

## THE COMMON DRUG REVIEW

# Faster access or more red tape?

In September 2003 the federal government and nine provinces launched a powerful new committee that will impact on citizens' access to new medicines in every province except Quebec. This new Canadian Expert Drug Advisory Committee (CEDAC) has authority to block the addition of new treatments to government drug plans, through a Common Drug Review.

All of Canada's federal, provincial and territorial governments operate drug insurance programs. Each has its own unique structure, with some provinces offering universal coverage and others offering seniors plans and/or programs for low-income citizens. Federal drug insurance programs include those for First Nations and veterans.

These plans do not provide access to all medicines. After Health Canada approves a new medicine as safe and effective for sale in this country, the manufacturer applies to have the treatment added to each drug plan's formulary (a list of medicines that are covered by the program). At this point, the clinical value of the medicine has been established and the governments are deciding individually whether or not to pay for it, or under what circumstances to do so. Only 15-40 per cent of federally approved medicines are added to the formularies. The inclusion rate varies considerably from government-to-government.

Each government has a separate process for making this decision. One early step is a review of the manufacturer's submission and academic literature about the new treatment, by an expert in pharmacoeconomics and/or clinical science. In September 2001, Health Ministers from across the country (excluding Quebec) agreed in principle to replace their individual reviews with one Common Drug Review.

At the time, the politicians spoke of an opportunity to "streamline" the system. On the surface, it would seem that one body making one recommendation for all governments would be more efficient. Now that the process is being implemented, there is always a danger that the initial goal of efficiency may not turn out to be the end result.

There is a real need to make sure that the review process does not become overly bureaucratic. The speed at which decisions are made to cover a new and clinically proven treatment determines how quickly patients can use the drug. Patients are right to demand timely access to the best new medicines.

We have several reasons to fear that the Common Drug Review will impede such access. The old provincial committees that made decisions about drug plans are not being dissolved. In fact, the new process still requires reviews at the provincial level. This

means that CEDAC meetings (the part of the process that makes decisions on formal recommendations to the provinces) are an “add on” to the previous system, rather than the “streamlining” that was promised.

Another concern is that the Common Drug Review could be a tool for cost-cutting, rather than an instrument to improve health outcomes. It has been stated that the body's recommendations will follow a “no means no, yes means maybe” principle. In other words CEDAC will have the power to reject a medicine for all participating drug plans, but not to force drug plans to make a promising new medicine available.

Provincial decision makers have delegated responsibility for rejections. They can now blame unpopular decisions on a distant committee in Ottawa – one that is not directly accountable to any electorate. This could leave patients with nowhere to turn.

As well, it is unclear whether one Common Drug Review will be more effective than several individual reviews. So far there is no evidence that a single review will have significant additional resources to make for a more thoughtful recommendation to the drug plans. But it is clear there will be no ability to compare reviews in participating provinces and benchmark best practices.

This kind of inter-provincial data is useful for determining the impact on patients. The ultimate success or failure of this system must not be measured solely by the standard of drug plan cost control, but also by its effect on health outcomes.

### **AstraZeneca's Position**

**AstraZeneca cannot support the decision to implement the Common Drug Review while questions remain about its impact on patient access to the best new drugs. In preparation for its first-year review in September 2004, we will track both the decisions of the new committee and of the individual drug plans to monitor the new system's impact on patients, and our competitors will do the same. If the final decisions take longer than before or if it is found that a greater portion of treatments are being rejected, then the new committee should be terminated immediately, and the concept rethought. In the future, we would also expect to see a greater role for patient advocates in formulary approvals to ensure that access to quality treatments is the main goal of public drug insurance plans.**