



New Study Reveals BC Government’s Healthcare Silo Approach to Drug Policy Cost \$43.5 million

January 22, 2009, Vancouver, British Columbia – A new study published in the journal, *Alimentary Pharmacology & Therapeutics*, reveals that a BC Government PharmaCare policy introduced in July 2003, which was intended to reduce costs by \$42 million with minimal impact on patient health, in fact, cost the healthcare system and patients \$43.5 million and had a significant impact on patients’ quality of life.

“This therapeutic substitution policy, which forces patients to switch from one of four Proton Pump Inhibitor brand medications to another brand name that is the cheapest or forego PharmaCare coverage, was made without any clinical studies or supportive data,” said Gail Attara, study co-author and executive director of The Canadian Society of Intestinal Research (CSIR). “It is not about generic substitution, but is about the government replacing one chemical for another non-bio-equivalent one, simply because it’s cheaper.”

Dr. James Gray, study co-author, clinical gastroenterologist, and Associate Professor at the University of BC explained, “Following this policy change, many patients who were forced to make a non-medically-necessary medication change experienced destabilization of their acid-related diseases and consequent symptoms. In some cases, severe symptoms such as relentless heartburn, and medication side effects including diarrhea, vomiting, nausea, chest pain, fatigue and, less commonly, vomiting blood, required visits to physicians and even hospitalization. We felt strongly that this increased use of healthcare resources would cancel out any possible savings to the drug budget, but we needed to examine the data to be sure.”

This original scientific paper focused on the impact of the therapeutic substitution policy of Proton Pump Inhibitor (PPI) drugs. During the three-year study period, as many as 87,000 patients in BC with acid-related diseases had to stop taking the medication that was working for them, and switch to the cheapest available PPI (n= 2003: 45,374; 2004: 24,676; 2005: 17,412). Researchers performed the most in-depth analysis of its type using the BC Ministry of Health Services linked health databases for the period 2003-2005, which they accessed by special permission. The study found that, as a direct result of the therapeutic substitution policy, there were \$24.65 million spent on additional physician services, \$9.75 million for additional hospital services, and \$9.11 million in increased PPI utilization, for a total of more than \$43.5 million.

“While anecdotal information existed, we knew we needed hard data to confirm that any potential short-term savings to a drug budget from policies such as this can be cancelled out by significant costs to physician and hospital budgets,” said Brett J. Skinner, co-author and director of biopharmaceutical and health policy research at the Fraser Institute, who collaborated with CSIR by taking the lead in data analysis. “This study points to the dangers of decision-making within healthcare budgetary silos.”

Therapeutic substitution requires patients to switch from one brand product to another brand product in the same therapeutic class. It is different from generic substitution where the drugs are bio-equivalent. This policy falsely assumes that all PPIs are the same but, by definition, patented medicines are different, as they elicit variable therapeutic outcomes and side effects. British Columbia was the first province to implement this kind of therapeutic substitution policy.



“Diversity within any therapeutic class is critical to optimizing patient care,” said Gray, “A physician needs all the tools available to properly care for patients using an individualized approach because one size doesn’t fit all when it comes to healthcare. Limiting or restricting coverage for specific medications makes the physician’s job more difficult and in the long run, is not beneficial for the patient.”

“On the August long-weekend in 2003, I went to pick up my PPI prescription, only to find that it hadn’t been filled due the new therapeutic substitution policy. Six weeks went by before I could see my doctor about this forced medication switch,” said Lynn Macdonald from Kelowna, BC “After PharmaCare repeatedly denied coverage for the medication that my doctor prescribed, and that had already been effectively treating my reflux, I was finally granted approval, four years later! Not only did I suffer from my acid reflux symptoms needlessly, my other health conditions worsened as well.”

A previous study associated with Harvard University, often cited by the BC Government as one that demonstrates the success of this policy, was too narrow to evaluate fully the impact of therapeutic substitution. For example, the earlier study was restricted to patients over 65 years old and looked at hospital utilization associated with only one extreme outcome, gastrointestinal hemorrhage.

“CSIR has discussed the study results with the Ministry of Health Services,” said Attara, “And we look forward to further discussion on initiatives to improve the quality of life for persons with acid-related diseases in British Columbia.” CSIR is asking for a public commitment from the BC Government to disallow any therapeutic substitution because it harms patients. Clearly, these drugs are all different, as are the patients who they are designed to help.

CSIR strongly urges other jurisdictions to review the study findings before considering or implementing any therapeutic substitution policies.

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