PharmaCare

PharmaCare was a topic for discussion in the Conversation on Health. PharmaCare coverage, the use of prescription medications and cost pressures were topics highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of PharmaCare.

PharmaCare Coverage

Many participants express concern that the PharmaCare plan is not responsive enough to the needs of British Columbians. Some feel that PharmaCare is too slow to approve new medications and that the approval process lacks transparency. There is also concern that the referenced based pricing system limits treatment options and is not flexible enough to meet patient needs.

Many participants feel PharmaCare leaves too much of the cost of prescriptions on the patient. They point to high deductibles, dispensing fees and prescriptions for drugs that are not covered, as costs that can limit access to medications for many British Columbians. Others express frustration that alternative medications and supplements are not covered, even if prescribed by a doctor, and do not count towards the PharmaCare deductible.

Drug formulary decisions should be based on scientific evidence, clinical expertise and the health experiences of patients, not based on economies which are hidden behind the guise of Pharmacare "sustainability".

– Online Dialogue, Coquitlum

Use of Prescription Medications

Some British Columbians feel that prescription medications are over-used, and frequently mis-used. They feel that non pharmaceutical options are often not adequately explored before a prescription is offered and that too often symptoms are medicated instead of determining the underlying problem. Participants are hopeful that improved public education and prescription supports for health professionals could address these concerns.
Every one of us has got a drug cupboard at home in [our] bathroom for the medicines you didn’t take. And a lot of the evidence suggests that’s because people weren’t really involved with the doctor and they took the pills 'cause the doctor told them to take it and they stopped them after two days.

–International Symposium, Vancouver

Many participants are troubled that prescriptions can only be renewed for a maximum of three months. Many see this practice as an added burden on patients and doctors and unnecessary for British Columbians on long-term or maintenance medications.

PharmaCare Cost Pressures

Participants express concerns about the rate at which PharmaCare costs are increasing. Many British Columbians feel that the Pharmaceutical industry is in part responsible for escalating drug costs, suggesting that the marketing of prescription medications and the extended length of patents are two of the leading causes of increasing costs. Some also question how we regulate the relationship between the manufacturers of prescription medication and those who prescribe to the public, and the effect that relationship has on drug usage.

A number of solutions are suggested to address increasing costs. Many participants express interest in a national formulary that would allow bulk purchasing, increased federal funding and consistent coverage across the country, as a means to limit increases in spending. Building on the existing referenced-based pricing system, many recommend including therapeutic and generic substitution as another way to control costs. Some participants feel that prescription medications are responsible for many of the recent gains in health outcomes and that further limiting spending and choice in drugs will lead to cost increases elsewhere in the health care system. They suggest that increasing spending on prescription medications will save the health care system money overall.

[We] have to learn something from New Zealand… a national formulary that is consistent right across the country, so that every province has the same package of drugs that are covered by the public system, and you have bulk purchasing power. Imagine, if you had ten provinces and three territories all getting together and saying, we are going to negotiate with big pharma… as a nation, right across the country.

– Focused Work Shop on Delivery Models, Vancouver
Conclusion

The PharmaCare plan and the role of pharmaceuticals in health care were the source of much debate during the Conversation on Health. Some British Columbians feel that, when used appropriately, pharmaceuticals can offer a non-invasive way to address many illnesses and conditions. However, they are concerned that the costs of pharmaceuticals are becoming an increasingly large burden for patients and the PharmaCare plan. There are a number of solutions proposed to address this concern, but there was no consensus on the best way to balance providing treatment options while controlling costs.
PharmaCare

This chapter includes the following topics:

PharmaCare Administration and Regulations
Costs of Prescriptions
Use of Prescription Medications
PharmaCare Coverage
Reference-Based Pricing and Generic Drugs
Pressures on PharmaCare
Pharmaceutical Industry

Related Electronic Written Submissions

| Contribution to the BC Conversation on Health |
| Submitted by Merck Frosst Canada Ltd.       |
| Is BC’s Health Care System Sustainable?     |
| Submitted by Canadian Centre for Policy Alternatives |
| Submission to the BC Conversation on Health |
| Submitted by the Summit on the Value of Medicine |
| Innovation our Passion: Better Health our Mission |
| Submitted by the Rx & D Canada’s Research-Based Pharmaceutical Companies |
| A Summary of the Public Forum on Health Care Organized by the Kamloops Citizens Concerned About Public Health Care |
| Submitted by Kamloops Citizens               |
| HEU Submission to the Conversation on Health |
| Submitted by the Hospital Employees Union    |

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Professional Compensation; Medical Services Plan and Seniors.
PharmaCare Administration and Regulations

Comments and Concerns

**PharmaCare Deductible**

**Special Authorities**

- **Comments on the PharmaCare deductible system:**
  
  - The PharmaCare deductible is too onerous for people on fixed income.
  
  - When Registered Retirement Savings Plans (RRSP) are cashed in, their value is added to your annual income and increases your PharmaCare deductible.
  
  - PharmaCare deductibles are too high for most British Columbians.
  
  - Through Fair PharmaCare, I subsidize the less fortunate with my family deductible of $1,900 before my family qualifies for drug assistance. Fair PharmaCare then imposes another financial restriction or fine as it pays only 70 per cent of my drug costs over $1,900 until I reach a second plateau of $2,550.
  
  - The PharmaCare deductible is based on the previous year’s income tax return and is a form of double taxation, which is unethical if not illegal.
  
  - With the PharmaCare family, maximum deductible set at $3,000, most patients will end up paying for their prescriptions and in so doing, subsidize other users. This is not equality and is unfair.
  
  - Fair PharmaCare is prejudiced against some people. Seniors should be entitled to equality with everyone else in terms of the PharmaCare deductible and not penalized because they worked hard, spent many years of their lives in university and saved money.
  
  - I am not able to work due to illness and I require many prescriptions but because I was able to save and have a Registered Retirement Savings Plan (RRSP) I am required to pay a large deductible.
  
  - It does not make any sense that the threshold for PharmaCare deductible is $15,000 when the threshold for Premium Assistance is $24,000. The thresholds should be set at $24,000 for both plans and an individual should be able to sign one form to qualify for both programs.
  
  - Keeping track of the PharmaCare deductible for those with many prescriptions is a headache.

- **Comments on Special Authorities:**
  
  - Special Authority criteria are outdated. We often get different advice and cannot rely on it from Maximus.
We should not be paying someone at PharmaNET to reject or approve a Special Authority when the community pharmacist has the same information, if not more.

The special authority system is too slow in responding to requests.

- PharmaCare is too focused on the cost, not the value.
- The PharmaCare program is the only program left over from the previous administration that the current government has not made more responsive to patient needs.
- The system is set up for safety and price but the customer or patient has been forgotten.
- PharmaCare will not pay for more than three months of prescriptions at a time.
- The provincial government encourages those on Vancouver Island and in the Lower Mainland to prepare for earthquakes, which includes having prescriptions on hand. However, the Government prevents earthquake preparedness for those who need longer-term medication, as prescriptions are only available in three month spans.
- Income testing for services is not realistic. The threshold for coverage should be just over the poverty rate.
- I had a coverage issue and was told to write PharmaCare to get a letter of exception from my Doctor so I could continue to use the same drug I have always used. No one ever responded to the letter that I wrote.
- The PharmaCare program is deteriorating. It is increasingly working against patients rather than for patients.
- The Ministry of Health does not have meaningful ongoing consultation with one of its principal interests, Canada's Research-Based Pharmaceutical Companies. The Ministry of Health projects and manages the PharmaCare budget without in-depth analysis and involvement from industry.
- It is unfair that every January I need to be re-assessed for Fair PharmaCare.
- We recently moved back to Alberta and now the Government says they cannot reimburse us for our heart medications we needed while waiting to get health care insurance in our new province. We have worked hard all our lives and now we cannot live in dignity because of this rule.
- I also believe that the 1941 birth year cut-off for PharmaCare coverage grandfathering is simply unfair. Everyone over 65 should have the same coverage.
- The more my health care costs rise the more money I need to withdraw from my Registered Retirement Savings Plan (RRSP) but doing so increases my PharmaCare deductible, which then costs me more. It is a vicious circle.
• In the east once you reach 65 years of age your prescriptions are taken care of. The PharmaCare system seems like a poor reward for working hard to earn a pension.

• Many pharmacies deliver dispensed prescriptions on a weekly basis. So someone taking three prescriptions gets a weekly pack delivered for free and PharmaCare is billed for seven days of each prescription, plus a dispensing fee for each one. For a 90 day prescription, pharmacies are charging at least 11 more dispensing fees, which is approximately $77 more per prescription, than if they delivered all the 90 day supply in one trip. There needs to be a rule that says only one dispensing fee may be charged per written prescription.

• Too many laboratory tests are required to receive medication. In the past, people were able to have one annual test and receive a prescription for one year of medication.

• Fair PharmaCare is not working for me and I doubt if it is even understood by most people. The financial burden for prescription drugs was shifted by the provincial government to the private insurance companies. My PharmaCare deductible is so ridiculously high that I will never receive any government help and I have no extended health care insurance.

• There is too much paperwork for Fair PharmaCare.

**Ideas and Suggestions**

**Deductible**

- Ideas about the PharmaCare deductible system:
  - Deductibles should be lower for people who live below poverty level.
  - Seniors have already paid their dues and should not have any deductible.
  - PharmaCare should be provided free for people with an income under $35,000 per year.
  - Create a pro-rated scale of coverage for those between low-income and higher income brackets, especially if they are married or have dependents.
  - We should base the PharmaCare deductible on personal, not family income. Children could be covered automatically.
  - Use a three to five year average income to determine the PharmaCare deductible.
  - Lower the allowable income level for people suffering from chronic illnesses.
  - Fair PharmaCare is already fair.
  - PharmaCare deductibles should be based on several years of income and there must be provision in case of a sudden drop in income.
The PharmaCare system is a prime example of a system working well. People use discretion in their prescription usage because they must also make their own contribution.

- PharmaCare should support the purchase of six months of prescriptions at a time, especially for out of country travelers and those with managed, chronic illnesses.
- There must be more advocates to help people deal with PharmaCare.
- Allow prescriptions written by a doctor who has moved to remain valid.
- Eliminate handwritten prescriptions.
- If it is possible to have a system of special authority pharmaceutical drug approval, surely it should not be too difficult to institute a similar program for those suffering from chronic diseases, which would prevent the abuse of such treatment modalities, and benefit many, while saving on the cost of pharmaceutical products.

### Outstanding Questions
- Why are static prescriptions not available for twelve months, instead of only three months?
- When will the Government recognize naturopathic medicine by allowing the cost of supplements and other remedies to count as part our Fair PharmaCare deductible?
- Why have special authorities if 98 per cent of all special authorities are approved and only doctors can apply?

### Costs of Prescriptions

#### Comments and Concerns
- PharmaCare will cover the costs of drugs only up to a certain point. If a pharmacy charges more than that, either the overcharges are absorbed by that pharmacy or if one is not paying the PharmaCare deductible, the patient absorbs that cost.
- The current PharmaCare program still costs too much for the working poor. We need a National PharmaCare plan.
- The cost of drugs is still prohibitive in many instances.
- Patients on lower incomes must make impossible choices between satisfying fundamental human needs and buying expensive drugs that have not been approved by the PharmaCare drug formulary.
- I require certain prescriptions to maintain my good health and not be a burden on the hospitals. I find myself having to spend a great deal of money annually, when
others are able to obtain the same prescriptions free. Under a true one-tier system prescriptions and all other medical expenses should be available to everyone, equally, at the same cost.

- I am a pharmacist and I am puzzled by the manner that PharmaCare gives away Air Miles to patients. I understand if the patient pays for their own prescription then they are entitled to the Air Miles which they have earned. What puzzles me is when a patient is over their deductible and PharmaCare is paying for the prescription, why is the patient still receiving the Air miles? These Air Miles belong to the Government and could be put towards travel costs for government employees and ministers. They would amass huge savings to the Government and to the taxpayers.

- With 46 per cent of total prescription drug costs funded out of the public purse and 54 per cent funded privately, I think governments would love nothing more than to offload more of those costs.

- The specialists can prescribe any medicine but when a family has to try and pay out $300 a month for it, because it is not covered, the whole family suffers. It can become a choice between putting food into our mouths and paying a medical bill.

- The cost of drugs has to be addressed. So many find it a real financial hardship to keep paying for medications that they must take, often for the rest of their life. All of the costs of research and experimentation by the drug companies cannot be passed on to the consumer.

- With Fair PharmaCare, patients with extended coverage piggyback their plan and then when the deductible is reached, the extended plans are off the hook for the cost of drugs.

- The PharmaCare formulary and the hospital based formulary are not harmonized. This causes problems for patients when they leave the hospital and have to pay for medications they had been receiving for free while hospitalized.

**Ideas and Suggestions**

- There must be more public transparency in drug pricing and dispensing fees.

- More price transparency of drugs for patients and doctors. For example, pharmacies need to advertise or make easily available their current prices, dispensing fees and policies.

- We should empower consumers with the knowledge of the costs of medicine to enable them to make informed choices.

- Prescriptions should be free for people on welfare and for seniors.

- More funding is required to help people on disability who need to be on medication.
• Drugs should be the same price throughout the province.
• The dispensing fee from drug stores should be the same from store to store.
• A catastrophic drug program seems to be an easy solution but is bad policy.
• Charge people for medication received in Emergency Departments.
• Not-for-profit medications should be produced.
• Government should offer generic medications at cost to patients.
• Access to drugs should not be contingent on what job you have, if your employer has a good benefits package or if you have enough money for drugs and the other necessities of life.
• The Government should lower the cost of prescriptions with legislation.
• There should be rebates on the price of prescriptions for non-smokers.
• PharmaCare is a good system that is helping low-income people afford drugs.
• Drugs are readily available at accessible prices.
• I would like to see access to medications for all British Columbians of any age, on an equal footing.
• You are going to get two kinds of benefits from a PharmaCare program where you have the federal government or the provinces deciding to pay a high percentage of the cost of prescription drugs. You are going to get equity and, while you will have shifted cost onto the taxpayer, you give government the vehicle for trying to push global costs down. You give yourself the opportunity and the mechanism to bring prices under control. It is a trade off but it is a trade off that says we as Canadians will pay less through the private insurance system and more through taxation. This also means that it will shift along the income distribution because people at higher incomes will be taxable. It will push more of the costs onto people with higher incomes and take them off people with lower incomes, which is part of the political dynamic.
• Place a yearly limit on drug coverage for British Columbians.
• There should be catastrophic drug insurance for people that have drug bills over a certain limit each year.
• Allow tax breaks or credits for non-prescription medicines.
• The Government should fund all medications for all residents in long-term care.
• Institute full PharmaCare coverage so that people are not held hostage by private insurance companies. I recently tried to upgrade my private health care insurance to increase coverage of my prescription costs. The carrier refused to do so because of my medical history. Their profit margin would have been reduced.
Use of Prescription Medications

Comments and Concerns

Side Effects

- Comments on the side effects of prescription medications:
  - People are getting sicker on drugs which do not have well documented benefits.
  - Some drugs have side affects that can cause incurable disabilities. These drugs should be banned.
  - On three occasions the drugs I have been prescribed have been recalled because they can cause heart attacks.
  - The fourth leading cause of death after cancer, heart disease and stroke is taking properly prescribed prescription drugs.
  - There is a concern that doctors at walk-in clinics are overlooking drug allergies that are stated on a patient’s chart or mentioned at the time of a visit.
  - I have only heard of one person dying from using vitamins but in the United States thousands of people die every year from taking Tylenol which is an over-the-counter drug. Who knows how much is covered up about the side effects of prescribed drugs for the sake of corporate profit.
  - Nearly all drugs have side effects that are often worse than the original problem.
  - There is no way to search for up-to-the-minute information on drug interactions or negative side effects before prescribing a drug.
  - So many prescription drugs create side effects that in turn require more intervention with other drugs to counteract the illness created by the first drug.
  - Conventional medicine has a horrible dependence on a cocktail of drugs, most of which actually weaken the body further and end up being more harmful than the disease itself.
  - The human body cannot endure the barrage of pharmaceuticals that is so commonplace in today’s society. There are better ways to treat illness.
  - Drugs for chronic problems such as back pain, migraines and arthritis often end up causing more health problems in the long run than they help with the original problem.
  - The health care system looks for easy, prescribed solutions.
  - Every one of us has a drug cupboard at home in the bathroom for the medicines we did not take. The evidence suggests that is because the patients were not really
involved with the doctor and they took the pills only because the doctor told them to take them and then they stopped after two days.

- Doctors treat symptoms with drugs and/or antibiotics when it is not necessary or without exploring all of the underlying issues.
- We are not offering preventative alternatives to drugs.
- Drugs are subsidized by the system but persons looking to reverse or prevent illness are punished by having to pay full costs for supplements and other preventative treatments.
- Pharmaceuticals can enhance and extend our lives but they are also overused and over prescribed.
- There is a concern surrounding pharmaceutical-abuse by First Nations Elders. Prescription drugs that contain codeine and tranquilizers are over-prescribed to people in First Nations communities.
- The PharmaNet data shows a pattern similar to the Medical Service Plan data: children in continuing care were prescribed more medications much more frequently and for longer periods of time than were children who had never been in care.
- In North America, the prevailing notion seems to be that a pill manufactured by a large pharmaceutical company and prescribed by a doctor is the only way to treat conditions. This approach is reactive rather than preventative.
- Doctors must be held responsible for being experts in regards to the drugs they prescribe. They should not be allowed to prescribe medications unless they know what the minimum overdose quantity is and how to recognize symptoms of overdose.
- Pharmaceutical companies have conned patients and doctors into believing that drugs are the answer to everything.
- Most drugs are worthless at best and potentially very dangerous. This is well documented with solid evidence.
- There is concern regarding over-prescription and addiction to pharmaceuticals by seniors.
- Addiction from prescribed medication in young people is on the rise. These addictions lead to adverse changes in personality.
- British Columbians have little or no education in prescription use.
- Fair PharmaCare has not stopped the over prescription of medications that can make the elderly sick and can result in numerous younger people being over medicated on anti-anxiety and anti-depressant medications.
• Pharmaceuticals are being prescribed for problems outside of the operational scope of that drug. For instance, Prozac is being prescribed for patients with angina pain, with fatal results.

• The over reliance on antibiotics for both bacterial and viral infections has very rapidly made these miracle drugs useless.

**Ideas and Suggestions**

**Side Effects**

• **Ideas about the side effects of prescription medication:**
  - Alternative care methods largely have no side effects while the opposite is true when dealing with pharmaceuticals.
  - Pharmacists should be able to catch drug errors.
  - Prescription drugs should be very carefully considered, as to their side effects, as each patient has different reactions.
  - Samples of drugs should be prescribed until it is known if patients can tolerate them.
  - Manufacturers of drugs need to be responsible and pay for the damage they do.

• Alternative medicines should be used. I realize that the drug companies have a stranglehold over the regulatory bodies, hospitals and doctors and that natural medicine and practices do not make money for the drug companies as they cannot normally be patented. The use of alternative medicines should be encouraged instead of more expensive and often dangerous drugs.

• Reduce drug use by encouraging alternative medicines and lifestyle changes.

• Make doctors accountable for the medication they prescribe by periodically auditing them.

• Doctors should not rush through appointments because simple diagnoses are then often missed and the patient ends up with a prescription.

• People should be weaned off pharmaceutical drugs.

• Provide more consumer education on pharmaceutical drugs and alternatives to them.

• Homeopathic remedies should be covered by PharmaCare.

• The Government should not increase the budget to cover pharmaceuticals.

• Launch Government awareness campaigns to educate the public on the use of pharmaceuticals only as a last resort option.
• Stop prescribing drugs for viruses because they do not respond to medication.

• Implement an electronic medication profile that is available to doctors and pharmacists in order to efficiently track drug use.

• Prescription drug users should have periodic reassessments to reduce over-prescription.

• Ensure health professionals are clearly communicating the proper use of medications to their patients.

**Outstanding Questions**

• Why does our medical only cover drugs? What about the thousands of British Columbians who are using natural supplements and paying out of their own pockets?

** PharmaCare Drug Coverage**

**Comments and Concerns**

*Plan G and Treatments for Mental Illnesses*

*PharmaCare Approval Process*

• **Comments on the No-Charge Psychiatric Medication Plan (Plan G) and coverage of treatments for mental illnesses:**

  • If an adult makes a very low income their medication is covered by Plan G but for those making slightly more, they must cover the cost of their medications that are absolutely necessary to maintain or improve their health. This essentially reduces their standard of living.

  • Pharmacies are shifting costs to the client. This is especially a problem in the area of mental health.

  • Some medications may cost $900 per month and must be paid for by the patient or client.

  • General practitioners should not rely on anti-depressants to treat depression without first ensuring that there has been a proper diagnosis and a thorough consideration of alternative forms of treatment.

  • Patients cannot afford the prescriptions so they do not follow the treatments and get sicker.
Over prescription of anti-depressants is a major concern. Many emotional imbalances leading to the prescription of medications could be addressed through diet, vitamin and mineral supplementation.

There are a number of new psychotropic medications available as first-line treatment, and when they work, they improve the client’s and family’s well being. New treatments mean better opportunity for receiving a chance for recovery.

- **Comments on the PharmaCare approval process:**
  - Decisions on drug coverage seem to be based on economics, not patient needs.
  - In the British Columbia PharmaCare Annual Performance Report, pharmacoeconomics are not associated with the introduction of the new drug evaluated or considered; therefore cost savings to other parts of the health care system are not taken into account. It appears that the only economics considered are the direct impact on the immediate PharmaCare budget of the next year with no consideration for the savings that could be reaped from other parts of our burdened health care system.
  - The Ministry of Health projects and manages the Pharmacare budget with little involvement from the pharmaceutical industry. Other industries, such as those engaged in the extraction of natural resources, have ongoing relationships and dialogues with their regulatory agencies.
  - The process for the approval of innovative medicines is conducted behind closed doors and all advising parties, such as the Therapeutic Initiative, are equally restricted. No stakeholders, including health care professionals, patients or the innovative medicine sponsor, are ever provided with any data around the process of approval or non-approval.
  - Very little of the information on why drugs are approved or not is shared with the public.
  - British Columbia’s Therapeutics Initiative does not make public the rationale behind its listing decisions and often does not call on the advice of disease-specific experts and consumers in making decisions.
  - The Executive Director of the Arthritis society states that, the way in which chronic disease medication is approved and covered is not working in the best interest of the patients. Timely access to the right medication is needed. PharmaCare should be seen as a strategic investment in our health and not as another expense to be cut.
  - It is important that PharmaCare increases transparency and improves governance to ensure that there is a better understanding of the decision making process and that we can be assured that the coverage decisions are based on evidence and not made on political ideology.
- Drugs are approved for use in Canada through a process called the Common Drug Review (CDR). Once drugs are approved, it is up to each province to decide whether to add them as a benefit under their respective drug plans. British Columbia takes longer than other provinces to make a listing decision and often that decision is to deny coverage. British Columbia has a parallel process to the CDR called the Therapeutics Initiative (TI). The duplicate system results in a backlog of much needed drugs waiting for listing in British Columbia.

- The backlog of drugs under review in British Columbia has grown from 22 to 60 in the past two years. It takes an average of 503 days to list a drug on the provincial formulary. British Columbia is the second slowest of all the provinces to list a new drug.

- Politicians should not have the right to pick the medications that PharmaCare pays for.

- It takes too long for new drugs to be covered by PharmaCare.

- Certain drugs are restricted because they are very expensive but if they are used in the short-term, you may prevent a major complication.

- In listing drugs, British Columbia is ninth out of 10 provinces in total listings, ninth out of 10 provinces in full listings and eighth out of 10 provinces in partial listings.

- We all want better and timelier access to medications routinely available to most Canadians through a publicly funded system. This is denied to us in British Columbia.

- PharmaCare is limiting treatment options for patients. Rather than striving for excellence and facilitating the delivery of better treatment options, PharmaCare is fostering mediocrity by limiting treatment options.

- PharmaCare does not cover over the counter drugs for residents in long-term care and the fact that a pharmacist has to dispense them in blister packs only adds to their cost.

- Medications are not covered in other provinces, even if a patient is sent there for treatment.

- PharmaCare does not cover all the drugs approved by the federal government.

- Doctors have outdated information and are prescribing drugs that are no longer covered by PharmaCare.

- Doctors write prescriptions for drugs that are not covered.

- People need to have both PharmaCare and private coverage to afford treatment. Too many drugs are de-listed.

- Insurance companies refuse to cover drugs when they are prescribed too often.
• Politicians and bureaucrats are given preferential treatment when it comes to drugs. Health Canada’s Common Drug Review (CDR) committee recommended that 28 new drugs be covered in provincial and federal drug plans. Of the 28, only 15 are reimbursed by PharmaCare, yet politicians and bureaucrats are covered for all.

• PharmaCare only pays for the slow acting type of insulin that came out in 1946 (MPH).

• PharmaCare is already too generous in its coverage.

• The policy on drug treatments for Hepatitis B needs to be made fairer. The drug I need to be on is not covered and this will force me to take a second job and put my health at risk.

• Some diabetic medications are deemed to be ineffective and are therefore not covered. This is outrageous and untrue based on my experience and makes it too expensive to pay for fully out-of-pocket.

• It is frustrating that the Government funds abortions but not birth control pills.

• Can anyone explain to me why Alzheimer medication is not on the formulary of PharmaCare and those in power continue to steadfastly deny its inclusion. These drugs have a proven track record of slowing the progression of the disease.

• PharmaCare does not fund drugs to treat Alzheimer’s because they are not cures.

• I feel strongly that a review needs to be done on the accessibility of HIV Post-Exposure Prophylaxis (PEP) medication in our emergency room hospitals.

• I am upset because the government is unable to help a cancer patient who will have to pay $7,000 per month for an anti-Cancer drug that is not yet approved in Canada.

• There is only one medication for Osteoporosis being covered by PharmaCare and it is not very effective

• PharmaCare does not cover programs, medications or services to help people quit smoking or to lose weight.

• Orthomolecular low cost medicine is not being used because most Medical Doctors are not familiar with the huge amount of scientific studies that are out there that show how it works for certain diseases.

• PharmaCare’s coverage of test strips accounts for 3.7 per cent or $29 million of the PharmaCare budget. They are looking to reduce its glucose strip costs by approximately 20 per cent. If this happens, tendering of strips will see British Columbians forced into using a certain product. If experience tells us anything, it is likely that patients will ultimately be left with the oldest (cheapest) version of the product. Patients will be forced backwards in time and technology.
• The demand for the use of Compounding Pharmacists is on the increase, yet the prescriptions they fill are not allowed as part of the PharmaCare system. This is not the only example of what seems to be penalization of the proactive person who takes ownership of their health.

Ideas and Suggestions

Plan G and Treatments for Mental Illnesses
PharmaCare Approval Process

• Ideas about the No-Charge Psychiatric Medication Plan (Plan G) and coverage of treatments for mental illnesses:
  • We need to reduce the role of drugs in the treatment of mental illness.
  • Provide free drugs, as needed, for those dealing with mental illness.
  • We should offer drugs at no charge to all mental health patients. Allow access to alternative drugs, such as cannabis at no charge.
  • Do not prescribe drugs for mental issues at walk-in clinics.
  • Allow complete access to all psychotropic medications as first-line treatment so the client is not burdened with secondary outcome. The costs of medications are not so high when compared to the costs of hospitalization, especially repeated stays.
  • Prescribe fewer pharmaceuticals and do more counselling and patient interaction with those suffering from mental illnesses.

• Ideas about the PharmaCare approval process:
  • The Government is refusing to admit the need for a PharmaCare program on a national level with a national formulary.
  • New drugs should be covered and formularies dealt with at the federal level, not the patchwork of provincial regulation we have today.
  • The therapeutics initiative is a group that gets some funding from the Government to look at new medications as they come out to see if they are worth the money and if they actually work. It has saved a very large amount of money for PharmaCare by not recommending coverage for new drugs with limited usefulness.
  • The effectiveness and uniqueness of a drug, from the standpoint of reducing risk to life or supporting reasonable health, should be considered when deciding whether to cover the costs of a drug. The cost of the drug and its generic alternatives should also be considered.
• The approval of new drugs must be sped up.
• Use a regional approach and let hospital pharmacists evaluate medications.
• If one of the purposes of the review process is to have a high quality review of submissions, then highly qualified and objective experts should be expected to participate in the process. The need for practicing specialists and experts who have been involved in the development of pharmaceuticals and biotechnology treatments should be welcomed into the system in order to ensure the Government has access to the most experienced and knowledgeable experts in a given field.
• In Quebec, citizens and clinicians, through their respective associations or groups, who want to submit their comments, have the opportunity to do so for a 30 day period after a file has been accepted for review. In Saskatchewan, residents or groups who disagree with decisions because they feel vital scientific information was missed have the ability to appeal in writing to the Province's Formulary Committee.
• Involve Pharmacists more in developing provincial medication formularies.
• Medications that are proven effective should be funded.
• We should require blind studies prior to having drugs approved.
• Prescription medications should be included as a PharmaCare benefit when the following criteria are met: an individual cannot reasonably afford the medication, there is no low cost alternative and failure to take the medication will result in a substantial increase in hospital admissions.
  • Pharmaceutical selection is adequate. Product information sheets on pharmaceuticals are adequate.
  • It should be easier to get patient-friendly drugs such as methadone.
  • Including prescription drug coverage in Medicare was one of the key recommendations of the Roy Romanow report.
  • Our income sensitive Fair PharmaCare Program is recognized across the country for its scope and its breadth.
  • Support the use of traditional medicines in First Nations communities.
  • The reason behind drug listing decisions should be public knowledge.
  • If we think drugs are expensive then we should compare it to the long-term costs of under treated or untreated chronic disease. The long-term costs are going to be a lot more expensive.
  • A study has been done that shows it is cheaper to pay for seniors prescriptions than to have them show up at the hospital because they did not take their medication.
• PharmaCare should cover newer Type I diabetes drugs to stabilize patients and prevent further medical costs down the line.

• Cancer drugs should be paid for by the Province as soon as they are approved.

• PharmaCare should cover a certain level of dental services to those using blood thinners or auto-immune suppressing drugs because these people have to avoid infection at all costs.

• British Columbians are entitled to the same prescription coverage as our politicians have.

• Traditional and herbal medicine should be recognized.

• PharmaCare should cover drugs that help in the prevention of illness.

• Life saving, catastrophic drug costs should be uniformly covered by public health care.

• We should not have universal drug coverage. Drugs should only be covered when you are in a hospital or other facility for a specific treatment, otherwise they should be the responsibility of the patient.

**Outstanding Questions**

• Why are all new drugs automatically not covered by PharmaCare?

**Reference-based Pricing and Generic Drugs**

**Comments and Concerns**

• The reference-based drugs program is not based on scientific research.

• Generic drugs drive the cost of health care through the roof and lead to increased spending.

• Generic drug prices in Canada are more expensive than they should be. In fact, Canadian generics are approximately 115 per cent higher than the equivalent products in America.

• Drugs are being removed from the formularies that are effective because of their costs.

• Restrictive policies like reference-based pricing and therapeutic substitutions do not provide patients with access to the latest, most effective drug therapies and creates a negative investment environment for companies.

• The Reference Drug Program in British Columbia is the one policy that is most emblematic of silo policy thinking at PharmaCare.
• Most health systems that have implemented Reference Drug Program and Therapeutic Substitution have abandoned the policy or are not expanding it to new therapeutic classes and a vast number of others have considered this policy only to reject it. This is because the balance of evidence shows that Reference Drug Program and Therapeutic Substitution does not succeed in lowering health care or drug costs, it is complex and costly to administer and it may actually harm patients.

• New Zealand’s experiment began in the early 1990s as part of their experiment with competition within their health system. The four purchasing organizations, created a subsidiary company known as PHARMAC which aggressively managed the schedule of around 3,000 publicly subsidized drugs, using techniques such as reference pricing and funding generics. PHARMAC claims to have kept the public funding of drugs in check and you can see that it would have been two and a half times as much in the absence of PHARMAC. The organization, however, has been controversial as the incentive with them is really to prescribe only drugs that are listed on the public’s schedule. Drug companies deeply dislike the organization and doctors and patients often challenge PHARMAC decisions. Most recently PHARMAC chose to fund Herceptin, the breast cancer drug for nine weeks instead of the fifty-two that most governments fund, and another very recent study found that New Zealand had some of the poorest access in Organization for Economic Co-operation and Development (OECD) countries to cancer drugs.

• Generic drugs take too long to go onto market.

• Our single payer system has not helped to keep generic drug prices down. What that tells you is it is not just the patent system that is keeping our prices up, it is the way in which the generic market place in Canada manages not to be competitive, and some of that has to do with kickbacks to pharmacists.

• Over 30 international studies have concluded that the primary effect of drug plan restrictions was to shift, not to reduce, health care costs.

• Reference-based pharmaceutical pricing means that the price of a drug will be determined by what the customer is willing to pay in order to live without the pain or the illness, rather than the actual production value of the drug.

• PharmaCare maintains that they have saved millions while providing no objective data to support their claims or the actual cost of policies transferred or created in other parts of our health care system.

• There is concern with reference based drug pricing in British Columbia. Doctors do not get paid for the extra time to fill out the necessary forms, but if you pay physicians to fill out the forms, then there is a dual incentive to bypass the reference pricing system. An e-prescribing process would make it easier to mitigate this dual incentive but at the same time clinical judgment and clinical professional autonomy needs to be preserved.
• Ironically, generic drug prices in Canada have been distorted by the drug pricing policies of federal and provincial governments. Pricing policies virtually preclude patented drug companies from competing with the generic versions of our innovation due to the structure of Canada's price control policies. The policies use the highest price of an existing drug in a therapeutic class as the price for setting the maximum allowable price for any new or future innovative medicine in that therapeutic drug class. No rational business would reduce the price of their now-off-patent drug to compete with the generics, as it would endanger any pricing of a future patented drug.

• Too many doctors are prescribing more expensive drugs when generics will do the same job. Government has allowed brand-name drug manufacturers increased time to maintain copyrights and prevent generic companies from saving the public money.

• The government should not force generic drugs on people.

• The cheap, generic drug is more expensive in the long run because the more expensive drug works better. The cheap option can mean more ambulance and hospitalization costs.

• Doctors should be able to prescribe the pharmaceuticals that will help the patient, not just what is approved by PharmaCare.

**Ideas and Suggestions**

• In the British Columbian context, it is worth noting that the provincial reference drug program has been successful in containing costs for a very limited number of drug categories by paying only for the lowest cost drug that is therapeutically equivalent. Annual savings as a result of the program are in the $24 million to $42 million range from the time the program was introduced in 1995 up to the end of the decade.

• Only about six per cent of the new drugs that come on the market are novel drugs for new conditions where they are stand alone agents.

• The pharmaceutical companies launched Vioxx with a huge marketing campaign as a treatment for arthritis. It was supposed to be the big save-all and it ended up having all kinds of problems after the fact. PharmaCare did not fund it. It was one of the cases that proved that reference-based pricing and the therapeutics initiative really works, because they had not found enough evidence to support the fact that this drug should be funded on the PharmaCare system.

• The reference-based pricing model is working well.
The province's initiative of evaluating new drugs for their benefit over existing drugs seems to be going well.

There are solutions to rising drug costs. The reference-based drug program saves PharmaCare close to $50 million a year by covering the most cost-effective options in five drug categories. If this was expanded to cover a broader range of drug groups, more could be saved.

If a patient has had years of success on a pharmaceutical, leave them alone. More money is wasted with repeat visits to the doctor and drugs being thrown away then it would probably have cost to provide the original medication. New prescriptions should be generic, but we should grandfather existing prescriptions and not ask people to change drugs that are working for them.

Doctors should be asked to rationalize why a patient needs a certain drug that is not on PharmaCare's formulary.

Doctors on the front line, working with a pharmacist, will be in the best position to determine the efficiency of a medication.

Mandate the prescription of generic drugs whenever possible.

There must be some leeway and some ability for each individual's case to be reviewed if the generic option is not working.

It has been shown that there are no negative consequences to patients from switching to reference based drugs. It was suggested that switching drugs was leading to increased hospital utilization rates. That might be true for the first prescription, but over the long term it did not lead to increased hospitalization rates and did not lead to more co-morbidity or other perverse effects.

The best medications, not the cheapest, need to be covered by PharmaCare.

We could save $30 million annually if British Columbia paid the same rate as Ontario does for generic drugs.

Today in Ontario, the first generic medicine in a category must be priced at 50% of the listed branded equivalent. In BC, there is no set policy. The first generic typically enters the market at a 10% -20% discount with the following entrants driving the discount down, depending on the number of entrants.

We should move beyond medicine rationing policies such as reference-based pricing and therapeutic substitution and embrace the positive impact innovative medicines have on the system and on development of the knowledge-based economy.

Once regulators and politicians recognize and understand pharmaceutical innovations decrease costs in other areas of the health care system, they can move beyond medicine rationing policies as cost containment vehicles and instead make
spending decisions that reflect the wisdom of investing in medicines as a means to achieve health care sustainability.

- Until such time as rigorous, high quality research, covering long-term impacts on health outcomes, is conducted to provide reliable guidelines to assist policy-makers; one should not consider expanding the implementation of such restrictive reimbursement policies as Reference Drug Program /Therapeutic Substitution.

- Pharmaceuticals should be crossed referenced with the equivalent generic drug so that these may be matched with the idiosyncrasies of the patient's conditions. If this information was available in a database it could save the patient and society a great deal of money.

**Pressures on PharmaCare**

**Comments and Concerns**

**Drug Pricing and Demand**

**Effectiveness of Drug Spending**

- Comments on drug pricing and demand:
  
  - One of the fastest growing costs in health care is the use of pharmaceuticals. More than $1.16 billion a year is now spent on prescription drugs. When we looked at the data, 80 per cent of the increase from 1995 to 2003 was due to the use of heavily marketed drugs. That is drugs that do not represent a real breakthrough in terms of value for money. They do not make you any better than some of the things that are already existing, but they cost more.

  - When a new treatment becomes available, we have what is called a 'treatment substitution effect' where old treatments are replaced by innovations. This can have two different results. It can reduce the number of patients needing treatment and the cost of treatment per patient (that is, vaccines that can reduce or virtually eradicate some diseases) which may result in significant cost savings for the health care system. The other possible result is that the new treatments are more expensive than the old ones and the immediate cost to the health care system increases. What is important to note is that in this case, academic evidence shows that the quality-adjusted price of medical care will still fall over time as new technologies and processes are adopted.

  - Marketing by drug companies make people think that more expensive drugs are more effective when they are not.

  - Advertisements marketing drugs and diseases lead to increased consumption.

  - The pharmaceutical industry is inflating demand.
• The out of control PharmaCare costs are due to the drug companies.

• We are exposed more and more to drugs being advertised on the television. Where are the Canadian Radio and Television Commission (CRTC) in this respect? It is illegal in Canada for the drug companies to do this, but it is being allowed to continue. For some people, if you tell them often enough about a condition, real or not, and the drug for it, they will believe it is reasonable to expect treatment. It is a matter of creating a market that does not exist.

• Drug companies are marketing drugs to doctors, resulting in the prescription of unnecessarily expensive proprietary drugs.

• The price increases of patented drugs are not cost drivers of the health care system. Canada ranks fourth lowest of eight countries on patented drug prices.

• The Canadian government controls Canadian drug costs. Suppliers adhere to these cost controls in order to sell to the Canadian market. Canadian consumers enjoy lower costs than their American counterparts and this keeps medical costs lower.

• The drug company’s agendas are being promoted as medical advice.

• I am concerned that the profit mark-up on prescription drugs can be as much as 200 to 500,000 per cent.

• **Comments on the effectiveness of drug spending:**

  • Every time PharmaCare refuses to list a drug, they are spending money, not saving it.

  • Cost containment within PharmaCare focuses on limiting supply rather than ensuring appropriate utilization and measurement of the value that medicines provide to patients, to the healthcare system and to society.

  • The health care system is not structured nor is there incentive to measure the value of health care interventions. As such, it is difficult to understand the relative value provided by investments in most health care interventions. In the absence of this knowledge, cost containment becomes an exercise of controlling expenditures in the silos whose rate of growth is the highest. The concern with this approach is that health care investments cannot be strategic and therefore have the potential to undermine both the quality and the cost-effectiveness of health care interventions.

  • Prescription drugs are in fact a very cost-effective tool to manage disease. When used effectively and appropriately they become key contributors to improved treatment of patients, improved health outcomes and the sustainability of the health care system.
• PharmaCare grows at least ten per cent year over year. If we take the brakes off, we could easily see it grow by over 25 per cent.

• Of the 5,200 new drugs that are available in Canada, the World Health Organization (WHO) lists 326 as essential. Most of the new drugs emerging on the market are not new therapies, but new versions of old therapies. Of about 100 new drugs emerging per year, only five could be classified as new, true breakthroughs in drug therapy.

• The extension of patents to drug companies has increased costs for the PharmaCare program.

• The North American Free Trade Agreement (NAFTA) has implications on pharmaceutical costs.

• Technology and the development costs of new pharmaceuticals have stretched the system’s ability to cope.

• There are three factors in the increases in the PharmaCare budget: volume, therapeutic choices and prices. The biggest cost pressure is volume.

• Drugs are now the second highest cost item in the whole health care system. That is due to higher levels of prescription drug use and the large price tag that comes with new pharmaceuticals.

• Drugs are an important component of the health care budget and have been increasing in cost as a result of a number of factors, including: demographic pressures; high public expectations; effective chronic disease management; a focus on primary prevention; the shift to outpatient care; increases in drug utilization; new therapies and emerging technologies; new diseases and areas of pharmacology; increases in overall fiscal pressures; professional fees; and, wholesale mark-ups.

• Not fixing a medical problem surgically and just putting the patients on a drug for life costs the system more money than getting the problem fixed in the first place would have.

• The production of pills costs pennies, yet the mark up is sky high. I would guess the profit margin is 10,000 per cent.

• One of biggest driving forces behind the pharmaceutical problem is the behaviour of the federal government. What we have in pharmaceuticals is a situation where the federal government makes a lot of the key policy decisions and the provincial governments pays for it.

• The prices of patented medicines have not been a factor in driving up health care budgets due to price regulation by the Patented Medicines Prices Review Board, price controls, and overall cost pressures in the health care system.

• 2004 was the 12th consecutive year that the patented medicine price level has either decreased or remained relatively unchanged.
Ideas and Suggestions

National Formulary
Bulk Purchasing
Role of the Provincial Government
Value of Drugs

- Ideas about a national formulary:
  - What would happen if the federal government contributed ten per cent of the costs of any drug that was on a national formulary? Governments could agree on the set of drugs that would be covered and provinces could opt in or not participate. You need a certain ideology of a government to go in that direction, but it is in their best interest to work cooperatively with the ten provinces and the territories to ensure that their overall debt load is as little as possible.

  Imagine having ten provinces and three territories negotiating collectively with the pharmaceutical companies on cheapest cost of a particular drug. To make your negotiation effective you have to be able to steer your purchasing. If that national committee has no influence over what is actually purchased, then the producers will just laugh at you. It has to be backed up by bulk buying and the ability to shift the contracts from one supplier to another.

  New Zealand has had virtually no cost escalation in their drug plan in the last ten to 15 years. The whole New Zealand market is a bidding market that forces the pharmaceutical companies worldwide to get into a negotiation process over prices. Not only do the brand name drugs come in cheaper but the generics are a lot cheaper in New Zealand than they are in this country.

  We should implement a national PharmaCare system, with reference-based pricing, bulk purchasing and the use of generics.

  The Government should be responsible for acquiring pharmaceuticals in order to assure fair prices.

  A national formulary creates two things; purchasing power and consistency. It is cost and efficiency and comparability. Harmonization would also really get to the issue of standardizing drug treatment in hospitals and in the community to ensure that patient safety is a big issue.

- Ideas about bulk purchasing and other purchasing strategies:
  - The British Columbia Cancer Agency has established a centralized purchasing system for cancer drugs, which has allowed negotiation of reduced prices for both oral and IV cancer therapies.
There may be savings through group purchasing and more purchasing clout, if the provinces would agree on the various drugs that they collectively approve for their PharmaCare programs.

The individual health authorities are trying to stay within their budget so they are negotiating with the drug producers on a much smaller scale, but nonetheless they are into bulk buying for their hospitals.

The Province needs to adopt tendering, bulk buying and other measures to decrease manufacturer’s costs.

Establish a province-wide single buyer system to purchase drugs needed by British Columbians.

Bulk purchasing would reduce the costs of drugs.

All else being equal, we should purchase drugs made by Canadian companies who pay taxes and buy drugs from companies having the lowest profit margin built into their cost. Cost alone should not be a factor.

Low-cost alternatives should be tried before more expensive options are considered.

• Ideas about the role of the provincial government:

  • Allow the rights to certain drugs to be owned by government and allow production of these drugs to be sustained by sales with no profit element.

  • The Provincial Government should set up their own pharmacy to help cut the costs of PharmaCare.

  • We should build a facility in this province that could produce generic drugs of high quality and much lower costs that would not only save dollars, but put the quality control in the hands of the government of the province.

  • Form a British Columbia pharmacy company to develop new drugs that operates on a not-for-profit basis.

• Ideas about the value of drugs to the health of British Columbians:

  • Research-based medicine is a part of a sustainable health care system. Innovative drugs, that better manage health issues, keep people out of hospitals, reduce wait times and enable people to manage their health outside institutions.

  • While expenditures on prescription medicines have increased, it is also true that innovative medicines have been responsible for improving the health outcomes of the citizens of British Columbia and the world, each year, for over a century. The global innovative medicine industry is responsible for developing more than 90 per cent of all medicines and vaccines in the world. The presumption that the
increased cost of public spending on innovative medicines is the primary cause of financial distress on our health system is at best misguided.

- Cost containment within PharmaCare focuses on limiting supply rather than ensuring appropriate utilization and measurement of the value that medicines provide to patients, to the healthcare system and to society.

- Data from the latest Canadian Institute for Health Information (CIHI) report on drug expenditures in Canada and the more recent PharmaCare 2005 Annual Performance report clearly show that while the overall cost of pharmaceuticals is increasing, the cost of prescription drugs does not represent a major component of the health care budget. The average cost of a prescription in British Columbia has also decreased in the past five years.

- Half of the gains in life expectancy over the last 50 years have come from drugs. If you rely on drugs more heavily, you save money.

- Drugs that are preventative and curative can save health care money.

- The PharmaCare program in British Columbia should not be focused on cost containment but focused on what can be done to enhance health.

- Stop all drug advertising.

- PharmaCare costs have increased by 25 per cent since 2001. New Zealand has alleviated this problem by having pharmacies compete with one another.

- The testing of new drugs is too onerous and increases the costs.

- We need to amend the federal acts that give such long protection to new drugs. The current situation of cost escalations was predicted when the Federal Government extended the drug companies’ monopoly. The revenue we might lose in drug company research and development is a drop in the bucket compared to the increased costs we have been experiencing.

- If a drug or remedy is being researched with public money, no patent can be taken out by a company or individual.

- PharmaCare should pay for experimental drugs if the patient is willing to sign a liability waiver.

- A tandem change in prescribing costs would also be beneficial and save chronic care patients such as asthmatics going without medications. A baseline dispensing charge to the patient of, for example, $35 for every prescription, regardless of cost, for medications approved by PharmaCare would control prescribing and ensure very few could argue cost as a reason not to take medication. This would pay for itself as cheaper medications would subsidize the more expensive ones. It would also encourage drug companies to look carefully at pricing as there would be more
to gain in sales from keeping prices down when negotiations for inclusion in an approved list took place on a larger scale.

- The alternatives to pharmaceutical medicine cost less.
- Drugs should be supplied to Canadians at a lower price and then sold to other countries at a higher price.
- A Columbia University study showed that every dollar invested in new medicines relieves the health care system of expenses seven times greater than in other medical areas.
- PharmaCare should only fund a small number of quality drugs.
- Educating elderly patients on proper drug use would lower their drug use.
- Prohibit or severely limit the quantity of drugs exported to the United States.
- Promoting healthy life styles would help lower our use of pharmaceuticals.
- The academic detailing initiative educates doctors directly about the costs and benefits of brand-name and generic pharmaceuticals, making them less reliant on Drug Company advertising. This initiative saves $1.50 for each dollar spent to run the program. There is no reason it could not be expanded to reach more doctors across the province.
- Charge Doctors a fee per prescription written to help limit drug use.

**Outstanding Questions**

- It would be interesting to know how much of the PharmaCare expenditures are associated with waste?
- Cuba makes its own drugs, so why not Canada?
Pharmaceutical Industry

Comments and Concerns

Health Care Professionals and the Pharmaceutical Industry
Government and the Pharmaceutical Industry
The Pharmaceutical Industry and Rising Costs

- Comments on the relationship between health care professionals and the pharmaceutical industry:
  - Pharmaceutical companies provide physicians with free samples in order to influence prescribing. The ability for pharmaceutical companies to provide samples should be eliminated.
  - Frequently, a doctor’s main education about a drug is what a pharmaceutical representative tells them in a social setting, usually involving the serving of alcohol.
  - Doctors get their only information from studies done by the drug companies that are biased.
  - The doctors have become sales representatives for the drug companies and our Government endorses this relationship.
  - Pharmaceutical sales people take doctors time away from patient care and only provide information that promotes the pharmaceutical industries interest.
  - Many prescribers have been co-opted, influenced inappropriately and pressured by the drug companies.
  - The Canadian Medical Association has a very strong, clear policy on relationship between physicians and industry, not only for drugs but for infant formulas, medical supplies and other ethical considerations.

- Comments on the relationship between government and the pharmaceutical industry:
  - The government allows drug companies to control the testing of new drugs, designing trials to suit their interests, not the consumers.
  - The patent system for the pharmaceutical industry and the pressure to generate profit does not serve the public interest, particularly on the research side and with the availability of university research information to the public.
  - PharmaNet is one of British Columbia’s great health care resources and it is underutilized. PharmaNet is a province-wide network that links all British Columbia pharmacies to a central set of data systems. This database is one of few in the developed world and provides researchers with a great resource to study
patient out-comes and medicine efficacy as well as to improve upon treatment protocols. It could also be a significant resource for monitoring patient safety in a real world setting. Unfortunately, it has been the experience of independent academic researchers sponsored by industry that access to PharmaNet is denied by PharmaCare. The same is not the case for academic researchers sponsored by the Ministry of Health. The double standard is unacceptable to all British Columbians. More importantly, British Columbians should know that the utility of PharmaNet is one of the reasons that industry can be attracted to invest in British Columbia’s chronic disease management requirements, as it allows true evidence based medicine on a large scale. PharmaNet is a truly underutilized asset.

- Competition for international industry investment in research and development, even within a corporation is fierce and investment logically flows to jurisdictions where industry is welcomed. Investment in British Columbia has been minimal.

- British Columbians should understand that in order for their life science industry to contribute to the health care system, there must be an enabling environment and an environment where the health care system collaborates with industry to bring innovation to its consumers. Today, the Ministry of Health does not promote collaboration with industry. In fact, the Ministry of Health and in particular PharmaCare openly shun collaboration with local and international industry.

- The drug companies make contributions to political parties to ensure their patents are protected.

- The unwillingness to use these alternative resources creates the impression of collusion with the drug companies. The drug companies are running the system, not the government.

- British Columbia is eighth among provinces in per capita university-based research funding.

- **Comments on the Pharmaceutical industry and rising costs:**

  - Drug and treatment researchers know that they have a guaranteed market if they come up with what is perceived to be an effective treatment.

  - Pharmaceutical companies manipulate the public through advertisements and misinformation.

  - The major pharmaceutical companies have turned symptoms into diseases. One example of this is Acid Reflux Disease, which is in normal cases a reaction to a bad diet.

  - Pharmaceutical companies use pressure tactics to introduce a new drug, knowing they have patent protection. Generic drug makers have to wait years to bring their products to the market.
There are seven or eight pharmaceutical companies, each trying to develop their own version of the Cadillac drug for a particular category. This results in these upward cost pressures and is diverting a lot of money for Research and Development. If your competitor has a blockbuster drug, you could spend a lot of money at high risk trying to find some other blockbuster drug, or you could spend less money at lower risk to find a related molecule that enables you to compete in the already established successful market. What are you going to do? It is not a difficult choice.

I am disgusted that our system allows pharmaceutical companies to pad their pockets. On the street this would be illegal.

Our politicians need to realize that the drug companies spend two dollars on advertising for every one dollar they spend on research and development. They would spend even more if we allowed direct-to-consumer advertising.

The monopoly of pharmaceutical companies is resulting in huge profits.

Virtually all medical research is done by private companies and only on medicine that is profitable. This can only make costs go up.

We know that pharmaceutical companies are not going to try to save the PharmaCare plan any money. Old drugs disappear to be replaced by patentable new versions in order to make good returns for the shareholders.

The drug Thalidomide, which caused birth deformities some 30 to 40 years ago, has now been found to help cure some forms of cancer and that drug companies have increased the cost to consumers by 1,000 per cent. This unconscionable price increase has led health insurers to not cover the cost, making it affordable only to the wealthy. I think the government should be able to intervene and prevent this price gouging.

Pharmaceutical companies base the costs of new drugs on the price an individual is willing to pay to live without the pain, rather than the actual production value of the drug.

Extended patent laws and the North American Free Trade Agreement (NAFTA) prevent the government from truly controlling the cost of drugs.

We should not be paying drugs companies to treat symptoms instead of searching for cures.

A large number of herbal medications have been banned in Canada because of the constant pressure and lobbying of the government by the pharmaceutical industries.

Many very good cures, treatment and prevention protocols exist already, but conventional medicine and corporations suppress them.
• Diseases are not being recognized or treated as quickly as developments could allow, due to commercial interests.

• Nutrients that the public wants and needs are being severely restricted in order to protect pharmaceutical dominance.

• The British Columbia Biotechnology industry is breaking new ground in research and development that has the potential to not only improve the health outcomes of British Columbians, but also to diversify the province's natural resource oriented economic base.

• Life expectancy is increasing in large measure due to innovative medicines.

• The pharmaceutical industry is investing over $60 billion per year in research and development globally and has over 5,000 compounds in active development. Only 20 to 30 compounds are expected to reach the market in a given year.

Ideas and Suggestions

Health Care Professionals and the Pharmaceutical Industry

Patents

• Ideas about the relationship between health care professionals and the pharmaceutical industry:
  • Get pharmaceutical companies out of doctor's offices and medical schools.
  • We should ban pharmaceutical companies from marketing drugs directly to doctors.
  • The prescribing of drugs should not have perks for doctors
  • Stop the kickbacks to doctors for prescribing certain medications. Doctors caught receiving kickbacks should lose their license.
  • Drug companies should not be allowed to incentivize doctors.
  • Increase the drug education of doctors using science-based information instead of brand-name information.
  • There is clear evidence that educating physicians is the most effective way of changing prescribing patterns and looking at the whole issue of appropriateness of drug prescribing.
  • There must be stricter ethical guidelines governing interactions between doctors and drug companies.
  • Reduce the power of pharmaceutical companies to determine criteria for treatment.
• Doctors should not be allowed to endorse pharmaceuticals.

• **Ideas about patents:**

  • Get rid of 23 year patent protection which leads to gross profits for multi-national companies at the expense of the public health care.
  
  • All cancer treatments, cures and drugs should belong to humanity and nobody should be allowed to make any profit.
  
  • We should have legislation for a more reasonable seven year drug patent protection.
  
  • We need to amend the federal acts that give such long protection to new drugs. The money we might lose in drug company research and development is a drop in the bucket compared to the increased costs in even one province, like British Columbia.

  • The Government should draft legislation to stop the practice of inflating drug costs.
  
  • Drug costs are a pittance compared to the cost of surgery and treatment.
  
  • Drug companies do make money, but they also provide us the drugs that keep us from keeling over.

  • Pharmaceutical companies need to stop their symptom-control approach to disease. It generates a lot of income, but creates more problems than it solves by ignoring the source of disease.

  • Create an independent board to oversee the pharmaceutical industry.

  • The Government could provide other tax incentives for the companies to encourage development without styming creativity.

  • Institute stricter guidelines on ethical behaviour for drug companies involved in research and development.

  • The federal government should control the cost of production and profit percentages of drugs.

  • Drug companies must make all of their research results public.

  • Our government should ensure that a drug company does not bury a potential cure in favor of a drug that offers results only when taken on an ongoing basis.

  • The regulation of the pharmaceutical industry or even the nationalization of the industry would reduce the costs dramatically.

  • Government should fund drug research in the correct areas, such as population health as opposed to anti-aging.

  • There must be better recognition of independent drug study reviews with more oversight on studies and true independent evaluation.
• We should create a forum for industry and government to dialogue based on mutual respect. Formal and regular interaction could provide comprehensive information for forecasting purposes related to PharmaCare expenditures and the means to explore options to optimize the use of medicines and other effective initiatives.

• Knowledge-based industries such as innovative pharmaceuticals are the growth engines of modern economies. The health care system must not be seen as a cost to be borne but as an opportunity for economic growth.

Outstanding Questions

• Why is something not done to limit the profits of the drug companies?

• Are there published, unbiased studies available that were not funded by the big drug companies?

• How much are BC doctors paid and what sort of incentives are they receiving from the pharmaceutical salesman that frequent doctor’s offices?