

CANADIAN HEALTH COALITION  
DRUG PLAN HEARINGS  
SASKATOON, SASKATCHEWAN

BRIEF PRESENTED BY  
COMMUNITY HEALTH SERVICES (SASKATOON) ASSOCIATION  
BOARD OF DIRECTORS  
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## **Introduction**

The Community Health Services (Saskatoon) Association (CHSA) is a health care non-profit cooperative funded by the provincial government with a global budget of \$10 million. The Association operates the Saskatoon Community Clinic. CHSA has about 10,000 members who have the right to participate in members' meetings and to elect the board. We take a multi-disciplinary approach to primary health care making effective use of a broad range of salaried professionals including primary care nurses, nurse practitioners, physical therapists, a nutritionist, an occupational therapist, pharmacists, physicians and counsellors.

We opened our doors in 1962 and we now serve about 20,000 patients in three locations. The Main clinic is downtown and serves patients from throughout the city and from nearby municipalities. The Westside Clinic (opened in 1972) serves primarily the people living in the core neighborhoods, which have a large Aboriginal population. We also provide services in Delisle, a rural community outside Saskatoon.

Our vision is healthy individuals in a healthy community. We strive for a world where communities, families and individuals experience optimal conditions for health through all stages of life, actively pursue and manage their own health, and are supported by a publicly administered health care system offering high quality primary health services provided by an integrated and innovative health care team. Our values include the belief that health care services should be universal, accessible, comprehensive, portable and publicly administered (see attached document for further information).

Applying these principles to issues of medically necessary medications means that we view such drugs as integral to the public good and not as commodities. In fact, the Community Clinic has a long history of supporting an equitable public pharmacy plan. For example, in 1966, the Clinic set up a formulary committee, the first in Canada, in response to its members' concerns about the cost of prescription drugs. This was five years before the Saskatchewan government's formulary whereby prescription drugs became available as a provincial public service. We are also motivated by the fact that we serve a relatively high proportion of low-income, high-risk and vulnerable families and individuals.

The information in this paper is updated from a brief and presentation made by our Association to the *House of Commons Standing Committee on Health: Study on Prescription Drugs, 2003*. In our opinion little progress has been made since then on the recommendations in this report. We believe it is time for the federal government to act on this very important issue facing Canadians.

**This brief focuses on issues related to consumer access to prescription drugs, and over the counter vitamin supplements, the role of patent laws**

**and certain practices of drug companies which are distorting the pharmaceutical marketplace.**

**CHSA patients particularly vulnerable to high prescription drug costs**

These patients include low-income seniors, the employed poor and single parents who reside in all neighbourhoods of Saskatoon as well as mainly non-senior residents served by our Westside Clinic, many of whom are of Aboriginal or Métis descent. It should be noted that while Treaty Indians have Federal drug coverage, non-status and Metis people do not. Over 20% of our patients are over 65 years of age; in the Saskatchewan general population, seniors constitute about 11%.

The Westside Clinic is situated in the neighbourhood where the average annual income is \$20,000 and 27% of the residents have less than Grade 9 education. In an adjoining neighbourhood, Pleasant Hill, the residents have an average income of \$21,928, almost 60% have incomes of less than \$20,000 and almost a quarter have less than Grade 9 education. Other nearby neighbourhoods have similar demographic profiles. In contrast, most of the neighbourhoods, outside of these core neighbourhoods, enjoy incomes that are twice or three times these levels and the residents, for the most part, are much better educated. (See City of Saskatoon website).

**Rising costs of prescription drugs and what these costs imply**

The important role of prescription drugs in the lives of Canadians has been well-documented. For example, 300 million prescriptions are filled in Canada each year amounting to about 10 prescriptions to each woman, man or child; Canadian families on average spend close to \$1,210 a year this way. People with chronic illnesses and some elderly people spend considerably more (Commission on the Future of Health Care in Canada). Furthermore, the cost of prescription drugs has risen faster than any other single health expenditure in recent years. The proportion of total health dollars spent on prescription drugs has doubled to 12% since 1980 and the total amount of money has gone from \$1.3 billion to \$12.3 billion. The average cost of prescription drugs is increasing; in the US; the average price of a new specialty drug is two and a half times higher than the price of similar older medications (Commission on the Future of Health Care in Canada). CHSA is deeply concerned about these rising costs which threaten spending in other areas of the health care budget. Provincial governments are faced with unenviable options such as restricting coverage to a narrower range of drugs and increasing deductibles and co-payments. We know that in Canada between 10 and 20% of the population is either uninsured or underinsured against drug costs and a disproportionate number are non-seniors who are unemployed or underemployed.

In Saskatchewan, in 2005, roughly 50% of all prescription drugs were paid for privately, roughly 38% were covered under the provincial Drug Plan, 12% were covered by the federal government (roughly 80% of which are NIHB drug benefits) and a very small amount were covered under WCB medical benefits (Gregory Marchildan and Kevin O'Fee, SIPP 2007). Escalating costs have led to a high deductible as part of our provincial drug plan, a system that penalizes those on lower and fixed incomes. People receiving Social Assistance have full drug coverage but assistance to low-income employed persons is meager. In July 2007 the Province introduced a Seniors Drug Plan. Residents 65 years of age and older now pay no more than \$15 per prescription for drugs covered by the Saskatchewan Formulary or approved under Exception Drug Status.

The experiences of our staff reveal the combined effects of accelerating drug costs and inadequate public coverage on our clients who have low incomes.

### **Evidence from some CHSA staff**

1) Louise Dufour, Aboriginal counselor, who works particularly with Aboriginal grandmothers:

“Many of the grandmothers are coping with conditions or circumstances which undermine their health including inadequate income, poor housing, stressful family situations and social isolation. Among our grandmothers’ group participants, there are individuals with heart disease, diabetes, high blood pressure, rheumatoid arthritis, vision loss and limited mobility. Therefore, with some having multiple diseases, these Aboriginal grandmothers often cannot afford all their medications. At times, they have to make decisions about which medications to get that month and also about what they need most - meds or their special diet food. For that month, they either go without some of their meds or food”.

2) Marilyn Mearns, Head of Pharmacy:

“In the last fiscal year (2006/07) the Pharmacy filled 43,152 prescriptions. We serve clinic patients as well as the general public. We are a high volume pharmacy.

Thank you for the opportunity to comment on the affordability and accessibility of drugs to the senior population and the working poor. I have spoken to my staff pharmacists and have noted some examples experienced by these groups.

On a regular basis, we serve clients who cannot afford their prescriptions. We know this because our practice is to give clients a price quote, when requested, before filling the prescription. We often hear that they have no money. Over the

years, we have developed internal policies and procedures to deal with such situations. Unfortunately, the help we can provide such clients is extremely limited. Each time the situation of someone not being able to afford their drugs happens at our Pharmacy, it reinforces for us the dire need to improve public drug coverage. Here are some examples that our Pharmacy staff have provided:

Some of our poorer clients can get assistance through the province's financial assistance plan but it is not always available in a timely fashion. For example, a gentleman had an appointment with a social worker the next week but was in immediate and desperate need of his Nitroglycerin prescription (a life threatening situation could occur if he did not have this med). The pharmacist sent him to see the on-call doctor, having told him to explain his financial situation to the physician. She [the pharmacist] explained that the clinic had a Benefit Fund for times such as these and that he would not have to pay. He was grateful for the care by all parties at the clinic. We know that without the pharmacist intervening, he would have gone without the medication.

Affordability has definitely become a factor over the last few years since our provincial drug deductibles have increased significantly. The pharmacists intervene in other ways also. We often call (3-4 times weekly) the provincial drug plan exceptional drug status line to make application on behalf of the clients to have their medication put on the drug plan. We also have the ability to call on a client's behalf to the provincial drug plan to have the entire cost of a medication covered in full by the government as an on-time only Emergency Assistance to cover one month's supply. The level of assistance provided is in accordance with the client's ability to pay.

The pharmacists feel that there are not enough low cost alternatives available to the clients. They often intercede for the patient suggesting to the physician generics that may be substituted to be able to save them money spent on their meds.

The Community Clinic dispenses three months' supply of pharmaceuticals with only one dispensing fee for every one month filling. Doing this for the clients is another way to lessen the burden of their drug costs. However, this is not standard practice in the community and raises the prospect of our pharmacy operating at a loss which may affect resources available for other clinic programs.

These accounts illustrate the dilemmas faced by many of our clients and the efforts of our workers to try to at least alleviate their problems with drug costs."

3) Renee Colwell, Registered Dietician:

“I often recommend vitamin /mineral supplements to patients according to current evidence based Practice Guidelines, but the working poor and those on welfare, do not have access to the funds to purchase vitamins or minerals as they are not covered by the provincial formulary. For example, Calcium and vitamin D are recommended for those with Osteoporosis. Vitamin D is recommended for breast-fed infants. It is recommended that pregnant women take a multivitamin containing folic acid and iron and those over 50 years of age to take a multivitamin containing Vitamin D and B12 supplements. A number of these supplements are recommended in Health Canada’s *Eating Well with Canada’s Food Guide*. All supplements are considered over-the-counter products. There is limited coverage for individuals of treaty status. All others must pay for these themselves.”

4). Jone Barry, Nurse Practitioner:

“Diabetes is a chronic disease that affects blood vessels throughout your body. If the cholesterol and blood glucose levels are not well controlled, the risks of irreversible microvascular and macrovascular damage occurs leading to chronic illnesses and possible death. Beta cells within the pancreas are responsible for producing insulin. In diabetes, these cells progressively die and are not able to regenerate. On average, people who have diabetes will need to start insulin therapy 10 years after diagnosis. Furthermore, many people will have metabolic syndrome with an increased waist circumference, high blood pressure, abnormal lipid values as well as their diabetes. This raises their risk of cardiovascular disease.”

The costs of this illness are overwhelming to many people who do not have insurance coverage or financial assistance. There are a variety of medications used to control the blood glucose. As the disease progresses, clients will be given 3 or occasionally 4 medications before starting insulin. Older insulins are available at reasonable costs. The most effective newer insulins are not covered by the provincial drug plan and are cost prohibitive to many people.

There are other drugs that are recommended by best practice standards for people with diabetes. These medications include statin medications, acetylsalicylic acid, angiotension converting enzyme inhibitors or angiotension receptor blockers. Many individuals will have other chronic illnesses and need three or four other medications.

Insulin syringes, reusable “pen” style reusable syringes, needles and glucometer test strips add to the rising costs to an individual. If you are on intensive insulin therapy, you will need to test your blood glucose four or more times daily. At 60 – 80 cents per test strip, the cost of test strips rises quickly.

Below are costs of medication commonly used when treating people who have diabetes.

Medications to treat diabetes and their average monthly costs:

Metformin	\$25 – 50/month
Glyberide	\$15 – 25/month
Diamicron	\$72 – 90/month
Gluconorm	\$115-230/month

Regular Insulin	\$25/month
Intermediate acting insulin	\$25/month
Rapid acting insulin	\$25 – 45/month
Long acting insulin	\$150/month

Medications to prevent complications from diabetes:

Statin	\$41 – 85/month
ACE-I	\$25/month
ARB	\$50/month
ASA	\$5/month

Supplies to monitor blood glucose cost up to \$2.50 – 3.50/day or \$75 – 90/month if on intensive therapy.

Individuals with diabetes can spend well over \$400 every month in an effort to prevent complications and control this progressive disease. This cost is beyond the means of many Canadians so medications are not filled regularly. As more and more people are diagnosed with diabetes and the cost of treatment continues to rise we will find more irreversible and avoidable complications taxing our system. It is imperative to develop a strategy to assist people with this financial burden.”

### **Patent Monopoly**

In recent years, several organizations including the Government of Saskatchewan have concluded that the changes created by Federal Bills 22 and C-91 and the concomitant Patented Medicines (Notice of compliance) Regulations of Canada’s Patent Act have delayed the entry of generic drugs and thus have contributed to the escalating cost of prescription drugs. Prior to this legislation, a system of compulsory licensing meant that generic copies of brand name drugs could come on the market within 5 to 7 years after the original drug appeared. CHSA notes and regrets that responsibility for this patent legislation was transferred from the Department of Health to the Department of Industry thus establishing drugs as commodities on a par with “shoes, ships and sealing

wax". In a 1997 brief to the Standing Committee on Industry which was reviewing Bill C-91, Mr. Eric Cline, then Minister of Health for Saskatchewan, said:

In Saskatchewan, we determined that the additional cost for pharmaceuticals to consumers and our drug plan in 1996 - for drugs that were caught in the retroactive nature of C-91- was \$3 million. In 1997, our cost will be \$7 million and by the end of the century - for this limited number of drugs alone our conservative estimate is a cumulative cost of \$31 million. It is important to note that these are actual utilization numbers and are very conservative because they do not include hospital drugs or other new products.

For years, CHSA has opposed the patent protection given for 20 years to transnational corporations and the ever greening process whereby this patent monopoly can be extended beyond the 20 year term. At the 2003 Annual General Meeting, CHSA members passed a resolution calling upon the Government of Canada to repeal the Patent Medicine Regulations that allow for this ever greening process. CHSA is deeply disturbed by the ways in which the development and sale of generic drugs are delayed by brand-name companies. They do this by introducing slight variations to existing drugs and also by filing lawsuits against generic companies by simply alleging patent infringement. It is important to note that innovator/brand companies do not have to prove patent infringement to get the automatic stay. They simply have to allege it and this is the only Canadian industry that works in this manner. Canada and the US are the only countries where there is a stay in the marketing of generics until patent issues are settled. These so-called "automatic injunctions" give a 2 year extension to the patent. We understand that 75% of the cases of alleged patent infringement since 1998 have been won by the generic companies but only after considerable delays in their being able to offer cheaper, safe alternatives to Canadians (The Hill Times, July 28, 2003)

We regret the fact that, in Canada, there has been little pressure from the large corporations with drug benefit schemes to change these rules, despite the very large costs they entail. It fell upon a coalition of unions and health care advocacy groups to file a complaint, in 2002-2003, with Canada's Competition Bureau against patent drug companies alleging anti-competitive practices. In the US, several large corporations, including Wal-Mart and General Motors have banded together to lobby for changes to the automatic injunctions granted by American law. Green Shield Canada, the company that runs Ontario's drug benefits programme, is also calling for these changes. Green Shield cites the case of Apotex, a generic version of Losec (an ulcer and heartburn medication) which cannot be sold in Canada because of litigation that has lasted 3 years after the original patent expired. For General Motors in the US, the lack of a generic version of this drug costs the company drug plan \$1.3 million every month (Canadian Health Coalition).

Furthermore, we understand that the drug companies are pushing for even more intellectual property protection. They argue that they need more time to recoup their investments in order to pay for the research and development of new drugs. We note that the pharmaceutical industry regularly ranks no 1 in Canada in profits as a percentage of their revenues and has the same ranking in their assets and their equity. According to the experts, most new drugs do not offer any significant improvements over existing therapies ( Patented Medicines Price and Review Board, 2000). We also understand that in Canada, basic research on pharmaceuticals makes up 16% of all Research and Development compared to 24.5% in the UK and 36% in the US. Even smaller countries do better than Canada in R & D. Most of the R & D money in Canada is spent on products that will build market share and not on those that will necessarily result in significantly better health outcomes (Canadian Health Coalition).

### **Distortions of the Pharmaceutical Marketplace**

This brief will discuss only some of the problems resulting from the present behaviour of drug companies.

#### **1) Marketing to and lobbying of prescribers and dispensers**

In Canada, drug companies spent about \$1.7 billion in 2000 on drug promotion and in the US the amount was more than ten times larger. CHSA finds many of these tactics of deep concern. Physicians and dispensers are frequent targets with all kinds of “goodies” being offered. In the US, about \$8,000 to \$13,000 are spent per year on each physician in promotion and inducements. The British Journal of Medicine reports that an American company called Time-Concepts LLC is offering doctors \$50 each time they listen to a short sales pitch from a drug company representative in their office and some doctors are taking the money despite strong disapproval from the American Medical Association (Kennedy, Mark, Ottawa Citizen, Sept 23, 2002). The Canadian Medical Association comments “... the companies involved [in inducements] are only too eager to tempt physicians to compromise their responsibilities to their patients and society for personal and corporate gain”. The CHSA policy is to give our physicians freedom to refuse to see drug representatives and many of them do so refuse. In addition, unlike many private pharmacies, the Community Clinic pharmacy does not participate in the practice of forwarding copies of doctors’ prescriptions (minus patient-identifying information) to a US corporation which then creates “prescribing profiles” of each physician (for a fee), for the use of the drug representatives. It is up to the provincial governments to regulate such practices, but we draw the attention of this committee to them.

## 2) Direct-to-consumer advertising

American firms spent about \$2.5 billion in 2000 on such ads. Reports indicate that many patients are demanding that their physicians prescribe the drug they saw on TV. Clearly, such blatant manipulation of the public is very undesirable and should not be allowed on Canadian programming. We have attached a recent article from our newsletter on this issue.

**CHSA recommends that the Government of Canada take all necessary steps to prohibit direct-to-consumer advertising of prescription drugs.**

Another ploy is to pay Hollywood and sports celebrities to discreetly promote a given product on TV talk shows. Once on air, these celebrities discuss their ailments and praise the drug without revealing their ties to the drug industry. Possibly, the CRTC might be able to prohibit such practices in Canada;

## 3) Skewing Health Research

The drug industry has now become a predominant source of funding for biomedical research in Canada. The National Forum on Health and other analysts have stressed the danger that much health research will be skewed to serve the interests of pharmaceutical corporations and that researchers and their sponsoring institutions have become hostages to these same interests. Medical journals have had problems with many articles written by researchers who did not disclose their funding by drug companies when submitting their work. The National Forum On Health (1997) concluded that these problems can only be mitigated by moving research funds away from the industry itself and into the hands of the public granting agencies. The more recent Commission on the Future of Health Care in Canada has recommended that the monitoring of health research should be placed in the hands of a new National Drug Agency. CHSA agrees with this recommendation.

## 4) Trade Agreements

As a result of two separate complaints against Canada at the World Trade Organization, Canada has had to give 30 drugs extra patent protection resulting in an extra \$40 million in drug costs and accompanying delay in the entry of generic products. Experts are voicing concern about the Free Trade Area of the Americas (FTAA) Agreement and the possibility that it could result in longer patent terms and more difficulties for the generic firms to use data generated by brand-name companies.

**CHSA recommends that that the federal government should listen to the critics who are sounding these warnings about Canada's trade agreements.**

### **A National Pharmacare Program**

CHSA's support for a national pharmacare program remains unchanged. Given this, we support the recommendations of the Romanow Commission on the Future of Health Care, including:

- a new National Drug agency with a comprehensive mandate to review, monitor and share information about prescription drugs, to contain their costs and to develop standards for the collection and dissemination of prescription drugs, on drug utilization and outcomes;
- a national prescription drug formulary created by the National Drug Agency;
- a new program on medication management to assist Canadians with chronic and life-threatening illnesses, to be integrated with primary health care approaches across the country.

The Commission also recommended a catastrophic drug transfer to the provinces. We believe an effective national drug plan would include an element that covers drugs that are prohibitively expensive, but required, for effective treatment.

On the subject of patent law, CHSA takes a more critical stance than the Commission which suggests that the Federal Government only "review" this issue. We believe that there is sufficient evidence that the present patent regime does delay the entry of generic drugs to an unconscionable degree and therefore, as a beginning step towards reform, **we recommend that the notice of compliance regulations that lead to "pre-emptory" law suits should be repealed.**

## ***Executive Summary***

**This brief focuses on issues related to consumer access to prescription drugs, and over-the-counter vitamin supplements, the role of patent laws, and certain practices of drug companies which are distorting the pharmaceutical marketplace.**

1. The Community Health Services (Saskatoon) Association is a health care non-profit cooperative funded by the provincial government with a global budget of \$10 million. CHSA has about 10,000 members who have the right to participate in members' meetings and to elect the Board. We take a multi-disciplinary approach to primary health care making effective use of a broad range of professionals who work together to provide a holistic programme of care for our patients.
2. We have two locations. The Main Clinic is in the downtown area of the city and the Westside Clinic serves the core neighbourhoods, which have a large low-income population with many Aboriginal residents. Our vision is healthy individuals in a healthy community. We strive for a world where communities, families and individuals experience optimal conditions for health through all stages of life, actively pursue and manage their own health, and are supported by a publicly administered health care system offering high quality primary health services provided by an integrated and innovative health care team.
3. Our values include the belief that health care services should be universal, accessible, comprehensive, portable and publicly administered. Applying these principles to issues of medically necessary medications means that we view such drugs as integral to the public good and not as commodities.
4. CHSA is deeply concerned about the escalating costs of prescription drugs and the threat they pose to provincial health care budgets such that provincial governments are faced with difficult options such as increasing deductibles and co-payments in their public drug coverage. These actions obviously create even worse problems for low-income people who have little or no private insurance.
5. Our brief provides stories from some of our "front-line" workers that demonstrate the dilemmas of many of our patients who cannot afford their prescribed medications and the efforts of our staff to try to solve these problems. These actions include: drawing upon the clinic's Benefit Fund, using generic drugs as much as possible, advocating on behalf of the client to the provincial drug plan and other interventions.

6. CHSA comments on Canada's patent regime: we note that several organizations, including the Government of Saskatchewan, take the view that Bills 22 and C-91 and the accompanying Patented Medicines (Notice of Compliance) Regulations have delayed the entry of cheaper generic equivalents thus blocking one means of lowering the high cost of prescription drugs.
7. CHSA is also disturbed by various other practices of companies that result in distortions of the pharmaceutical market. These include the practices of marketing to and lobby of physicians and dispensers and placing such professionals at risk of conflict of interest, direct-to-consumer advertising and the danger that biomedical research will be skewed to serve the interests of pharmaceutical corporations.
8. We believe that Canada's trade agreements warrant investigation since two decisions by the World Trade Organization have already created extra drug costs for Canada and there are concerns about the FTAA (Free Trade Area of the Americas) Agreement having similar results.
9. CHSA supports a national pharmacare program. As initial steps, we support the following recommendations of the Romanow Commission:
  - a) a new National Drug Agency with a comprehensive mandate to review, monitor and share information about prescription drugs, to review Canada's patent law in order to improve access to generic drugs and to contain costs and to develop standards for the collection and dissemination of prescription drug data on drug utilization and outcomes;
  - b) a national prescription drug formulary created by the National Drug Agency;
  - c) a new programme of medication management to assist Canadians with chronic and life-threatening illnesses, to be integrated with primary health care approaches across the country.
10. However, on the subject of patent law, CHSA takes a more critical stance than the Romanow Commission. We believe that there is sufficient evidence that the present patent regime does delay the entry of generic drugs to an unconscionable degree and therefore, as a beginning step, we recommend that the notice of compliance regulations that lead to "pre-emptory" law suits should be repealed.
11. CHSA recommends that consideration be given to public coverage of vitamins and minerals that are recommended as part of Health Canada's *Eating Well with Canada's Food Guide*.

## **RECOMMENDATIONS:**

- 1. CHSA recommends that the Government of Canada take all necessary steps to prohibit direct-to-consumer advertising of prescription drugs;**
- 2. CHSA recommends that the Government of Canada should listen to the critics who are concerned about the effects of Canada's trade agreements on the entry of generic drugs;**
- 3. CHSA recommends that the Government of Canada take a leadership role in ensuring equitable access to medically necessary medications through a National Pharmacare Programme. As initial steps, we support the following recommendations of the Romanow Commission including:**
  - a) a new National Drug Agency with a comprehensive mandate to review, monitor and share information about prescription drugs, to review Canada's patent law in order to improve access to generic drugs and to contain costs and to develop standards for the collection and dissemination of prescription drug data on drug utilization and outcomes;**
  - b) a national prescription drug formulary created by the National Drug Agency;**
  - c) a new programme of medication management to assist Canadians with chronic and life-threatening illnesses, to be integrated with primary health care approaches across the country.**
- 4. CHSA recommends that consideration be given to public coverage of vitamins and minerals that are recommended as part of Health Canada's *Eating Well with Canada's Food Guide*.**