Drug costs in Canada

IN RESPONSE TO THE CPJ EDITORIAL “THE MISREPRESENTATION of High Drug Costs: Who Is Looking out for the Patient?” (March/April 2017), the Canadian Agency for Drugs and Technologies in Health (CADTH) would like to bring to your attention the CADTH Common Drug Review (CDR) and pan-Canadian Oncology Drug Review (pCODR) programs, which were not mentioned or considered in this editorial. These CADTH programs play an important role in Canada’s public drug plan considerations as to whether a drug will be eligible for public reimbursement. Through the processes of the CDR and the pCODR, CADTH conducts thorough and objective evaluations of the clinical, economic and patient evidence on drugs and uses this evaluation to provide reimbursement recommendations and advice to Canada’s federal, provincial and territorial public drug plans, with the exception of Québec. As part of this process, we engage experts who have experience in treating patients with a particular condition for which the drug is intended. The clinical experts augment the discussion with the representatives of our expert advisory committee, which includes physicians, pharmacists, economists, patients and public members.

All CADTH CDR and pCODR recommendations and reasons for recommendations are publicly posted to the CADTH website. Participating drug plans make their final reimbursement and coverage decisions based on the CADTH recommendations and other factors, such as drug plan mandates, jurisdictional priorities and budget impact.

We appreciate the opportunity to provide Canadian pharmacists with this information as to how evidence is reviewed for drug formulary considerations in Canada. For more information, visit www.cadth.ca. ■

—Brent Fraser

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Drug costs in Canada

WE ARE WRITING THIS LETTER IN RESPONSE TO A RECENT EDITORIAL written by Bachynsky and Tsuyuki,¹ titled “The Misrepresentation of High Drug Costs: Who Is Looking out for the Patient?” While we appreciate alternative points of views and any suggestion that tries to bring awareness to the different things that pharmacists can do to help their patients, we believe there are many points that were raised in your editorial that are not entirely correct. In fact, we feel that some portions of your editorial are contradictory to what many in the pharmacy profession feel our roles as pharmacists are and the messages we should be sending as part of the health care team.

We agree with your introductory message that pharmacy is often an easy target for cost reductions, as drug expenditures may be seen as that “easy fix.” There are many drivers to rising health care costs, and drug costs are but one piece of the puzzle. What concerns us is that the editorial makes no distinction between drug costs and cost-effectiveness of drug therapies.

We respectfully disagree with your second statement under the heading “What Can We Do about This?” that decisions for drugs not to be included on a formulary are sometimes made without evidence. Before drug plans decide to list or not list a drug on a formulary, these medications are reviewed by the CADTH Common Drug Review (CDR) or the CADTH pan-Canadian Oncology Drug Review (pCODR). For drugs

submitted to the CADTH CDR program, the Canadian Drug Expert Committee, which consists of pharmacists, physicians, health economists and members of the public, reviews the evidence for which the medication received Health Canada approval and makes recommendations to the participating drug plans as to whether or not to list medications as a benefit and under what conditions. Similarly for cancer drugs, the CADTH pCODR Expert Review Committee, consisting of pharmacists, oncologists, family physicians, health economists and patient representatives, reviews the evidence and makes recommendations to drug plans and cancer agencies. In all cases, the evidence evaluated is fully available for everyone to read (<https://www.cadth.ca/>).

In your third statement under “What Can We Do about This?” you state that as pharmacists, we should be telling our patients that “their drug benefit program is not acting in their best interest.” This is a dangerous and extremely adversarial position that you are suggesting pharmacists to take. It risks ruining lines of communication between drug plans and pharmacists and puts the patient in a precarious situation. Yes, having patients research the situation and taking action themselves is one option, as they are their own best advocate. However, this can be difficult for most patients, as the vast majority are not health care professionals, and this can be a daunting

task. More reasonably, it would be advisable for the pharmacist to research why a medication may not be a benefit and provide a broader perspective to the patient. In addition, while we do agree that contacting one's MLA with any type of concern is meritorious, your suggestion to have patients tell their MLAs that decisions to cover medications are not based on evidence is erroneous and misleading. That there is bias in government decisions on drug benefits is not a stance that pharmacists should be promoting, particularly as a foundation of our profession is evidence-based medicine.

In terms of what pharmacy organizations can do, an important distinction needs to be made between clinical guidelines and formulary listings. Clinical guidelines are based on clinical evidence, and most do not take cost into consideration, whereas decisions to list medications on formularies must include both clinical effectiveness and cost-effectiveness. Of course, cost-effectiveness should be considered with drugs as well as any other health intervention. To do otherwise risks inappropriate use of health care resources. As clinicians and tax payers, how could we suggest otherwise?

We fully agree with the point you raised that describes pharmacists as drug experts. However, most pharmacists do not have the time to fully evaluate the literature on which a formulary recommendation is based, nor do most pharmacists have a strong background in pharmacoeconomics to determine if a drug is cost-effective or not. A critique of the evidence and pharmacoeconomics is the process undertaken by drug plans before a listing decision is made. Prior to pharmacy organizations advocating that pharmacists should be the ones deciding if drugs make it onto formularies or not, we feel pharmacists should become familiar with the evidence that has led to those listing recommendations.

Last, there are instances in your article where you suggest pharmacy organizations partner with disease-based charities

or meet with pharmaceutical companies for more information. Yes, these are worthwhile activities to stay up to date and ensure patients receive the best care. However, it is important to distinguish between what their roles are and the roles of pharmacists and pharmacy organizations. Evidence-based medicine is at the core of our profession, and if the evidence, or lack thereof, points to a medication not being cost-effective, then that decision should be supported and communicated to patients, so that we may help them find other solutions. We agree that there are special situations where individual requests can and should be made to drug plans or to manufacturers to try and get medications covered for some of our patients. This is an area where pharmacists can work with their patients, physicians, industry and the drug plans.

This is an important issue and one that we should keep talking about—agreed. Rising drug (and health care) costs are not going away. Hence, we feel it is important that it is recognized that decisions to list (or not) medications on formularies are done with due diligence and based on the best possible evidence available. ■

—Kerry Mansell, BSP, PharmD, MBA
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Reference

1. Bachynsky JA, Tsuyuki RT. The misrepresentation of high drug costs: who is looking out for the patient? *Can Pharm J (Ott)* 2017;150:74-75.

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Authors' response

Thank you to those who took the time to write to us. This kind of discussion is needed.

We would like to reiterate our main point, which is that drug costs are a small fraction of the health care budget, yet are sometimes unfairly targeted for their contribution to health care costs, and pharmacists get caught in the middle.

High-quality evidence must be the core of formulary and coverage decisions (they aren't always). Finally, it is most certainly the role of pharmacists to advocate for their patients when it comes to access to proven efficacious therapies. To suggest less assertive approaches is a step backwards for pharmacy practice and repudiates our societal responsibility. ■

—John A. Bachynsky, PhD
—Ross T. Tsuyuki, BSc(Pharm), PharmD, MSc, FCSHP, FACC

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