הביטאון למדיניות וכלכלת תרופות
ISRAEL DRUG BULLETIN

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SICK FUNDS AND THE ISRAEL DRUG ECONOMY: AFFORDABLE MEDICINES FOR WHOM?

- שיעור הגידול **בהוצאות** של כלל קופות החולים בסעיף התרופות ממשיך לרדת; הדבר נכון גם לגבי **העלויות נטו** (הוצאות פחות הכנסות). זאת, למרות הגדלת התקצוב עבור תרופות חדשות להכללה בסל וכן פעילותן הגוברת של קופות החולים במכירת תרופות מחוץ לסל (מרשמים ותרופות מעבר לדלפק).
- גרעין הפעילות של קופות החולים נעוץ במחויבותן לספק **תרופות-מרשם שבסל** שמומנו ציבורית. ההוצאות על תרופות אלה מהוות כ-64% מכלל הפעילות של קופות החולים בתחום התרופות. תקציבים נוספים בסך כ-700 מיליון ש״ח, בעיקר עבור תרופות-מרשם שבסל בשנים 2006 ו-2007, מהווים **כ-10% מההוצאות לשנה** על גרעין פעילות זה. ואולם תקציבים נוספים אלה אינם מיועדים למטרה זו.

ההוצאה לנפש על תרופות שבסל – כ-100$ לשנה – נמוכה מאוד בקנה מידה בינלאומי; העלות נטו לנפש לקופות החולים היא כ-56$ לשנה. בכללית, ההוצאה לנפש בכלל ועל תרופות שבסל, היא הנמוכה ביותר.

ההוצאות על תרופות שבסל מהוות 12.9% מסך ההוצאות של קופות החולים; העלויות נטו על גרעין פעילות זה מהוות 7.2% בלבד (בכללית, 5.8%).

- נראה שההוצאה הנמוכה על תרופות-מרשם נובע מ**מחירן** הממוצע הנמוך של תרופות גנריות נפוצות, ולא משיעור צריכה נמוך. נראה שבישראל העלות הממוצעת של מרשם שבסל נמוכה באופן ניכר מאשר במדינות אחרות.

בהתבסס על מדגם תרופות-סל נפוצות, מחירי המחירון הממשלתי (המשמש בסיס לקביעת התשלומים ע״י המבוטחים) היו גבוהים ב-87% בממוצע מאשר מחירי השוק ששילם מוסד בריאות בגודל בינוני ב-2006. הביטאון מציין כי גופים ציבוריים ופרטיים במדינות אחרות קראו תיגר על מעמדם המשפטי, או אחר, של ״ההסדרים״ הנוגעים להבדלים שבין מחירי המחירון למחירי השוק.

- שיעורי הגידול של **ההכנסות** מתרופות בקופות החולים גבוהים דרך קבע משיעורי הגידול של ההוצאות בסעיף זה. סך ההכנסות שמשלמים מבוטחי הקופות עבור תרופות גֶדֶל בכ-1/4 מיליארד שקל ועשוי להתקרב לכ-3 מיליארד שקל ב-2007. הקופות עושות **רווחים** ממכירת תרופות שאינן בסל. בכללית, ההכנסות לנפש מתרופות שבסל הן הגבוהות ביותר, והנמוכות ביותר במכבי. באשר להכנסות מתרופות שאינן בסל, בכללית הן שוב הגבוהות ביותר, הנמוכות ביותר במאוחדת ובלאומית.
- סך **מימון** ההוצאות על תרופות ע״י מטופלים ממשיך לגדול בלא הפרעה שנה אחר שנה: 47.0% ב-2004, עלייה מ-44.5% ב-2003, בהשוואה ל-27.2% ב-1992. ייתכן כי ב-2006, בפעם הראשונה, מימון המבוטחים הגיע ל-50% ויותר, ובכללית הוא הגיע ליותר מ-55%. באשר למימון בגין תרופות שבסל, המימון ב-2007 יעלה כנראה על 50% ועשוי להגיע ל-55% ע״י מבוטחי הכללית.
- **מסקנות:** השינויים במחיריהן של כמה תרופות שנעשו לאחרונה במחירון הממשלתי והצעת הכנסת לקבוע תקרת רבעון למשפחות, אין בהם די כדי להשפיע על הגורמים המונחים ביסוד אי-השוויון בטיפול התרופתי. גורמים אלה קשורים לא רק למחירי המחירון, אלא גם **לתשלומי המינימום הגבוהים** יחסית **ולמספר ולתדירות** המרשמים לחולה. גורם נוסף הוא העובדה כי התשלום עבור תרופות קשור **לעוצמת** הטיפול, גורם ה״מעניש״ כספית את החולים הזקוקים למינון גבוה יותר ו/או לתקופת טיפול ממושכת יותר.
- **המלצות:** פיתרון אפשרי הוא השימוש בתשלום קבוע או סטנדרטי, כפי שנהוג לגבי שירותים לא-תרופתיים. פיתרון אחר הוא מתן פטור מראש מתשלום לקשישים, לחולים כרוניים, לילדים בגיל הרך ולקבוצות סוציו-אקונומיות נמוכות. מקור למימון הפחתה אפשרית בהכנסות הקופות בעקבות שינויים במדיניות התשלומים, הוא **ייעוד** תוספת המימון הממשלתי להוספת תרופות חדשות לסל **ספציפית להוצאות על סל התרופות**.

In recent years the sick funds have attained fiscal balance. 2004 was the first year this was achieved by all four funds; it was repeated in 2005,[1] and with substantial extra State funding for updating the basket with new drugs and technologies, the expectation is that this trend continued into 2006.

At the same time, inequality of access to health services has reached worrying proportions in recent years. A particular focus of concern is the financial inaccessibility to drugs, with a high percentage of patients forfeiting prescribed and/or recommended medications. One consumer survey[2] indicates this applies to 15% of the

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general population, 19% of the chronically ill and 23% of the lowest income quintile; another survey, commissioned by the Israel Medical Association, gives 19% of the general population. [3]

A major theme of this article is that, in the drug economy, on the one hand, affordable medicines are made available to health institutions (mainly the sick funds, but also to those of the Ministry of Health [MoH]), whereas on the other hand, government appears to be incapable of ensuring that affordable medicines are available to the large and growing vulnerable sectors of the population (elderly, chronically ill, children and weaker socio-economic groups).

ANALYSING SICK FUND ACTIVITY IN THE DRUG ECONOMY

In this latest data-driven comprehensive update on the drug economy in Israel, I continue, firstly, to analyse the level and trends in aggregate sick fund expenditures on drugs supplied to outpatients in the community (excluding expenditure by hospitals). This is based on analysis of data provided by the MoH in its latest annual report of the financial activities of the sick funds.[4] I also analyse net costs: the net financial burden (expenditures less revenues) on the sick funds of their activity in the drug economy. Expenditure (and net costs) on drugs are then put within the context of total sick fund expenditures. Secondly, I consider the two elements which underpin expenditure levels and trends: actual prices and prescription volumes. Data is presented for the first time on actual institutional prices for a sample of frequently prescribed drugs. Furthermore, based on prescription volumes, I provide an estimate of average costs per prescription. Thirdly, I analyse sick fund revenues from drugs as well as the level and trends in financing by patients (i.e. ratio of revenues to expenditures). Finally, I raise a number of issues that ought to be considered in any effective reform of prescription copayment policy.

Analyses are carried out using two indicators of sick fund activity in the drug economy. The first indicator is an inclusive one (used in previous Bulletins and other publications), that reflects overall activity by the sick funds in the drug economy; it covers drugs and other (non-drug) (ציוד) supplies whether they be in the basket or not and also includes sick fund "overheads". The other indicator focuses on the core mandatory activity of sick funds: the provision of reimbursable (prescription) medicines within the National Health Insurance (NHI) basket (excludes expenditure on non-basket drugs and non-drug supplies).

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SICK FUND EXPENDITURES: OVERALL ACTIVITY

Aggregate expenditure in all sick funds grew by 5% in 2004, to reach NIS 4.92 billion, and by 6.5% p.a. on average during 2001-2004 (Table 1). Thus the long-term trend of declining growth rate in expenditure continues: 10.2% p.a. during 1999-2001; 15.8% p.a. 1995-1998; and 28.2% p.a. 1992-1994 in the pre-NHI era (Table 1). This trend in sick fund expenditures is similar to the trend seen in national drug expenditure (includes non-sick fund expenditures) from 1992 to 2002.[5] The main reasons for these trends have been discussed elsewhere[5]: generic competition, buying power of sick funds, and copayments.

A similar growth rate is estimated for "direct" expenditure (excluding overheads) on basket drugs and other supplies: about 7% p.a. during 2001-2004. The growth in direct expenditure on drugs and other supplies not in the basket is estimated to be higher (~10% p.a., 2001-2004). The breakdown of expenditure on non-basket drugs is thought to be approximately 70% on prescription medicines and 30% on OTC drugs. Expenditures on other non-drug supplies are not insignificant: about NIS 550 million in 2004.

Comparison of expenditure by sick fund: The aggregate per capita expenditure (age-adjusted) was NIS 685 p.c. in 2004 (Table 2). Clalit patients have the lowest overall expenditure (NIS 650 p.c.), presumably a result of Clalit's size and purchasing power and thus lower prices. Part of the relatively large overall outlay by Maccabi (NIS 741 p.c.) is explained by its large expenditure on non-basket drugs (NIS 122 p.c.), for sale to a relatively well-off membership with high levels of supplementary insurance. Leumit had a particularly low level of per capita expenditure on non-basket drugs in 2004 (NIS 44 p.c.) (Table 2).

Net Costs

Due to the continuously greater rates of increase in revenues than the rates of increase in expenditures, the average growth rate in net costs was only 3% p.a. during 2001-4 (Table 1). In 2004 net costs were almost the same as in 2003. Over the longer term the growth rate in net costs continues to decline: 5.4% p.a. during 1999-2001; 15.9% p.a. 1995-1998; 25.5% p.a. 1992-1994 (Table 1). The estimated growth rate in net costs for basket drugs and other supplies (3.5% p.a., 2001-2004) is similar to the overall growth rate.

Profits from sale of non-basket drugs: The growth rate in sick fund profits (revenues less expenditures) from sale of non-basket drugs and supplies was estimated to be 8.1% p.a. during 2001-2004. These profits reached NIS 110m in 2004, compared to NIS 60m in 2003. Of interest is that profits from sale of non-basket drugs increased substantially in those years when net costs on basket drugs remained stable (2002 and 2004). In contrast, in 2003, profits on non-basket drugs declined substantially as net costs on basket drugs increased substantially, possibly reflecting the transfer of non-basket drugs (at a profit) to inclusion in the basket (at a net cost).

SICK FUND EXPENDITURES: CORE ACTIVITY

The MoH recently disclosed,[4] data on expenditure on drugs only, excluding expenditure on non-drug supplies. This allows us here for the first time to analyse data on the core publicly funded activity of sick funds in the drug economy - supplying insurees with reimbursable prescription medicines. We learn that expenditure on this core activity accounts for just NIS 3.13 billion out of the overall sick fund activity of NIS 4.92 billion (i.e. 64%). It is estimated that additional expenditure on reimbursable prescriptions accounted for only about 61% (NIS 142 million) of overall additional expenditures of NIS 232 million in 2004.

We also learn that the extra funding of NIS 700 million in 2006, intended for reimbursing the sick funds for including new prescription medicines in the basket,[6] represents about 20% of current annual expenditure on reimbursable prescription medicines. If no extra funds for updating the basket with new drugs will be made available for 2007, then this extra funding represents about 10% of annual expenditure for 2006-2007. Perhaps the substantial injection of extra funds for new drugs since 2005 will have an impact on future trends in sick fund expenditures? From earlier published work[5] this appears to be unlikely: substantial extra funding for new drugs during 1998-2002 appeared to have no discernible impact on the long-term decline in expenditure growth rates.

In per capita terms, only NIS 436 ($97 p.c.) (Table 2) was directly expended by the sick funds on the acquisition of reimbursable prescription medicines for their insurees, remarkably low by international (i.e. OECD) standards.[5] Clalit had the lowest expenditure (NIS 404 p.c.), followed by Maccabi (NIS 452 p.c.) and the two smallest funds with the highest expenditures (NIS 517-519 p.c.) (Table 2).

Net costs: In 2004 the net costs to the sick funds for the core activity of providing the population of Israel with reimbursable prescription medicines was NIS 1.7b, unchanged from 2003. In per capita terms this is a remarkably low NIS 253 ($56 p.c.).

SHARE OF DRUGS IN SICK FUND ECONOMY

Overall Activity in the Drug Economy

Within the context of the total sick fund economy, the share of overall activity in the drug economy (covers basket and non-basket drugs, non-drug supplies and overheads), was 20.2% in 2004 (19.9% in 2003) (Table 3). Since 1992 (15.5%) it has increased continuously apart from the years 2001, 1999 and 1994 (Table 3). This is mainly a result of increased sick fund activity in the provision of non-basket prescription medicines to a growing number of insurees with supplementary insurance, as well as their increased presence in the OTC market.

This measure, however, is not an indication of the share of total drug expenditure in the national health economy. Within national health expenditure, the share that is accounted for by total expenditure on drugs and other supplies for outpatients is considerably less: 10.8% in 2002, a relatively low share by international standards.[5]

The increased overall activity by sick funds in the drug economy is driven by their need to increase revenues and has contributed to their improved financial stability in recent years, particularly in Clalit. This is also reflected in the much lower proportion of net costs (expenditure less revenues) on drugs in the total sick fund economy: 10.7% in 2004, varying from of 9.9% (1995) to 12.4% (2004) (Table 3).

Core Activity

Expenditure on reimbursable prescriptions accounted for 12.9% of total sick fund expenditure in 2004; net costs on this core activity accounted for only 7.2% (in Clalit, 5.8%).

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PRESCRIPTION VOLUME AND COST

According to prescription market research (IMSHealth) and to sick fund sources, the total number of prescription items prescribed in the year 2005/6 was almost 90 million. The number of reimbursable prescriptions actually dispensed will be less. Assuming it to be in the range of 80-85 million prescriptions p.a., then the average number of reimbursable prescriptions is about 12 per capita. For comparison, in England & Wales in 2005/6 the number of NHS prescriptions dispensed was 13.5 p.c.[7] The number of prescription items are affected by the quantity of medicine and/or treatment period per prescription. For instance, in Israel, prescriptions are usually for upto a month's treatment, whereas in the UK, where 89% of prescriptions are exempt from copayment, prescriptions for chronic medications for stable patients may be for longer periods.

This estimated volume of dispensed prescription medicines in Israel suggests that the low expenditure on drugs in Israel, as noted above and as compared with most OECD countries,[5] is more likely due to low prices, rather than to a relatively low volume consumption of medicines by the average Israeli. Cross-national drug price comparisons are notoriously difficult to carry out, particularly for discounted generic medicines.

This conclusion gains further support if one compares the average cost per prescription in Israel with that elsewhere. The average cost to a sick fund of a reimbursable prescription is about NIS 38 ($8.5) per prescription (2004 data). In comparison, the cost to the Australian government of a subsidized (PBS) prescription is on average A$31.2 (US$22.35).[8] In England & Wales the average ingredient cost of medicines dispensed in the NHS in 2005/6 was £10.42 (plus a dispensing fee of £1.03 per prescription).[7] In Spain the average cost of a prescription is US$17.47.[9] There is no published data on the breakdown of sick fund overheads for providing Israeli patients with reimbursed prescriptions only. Even after factoring in all their overheads, including those for

providing non-basket drugs and non-drug supplies, the average prescription cost of a basket drug is still far less in Israel than in these countries.

MARKET PRICES *VERSUS* LIST PRICES

In any public debate about drug policy, one important piece of information is invariably lacking: the actual market price of drugs, as distinct from the government-controlled list (maximum) price. In contrast, this piece of information is known to stakeholders (industry and sick funds) and policymakers (Treasury, sick funds and the MoH). One may note the dual role of the MoH as a regulator of controlled prices and also as a purchaser of drugs at discounted prices. Because the major purchasers in Israel are a small number of institutions with considerable purchasing power, actual prices are thought to be considerably lower than the MoH-controlled prices. Any substantial price differential has implications in two key drug policy areas: copayments made by patients (as they are based on list price) and extra State funding to the sick funds for new drugs (calculated according to or close to list prices). But how much do list and actual market prices differ?

A major part of the total volume of prescribed medicines is made up by a relatively small number of well established products, most of which are off-patent. Data is presented here (Table 4), for the first time, on the actual purchase price of 23 of such high-volume drugs, which make up a substantial part of the total market for prescription medicines in Israel. Nearly all the drugs in the sample are off-patent and most have a number of generic versions. The prices presented are those provided to *PHARMA Bulletin* by an institution with a substantial drug budget, which is still considerably less than that of any of the sick funds. In this usually competitive market, it is reasonable to assume that **all** four sick funds, and even the MoH itself, can obtain prices similar and often lower than those shown here. The institution's acquisition prices do not include the cost of the institution's overheads for pharmacy maintenance and salaries. In order to make this institution's purchase prices more comparable to government list prices, I present here the government-listed **pharmacy purchase price** (Table 4).

Analysis of the data shows that the average price paid by the institution for these 23 drugs was NIS 15.4 (range NIS 1.8 to 55.4), compared to average government list price of NIS 28.8 (range NIS 7.2 to 92.0) (Table 4). In other words, the government-controlled list price was 87% more than the actual price obtained by a medium-sized institutional purchaser in 2006. These data suggest that for a majority of prescriptions in Israel, the government was listing a (pharmacy purchase) price almost 90% more than the price actually paid by a small institutional purchaser. One may assume that this differential is even greater and could exceed 100% in the case of the larger institutional purchasers – the four sick funds and the MoH itself.

Copayments

In addition, I present data on the monthly prescription copayments for these 23 drugs charged by Clalit and Meuhedet (Table 4). Copayments charged by Maccabi and Leumit are based on the same method as in Meuhedet (15% of government list price with a minimum copayment of NIS12) and are thus unlikely to differ much from that of Meuhedet.

The average copayment for these 23 drugs charged by Clalit is NIS 16.0 (range NIS 11 – 44) and by Meuhedet NIS 13.6 (range NIS 11.9 to 21.6) (Table 4). Copayments made by patients were greater than the institutional purchase price in 15 out of the 23 drugs in the case of Clalit, and 12 out of 23 in the case of Meuhedet. For about half of the 23 drugs the acquisition price was less or the same as the usual minimum copayment (NIS 11/12) per prescription charged by sick funds.

A recent Treasury proposal to reduce government-list prices for some drugs has just been implemented by the MoH. About one week after its implementation, the average list price of the sample declined by only 9%. It is not clear what impact this will have on the price differential seen here: sick funds may expect suppliers to reduce prices. The impact of any list price reductions on copayments for the great majority of prescriptions will probably be marginal, not least because of the frequency of relatively high minimum copayments charged per prescription.

IS THE USE OF THE GOVERNMENT LIST PRICE DEFENSIBLE?

The State uses the government-list price in two areas: as a basis for raising "taxes" (user fees) from patients who require prescriptions, and also as a basis for paying sick funds for updating the basket with new prescription drugs. The original purpose of government controlled prices - a regulatory check on prices being charged by drug companies in the Israel market - is arguably redundant to a great degree in the price competitive market of today, particularly for off-patent medicines. Its main purpose for the last 15 years appears to be as a means of helping sick funds to achieve fiscal balance.

In other health systems and in other jurisdictions, the position, legal or otherwise, regarding "arrangements" involving differences between listed and market prices are being questioned and even challenged in courts, sometimes successfully. In one of these law suits in the USA, the plaintiffs including employers and unions claimed that they

overpaid for their drugs, as a result of collusion between a publisher who produced drug price tables and a drug wholesaler who provided the price data.[10] Drug firms were the subject of another law suit by the State of Illinois in which it was claimed that government programmes overpaid because the drug firms were alleged to have fraudulently published list prices of a drug which did not take into account actual price paid.[11] In Australia, the government is requiring manufacturers to reveal the special prices which they sell drugs directly to pharmacies; the government will then lower the amount it pays to pharmacies for these drugs.[12]

In Israel there does not yet appear to be public awareness of the problematics of these government-sick fund pricing arrangements, which mainly benefit the latter at the expense of health insurees in particular and the Israeli taxpayer in general. Recently, a class action claim was made by Clalit and Maccabi insurees against the sick funds for basing copayments on the list price *inclusive* of VAT.[13,14] With regard to new drugs added to the basket, by negotiating market prices before extra funding decisions are made, and not after as is currently the practice, the State would have further funds available for adding more new drugs to the basket.

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TRENDS IN SICK FUND REVENUES

Overall sick fund revenues reached NIS 2.31 billion in 2004, a 10.7% annual increase; average growth was 11.2% p.a. during 2001-2004 (Table 1). Recent revenue growth rates are less than in earlier periods: 19.4% p.a. during 1999-2001, 15.8% 1995-1998, and 34.5% in the late pre-NHI era (1992-1994). Since 1998 revenue growth rates are invariably higher than expenditure growth rates (Table 1).

Overall revenues increased in 2004 by NIS 220 million, almost matching the NIS 232 million increase in overall expenditures in 2004. Based on recent growth rates, total sick fund revenues from patients are growing by about NIS 250 million p.a. and may reach about NIS 3 billion this year.

In 2004, the NIS 132 million increase in revenues from reimbursable prescriptions almost matched the NIS 142 million increase in expenditure on this publicly funded activity. 35% of overall revenues are from the sale of drugs not in the basket (prescriptions and OTC drugs): NIS 801 million in 2004, an annual increase of NIS 88 million.

The growth rate of revenues from basket drugs appear to be slightly greater than that from non-basket drugs but they are not significantly different, both about 10% p.a. Revenues from non-drug supplies are marginal (estimated about NIS 30 million out of a total of NIS 2.31 billion).

Comparison of Revenue by Sick Fund

Across sick funds, per capita revenue was NIS 190 from basket drugs and NIS 127 from non-basket drugs in 2004 (Table 2). Per capita revenues, adjusted for age differences, from basket drugs are highest in Clalit (NIS 205 p.c.) and lowest in Maccabi (NIS 155 p.c.). With regard to non-basket revenues it is again highest in Clalit (NIS 139 p.c.) and lowest in Meuhedet and Leumit (both about NIS 93 p.c.) (Table 2).

The higher per capita revenue in Clalit for basket drugs may be explained by its relatively large share of elderly and/or chronically ill patients, who are charged copayments not linked to the particularly cheap acquisition prices attained by Clalit (it has the lowest per capita expenditure; Table 2). The higher per capita revenues in Clalit from non-basket drugs is probably driven by its OTC sales business, facilitated by its large chain of clinic-based pharmacies.

FINANCING OF COSTS BY PATIENTS

The ratio of revenues to expenditures in the drug economy – an indicator of the extent of financing by patients – rose to 47.0% in 2004 for overall sick fund activity, up from 44.5% in 2003; in 1992 it was only 27.2% (Table 5). Financing by Clalit's patients was 53.7% in 2004, up from 51.1% in 2003, compared to only 29.0% in 1992 (Table 5). At this rate one may reasonably assume that financing of overall drug costs by patients in Israel exceeded the 50% mark for the first time in 2006, and that Clalit's patients are financing over 55% of these costs.

The extent of financing by patients for "reimbursable" prescription medicines in the basket is provided, for the first time, from data disclosed recently by the MoH for the year 2004. This shows that the financing reached 37.1% in 2004, up from about 33% in 2001 (MoH calculation, based on undisclosed 2001 data). In fact, this is an underestimate as the expenditure includes all overheads, irrespective of the fact that some are used to provide non-basket drugs as well as non-drug supplies. Deducting overheads altogether – in order to give the extent of financing based on close to the acquisition price of reimbursable prescriptions – indicates 43.6% patient financing (Clalit 50.6%) of this core activity in 2004, up from about 39% in 2002 (MoH calculation, based on undisclosed 2002 data). Based on recent trends, one may assume that patients in Israel are also financing now about half of the acquisition costs of supposedly publicly-funded prescription medicines (at least 55% in Clalit).

REFORMING COPAYMENT POLICY

In the absence of a serious reform to current copayment policy, the problem of patients financing in effect most of the cost of drugs in the basket will only continue to get worse from one year to the next. It is doubtful whether minor adjustments such as the introduction of family-based ceiling payments, which are

currently in the committee stage in the Knesset, really address the underlying problem of drug copayments for the large and growing vulnerable sectors of the population. According to MoH calculations, a NIS 1000 ceiling per family per quarter would mean a decline in revenue of NIS 30 million. If this overcomes Treasury opposition and is finally approved, and even assuming patients were to fully exploit this concession (unlikely from what we know regarding poor public awareness and responsiveness), NIS 30 million is about 1% of an estimated NIS 3 billion of current sick fund drug revenues.

Reforming copayment policy requires a better data-based understanding by policymakers of the underlying problems. There are three main interlocking issues:

- The absence of a linkage between the level of copayments made by patients and the level of actual prices paid by the sick funds. This is exacerbated by the application of minimum copayments which are often relatively high compared to actual prices. As a result, patients are the major source of financing of drug costs, especially in Clalit where this "delinkage" is strongest.
- The strong linkage between copayments made by patients and the number and frequency of prescriptions. Again, the use of minimum copayments per prescription item exacerbates the problem. This linkage is mostly a problem for those requiring chronic medication and/or multiple medication.
- The linkage between level of copayment and intensity of therapy needed. Copayment policy is notable for the way it "punishes" those whose intensity of need is greater for a particular drug therapy. For example, a patient who requires a higher daily dose or strength of medication (e.g. from 10mg to 40mg of simvastatin; from 20 units to 40 units of insulin), or a patient who requires antibiotic for 10 days rather than 5 days or two bottles of antibiotic rather than one bottle. The strength of this linkage does not apply to copayment for other forms of health care services.

The prescription copayment system is a reminder of an era, unlike today, when sick funds had little control of prescribing and there were concerns of over-utilization. Today in an era of very cheap, effective medications, charging patients substantially more because, for example, they need a higher dosage of a particular medicine does not equate with an equitable health service.

In some countries, prescription copayment policy is designed precisely to avoid this last problem, for example, by the use of fixed or standard copayments that are independent of the intensity of a therapy, or even the specific therapy itself. A proposal for fixed copayments can incorporate graded multi-level charges, as is seen in the USA – a lower one for generics, a middle level charge for "me-too" drugs, and a higher one for patent-only drugs,. Recent initiatives in the USA, by large retailing groups such as Wal-Mart, are based on low standard copayments for frequently prescribed generics.

In addition, policymakers should consider granting upfront exemption from copayment for drugs in the basket to the elderly, chronically ill, young children as well as weaker socio-economic groups. In a broader context, a meaningful reform in prescription copayment policy, if carried out, could help contain the growing share of private funding in the national health economy, which at 32% is one of the highest anywhere.

One source of funding for any possible drop in sick fund revenues, as a result of reforms in copayment policy, could be the earmarking of extra State funding for new drugs added to the basket specifically for expenditures on the drug basket.

References

1. Lipschitz Y, Ministry of Health, correspondence 8.11.06.
2. Gross R et al, Public Opinion on the Level of Service and Performance of the Health System in 2003, in Comparison with Previous Years, Myers-JDC Brookdale Institute, 2005 (Hebrew).
3. הראל ר', **אי-שוויון נפש**, זמן הרפואה, עמ' 8, יוני-יולי 2006.
4. ולדמן-אשרוב מ' ואברהם י', **דוח ציבורי מסכם על פעילות קופות החולים לשנת 2004**, נובמבר 2006.
5. Sax P, Spending on Medicines in Israel in an International Context, IMAJ 7:286, 2005.
6. Tamir O et al, Year 2006 Update of the Israel National List of Health Services, IMAJ 8:595, 2006.
7. General Pharmaceutical Services Bulletin, DoH, November 2006.
8. Pharma Marketletter, p. 16, 6.11.2006.
9. Rodriguez-Monguió R & Villar F, Health Care Rationing in Spain, Pharmacoeconomics 24:537, 2006.
10. Pharma Marketletter, p. 13, 16.10. 2006.
11. Pharma Marketletter, p. 14, 11.9.2006.
12. Pharma Marketletter, p. 15, 4.12.2006.
13. www.haaretz.co.il 18.9.2006 (Hebrew).
14. Y. Danon, www.globes.co.il 17.9.2006 (Hebrew).

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Table 1: TRENDS IN OVERALL SICK FUND ACTIVITY IN DRUG ECONOMY (annual % change)

Sick fund aggregate, change in	*2004*	*2004-2001*	*2001-1999*	*1998-1995*	*1994-1992*
Overall expenditure	4.95	6.5	10.2	15.8	28.0
Overall net costs (expenditures less revenues)	0.35	3.0	5.4	15.9	25.5
Overall revenues	10.7	11.15	19.4	15.8	34.5

Table 2: PER CAPITA[1] EXPENDITURE AND REVENUE (2004): AGGREGATE AND BY SICK FUND (NIS)

	Expenditure			*Revenue*	
	Overall[2]	Basket	Non-Basket	Basket	Non-Basket
Sick fund aggregate	685	436	96	190	127
Clalit	650	404	94	205	139
Maccabi	741	452	122	155	125
Meuhedet	738	517	96	193	92
Leumit	723	519	44	169	94

[1] Age-adjusted.
[2] Includes overheads and expenditures on non-drug supplies.

Table 3: SHARE OF OVERALL EXPENDITURE[1] ON DRUGS IN SICK FUND ECONOMY (%)

Drugs as % of total expenditure	*2004*	*2003*	*2002*	*2001*	*2000*	*1999*	*1998*	*1997*	*1995*	*1994*	*1992*
Expenditures	20.2	19.9	18.4	17.8	18.2	17.2	17.6	16.8	14.7	14.3	15.5
Net costs	10.7	11.0	10.4	10.4	12.4	11.6	11.8	11.6	9.9	10.0	11.3

[1] Includes overheads and expenditure on non-drug supplies.

Table 4: MARKET PRICE *VERSUS* GOVERNMENT LIST PRICE AND COPAYMENTS (NIS) (2006)

			Copayment	
Medicine	*Market price[1]*	*Government[2] list price*	*Clalit*	*Meuhedet*
Amiloride/Hydrochlorothiazide (Kaluril) x 30	15.90	15.97	11.00	12.00
Amlopidine 5mg (Teva) x 30	25.80	65.00	16.50	18.00
Amoxicillin 250mg (Moxypen Forte) x 60ml	4.10	7.43	11.00	12.00
Amoxicillin 500mg (Moxivit Forte) x 10	3.20	8.24	11.00	12.00
Atenolol 50mg (Normalol/Normiten) x 30	2.70	7.44	11.00	11.90
Cefuroxime 500mg (Cefurax) x 10	32.40	75.00	22.00	21.10
Cephalexin 500mg (Cefovit) x 10	4.40	10.48	11.00	12.00
Cilazapril 2.5mg (Vascase) x 28	37.80	32.1	11.00	12.00
Citalopram 20mg (Recital) x 28	55.40	76.50	12.00	17.98
Co-amoxyclav 500mg (Amoxiclav-Teva) x 20	23.00	41.20	44.00	12.00
Diclofenac 100mg (Betaren) x 10	2.00	7.45	11.00	11.85
Domperidone (Motilium) x 30	12.00	27.29	33.00	12.00
Enalapril 10mg (Enaladex) x 30	10.20	11.15	12.00	12.00
Fluoxetine 20mg (Flutine) x 30	10.50	38.00	22.00	12.00
Glibenclamide 5mg (Glibetic/Gluben) x 30	1.80	7.44	11.00 (x 50)	11.85
Hydrochlorothiazide (Disothiazide) x 30	2.70	10.47	11.00	12.00
Lorazepam (Lorivan) x 50	2.33	7.45	7.11 (x20)	11.85
L-Thyroxine 100mcg (Eltroxin) x 100	17.80	26.29	11.00	12.00
Metformin 850mg (Glucomin/Gluophage) x 30	3.60	7.44	11.0	11.85
Naproxen 500mg (Naproxi) x 30	13.50	18.98	30.00	12.00
Oxybutinin 5mg (GM) x 30	5.70	7.19	22.00	12.00
Paroxetine 20mg (Paxxet) x 30	29.10	92.00	14.40	21.62
Ramipril 5mg (Teva) x 30	38.40	62.90	11.70	17.57
Average	15.42[3]	28.84[4]	16.00	13.60

[1] Price to institutional purchaser.
[2] MoH-approved price to private pharmacy.
[3] The equivalent retail price is about NIS 24.40 (including VAT).
[4] The equivalent retail price is about NIS 45.70 (including VAT).

Table 5: PATIENT FINANCING OF DRUG COSTS: RATIO OF OVERALL REVENUES TO OVERALL EXPENDITURES[1] (%)

	2004	*2003*	*2002*	*2001*	*2000*	*1998*	*1997*	*1995*	*1994*	*1992*
All sick funds	47.0	44.5	44.1	41.6	37.3	32.6	30.7	32.8	30.1	27.2
Clalit	53.7	51.1	51.0	48.7	43.6	37.9	35.6	36.9	34.8	29.0

[1] Includes overheads and expenditures on non-drug supplies, which provide insignificant revenues.