

CANADIAN TREATMENT ACTION COUNCIL



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Ontario Government proposing "Cheapest Drug First" Cost-Containment Policy

by Jane Hamilton, Best Medicines Coalition

THE MINISTRY OF HEALTH recently confirmed the province is considering a new system to reduce spending in the Ontario Drug Benefit (ODB) Program. It's called "reference-based pricing", but groups such as the Best Medicines Coalition, CARP (Canada's Association for the Fifty-Plus) and CTAC are calling it "cheapest drug first". This is yet another "cost containment" measure implemented by government. This system currently exists in BC and may spread to other provinces.

This scheme will force doctors to prescribe based on a list restricting access and choice. This does not mean a generic substitution, where the patient is getting the same (patented-expired) chemical. It means Ontarians will be prescribed a different, patented, unique drug with a somewhat similar performance in place of the one prescribed by the doctor.

Although reference-based pricing is being suggested as a cost-containment strategy, these "cheapest drug first" policies actually result in higher costs to the healthcare system. Switching patients who are already stabilized on one medication does not work for the patient, or the healthcare system. When patients fail on the cheapest drug, there are greater costs to other areas of the healthcare system — for example, increased doctor visits, hospital visits and diagnostic testing. All of this results in higher overall costs to the healthcare system.

In July 2003, the British Columbia PharmaCare Program introduced a "cheapest drug first" policy for a class of medication, used to treat severe heartburn from reflux disease (GERD). They called it "therapeutic substitution". No matter which medication patients were prescribed, they could only get reimbursed if they took the product the

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Ontario Government proposing “cheapest drug first” cost-containment policy

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BC government decreed to be “preferred”. The cost differences ranged between 60–90 cents per daily dose.

“The real-life stories of patient harm in BC is overwhelming. In the first six months of the new PharmaCare policy, 39,000 prescriptions were filled for the cheapest drug, and 9,600 people had treatment failure,” said Gail Attara, Executive Director of the Canadian Society of Intestinal Research. “It is imperative that doctors have a choice in determining the right treatment for the patient.”

Based on the BC PharmaCare experience, the government of Ontario is considering a similar program for the same class Proton Pump Inhibitors (PPIs).

“We recognize that cost-effectiveness is important, but consider cost-containment policies penny-wise and pound foolish,” said Louise Binder, Chair of CTAC. “The Ontario government may be saving a penny or two now with these cost-containment schemes, but they will pay a lot more later as the burden shifts to other areas of the healthcare system.”

Currently, the Government of Ontario seems prepared to undertake restrictive drug pricing policies without any meaningful attempt to listen to those who will be negatively impacted or to find solutions that will result in better patient health. In a joint letter from the BMC and CTAC, the groups called on the government to:

“Cheapest drug first” policies actually result in higher costs to the healthcare system.



1. Reject any plan that considers cost-containment strategies for the Ontario Drug Benefit plan that could include therapeutic substitution, reference-based pricing, maximum allowable cost and/or lowest cost alternative pricing. Instead, adapt the Australian system of integrated education for drug prescribing and utilization.
2. Engage stakeholders in a meaningful way to create the best system for Ontario that could be a best practice model for other provinces.
3. Implement a generic drug strategy for Ontario similar to the Patented Medicines Prices Review Board.
4. Form a permanent Patient Advisory Committee to advise the ODB on policy and procedures that impact patients.
5. Amend rules that require monetary bulk buying discounts to be charged against general revenues instead of directly against the drug budget. Negotiate such discounts with the pharmaceutical industry. ■



Canadian Treatment Action Council

CTAC has initiated a Capacity Building project

Through a series of learning modules, CTAC hopes to increase the ability and skills of its members to understand and act on treatment access advocacy issues. The modules will be offered in English and French as a series of tele-workshops and participants will have the option of working towards a Treatment Access Issues

certificate. All of the modules will be available on CTAC’s website as they are developed. For more information or to register, please contact Sugandhi Wickremarachchi at (416) 410-1369 or sugandhi@ctac.ca. Information about these modules will be available on CTAC’s website in the near future.

Access to Treatment in the Developing World

“The 3 by 5” Updates at CROI

by Enrico Mandarino

AT THE RECENT 12TH CONFERENCE on Retroviruses and Opportunistic Infections (CROI), almost 4,000 of the world’s leading researchers gathered to share the latest in scientific knowledge on HIV/AIDS. This year’s conference seemed to have more of a clinical focus with sessions on complications associated with antiretroviral therapy and ways of preventing, reversing, and predicting them.

There were also sessions on access to treatment worldwide with a symposium on scaling up care for the developing world. The keynote address at the opening ceremony was given by Dr. Jim Kim of the World Health Organization (WHO). He spoke passionately about the need to intervene now with antiretroviral therapy (ART) to prevent more deaths and hardships.

Global activity on HIV was very limited at the time when the global program on HIV was terminated in 1994. To be able to play its designated role within the UNAIDS family, the WHO needed a clear, measurable target that would fundamentally transform how HIV/AIDS business is done, hence the “3 by 5 campaign”, which is the goal to provide ART to at least 3 million people in resource-limited settings by the end of 2005.

According to the WHO, also desperately needed is a shift in global HIV advocacy. Putting HIV/AIDS on the agenda at high-level meetings to draw the world’s attention is not working, despite the message of the previous 10 years that the epidemic is getting worse. Dr. Kim said now in 2005, “we are in the era of results and we can no longer just do the body counts, we must deliver.”

Prevention, development and implementation of health care systems that monitor the progress, challenges and prospects of delivering ART to the developing world are now the core of how the WHO is addressing HIV/AIDS. Many of the world’s leaders have committed to pushing this agenda forward. There is now \$20 billion to do this work and the WHO believes that HIV/AIDS treatment and scale-up in resource poor settings is still feasible and effective, and is increasingly becoming affordable.

Over the second half of 2004 the number of people in Africa starting treatments has more than doubled and more than tripled in Mozambique and Uganda. Botswana and Brazil have achieved their 3 by 5 targets. This success is mainly due to the set-up of sites with the proper infrastructure to provide free prevention and antiretroviral therapy as well as counselling and support.

The interim goal of 700,000 people on treatment at the end of 2004 has been met. To achieve the WHO’s target, this number will have to increase by more than double in the first 6 months of 2005, and again in the last 6 months of 2005. The lofty goal of 3 by 5 is still possible.

Four key points to success for ART Scale-Up:

- Political will
- Availability and quality of affordable drugs
- Accelerating prevention through scaling up treatment
- Public health approach to antiviral treatment scale-up ■

Reference: Address by Dr. Jim Kim, CROI Opening Ceremony, February 22nd, 2005.



Cross-border Internet Pharmacies — Industry at Crossroads



by Philip Lundrigan

Recent Developments in Canada

For some time now, CTAC has been calling on the government of Canada to ban cross-border internet pharmacies (CBIP). A plethora of consumer groups, professional associations, health care providers, patients and others have recognized the potential for drug shortages and increased drug prices, and have lent their voices to the call for a ban. It would seem that decision makers are hearing and heeding the call.

The federal government is considering changes to the one-billion-dollar-a-year industry. The issue is not new, but it is only since President George Bush's recent visit to Canada that media interest has really developed. On January 5th, the Associated Press reported that, "Representatives of both the U.S. and Canadian governments say Bush discussed the issue with Prime Minister Paul Martin when he visited last fall. That has sparked accusations that Bush pressured Martin to change Canadian policy — an accusation the White House denies." Perhaps it is coincidental that at the time the President was planning to visit Canada, Minister Dosanjh began to publicly raise concerns about prescription drugs from Canadian pharmacies going to the U.S.

In his speech to Harvard Medical School in Cambridge, Massachusetts in November, 2004, Minister Dosanjh said, "From the perspective of the Government of Canada this is a very simple matter, encompassing two key priorities: ensuring that prescription drugs sold in Canada are safe; and ensuring that we have sufficient supply of prescription drugs to meet the needs of Canadians."

Minister Dosanjh went on to say that, "... it is difficult for me to conceive of how a small country like Canada could meet the prescription drug needs of approximately 280 million Americans without putting our own supply at serious risk. To me it is a matter of common sense that Canada cannot be the

"...there are Americans who oppose this practice, but their motives differ from those of Canadians who are opposed..."

drug store of the United States. Neither American consumers nor Canadian suppliers should have any illusions otherwise."

Since January, various media have reported that Minister Dosanjh is considering options to crack down on CBIP. However, the Minister is receiving opposition to his plans from those who support this activity, including a cabinet colleague. On February 4, 2005, CBC News reported that, "Treasury Board President Reg Alcock met with federal Health Minister Ujjal Dosanjh in Ottawa Thursday to discuss ways Ottawa could address medical concerns about internet pharmacies without killing the industry." Mr. Alcock, a Manitoba MP, has been joined by Manitoba's Premier, Gary Doer, in defending the industry's 4,000 jobs, 2,500 of which are in Manitoba.

Options being considered by Minister Dosanjh include:

1. preventing Canadian doctors from co-signing prescriptions for American patients without "attending upon them", as required by Canadian law,
2. banning prescriptions for patients who are not present in Canada, and
3. banning the cross-border sale of drugs which are high in demand in Canada and/or drugs whose supply is, or may potentially be, threatened in Canada.

The idea of a total ban on the cross-border prescription drug trade has been proposed by many opponents of the cross-border trade but, until recently, this sentiment had not been echoed by the Minister. On February 18, 2005 Randall Palmer of Reuters

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Cross-border Internet Pharmacies

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“...it is a matter of common sense that Canada cannot be the drug store of the United States...”

Minister Dosanjh

News Agency reported Minister Dosanjh saying, “The Canadian government is considering a total ban on exports of price-controlled patented drugs as a way of preserving the country’s lower prices for medicine.” Apparently, the Minister is considering changes to Canada’s drug pricing legislation that would require patented drugs whose prices are reviewed and authorized by the Patent Medicines Prices Review Board (PMPRB) be sold only for consumption in Canada.

It would seem that the Canadian International Pharmacy Association (CIPA) (the umbrella group that represents the vast majority of CBIP) saw the writing on the wall earlier this year. CIPA has recognized the potential dangers its industry could present to Canadians and is keenly aware of the growing opposition to CBIP. David Mackay, CIPA’s executive director, has suggested on numerous occasions that a ban on wholesale purchases by Americans would be the solution that ensures Canada’s drug supply is not threatened.

While a ban of wholesale shipments to the U.S. cannot, in and of itself, solve the problems of CBIP, the idea represents an additional tool in ensuring a safe and available supply of drugs for Canadians. Apparently Minister Dosanjh has added this suggestion to his list of potential solutions.

Two specific effects of the cross-border internet trade that don’t seem to be getting much attention are:

1. pressure by the industry to increase drug prices in Canada and
2. pressure to dismantle or change Canada’s drug price regulation.

CTAC has called for measures to strengthen and preserve Canada’s drug price regulation with an expanded and enhanced role for the PMPRB.

South of the Border

The issue of CBIP has also garnered attention south of the border, but for very different reasons. The supporters of the

cross-border prescription drug trade are largely un- or under-insured American consumers. Many American state and municipal governments have endorsed the importation of cheaper prescription drugs from Canada and other countries.

However, there are Americans who oppose this practice, but their motives differ from those of Canadians who are opposed. The U.S. Food and Drug Administration (FDA – the body that approves and regulates drugs in the U.S.) argues that importing drugs from Canada and other countries presents monumental challenges in terms of the FDA’s ability to assure the safety and efficacy of those drugs. The largely U.S.-based pharmaceutical industry has been in a bit of a panic over eroding profits as a result of American consumers buying their drugs in Canada, and have strongly opposed the practice of CBIP. In fact, some companies have refused or limited the supply of drugs to Canadian pharmacies that then ship those drugs back to the U.S.

The issue of CBIP (which exists because of lower prescription drug prices in Canada) has been on the U.S.’s radar for some time and has caused the U.S. federal government to take a closer look at the phenomenon. In December 2004, the U.S. Department of Health & Human Services Task Force on Drug Importation released its “Report on Drug Importation”. Key findings of the report include:

1. The current U.S. drug regulation system has been very effective in protecting public safety, but is facing new threats. It should be modified only with great care to ensure continued high standards of safety and effectiveness of the U.S. drug supply.
2. There are significant risks associated with way individuals are currently importing drugs.
3. It would be extraordinarily difficult and costly for “personal” importation to be implemented in a way that ensures the safety and effectiveness of the imported drugs.
4. Overall national savings from legalized commercial importation will likely be only a small percentage of total drug spending and developing and implementing such a program would incur significant costs and require significant additional authorities.
5. The public expectation that imported drugs are less expensive than American drugs is not generally true.

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Access 101: The lowdown on treatment access through clinical trials

by Maia Joseph, Communications Project Coordinator and Editor, Canadian HIV Trials Network

CLINICAL RESEARCH IN HIV/AIDS has long been associated with access to new treatments. However, the promise of access is neither clear-cut nor guaranteed. Finding the right trial at a convenient location is one part of the challenge; other hurdles include getting into the trial and being assigned to the study arm that receives the experimental therapy. Treatment access advocates have an important role to play in making sure that the best clinical trials go ahead, and that they are available to a wide range of people living with HIV/AIDS.

Clinical trials: the basics

Let's start with a definition: clinical trials are carefully designed experiments that allow investigators to test new drugs and other therapies in people. Treatment testing begins in the lab with test-tube and animal experiments, but ultimately trials in humans are the only way investigators can determine whether a treatment is safe and effective. Investigators first test the new treatment on a very small group of people. If that trial goes well, they conduct larger studies involving more participants. A drug will be approved for marketing only after it has passed through multiple clinical trials.

At the moment, entry inhibitors targeting the CCR5 receptor on immune cells are a particularly popular topic of clinical study in HIV treatment. Pfizer, Schering-Plough and GlaxoSmithKline are all conducting CCR5-antagonist trials in Canada.

Investigators are also addressing a range of other pressing clinical questions. At the Canadian HIV Trials Network (CTN), investigators are studying vaccines for therapeutic use (to boost the immune response against HIV), structured treatment interruptions (a.k.a. drug holidays), approaches to treating drug-resistant HIV, treatment options for HIV/HCV co-infection, and a psychological intervention to improve adherence to

HAART.

Finding the right trial

For a country of its size, Canada is home to a relatively large number of clinical trials. Nevertheless, a point of frustration for some people living with HIV/AIDS is that the trials they want are being run elsewhere — usually in the US — or are not taking place at all. Moreover, the sometimes lengthy process of getting a trial going in Canada can limit access to international trials that do enroll here, since participants from other countries can potentially fill the quota for a trial before it even opens in Canada.

Work also needs to be done to ensure that Canadian clinical research meets the diverse needs of this country's HIV+ population. To date, relatively few trials have addressed issues such as the gender-specific pharmacokinetics of antiretroviral drugs or accessibility to marginalized groups such as prisoners and Aboriginals living on reserves.

Staying informed

Running relevant and accessible trials is vital, but ensuring that community members know about these trials is just as important. Infectious diseases specialists and general physicians work hard to stay up to date on treatment options in clinical trials and to pass relevant news on to patients. The CTN compiles a bilingual list of trials enrolling in Canada, which it posts on its website and distributes quarterly in poster form.

Still, the number of clinical trials today makes it difficult for doctors to remain fully informed, so people living with HIV/AIDS must be proactive. With the help of the CTN and the Canadian AIDS Treatment Information Exchange (CATIE), as

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Access 101: The lowdown on treatment access through clinical trials

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well as local AIDS organizations, you can keep an eye on the clinical trials pipeline, and ask your doctor to seek out more information about trials that look promising.

Getting into the trial and onto the treatment

The purpose of a clinical trial is to help investigators answer questions they have about a particular treatment, and trials are designed with this goal — and not access — in mind.

Inclusion and exclusion criteria determine which individuals are eligible to enter a clinical trial. Potential participants attend a screening visit, where a doctor decides whether they meet the trial's eligibility criteria, which often include viral load, CD4 cell count, treatment history and state of health.

Most clinical trials are comparative studies that evaluate the experimental treatment against a placebo or an approved treatment. While it is unethical for trials to deny participants a treatment that is of proven value to them, participants can be assigned to a study arm that receives only the conventional treatment, or this treatment plus a placebo. Participants are usually randomly assigned to a treatment group, often through a double-blind process (in other words, neither the participant nor the investigator knows who is receiving the experimental treatment until the end of the study).

Expanded access: the pre-marketing frontier

People living with HIV/AIDS who desperately need to try an experimental treatment may have better luck with an expanded access program. Typically, all participants in expanded access programs receive the experimental treatment. However, this option usually is not available until just prior to the approval of a treatment for marketing.

Compassionate access programs are perhaps the most well-known form of expanded access. These are provided for drugs in the late stages of development, when the manufacturer makes the treatment available on a less restrictive basis than for a standard clinical trial. Participants must still meet certain entry requirements, such as having a

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The four phases of clinical trials: a quick overview

Phase I:

A small number of people (20-80) with or without HIV receive the treatment. Researchers determine a safe dosage range, study how the treatment is processed by the body, evaluate safety and identify side effects. These trials are usually 2-3 months long. They are riskier than later trials, because less is known about the treatment.

Phase II:

A larger number of people (100-300) with HIV receive the treatment. Researchers determine the best dose, evaluate effectiveness and identify medium-term side effects. These trials normally span a few months to a year.

Phase III:

A large number of people (1,000-3,000) with HIV receive the treatment. Researchers determine if the treatment remains effective and identify long-term side effects. They also compare the treatment to commonly used therapies. If a treatment is successful at this point, it may be approved for general use.

Phase IV:

Researchers often study a treatment after it has been approved in what are called "post-marketing" trials. They watch for additional side effects or problems, or test the treatment in different prevention and/or treatment strategies.

** Today, many clinical trials combine phases. For example, Phase I/II trials might evaluate safety and determine the best dosage, while Phase II/III trials might study both medium- and long-term effectiveness and side effects.*

Access 101: The lowdown on treatment access through clinical trials

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CD4 count below a specified level, and numbers of participants may be severely restricted. Thousands of HIV+ Canadians have accessed new antiretroviral drugs through compassionate access programs since the mid-1990s.

In Canada, a few therapies associated with HIV can also be accessed prior to marketing approval through Health Canada's Special Access Program. In response to a doctor's request, Health Canada may authorize a manufacturer to release experimental treatments listed in the program. Unlike clinical trials, some manufacturers charge a fee for treatments released through the Special Access program.

Access and altruism

The final word on clinical research and treatment access is that a trial may allow participants to access a new, beneficial

therapy, but there is no guarantee. The primary motivation for enrolling in a trial should be to help others living with HIV in the future by contributing to the advance of clinical knowledge. Still, altruism is ultimately connected to access: participating in HIV/AIDS research now increases the possibility that better treatments will be available to all people living with HIV/AIDS not too far down the road.

For more information on clinical trials, contact the Canadian HIV Trials Network by telephone at 1-800-661-4664 or by email at ctn@hivnet.ubc.ca. To view the CTN's online list of enrolling trials in Canada, visit www.hivnet.ubc.ca/ctn.html and click on the "Clinical Trials" link. The Canadian AIDS Treatment Information Exchange (CATIE) also provides treatment and clinical trials information. Contact CATIE by telephone at 1-800-263-1638, email questions@catie.ca or visit www.catie.ca. ■

The Importance of and Access to Traditional Health and Wellbeing Systems

by Randy Jackson, Canadian Aboriginal AIDS Network

IN THE SUMMER OF 2004, the Canadian Aboriginal AIDS Network (CAAN) conducted a nation-wide community-based survey of 195 Aboriginal people living with HIV/AIDS. The primary goal of this study was to document the extent to which the services needs of Aboriginal people living with HIV/AIDS are being met and to identify deficiencies in the provision of those services. Service utilization and effectiveness are analysed by Aboriginal identity, geographic region, disease stage, gender, age and mode of transmission. Recommendations made by Aboriginal people living with HIV/AIDS point to ways in which access to and delivery of services can be improved. While a number of different service areas are explored in this larger study, this article focuses on the importance of and access to traditional health and wellness systems.

For participants in this study, a majority (60.5%) use/need traditional Aboriginal health and wellness systems. Use and need differ significantly by Aboriginal identity: 66.5% of First Nation

people living with HIV/AIDS use or need access, compared to 35% for Inuit, Innu and Métis. Between 35-45% of Aboriginal people living with HIV/AIDS seek the support of sharing/healing circles, Elders, traditional medicine, other ceremonies (e.g. sweat lodge, etc.), sharing and healing circles and camps or retreats. However, possibly indicating a service design feature that serves to hamper utilization rates, Aboriginal people living with HIV/AIDS in poorer health (52.8%) tend to use/need such services less frequently than those in better health (70%).

From CAAN's perspective the extent of use/need is not entirely surprising. Our experience working with Aboriginal communities as well as strong evidence in the academic literature supports the use of cultural health activity. The more individuals are provided opportunities to learn about and connect with traditional culture, the stronger their resolve and ability to cope with negative encounters and events (Assembly of First Nations 2001; Walters

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The Importance of and Access to Traditional Health and Wellbeing Systems

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and Simoni, 2002). Use/need rates for the participants in this study reflect the extent to which cultural values, belief and practices shape individual responses to HIV illness. These become important considerations where facilitating access is concerned in the context of health, well-being and quality of life.

The benefits of access to traditional health and wellness service need never be underestimated. It's in this vein that the notion of user-satisfaction becomes an equally important consideration. Like other populations living with HIV/AIDS, if Aboriginal people living with HIV/AIDS are unsatisfied with the care they receive by the mainstream medical establishment, they will tend not to comply with treatment recommendations (Ickovics and Meade, 2001 and Roberts, 2003). Being satisfied means there is clear communication and respect for varying social and cultural contexts (Brown et al., 2001). For Aboriginal people living with HIV/AIDS, the ideal situation would be to provide traditional healers the same respect and access as mainstream medical professionals (Assembly of First Nations, 2001). In our study, participants provided numerous unsolicited feedback calling for "more participation of ... spiritual healers" and "increased access to traditional practices such as sweats, talking circles and healers."

Despite the perceived importance of and use/need of traditional health and wellness services, several complicating barriers to access need to be considered in designing and delivering such programs to Aboriginal people living with HIV/AIDS. First, from this study, the notion of cultural competence emerges as an overarching design/delivery feature. In many cases Aboriginal people living with HIV/AIDS were not able to positively evaluate their experience in mainstream health settings. Often participants called for an increase in dedicated funding and human resources to promote existing or establish new traditional Aboriginal health and wellness services. Types of service recommendations include:

- Elders who are knowledgeable about HIV/AIDS available at local health clinic and in community service organizations
- more information on the use and interaction of traditional medicines with antiretroviral therapies, and
- increased access to ceremonies in closer proximity to place of residence.

All would serve to promote and support cultural self-identity in the context of HIV/AIDS. However, other important logistical barriers that hamper access need equal consideration. Lower than expected use of traditional Aboriginal health and wellness services by Aboriginal people living with HIV/AIDS in poorer health deserve attention as well. It may be this group is simply unable to circumvent obstacles or lack viable options to public transit to access traditional services.

Eliminating barriers to this form of care are important if Aboriginal people living with HIV/AIDS are to find effective support for HIV infection. The position of CAAN on this point is one where a forceful advocacy campaign for appropriate allocation of funding to account for these concerns is considered under the newly announced Federal Initiative on HIV/AIDS in Canada. Copies of findings will be made available by contacting CAAN at: 1-888-285-2226 or info@caan.ca. ■

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Clinical Trials: Update



by *Jim Boothroyd*,
Director of Communications
at the Canadian HIV Trials Network

Results in for study of STIs

Dr. Sharon Walmsley of Toronto presented the results of her structured treatment interruption (STI) clinical trial (CTN 164) at the Conference on Retroviruses and Opportunistic Infections in Boston in late February in a poster titled "A Prospective Randomized Trial of Structured Treatment Interruption vs Immediate Switching in HIV-infected Patients Experiencing Virologic Failure on HAART."

The trial had recruited 147 participants at sites across Canada when it closed in the fall, making it one of the largest prospective STI studies completed to date.

It was distinct from previously published studies in that it focused on people with less advanced HIV disease — those who have experienced virologic failure with their options in first- and second-line antiretroviral treatment, but in whom a salvage regimen could be adequately constructed.

In addition, the study allowed for the use of prophylaxis for opportunistic infections, where indicated by guidelines.

The results suggest that a 12-week STI prior to the initiation of a salvage HAART therapy does not improve outcomes. There was no difference in the percentage of patients who could sustain a viral load of < 50/mL for 3 months, and there was a statistically lower CD4 cell count rise but similar viral load reduction at 60 weeks.

(To read the full abstract, go to www.RetroConference.org/2005/Home.htm)

Dr. Walmsley's results and those of other studies involving STIs are highly relevant. Guidelines published in the fall by the United States Department of Health and Human Services state that further data from controlled clinical trials are needed to assess whether structured treatment interruptions are effective and safe. ■

CALENDAR OF EVENTS SPRING 2005

● April 14th

Positive Women's Network: Springboard 2005
Vancouver, British Columbia
Contact: pwn@pwn.bc.ca or 604-692-3000

● May 12th-15th

Canadian Association for HIV Research Conference (CAHR)
Vancouver, British Columbia
Contact: info@cahr-acrv.ca or 604-642-6429 x307

● June 6th

CTAC Skills Building Event

Calgary, Alberta

Join CTAC for a day of skills building in Calgary! All are welcome to attend. Please see www.ctac.ca for details and to register for the events.

● June 15th-19th

Canadian AIDS Society (CAS) PLWHIV/AIDS Forum and Annual General Meeting
Ottawa, Ontario

Contact: CASinfo@cdnaids.ca or 1-800-844-1058

● June 20th-21th

Canadian AIDS Treatment Information Exchange (CATIE) Annual General Meeting and Educational Conference

Ottawa, Ontario

Contact: info@catie.ca or 1-800-263-1838

● October 15th-18th

CTAC Annual General Meeting

Moncton, New Brunswick

Contact: ctac@ctac.ca or 416-410-6538

● October 26th-30th

5th Canadian HIV/AIDS Skills Building Symposium
Montreal, Quebec

Scholarship Deadline: June 30th, 2005

Registration for the Symposium is open! Register online at www.hivaidsskills.ca

For more information visit

www.hivaidsskills.ca or call 1-877-998-9991

Cross-border Internet Pharmacies

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6. Legalized importation will likely affect the future development of new drugs for American consumers.
7. The effects of legalized importation on intellectual property rights are uncertain but likely to be significant.
8. Legalized importation raises liability issues for consumers, manufacturers, distributors, pharmacies and other entities.

It is clear that the authors of the report have concluded that the practice of CBIP presents real and potential problems for U.S. consumers and regulators, while the benefit of such practice is seen as minimal to non-existent.

Conspicuously absent from the American side of the debate is discussion about the fundamental reason that Americans are going to other countries to purchase their prescription drugs — namely, the absence of drug price regulation in the U.S. It has been widely reported that the pharmaceutical industry has provided generous support for President Bush and he in turn has been very kind to the industry. It seems very unlikely that a discussion of prescription drug prices in the U.S. will be initiated from the top. There is support on both sides of the border to ban CBIP and the governments of both countries have signalled their preference to stop this practice, albeit for very different reasons. We seem to be slowly getting to the right place. The recent moves by the Canadian federal government to address this potentially critical issue are a departure from the lip-service previously paid to CBIP.

While the U.S. free market system decides the price of drugs, i.e., whatever the market will bear, there will continue to be pressure on both our supply of drugs and our drug price regulation system. Minister Dosanjh has been making firm commitments to address the CBIP issue. If he sticks to his guns and does in fact ban cross-border shipments of Canadian drugs, it just might cause Americans to look at implications, both inside and outside of their country, of the absence of drug price regulation in the U.S.

More articles on this issue can be found in the following back issues of the CTAC newsletter: January 2005; March 2004 and June 2004. Current and back issues of the newsletter are available online at ctac.ca/english/newsletter.html ■

CHAIR'S REPORT SPRING 2005

by Louise Binder



RECENTLY I'VE CONSIDERED WRITING

a book of fiction, à la The Da Vinci Code, feeding my paranoia about conspiracies and secret deals to destroy the last vestiges

of our already tattered health care system. Many signs point in this direction, most of them fairly obvious, such as the provincial government schemes to restrict access to provincial reimbursement plans and the ongoing feud with Ottawa for more funding.

On the other hand, the federal government appears of late to be fairly enlightened on the issue of health care, working to stop cross border internet pharmacies, increasing federal funding for AIDS and bringing in a budget that had a number of positive health care aspects.

In early March I attended what began as a promising teleconference chaired by the Ministers of State and Health regarding the new budget. When asked why the Hepatitis C Strategy had only been given one year of funding, Chief Public Officer of Health David Butler-Jones answered that this was interim funding while he develops integrated strategies on infectious and chronic diseases. In future, Hepatitis C will be funded through an integrated strategy.

At the time, his comment went unchallenged but created a red flag for me (and I hope for you, too). My interpretation is that the federal government is considering eliminating discrete funding for HIV/AIDS and create a pooled funding arrangement for a group of as yet unspecified diseases. This would contradict the Health Minister's comments at recent budget hearings where he identified HIV/AIDS as having its own discrete funding allocation. I am very concerned that the funding so badly needed for HIV/AIDS work, and for which we have fought so hard, is going to be swallowed up in some infectious disease strategy. We trust that the Minister of Health's view will prevail.

Adequate funds must be provided for all diseases including Hepatitis C. Trying to hide chronic underfunding by rolling the funds for a number of diseases into one budget line just won't wash. We must let the federal Ministers of Health and State, Chief Public Health Officer and our MPs know that so many resources are required to deal with the HIV/AIDS epidemic everywhere across this country and we will not stand for this. Write, phone and visit them now. ■

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CTAC POSITION PAPERS

Papers

- 2001 - "Improving our Health: The Need to Enhance the Post-Approval Surveillance System for HIV/AIDS Drugs in Canada", author: David Garmaise.
- 2001 - "Making Treatments Accessible: A Policy Paper on Determining Appropriate Pricing for Brand-name Pharmaceutical Treatments for HIV/AIDS in Canada", author: Glen Brown.
- 2000 - "Position Paper on Direct To Consumer Advertising (DTCA) of Prescription Medications", author: Phillip Lundrigan.
- 1999 - "Timeliness and Transparency: Assessing the Review Process for HIV Drugs", author: David Garmaise.

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Full Membership

- Person living with HIV/AIDS
- Group, organization and/or project with a substantive HIV/AIDS mandate

Associate Membership

- Any individual
- Group, organization and/or project whose substantive mandate coincides with the objectives of the Corporation

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Organizational Mandate

The mandate of the Canadian Treatment Action Council (CTAC) is to work with the public and private sectors to:

1. **Support access to therapies and treatments** for people living with HIV/AIDS by informing research and public policy, and by promoting public awareness
2. **Provide mentoring and skills building** in these areas to people living with HIV/AIDS
3. **Encourage and facilitate the exchange** of related information to stakeholders

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