Presentation to the Reference Drug Program Consultation Panel

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Monday, January 28, 2002

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By Glen Hillson for the BC Persons With AIDS Society

Good Afternoon. Thank you for the invitation and opportunity to speak to you today about BC's Reference Drug Program. The BC Persons With AIDS Society has 3600 HIV-positive members and is the largest organization of HIV-positive people in Canada.

People living with HIV/AIDS rely heavily on prescription drugs to slow disease progression, maintain health and extend life. The therapeutic class of drugs known as antiretrovirals – drugs whose mechanism of action is to slow or halt HIV replication - accounts for 5% of the total Pharmacare budget. As well, many of us use a variety of other drugs to manage the effects of our illness – effects such as symptoms, side effects and opportunistic infections arising from compromised immunity.

The classes of drugs presently included in the RDP are not widely used by people with AIDS – at least not for conditions related to their HIV infection. We do however rely heavily on a strong, rational, publicly funded system of drug distribution that ensures equality of access. For such a system to effectively meet the needs of all residents of BC its design must be evidence-based, it must be cost effective and must compliment other facets of the overall health care system to ensure delivery of comprehensive, quality care.

When the RDP was first introduced in 1995 it was very controversial and in many cases public opinion cut across traditional lines of support and affiliation. Among health care consumers there was uncertainty and concern about how RDP would affect them. A full range of opinion was reflected among consumer advocacy groups. For this reason, the RDP has been subjected to unprecedented evaluation and scrutiny to assess its effects. Different impacts of the program have been evaluated by at least four different research groups from Harvard, U of Washington, UBC, and McMaster. Although funded by the BC government this evaluation work was conducted independently and was encouraged by a range of stakeholders including the drug industry who are the most vociferous opponents of RDP.

I would like to talk briefly about the context of RDP in the greater scheme of health care delivery in BC and the rest of Canada, both because that context is the subject of one of the most wide ranging and important public discourses on health care in our history and because a meaningful assessment of RDP in relation to possible alternatives must include a broader discussion of cost containment options.

The public discourse presently occurring, places a large emphasis on assertions of rising costs of health care in general, and drug programs in particular. Some stakeholders call current systems unsustainable. Regrettably, strategies that are marketed by governments as intended to contain costs are little more than manoeuvres to shift costs. BC has the lowest per capita total drug expenditure in Canada even though BC's population has the highest percentage of seniors. What troubles the present government is that BC's public purse funds a greater proportion of these costs than other provinces.

And in order to alleviate that circumstance and pave the way for tax cuts and redirected spending, they propose to shift drug costs to individuals, to private insurance plans and to employers.

Bulk purchasing by Pharmacare and RDP have proven to be the most effective tools currently at our disposal for containing drug costs without adversely impacting health outcomes. Recently the Canadian premiers talked of the creation of a national crown corporation for the bulk purchase of drugs. This combined with greater price competition, have the potential to help keep costs down. However, the present reality is that drug price regulation in Canada by the PMPRB has proven to be relatively ineffective. Exceedingly generous patent protection for research drug companies leave very little room for competition. This has made the drug industry the most profitable industry in the world. The RDP has had the greatest effect in stimulating price competition here and in countries such as Germany and New Zealand. In many instances drug companies have reduced prices as a means of competing for market share with the reference drugs.

I would like to discuss some of the benefits and myths about the RDP. According to Pharmacare estimates, the RDP has saved Pharmacare $161 million since it was introduced in 1995. In 1999 the estimated saving was $44 million. Opponents of the program have argued that higher costs result elsewhere in the health system because of the RDP, due to increased doctor visits and discarded drugs. This argument appears to have been ideology-based, having little evidence to support it. The RDP works because the program is evidence-based. Since its inception, intensive independent evaluation has demonstrated that the RDP reduces the overall cost of health care.

Some argue that the RDP substitutes cheap health care for optimal health care. Evaluation of the program reveals that it has had no adverse impacts in terms of hospitalisations, morbidity, mortality or other patient outcomes. In fact, the cost shifting strategies that are being set in motion can and do place life saving drugs out of reach for some people resulting in poorer population health outcomes. This is what occurred in the province of Quebec when drug costs were shifted to the poor.

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

The RDP in BC has worked very well and BC should look at other therapeutic areas to achieve additional cost savings. Residents of BC have come to appreciate and support the program because it has not adversely impacted health outcomes; it helps make the Pharmacare program more sustainable and rational, and it limits profit gouging by corporations. Doctors have also come to realize the long-term benefits of the RDP in terms of their patients having sustainable, long-term access to quality care.