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## **Presentation to the Canadian Health Coalition National Drug Plan Hearings (Vancouver)**

Ken Buchanan,  
Secretary, BC Persons With AIDS Society

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The British Columbia Persons With AIDS Society (BCPWA) is a registered charitable society run by and for persons living with HIV disease and AIDS. It is Western Canada's largest AIDS organization with a membership of more than 4,400 HIV-positive full voting members – perhaps as many as one-third of all HIV-positive British Columbians. The Society's services are available to and regularly accessed by many of the 12,000-plus individuals with HIV / AIDS in BC. Unique among major HIV/AIDS agencies in Canada, BCPWA's Board of Directors is composed entirely of HIV-positive members, and all of its programs are operated by committees led by HIV-positive persons.

Pharmacare is a program very dear to HIV-positive British Columbians specifically because it is estimated that roughly five percent of all Pharmacare pharmaceutical expenditures are directed to the purchase of drugs intended to suppress and / or mitigate the functioning and effects of HIV. Under a separate “plan” within the overall program, Pharmacare pays the entire cost of purchase and distribution of all HIV / AIDS drugs prescribed to resident British Columbians as a matter of public policy. We believe this system, unique to BC and its Centre for Excellence in HIV/AIDS (which administers the program), could serve as a model for a national Pharmacare program in which all Canadians receive the pharmaceuticals they need at no direct personal cost. Obviously, this is an “ideal”, and there will be many intervening steps prior to our arriving at this destination.

However, lest we consider such an eventual outcome hopelessly utopian, let us remember our national healthcare system, created over 40 years ago, was intended to be universal, throughout and across the country, and free of direct charge to those availing themselves of it – and as originally conceived by its architect, Justice Emmett Hall and his Royal Commission, it included a national Pharmacare component. To this day, many parts of our system are just that – universal and free of direct charges. So we believe that, as our system – like our population – ages; and as the burden on that system – like our population – increases, there is a need to mitigate strains on the system. Frankly, making Canada's Pharmacare program both national and universal – like our “medicare” – simply makes sense.

Something must be done, and done now!

Of course, this has been said repeatedly in the past, yet ‘now’ just keeps getting later and later.

BCPWA believes that a National Pharmacare program is imperative. Prices keep going up; gaps and differences among provincial drug formularies are too varied; and, therefore, access (particularly to new medications) varies from province to province – making a mockery of the core principles of universality and equality of access. We need a National Pharmacare program to remedy these discrepancies, and to give Canadians a fuller national healthcare program which is truly portable and which, therefore, gives Canadians the mobility they are guaranteed in Section 6(2) of the Canadian Charter of Rights and Freedoms. Until current discrepancies in the availability and pricing of prescriptions are addressed through a National Pharmacare Program, this mobility will really remain only partial.

We need to strike a balance between cost containment of medications – in this time of ever-escalating prices – and full access, particularly to new, life-saving drugs, across Canada. It can be argued that a National Pharmacare Program – through such strategies as targeted bulk-purchasing and their resulting savings – could permit provinces to utilize resources and so more effectively address basic issues for Canadians (such as housing). It would thereby remove unnecessary burdens in the healthcare system by bettering Canadians’ lots across the spectrum of the determinants of health.

The far-sighted creators of the Canada Health Act recognized:

“that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

“that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians”

The Parliament of the day chose:

“to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof.”<sup>1</sup>

As we have stated long before now, the healthcare system was never fully set up. Addressing this deficiency through the establishment of a National Pharmacare program helps correct this flaw.

We have also stated that changes to any aspect of the current Pharmacare regime in BC should be undertaken following a broad-based public consultation of any and all British Columbians wishing to make their considerations known. It is for this reason that BCPWA welcomes this undertaking by the Canadian Healthcare Coalition, and it is why we are presenting this brief here. Further, we believe that consonance of opinion among the majority of British Columbians on any particular element of Pharmacare which emerges from just such an open, public consultation process must be respected at least to the degree that no steps are taken in clear contravention of it.

Equally important is the fact that this issue be addressed in an effective, and not merely a simplistic, manner. This is why we believe that nationalizing the program using suggestions at least similar to ours, below, must be undertaken.

Pharmacare costs are rising. Indeed, all Canadian provincial jurisdictions – and most national and sub-national jurisdictions in the developed world – are facing rapidly rising pharmaceuticals costs. Among other reasons, this is because of an ineffective federal drug prices review system. This system has resulted in a regime of pricing for new drugs that guarantees huge and ever-rising drug prices for both the patent and generic pharmaceuticals industries (prices now sufficient to make the pharmaceutical industry, generally, the most profitable legitimate endeavour in the world). This insanity cannot continue and still serve well the healthcare system – or, indeed, our population.

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<sup>1</sup> Canada Health Act: Preamble

The rising costs of prescription and generic drugs is a very complex issue and presents some formidable barriers regarding access to treatment. Canada must play a lead role in addressing drug prices in order to ensure that Canadians benefit from available current and new treatments.

As costs continue to rise, provincial formularies and private insurers have begun to refuse coverage of the higher priced new drugs, thus limiting treatment options. In other instances, when a new drug is added to a formulary, another drug is removed. For many serious, life-threatening illnesses, access to a broad range of treatment options is essential to customize treatments to individual needs to maximize efficacy and minimize toxicity.

In BC, bulk purchasing by Pharmacare, and the Reference Drug Program (RDP), have proven to be the most effective tools currently at our disposal for containing drug costs without adversely impacting health outcomes. BCPWA has long advocated for the creation of a national Crown Corporation for the bulk purchase of drugs nationally. This, combined with greater price competition, has the potential to help keep costs down. However, the present reality is that drug price regulation in Canada by the Patented Medicines Prices Review Board (PMPRB) has proven to be relatively ineffective (except compared to the regime obtaining by our neighbour to the south). Continued and still generous patent protection for new pharmaceuticals produced by drug companies leaves very little room for competition. The RDP and variants of it have had the greatest effect in stimulating price competition here and in countries such as Germany and New Zealand. In many instances drug companies have reduced prices as a means of competing for market share with the reference drugs. Since its inception, intensive independent evaluation has proven that the RDP reduces the overall cost of health care.

Some argue that the RDP substitutes cheap health care for optimal health care. Evaluation of the program in BC reveals that it has had no adverse impacts in terms of hospitalisations, morbidity, mortality or other patient outcomes. However, such outcomes have indeed been associated with cost shifting strategies like those in the province of Quebec, when drug costs were shifted to the poor in consequence of a reorganization of the province's Pharmacare plan with associated de-listing of some essential pharmaceuticals.

The drug industry has argued – perhaps threatened – that the RDP creates an unfriendly commercial environment for them. However, from 1988 to 1999 Rx&D reported that industry investment in BC increased 398%, so that argument seems unsupported by the evidence at hand. And although BC represents 13.3% of Canada's population, and it only receives 3.3% of the national pharmaceutical R&D spending, that is an amount that has not changed in percentage terms since 1988. The drug industry waves the flag for innovation and R&D investment every time there is a potential threat to profits. In truth, the eleven Fortune 500 drug companies spend 12% of revenue on R&D and 2.5 times that amount on administration and marketing. And as for innovation, a recent study of drugs approved in the US between 1982 and 1991 revealed that 53% of the newly discovered drugs provided "little or no therapeutic gain" compared to drugs already marketed. The RDP helps to avoid paying premium prices for newer "me-too" drugs that offer no significant improvement over the reference drug. Industry devoted a telling portion of its massive profits to opposing the RDP through full-page newspaper advertisements and a court challenge. In doing so, they inflicted additional waste on the public purse.

When assessing industry arguments on RDP it is crucial to remember that drug companies are exclusively accountable to their shareholders and are required in the discharge of their fiduciary responsibility to be motivated entirely by profit.

All that noted, let us note as well one very important consideration: there will always be instances in which reference pharmaceuticals do not work with particular consumers. This is well documented and must be taken into account in any program seeking to minimize pharmaceutical costs through reference-based pricing, bulk buying and similar strategies. In a nutshell, any such scheme must be certain to provide an adequate “loophole” – such as BC’s “Special Authority” program – enabling health care consumers in concert with their treating physicians and/or specialists to secure fully covered access to alternative pharmaceuticals when the reference pharmaceutical, for whatever reason, proves inappropriate to their particular circumstances. HIV-positive British Columbians are acutely aware of this necessity, as experience has shown different people respond dramatically differently to the various antiretroviral pharmaceuticals available (21 and counting in BC). This is due to a variety of factors – ranging from the particular genetic “type” of HIV involved, to the particular genetic “type” of consumer involved, to apparently determining factors at which we can’t yet guess. Such differences are to be found to a greater or lesser degree with most collections of different pharmaceuticals intended to address particular conditions. Any public Pharmacare regime must take cognizance of and be responsive to this fundamental reality.

Specifically addressing the needs of BC’s HIV-positive population, the province covers the cost of all antiretroviral medications prescribed through the BC Centre for Excellence in HIV/AIDS – 5% of BC’s Pharmacare budget. However, many other drugs are frequently prescribed for HIV patients. Drugs such as antibiotics, antifungals and chemotherapy agents are just some examples of prescribed treatments for opportunistic infections and cancers experienced by PWAs. Prescription drugs are also often necessary for the management of symptoms and side effects such as pain, diarrhea and other intestinal problems, depression, insomnia and much more. These prescriptions are handled through community pharmacies. The ease or difficulty of access depends on the particular drug, as well as on the circumstances of the individual.

Certain drugs are only covered under “Special Authority” by Pharmacare, while others drugs are not funded at all. In most instances, special authority is sought through an application for an individual patient. Another method is to grant physicians with certain patient populations (such as HIV / AIDS) blanket authority for drugs commonly prescribed in that population. Antifungal agents such as fluconazole and itraconazole are covered by these special authority provisions, but some physicians who commonly treat HIV patients have been granted special prescribing authority and are not required to do the paperwork for individual patients. Some other examples of special authority drugs are:

- methadone for heroin addiction
- loperamide (immodium) for diarrhea
- zopiclone (immovane) - a sleeping medication
- Losec (omeprazole) for stomach ulcers
- Rebetrone for hepatitis C, and
- Lamivudine (3TC) for hepatitis B.

Some of the drugs that are not covered at all are:

- Serostim (human growth hormone) for wasting
- L-acetyl carnitine for peripheral neuropathy
- Smoking cessation medications (Nicoderm, Zyban)
- Erectile dysfunction medications (Viagra, Muse, prosteglandin)

What follows are a few suggestions to address the ills of our current Pharmacare program. These are not intended to be exhaustive. Rather, these are a few suggestions held by BCPWA to be worthy of public debate and consideration.

Including bulk purchasing provisions in a National Pharmacare Program could bring some downward pressure to bear on ever-increasing pharmaceutical prices. This may be the single most effective step that could be taken to control and perhaps even reverse the dramatic rise in costs. If nothing else, we believe in the creation of a national pharmaceuticals purchasing and wholesaling Crown Corporation that would act as the sole purchaser and distributor of pharmaceuticals listed on any provincial Pharmacare formulary. Further, there is the prospect of long-term co-operation with similar public purchasing and distribution enterprises in other countries, such as Australia and New Zealand. It would be very helpful if Canada, having established its own such enterprise, could initiate contact with other such countries, and perhaps act as an international advocate and facilitator for interested countries.

It cannot be stressed strongly enough that this Crown Corporation must be at arm's length from government (although probably housed within Health Canada). This helps ensure the necessary freedom from political influence that other Crown Corporations have as their means to pursue economic and social objectives. This Corporation can then deal with the distribution and pricing of pharmaceuticals, plus be able to access financial markets to provide financing.

Quite interestingly, British Columbia has the highest percentage of seniors (the age group with the highest per capita consumption of pharmaceuticals) in the country. British Columbia also spends less of its total health care budget on pharmaceuticals than any other province. Of course, this is due principally to the "Fair Pharmacare" regime introduced by the Liberal government several years ago, a regime which significantly increased "deductibles" and "co-payments", and so effectively shifted the burden of cost onto consumers; but it is due, as well, to the effective functioning of its Reference-Based Drug and bulk purchasing programs. Imagine the buying power of such a national system for smaller, less-populated provinces.

BCPWA believes that transparency by both industry and government regarding all aspects of prescription drugs (research, licensing, pricing, public information, etc.) is key. We further believe in the responsibility of the state to create the conditions necessary to permit its citizens to maximize their health. Finally, we believe in the need for safe, effective and accessible products, recognizing that safety, efficacy and accessibility may be defined differently depending on the state of one's health.

Finally, The Canadian Agency for Drugs and Technologies in Health Canada's Common Drug Review (CDR) process – conducted as a joint project with the provinces and territories – is one which we believe should expand such that it may be converted into the kind of national formulary system suggested above. In this way, the aforementioned balance between cost containment and access can be better addressed.

Our recommendations, in summary:

The Government of Canada must immediately engage with selected potential international partners (Australia, New Zealand and certain members of the European Union, for example) to explore ways to ensure that prescription drug prices are contained while at the same time not restricting access to new medicines.

The federal and provincial / territorial governments must collaborate in the bulk purchase of prescription drugs through the creation of a national pharmaceuticals purchasing "pool" – probably in the form of a federally chartered Crown Corporation – to leverage their thus-enhanced purchasing power and market share and so keep prices down, enabling reduced costs and improved patient access.

Serious consideration should be given to metamorphosing the Common Drug Review into this arm's length Crown Corporation for purposes of bulk buying in conjunction with other governments and coordinated with our provinces and territories.

When pursuing such strategies as Reference-Based Pricing, any Canadian jurisdiction so engaged must be certain to provide an adequate "loophole" – such as BC's "Special Authority" program – enabling health care consumers in concert with their treating physicians and/or specialists to secure fully covered access to alternative pharmaceuticals when the reference pharmaceutical, for whatever reason, proves inappropriate to their particular circumstances.

As we said at the beginning: Something must be done, and done now. If not, costs will continue to rise, access to essential pharmaceuticals will necessarily become ever more restricted and, with that, will come an unnecessary worsening of our healthcare system generally. (One very real consequence may be that individuals may opt to – or be compelled to – move to where they deem their healthcare needs will best be met, putting unnecessary burdens on particular jurisdictions while other citizens remain put and so don't get the access they require.)

This is not what the Canada Health Act set out to do, but it's what is happening. Canada's federal government must create a National Pharmacare Program now.