ALBERTA DISABILITIES FORUM
HEALTH WORKING GROUP

PHARMACEUTICAL BACKGROUNDER ON MEDICATION PURCHASING

Summary of Relevant Points

1. Alberta Health and Wellness entered into Phase 2 of the Pharmaceutical Strategy in 2009. The purpose of Phase 2 is to explore ways to get better value and achieve the best outcomes for the money spent, considering factors such as people living longer, early diagnosis, and treatment.

2. Adjusting government purchasing processes is one of the ways that Alberta Health and Wellness can reduce costs through examining medication purchasing patterns.

3. Two methods of purchasing are being considered:

a) **Bulk Purchasing -** off-patent medications (generic) or mediations where there are multiple licensed suppliers and manufacturers. Typically tendering for multi-source mediations is a method of trying to get the best price for that particular medication.

b) **Reference Based Pricing or Therapeutic Substitution -** taking the tendering concept and applying it to a class of medications to see which manufacturer will give the best price, and then offering only those medications to patients

Comparison List for Medication Purchasing Streams

Bulk Buying/multisource tendering or generic tendering	Therapeutic Substitution/ Reference Based Pricing
- off-patent medications (generic) or medications where there are multiple suppliers for a particular medication	**Reference Based Pricing** –"Pharmacy plan substitutes the full cost of the least expensive medication known as the "reference" medication. Consumers can fill prescriptions for more expensive medications in the class and pay the difference out of pocket; the physician may also apply for full coverage of the more expensive medication if the patient meets precise criteria" (Skinner, Gray & Attara, 2009, p. 883). **Therapeutic Substitution**-Taking a class of medications and seeing which manufacturer within a class will give the best price. Only one medication in the class is covered. The patient is then required to change his or her medication to the selected medication to be eligible for coverage. The patient must pay the full price if he or she wants another medication and is not allowed to pay the difference, even if the doctor wants him or her to have that medication (Skinner, Gray & Attara, 2009, p. 883).

- Alberta is paying some of the highest generic prices in Canada. The Government of Alberta sees an opportunity to evaluate how multi-source medications are being purchased by evaluating whether the best price is being received and exploring ways to restructure its purchasing patterns to get better value for generic medications. - Government is being fiscally responsible by exploring methods to get better prices on multi-source medications. - Government is looking at the same molecule of a medication. - It is best to have as many medications available to patients as possible within a class recognizing that every patient is unique. This will provide as many options as possible for the patient when he/she is trying to find the best medication given the clinical picture, side effects, and contraindications.	- Tendering classes of medications is a serious concern. The implications to patients and caregivers are pronounced. - Evidence from BC about the effects of therapeutic substitution on Proton Pump Inhibitors (PPIs). From a medication budget point of view, it was a predicted cost savings would result. However, the opposite was true. The resulting additional costs of the extra visits to physicians, diagnostics, and hospitalizations that resulted from the "return of symptoms, such as severe heartburn and some reported side effects including diarrhea, vomiting, nausea, chest pain, fatigue and, less commonly, vomiting blood" (Skinner, Gray & Attara, 2009, p. 883). Skinner, Gray & Attara state "implementation of Therapeutic Substitution policy for PPIs in BC probably generated significant direct, avoidable, net healthcare costs over the period 2003–2005, potentially totaling up to $43.51 million" (2009, p. 888). - Policy makers may narrowly look at the medication budget in isolation of other parameters. It's important to not focus only on cost to the detriment of patient outcomes. - Potential slippery slope should tender of single source medications be a policy that government is seriously considering.

4. **Single-source means the medication is still on patent (brand medications).** Canada has a national pricing board that sets prices for every new medication that enters the market; consequently prices for medications in a particular category will be set closely. For example, if a new anti-depressant enters the market, it will likely be priced in the same range as the other anti-depressants on the market. Typically those medications in a class are not tendered because the prices are set by a Canadian board that prices them similarly. It is best to have access to as many medications as possible on a formulary so that choice is available to both physicians and patients.

5. **A Cautionary Tale**

- British Columbia and New Zealand use a tendering concept for multi-source or generic medications that is applied to a single class of medications. One scenario looks at the same molecules and the second looks at a class of medications.

- For example:

  - If an antidepressant is off-patent and there are five manufacturers of this medication in a multi-source tender, all manufacturers of the selected molecule would be asked to give a best price.

  - If the antidepressant is not off-patent and all manufacturers of medications in a class of antidepressants are asked to give their best price, a class of medications is being used. The medication offered for the best price in that class is then offered to patients. This is called therapeutic substitution or referenced-based pricing. The concern with this approach is that it does not put the patient first but puts finances first.

  - To use depression as an example, in a tender for the class of anti-depressants, the government might select only two medications, based on best price. These medications now become the standard medications available to patients who are suffering from depression. This limits choice. For some patients these medications may work well, for some they may not.

  - Tendering for multi-source medications for generic medications does have the opportunity to save the government money. However, if the concept is taken further, tendering could be done for entire classes of medications; this measure would drastically reduce the number of available medications.

6. Health Working Group Comments

Generic medications may have different effects from patent medications due to use of a different buffer or coating being used, even though the active ingredients may be the same. Issues arise with the 10% allowable Canadian window of acceptance, individual variance of patient responses, multi diagnoses/medications causing complexity, and/or variance of single or multi dosage causing low or high probability of side effects.

Billing and insurance plans become more complex if a person chooses to pay the difference between the price of an approved medication and the patent one they would rather take.

Some provinces and insurance plans have examined the process. They say, “This is how much we will pay and if you want something other than

that you have to pay the difference". Max pricing or maximum allowable cost is the name of this practice.

In some cases, the patient may have to try an approved medication first and go through a process of documenting that the approved medication had been tried and failed. The physician may feel obligated to prescribe the approved medication rather than the right medication based on the condition of the patient. The decision is then based on the price rather than the patient need. The patient may have to pay the difference in costs and be too tired and unwell to fight to receive the medication needed.

Every effort should be made to increase access. Little differences can make a significant impact on the ability to work and lead an active life.

7. Policy Implications

Examining the purchasing patterns for generic medications is important. Alberta is paying significantly higher amounts for medications than other jurisdictions; it is important for Alberta to find value for the generics that are being purchased.

There are several costly brand name medications coming off patent that Alberta Health and Wellness is purchasing. If the Alberta Government is able to negotiate better prices on new off-patent medications, there is potential to save money. The money saved could be directed towards listing more medications for a broader range of diseases and chronic illnesses to give more options for patient choice.

It is difficult to predict what the demand will be for a particular new medication. The Alberta Government is looking to collaborate with industry to predict responses to new medications.

Clinical practice guidelines developed by the medical community are in place for almost every condition. These guidelines for physicians to follow are based on clinical pathways that were developed from medical evidence from around the world. Clinical practice guidelines typically include more than one option so that patients and physicians can decide together on the best choice. Very rarely is a single medication recommended. Clinical Practice Guidelines allow for a range of choices to account for individual differences.

There is a pilot being undertaken through Rx&D, the umbrella organization for the pharmaceutical industry, about chronically ill people who are on many medications to examine how the medications interact and how the generic molecules can affect the patient's condition.

> The Alberta Government and the people of Alberta should strive for improvement in patient outcomes and best management of patient conditions which would keep people engaged in the community.

Review of the Research Literature

Forty-one studies on the efficacy of generic medications compared to their patent brand and other generics were found during a literature search at the library of a pharmaceutical company.

Five of the studies discussed comparisons of brand name and generic medications amongst all classes while the remainder discussed a single medication or class (Al J, Bhareth, et al, 2008; Genazzani A, & Pattarino, F, 2008; Yim D, 2009; Hellström J & Rudholm, N, 2004; Meredith P. 2003). Because the emphasis is on policies and procedures as opposed to specific medications, the medications by class and the medication studies were grouped under the classes listed to avoid mentioning medications by name.

One study in the anti-inflammatory class recommended caution in substituting medication (Ilic, Sefik, Jankovic & Vujansinvic, 2009). An acne medication reviewed was contraindicated for generic substitution (Taylor and Keenan, 2006). The antibiotic class had one study about a specific medication indicating there was no difference in patient response or clinical cure rate to the brand or generic medication (Snyman et al 2009). Two anticoagulant medication studies recommended caution (Witt et al 2003; Halkin, et al), while one recommended generic substitution (Lee, Chung, & Yang, 2005).

One antidepressant study revealed the generic substitution required strong caution as patients experienced relapse of symptoms that were reversed when they were returned to the brand name (Van et al, 2007). The antiepileptic medication had 8 studies exploring various types of medication, and 7 indicated strong caution (Van et al 2009; Berg et al, 2008; Heaney & Sander, 2007; Krämer, Biraben, Carreno, Guekht et al 2007; Makus & McCormick, 2007; Haskins, Tomaszewski, Kenneth,& Crawford, 2005; Wilner, 2004) in generic substitution, while one indicated that substitution was contraindicated unless all parties were informed of the risk (Papsdorf, et al, 2009). Antiepileptic agents were high risk for changes in both side effects and the reduced risk of seizure control. The anti-inflammatory class of medication had one study discussing a single medication that indicated that the substitution from brand to generic or vice versa required caution as some patients responded differently (Papsdorf, et al, 2009).

There was one study of beta – blockers that recommended caution in generic substitution (Smith et al, 2006). Two other studies of cardiac medication recommended caution in generic substitution (Kesselheim et al, 2008; Mignini et al, 2008). Two cholesterol lowering medications were found to be safe and recommended for generic substitution (Wiwanitkit et al, 2002; Cheetham et al,

2005). A study of a single medication for the treatment of Benign Prostatic Hypertrophy found that generic substitution was safe (Tsai et al, 2007).

One cancer medication was not recommended for generic substitution as 90% of the bioequivalent agents reviewed had decreased levels of the molecule or serious impurities or both. This was a multi-country study (Vial et al. 2008). One medication for glaucoma recommended caution with any generic substitution (Narayanaswamy, et al, 2007).

Two studies of a neuroleptic medication indicated that generic substitution was safe and recommended (Alessi, et al, 2006; Stoner, et al, 2003). One study reviewing the entire class of psychoactive medications strongly recommended cautions with any generic substitution (Borgheini G, 2003). Further studies that include ill people as well as healthy people were recommended in order to better predict clinical outcomes (with people who are already ill or have other comorbidities) demonstrated that generic substitution might affect patient outcomes and responses (Borgheini G, 2003). This study makes also makes two other important points:

"…bioequivalence and therapeutic effectiveness are not necessarily the same…." (Borgheini G, 2003) and "Few publications compared the bioequivalence of brand name and generic psychoactive drugs that have not been noted in the original bioequivalence studies." (Borgheini G, 2003)

Five studies explored all classes of medications with respect to generic substitution. All five dealing with the global issue of generic substitution recommended caution across all categories with respect to generic substitution (Al J, Bhareth, et al, 2008; Genazzani A, & Pattarino, F,2008; Yim D, 2009; Hellström J & Rudholm, N, 2004; Meredith P. 2003)

One study emphasized a strong need for heightened caution in generic substitution as the testing is done on healthy individuals, which is not necessarily an accurate way to predict how the generic agent will perform when used on a person with an illness:

"The exclusive use of normal and healthy volunteers in bioequivalence studies has been criticized. It is assumed that bioequivalence in this patient population will equate to both bioequivalence and comparable efficacy and tolerability in patient populations, but the validity of this assumption is questionable." (Meredith, 2003)

Another study noted an increase in the generic market share was accompanied by an increase in reported side effects for all the areas examined:

"….increasing generic market shares increases the number of side effects for 7 of the 15 substances. Generic substitution laws and measures to increase generic substitution may thus have unintended consequences since these results

show a positive relationship between generic market shares and reported side effects." (Hellström & Rudholm, 2004)

It is important in terms of informing any policy to consider the points made in this study:

"For economic reasons, the use of generics substitution is increasingly being supported by health authorities. Potentially, this may be problematic for drugs with a narrow therapeutic window if quality control and/or bioequivalence are not optimal. Many developing countries do not have the resources or expertise to carry out appropriate quality control resulting widespread distribution of substandard or even counterfeit medications. Even in countries where standards are well-regulated, substandard medications reach the market from time to time". (Meredith, P 1996)

The WHO has initiated programs to prevent the distribution of substandard preparations and has drafted guidelines for testing bioequivalent based on internationally accepted reference medications. Until means can be provided- first to enforce internationally accepted production standards, and second, to permit uniform testing of therapeutic agents – the safest clinical choice, particularly in countries where registration requirements and quality control are minimal, must remain the branded product. (Meredith, PA 1996)

Independently Reviewed Research and Position Papers

Two independent articles by Canadian psychiatrist Dr. Kenny Handleman, explain the potential consequences of bioequivalence with respect to Concerta, an ADHD medication. He stated the amount of active molecule can vary up to 20% on either side of the generic medication. Therefore, if a patient is switched from Concerta, to the generic equivalent, Novo-Methylphenidate ER-C, he/she can receive either 20% less or 20% more of the methylphenidate molecule which is a variance in actual dose of up to 40% (Handleman, 2006). The actual amount of bioequivalence standard for a generic medication is 10% on either side of the amount of available medication as compared to the brand name.

In addition, Dr Handleman notes the way the medication is prepared for market is also different with respect to the technology of the coating. The brand Concerta is fitted with a laser-drilled capsule and an external coating of rapid release methylphenidate. The capsule is an osmotic capsule. This allows the water from the gut to come into the capsule to expand a polymer that pushes the medication out of the pre-drilled laser hole to deliver the medication in a controlled and sustained fashion over 24 hours (Handleman, 2010).

To date, there is no available scientific data for the composition of the Novo-Methylphenidate ER-C capsule. The Novopharm company was successful in a lawsuit to force the brand manufacturer, Janssen-Ortho, to forfeit its patent rights long before their expiration (Concerta was patented in 2000 in the US and in 2004 in Canada, but the patent was broken by the lawsuit in 2010), and the

generic formula has not been released for either the molecule or the coating to indicate the potential impacts for how the generic medication might work in the patients. In addition, the pharmacies do not have to tell the patients the medications are being changed (Handleman, 2010).

Rx&D Policy Paper on Therapeutic Substitution

Rx&D provides ethical guidelines to the pharmaceutical industry in Canada. The 2006 Rx&D Policy Directions Position Paper on therapeutic substitution is congruent with the literature reviewed. The following points from the position paper are summarized below:

a) Therapeutic substitution is defined as a pharmacist dispensing a different (usually cheaper) medication than one prescribed by the doctor.
b) Rx&D believes this practice "replaces a physician's choice of treatment for an individual patient with the judgment of government officials who seek to cut costs."
c) It fails to account for individual responses to the same medications due to the effectiveness of the product or side effects. The individualized treatment of each patient is a basic principle of medical practice.
d) In therapeutic substitution, all medicine within a therapeutic class is viewed as being the same. However, each medicine within a class has different molecules that are metabolized differently, different outcomes as part of therapeutic goals, and different side effects.
e) "When patients and doctors decide on treatments based on individual circumstances and knowledge, they have a right to expect that their decisions will be honoured."
f) Therapeutic substitution discounts a medical decision already made by the prescribing doctor and can interfere with the expectations and health of patients.
g) "Government-forced therapeutic substitution puts health care professionals in a difficult situation of choosing cost over best quality of care."
h) "Restricting choice of therapies can increase overall health care costs."
i) "Health care providers and patients are in the best position to make choices about a patient's health."
j) Individualized treatment helps minimize side effects, increases the chance of patients following treatment, and ultimately improves health and quality of life.
k) "Doctors base their decisions on clinical practice guidelines that incorporate all treatment options accepted in the medical community". Therapeutic substitution narrows the accepted treatment options.
l) The doctor patient relationship represents the first interaction with the health care system, and is therefore an important means of moderating behaviors and illness, as well as diminishing further demands on the wider system.
m) "F/P/T governments should give doctors and patients more choice in terms of appropriate and optimal treatments."

n) Rx&D is concerned that therapeutic substitution will lead to reduction in research and development of new medications.

Canadian Generic Pharmaceutical Association

Patient holders may market a particular medication under its brand name and give a license to other companies or generic firms to market the same medication under another name.

Depending on the scope of practice in a particular province, a pharmacist may substitute a medication. Generally, the decision to do this is governed less by the pharmacist and more by the medication plan of the patient. If a doctor specifies “no substitution” he or she will have to justify a reason for the request such as bad side effects or allergy to a particular filler.

With respect to fillers, patients have just as much chance of being allergic to brand name as generic fillers. There were problems with brand name medications that were brought on the market, marketed heavily, and later discontinued because of severe liver, cardiac, teratogenic effects or even death. Just because a medication is new, does not guarantee that it is effective or any safer than a generic.

Sometimes a medication that has been on the market for the entire patent period has a well-established side effect profile and can actually be safer because it has been in use longer and has been used by a greater number of people.

When choosing between a brand and a generic medication, there is more to think about than fillers. For example, new medications are tested against placebos rather than other medications in their class that are already on the market. The Common Drug Review does take into account whether or not a new medication in a particular class works better than the other medications in the class. In addition, there should be an evaluation of benefits of other medications against health improvements that do not require medications.

Generally, most new medication is tested using only one medication and on healthy males. There are also other contraindications and interactions that are usually not found in pre-market testing; for example, interaction of a medication with grapefruit.

In terms of bio-equivalence, there are variances from brand name to the generic in terms of the amount of available medication to the patient, which is legislated at 10% on either side of the original medication. However, similar variances can also occur within brand name medications manufactured on different days by the same company. If the medication has this variance from one prescription period to another, the effect on the patient may be that a medication was changed due to a change in patient response when it might not have been necessary to do so.

Andre Picaud of the Globe and Mail stated that “reference based pricing means paying for what works.” The Patented Medicine Prices Review Board looks at the relative innovation of medication as well as research and development spending in Canada. Their annual report states that there were 170 new active substances introduced in Canada between 2001 and 2008. Only 19 of these were categorized as break-throughs or substantial improvements over existing medicines.

To compensate for moving to referenced based pricing system governments are paying “professional fees” to support services the pharmacy might provide in place of manufacturer allowances. Ontario and Quebec cap the professional allowance at 20% of the price while the Alberta government does not have interest in regulating professional allowances.

Over half of all prescription medications sold in Canada is generic. Canada is a leading manufacturer of generic medication.

In responding to questions about the merit of bulk buying, multi-source or generic tendering vs reference based pricing and therapeutic substitution, the Canadian Generic Pharmaceutical Association is against tendering for generic medication. The generic industry introduces competition to the market. Development of a generic medication takes years and often a company must litigate to invalidate a patent rule or prove they are not infringing patent. If a company takes that risk only to lose the market to a cheaper generic medication it means they lose the cost of the litigation; therefore, tendering for generic medication would cripple competition. It also has the risk of favouring manufactures from lower cost jurisdictions that may have lower quality.

We must be mindful of the risk of over prescription in general and that medications are sometimes marketed in “waves” such as ulcer medication and the new statins. All medications have side effects.

One of the reviewers noted that “consensus” dictates all diabetics should be on a statin to prevent heart disease, and because their long-term disability dictates “compliance with treatment plan” is a requirement, a person can be locked in to the use of the statin.

Alberta College of Pharmacists

The Alberta College of Pharmacists is responsible for regulating pharmacists and pharmacy technicians under the Health Professions Act in Alberta.

Health is looked at from a holistic perspective though the expertise is related to the appropriate use of medication.

The College supports the health quality matrix developed and endorsed by the Health Quality Council of Alberta.

Patients need to be central to their overall plan of wellness.

The president of the College was a member of the Minister's Advisory Committee on Health. Many of the changes to the pharmacy profession that are coming up are directed at making pharmacists more active in the overall care of patients using medication.

Twenty-five percent of hospitalizations have a medication incident related to them. There is a subset of those that are preventable. Pharmacists have a responsibility to work with patients and other health professionals to help safeguard against this.

Pharmacy technicians are graduates of one of four accredited schools in Alberta (three of publicly funded). The programs range in length from ten months to two years. They are able to take instruction from the pharmacist, enter the right data in the computer, put the right pill in the right bottle with the right label, and make sure the patient receives it.

This frees the pharmacist to receive the patient, do a comprehensive assessment of history, lab tests, interview, and review of existing medication use. They can also coordinate with the health care team to suggest revisions to the medication plan. Through Alberta Netcare, pharmacists will have comprehensive information about medications people take, access to lab results, and so forth. The College is in discussion with the province to establish changed reimbursement mechanisms for this enhanced service. The hope is to improve communication with the health care team to establish clear goals and improve patient outcomes.

Health Canada monitors and licenses all new medication in Canada. New medications come onto the market faster than they have in the past; therefore, post market surveillance and monitoring is going to become very important in Canada. This makes it difficult for deciding what medications are most beneficial because over time as the medications are used post market, this may change. All these factors contribute to the costs of bringing a new medication to market.

Generic medication costs less to bring it to market. Generic medication is an important part of our system. Canadians should have confidence in generic medication. However, patients with chronic conditions being changed from one medication to another must be monitored closely due to slight changes in absorption rates, excretion rates, and level of therapeutic response or side effects. The levels must be adjusted according to patient response. PPS2 (Provincial Pharmaceutical Strategy Part 2) must consider this as part of their process. We do know that Alberta Government established prices that will be reduced from 75% of a brand name to 45% of the brand name.

Industry-wide, the college has noted pharmacists are reporting certain medications are in short supply causing temporary lack of availability.

The College of Pharmacists feels that pharmacists should be able to initiate special authorization requests because pharmacists are in a unique position to be able to recommend appropriate recommendations regarding medication usage.

In response to questions from the ADF Health Working Group members with respect to changing a medication from one brand to another or from brand to generic, patients should be informed of such changes. Changes usually occur because of the availability of one medication over another and whether or not it is covered on the medication benefit list. However, patients should be informed and educated about what they should report to a health care provider by way of changed response, and patients should be monitored to ensure such transitions are made appropriately.

There are differences in the ways that urban pharmacies need to function as opposed to rural pharmacies. Sometimes rural pharmacies contract additional pharmacists to come in and help with more direct patient service to review medications and make recommendations.

Some pharmacists in the Capital Health Region are becoming involved in homecare and some are becoming involved in long-term care.

Variances that occur between brand and generic formulations can also occur between different lots of a brand medication and with different dosage forms (for example tablet vs liquid or oral vs injectable).

The Alberta College of Pharmacists also made the following 22 recommendations in their submission to Alberta Heath and Wellness position paper:

1. Manufacturers should share risk as a precursor to new medications being added to the provincial drug benefit list.

2. Marketing and promotional practices by manufacturers that negatively impact objective decision-making by health professionals should be restricted as a condition of their medications being listed as provincial drug benefits.

3. Marketing and promotional practices by manufacturers directed at patients that have the potential to inappropriately increase the demand for specific drug medications, or to negatively impact patient behavior, should be prohibited as a condition of their medications being listed as provincial drug benefits.

4. Drug sampling through health professionals should be prohibited, and replaced with alternative approaches that are environmentally friendly, more cost effective, and that ensure the capture of “starter/trial doses” on each patient’s health record.

5. Provincial tax structures should be reviewed to ensure that Alberta is attractive globally to the pharmaceutical industry as the place to research and develop new medications.

6. The purchasing and pricing policies and processes for medications included in provincial drug benefit programs should incorporate accountabilities at both the pharmacy and wholesale levels.

7. Legislation should be enacted, placing the following conditions on the use of inducements exchanged in return for professional goods and services provided by pharmacists ,pharmacy owners, or any other regulated health professional:
    a. Inducements shall not be provided in return for prescribing any treatment;
    b. “Bonus” inducements shall not be provided in return for any drug prescribed or dispensed in a pharmacy; and,
    c. Inducements shall only be awarded based on the amount personally paid by the client.

8. Alberta Health and Wellness should legislate that all prescribers include an indication for use, diagnosis, or patient specific therapeutic goal on each prescription to facilitate effective communication between health professionals and to enhance informed decision-making.

9. Deployment of a system-to-system interface between the Electronic Health Record (EHR), pharmacists and pharmacies, and physicians and physician offices should remain a priority, with implementation occurring at the earliest date possible.

10. Strategies to transmit electronic prescriptions should be deployable within 1 year of system-to-system interfaces being available between the EHR and pharmacist and physician practice management software.

11. Physicians should be mandated to transmit all narcotic and controlled substances via electronic means, within 1 year of when processes to prescribe electronically becoming available.

12. Alberta Health and Wellness, through Alberta NETCARE, should support and sponsor a Vendor Conformance & Usability (VCUR) process to standardize all pharmacy practice management software.

13. Alberta Health and Wellness should fund demonstration projects based on new practice models and new economic models for pharmacist services. The Health Quality Matrix should be used as a tool for measuring success.

14. Opportunities to reimburse pharmacists, rather than pharmacies, for professional services must be explored.

15. Health services should be reimbursed consistently, regardless of the provider of care. If two health professionals are equally capable of delivering a health service, they should be reimbursed comparably for providing the same service. For example, patients should not be incented to visit a physician for a service because it is publically funded, when the same service may be available from a pharmacist, but only at a cost to the patient (i.e. follow-up assessment in advance of refilling a prescription).

16. The scope of medications and services reimbursed through drug benefit programs should be reviewed and revised. Priority should be given to medications used for chronic illness, and high cost treatments that may be catastrophic to individuals or families without program support. Except for the destitute, disabled, and working poor, patients should increasingly take ownership and partner in paying for their health needs, including drug therapy.

17. Alberta Health and Wellness should partner with other provinces and Health Canada in determining a catastrophic drug program.

18. The national common drug review process should serve as a foundation for determining drug benefits paid for through government programs.

19. Partnerships with other western provinces should be sought to achieve greater commonality in provincial drug program policy and benefit determination.

20. Alberta Health and Wellness should ensure amendment to the Health Professions Act and the Health Information Act, to ensure that the Alberta College of Pharmacists and the College of Physicians and Surgeons of Alberta have jurisdiction to establish quality assurance programs; and in doing so, have access to personal information necessary to make these programs responsive and effective.

21. Alberta Health and Wellness should develop systems, and support research, to better understand the complete value proposition of drug therapy across the health system. In the absence of such knowledge, it will be increasingly difficult to make informed decisions about our constantly evolving provincial pharmaceutical strategy.

22. Targeted resources should be provided to the Health Quality Council of Alberta to facilitate changes in practice by health team members involved in drug therapy as is being delivered by the Health Quality Council in Saskatchewan (Alberta College of Pharmacists 14 April 2008, Updated 28 July 2008, Pages 1, 2 and 3).

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