

## The High Hidden Cost of Missing Therapy

by CHRIS BONNETT

It's easy to reduce drugs to financial and economic commodities, because those attributes are the easiest to measure. The health impacts are obviously crucial considerations, but harder to observe and calculate because there can be significant differences in the individual effects of treatments.

In the meantime, drug cost can be a high or insurmountable barrier, and creates disparities between those who can access treatment and those who cannot. Many years of "social determinants" research makes it clear that those with the lowest incomes are more likely to be in poor health. Even when they have drug coverage, they feel less satisfied with its quality.<sup>1</sup>

Many older people reduce their drug use in order to extend their prescriptions. This may occur by delaying refills, by skipping doses, or by taking smaller doses than recommended by their physician. The effect of cost-sharing on prescription drug use was reviewed using six recent studies from academic journals. Three of those articles were studies drawing conclusions from a broad review of other research. Some findings:

- Generally, co-payments were significantly and negatively correlated with adherence to treatment.<sup>2</sup> Higher drug cost sharing tends to increase the likelihood of adverse health events, emergency department use, hospitalization, and less favourable outcomes.<sup>3</sup>
- Those with out-of-pocket costs of even US\$100 were five to ten times more likely to reduce their drug use than those with personal expenditures below US\$50.<sup>4</sup>
- One review of 16 studies found that those in poor health had significantly greater risk of not using their drugs as prescribed.<sup>5</sup> Other vulnerable populations are those with poor health literacy, impaired cognitive function, or those who are socially isolated.<sup>6</sup>

In summary, any drug insurance is likely to improve access to prescription medicines, and those with lower incomes and the disadvantaged among us have generally worse health status and outcomes. Perhaps our collective effort should be to target new resources at the most vulnerable, and work harder to implement the catastrophic drug program that has been recommended by so many experts for so many years.

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### References

- 1 sanofi-aventis Healthcare Survey, 2006. See *Income and Perception*, p. 17. Available at: [www.sanofi-aventis.ca](http://www.sanofi-aventis.ca).
- 2 Piette JD, M Heisler, R Horne, GC Alexander, 2006. A conceptually based approach to understanding chronically ill patients' responses to medication cost pressures. *Social Science & Medicine* 62: 846-57. Other studies reviewed came to a similar conclusion.
- 3 Tambllyn R, R Laprise, JA Hanley, et al, 2001. Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons. *Journal of the American Medical Association* 285(4): 421-29.
- 4 Briesacher BA, JH Gurwitz, SB Soumerai, 2007. Patients at Risk of Cost-Related Medication Non-Adherence: A Review of the Literature. *Journal of General Internal Medicine*, 22, 864-71.
- 5 Ibid.
- 6 Op cit, Piette et al.

## A Catastrophic Formulary?

by COLLEEN SAVAGE

Some of the proposals for a catastrophic drug plan recommend a formulary-based system.

Drug plan managers rely on formularies as part of a tool kit to control costs. Drugs can be added slowly or deleted, manufacturers can be pushed to negotiate and compete for listings, rules about generic pricing and therapeutic equivalence can be set rather arbitrarily. It's a payers' game.

Unfortunately, the formulary system is precisely why there are cancer patients (and others) facing catastrophic drug costs. When the recommended treatment is not listed in the applicable formulary, the threat of cancer is magnified. An employment-based benefits plan might or might not help (see "Does private insurance protect Canadians from the cost of cancer drugs?" in this issue).

The formulary approach implies:

### 1. that formularies provide enough choices to treat virtually all diseases.

Multiple outdated choices are not a substitute for optimum treatment of major diseases.

### 2. that important drugs with proven clinical merit are always listed on provincial formularies.

The assumption is that a legitimate catastrophic drug cost cannot happen outside that list. This is countered by the number of patchwork, tightly controlled "exceptional access" provisions the provinces have had to institute, while still withholding cancer drugs from many, and by their own admission that drug cost is a significant factor in decisions to list or not list a new drug.

### 3. that the use of an unlisted drug is unnecessary or irresponsible and needs to be actively discouraged, for example by forcing patients to pay for that drug themselves.

The inconsistent decisions about whether to fund cancer drugs in this country demonstrate the spurious nature of this assumption. A cancer drug that is vital for patients in BC does not become useless for the same disease in another province.

**4. that the dissonance between cancer drugs recommended, with guidelines, by cancer agencies vs. the lists approved for funding is unimportant.**

Cancer specialists who participate in Disease Site Groups and other types of expert panels create guidelines for the recommended use of new cancer drugs. These guidelines become the expected standard of care for cancer patients in their particular jurisdiction. When provincial governments decide not to cover some of these drugs, the conflict between the accepted standard of care and the available standard of care is felt by oncologists and their patients.

**5. that nobody truly needs a new drug during the lag time between Federal Notice of Compliance and completion of all the other provincial reviews.**

A new and promising agent might be delayed in the provincial drug review and approvals process for a year or two after Health Canada permits the drug to be marketed in Canada. During that time, patients must rely on their own financial resources in order to obtain such a treatment. Alternatively, cancer patients can hope for a clinical trial that is: a) nearby, b) still recruiting patients, c) clinically appropriate, and d) does not exclude their particular health status.

Proposals for a formulary-based catastrophic drug plan, typically written several years ago, did not envision the pace of drug discovery—or the pace of provincial retreat from covering them. Formularies are generally slow to list and more often than not the listings are restrictive, to exclude numerous otherwise treatable patients. It took an Ombudsman investigation to lift the preposterous restrictions on Avastin in Ontario.

Income-testing Canadians for catastrophic drug coverage is intrusive enough, these same individuals should not have to prove that their disease is serious enough, their oncologist qualified enough, the clinical evidence clear enough, or their province parsimonious enough, to justify the treatment.

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## No Hope for a Universal Catastrophic Drug Plan?

by DOUGLAS EMERSON

Existing provincial and territorial drug plans have failed to keep up with the dramatic shift in health care from in-hospital treatment to out-patient pharmaceutical therapies. While this impacts patients in virtually all aspects of health-care, nowhere is it more evident than oncology. New therapies are recommended but remain unfunded, leaving patients with few options: come up with tens of thousands of dollars to pay for their treatment privately, accept outdated therapies, or walk away from treatment altogether in order to protect the family's financial future.

The obvious solution is a catastrophic drug plan for all Canadians. But despite a wide range of studies echoing the critical need for such a program, we enter 2010 with no plan in sight—and with the possibility of one seemingly farther away than ever.

As we have previously reported, provincial and territorial health ministers met in September 2008, and reiterated a commitment to provide catastrophic drug coverage for Canadians. The proposed funding would be set at five per cent of average annual household income (\$5.03 billion based on 2006 figures), with funds split 50/50 between the federal government and the corresponding province or territory. The stage seemed to be set to finally implement a plan. However, as Parliamentary researcher Karin Phillips notes in a review published a full year after the health ministers' announcement, "...according to the Provinces and Territories, inability to agree on this cost-sharing arrangement is delaying any further progress. The Health Council of Canada notes that unless this political impasse is overcome, 'the National Pharmaceuticals Strategy will remain largely a prescription unfilled.'"<sup>1</sup>

Our governments' continued lack of leadership on this issue has neglected thousands of Canadian households who face insurmountable costs associated with essential prescriptions. Each day that passes leaves more families unable to cope.

There simply are no acceptable excuses for this egregious failure to act: it is an offence to all Canadians, and to the very spirit of public healthcare.

**Douglas Emerson** is a marketing and communications professional working in Toronto. He lost his father to Multiple Myeloma in 2005.

### References

- 1 Phillips, Karin: "Catastrophic Drug Coverage in Canada"; Library of Parliament, September 1, 2009. <http://www2.parl.gc.ca/Content/LOP/ResearchPublications/prb0906-e.htm#a15>