



Best Medicines Coalition

National Pharmaceuticals Strategy

Issue Paper

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Introduction

The positions taken in this Paper and recommendations made are based on the issues that patients and consumer groups have identified within the current and proposed Canadian federal, provincial, and territorial (F/P/T) administrations of healthcare, drug review, and drug coverage process.

As part of the 10-year plan to strengthen healthcare, Canadian First Ministers¹ agreed to develop a National Pharmaceuticals Strategy (NPS). They agreed that no Canadian should suffer undue financial hardship in accessing needed drug therapies, and that affordable access to drugs is fundamental to equitable health outcomes for all our citizens. What they have neglected to do, however, as this Strategy has unfolded, is gather information directly from viable, knowledgeable sources. It is the BMC view that, unequivocally, Canadian patients, as healthcare consumers, must be part of the decision process that fundamentally affects every aspect of their lives, stemming from their health state.

The primary issue for millions of Canadian patients, consumers of healthcare, and Canadians generally, is that the healthcare system, including the current national Common Drug Review (CDR) and the proposed National Pharmaceuticals Strategy (NPS) are focused on *cost containment* rather than what it should be. It should be a patient-centered or patient-focused system that strives to meet the needs of patients – treatment, care, improved quality of life, and ultimately improved health outcomes.² What makes matters worse is that the NPS discussions are not transparent and inclusive of those who have the facts or experiences to contribute to the development of a uniquely Canadian National Pharmaceuticals Strategy.

Background

Government Collaboration

In recent years, there has been a growing trend of collaboration between F/P/T governments in Canada, touching on a number of public policy issues. This heightened interaction culminated with the establishment of the Council of the Federation on December 3, 2003, which is intended to serve as a mechanism to promote policy coordination and dialogue between P/T Premiers in their discussions with the Federal government. Most recently, there have been a number of high-profile meetings between F/P/T leaders in Canada, in the form of First Ministers' Meetings (FMMs).

In light of the importance placed by Canadians on our healthcare system and the groundswell in dialogue on how it should be optimally managed, healthcare

¹ First Ministers include the Prime Minister and all provincial and territorial Premiers

² Bauman, AE, Fardy, JH, & Harris, PG. (2003). Getting it right: why bother with patient-centred care? *MJA* 179(5): 253-256. www.mja.com

reform has been a major topic of focus for these meetings. Mirroring the Council, is further collaboration between federal and provincial civil servants. For example, the Conference of Deputy Ministers of Health (CDMH) acts as a parallel collaboration forum comprised of Deputy Health Ministers across the country. In addition, the National Pharmaceuticals Strategy Working Group, composed of all the drug plan managers, meets regularly to discuss pharmaceuticals policies.

Lack of Accountability

The entire F/P/T structure is becoming another level of government veiled in secrecy, propelled by unelected officials who are unaccountable to the Canadian public. This bureaucratic level is making decisions that seriously affect the lives of Canadians, including restricting their access to life saving and life improving therapies.

An offer refused

Very knowledgeable patient groups have offered government their services to work with them to forge viable solutions that will work for patients while addressing fiscal restraint but, regrettably, government is not accepting this offer.

Burden of Healthcare

A major component of the health reform debate is how to cope with the growing cost burden of our publicly funded healthcare system. The statistics now show an all time high of \$142 billion³ being spent in Canadian healthcare. Of this amount, a large percentage is the cost associated with chronic diseases which impact over half of Canadians and cost the economy 77 billion dollars.⁴

The specific amount spent on drugs has gone up the most of all expenditures, to \$24.8 billion, of which 83% are attributed to prescription medicines. Over 80% of Canadians support the fact that the drug costs need to be controlled and that Canadians are being prescribed and/or taking too many unnecessary prescriptions, but 92% believe that, “all Canadians should have access to all needed medications” as determined by their physicians, and that the government should cover these.⁵

Enhancement of Healthcare

Concurrent to this ongoing debate has been enrichment on the delivery side of medical care in Canada and across the globe. New advancements in life sciences technology for diagnosing and treating patients now exist for those whom, previously, there was either no treatment available, or the only option was to resort to costly or invasive interventions such as surgery. For example, thanks to the discovery of new pharmacological treatments for gastrointestinal disease,

³ Canadian Institute of Health Information (2005). *Drug Expenditures in Canada*. www.chihi.ca.

⁴ Canadian Coalition for Public Health in the 21st Century (August 2005). Chronic disease – A public health issue. *Public Health Facts*. (coalition2cpha.ca).

⁵ Pollara (2005). *Health Care in Canada Survey*.

hospitalization rates for ulcer patients decreased 75% in Canada between 1983 and 2001.⁶ For previously untreatable conditions like HIV/AIDS, hospitalizations from 1993 to 2001 dropped 73%.⁷

Natural Increases

A natural result of the increased use of non-invasive therapies to treat diseases has been that total spending on prescription medicines in Canada has grown almost twice as fast as spending on hospitals and physician visits in recent years.⁸ Unfortunately, while this growth rate has received widespread attention in the media, the reasons for it have not. Consequently, some have declared that drug spending is “out of control” and called for knee-jerk policy reactions to contain them, without consideration that restricting access to medicines could undo the benefits they have brought to improving quality of life for patients, including tremendous savings to the overall healthcare system through fewer hospitalizations. The benefits of pharmaceutical use and the resulting savings in other parts of the healthcare system and improved quality of life for Canadians can no longer be ignored.

Overreaction

The increased pressure to “do something” about increasing drug costs has resulted in a number of measures taken by governments to restrict coverage of medicines on public drug plans. Additionally, new administrative layers such as the Common Drug Review (CDR) – that seem to base decisions on cost considerations alone – resulted from F/P/T collaboration. At *no point* in the process are patients’ needs or the long-term impact of these decisions on healthcare in Canada taken into consideration. Most recently, this has manifested itself in the proposed National Pharmaceuticals Strategy (NPS). The Strategy, currently under consideration by government task forces, is not transparent and has had only limited consultations with such key stakeholders as patients, their doctors, and other healthcare providers.

Inclusion and Accountability are Essential

Governments must change this flawed process immediately because carrying on in the current manner is wasting taxpayers’ money that might be better spent in delivering much-needed healthcare. It is essential that numerous cross-Canada consultations and involvement of the public, including patients, take place before an NPS is developed.⁹

In a time when government is talking about transparency, accountability, and openness, informed patients should be fully engaged in discussions and be encouraged to raise concerns pertaining to this important healthcare issue. It is

⁶ Source: *OECD Health Data 2005*.

⁷ *Ibid.*

⁸ Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends 1975-2004*, 2004.

⁹ Kovacs Burns, K. (2006). Under Public Scrutiny: A Preliminary Study on the Public’s Perceptions of NPS. CHSPRS conference on NPS, Vancouver, B.C. February 2006.

our position that the current direction of F/P/T collaboration is a threat to patient care in Canada, particularly with respect to the ability of physicians to make the right treatment choices and consider the needs of individual patients.

Patients must be engaged in these meetings and on the various task forces early in the process in order to contribute effectively and for their needs to be addressed within the solutions. We must remember that the healthcare system in its entirety exists for patients – and their needs must be paramount.

A look ahead in this Paper

Subsequent sections of this paper will provide details on the implications of F/P/T collaboration on patient health, particularly with respect to the Common Drug Review and National Pharmaceuticals Strategy. We also provide our vision of health policy reform that includes placing patients back at the centre of healthcare decision-making, shifting them from the fringes, where the people who are making not well informed and detrimental decisions about their health ignore them. BMC's intent is to raise awareness among patients of what is happening within the Canadian healthcare system, pointing out why, as patients, we should all be concerned about restrictive policies that limit access to necessary treatments. We also provide a positive vision for the future of Canadian healthcare.

International Examples

There are examples from around the world, which prove that patient-centred policies and decisions can deliver the best health outcomes. We believe that Canadian patients are able to provide intrinsic insight, allowing government to produce a uniquely Canadian solution, independent of other jurisdictions, many of whom struggle to deliver a viable, sustainable alternative. Canadian patients are unwilling to allow health regulators or even qualified experts to arrive unilaterally at decisions without meaningful input from those affected by the decisions. The Best Medicines Coalition (BMC) is committed to engaging with government to address issues collaboratively and constructively, which affect our safe, timely, and equitable access to the best medicines, while upholding fiscal responsibility across all the silos of healthcare spending.

Further to this position paper, the BMC has a package of Position Statements (2003/04) for various aspects and issues about the current drug and pharmacare programs across Canada, which are of concern to its many members, and which need to be addressed and/or changed. The position statements are based on the following principles:

- A. Individuals need access to drugs through an effective and efficient drug review and approval process.
- B. There needs to be an effective and responsive post-approval monitoring or surveillance system for drugs once they are released into the market and prescribed to individuals.

- C. The costs and access to drugs/medicines must not be a burden to individuals.
- D. Public participation/involvement and engagement in the various aspects of reforming Canada's drug review, approval, and monitoring systems is critical to ensuring optimal outcomes.

Each of these principles is addressed in the BMC position statements, which attempt to recognize or acknowledge the strategies of government, Health Canada, The Kirby Report and the Romanow Commission's Directions for Change (Future of Healthcare in Canada Report, November 2002). All BMC position papers are posted at www.bestmedicines.ca.

Current State of F/P/T Collaboration

Common Drug Review

One of the more notable products of F/P/T collaboration was the creation of the Common Drug Review in 2003. This body reviews new drugs, provides recommendations to participating drug plans in Canada on whether a product should be reimbursed, and includes more specific reports regarding what sort of coverage restrictions should be put in place, if any. While the original intent of the CDR was to reduce duplication of effort by not having the same product reviewed in each province, two years later, the provinces still conduct their own reviews *in addition* to the time it takes for CDR to provide its recommendations. To compound the problem, CDR's safety and effectiveness evaluations also duplicate work conducted by Health Canada.

CDR Process

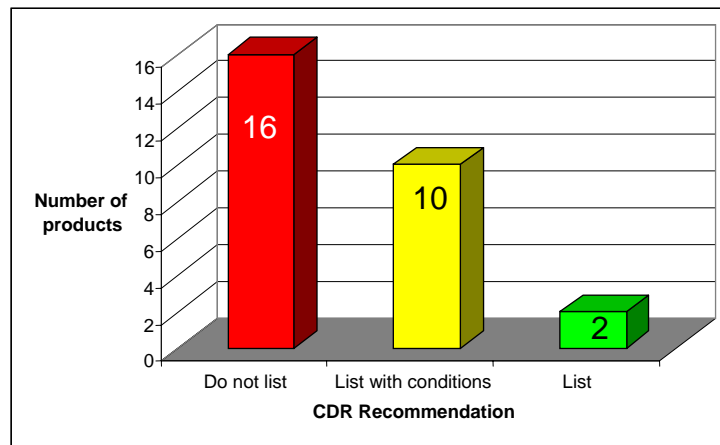
After Health Canada performs a rigorous and scientific review and approves a new medicine for use in Canada, the manufacturer must submit additional product evidence to the CDR. These data include clinical evidence for safety and efficacy, as well as substantiation around epidemiology and pharmacoeconomic data for cost-effectiveness. Further, the manufacturers must submit a summary of unpublished or ongoing clinical trials related to the product. The information is then forwarded to the Canadian Expert Drug Advisory Committee (CEDAC) for review, after which a listing recommendation is made and forwarded to participating drug plans and manufacturers for comments before the final recommendation is confirmed.

Impact on Patient Access to Medicines

As of July 21, 2005, it has taken an average of 178 calendar days for CDR to review new drugs since its inception.¹⁰ Depending on the timing of CEDAC meetings, this is between 18 and 52 days longer than the target timelines for reviewing and providing final recommendations for new products. As stated at the beginning of this section, this review time is *in addition* to provincial reviews, which took an average of 464 additional calendar days in the period between February 2003 and February 2005.¹¹ When lives are stake, these additional delays in the review process are simply unacceptable.

Not only does CDR's track-record indicate delayed *time* to listing on public drug plans, but it has also reduced the *number* of drugs listed on provincial formularies. The chart below illustrates the current CDR track-record with respect to listing recommendations:

Chart 1: CDR Final Recommendations up to July 21, 2005



Source: Common Drug Review – *Recommendations* website (Updated July 21, 2005, World Wide Web: https://www.ccohta.ca/CDR/cdr_recommendations.cfm)

As of February 20, 2006, CDR had rejected 21 of 25 (60%) new drugs approved for sale by Health Canada. The CDR has rejected all “first in class” products. In the area of biologics, the situation is even worse. Of the 10 biologics reviewed, the CDR rejected 7 (70%). Of the three recommended for reimbursement by CDR, the reimbursement level of participating F/P/T plans represents about 60%. CDR has rejected all biologics for treatment of diseases where no alternative exists.

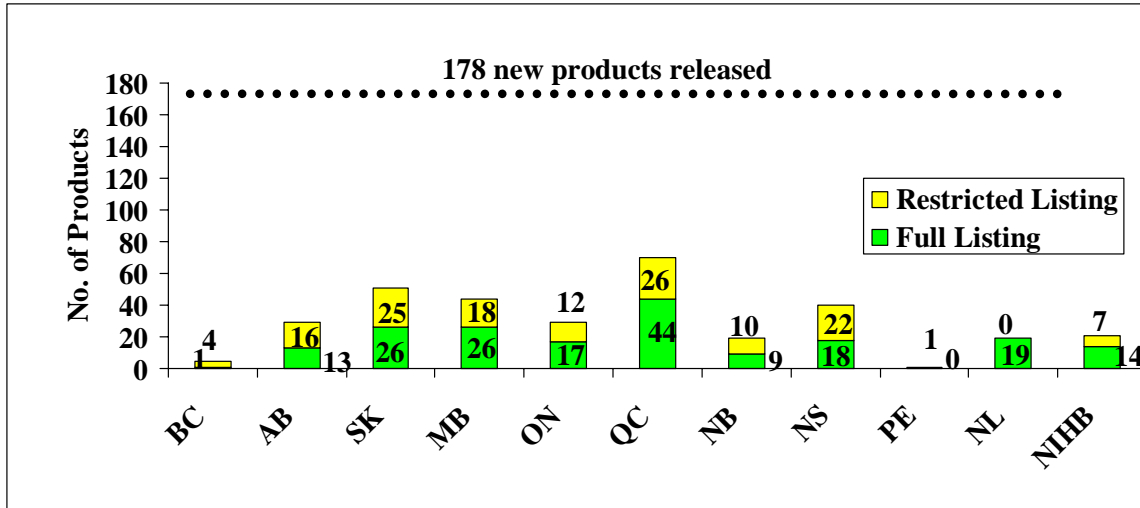
Further, if public drug plans only review the products that receive some form of positive recommendation from CDR, patients are not guaranteed access to the product. In fact, the chart below demonstrates that of the 178 new drugs

¹⁰ Common Drug Review – *Submission Status* website (Updated July 21, 2005, World Wide Web: https://www.ccohta.ca/CDR/cdr_sub_tracking_e.cfm)

¹¹ IMS Health Canada: *Formulary Acceptance: Monitoring and Evaluation* (FAME) database (May 2005)

launched from February 2003 to February 2005, only 30 became available on public drug plans.¹² CDR decisions are also influencing private drug plan formulary decision-making, where private drug plans cover more people than public ones.

Chart 2: Drugs added to public formularies: Feb. 2003 – Feb. 2005



Source: IMS Health Canada: *Formulary Acceptance: Monitoring and Evaluation Database* (May 2005)

As the data clearly show, CDR has not delivered on its promise for increasing the efficiency of the drug review process and, in fact, has added a new barrier to patient access. To make matters worse, the CDR has no mandated public accountability and its activities lack transparency, since they are not subject to *Access to Information* requests. Consequently, it is our view that governments use CDR as a shield to providing timely access to patients. For example, the Ontario government refused to cover Fabrazyme® (agalsidase beta) to treat a rare genetic disorder until CDR issued a recommendation to do so.

Interestingly, Quebec, the only province not part of the CDR, had the best record in 2005 for approval times, at 263 days on average to list 11 drugs.

The CDR is looking for additional powers to review drugs, which will worsen patients' access to medications.

National Pharmaceuticals Strategy

Today, promises similar to those made when forming the CDR proliferate around optimizing pharmaceuticals management to describe a new initiative – the National Pharmaceuticals Strategy.

¹² IMS Health Canada: *FAME* database.

In September 2004, the First Ministers (except Quebec) met to discuss their strategy for healthcare reform. Among several policy initiatives announced following that meeting was a directive to form a Ministerial Task Force (co-chaired by Health Canada and British Columbia) to develop and implement the National Pharmaceuticals Strategy and to report on progress by June 30, 2006, to include the following nine actions:¹³

- Develop, assess and cost options for catastrophic pharmaceutical coverage;
- Establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness;
- Accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process;
- Strengthen evaluation of real-world drug safety and effectiveness;
- Pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines;
- Enhance action to influence the prescribing behaviour of healthcare professionals so that drugs are used only when needed and the right drug is used for the right problem;
- Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record;
- Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and
- Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.

F/P/T governments subsequently identified five focus areas to move the nine priority areas forward. The five focus areas are:

1. "Real world" drug safety and effectiveness
2. Expensive drugs for rare diseases
3. Drug pricing and purchasing
4. Catastrophic drug coverage
5. Common drug formulary

To date, the only meeting involving stakeholders took place in September 2005 on Real World Drug Safety and Effectiveness and there have been no other consultations with stakeholders. Regrettably, this Ministerial Task Force is not communicating to the public any details regarding the participants, meeting schedules, minutes, and agendas.

¹³ Office of the Prime Minister of Canada, "A 10-year plan to strengthen healthcare" (News Release, September 16, 2004, World Wide Web: <http://pm.gc.ca/eng/news.asp?id=260>).

Wrong Focus

Several of the nine elements of the NPS appear to be based solely on cost containment rather than patient needs. In light of the track-record of programs like CDR, the current direction of the NPS paints an ominous picture for the future of patient care in Canada. In the section that follows, we examine specific elements of the NPS and their potential impact on patients, based on international experiences.

Current Direction and Lessons from Abroad

Taken at face value, many of the nine points of the NPS seem to make sense. For example, catastrophic drug coverage should be a priority in reforming pharmaceuticals management in Canada. No Canadian should face financial hardship to pay for needed medical care – this was part of the basis for creating the Canada Health Act (CHA). However, unlike physician or hospital visits, prescription drugs are not under the CHA umbrella. Although public or private drug insurance pays for most drug costs in Canada, approximately 3% of Canadians have no access to “catastrophic” prescription drug insurance of any kind.¹⁴ We agree that policies to fill this coverage gap would promote appropriate access for this segment of the population.

National Drug Formulary

While catastrophic coverage is aimed solely at enhancing patient access, the creation of a National Drug Formulary, based on cost containment, purchasing strategies and influencing physician prescribing behaviour imply the opposite effect.

Currently, individual F/P/T governments run the public drug plans in Canada. Most provincial plans provide coverage for seniors and citizens receiving social assistance while federal drug plans provide coverage for numerous groups, including Aboriginals, Veterans, Canadians living in federal correctional facilities, the RCMP, and military personnel. Since each plan conducts its own review of new products for coverage, the number of drugs covered on public plans varies across the country. For example, between February 2003 and February 2005, Quebec added 70 new drugs to its list of drugs covered (referred to as its ‘formulary’).¹⁵ Over the same time period, British Columbia added five.¹⁶ The NPS is based largely on the British Columbia model of restricting access to innovative medicines. For example, a patient in British Columbia with Alzheimer’s disease, arthritis, diabetes, gastroesophageal reflux disease, or asthma does not have equal access to the same medicines that people living in other provinces do.

¹⁴ See Applied Management Consultants: *Canadians’ Access to Insurance for Prescription Medicines* (vol. 2), 2000. “Catastrophic drug costs” refer to drug costs exceeding 4% of annual family income.

¹⁵ IMS Health Canada: *FAME* database.

¹⁶ *Ibid.*

Restrictive cost containment policies

There are several reasons for this difference. British Columbia's public drug plan (BC PharmaCare) was recently overhauled and modeled, in part, after that of New Zealand. The BC PharmaCare program operates under restrictive policies of reference-based pricing (RBP) and therapeutic substitution. RBP is a process of containing drug costs by grouping drugs into a single class (usually drugs to treat the same disease or that have a similar physiological way of interacting with the body), takes the lowest price out of the category, and only reimburses products up to that amount. The patient must then pay any cost difference between a drug and the reference price. While this might save money in the short term for the drug plan, patients must pay more out-of-pocket, and have restricted access to the drugs they need. Other provinces are now using similar restrictive access policies, calling them by different names, such as lowest cost alternative or maximum allowable cost. They all serve to limit patients' access to medication they need to manage their health conditions.

Therapeutic substitution means that drugs deemed 'therapeutically equivalent' can be exchanged for one another, often a generic copy of a patented product. It is possible for governments to save money because generic drugs are typically less expensive than brand names/patented products. However, therapeutic substitution also applies when a formulary substitutes one patented product with a similar *but not identical* patented product, and only pays for the cheapest one. With this cost containment policy, the needs of patients who have better treatment outcomes by the drug not covered are disadvantaged. This is an example of how decisions based solely on cost containment can have negative implications on patients. It is therefore critical that decision-makers consider longer-term health impacts and costs for patients who do not have access to the products they need to become and keep well. In addition, under this BC model, patients who want to use a non-designated medication, have to pay the entire cost themselves, not just the difference between the costs of the two products.

A Canadian example of cost-containment backfiring

When BC PharmaCare forced patients to switch their medication as of July 2003, the 'switch-to' medication did not work for 25% of the people. This natural experiment in the 'real world' proved unequivocally in a Canadian population that not all patients react the same way to one medication. The clear and present danger in applying medicine rationing policies like that experimented with in BC to the national initiative is widespread increased utilization of healthcare services by patients whose disease is no longer managed by a pharmaceutical product, which is much less costly in the long-run than hospitalizations.

Ultimately, cost containment in BC has meant that patients living in that province have more barriers to access prescription medicines than any other jurisdiction in the country.

Access to medicines – Lessons from “Down Under”

Australia’s Pharmaceutical Benefits Scheme (PBS) represents the single purchaser of pharmaceuticals in Australia, and private insurance is almost non-existent in the country.¹⁷ This differs significantly from the Canadian system as we have many varied plans for prescription drugs such as diverse public jurisdictions and a wide range of private insurance payors. Australia has a national formulary that uses reference pricing and therapeutic substitution, and has created an environment where patients have highly restricted access to new medicines. Additionally, the PBS has set up barriers that discourage doctors from prescribing newer or more expensive medicines by forcing them to seek special government approval for the prescription. Even when no special government approval is required, patients are required to pay up to \$28.60 per prescription.¹⁸ The national formulary, purchasing strategies, and cost containment schemes in place in Australia are similar to the proposed NPS in Canada.

In New Zealand, prescription medicines are available through a tendering process where the government uses its single-buyer (or “monopsonist”) power to negotiate the lowest price for drugs through the Pharmaceutical Management Agency (PHARMAC). The “winning” bid gets the tender, and that is the only drug available to patients. The winning bid is not determined by the price of one drug however – drugs by one manufacturer are often listed as “package deals.” For example, Actos® (pioglitazone) is the only drug in its class covered in New Zealand despite having lower global prices than another drug in the same class, Avandia® (rosiglitazone maleate). However, Actos® was listed because it was sold in a package deal with Zyprexa® (olanzapine). This process was confirmed in a recent presentation by the president and CEO of PHARMAC, who indicated that among the central influencers of drug coverage were “package agreements” and “Ministerial direction.” Unfortunately, since not all patients react the same way to the same drugs, this process forces physicians to prescribe drugs that are cheapest for the government rather than the optimal therapy for individual patients. It is a dangerous move for a healthcare system to focus on cost containment, at the risk of patient health.

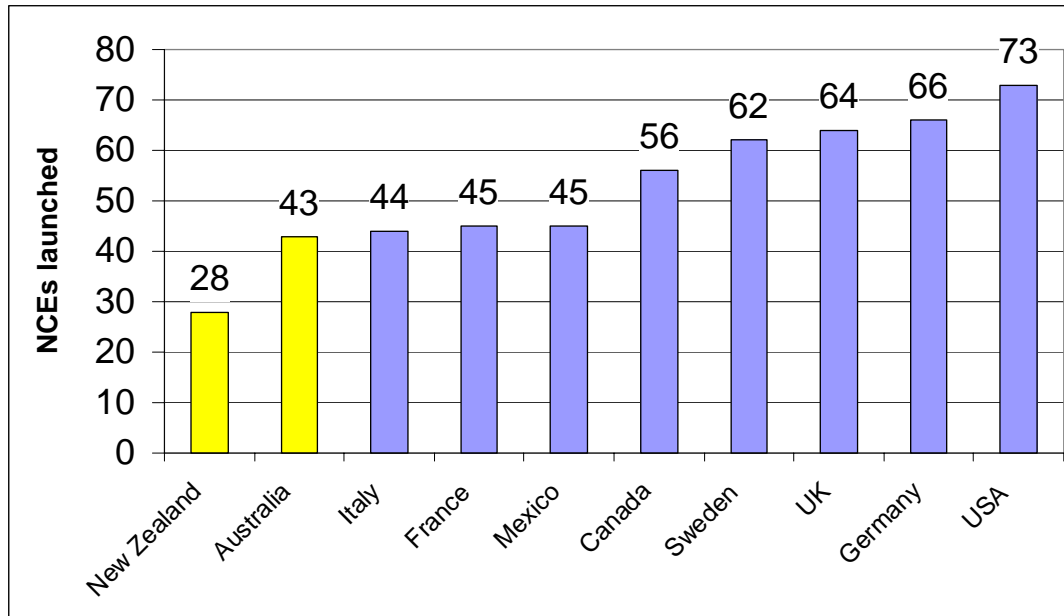
The systems in Australia and New Zealand have thus far demonstrated negative impacts on patients and the healthcare systems in those countries. For example, there were 85 new drugs released into the world market between 1994 and 1998. Of those drugs, 56 were available for sale in Canada, as demonstrated in chart 3 below. By comparison, 43 were launched in Australia and only 28 in New Zealand. While the number of drugs made available in Canada still pales in comparison to other countries like the United Kingdom and the United States,

¹⁷ Colleen M. Flood: “Prescriptions from Down Under: Can Canada Import Australia’s Pharmaceutical Benefits Scheme?” (Paper presented at the Institute for Research on Public Policy conference: *Toward a National Strategy on Drug Insurance: Challenges and Priorities*, September 2002)

¹⁸ Australian Department of Health and Ageing: *Schedule of Pharmaceutical Benefits for Approved Pharmacists and Medical Practitioners* (April 1, 2005)

patients in Australia and New Zealand are clearly disadvantaged when it comes to access to the newest therapies available.

Chart 3: New Chemical Entities launched in selected countries (1994-1998)



Source: Patricia Danzon: *The Impact of Price Regulation on the Launch Delay of New Drugs – Evidence from Twenty-Five Major Markets in the 1990s*. NBER Working Paper 9874 (July 2003)

Additionally, the systems in Australia and New Zealand correlate with worse patient health outcomes than in Canada and other developed countries. In 2001, there were approximately 77 coronary bypass surgeries per 100,000 population in Canada,¹⁹ whereas in Australia there were 85, and in New Zealand there were 105. In the same year, there were 52 deaths from heart attacks (acute myocardial infarctions) per 100,000 population in Canada, 60 in Australia, and 68 in New Zealand.²⁰ Finally, the negative impact on patients is accompanied by higher administrative costs for healthcare. In 2001, Australia spent \$84 (\$US PPP) on health administration and insurance, while Canada spend \$12.²¹ Clearly, restrictive, shortsighted systems like those in place in Australia and New Zealand might save some money within the drug budget in the short term, but overall health costs go up and patients are severely disadvantage compared to patients in other countries.

Similar findings in a paper released in August 2005 examining New Zealand's pharmaceutical management policies show, in particular, that while these policies have generated some short-term savings within the drug budget, they have "negatively impacted on health outcomes, patient autonomy, patient choice, and

¹⁹ *OECD Health Data 2005*.

²⁰ *Ibid.*

²¹ *Ibid.*

the ability to maintain a medical workforce.”²² In addition, savings that were generated for the government were achieved by shifting costs onto the general public. It concludes by calling for a full public review of New Zealand’s policies. According to a recent national poll, this is a view supported by almost 70% of the New Zealand population.²³

If a national formulary is to be based only on considerations of cost containment in the drug budget, it is expected that cost-containment policies such as RBP and therapeutic substitution would become part of a BC-style system at the national level. The experiences of Australia and New Zealand demonstrate the negative impact this would have on patients and the ability of their doctors to prescribe the most appropriate therapies. However, since the NPS is to include elements to “influence physician prescribing behaviour,” limiting treatment options appears to be in line with the planned NPS direction.

Reference pricing – the Nordic experience

It is worth considering other examples where theoretically appealing cost-cutting measures have failed at both the economic and patient outcome levels. Over the last five years, Norway and Sweden abandoned their reference-pricing regime because the expected cost savings did not materialize. To focus on the Norwegian example, a government-commissioned study in the country found that RBP had an adverse effect on appropriate prescribing and patient quality of life.

According to the study, conducted by the ECON Centre for Economic Analysis, “the reference pricing system increases the risk of incorrect use of medicines.”²⁴ The report finds that patients have, in many cases, been forced to switch medicines to comply with reference-pricing regulations and doctors have been unduly burdened with navigating a system to determine which products are reference-priced, requiring special handling.

This has offset anticipated savings through a more time-consuming process for prescribing drugs, and patients are being forced to stop using treatments that has stabilized their conditions and start using something else. For example, the ECON study found that “both doctors and pharmacies have had response from patients that indicates that they feel uncertainty/confusion concerning the reference products’ packaging look, effect, or use.”²⁵

Following the release of this report, the system in Norway was abandoned and replaced with one similar to that of Canada’s recent system before “cost containment” policies crept in, where prices are set according to a basket of

²² Alex Sundakov and Viktoria Sundakov (Castalia Strategic Advisors), *New Zealand Pharmaceutical Policies: Time to Take a Fresh Look* (August 2005)

²³ “Drug-maker’s survey hits at PHARMAC,” *The New Zealand Herald* (August 30, 2005)

²⁴ ECON Centre for Economic Analysis, *Evaluation of the reference pricing system for medicines* (Prepared for the Norwegian Ministry of Health and Social Services, 2000) p. 41

²⁵ *Ibid*, p. 42

international competitors and decision-making has been decentralized. While Norway's experience has led them away from a national system based on reference-pricing, the current direction of Canada's NPS appears to be heading full force toward this restrictive access policy, clearly heading the wrong way.

Healthcare at a Crossroads

BMC recommendations for building a patient-focussed pharmaceuticals strategy in Canada

In previous sections of this Paper, the BMC demonstrated how narrowly defined considerations of cost containment have negative implications for patients and ultimately not generate anticipated cost savings across the healthcare system. While we strongly advocate optimizing access to medicines for patients, we do appreciate that decision-makers in Canada face their own constraints in terms of financial and public accountabilities. However, the current direction of health policy is increasingly alienating consumers, patients, physicians, and other healthcare providers.

In the following section of this Paper, the BMC recommends a number of measures that are reasonable and easily implemented as the development of a National Pharmaceuticals Strategy moves forward. These recommendations do not compromise patient access to medicines or patient health outcomes. It is no leap to conclude that a healthier population leads to a healthier economy.

Overarching principles for a National Pharmaceuticals Strategy that benefits all Canadians

Eliminate barriers to access

As this paper has demonstrated, there are numerous barriers that exist in Canada, which either delay or block access to needed medicines. This is particularly so for newer drugs. It can also take the form of the dropping of an effective older medication from formulary coverage due to "cost containment." The Common Drug Review has created redundancies in the drug review process by adding another layer of bureaucracy between patients and newer medical therapies. Decision-makers must consider taking the following actions with respect to CDR:

- Bring drug review times in line with stated targets
- Revise CEDAC to allow for greater transparency and stakeholder input
- Eliminate provincial review processes that take place in addition to CDR, or eliminate CDR.

Expediting consumer and patient access to physician-prescribed medications does not compromise safety, since Health Canada establishes safety as a condition of approval to market the drug in Canada before manufacturers submit to the CDR for review for reimbursement recommendations.

Ensure patient involvement and public accountability

Ultimately, patients are the *most affected group* by any decision that involves access to medications or quality of medical care. Consequently, patients are the most important stakeholder in the decision-making process and have a vital place at the table in health-related policy dialogue. Unfortunately, as we have observed in Canada with both CDR and NPS, there has been no meaningful consultation with patients, which is why pharmaceutical policy is increasingly focused on cost containment instead of patient access. While it is important to consider optimal use of limited resources – such as appropriate use campaigns that ensure only those who need a medication are taking it – this needs to be balanced by the needs of key stakeholders like patients and the health professionals who care for them. Four things must therefore happen if the current process is to put patients back at the centre:

- Informed patients must have a seat at the table as part of the Canadian Expert Drug Advisory Committee (CEDAC);
- Groups like the CDR and the NPS Task Force must show greater transparency and accountability by holding meaningful and open consultations with patient groups. These should not take place in silos but multilaterally as equal partners with other stakeholders, including medical, nursing, and pharmacists associations, alternative health organisations, pharmaceutical companies, and others;
- All organizations and initiatives such as CDR that make decisions impacting patient access must be overseen by an elected representative and have direct and mandated accountability to the Canadian public;
- CDR's powers should not be expanded past new drugs until it has corrected the fundamental problems with the current system; and
- Policy discussions must focus on health outcomes and patient access in addition to cost considerations.

In undertaking these measures, a responsible government must take a more holistic approach to healthcare that appreciates the needs of patients, the views of doctors, and the impact that access to needed therapies can have on improving the nation's health and producing the demonstrated reductions in overall healthcare costs. Doing so ensures that Canada is a world leader in providing medical care, and ensures the sustainability of the healthcare system for future generations.

BMC recommendations based on the five areas of focus outlined by the NPS Secretariat:

1. "Real world" drug safety and effectiveness

- A *transparent* post-marketing surveillance strategy must be forged, which sets standards that provide the means of thorough and ongoing evaluation of safety and effectiveness of drugs. Following through on the findings of the Canadian Patient Safety Institute and learning from them will be one means of evaluating what is working and what is not.²⁶
- Reduce drug review times to the targeted 355 days while ensuring evaluations of safety and effectiveness of drugs.
- Probation of drugs released into the market should be at least two years, to allow for adequate safety and effectiveness assessments.
- F/T/P governments must put into place a collaborative process for collecting and sharing information as well as reporting side effects and adverse reactions associated with drugs, supported through the collection of medication incident reports as part of an expanded Regional Adverse Reaction Reporting Program through the Marketed Health Product Directorate of Health Canada.
- Recommendations of the Standing Committee on Health concerning *Opening the Medicine Cabinet: First Report on Health Aspects of Prescription Drugs*, should be implemented and enforced.
- "Providers, who must work with patients, as partners, are the key to any system redesign to confront patient safety"; it is imperative to involve patients and physicians as well as others involved in healthcare delivery to find out how and why systems that work well, reduce errors and adverse events.^{27, 28}

Discussion

The government must ensure active post-marketing drug surveillance strategies and standards are in place that allow safety and effectiveness of drugs to be evaluated on a thorough and ongoing basis. This must include a correlation to international data.

However, until Health Canada approves drugs for sale in Canada, real world safety and effectiveness cannot be determined. According to a report commissioned by the government of the United Kingdom, Canada lags

²⁶ CIHI (2005). *Medication Incident Reporting and Prevention Systems: Environmental Scan*. Ottawa: CIHI. p.3.

²⁷ One World Inc. (2005). *Working Conference on Strengthening the Evaluation of Real World Drug Safety and Effectiveness: Summary Report*. Ottawa. p.ii.

²⁸ Arah, OA & Klazinga, NS (2006). How safe is the safety paradigm. *Qhc.bmjournals.com* at www.qshc.com

significantly behind other developed countries in regulatory approval times.²⁹ At the same time, there is no evidence to demonstrate that the delay is due to more rigorous safety and effective reviews; even though some government bureaucrats contend that the delay is to protect the patient.

The government must support the collection and reporting of adverse reaction and medication incident reports made through an expanded Regional Adverse Reaction Reporting Program, as part of the Marketed Health Product Directorate (MHPD). *Minimum standards* should be set by the MHPD for drug surveillance information and should be disseminated to and used by physicians and other health professionals, pharmacists, patients, and the general public.

2. Drugs for Rare Diseases

- A policy for rare disorders should be developed as a priority, and with those most affected, to safeguard the rights of people with rare disorders and their access to best medicines and treatment. This is supported by a study that suggests that every dollar invested in new treatments and medicines relieves the health care system of expenses seven times greater in other medical or emergent areas such as hospitals (emergency departments), physicians/specialists, and home care.³⁰
- A strategy must be developed for a coherent, justifiable rule to determine how much to pay for orphan drugs.
- Canada must join the global fight to protect those individuals with rare disorders, and support global research and development for new effective medicines.

Discussion

The BMC believes in and supports the creation of a policy to assist those faced with expensive drugs for rare diseases³¹ (or an orphan drug policy) that has guidelines and opportunities to provide/develop/offer treatments for rare disorders in Canada. Any such policy should include the development of a social program that provides funding to enable individuals affected by rare disorders to obtain access to appropriate treatments.

Given the high cost of drugs for rare diseases, orphan drugs cannot be assessed within the standard cost-effectiveness evaluation framework. The BMC recommends that a strategy to provide a coherent, justifiable rule for determining when and how much to pay for orphan drugs is needed, as are incentives for innovation in the global fight against rare diseases.

²⁹ Department of Health (United Kingdom): Pharmaceutical Industry Competitiveness Task Force, *Competitiveness and Performance Indicators, 2004* (p. 40)

³⁰ Ottawa (2006). Patients are waiting longer to access new medicines in Canada. *IMS Report*.

³¹ Canadian Organization for Rare Disorders: Orphan Drug Policy Position Statement.

3. Drug pricing and purchasing

- A national drug pricing and purchasing plan should make every effort to control the cost of drugs to patients and consumers.
- No plan should put patient access at risk by making drug supplies dependent on a few manufacturers, or by limiting/restricting access of more expensive drugs to physicians and their patients.
- NPS must have the resources, through research or other, to identify the factors contributing to escalating drug expenditures, and the means to control these expenditures with consideration of the cost-benefit trade-offs for patients/consumers, governments, and manufacturers.³²

Discussion

A strong message to Canadians from some economic alarmists has been about the rising expenditures of healthcare, and particularly of prescription drugs, and the impact this could have on the sustainability of Canada's existing healthcare system. The Canadian Institute of Health Information reports that overall drug spending in Canada in 2002 reached \$18.1 billion. "This translates to \$577 per Canadian, of which roughly \$209 was subsidized by public drug benefit programs, \$152 was covered by private insurers, \$216 was paid out-of-pocket (\$103 on prescribed drugs, and the remaining \$113 on over-the-counter drugs and personal health supplies)."³³ Of the total drug expenditures in 2002, prescribed drug spending came to \$14.6 billion, which represents about 80.3% of the total and is a 10% increase over 10 years.

For individuals specifically, our current system provides full funding for acute institutional care, including all drugs provided during a hospital stay. However, on discharge, this expense is transferred to the patient or his/her insurer. Yet our goal is – or should be in a system created to provide for patients – to fund the service or product the patient needs, and not the institution. There is no logical or equitable reason why drug costs should be transferred to the individual from the institution. Patients at home have no opportunity to bulk purchase the drug and negotiate prices accordingly, so it is a greater burden to the system to send the patient home without the ongoing discounts provided to the institution.³⁴

For patients, "the value of pharmaceuticals should be measured in the context of the overall burden of illness, and the positive impact of medicines on direct and indirect illness costs. New medicines offer medical and technological advances in the treatment of diseases, both in terms of mortality (increased life expectancy and decreased infant mortality) and morbidity (decreased illness and thus use of healthcare resources, less disability and better quality of life.)"³⁵

³² Dugal, R, Mani, A, & Potvin, K (2002). Look beyond budgets to the broader benefits. *Healthcare Papers* 3(1): 77-82.

³³ Canadian Institute of Health Information (CIHI). (April 23, 2003). Spending on prescribed drugs continues to increase. *News Release*.

³⁴ National Forum on Health, 2002. Pharmaceuticals and the Healthcare System. p.1.

³⁵ Rx&D. (2003). Submission to Ontario Drug Benefit. p.11.

While BMC supports reducing cost barriers to drug access, the process of bulk purchasing is of concern because of its impact on drug supplies, as recently demonstrated by the flu vaccine shortages of 2004. Since vaccines are bulk purchased through a tendering process, these products are usually supplied by, at most, two or three companies in any given country. In 2004, a company providing 50% of the American supply had manufacturing problems that resulted in a massive shortage of flu vaccines. Access to immunization was highly restricted, and many Americans came to Canada to obtain the vaccine, using up the Canadian supply. A national drug pricing and purchasing plan should make every effort to control the cost of drugs to patients and consumers. At the same time, no such plan should put patient access at risk by making drug supplies dependent on a few manufacturers, or limiting treatment options by favouring one manufacturer over another. Greater pharmaceutical and other health manufacturers' investment in Canada would encourage increased choice, innovation, cost-effectiveness, and availability.

Efforts to keep formularies economically prudent should ensure that:

- patient access to medications that improve long-term health or quality of life is not restricted;
- cost cuts are not deferred to the patient; and
- physicians' options to prescribe the medications they believe are right for their patients must be unrestricted.

Any NPS must identify the factors contributing to the rapid growth in drug expenditures, and implement strategies for controlling these expenditures. Canada needs an examination of the trade-offs between costs and benefits for patients and consumers, drug manufacturers, and governments. Some strategies could include:

- ensuring suggestions of "cost-effectiveness" from jurisdictions outside of Canada be validated by real-world experience in this country
- disseminating the evidence to physicians who prescribe the medications
- re-evaluating the evidence on drug costs and prices
- increasing the transparency around the acquisition costs of drugs
- including generic pricing as part of the pricing review system in Canada

4. Catastrophic Drug Coverage

- NPS must be created with the solid foundation that no Canadian will face financial hardship in order to receive the best medical care available. This includes prescription medicines.³⁶
- F/P/T governments must work collaboratively on NPS, and not lose sight of the special needs of patients dealing with diseases or medical conditions requiring expensive treatments or medicines. Over 87% of

³⁶ Romanow Commission (2001). *The Future of Canada's Health Care*.

Canadians believe that if one province provides a drug, other provinces should automatically cover it as well. There should be a maximum amount people would pay personally out of their own pocket. Physicians should not be limited in their prescribing of best medications because of availability of drugs or because of the patient's insurance coverage or lack thereof.³⁷

- It will be necessary to establish a gold standard for pharmacare coverage that supports equity for all Canadians, including those with persistent chronic disease requiring expensive treatment/medicines.³⁸ Consideration must be given to those households where even 3% of income is too much to bear out-of-pocket for their prescription needs. This is catastrophic consideration.³⁹

Discussion

Numerous Canadian studies, including the Romanow Commission and the Kirby-LeBreton report, call on governments to make life-saving drugs universally accessible. In addition, the newly elected Conservative Party's platform contained a commitment to implement a catastrophic drug plan.

The Kirby-LeBreton proposals call for "catastrophic" coverage of drug expenses greater than 3% of a family's income. This would protect those individuals not covered by a public or private plan from financial hardship, which mostly include low-income Canadians and anyone requiring high-cost drugs to treat rare or complex diseases.

The program should be based on the principle of access to the most effective treatment for the patient, and recognize the physical and emotional hardship that comes in dealing with such diseases. It is paramount that governments in Canada work in a collaborative manner to establish appropriate cost sharing between the Federal government and the provinces, and not lose sight of the special and diverse needs of patients and their families.

5. Common drug formulary

- Governments must eliminate the duplication of efforts created by the Common Drug Review, and other levels of administrative redundancy.
- Provincial drug plans must revise their approvals of drugs to the formulary listing, not by the CDR recommendations but by the scientific evidence that supports the benefits for their population and their healthcare delivery.

³⁷ Pollara Research (2005). *Health Care in Canada Survey 2005*. www.hcic-sssc.ca

³⁸ Hoel, M. (2005). Concerns for equity and the optimal co-payments for publicly provided health care. *CEsifo Working Paper No 1620*. at www.DESifo-group.de

³⁹ Coombes, MF, Morgan, S, Barer, ML, Pagliccia, N. (2004). Who's the Fairest of Them All? Which Provincial Pharmacare Model Would Best Protect Canadians Against Catastrophic Drug Costs? *Longwood's Review*2(3): 13-26.

- There needs to be universal and equitable access to drugs across Canada regardless of a NPS or provincial plans. A national plan makes sense for many reasons including joint efforts around cost savings for administration of the NPS as well as consistency in drugs across Canada.

Discussion

Governments must eliminate the duplication of effort and resulting increased barriers, which came with the formation of the CDR. A recent report on the CDR by IMS Health finds that provincial drug plans have listed drugs on their formularies in an identical manner to the CDR recommendation in all but one case.⁴⁰ This means that the CDR is making recommendations that the provinces' advisory bodies would have ultimately chosen independently.

To date, CDR has turned down 60% of the applications for new therapies. In addition, provincial uptake of CDR recommendations over the last two years has been low. For example, between May 2004 and December 2005, British Columbia listed only 21% of products recommended for coverage by CDR. This compares to 24% for Alberta and Ontario, and a national average of 27%. Meanwhile, Quebec, which does not participate in CDR, listed 58%.⁴¹ Not only does the CDR process negatively affect patients, but it also stifles research and discourages industry from investing in Canada and conducting clinical trials here. It also means that Canadians are at a standstill, not getting new and innovative medications that could enhance health outcomes, which are important for the country's entire economy.

Irish Example

To use an international example, Ireland automatically reimburses all drugs, once approved for sale by regulatory agencies. Seniors and social assistance recipients are eligible for full coverage of all drugs. Additionally, patients living with one of 14 chronic diseases have 100% of drug costs related to their condition reimbursed, including drugs to treat complications of their disease. All other Irish citizens are covered either by private plans through employers, or may purchase a publicly-subsidized plan with a deductible of up to €85 (Euros) per month. The government is able to finance its drug access regime through substantial investments by the pharmaceutical industry, which employs almost 50,000 people through direct and indirect employment and, in 2004, exported approximately \$18.6 billion worth of products.⁴² These compare to approximately 32,000 people employed directly and indirectly in Canada and \$3.4 billion worth

⁴⁰ Darrell Ethell and William Amegatse: "Uptake of CDR Recommendations by Provincial Drug Plans," *Provincial Reimbursement Advisor Quarterly* (IMS Health Canada, February 2005)

⁴² Irish Pharmaceutical Healthcare Association: *The Pharma Industry At-A-Glance* (2005) (<http://www.ipha.ie/htm/info/download/Pharma%20Industry%20at%20a%20Glance%202005.pdf>)

of exports.⁴³ In addition, Canadian governments silo approach to healthcare budgeting means that savings in other parts of the healthcare budget resulting from the use of medications to control disease, e.g. hospital budgets, physician visits, diagnostic costs etc., are not recognized. Not factored into the overall economic perspective are the quality of life and productivity of Canadians.

Alternative to Duplication

Elimination of effort duplication can occur if either provincial drug plans abolish their review processes and take up all CDR recommendations or the CDR is abolished and the system returns to jurisdiction autonomy. Decisions around this issue must address the fundamental problems with CDR that make it poorly functioning or decision-makers should eliminate the CDR, as in its current form it does not meet the needs of Canadians. It is intuitive that provinces should be able to tailor their drug plans to the specific needs of their populations and to complement the structure of their healthcare systems. Based on Quebec's experience, CDR is not efficient and does not provide a more quality result.

Notwithstanding any decision above, BMC recommends that access to medicines for patients be based on physicians' choice for their patients, while at the same time recognizing the impact on increased business investment by the pharmaceutical industry in this country to finance any potential increases in government spending. It is paramount to remember the overall benefit that medications bring to healthcare.

Summary

There are some strong but basic recommendations which BMC is making and which are supported by others in reports or studies. These include:

- The federal and provincial governments must collaborate on the NPS and standards to ensure Canadians receive the best drug plan to meet their needs, and that cost containment not be the driving force for this plan.
- The five priority areas for the NPS must receive the governments' full attention and support. The other four areas will still need to be addressed before too long:
 - Enhance action to influence the prescribing behavior of health care professionals so that drugs are used only when needed and the right drug is used for the right problem.
 - Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record.
 - Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs
 - Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.

⁴³ Canada's Research-Based Pharmaceutical Industry (Rx&D): *About Rx&D* (http://www.canadapharma.org/About_Rx&D/)

- The NPS policies must be patient-focused or centred, guided by principles of physician choice, patient access and needs based on scientific evidence in clinical practice guidelines, and containing drug costs by providing the best treatments and medicines as preventative measures for complications, which improve health outcomes and in turn, reduce the need for extra doctors' visits or visits to the emergency department, or hospitalization.
- Government transparency and accountability, and public involvement must be in place from the outset -- this will go a long way towards ensuring support by the Canadian public for the NPS that will be developed, and ensuring public ownership and accountability as well.
- More research in different areas and aspects of the NPS should be promoted and funded through credible funding agencies, such as the Canadian Institutes of Health Research. Canadians have indicated they would support research which is innovative and leads to improved health outcomes for patients and Canadians generally.⁴⁴ Before Reference-based pricing is instituted, the government and Canadians need to assess the findings coming out of B.C. and New Zealand which have this pricing system in place. Most of the studies indicate problems primarily with patients, but also with physicians who desire to have choices in prescribing or to use the special authorization process when necessary, but cannot in this system.⁴⁵
- More needs to happen with setting up information databases to track prescribing behavior of physicians through the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS), drug needs and use (medication management) by patients and Canadians through various means such as the National Prescription Drug Utilization Information System (NPDUIS)⁴⁶, patents and pricing decisions for all patent and generic drugs related to drug plan(s) proposed⁴⁷, health outcomes for improvement, and adverse drug reactions and related indicators or measures⁴⁸. These databases are necessary for ensuring proper evaluation of any drug in review or on the market or the entire NPS through credible research methods in tracking longitudinal changes.
- Through the gathering of credible evidence, decision makers will be better informed as well the stakeholders. Drug policies or policies for NPS are dependent on solid evidence to support and inform the decisions made for policies which will impact all Canadians.⁴⁹

⁴⁴ Pollara Research (2005). *Health Care in Canada Survey 2005*.

⁴⁵ Reference Based Pricing Literature Review – unauthored document.

⁴⁶ Sketris, IS, Brwn, MG, & Murphy, AL (2004). Policy choices for pharmacare: the need to examine benefit design, medication management strategies and evaluation. *Healthcare Papers* 4(3): 36-45.

⁴⁷ Ouellet, B. (2005). Drug pricing: Current trends and future directions. *Pharmac Sales and Marketing Summit 2005*. Toronto. November 21.

⁴⁸ Lindberg, MC. (2002). Let evidence be the arbiter. *Healthcare Papers* 3(1): 43-46.

⁴⁹ Gray, J. (2002). Drug policy: An oxymoron? *Healthcare Papers (Commentary)* 3(1): 56-62.

- A good starting point for looking at the fundamental principles of a National Pharmacare Program, whether it becomes NPS or not, is the information gathered through focus groups in 2004. “Consumers and patients agreed that they have a legitimate right to help determine how the National Pharmacare debate should move forward”⁵⁰

While the Federal government considers how to address pharmaceutical management in Canada, all levels of government should be mindful of the impact that policy measures based solely on containing costs in the drug budget have on the ability of patients to access the medicines they need. They will also need to consider the positive impact that access to medicines has on other healthcare costs like reduced hospitalizations and physician visits. Unfortunately, to date, cost-cutting no matter what the cost to patients appears to be the direction of policymaking, which should come as no surprise due to the lack of patient input. Patients not being consulted as equal partners and any requests for additional information regarding the NPS plans and processes are often denied.

It is unacceptable for politicians to use third party review bodies like CDR as a shield to providing access to needed care while at the same time avoiding accountability for those decisions. Policy in Canada must be patient focused – guided by principles of physician choice and patient access *in addition to* the best available scientific evidence for cost effectiveness.

Governments must act now to create transparency and enable accountability by opening a meaningful dialogue with all stakeholders to ensure that Canadian health policy acts as a facilitator, rather than a barrier, to the best available care. Let’s look less to questionable propaganda from abroad about “working” policies where the whole picture is not provided, and more to seeking a uniquely Canadian solution right here from real life experiences within our homeland.

Elected representatives must be accountable to the public they serve.

⁵⁰ Hosted by Ward Health and CTAC, National Pharmacare Program, Canadian Focus Groups, November 10-28, 2004. Synthesis Document.

Appendix 1

Best Medicines Coalition

The Best Medicines Coalition (BMC) was formed in 2002 as a grassroots group of consumer and advocacy organizations. The BMC is a broad-based alliance of organizations and individuals working in, or promoting, education, care, research and consumer-focused advocacy on issues related to drug review reform, drug access and health policy development. The members of the BMC represent millions of Canadians living with, or affected by, chronic disease or illness.

The BMC believes the safe and timely access to the best evidence-based medicines is a key component of effective healthcare prevention and treatment for all Canadians and is committed to ensuring consumer participation, engagement, transparency and accountability of the Canadian drug review and approval process.

The BMC is well positioned to work with government and other interested parties to develop an effective model for the meaningful and equitable inclusion and participation of consumers/patients in Canada's drug review system. This could include the development of training and education sessions for patients to ensure their meaningful inclusion on the various committees and bodies responsible for the drug review process.

BMC Participating Organizations include:

The Asthma Society of Canada - www.asthma.ca
Arthritis Consumer Experts - www.arthritisconsumerexperts.org
CARP – Canada's Association for the Fifty-Plus - www.fifty-plus.net
Cancer Advocacy Coalition of Canada - www.canceradvocacy.ca
Canadian Arthritis Patient Alliance - www.arthritis.ca/capa
Canadian Breast Cancer Network - www.cbcn.ca
Canadian Cancer Advocacy Network – www.neutropenia.ca
Canadian Hemophilia Society - www.hemophilia.ca
Canadian Hepatitis C Network/Hepatitis C Foundation of Québec
Canadian Organization for Rare Disorders - www.cord.ca
Canadian Osteoporosis Patient Network - www.osteoporosis.ca
Canadian Society of Intestinal Research - www.badgut.com
Canadian Treatment Action Council - www.ctac.ca
Epilepsy Canada - www.epilepsy.ca
HepCure - www.hepcure.ca
Lymphoma Foundation of Canada - www.lymphoma.ca
Osteoporosis Canada - www.osteoporosis.ca
Tourette Syndrome Foundation of Canada - www.tourette.ca
Yellowhead Tribal Council - http://www.ainc-inac.gc.ca/ps/lts/fng/mp/pg14_e.html

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