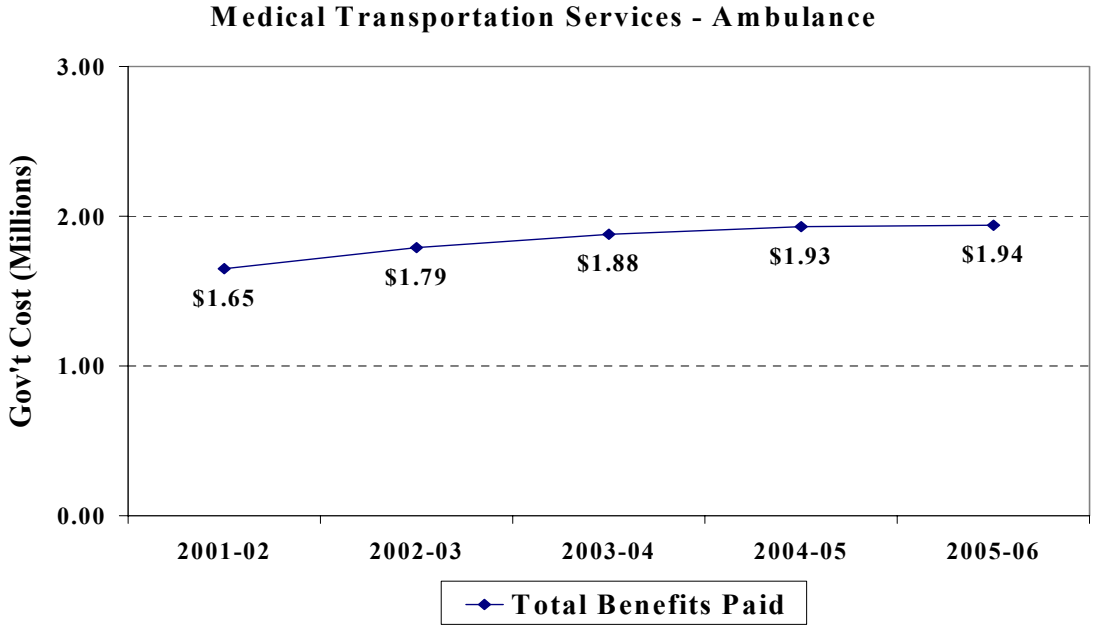
6. Chiropractic Services

The services of chiropractors are fully covered for Supplementary Health, Family Health Benefits and Saskatchewan Income Plan beneficiaries.



7. Medical Transportation – Ambulance

Benefits include coverage for emergency medical transportation by road ambulance.



8. Medical Transportation – Northern Medical Transportation Program

This Program supports:

- emergency medical evacuation from sites in the North for Saskatchewan residents; and
- non-emergent medical transportation for Supplementary Health beneficiaries and Family Health Benefits children, residing in the North.

During 2005-06 the costs of the medical transportation for the Northern Medical Transportation Program was $2.5 million.

Saskatchewan Aids to Independent Living (SAIL)

BACKGROUND

- SAIL began providing benefits on April 1, 1975, to eligible residents for prosthetic/orthotic devices.

- On August 1, 1975 SAIL benefits expanded to provide equipment loans and equipment repairs for all residents of the province.

- On April 1, 1976 SAIL took over responsibility for: the Paraplegia Program which covers the cost of appliances recommended by the attending physician; the Cystic Fibrosis Program which provides drugs and special appliances for certain beneficiaries; and the Chronic End Stage Renal Disease Program which provides assistance with the cost of necessary medications for certain beneficiaries.

- In 1979-80 the Ostomy and Home Hemophilia programs were added.

- In 1984-85 coverage expanded to include aids and services required by the blind residents in the province.

- In June 1987 the responsibility for the acquisition, distribution and repair of Special Needs Equipment (eg. wheelchairs, patient lifts, etc.) was transferred to the Saskatchewan Abilities Council. SAIL continues to fund the full cost of the program.

- In August 1987 took over administration of the Home Oxygen Program from the Drug Plan.

- In September 1987 responsibility for the acquisition, distribution and repair of equipment required by the blind was transferred to the Canadian National Institute for the Blind (CNIB). SAIL continues to provide funding to CNIB for delivery of these services.

- In 1996-97 benefits under the Home Oxygen program were granted according to certain medical criteria.

- In 2003-04 the Nutritional Products program was added to assist with the incremental cost associated with using nutritional products in place of a regular diet.

TABLE 15

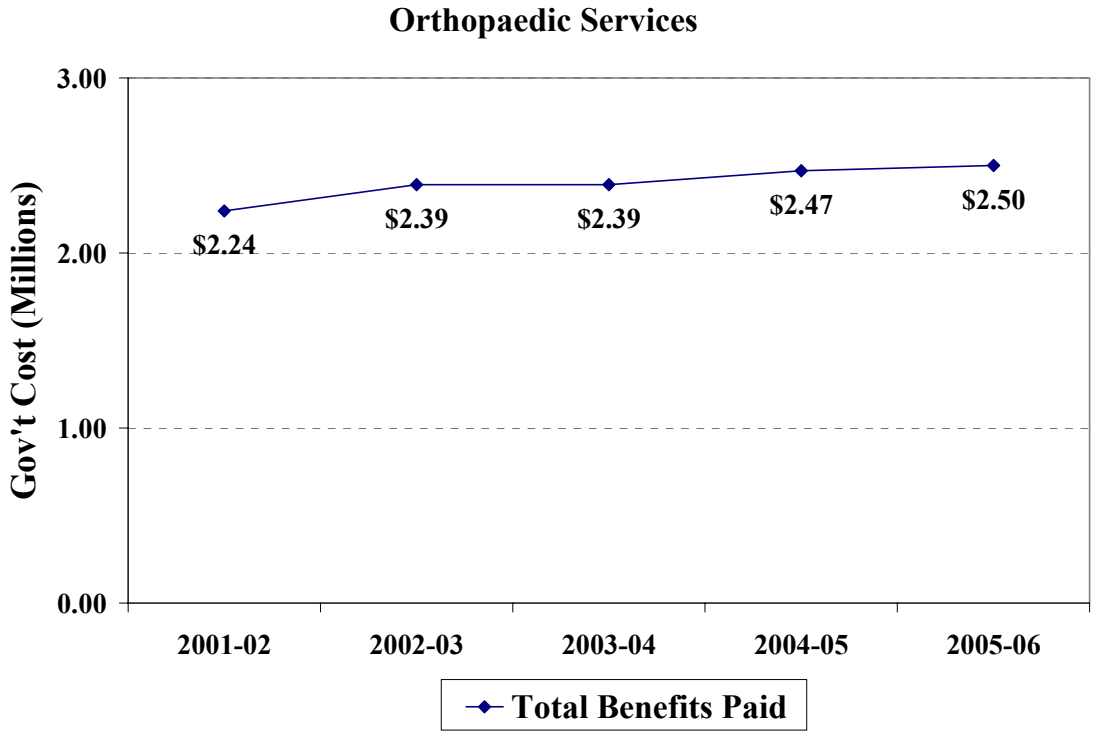
1. Orthopaedic Services

Prosthetic Appliances – Artificial limbs and accessories are supplied, fitted, adjusted and repaired without charge.

Orthotic Appliances – Higher-cost back braces, knee braces and splints are supplied, fitted, adjusted, and repaired without charge.

Specialized and adaptive seating, and custom-built footwear are also provided by SAIL. All of the above services are supplied by the orthotics and prosthetics departments of the Wascana Rehabilitation Centre in Regina and the Saskatchewan Abilities Council in Saskatoon.

Custom pressure or burn garments are supplied and fitted without charge. SAIL arranges for the supplier to provide garments.

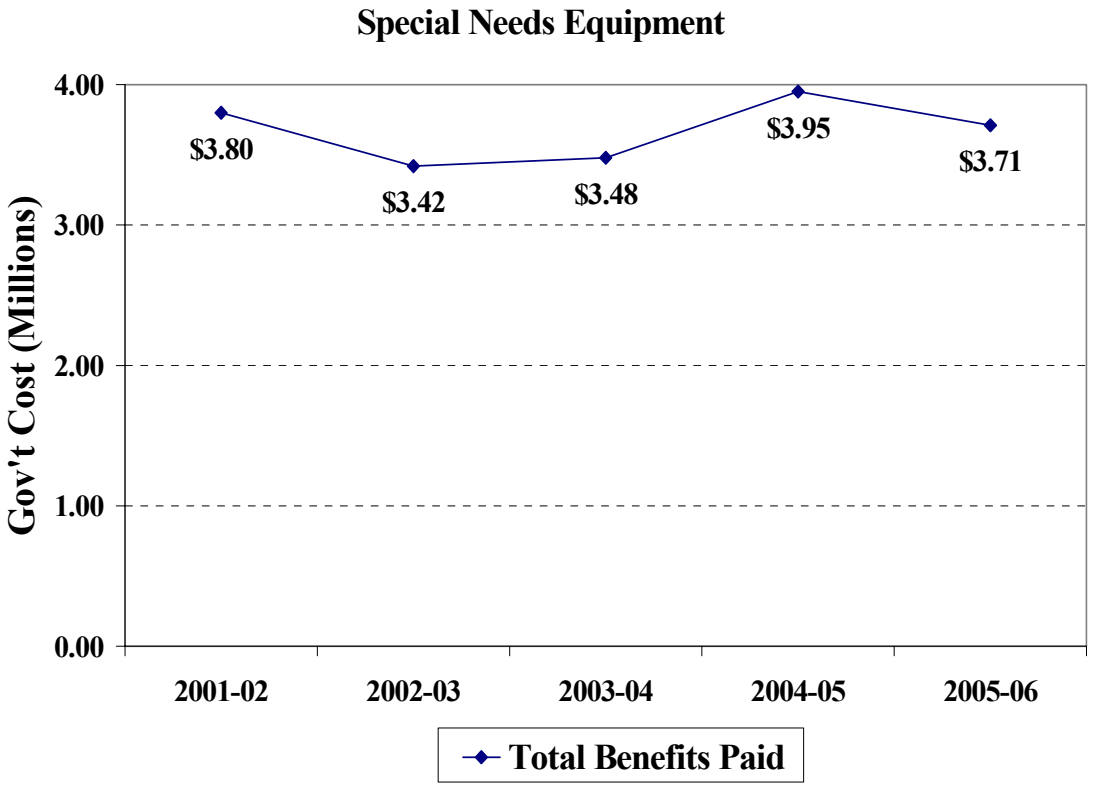


1. Special Needs Equipment

Mobility Aids – Wheelchairs, walkers, and specialized crutches are loaned, maintained and repaired without charge. Eligibility is assessed based on long-term need.

Environmental Aids – Higher-cost equipment such as hospital beds and accessories, transfer assists and commodes are loaned, maintained and repaired without charge. Eligibility is assessed based on long-term need.

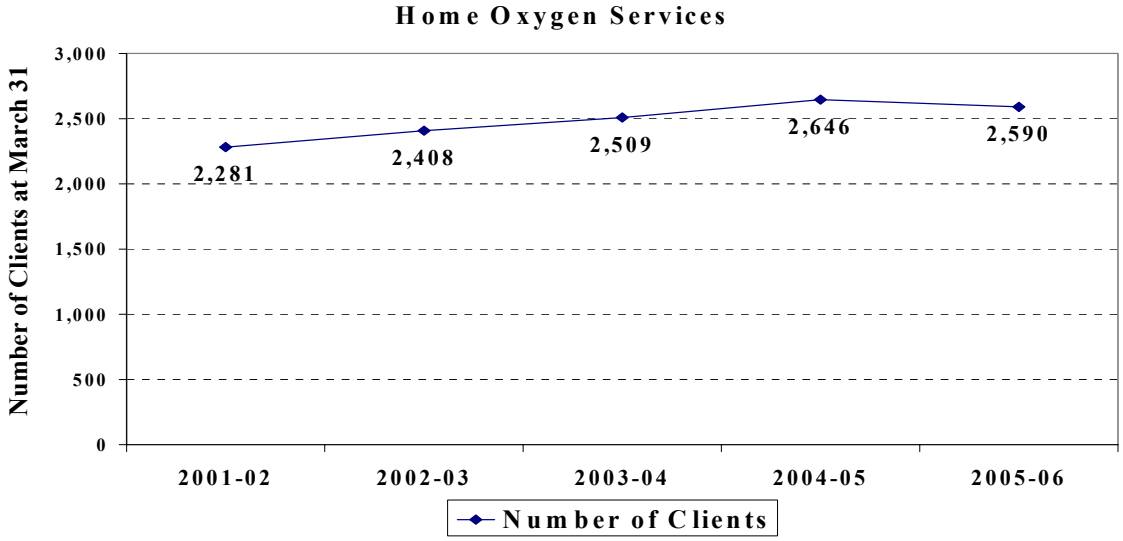
The Special Needs Equipment Program is operated by the Saskatchewan Abilities Council under contract with SAIL. Equipment depots are located in Prince Albert, Regina, Saskatoon, Swift Current and Yorkton.

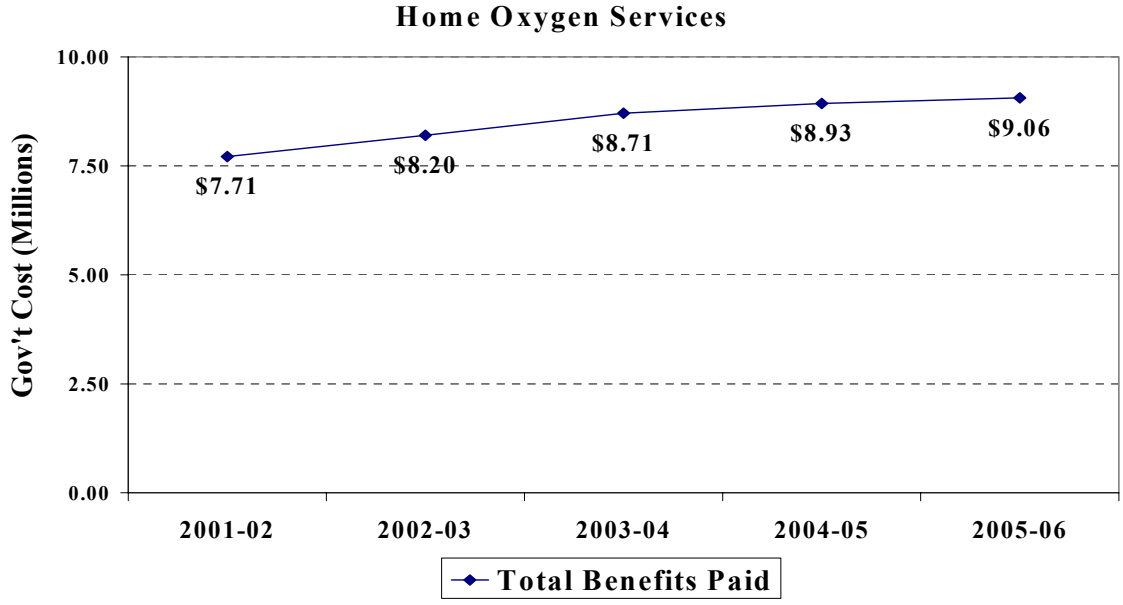


3. Home Respiratory Services

Home Oxygen Therapy – Home oxygen and related equipment are benefits under SAIL for Saskatchewan residents who meet medical criteria. The systems are supplied by private medical oxygen supply firms under contract with SAIL.

Respiratory Equipment – SAIL shares the purchase cost of aerosol therapy compressors for eligible beneficiaries, who are responsible for maintenance and repairs. Home respiratory equipment such as ventilators, continuous positive airway pressure (CPAP) units, suction pumps, and tracheostomy humidification packs are loaned, maintained and repaired without charge. Eligibility is based on specific medical criteria.





4. Nutritional Products

The program assists with the cost of specialized nutritional products for persons with complex medical conditions who rely on those products as their primary nutritional source. Program benefits are cost shared between clients and Saskatchewan Health, with the patient's portion varying based on a number of factors, including family income.

The program commenced September 1, 2003. During 2005-06, 54 clients were receiving benefits with expenditures totaling $80,013.

5. Special Benefit Programs

In addition to regular SAIL Program benefits, extended coverage is provided to beneficiaries with particular disabling conditions.

Paraplegia Program – Drugs listed in the Saskatchewan Formulary, drugs approved for coverage under the Drug Plan Exception Drug Status program as well as certain non-Formulary drugs are available at no charge.

Incontinence management and dressing supplies for chronic conditions are available without charge.

Specialized rehabilitation equipment is loaned, maintained and repaired without charge. Financial assistance is also provided for vehicle hand controls, ramps and wheelchair lifts.

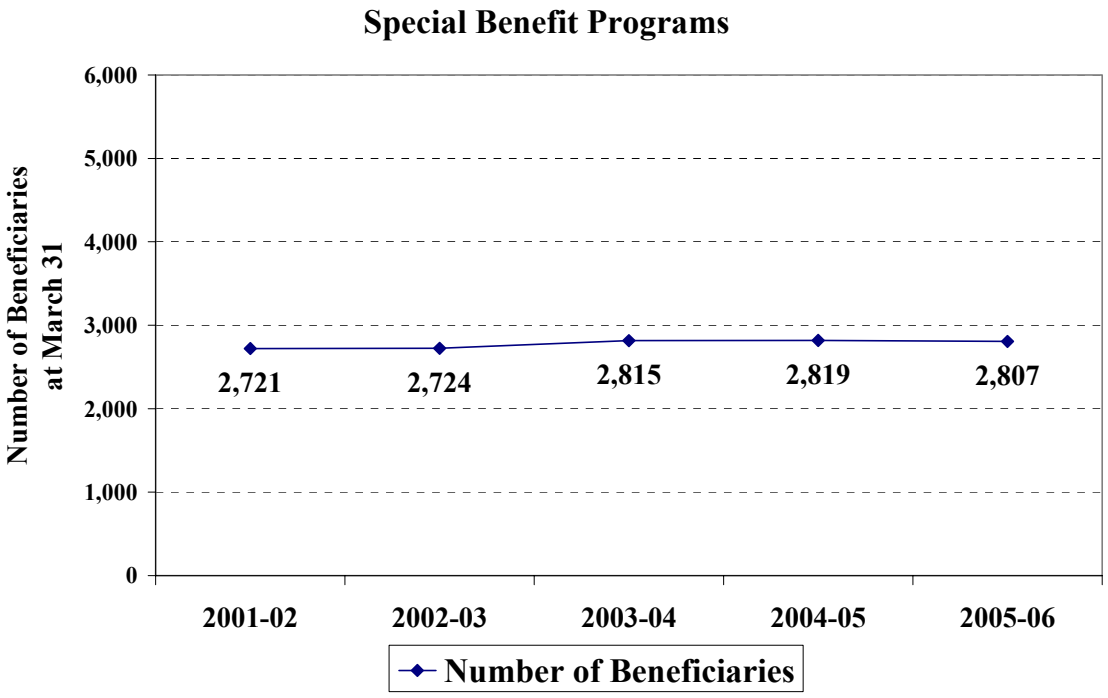
Cystic Fibrosis Program – Drugs listed in the Saskatchewan Formulary, drugs approved for coverage under the Drug Plan Exception Drug Status program as well as certain non-Formulary drugs are available at no charge. In addition, certain food supplements and digestants are covered.

End Stage Renal Disease Program – Drugs listed in the Saskatchewan Formulary, drugs approved for coverage under the Drug Plan Exception Drug Status program as well as certain non-Formulary drugs are available at no charge to persons with end-stage renal disease or renal transplant recipients.

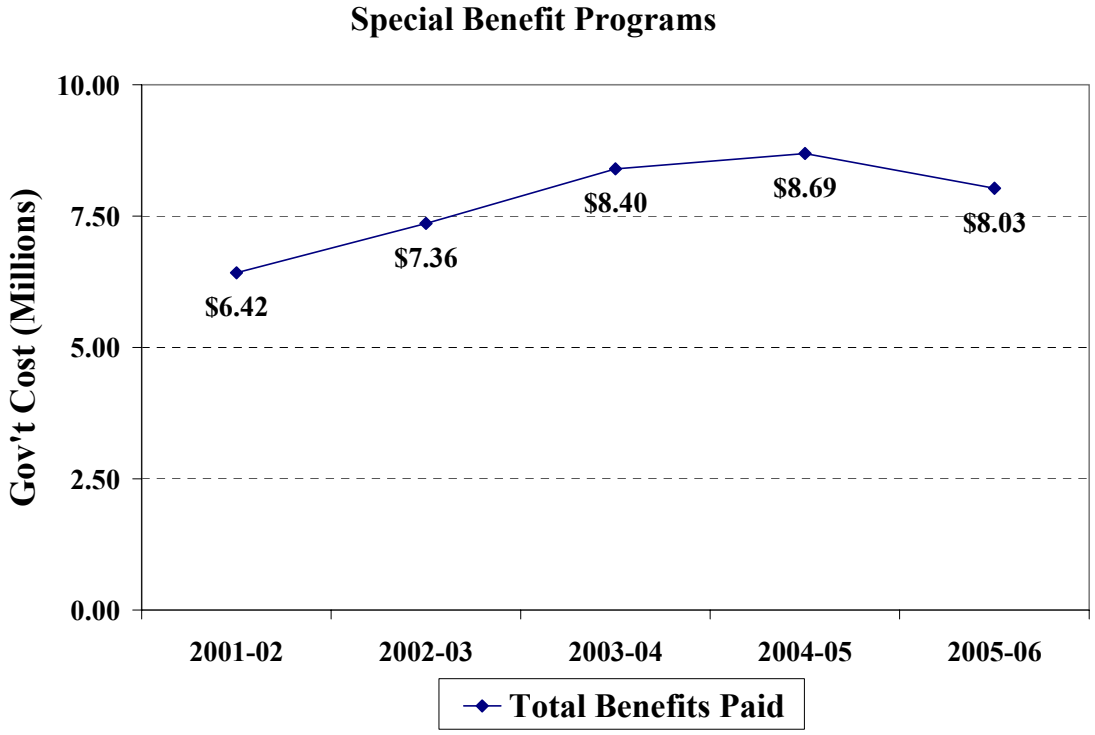
Ostomy Program – SAIL provides 50% reimbursement of certain ostomy supplies, such as appliances, adhesives and adhesive removers, to eligible persons referred by enterostomal therapists.

Aids to the Blind Program – Financial assistance is provided for aids such as braille watches, talking calculators and low-vision eyewear. Braillers, talking book machines, tape players and recorders are loaned, maintained and repaired without charge. Magnifiers and telescopes are supplied without charge.

Low vision eyewear is provided through optometric/ophthalmic dispensers. Equipment services are provided by the Canadian National Institute for the Blind (CNIB) under contract with SAIL.



Note: The Special Benefits Programs charts show only the number of caseloads and program expenditures for Paraplegia, Cystic Fibrosis and Renal Disease.



TABLES 16, 17, 18