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בחלק ב׳: New Drugs for Depressive and Anxiety Disorders

MONITORING PRESCRIPTION CHARGES IN CLALIT AND OTHER SICK FUNDS: THE IMPACT OF GENERICS

- הדעה הרווחת היא כי קופות החולים גובות ממבוטחיהן תשלום דומה עבור רוב התרופות. ואולם, בהתבסס על מדגם של 38 תרופות מרשם **נפוצות**, עולה כי שירותי בריאות כללית גובה ממבוטחיה 45% יותר מאשר קופת חולים מאוחדת.
- עבור כמה מתרופות המרשם הנפוצות ישלם חבר בכללית עד פי 3.5 יותר מאשר חבר במאוחדת (לדוגמה, פי 3.3 עבור האנטיביוטיקה **Augmentin/co-amoxyclav** ; פי 3.7 עבור התרופה לכיב קיבה **Losec/omeprazole**).
- התשלום במאוחדת עבור מדגם של 8 תרופות מובילות ירד במשך חמש השנים האחרונות בכמחצית, מ-238 ₪ ל-128 ש״ח. מגמה זו משקפת מדיניות ושיטת תשלום המאפשרת גם למבוטחיה ליהנות ממחירים מופחתים עובר תרופות שהפטנט שלהם פג. לעומת זאת בכללית, סך התשלומים עבור התרופות הללו ירד רק במעט, מ-233 ₪ ל-227 ש״ח.
- המחקר מצביע על כך כי לעיתים קרובות הכללית אינה מאפשרת למבוטחיה ליהנות מהמחירים המוזלים של תרופות גנריות. זאת, חרף העובדה שהכללית, בשל גודלה וכוח הקנייה שלה, נהנית יותר מאשר קופות אחרות מהנחות גדולות מספקים.
- על משרד הבריאות לנטר **יישום** מדיניות הוגנת ושוויונית של תשלומים עבור תרופות, במיוחד בקופה הגדולה בישראל, אליה משתייכים רוב הנצרכים והחלשים. רצוי שניטור מסוג זה יעשה שימוש במדגם של תרופות מרשם נפוצות ושתוצאותיו יפורסמו מפעם לפעם.
- דרושה הורדת הרמה ההולכת וגדלה של שיעור ההשתתפות של חברי קופות החולים עבור תרופות, שמגיע בכללית לשיא של 52% עבור כלל התרופות ו-43% עבור התרופות שבסל, שיעורים שהם מהגבוהים בעולם.

It should be the aim of government to ensure equal patient access to pharmaceutical benefits at prices that are the same for all. However, as discussed in an earlier ***PHARMA Bulletin***, in 2001,[1] there are two key, related issues in the way charges for prescriptions are administered in Israel: the lack of transparency, mainly in Clalit sick fund, and the problem of inequity as manifested by the "growing evidence that certain groups in the population are going without drug therapy because of the increasing burden of payments." Furthermore, "in the light of increasingly aggressive cost-sharing methods," it was argued "that it is time for a uniform, rational and transparent method of copayment to be implemented by all sick funds."

Specifically, I also drew attention to the difference in payments made before and after patent expiry of a leading frequently-prescribed drug (simvastatin). This showed that in this case Clalit, unlike the other sick funds, was continuing to charge its patients at the same level ignoring the fact that the price of the drug had declined significantly.[1]

In recent years, reports on the issue of copayments have been published by Mevaker HaMedina[2] and by the MoH's ombudswoman,[3] as well as survey-based data[4] which add to the evidence of financial inaccessibility and inequity with regard to pharmaceutical benefits. Minor amendments to widen the framework of the exemptions and refunds for prescription charges have been proposed and some have been accepted. The latest proposal considered by the previous Knesset would allow such exemptions to take into consideration family, and not just individual, expenditures on medicines. In the meantime, though, the copayment juggernaut continues uninterrupted, bringing in every year even greater revenues to the sick funds and causing large numbers of patients to forfeit medications because of the cost.

From ***PHARMA Bulletin***'s regular analyses[1,5] of the sick fund drug economy we have shown that cost-sharing has continued to grow almost unabated since the early 1990s. The drastic increases in prescription charges, approved by the Knesset in August 1998 (alongside introduction of charges for visits to specialists and for tests) caused the situation to worsen in the last several years. According to one analysis of interviews with top managers and policy-makers, "the copayment decision was not data driven because policy-makers were concerned primarily with increasing sick fund revenues."[6]

In 2003, the last year for which data is available from the MoH,[7] the revenues alone from drugs in the basket totalled NIS 1.364 billion out of a total expenditure on such drugs of NIS 3.512 billion for all sick funds i.e. patients are sharing in 39% of the acquisition costs. (According to the MoH's calculation based on undisclosed data, the share drops to 34.3% if one takes into account sick fund 'overheads'). In addition, the sick funds enjoy another NIS 724 million of non-basket drug revenues, for prescription medicines sold to patients via supplementary insurance and for non-prescription (OTC) medicines. This year, I forecast that total drug revenues collected by the sick funds from patients for drugs could reach around NIS 2.5 billion ($550 million).

With the extension of pharmaceutical benefits in the USA's Medicare programme starting in 2006, Israel may soon take over even the USA in the extent of private out-of-pocket financing of national drug expenditure.[8]

CLALIT AND THE OTHER SICK FUNDS

Clalit has a complex and non-transparent method of fixing prescription charges, based mainly on "*manot*" (i.e. number of doses) which can vary for each and every drug preparation. It also has by far the largest number of vulnerable or disadvantaged members, whether they be aged, chronically ill and/or from weaker socio-economic groups. For example, about 13% of Clalit's membership is over 65 years old, compared to about 6% in Maccabi.

The extent of cost-sharing by patients varies significantly between Clalit and the three other sick funds. In 2003, Clalit's patients contributed no less than 43.2% of the cost of the fund's acquisition of medicines in the basket, compared to 36%, 34.4% and 31.4% for Maccabi, Meuhedet and Leumit respectively. If one adds in Clalit's revenues from sale of non-basket medicines, Clalit collects over half (51.9%) of its drug acquisition expenditures from its patients. This places Clalit's patients in the number one place worldwide in out-of-pocket cost-sharing by patients among national health systems financed by "public" funds.

THE STUDY: DATA AND ANALYSES

The main **purpose** of this study is to monitor prescription charges in Clalit and other sick funds and also to assess the impact of generics on these charges. As a result, it may go some way to explain how revenues (in absolute terms) and cost-sharing (in % terms) by patients have reached such staggering levels, particularly in Clalit. It should allow policy-makers to make decisions which are also data-driven, and not just driven by political and macroeconomic considerations.

In order to do this, it was decided to identify and concentrate on a large enough sample of medicines that might be reasonably "representative" of the total volume of prescriptions and thus the total volume of prescription charges. Thirty-eight frequently or commonly prescribed prescription medicines were first

identified (see Appendix for details of the Study Method and the list of sampled drugs). All the medicines, apart from one, are in the basket and nearly all have generic versions.

Using this 38-drug sample I then identified 15 drugs for which there was significant variation in prescription charges between Clalit and other sick funds (using Meuhedet as a "surrogate" for Maccabi and Leumit due to the similar method of copayment and similar percentage charge [13.5%-15% of the ceiling price]). In addition, analysis of trends in prescription charges in Clalit and Meuhedet were carried out using a small sample of drugs for two time periods: from 1995 to 2005 and from 2000 to 2005. Lastly, an analysis was carried out to assess the impact of generic availability on prescription charges fixed by Clalit. 11 drugs out of the original 38 were identified as having moved from status of patent-only in 2000 to generic by 2005. In the case of the other sick funds with a more direct and transparent method of fixing charges, generic availability normally results in lower prescription charge. In the case of Clalit, due to its complex and non-transparent method, the impact of generic availability on prescription charges is not clear and needs to be assessed.

The next three sections describe the findings of these analyses.

COMPARING PRESCRIPTION CHARGES IN CLALIT AND MEUHEDET

Prescription payments paid by Clalit patients for 38 frequently-prescribed medications (NIS 961) total 45% more than those paid by Meuhedet patients (NIS 663) (**Table 1**).

Table 1: Payments and Cost-Sharing by Patients for 38 Frequently-Prescribed Drugs[1], by Sick Fund

Cost-Sharing[2] as % of Ceiling Prices		*Payments (NIS)*	
Meuhedet	***Clalit***	***Meuhedet***	***Clalit***
23.4	34.0	663	961

[1] See Appendix for list of drugs with charges and ceiling prices.

[2] This share is an underestimate of the true level of cost-sharing, as all sick funds benefit from discounts from suppliers and also from pharmacies.

As a share of the total of the (MoH-approved) ceiling prices for these drugs (NIS 2,828), Clalit patients contribute 34%, whereas Meuhedet patients contribute 23%. However, the real extent of cost-sharing by patients

Table 2: Differences in Charges by Sick Funds for Frequently-Prescribed Drugs[1]

Prescription Charge (NIS)		*Use of Drug*	*Higher Charge in Clalit:*
Meuhedet	*Clalit*		
12.00	44.00	antibiotic	co-amoxyclav 500mg 20 tabs
58.45	91.92	analgesic	etodolac 400mg 30 tabs[2]
12.00	24.89	antiulcer	famotidine 40mg 30 tabs
12.00	22.00	antidepressant	fluoxetine 20mg 30 tabs
40.31	133.80	antimigraine	Imitrex 50mg 6 tabs[3]
12.00	30.00	analgesic	naproxen 500mg 20 tabs
14.16	22.00	cardiovascular disease	nifedipine SR 30mg 30 tabs
19.83	66.00	antiulcer	omeprazole 20mg 30 tabs
12.00	22.00	urinary disorders	oxybutynin 5mg 30 tabs
21.71	33.00	lowers cholesterol	pravastatin 20mg 30 tabs
56.58	86.75	asthma	Seretide 50/250mg 60 doses[3]
12.00	22.00	lowers cholesterol	simvastatin 20mg 30 tabs
Higher Charge in Meuhedet:			
18.00	12.85	antidepressant	citalopram 20mg 28 tabs
21.60	14.40	antidepressant	paroxetine 20mg 30 tabs
17.60	11.70	cardiovascular disease	ramipril 5mg 30 tabs

[1] Out of a sample of 38 drugs, these drugs showed a significant variation in payments between the two sick funds.
[2] Drug is not in basket. [3] Generic versions not available.

in both sick funds is higher, as noted earlier, as a result of discounts that the sick funds obtain, mainly from suppliers but also from private pharmacies; Clalit obtains the largest discounts because of its size and centralised logistic operations.

For the majority of the 38 sampled drugs the prescription charges are quite similar in the two sick funds (see Appendix). However, the charge for almost 40% (15) of these frequently-prescribed medicines differs significantly between the two sick funds (**Table 2**). For the majority of these medicines (12), the charge in Clalit is significantly greater than that in Meuhedet.

There are substantial differences in charges for some of the leading drugs prescribed in Israel: **omeprazole** (Losec and generics), the standard treatment for ulcer, reflux disease and helicobacter pylori infection; another is the frequently-prescribed antibiotic **co-amoxyclav** (Augmentin and generics) (**Table 2**). These two examples indicate that Clalit patients could be paying up to about 3.5 times more than patients in other sick funds.

COMPARING TRENDS IN PRESCRIPTION CHARGES WITH TIME

Ten years ago in 1995, as National Health Insurance (NHI) was being introduced, we drew attention[9] to the much larger payments then being made by Meuhedet patients (NIS 676), compared to those paid by Clalit (NIS 306) based on a small sample of six drugs that at that time were all patent-protected (no generic versions) (**Table 3A**). This large variation probably reflected the pre-NHI situation when there was relatively less government regulation of sick funds in general, and almost no oversight of prescription charges. In the pre-NHI era the copayment policy was an instrument that could be used by sick funds to keep the less well-off and less healthy from joining a sick fund. In 1994 Meuhedet responded to the imminent introduction of NHI by significantly increasing copayments. In contrast, Clalit's payment policy perhaps reflected their major concern at that time of trying to stem the rapid decline in its share of total sick fund membership.

By 2005 the total payment for these same six drugs, or by now their cheaper generic equivalents, had been drastically reduced in Meuhedet (to NIS 163) whilst in Clalit it had increased somewhat (to

NIS 341) (**Table 3A**). Whereas in early 1995 Meuhedet patients were paying for these drugs more than double than those in Clalit, ten years later this has been reversed so that today Clalit patients are paying more than double than those in Meuhedet. The decline in payments made by Meuhedet's patients is even more remarkable when seen in the context of the substantial government-approved increase in prescription charges in August 1998; Meuhedet's charge was increased from 10% to 15% of the ceiling price.

On the basis of another sample of eight frequently prescribed drugs (**Table 3B**), in 2000, payments in both sick funds appeared to have converged in 2000 and were similar in aggregate; the total payment was NIS 233 in Clalit and NIS 238 in Meuhedet. However, by 2005, whereas total payments for these drugs in Clalit is almost unchanged (NIS 227), in Meuhedet it is now only about half (NIS 128). Charges for 7 out of the 8 drugs declined in Meuhedet. In Clalit the charge declined in only three cases and in one case (Augmentin) it even doubled, in spite of the availability of generic versions of this drug.

Table 3 (A & B): Changes in Prescription Charges (NIS) with Time, by Sick Fund

A: 1995 versus 2005				
Meuhedet		***Clalit***		
2005	***1995***	***2005***	***1995***	
23.00	72.00	66.00	16.50	Favoxil 100mg x 30
74.20	180.00	132.00	174.00	Imitrex 100mg x 6
21.70	63.00	33.00	33.00	Lipidal 20mg x 30
19.80	210.00	66.00	33.00	Losec 20mg x 30
12.00	69.00	22.00	16.50	Prozac 20mg x 30
12.00	82.00	22.00	33.00	Simovil 20mg x 30
162.70	**676.00**	**341.00**	**306.00**	**Total**
B: 2000 versus 2005				
Meuhedet		***Clalit***		
2005[1]	***2000***	***2005[1]***	***2000***	
12.00	19.20	44.00	21.00	Augmentin 500mg x 20
18.57	41.80	12.40	28.00	Fosalan 10mg x 30
21.70	33.80	33.00	31.50	Lipidal 20mg x 30
19.80	53.60	66.00	63.00	Losec 20mg x 30
18.00	23.00	16.50	23.00	Norvasc 5mg x 30
14.20	24.30	22.00	24.90	OsmoAdalat 30mg x 30
12.00	30.00	22.00	31.50	Simovil 10mg x 30
12.00	12.10	11.00	10.50	Vascase 10mg x 28
128.30	**237.80**	**226.90**	**233.40**	**Total**

IMPACT OF CHEAPER GENERICS ON PRESCRIPTION CHARGES IN CLALIT

In order to analyse specifically the impact of the availability of cheaper generics on prescription charges by Clalit, 11 drugs (amongst the 38 frequently-prescribed

drugs) were identified as having undergone transition from patent-protected (no generic versions available) in 2000 to one where generic versions had become available by 2005 (**Table 4**).

Table 4: Changes in Prescription Charges in Clalit with Availability of Cheaper Generic Versions

Generic Version (2005)		*Original Patent-Only (2000)*	
Charge (NIS)	***Generic***	***Charge (NIS)***	***Brand***
22.00	simvastatin 20mg x 30	63.00	Simovil 20mg x 30
33.00	pravastatin 20mg x 30	31.50	Lipidal 20mg x 30
16.50	amlodipine 5mg x 30	23.00	Norvasc 5mg x 30
11.40	ramipril 5mg x 30	10.50	Tritace 5mg x 28
22.00	nifedipine SR 5mg x 30	24.90	Osmo-Adalat 5mg x 30
66.00	omeprazole 20mg x 30	63.00	Losec 20mg x 30
25.00	famotidine 40mg x 30	31.50	Gastro 40mg x 30
44.00	co-amoxyclav 500mg x 20	42.00	Augmentin 500mg x 20
32.50[1]	etodolac 400mg x 30	47.00[1]	Etopan 400mg x 30
22.00	oxybutynin 5mg x 30	10.50	Novitropan 5mg x 20
12.40[2]	alendronate 10mg x 30	28.00[2]	Fosalan 10mg x 30

[1] Charge for patients with supplementary insurance (Mushlam) [2] Charge for patients with approval (Ishur)

In spite of the availability of cheaper generics, for 6 of the 11 drugs there was either an increase or almost no change in prescription charges in Clalit. For only 3 drugs was there a significant decline in the charge (one of which is available only via supplementary insurance) (**Table 4**). It should be noted that this analysis does not take into account **when** the prescription charge was reduced. There is some evidence that Clalit may delay reducing the prescription charge well after the introduction of generic versions and after other sick funds have done so.[1]

DISCUSSION

In the strict budgetary environment of the NHI era, sick funds have been forced to cut costs, mainly by exploiting the growing level of competition in the pharmaceutical market, especially from cheaper generics, but also from the availability of alternative "me-too" products for the same therapeutic purpose. Prices have declined with time, which benefits all the sick funds. In the case of the three smaller sick funds, the prescription charge is trans-parently a percentage of price; as a result their patients can be seen to benefit in a direct and consistent manner.

The data and analyses presented here provide evidence that the method for fixing prescription charges in Clalit often prevents patients from sharing the benefits of much lower acquisition prices for frequently-prescribed medicines. Furthermore, the non-transparency of the method hides this reality from patients (and from policy-makers?). The analysis also helps to explain the particularly high level of cost-sharing by Clalit patients.

According to a newspaper report,[10] Clalit has apparently submitted recently to the MoH a "final application to change to a method as in the other sick funds". (A request by ***PHARMA Bulletin*** for further details from Clalit was ignored.) Judging from past experience, any adjustment resulting from closed negotiations between mainly economists in the Treasury, MoH and Clalit could produce, however, a copayment system even more confusing and less transparent than the existing one.

Policy-makers and legislators should be aware of other means than those discussed up to now, that are being used to increase drug revenues from patients. One way a sick fund may continue to enjoy higher revenues than which it is entitled to, is by *delaying* the reduction of copayments for drugs that are added to the basket for the first time. Furthermore, patients of all sick funds are being penalised by multiple charges for drugs which are packed in an inappropriately small number of doses, smaller than the typical duration of therapy (e.g. 10 x amoxicillin [Moxypen] capsules 500mg, which is sufficient for only three days of antibiotic therapy). Similarly, unnecessary multiple charges result when the only available strength of the drug (e.g. a 50mg tablet) is lower than the typical dosage (e.g. 100mg).

In the broader context, policy-makers and legislators have to decide whether charges for prescriptions, over and above health taxes, are fair and equitable, and whether they are content to see them continuing to rise to USA levels of cost-sharing. If presumably this is not their intent, then the government will probably have no choice but to increase the funding of the basket of services supplied by the sick funds who have had to resort to such aggressive copayment measures.

In the meantime, prescription charges for all commonly prescribed drugs in the basket, identified as being substantially overcharged by any one sick fund, should be reduced to similar levels in the other funds as soon as possible. In the case of Clalit, this could be funded mainly, if not completely, by a modest increase in the hundreds of less frequently prescribed drugs.

Philip Sax, PhD

Postscript: Further on-going evaluation of prescription charges, based on typical costs of therapy for a leading therapeutic class of drugs, including drugs both in and out of the basket, confirms (and extends) most of the main findings of this study. Details to be published soon.

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APPENDIX

STUDY METHOD

In all 38 frequently or commonly prescribed products were identified. Many of them are leading drugs in the overall Israeli market and/or leading drugs in their therapeutic class. They were identified by the author's intimate knowledge of the Israeli pharmaceutical market supported by industry sources, prescribing physicians and community pharmacists. The purpose was to identify high volume drugs and not necessarily high-expenditure drugs. Thus the sample does not contain very expensive drugs with modest volumes, even if these drugs may be ranked high in expenditure terms. Apart from one drug (etodolac) all the drugs are in the basket; nearly all the drugs are off-patent and most have generic versions.

There are probably about 800-900 prescription drugs in regular use in the community. However, most heavy prescribing involves about 50-100 medicines only. These 38 drugs in all their various forms and versions may account for at least 50% of the total number of prescriptions (i.e. volume of prescription payments made by patients).

In most cases the medicines chosen have a variety of dosage strengths and forms. The more commonly prescribed oral dosage form and strength were selected.

Where different payment options were available (usually Meuhedet), the cheapest option was used in the calculations. Data for Meuhedet is indicative also of payments made by Maccabi members, who similarly pay 15% of ceiling price subject to a similar minimum payment; Leumit members pay slightly less (13.5% of ceiling price) and presumably their level of cost-sharing is even less than that of Meuhedet for most drugs.

Prescription Charges and Ceiling Prices of 38 Frequently-Prescribed Drugs

Ceiling Price[1]	*Prescription Charge*		
	Meuhedet[2]	*Clalit*	*drug or Brand Name*
180	27.00[2]	26.00[2]	alendronate 70mg x 4
102.30	18.00	16.50	amlopidine 5mg x 30
13.10	12.00	11.00	amoxicillin 250mg x 60ml
17.85	12.00	11.00	amoxicillin 500mg x 10
10.46	10.46	11.00	aspirin 100mg x 28
15.37	12.00	10.30	aspirin 75mg x 28
11.90	11.90	11.00	atenolol 50mg x 30
140.60	21.10	22.00	cefuroxime 500mg x 10
16.57	12.00	11.00	cephalexin 500mg x 10
119.85	17.98	11.99	citalopril 20mg x 28
64.80	12.00	44.00	co-amoxyclav 500mg x 20
11.85	11.85	11.00	diclofenac 100mg x 10
16.80	12.00	11.00	Disothiazide 25mg x 30 (hydrochlorothiazide)
13.02	12.00	11.00	Eltroxin 100mcg x 100 (thyroxine)
17.77	12.00	12.00	enalapril 10mg x 30
108.14	58.45	91.92	etodolac[3] 400mg x 30
24.89	12.00	24.89	famotidine 40mg x 30

Ceiling Price[1]	*Prescription Charge*		
	Meuhedet[2]	*Clalit*	*drug or Brand Name*
69.90	12.00	22.00	fluoxetine 20mg x 30
11.85	11.85	11.00 (x 50)	glibenclamide 5mg x 30
29.47	12.00	11.00	Gluco-Rite 5mg x 30 (glipizide)
286.75	40.31	133.80	Imitrex 50mg x 6 (sumatriptan)
25.49	12.00	11.00	Kaluril x 30 (amiloride/ hydrochlorothiazide)
203.45	30.52	33.00[2]	Lipitor (atorvastatin) 10mg x 30
11.85	11.85	7.11 (x 20)	Lorivan 50 (lorazepam)
11.85	11.85	11.00	metformin 850mg x 30
43.55	12.00	33.00	Motilium x 30 (domperidone)
30.28	12.00	30.00	naproxen 500mg x 30
94.38	14.16	22.00	nifedipine SR 30mg x 30
132.20	19.83	66.00	omeprazole 20mg x 30
26.10	12.00	22.00	oxybutinin 5mg x 30
144.15	21.62	14.40	paroxetine 20mg x 30
144.75	21.71	33.00	pravastatin 20mg x 30
106.00	17.57	11.70	ramipril 5mg x 30
377.20	56.58	86.75	Seretide Diskus 50/250mg x 60 (salmeterol/ fluticasone)
48.20	12.00	22.00	simvastatin 20mg x 30
51.20	12.00	11.00	Vascase 2.5mg x 28 (cilazapril)
83.50	12.53	11.00	Vascase Plus x 28 (cilazapril/ hydrochlorothiazide)
11.01	12.00	11.00	zopiclone 7.5mg x 20

[1] Ceiling price fixed by the MoH (the so-called Yarpa price) of the cheapest version.

[2] Charge for patient with approval (*ishur*) [3] Not in basket.