REPORT OF THE

REFERENCE DRUG PROGRAM CONSULTATION PANEL

TO THE

HONOURABLE SINDI HAWKINS
MINISTER OF HEALTH PLANNING
BRITISH COLUMBIA

APRIL 2002

April 5, 2002

The Honourable Sindi Hawkins
Minister of Health Planning
Government of British Columbia
Victoria, BC V8V 1X4

Dear Minister Hawkins:

We have the honour to transmit herewith the Report of the Reference Drug Program Consultation Panel. It has been our pleasure to serve you and the Government of British Columbia by undertaking this enquiry into possible cost-effective alternatives to the current Reference Drug Program.

We trust that you will find the Report helpful and would be pleased to speak or meet with you should you wish any elaboration on our findings.

Yours truly,

REFERENCE DRUG PROGRAM CONSULTATION PANEL

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EXECUTIVE SUMMARY

The Reference Drug Program (RDP) was introduced in British Columbia in 1995 as one of the programs of Pharmacare. Its purpose was to contain escalating drug costs as a means of keeping drug insurance coverage affordable for the future. The RDP addresses five categories of drugs in which chemically different products are considered to have a therapeutically equivalent effect. Where there is no evidence that a higher-price drug in a category is more effective and/or provides a therapeutic benefit with fewer negative side-effects, Pharmacare pays only the cost of the preferred or "reference" drug.

In response to concerns raised about the program, the RDP Consultation Panel was appointed by the British Columbia Minister of Health Planning to work with doctors, pharmacists and others to find a cost-effective alternative to reference-based pricing.

A total of 46 submissions were made to the Panel from physicians, pharmacists, specific disease groups, community organizations, pharmaceutical companies, public policy institutes, academics and individuals. These submissions represented a range of contradictory views and beliefs with no overall consensus. While the Panel heard many opinions and ideas, it received little in the way of hard scientific or economic analysis.

The major concerns expressed to the Panel regarding the RDP related to: the validity of the concept of therapeutic substitution and the evidence base underlying the program; opposition to interference in the doctor/patient relationship; the program being perceived as a barrier to patients receiving the most effective medication and the subsequent impact on quality of care; the administrative burden associated with the program; possible cost-shifting to other components of the health care system; confusion about Pharmacare programs generally; and the negative impact of the program on industry investment in British Columbia and consequent innovation.

A number of submissions strongly supported the RDP as an equitable way of saving money that can then be applied to other parts of the health care system. The flexibility inherent in the program, through the ability to apply for Special Authority exemptions when required, was considered a critical element of its success.

The major alternatives proposed to the RDP were: fundamental structural change involving a shift in the balance of payments among government, private insurers and patients; disease management programs whereby industry, government and health care providers would cooperatively design and implement programs to address specific health conditions; administrative standardization and simplification; bulk buying of generic drugs; and delisting, i.e. making certain drugs ineligible for reimbursement.

Expanding a system of maximum reimbursement costs and providing additional information to physicians and patients to support informed decision-making were proposed either as cost-saving alternatives or possible modifications to the Reference Drug Program.

Other suggested program modifications included: expansion of the RDP into other drug categories; providing incentives for physicians and patients to ensure use of the most cost-effective drugs; reinstating drug utilization reviews; and changing the program name to provide a more positive public perception.

Conclusions

The RDP Consultation Panel has concluded that the British Columbia Reference Drug Program offers an effective way of controlling some Pharmacare costs. Conservative estimates agree that the RDP has resulted in direct cost savings to Pharmacare of approximately $12 million in the current fiscal year. There appears to be little evidence of additional cost to other government programs over the long term, although there is some indication of added administrative costs to physicians and pharmacists. With regard to patient health, based on the evidence presented to it, the Panel concludes that the effect of this program, particularly with respect to hypertension, warrants further investigation.

The Panel has concluded that none of the alternatives presented to it would result in direct short-term savings comparable to those associated with the RDP. Some of the alternatives and modifications proposed, however, appear to have potential for long-term savings to Pharmacare or increased economic benefit to government as a whole.

The Panel endorses the principle of cost-containment as a legitimate government objective. It supports the Reference Drug Program as a component of that approach but has concerns about the limited nature of the expected savings associated with the program over time.

Recommendations

As none of the alternatives or modifications presented would result in direct short-term savings to Pharmacare equivalent to those currently associated with the RDP, the Panel recommends that:

1. The Reference Drug Program should be maintained, at least on a short-term basis.

Because of the time-limited nature of the savings associated with the RDP and the limited opportunities for expansion presented by current program design, as well as to minimize the confusion associated with the various cost-containment programs of Pharmacare, the Panel recommends that:

2. Pharmacare's program structure should be redesigned in such as way as to maintain the ability to manage costs within a more integrated framework. Such a framework should provide improved transparency and greater clarity.

   Specifically, Pharmacare should consider a simplified pharmaceutical classification system. In this regard, the submission from the University of British Columbia

Faculty of Pharmaceutical Sciences is recommended for consideration and further analysis by government**.** The Panel recommends consideration of three drug categories:

1) full benefit;
2) restricted coverage
    a) pharmacist or physician approved against criteria
    b) Pharmacare approved in exceptional cases; and
3) not covered.

In effect, this proposed design would eliminate the RDP as a separate program based on therapeutic substitution, while retaining its cost-containment effect.

3. Program redesign should include meaningful consultation with stakeholders, including health care professionals, academics, industry representatives and others.

4. In particular, frank discussions should be held with the pharmaceutical industry to explore the possibilities for substantially improved investment in research and development in British Columbia.

To support the proposed redesign as well as future program and policy development, the Panel recommends that:

5. Various co-payment and incentive options, e.g. sliding scale, stepped scale, percentage allocations, etc., should be reviewed to identify those which provide the optimum balance of cost-containment, incentives for physicians and patients to choose cost-effective alternatives, as well as protection for the poor and critically ill.

6. Drug utilization reviews should be reactivated, either through the BC College of Physicians and Surgeons, the body currently responsible for them, or by transferring responsibility to another agency willing to undertake this role to support program development.

7. Physicians, pharmacists and the public should be provided with better information to encourage shared responsibility and support informed and cost-effective decisionmaking with respect to drug use.

To encourage a more integrated approach to overall pharmaceutical and health care management, the Panel recommends that:

8. British Columbia should continue to play a lead role in encouraging coordinated inter-provincial drug approval, access and cost-containment measures.

9. British Columbia should work with the other provinces to urge the federal government to include prescription drugs within the provisions of Canada *Health Act* and to work toward a national pharmacare program.

In the event that the recommended Pharmacare program redesign, as discussed in recommendation 2 above, is not feasible within a reasonable period of time, e.g. one-to-two years, the Panel recommends that:

10. The Reference Drug Program should be expanded into appropriate additional therapeutic categories in order to maximize its cost-savings potential.

I THE REFERENCE DRUG PROGRAM

The British Columbia Pharmacare program helps BC residents pay for eligible prescription drugs and designated medical supplies through a range of programs and services designed to maintain high quality, affordable prescription drug coverage for all British Columbians. The Reference Drug Program (RDP) is one of the programs of Pharmacare.

New drugs eligible for sale in Canada are approved and prices set by the federal government; however, drug costs are not included in the *Canada Health Act,* i.e. are not covered under the federal Medicare system. It is the prerogative of each province to determine which drug costs it will reimburse, to what extent and to whom.

Pharmacare Review Process

All new drugs introduced in British Columbia are subject to Pharmacare's drug review process. This requires that pharmaceutical companies submit product information to Pharmacare in order to permit assessment of a drug's eligibility for benefits, if any, under the program. The information is reviewed by Pharmacare staff who forward the submission to the Therapeutics Initiative (TI). The TI is an evidence based drug assessment and educational organization established in 1994 by the Department of Pharmacology and Therapeutics in cooperation with the Department of Family Practice at the University of British Columbia. The TI's objective is to provide physicians and pharmacists with up-to-date, clinically relevant drug therapy information.

(Until recently, new drug information was also reviewed by a Pharmacoeconomics Initiative (PI) which looked at the issue of cost-effectiveness; the contract for the PI was terminated effective January 31, 2002.)

The TI reviews a new drug to assess its therapeutic benefit based on evaluation of evidence that has been published in medical journals. It then provides information to the Drug Benefit Committee of Pharmacare. This committee makes recommendations to the Executive Director of Pharmacare who makes a final decision on whether a new drug should receive full, partial or no benefits under Pharmacare.

A. Purpose and Scope

The Reference Drug Program was introduced in British Columbia in 1995 as one of the programs of Pharmacare. It was intended as a means of keeping prescription drug *insurance coverage* affordable for the future. In the period 1990-1994, immediately prior to the establishment of the RDP, Pharmacare's expenditures grew at a rate of approximately 15 percent per annum. This growth in expenditures is attributed primarily to three major pressures: utilization, i.e. more prescriptions per person; rising drug prices; and the substitution of more costly new drugs for existing therapies.

As expenditures continue to rise in an atmosphere of fiscal constraint, Pharmacare needs to balance the delivery of services in a cost-effective and safe manner.: One way in which Pharmacare seeks to control escalating costs is through programs such as the RDP.

The RDP is based on the principle that society should pay for an evidence-based standard of drug therapy. If there is no evidence that a higher-price drug is more effective and/or provides a therapeutic benefit with fewer negative side-effects, the extra cost should not be covered by a publicly funded drug benefit insurance program.

Five therapeutic classes of drug currently fall within the RDP. As defined by Pharmacare, they are:

1) Histamine - 2 receptor antagonists (H2RA) for the treatment of certain upper gastrointestinal complaints and non-ulcer dyspepsia;
2) Nitrates for the treatment of stable angina;
3) Non Steroidal Anti-Inflammatory Drugs (NSAIDS) for the treatment of osteoarthritis, lower-back pain, myofascial pain syndromes and other inflammatory conditions;
4) Angiotensin Converting Enzyme (ACE) Inhibitors for the treatment of hypertension; and
5) Dihdropyridine Calcium Channel Blockers (CCBs) for the treatment of hypertension.

For most common medical conditions, drug manufacturers market a wide variety of similar prescription drugs. These drugs may vary greatly in price but are designed to achieve the same medical effect on the majority of patients.

An independent RDP Expert Advisory Committee, consisting of physicians, pharmacists, economists and pharmacologists, considers the evidence base for inclusion in the RDP. The Committee provides advice on which prescription drug products within a group of similar medications (the five therapeutic classes) are equally safe and beneficial. The cost of the preferred drug(s) is then designated as the "reference price", i.e. the price Pharmacare will pay for any medication in that class.

B. How it Works

Neither Pharmacare nor the RDP approve or prohibit drugs for use in British Columbia; they consider only the extent to which drug costs will be reimbursable to patients. Doctors are free to prescribe the medication they consider best for their patients. Patients eligible for Pharmacare benefits receive full coverage for the preferred "reference" prescription drug. Doctors and patients may choose a more expensive drug, in which case the patient pays the difference in price. If a patient requires a more expensive drug for medical reasons, the doctor can obtain a Special Authority (SA) from Pharmacare for coverage of that drug.

Special Authority Process

The program design provides flexibility to allow for the provision of full Pharmacare benefit coverage of non-reference drugs if a patient has a specific clinical need or if the

central computer of the provincial pharmacy prescription network (PharmaNet) has flagged the patient as an exception by virtue of use of certain other drugs. In these cases, full coverage of the prescribed medication may be provided through a Special Authority.

To seek an SA, a physician submits a request by fax or telephone indicating that a patient is unable to tolerate or does not therapeutically benefit from the reference drug. Pharmacare reviews the application and, if it is accepted, grants a Special Authority, usually within 24-48 hours, for another drug in the class to be fully funded. When a physician prescribes a non-reference drug without an SA, the PharmaNet computer alerts the dispensing pharmacist, who informs the patient and/or physician of the policy and suggests the following options:

1. if there is a patient-specific reason for the use of a non-reference drug, the physician can apply for an SA;
2. if there is no patient-specific reason for the use of a non-reference drug, the physician can change the prescription to a reference drug; or
3. the patient can choose to pay the difference in price between the prescribed drug and the reference drug.

A Special Authority process is also in place for two other Pharmacare programs, the Low Cost Alternative (LCA) Program that provides coverage for the lowest cost generic, i.e. chemically identical, drug available and the Limited Coverage Drug (LCD) Program that identifies drugs covered by Pharmacare only in particular circumstances. The RDP accounts for only a small percentage of Special Authority requests, i.e. 10% in 2001.

C. Experience of Other Jurisdictions

A number of countries throughout the world and a variety of jurisdictions in North America have initiated cost-containment policies and programs similar in purpose and effect to British Columbia's Reference Drug Program. As of February 2002, reference based programs that included therapeutic substitution, as in British Columbia, were present in New Zealand, Australia and the Netherlands. In 1991, Germany introduced a reference based program similar to BC's; in 1996, application of the reference program to new drugs was discontinued. Norway has discontinued its reference pricing program. France considered introducing a reference program but elected not to. Sweden and Denmark permit generic substitution similar to British Columbia's LCA (generic substitution) Program. In Canada, Nova Scotia has a Special Maximum Allowable Cost program, similar to the RDP, in place for H2 receptor antagonist anti-ulcer drugs and NSAIDs. In the US, Michigan has introduced a reference program similar to BC's RDP. Oregon is considering referencing four drug classes, but will first conduct a scientific review to demonstrate that therapeutic substitution is valid.

Reference pricing is one of a variety of tools used by policy makers to control drug expenditures. It is not a solution in and of itself to the problem of escalating drug budgets. Reference pricing is generally complemented by other cost-control measures, such as the use of lowest-cost generic drugs, national price controls, tiered pricing, etc.

Different jurisdictions have shown varying levels of effectiveness in cost-control due to reference pricing. The greatest savings have generally been seen in the immediate few years after implementation. .

Reference systems around the world differ in their product coverage and policies toward exemptions. A key feature of British Columbia's RDP and its Special Authority process is the accessibility it provides to alternative medication.

There has been little study of the health impact of reference pricing, and much of the evaluative literature on reference pricing is descriptive not empirical. The most scientifically valid assessments of reference pricing have been based on the British Columbia experience.

II REVIEW PROCESS

A. Reasons for Review

Since implementation, a number of concerns have been raised about the RDP. Many people are opposed to the notion of a physician's instructions being influenced by a government process based on cost-saving. Some physicians consider that the program limits their ability to prescribe what, in their opinion, is the best medication for a particular patient. Brand-name drug companies have expressed concern about the validity of therapeutic substitution and the effect of the RDP on patient choice, market share and revenue. They argue that such programs ultimately impair their research and development capacity to produce new and improved products.

In contrast to these views, the government reports that the RDP has resulted in direct cost-savings of approximately $12 million in the current fiscal year, with no apparent impact on patient health and no discernible cost increases in other parts of the health care system.

B. The Panel

As a result of these conflicting views, the Minister of Health Planning on November 23, 2001, appointed a Panel to work with doctors, pharmacists and others to find a costeffective alternative to reference-based pricing. A copy of the Panel's Terms of Reference is attached as Appendix 1.

The five-member panel consists of

Chair: George Morfitt, former Auditor General of British Columbia

Members: John *Esdaile,* MD, professor and Head of Rheumatology in the Department of Medicine at the University of British Columbia and Scientific Director of the Arthritis Research Centre of Canada;
Arlene Gladstone, social worker and former Executive Director of Family Services of the North Shore;
Marshall Moleschi, pharmacist and Director of Member Services for the Health Association of British Columbia; and
Andrew Saxton, businessman with experience in financial, tourism and communications industries, volunteer with health-related organizations and a member of the President's Community Advisory Council as well as the Dean of Faculty of Medicine's Community Advisory Council at UBC.

C. Identification of Stakeholders

The stakeholder list utilized for the recently completed Pharmacare Consultation was used as a starting point in identification of those potentially interested in the RDP. Panel members augmented the Pharmacare Consultation stakeholder list with additional organizations they considered might add value to the review.

Stakeholders included a cross-section of organizations representing physicians, pharmacists, specific disease groups, community organizations, pharmaceutical companies, public policy institutes, academics and others. Letters were sent to identified stakeholders informing them of the Panel, its Terms of Reference and inviting them to make a written submission or to meet with the Panel. A website was established and members of the public invited to offer suggestions by that means. As word about the Panel's work spread, additional stakeholders contacted the Panel to request the opportunity to meet. A complete stakeholder contact list is attached as Appendix 2.

A total of 46 submissions were made to the Panel. A list of submissions is attached as Appendix 3. Thirty-one submissions were presented in meetings held throughout January and February 2002; the remainder arrived by mail, fax and e-mail via the website. Complete submissions are provided as Appendix 4.

Pharmacare staff provided background materials, responded to requests for information and met with the Panel, at its request, on three occasions to provide additional information.

D. Criteria for Analysis

In considering the various submissions, the Panel kept in mind its specific mandate from the Minister, i.e. to evaluate proposed cost-effective alternatives to the RDP in terms of projected cost savings, evidence in support of these savings, and impact on patients and other areas of the health care system.

Within this framework, the Panel considered the following issues:

- the *nature of the proposal, i.e.* whether it proposed that the RDP be eliminated, replaced or modified in some way;
- the *cost impact of the proposal,* i.e. how much the proposed change is estimated to save annually, whether supporting data/economic models are available, how much it would cast to implement, whether costs would be transferred to others, and whether there are implications for other social/economic costs;
- the *health* impact, on individuals or on society as a whole;
- *impact on choices available,* to patients, physicians and pharmacists;
- *flexibility,* i.e. the extent to which the proposal incorporates provisions to deal with unexpected circumstances;
- *fairness*, i.e. whether various interests are fully considered;
- *transparency,* of decision-making processes as well as simplicity and provisions for public and professional information;
- *accountability,* i.e. the extent to which the proposal provides for appropriate public accountability.

E. What was Heard

The Panel received a full range of opinions on the Reference Drug Program with no overall consensus. The Panel did, however, hear a common concern that the province's health care system work effectively and at reasonable cost, both to government and to individuals. Where submissions differed was on the means of achieving that end and on the appropriate distribution of costs between individuals and society as whole.

The Panel learned that there is considerable confusion about how the province's Pharmacare system is currently organized and operates. Even those most closely connected to the system, e.g. physicians and pharmacists, frequently confused various Pharmacare programs. A number of the concerns expressed ostensibly in connection with the RDP turned out, in fact, to be related to the Limited Coverage Drug Program.

The Panel heard a variety of contradictory views and beliefs and, at times, almost diametrically opposed interpretations of the same information. It received little, however, in the way of hard economic analysis of alternatives. Generally speaking, presentations encompassed the following perspectives and demonstrated that, even within particular communities of interest, there is a wide variety of opinion.

From physicians

Some doctors and their representative organizations expressed concern about the uncompensated workload involved in explaining government policy to patients and having to apply for Special Authority when required. The Panel heard concerns about professional independence and the desire to ensure economic access to new drugs for patients. One positive aspect attributed to the RDP was the extent to which it prompts physicians to think about their prescribing choices. In general, the Panel heard that,

while the concept of the RDP is acceptable to most physicians, they would like to see administrative improvements, adequate consultation with physicians and pharmacists, and clear evidence to support any expansion.

From pharmacists

Pharmacist and pharmacy representatives also expressed concern about the burden placed on them to explain government policy to patients. The Panel heard that the time involved in dealing with patients' concerns about drug substitution, conferring with doctors about prescriptions and assisting with requests for Special Authority was significant and should be compensated. It was suggested that pharmacists are better equipped than Pharmacare staff to make decisions about SAs and that savings could be achieved by transferring decision-making responsibility to them. Support was expressed for the re-instatement of Drug Utilization Reviews (see page 21).

From pharmaceutical wholesalers

The Panel received information on existing pharmaceutical distribution networks and was urged to recommend maintenance of the current system rather than a move toward bulk purchases of generic pharmaceuticals, as occurs in Saskatchewan.

From the pharmaceutical industry

Support for the RDP is strong within the generic pharmaceutical industry. It was suggested that the existing program could be supplemented with pilot projects, e.g. development and better utilization of prescribing and clinical practice guidelines, economic incentives for patients, etc., together with improved education and information systems. Considerable opposition was expressed to tendering or bulk buying which was seen as being disruptive to the industry and potentially leading to less choice for patients.

Brand-name manufacturers questioned the validity of the evidence base for the RDP and the lack of transparency in decision-making, as well as the concept of therapeutic substitution in general. The pharmaceutical industry proposed disease management or patient health programs, run cooperatively by government, industry and health care practitioners, as effective alternatives to the RDP, together with structural changes to Pharmacare as a whole.

Concern was expressed about the deterrent effect of the RDP on research and development investment in British Columbia and subsequent innovation. It was emphasized that the savings attributable to the RDP pale in comparison to the negative effect of the program on the relationship between industry and government.

From community representatives

Organizations representing specific disease or population groups and community organizations expressed a range of views. Some consider that the RDP limits access to the newest and "best" drugs. Others expressed concem about the lack of transparency in decision-making. Still others support the concept of the RDP while opposing its application to specific medical conditions. An alternative view supports the RDP as a way of saving money that can then be reinvested in the health care system as a whole.

Some seniors' organizations expressed particular concern about the possibility of an increased co-payment model that would place more of the cost of drugs on patients.

From the academic community

The Panel heard from:

- academics involved in research activities which could benefit from increased funding from the pharmaceutical industry;
- those involved in evaluation of the RDP; and
- other academic perspectives.

The research group argued that research investment currently deterred by the RDP would far outweigh the annual cost-savings attributable to the program. Doubts were expressed about the validity of the evidence base underlying the RDP. Those involved in evaluation of the RDP support its continuation but propose modifications to maintain it as a dynamic program. The third group emphasized that the RDP is one small program and should not be considered as the government's only, or even primary, cost-containment measure. They suggested that efforts be made to improve the transparency of current decision-making and to minimize the administrative burden. The importance of providing information on the evidence base supporting RDP decisions and on the options available to physicians and patients was stressed.

From the provincial government

From government representatives, the Panel heard of escalating expenditures on prescription drugs and the need for an effective way of controlling those costs. As the price of new drugs entering the market is set federally, cost-containment means open to British Columbia are limited to control of utilization or restricting the scope of and access to programs. Program administrators consider that the RDP does an effective job of containing costs with no notable impact on patient health or costs to other parts of the health care system. The Panel was informed that a number of administrative improvements have been made since the introduction of the RDP and that more are planned to deal with outstanding issues.

From policy institutes

The policy institutes that appeared before the Panel presented a full spectrum of views. One perspective is that drug costs represent only a small proportion of the overall cost-drivers in the health care system and that programs such as the RDP cost British Columbia more in terms of lost investment and subsequent innovation than they save. At the other end of the spectrum is strong support for the RDP as an evidence-based, cost-effective tool. The proponents of the latter view urge expansion of the program and additional follow-up research. Another institute stressed the importance of considering the RDP as one tool among many, but not the solution to the problems of Pharmacare or health care budgets generally. It emphasized the importance of flexibility, e.g. the Special Authority process, in the success of the program.

III ISSUES

The following major issues related to the RDP were raised with the Panel by various submissions:

i. Savings

Cost-saving estimates associated with the RDP have varied considerably. Initially upon implementation of the program, cost-saving estimates were calculated by the Ministry of Health, based on cost per month and cost per patient before and after policy implementation. This was a rudimentary analysis that did not attempt to quantify cost impacts outside of Pharmacare. Savings for the first year of implementation were estimated at $30 million.

Three major independent academic evaluations of different aspects of the RDP were commissioned and have now been completed. A study by academics at McMaster University was published in the *Canadian Medical Association Journal* in October 2001; a study by academics at Harvard University was published in the *New England Journal of Medicine* and the *Canadian Medical Association Journal* in March 2002; the remaining study by researchers at the University of Washington is scheduled for publication in Summer 2002 in another reputable medical journal. These studies variously conclude that there are cost-savings associated with the RDP.

Current Ministry estimates of cost-savings directly attributable to the RDP for 2000 are $11.8 million. (An original estimate of $50 million annual savings included savings associated with proton pump inhibitors; however, these savings are more accurately attributable to the Limited Coverage Drug Program.) Independent analysis confirms that this estimate of approximately $12 million is reasonable and possibly conservative.

The Harvard study identified first-year cost-savings of $6.7 million associated only with ACE inhibitors. The McMaster study estimates a saving of $4.3 million annually over the first three-and-a-half years in the category of oral nitrates alone; it suggests, however, that cost-savings are primarily attributable to decreases in drug costs which may themselves be due to a wide variety of factors unrelated to the RDP, as well as some cost-shifting to patients.

What is also clear, however, is that, if the RDP remains static, i.e. if it is not expanded into other therapeutic categories and does not capture new drug therapies, these cost-savings will decline over time as patents expire and genetic products enter the market. As currently constituted, the RDP is a time-limited cost-containment device. One estimate suggests that savings from the RDP would amount to approximately $76 million over the ten-year period 2001-2010 (or an average of $7.6 million annually) if the program were continued as currently structured.

ii. Cost- shifting

Concerns were raised about the RDP shifting costs to other parts of the medical system, e.g. through increased visits to doctors, emergency rooms, increased hospitalization, etc. In fact, the evidence available through Ministry information and the three independent studies noted above indicates that cost-shifting is not a significant issue. Having said that, the Harvard study indicates a slight increase in hospitalization after patients switched drugs; the McMaster study attributes eight percent of identified savings to patients purchasing drugs for which they received only partial reimbursement. The studies do not address the issue of indirect costs, e.g. increased administrative burden on doctors and pharmacists or their time spent explaining the policy to patients.

iii. Health impact

It was suggested that the RDP may have a negative impact on the health of patients in that it delays or prevents them from obtaining effective or the most appropriate medication. Six months after implementation of the first phase of the RDP, the Reference Drug Program Expert Advisory Committee was formed to develop and implement procedures to evaluate the impact of the RDP on the delivery of health services and patient outcomes. A preliminary analysis of hospitalization rates and medical services did not show a significant impact resulting from the RDP. Although the Harvard study does not highlight evidence of adverse impact on patient health, an editorial accompanying the Canadian publication points out that the Harvard data shows reduced drug use, which could indicate under-treatment of high blood pressure.

A number of patient groups raised examples of instances of negative impact on patients; in almost every case, however, these were related to the rules governing the progressive approach required under the Limited Coverage Drug Program. While there are links between the two programs, the problems identified could not be attributed directly to the RDP.

iv. Equity of access

A number of submissions to the Panel expressed concern that the RDP is inherently unfair in that it restricts access to potentially more effective drugs to those who can afford to assume part of the cost. Others argued that the RDP incorporates equity of access both through the Special Authority process which permits physicians to apply for exemptions in cases of special need and in the larger philosophical sense that, by saving health care dollars in this area, the RDP makes it possible for the health care system as a whole to be accessible to more people. It was also emphasized to the Panel that newer, more expensive drugs are not necessarily more effective than older, less costly medications.

v *Professional independence*

The RDP is perceived by some as intruding inappropriately into the relationship between physicians and patients. The Panel heard appeals that the professionalism and independence o f physicians be respected and in no way compromised by efforts to influence their decisions on best practices. The Panel also heard reports, from physicians among others, that the RDP had a positive impact in encouraging physicians to give careful second thought to their prescribing habits.

vi. Special Authority process

Numerous concerns were expressed to the Panel about the unnecessarily time-consuming and burdensome nature of the Special Authority process. Physicians expressed concern about the time required to fill out and process extra forms; pharmacists were particularly concerned about the time involved in explaining government policy to patients when presented with prescriptions for a non-referenced drug. Representatives of both groups expressed concern about possibly delays in a patient receiving appropriate therapy.

Few people, however, were able to distinguish between the SA process as it applies to all Pharmacare programs and the SA process specific to the RDP which amounts to only 10 percent of all Special Authority requests. It was pointed out that 95 percent of all SAs are approved. While some see this as a positive comment on the efficiency of the system, others question whether the administrative process is really necessary or whether physicians should simply be provided with criteria, asked to make appropriate judgements and monitored for compliance.

Many participants spoke favourably of the SA process as providing the necessary flexibility to ensure that the RDP can meet the needs of individual patients. They commented that administration has improved considerably since the early days of implementation. The vast majority of SA requests are now made by telephone and approved within two business days

vii. Validity of the evidence base

The Panel heard concerns from a number of participants that the evidence base underlying the RDP is flawed. There is a strong body of opinion that questions the entire basis for therapeutic substitution, arguing that the various medications are not interchangeable and that health care providers require options to respond to particular circumstances. The Panel was informed that many physicians do not consider the drugs to be interchangeable and have not been provided with sufficient evidence that they are. On the other hand, there is an equally strong body of opinion that considers the RDP to be based on a thorough review by the RDP Expert Advisory Committee of the best evidence available.

viii. Transparency of decision-making

Closely aligned to concerns about the validity of the evidenc**e** base, but even more widespread, are concerns about *the* transparency of the decision-making process underlying the RDP. Phannacare's decisions as to which drugs it will fund and to what extent has limited participation by current practitioners. Detailed information supporting its analyses is not available for review; leaving the process open to criticism. Although not directly related to the RDP classification process, similar criticism was directed toward the Therapeutics Initiative.

ix. Symbolism/deterrent effect

The Panel was made aware of the extent to which the existence of the RDP carries a symbolic weight out of proportion to its size or importance in the overall scheme of Pharmacare. Not only representatives of pharmaceutical companies, but policy institutes, academics and others commented on the RDP as indicative of a government attitude that is hostile to industry and innovation.

Perhaps the most frequently heard argument against the RDP was concern that its existence acts as a deterrent to investment in British Columbia by the pharmaceutical industry. Examination of pharmaceutical investment in other provinces on a per capita basis indicates that BC lags seriously behind its potential in this area. There is a strong body of opinion that elimination of the RDP would signal a major change in attitude toward industry on the part of the British Columbia government and that such a shift would be responded to by rapid and significant investment in the province. It is argued that this investment, both independently and in terms of spin-off benefits, would vastly exceed any savings currently associated with the RDP.

Such a strategic shift might include broad-based partnerships with academia, industry and the professions of pharmacy and medicine to develop and implement disease management programs, drug utilization reviews, as well as professional and public education programs. The result, in the view of proponents, would be a more financially manageable health care system that would provide better health care outcomes for patients.

Other submissions noted that pharmaceutical industry investment in British Columbia has remained consistent at approximately three-to-four percent of its total investment in Canada since well before the introduction of the RDP and that investment decisions are governed by broader political and infrastructure considerations. They suggest that recent changes in British Columbia's tax structure together with other political initiatives should be sufficient to demonstrate to the pharmaceutical industry that the business climate in the province has undergone a fundamental shift and that ultimately the industry will make good business decisions to invest in the talent and potential for profit in British Columbia.

x. Confusion/arbitrariness

The Panel was made aware of widespread confusion around the multiplicity of Pharmacare programs. The vast majority of presenters, no matter how knowledgeable in their fields, at some point confused the RDP with the Low Cost Alternative or, more frequently, the Limited Coverage Drug Programs. A contributing factor to concerns about the RDP is the apparent arbitrariness of decision-making with respect to various Pharmacare programs. For example, the decision by Pharmacare to place proton pump inhibitors in the LCD is linked in the minds of many to the RDP. Both programs are perceived as impeding access to effective drug therapies. The complexity of the Pharmacare program design leads to confusion that undermines the credibility of the RDP even when it is not, in fact, the issue at hand.

There is also considerable confusion around the role of the Therapeutics Initiative with respect to the RDP. The TI is perceived by many as more involved with RDP decision-making than is the case, and some concerns about the TI are reflected onto the RDP.

Xi. *Holistic approach*

The Panel heard from numerous presenters, both in favour of and opposed to the RDP, of the need for British Columbia to take a more holistic approach to health care. The Panel was urged neither to isolate pharmaceutical costs as a major contributor to the cost crisis facing health care nor to identify the RDP as an overly significant cost-containment tool.

It was pointed out that pharmaceutical costs represent only approximately 15 percent of expenditures in the health care system and that the RDP is one very small component of that category. It was pointed out that, no matter what cost-saving measures are undertaken with respect to pharmaceuticals, health care expenditures as a whole will continue to be problematic. It was suggested by a number of people that the current `patchwork" of small programs should be replaced by an integrated, uniform system. It was also noted that the concept of formularies, i.e. lists of drugs for which full or partial funding is provided, is used in all jurisdictions and, increasingly, even by private health care insurers. It was proposed that hospital and Pharmacare formularies should be made more consistent.

A number of submissions argued that prescription drugs should be part of the Canada Health Act and covered by a national pharmacare program. It was also suggested that there should be a coordinated federal-provincial approach to controlling pharmaceutical costs.

IV PROPOSED ALTERNATIVES/MODIFICATIONS

A. Alternatives

A number of submissions to the RDP Consultation Panel proposed the elimination of the RDP and suggested that similar or greater cost-savings could be achieved through a variety of possible alternatives. Little in the way of hard economic analysis was provided, however, to support these proposals.

i. Structural Change

Numerous submissions argued that the health care system as a whole requires fundamental structural change if it is to be able to meet the expanding needs of an aging population. It was suggested that the savings currently associated with the RDP, if it were discontinued, could be recouped by a variety of different co-payment systems, i.e. that government, private insurers and individuals should pay different proportions of drug costs through varying means. Suggestions included: individual medical accounts; a further increase in deduction levels; a stepped approach whereby different co-payments would increase in relation to the total amount expended; Pharmacare becoming the payer of last resort only when other alternative insurance schemes have been exhausted. All of these proposed structural options involve placing an increased burden on individuals to meet their pharmaceutical needs.

Other submissions expressed strong opposition to a co-payment approach, citing issues of equity and fundamental fairness. It was stressed that cost-shifting negatively affects people with low incomes. They noted that user fees in other jurisdictions have served to dissuade the poor and those who perceive themselves to be poor from utilizing health care services, with consequent higher costs to the health care system down the line. In addition, it was also suggested that a single-payer approach is more efficient.

It was noted that a number of structural changes, e.g. changes in deductible levels, have recently been implemented by Pharmacare and more are planned, and that cost savings associated with these changes have already been included in the government's financial projections.

ii. Disease management programs

One of the more frequently proposed alternatives is the concept of government/industry partnerships focused on the management of particular diseases. Such programs could include clinical treatment coupled with patient counselling, professional and public information programs and other initiatives considered likely to have a positive influence on a particular medical condition. Examples were provided of successful disease management (or patient health)

programs in British Columbia and other jurisdictions, where industry has invested money to work with government, physicians, pharmacists and other health professionals to develop focused, effective programs aimed at particular diseases**.** A number of submissions suggested that, if disease management programs operated properly, there would be no need for the RDP, as proper drug utilization would save money.

iii. Administrative standardization/simplication

One submission, from University of British Columbia Faculty of Pharmaceutical Sciences, dealt directly with the issues of the symbolic importance of the RDP, the need for the government to contain costs, and the complexity of the current Pharmacare structure. It suggested that the RDP adds another layer of administrative complexity to Pharmacare management and argued that the same cost controls could be obtained by standardizing the application criteria and classification system for all pharmaceuticals.

Under this system, Pharmacare would categorize all pharmaceuticals in one of four ways: I. approved for full benefit coverage; 2. approved with restrictive criteria managed by physicians and pharmacists; 3. approved by central special authority, i.e. limited selection of drugs; and 4. not covered. The RDP would be eliminated, while the cost-saving elements of its design would be determined by the placement of the drugs into different categories.

Many submissions dealt with administrative aspects of the RDP. The usefulness of a process in which 95 percent of Special Authority requests are routinely approved was questioned. It was suggested that, in these routine instances, physicians could simply write the reasons for selecting the non-referenced drug on the prescription and have the pharmacist enter it on PharmaNet for monitoring purposes. A number of groups suggested that pharmacists are better placed than Pharmacare staff to undertake program administration and to make decisions about Special Authority approvals. It was further proposed that the RDP could be eliminated and pharmacists entrusted to make appropriate cost-effective decisions regarding drug substitution under established criteria and accompanied by effective program monitoring.

iv. Bulk buying

It was suggested that British Columbia should exercise its economic muscle by issuing tenders for generic drugs and buying them in quantity at the lowest price. Generic drug manufacturers are opposed to the introduction of bulk buying on the basis that it would lead to reduced margins and potential loss of market share by individual manufacturers.

v. Delisting

It was suggested that savings could be achieved by making certain additional drugs ineligible for any reimbursement. Others were strongly opposed to this approach as because it would shift costs to consumers.

B. Alternatives or Modifications

The following two approaches were suggested as appropriate either as cost-saving alternatives to the RDP or as possible modifications to the existing program:

i. Maximum reimbursement costs

It was suggested that Phannacare could set maximum reimbursement costs for drugs that treat similar clinical conditions but are not necessarily from the same therapeutic class. This would be an alternative to, or expansion of, the RDP that would allow Pharmacare to control costs while, at the same time, allowing additional choices for physicians and patients. It was suggested that this would be a cost-effective alternative in situations where a newly marketed drug is a more expensive alternative to current therapies. It could also allow some coverage of new drugs which might otherwise be denied benefit status.

ii. Physician/patient information

The majority of submissions to the Panel, whether in favour of or opposed to the RDP, suggested that one of the most effective ways of saving money on pharmaceutical expenditures is to increase the independent, evidence-based information provided both to physicians and to patients. This was proposed as both an alternative and as a possible extension or modification of the RDP. It was suggested that doctors and patients have no reason to want to increase costs to the health care system unnecessarily and that providing them with information to support rational decisions had considerable cost-saving potential. Concern was expressed about increased direct-to-consumer advertising by pharmaceutical companies and its likely impact on patient demands and expectations.

C. Modifications

Other submissions proposed that the RDP be modified along the following lines:

i. Expansion

A number of submissions supported the RDP as an effective cost-containment measure and urged its expansion into other therapeutic areas where there is a large difference in the price of drugs and only a small difference in effectiveness. Statins, i.e. chloresterol-lowering drugs, were suggested as a possible area for expansion, as were asthma drugs. It was noted, however, that there is a limited

number of categories where sufficient evidence exists to permit expansion of the RDP. On the other hand, others argued that the cost, in terms of relations with the pharmaceutical industry and consequent impact on research and development expenditures in British Columbia, outweighed the limited cost savings that would be realized from expansion of the RDP. It was urged that any expansion of the program be accompanied by evidence-based evaluation.

ii. Incentives for physicians and patients

It was suggested that the cost-effectiveness of the RDP could be enhanced by providing incentives to physicians and patients to choose the reference drugs. One proposal was that, instead of having to apply for a Special Authority in the 95 percent of cases where SAs are automatically approved, physicians be provided with virtual dollar flexibility accounts. Similar economic incentives were suggested to encourage patients to select less expensive, equally effective drugs, e.g. individual patient drug accounts, variable co-payments, etc.

iii. Drug utilization reviews (DUR)

DUR is a structured process used to assess the quality of drug therapy by evaluating data on prescribing, dispensing and/or patient use. The information can provide valuable feedback to physicians, pharmacists and policy makers and can help to shape healthy and cost-effective use of pharmaceuticals. A number of submissions focused on the need for policy decisions to be based on accurate, reliable and comprehensive information. Concerns were raised about the demise of drug utilization reviews which could provide the province with the necessary information on which to base new program initiatives.

The Panel was informed that, since transfer of responsibility for DUR to the College of Physicians and Surgeons from the Drug and Poison Information Centre some years ago, little in the way of educational material or published studies has been generated. The government was urged to re-instigate DUR and ensure that the information generated is widely distributed.

iv. Change of name

It was pointed out by a number of people that the name of the Reference Drug Program may be an issue. All jurisdictions and even private insurance companies use drug formularies, i.e. lists of drugs supplied under various plans and the price that will be reimbursed. It was pointed out that Nova Scotia's Special MAC (maximum allowable cost) plan has not attracted anywhere near the amount of opposition as has the RDP. A more positive name, e.g. Automatic Coverage Program, was suggested as having potential to change public perceptions of the program's value.

V CONCLUSIONS

The Panel considers that an effective approach **to** managing pharmaceutical costs must be sustainable over the long term, transparent i**n** its decision-making and operation, and comprehensive in its approach. It has become clear to the Panel that the linkage among various Pharmacare programs and policies has a direct impact on the credibility and sustainability of the Reference Drug Program. Consequently, while the Panel offers conclusions and recommendations with respect to the RDP as requested, it does so in the context of advising Pharmacare to consider a clearer, more comprehensive approach overall.

Reference Drug Program

The RDP Consultation Panel has concluded that the British Columbia Reference Drug Program offers an effective way of controlling some Pharmacare costs. Conservative estimates agree that the RDP has resulted in direct cost savings to Pharmacare of approximately $12 million in the current fiscal year. There appears to be little evidence of additional cost to other government programs over the long term, although there is some indication of added administrative costs to physicians and pharmacists. With regard to patient health, based on the evidence presented to it, the Panel concludes that the effect of this program, particularly with respect to hypertension, warrants further investigation.

The Panel has concluded that none of the alternatives presented to it would, in the short term, result in direct savings comparable to those associated with the RDP. Some of the alternatives and modifications proposed do, however, appear to have potential for long-term savings to Pharmacare or increased economic benefit to government as a whole.

The Panel accepts that, while the RDP may not be evidence-based in the scientific sense of the term, i.e. it is not based on a meta-analysis or synthesis of quantitative data, it is based on published evidence examined by the RDP Expert Advisory Committee.

With respect to the impact of the RDP on the professional independence of physicians, the Panel notes that every profession operates within a system of checks and balances. The RDP may impose a constraint on the doctor/patient relationship but, in the opinion of the Panel, it is not unreasonable or excessive.

The Panel considers that the existence of the Special Authority process and the relatively broad criteria for their approval provides the necessary flexibility to ensure equitable access for individual patients to the drugs best suited to their needs.

Program administration has been improved over time and is continuing to be fine-tuned to the point where it appears to be less of an issue for the majority of users. Procedures and issues around possible delay in therapy may continue to require attention.

Costs to Ph.armacare associated with RDP administration, estimated at $100,000 or approximately 10 percent of total SA administration, are reasonable**.**

The Panel does have concerns about some aspects of the RDP. The design of the program is not clear to many stakeholders, nor is it clearly distinct from other Pharmacare programs designed to contain costs. The linkages and overlaps, particularly between the RDP and the Limited Coverage Drug Program, result in considerable confusion, and problems encountered with other programs are frequently attributed inaccurately to the RDP.

Furthermore, any program that hopes to maintain its value over time must be able to adapt to changing circumstances. This is particularly true of the RDP, operating within the rapidly evolving context of pharmaceutical development. The current static nature of the RDP not only limits its cost-saving potential but will lead to a gradual diminishment in its intrinsic value. Without expansion, as patents expire and generic drugs are approved, the savings resulting from the RDP are not sustainable. There appears, moreover, to be a limited number of additional therapeutic categories into which expansion of the RDP would be appropriate.

The Panel considers it appropriate for the province to try to contain pharmaceutical costs. No provincial program can cover all things; budgets are not unlimited. Decisions, however, must be fair and transparent. In the Panel's view, legitimate concerns have been raised about the lack of transparency of policy and program decision-making. Opening the decision-making process to more involvement by practicing professionals along with better communication of information to professionals and the public would greatly increase the RDP's credibility.

The larger picture

There is no doubt that the RDP is a flashpoint for relations between the provincial government and the pharmaceutical industry. Rightly or wrongly, the RDP is seen as a symbol of an uncooperative and hostile climate and has, according to industry accounts, negatively influenced the amount of its investment in British Columbia. The industry made clear its willingness to discuss meaningfully enhanced investment in a new environment.

The Panel has heard that a critical issue is reasonable market access, measured by the number of compounds introduced in the past year that were accepted by the province for reimbursement benefit. By that standard, one could argue that all of Pharmacare's cost-containment programs, i.e. the Reference Drug Program, the Low Cost Alternative Program and the Limited Coverage Drug Program, limit market access. The issue at hand, therefore, is larger than the RDP.

It is the Panel's view that government cost-containment strategies and many of the alternatives proposed are not necessarily mutually exclusive. There are examples of disease management programs, for example, currently operating in British Columbia, and

the provincial government is already undertaking some fundamental restructuring of Pharmacare co payment arrangements. In order for these and other alternatives to work to best effect, however, it will be necessary for the government to identify a clear vision and strategy for the future of the pharmaceutical management system and work to foster a cooperative climate among all partners. The establishing of that healthy climate of cooperation will require government to work more closely with industry, academia and all members of the health care system.

Given that RDP expansion opportunities are limited and cost-savings do not appear to be sustainable over time, together with the Panel's view that Pharmacare as a whole would benefit from simplification and greater clarity, it would seem logical to combine the opportunity for restructuring with efforts to work with industry to secure greater pharmaceutical investment in British Columbia, while retaining Pharmacare's ability and responsibility to contain costs in the interests of all British Columbians.

The Panel further considers that British Columbia's efforts to contain pharmaceutical costs would benefit from a broader, more comprehensive approach, including increased inter-provincial and federal-provincial cooperation.

VI RECOMMENDATIONS

As none of the alternatives or modifications presented would result in direct short-term savings to Pharmacare equivalent to those currently associated with the RDP, the Panel recommends that:

1. The Reference Drug Program should be maintained, at least on a short-term basis.

Because of the time-limited nature of the savings associated with the RDP and the limited opportunities for expansion presented by current program design, as well as to minimize the confusion associated with the various cost-containment programs of Pharmacare, the Panel recommends that:

2. Pharmacare's program structure should be redesigned in such as way as to maintain the ability to manage costs within a more integrated framework. Such a framework should provide improved transparency and greater clarity.

   Specifically, Phamacare should consider a simplified pharmaceutical classification system. In this regard, the submission from the University of British Columbia Faculty of Pharmaceutical Sciences is recommended for consideration and further analysis by government. The Panel recommends consideration of three drug categories:

   (1) full benefit;
   (2) restricted coverage a) pharmacist or physician approved against criteria b) Pharmacare approved in exceptional cases; and
   (3) not covered.

In effect, this proposed design would eliminate the RDP as a separate program based on therapeutic substitution, while retaining its cost-containment effect.

3. Program redesign should include meaningful consultation with stakeholders, including health care professionals, academics, industry representatives and others.

4. In particular, frank discussions should be-held with the pharmaceutical industry to explore the possibilities for substantially improved investment in research and development in British Columbia.

To support the proposed redesign as well as future program and policy development, the Panel recommends that:

5. Various co-payment and incentive options, e.g. sliding scale, stepped scale, percentage allocations, etc., should be reviewed to identify those which provide the optimum balance of cost-containment, incentives for physicians and patients to choose cost-effective alternatives, as well as protection for the poor and critically ill.

6. Drug utilization reviews should be reactivated, either through the BC College of Physicians and Surgeons, the body currently responsible for them, or by transferring responsibility to another agency willing to undertake this role to support program development.

7. Physicians, pharmacists and the public should be provided with better information to encourage shared responsibility and support informed and cost-effective decision-making with respect to drug use.

To encourage a more integrated approach to overall pharmaceutical and health care management, the Panel recommends that:

8. British Columbia should continue to play a lead role in encouraging coordinated inter-provincial drug approval, access and cost-containment measures.

9. British Columbia should work with the other provinces to urge the federal government to include prescription drugs within the provisions of *Canada Health Act* and to work toward a national pharmacare program.

In the event that the recommended Pharmacare program redesign, as discussed in recommendation 2 above, is not feasible within a reasonable period of time, e.g. one-to-two years, the Panel recommends that:

10. The Reference Drug Program should be expanded into appropriate additional therapeutic categories in order to maximize its cost-savings potential.

Appendix 1

MINISTRY OF HEALTH PLANNING
Reference Drug Program Consultation Panel
Terms of Reference

In keeping with the New Era commitment to *"work with doctors, pharmacists and others to find a cost-effective alternative to reference-based pricing",* the Ministry of Health Planning is establishing an independent RDP Consultation Panel. The panel will consist of a physician, pharmacist and lay representatives to solicit input from stakeholders and will review and seek a cost-effective alternative to the Reference Drug Program.

Principles

The panel should:

• be informed by a comprehensive understanding of both the advantages and disadvantages of *RDP;*

• promote substantive discussion with stakeholders:

• consider public input.

Mandate

• By reviewing available literature, communications and other related material concerning RDP.review of the efficacy of the current RDP program in terms of:
  • cost savings; and.
  • impact on other parts of the health care system and patients

• Define appropriate stakeholders to include in the consultation process.

. Invite and meet with stakeholders to identify and discuss their proposed cost-effective alternatives to *RDP.*

• Evaluate alternative policies in terms of.
  • projected cost savings.
  • evidence in support of these savings: and
  • impact on patients and other areas of the health care system

• Review comments and suggestions from the public via the Ministry of Health Planning website established by Ministry staff for the RDP consultation process

• Recommend cost-effective alternative policy(ies) to the RDP

• Prepare a report for the Minister of Health Planning

Report

The report of the panel will be delivered to the Minister of Health Planning no later than March 31 2002

RDP CONSULTATION PANEL

Appendix 2

STAKEHOLDER CONTACT LIST

Organizations/Individuals Contacted by Panel	Meeting	Written Submission Only	No Response	Chose Not to Participate
ALS Society of BC		X		
Alzheimer Society			X	
The Arthritis Society, BC & Yukon Division	X			
Association of Registered Nurses of BC				X
BC Better Pharmacare Coalition	X			
BC Biotechnology Alliance	X			
BC Centre for Excellence in HIV/AIDS rec'd.Dr. Anis	X			
BC Council for Families			X	
BC Cystic Fibrosis Association			X	
BC Lung Association	X			
BC Medical Association		X		
BC Parkinson's Disease Association			X	
BC Persons with AIDS Society	X			
BC Pharmacy Association	X			
BC Schizophrenia Society			X	
Canadian Association of Retired Persons	X			
The Canadian Association of Chair Drug Stores	X			
Canadian Centre for Policy Alternatives	X			
Canadian Diabetes Association		X		
Canadian Drub Manufacturers Association	X			
Cerebral Palsy Association of BC			X	
Chain Drug Association of BC				X
College of Pharmacists of BC				X
College of Physicians and Surgeons of BC				X
Council of Senior Citizens			X	

End Legislated Poverty			x	
Dr. Robert Evans, Department of Health Sciences, UBC	X			
Federal Superannuates National Association		X		
The Fraser Institute	X			
Dr. Tom Hazlett, University of Washington	X (phone)			
Heart and Stroke Foundation of BC & Yukon		X		
Kidney Foundation of Canada, BC Branch				X
Dr. Wendy Leong	X (phone)			
Dr. Heather Morrison	X			
Osteoporosis Society of BC			X	
Pacific AIDS Network			X	
Pacific Blue Cross				X
Pharmawatch	X			
Poverty Action Network				
Red Road/HIV/AIDS Network				
Rx&D	X			
Seniors' Advisory Group				
Social Planning and Research Council of BC	X			
Therapeutics Initiative	X			
UBC, Faculty of Medicine	X			
UBC, Faculty of Pharmaceutical Sciences	x			
The Vancouver Board of Trade			X	

Organizations/Individuals Initiating Contact	Meeting	Written Submission Only
Canadian Genetic Diseases Network		X
Canadian Wholesale Drug Association		
Dr. Bruce Carleton, RDP Evaluation Sub-committee	X	
Michael Crawford		X
GlaxoSmithKline	X	
IMS Health Canada		X
Claude Laforest		X
Dr. Bill McArthur	X	
Merck Frosst Canada Ltd.	x	
Mood Disorders Association of British Columbia		X
Pfizer Canada	X	
REACH Community Health Centre		
Blake Reynolds		X
Jeff Rue er		
Dr. Indira Samarasekera, VP, Research, UBC	X	
Dr. Sebastian Schneeweiss, Harvard University	x	
David Schreck		X
UBC Doctors - Fleming et al		

Appendix 3

RDP CONSULTATION PANEL

LIST OF SUBMISSIONS

ID #:	From	Date/Manner Received	Support	Neutral *	Oppose
001	David Schreck	Nov 26/01 E-mail	X		
002	Michael Crawford	Dec 8/01 E-mail	X		
003	Jeff Rueger	Dec 10/01 E-mail	X		
004	Dr. Aslam Anis UBC & Providence Health Care	Jan 7/02 Presentation		X	
005	Dr. Bernard Bressler VP, Research and Education Vancouver Hospital and Assistant Dean, Research Faculty of Medicine UBC	Jan 7/02 Presentation			X
006	Dr. Indira Samarasekera VP, Research, UBC	Jan 8/02 Presentation			X
007	Canadian Wholesale Drug Association	Jan 8/02 Presentation n		X	
008	Federal Superannuates National Association	Jan 15/02 E-mail	X		
009	Canadian Diabetes Association	Jan 16/02 Fax	X		
010	BC Medical Association	Jan 14/02 Fax	X		
011	Council of Senior Citizens' Organizations of British Columbia	Jan 15!02 Letter	X		
012	Mood Disorders Association of British Columbia	Jan 16/02 Letter		X	
013	GlaxoSmithKline Inc	Jan 25/02 E-Mail Presentation			X

014	UBC Faculty of Pharmaceutical Sciences	Jan 25/02 E-mail Presentation on Jan 29/02			X
015	BC Persons with AIDS Societ	Jan 28/02 Presentation	X		
016	The Fraser Institute	Jan 28/02 Presentation			X
017	Pharmawatch	Jan 29/02 Presentation	X		
018	Dr. Heather Morrison	Jan 29/02 Presentation	X		
019	ALS Society of BC	Feb 1/02 Fax	X		
020	Dr. Wendy Leong	Feb 4/02 Presentation conf call		X	
021	BC Biotech Alliance	Feb 4/02 Presentation			X
022	REACH Community Health Centre	Feb 4/02 Presentation	X		
023	Dr. Robert Evans, UBC	Feb 4/02 Presentation	X		
024	Pfizer Canada Inc.	Feb 5/02 Presentation			X
025	SPARC BC	Feb 5/02 Oral Presentation	X		
026	The Arthritis Society - BC_&_Yukon Division	Feb 5/02 Presentation		X	
027	BC Better Pharmacare Coalition	Feb 5/02 Presentation			x
028	Blake Reynolds	Feb 5/02 E-mail		X	
029	Canadian Genetic Diseases Network	Feb 8/02 Letter			
030	! Canadian Association of Chain Drug Stores	Feb 20/02 Presentation		X	
031	Pharmacy Association	Feb 20/02 Presentaion		X	
032	BC Lung Association	Feb 20/02 Presentation			X
033	Canadian Centre for Policy Alternatives	Feb 20/02 Presentation	X		
034	Dr. William McArthur	Feb 20/02 Presentation			X

035	Dr. Sebastian Schneeweiss	Feb 20!02 Presentation	X		
036	Canadian Association of Retired Persons	Feb 21/02 Presentation			X
037	Rx&D	Feb 21/02 Presentation			X
038	Canadian Drug Manufacturers Association	Feb 21/02 Presentation-	X		
039	Merck Frosst	Feb 21/02 Presentation			X
040	Dr. Bruce Carleton, RDP Evaluation Sub-Committee	Feb 21/02 Presentation	X		
041	UBC Doctors - Fleming et al	Jan 28/02 Letter			X
042	Claude Laforest	Feb 14/02 e-mail		X	
043	Dr. Tom Hazlett University of Washington	Feb 26/02 Meeting	X		
044	Dr. James Wright Therapeutics Initiative	Feb 26/02 Meeting		X	
045	IMS Health, Canada	Feb 25/02 E-mail		X	
046	Chris Aikman	Mar 15/O1 E-mail	X		

*Neutral may mean: supports RDP in principle while opposed to particular application; opposes the way in which the RDP is administered but has no difficulty with the concept; no opinion provided; or submission deals with another issue.