

# CANADIAN TREATMENT ACTION COUNCIL



## Pharmacists, Patients, Seniors Applaud Government Action on Internet Pharmacies

### INSIDE

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Pharmacists, Patients, Seniors Applaud Government Action on Internet Pharmacies. . . . .	1
National Pharmacare: Where Are We Now? . . . . .	3
Costly new therapies put CTAC's advocacy skills to the test. . . . .	4
Women's Issues: Update Blueprint for Action on HIV and Women in Canada. . . . .	6
Provincial Update. . . . .	7
Latest News on Microbicides. . . . .	7
Clinical Trials: Update. . . . .	8
Calendar of Events. . . . .	8
Ministers confirm their commitment to fighting HIV/AIDS in Canada. . . . .	9
Chair's Report. . . . .	9
Board and Council Members. . . . .	10



### Time to end unethical practices, risk to Canadian health care

by Jane Hamilton

**EARLIER THIS YEAR**, the Canadian Treatment Action Council (CTAC) joined a coalition of groups representing Canadian pharmacists, patients and seniors to call on the federal government to prohibit the practice of cross-border internet pharmacies and the exportation of pharmaceutical drugs to the U.S.

The group, which included CTAC, CARP – Canada's Association for the Fifty-Plus, the Best Medicines Coalition (BMC), Canadian Pharmacists Association (CPhA), the Coalition for Manitoba Pharmacy and the Manitoba Society of Seniors presented a set of recommendations for federal and provincial governments, provincial regulatory bodies for pharmacists and physicians, the pharmaceutical industry and patients/consumers.

In November, Health Minister Ujjal Dosanjh rightly called practices of the internet pharmacy exporters "unethical" and "unprofessional". The Minister indicated that the government is discussing measures to end the cross-border drug trade, including changes to the Food and Drug Act that would prohibit Canadian doctors from signing prescriptions for anyone but Canadians and visitors to Canada. This would effectively end the practice of "co-signing", whereby cross-border internet pharmacies pay doctors up to \$10 to sign off on each American prescription so that it can be dispensed by a cross-border drug trader.

On December 6, 2004, cross-border drug trading reached a new milestone when Kansas became the fifth U.S. state to launch an official program encouraging all citizens to purchase their prescription drugs through Canadian Internet pharmacies.

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## Internet Pharmacies

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Drugs that are meant for Canadian use are increasingly being exported to the U.S. and this could result in a worsening of existing drug shortages for Canadians.

The five states, which also include Illinois, Wisconsin, Washington and Missouri, have a combined population of 33 million – one million more than the population of Canada.

In a letter sent to its members last month, the Manitoba pharmacy regulator informed internet pharmacies in that province that they must end the practice of “co-signing”, whereby Canadian-licensed doctors are paid up to \$10 simply to add their signature to a prescription coming from the U.S. The Canadian doctors never see or examine the U.S. patients, a practice condemned as unethical care by provincial medical regulators.

Because internet drug traders rely completely on “co-signing”, cross-border traders are now threatening to leave Manitoba, in search of provinces with less stringent standards.

“We need to ensure that the internet pharmacies don’t just move from province to province,” explained Louise Binder of CTAC. “This is why we need a national solution at the federal level. Drugs that are meant for Canadian use are increasingly being exported to the U.S. and this could result in a worsening of existing drug shortages for Canadians.”

The Colleges of Physicians and Surgeons in British Columbia, Saskatchewan, Manitoba, Ontario and elsewhere have censured and fined doctors engaging in the practice of “co-signing”. Some of these doctors have made hundreds of thousands of dollars per year through this practice, which the groups lobbying for an end of this unethical practice view as “selling signatures for cash”.

“We will continue to advocate on behalf of concerned Canadian patients until the cross-border drug trade industry is stopped,” said Binder. ■

**A**long with being concerned about the unethical practice of cross-border internet pharmacies, the groups are also concerned that:

- ▶ Drugs that are meant for Canadian use are increasingly being exported to the U.S. This could result in a worsening of existing drug shortages for Canadians.
- ▶ The risk of further delays by pharmaceutical companies in bringing breakthrough drugs to market in Canada because the drugs are diverted into more profitable U.S. markets. There have already been reported cases in Canada.
- ▶ Drug prices in Canada will likely rise to combat cross-border internet pharmacies. While the prices of patented drugs are currently regulated in Canada, drug importation legislation in the U.S. Congress and surging demand from Americans are putting pressure on Canadian prices to rise.
- ▶ The increased price of Canadian medicines will place further burdens on the already strained public and private drug plans and individuals who rely on these plans. This will make it nearly impossible for many individuals who purchase their own drugs to afford them. The result will be fewer affordable drugs in Canada for Canadians.

# National Pharmacare: **Where Are We Now?**

by Elisabeth Fowler

**THE FIRST MINISTERS MEETING** on *The Future of Health Care* held September 15, 2004 succeeded in producing a shared agenda to renew health care in Canada, focusing on a consensus to ensure Canadians have access to the care they need, when they need it.

Prime Minister Paul Martin announced \$41 billion of new federal funding to support a 10-year plan to strengthen health care. This money will be made available through the Canada Health Transfer and will also begin to address the issue of national pharmacare. An additional \$500 million has been allotted to help progress catastrophic drug coverage and home care. A task force was mandated at the meeting to develop and implement a national pharmacare strategy.

The ministerial task force is charged with developing a pharmaceutical strategy for implementation by June 30, 2006 (please see table at end of the article for more details).

Health ministers met for a second time in mid-October to discuss in detail the goals outlined during the First Ministers meeting in September. In October it was decided that the National Pharmaceutical Strategy task force would be chaired by Federal Minister of Health, Ujjal Dosanjh, and co-chaired by British Columbia's Minister of Health, Colin Hansen.<sup>1</sup> The provinces have agreed to focus on studying bulk-buying, and are committed to seeing the 10-year plan to improve health care come to fruition. Additional action items that were looked

at more carefully at the meeting in October include wait time reduction, improving access, home care, primary care reform, access to care in the north, prevention and health promotion, innovations, accountability and dispute resolution. The Ministers hope to base their goals on the principles of universality, accessibility, portability, comprehensiveness and public administration set out by the Canada Health Act.

Federal Health Minister Ujjal Dosanjh and his provincial counterparts "decided to reflect on how to proceed and will meet again in January".<sup>2</sup>

In the meantime, while it appears unlikely that progress will be made with national pharmacare in the immediate future, there is a genuine ambition to create a system where the needs of Canadians are met. ■

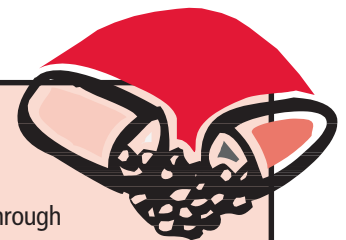
**Editor's note:** CTAC has been following this issue and will be developing a position on it. In preparation for this, CTAC held focus groups in Vancouver, Montreal, Calgary, Toronto and Moncton in the fall. The information gathered from these focus groups will help CTAC to develop its position. Check future issues of the CTAC newsletter for more information.

<sup>1</sup>CBC News – Health Ministers Upbeat After Annual Meeting, Web Posted October 17, 2004, Accessed November 30, 2004, [www.cbc.ca/news](http://www.cbc.ca/news)

<sup>2</sup>The Canadian Press, CTV's Sarah Galashan, 10.2004

## Ministerial Task Force for National Pharmaceutical Strategy:

Catastrophic Drug Coverage	Determine cost options, develop and assess options.
National Drug Formulary	Establish a common drug formulary for participating jurisdictions.
Drug Approval Process	Access to breakthrough drugs for "unmet health needs" will be accelerated through improvements to the approval process.
Safety Surveillance	Evaluation of 'real-world' drug safety and effectiveness.
Buying Strategies	Purchasing strategies that will allow provinces to obtain the best prices for drugs and vaccines.
Prescribing Procedures	Ensuring action that drugs are used only when needed and the right drug is used for the right problem.
Electronic Health Records	Broaden the practice of e-prescribing through accelerated development and deployment of electronic health records.
Non-Patented Drug Access	Accelerate access to non-patented drugs & achieve international parity on prices of non-patented drugs.
Cost Analysis	Analysis of cost drivers & effectiveness, using best practice models.



\*Quebec will have its own pharmacare program.

# Costly new therapies put CTAC's advocacy skills to the test



**To list or not to list, that is the question**

*by Louise Binder and Ron Rosenes*

**OBTAINING COVERAGE** for costly new HIV therapies on the provincial formularies has put the advocates at CTAC on a steep learning curve. As health care costs spiral upwards, governments have moved into a cocoon of cost containment. Advocates now have to jump through many hoops to convince government drug plans to list every antiretroviral that is approved for sale in Canada on provincial drug reimbursement plans. While the science and the art of treating HIV have made great advances, the development of drug resistance means that we need every treatment option available through public drug programs, particularly for those whose present regimen is failing.

Let's look at some recent examples. Fuzeon (Enfuvirtide, T-20) was approved for sale in Canada in July, 2003. It is the first drug in a new class of entry inhibitors that prevents the fusion of HIV with the CD4 cell, stopping HIV before it can get into the cell. New technology and novel targets come at a very high price. Fuzeon is complex to manufacture, and must be prepared and injected subcutaneously by the patient. It often causes a reaction at the injection site, but it is saving lives. Most, though not all, of the provincial formularies have agreed that Fuzeon is a valuable salvage therapy and will cover it for that purpose only. Each request by a physician is reviewed on a case by case basis. It makes sense to reserve its use for

salvage given the high cost and no one is arguing that it be used as a first line therapy. The role of advocacy has been to ensure appropriate criteria for use in salvage settings. This has been somewhat successful depending on the province.

Videx EC (ddl, Didanosine) is another story. It is not a new drug; it is a reformulation into an extended release pill of the buffered tablet that has been the cause of serious gastrointestinal problems in HIV+ users. ddl is considered a "backbone" drug in many combinations, but the new extended release form has been difficult to get onto many provincial formularies because it is priced one-third higher than the original. We have made strong arguments that there are savings to be realized from the new formulation because people do not need to purchase more drugs to counteract these gastrointestinal side effects.

As well, the total cost of some combinations containing Videx EC can actually total less than others. That is why it is important to look at costs based on combinations, which are how these drugs are used. Unfortunately, governments do not always appear to heed logical pharmacoeconomic arguments and think that "cost effectiveness" is only about the price of a single "comparable" drug. What about the social costs and the costs of medications needed to deal with side effects? What about the fact that everyone seems to have a different virus that reacts in a particular, sometimes mysterious, way to drugs? At a recent skills building in Toronto, advocates agreed that it is far easier to make the case for new formulations or for new drugs in existing classes that are cost neutral (cost the same).

An additional layer of approval for coverage by provincial drug plans has added a major hurdle in the last year. The Common Drug Review (CDR), which was meant to create a single and unified system of approval to the various provincial drug plans, has so far succeeded mainly in adding a layer of non-transparent bureaucracy, and not a very knowledgeable one at that. While the CDR gets up and running (Quebec has opted out of CDR), the provinces continue to do their own reviews with the result that another six months have passed before the decision to list is made. To list or not to list, that is the question. If the CDR says yes, the provinces can still turn the recommendation down, so, in effect, "no" means "no" and "yes" means "maybe". CTAC is developing a position

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## CTAC's advocacy skills

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paper in the near future on CDR with recommendations on how to improve its many shortcomings.

Atazanavir (Reyataz) is the first HIV drug to go through CDR. A check on the Health Canada (HC) website reveals that it took almost 6 months after the drug was approved by Therapeutic Products Directorate (TPD) at HC to recommend this new protease inhibitor (PI) to the drug plans for listing. It is priced the same as Kaletra but it is usually boosted with ritonavir which adds to the cost. It received a priority review at TPD but not at CDR. Clinical studies continue to show that this PI has a favourable lipid profile, i.e. that it does not appear to raise the levels of fats in the blood compared to other drugs in the same class. Ironically, Aboriginal people who receive their health benefits from a federal drug program (Non-insured Health Benefits Program) can only access Atazanavir if they have failed other PIs. Disproportionately high levels of lipids among Aboriginal people make this a strange exception.

The story of tenofovir is stranger still. While the U.S. Department of Health and Human Services guidelines recommend this nucleotide (a subclass of nucleosides) for first line treatment, the CDR has recommended that the provinces list it only, with much documentation, for deep salvage. The manufacturer succeeded in convincing the Canadian price regulator, Patented Medicines Prices Review Board (PMPRB), that the higher price for tenofovir than other nucleosides based on its different molecular form was not excessive (the PMPRB didn't feel that tenofovir, a nucleotide, was much different than a nucleoside and classed it as such). It delayed launching the drug for many months thereafter, concerned that the big price difference with the U.S. would cause a problem if Americans turned to cross-border internet pharmacies for lower prices. Delays have been compounded by the unfavourable CDR review, which we suspect favoured price over the potential benefits for some of the reduced side effects.

## What about the **social costs** and the **costs of medications** needed to deal with **side effects**?

### How can you get involved in advocacy for drug coverage in your province?

We are living in a world of cost containment and fiscal restraint. Health care budgets and the publicly-funded drug reimbursement plans in particular have come under fire. Unfortunately, the decision-makers are often less than creative in how they deal with the issue. Increasingly, decision-makers are refusing point blank to list the drugs we need, aided and abetted by the CDR; or they are using valuable human resources to deny coverage for drugs that are available by exception only. It feels like the exceptions are becoming the rule.

It is easy to understand why people think that there is nothing they can do to influence these decisions. We would strongly argue that this is not the case. We may not win every battle but this does not mean that we should sit back and let governments make life-altering decisions about drug coverage without having to justify their decisions. We must continue to let government know that we are watching their actions closely.

If there is a provincial or local organization that takes on these issues, let them know you are being denied coverage. Contact CTAC to find the name of the provincial representative in your area by either visiting [www.ctac.ca/english/contact.html](http://www.ctac.ca/english/contact.html) for a list of provincial representatives and their email addresses; emailing the CTAC office at [ctac@ctac.ca](mailto:ctac@ctac.ca) or calling us at (416) 410-6538. Get your doctor or pharmacist involved. He or she can be a great ally in supporting the claims you are making and can also describe the countless wasted hours spent to compile information or to order expensive and unnecessary tests.

Write directly to the government to explain the problem and demand a meeting with the decision makers. Personal stories combined with arguments from treatment advocates are very strong tools. CTAC is developing tools to help you build your advocacy case. We can help you build a team or form a network

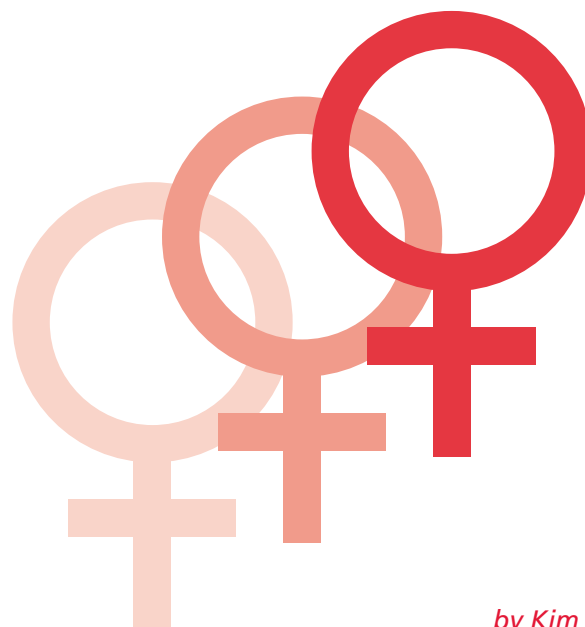
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## WOMEN'S ISSUES: UPDATE

# Blueprint for Action on HIV and Women in Canada

The Planned Parenthood Federation of Canada (PPFC) hosted a meeting on September 11 & 12, 2004 in Ottawa, Ontario. The purpose of this meeting was to bring together a small, representative number of groups who work in the area of HIV & women. The goal of the meeting was to explore the interest in forming a new coalition of groups in order to bring women's HIV/AIDS issues forward on the national agenda.

The group decided unanimously that the 2006 International Conference on HIV/AIDS would provide us with an opportunity to showcase women's specific HIV/AIDS concerns. To that end, the following coalition name was proposed: Blueprint for Action on HIV and Women in Canada: Toward 2006. The goals identified by the group are to work to ensure that the international conference features a component addressing the global issue of women and HIV and to develop a series of recommendations or demands to Canada's political leadership regarding specific policy and program changes impacting women living with and affected by HIV/AIDS in



by Kim Thomas

Canada. These demands will be prepared through extensive consultation, including two stakeholders meetings scheduled over the coming two years.

The coalition plans to approach other AIDS organizations (national and regional), women's health organizations and other stakeholders to participate in this coalition. If your organization is interested in more information about this coalition, please contact Helen Kahlke at PPFC at (604) 853-8623 or [hkahlke@ppfc.ca](mailto:hkahlke@ppfc.ca). For more information about CTAC's role in this coalition, please contact Michelle Marchione at (416) 410-6538 or [ctac@ctac.ca](mailto:ctac@ctac.ca). ■



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**CTAC's advocacy skills**  
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that includes people from other disease and disability groups. Governments need to be reminded that we are more than a cost to the health care system. The greatest argument we can make is that we want to lead healthy and productive lives. ■

*For more information on the CDR see "Common Drug Review: Slow or Slower" in the October 2003 newsletter, Volume 5, Issue 3 and "You want that drug...when?" in the October 2004 newsletter, Volume 6, Issue 3 available online at [www.ctac.ca/english/back\\_issues.html](http://www.ctac.ca/english/back_issues.html)*

# PROVINCIAL UPDATE

by Philip Lundrigan

## Equitable access for all

Equitable and timely access to appropriate treatments has been fundamental to the work of CTAC since its inception. While CTAC defines "treatments" very broadly, this article will focus on prescription drugs. There are numerous layers of bureaucracy and approvals that are necessary before prescription drugs actually reach the hands of those who need them. At the federal level we have the drug approval process (Therapeutic Products Directorate – TPD), pricing review (Patented Medicines Prices Review Board – PMPRB), and a national review process initiated by the provinces (Common Drug Review – CDR), which includes a pharmacoeconomic review. The Canada Health Act has, as one of its pillars, accessibility, but since health care is administered by the provinces/territories, each province or territory ultimately makes its own decisions about what drug coverage will be provided to its citizens and under what conditions. When federal drug programs (such as the First Nations and Inuit Health Branch, Canadian military, police) coverage are added

to the mixture we end up with prescription drugs being covered by some 19 different drug programs in Canada.

Many factors are taken into consideration by the various drug plans when making decisions about what that particular plan will cover including: number and demographics of population, seriousness of illness being treated, other currently available treatment options, and of course drug cost. The result is that treatment access varies quite significantly across the country. ■

## Erratum

Ward Health Strategies was omitted from our list of funders in our 2003/2004 Annual Report. We wish to acknowledge Ward Health Strategies for its ongoing contributions to the work of CTAC and to apologize for this omission.

## Latest News on Microbicides

by Joanne Acri

To mark World AIDS Day, The Honourable Aileen Carroll, Minister of International Cooperation, made a groundbreaking speech about the impact of HIV/AIDS on women and girls around the world, and what Canada and Canadians can do to stop the spread of this deadly disease.

The Minister announced a total package of over \$100 million in new funding to help protect women and girls from HIV. One component of this package is the significant contribution of \$15 million over 3 years for microbicide research, a desperately needed prevention strategy for women in developing countries who may not be able to insist on condom use. Microbicides are intended as vaginally applied products that prevent HIV transmission and are seen

as crucially important for women who will be empowered to stop the spread of this disease.

The efforts of many individuals, groups and lobbyists helped to bring microbicides into the spotlight here in Canada, including the group championing this work in Canada, the Microbicides Advocacy Network (MAG-net), in which CTAC participates.

Of the 37.5 million people infected with HIV worldwide, more than half, 19.2 million, are women. In Canada, nearly 25% of new infections occur in women, up from 12% just a few years ago. Young women aged 15 to 29 years account for almost 40% of new HIV infections reported among women in Canada. ■

## Clinical Trials: Update



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

### Rescue therapy trial: safe and relevant

At meetings in Washington, in October, an independent data safety monitoring board declared that the tri-national study known as Options in Management of Antiretrovirals (OPTIMA or CTN 167) is safe, and addresses questions of clinical relevance.

The objective of this randomized, controlled trial of clinical management is to compare the effect of different management strategies on survival time to AIDS or other serious health problems, virologic and immunologic response, quality-of-life measures and other health outcomes during an average of two years of follow-up.

Participants are allocated randomly to one of four treatment groups: mega-antiretroviral therapy (mega-ART, five or more anti-HIV drugs) or standard-ART (up to four anti-HIV drugs) with or without a three-month antiretroviral drug-free period (structured treatment interruption) before re-treatment. Eligible participants must have had the failure of at least two multi-drug regimens containing drugs of each of three classes.

There has been controversy about interrupting anti-HIV treatment in this setting – even temporarily – as clinical opinion is divided. And the few clinical trials that have been conducted of treatment interruptions before so-called salvage, or rescue, therapy have generated mixed results.

Many questions therefore remain. The OPTIMA study is large enough to address these questions.

“We’re not surprised, but pleased to be given this green light by the independent data and safety monitoring board as it confirms what we have suspected – this trial is safe and highly relevant,” says principal investigator Dr. William Cameron.

“We need the results of studies such as OPTIMA to help settle differences of clinical opinion.”

For more information on this study, contact the Canadian HIV Trials Network’s Information Manager, Sophie Geeraerts, at 1-800-661-4664. ■

## CALENDAR OF EVENTS WINTER 2005

- **February 3<sup>rd</sup>-4<sup>th</sup>**  
**Epidemics in Our Communities**  
Regina, Saskatchewan  
Contact: [aidsprograms@sasktel.net](mailto:aidsprograms@sasktel.net) or 304-924-8420
- **February 22<sup>th</sup>-25<sup>th</sup>**  
**Conference on Retroviruses and Opportunistic Infections**  
Boston, Massachusetts  
Contact: [info@retroconference.org](mailto:info@retroconference.org) or 703-535-6862
- **April 10<sup>th</sup>-13<sup>th</sup>**  
**17<sup>th</sup> National HIV/AIDS Update Conference**  
Oakland, California  
Contact: [robert.giannasca@amfar.org](mailto:robert.giannasca@amfar.org) or 212-806-1754
- **May 12<sup>th</sup>-15<sup>th</sup>**  
**Canadian Association for HIV Research Conference**  
Vancouver, British Columbia  
Contact: [info@cahr-acrv.ca](mailto:info@cahr-acrv.ca) or 604-642-6429 x307
- **June 15<sup>th</sup>-21<sup>st</sup>**  
**Annual General Meetings and PLWHIV/AIDS Fora**  
Ottawa, Ontario
  - Canadian AIDS Society  
Contact: [CASinfo@cdnaids.ca](mailto:CASinfo@cdnaids.ca) or 1-800-844-1058
  - Canadian AIDS Treatment Information Exchange (CATIE)  
Contact: [info@catie.ca](mailto:info@catie.ca) or 1-800-263-1838
- **October 15<sup>th</sup>-18<sup>th</sup>**  
**CTAC Annual General Meeting**  
Location TBA  
Contact: [ctac@ctac.ca](mailto:ctac@ctac.ca) or 416-410-6538

## Save the Date!

CTAC’s Annual General Meeting will be held

**October 15-18**

**[www.ctac.ca](http://www.ctac.ca)**

## Ministers confirm their commitment to fighting HIV/AIDS in Canada

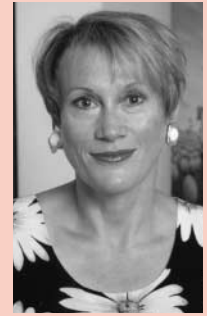
**AT A BREAKFAST HOSTED** by Canadian AIDS Society on World AIDS Day, Ministers Ujjal Dosanjh (Health) and Dr. Carolyn Bennett (State-Public Health), spoke passionately about HIV/AIDS and the need for enhanced partnerships between Health Canada, the new Public Health agency, national organizations, community-based AIDS organizations and people infected with and affected by HIV/AIDS. They also stated that other federal government departments need to be at the table in the fight against HIV/AIDS. With that said, Minister Dosanjh announced the creation of an ADM (Assistant Deputy Ministers) roundtable that will be led by the Public Health Agency of Canada which will facilitate the implementation of the federal government's new initiative to address HIV/AIDS in Canada.

In her address, Dr. Bennett spoke of the increase of HIV infection rates among women and girls and the need for prevention programs which address women's sexual health. Dr. Bennett stated that programs and policies need to enable women to determine their own protection from HIV and to improve their health when living with HIV/AIDS. Minister Dosanjh noted that an announcement regarding the \$5-million to community-based AIDS organizations will be made over the next two to three weeks. The funding issue was also on the agenda at a meeting held on November 30, 2004, which was attended by nine national HIV/AIDS groups, including CTAC.

Minister Dosanjh expressed his support for needle exchange programs in prisons and said that he would be addressing the issue with the Deputy Prime Minister and Minister of Public Safety and Emergency Preparedness, the Honourable Anne McLellan. Minister Dosanjh also addressed the growing infection rates among Aboriginal communities. *With excerpts from : Advocacy Update / Mise à jour : Défense des Droits, December 3, 2004 Canadian AIDS Society / Société canadienne du sida ■*

## CHAIR'S REPORT WINTER 2005

by Louise Binder



**AS WE ENTER** the middle of the decade of the new millennium, I have been wondering how "new" it really is. Research into the development of drugs that actually stop HIV from entering our cells is very hopeful and exciting. If successful, they may lead us much closer to HIV eradication since HIV circulating in the blood with no way to enter healthy cells dies within about six hours. We are also getting second and third generation drugs in existing classes that appear to be less toxic and without cross resistance to other drugs in their class.

As I have been listening to researchers describe these advances with growing excitement, I have also been wondering why I am not as wholeheartedly encouraged as I should be. I have this feeling that these drugs will be like many others for people with HIV/AIDS in Canada. We already see the Common Drug Review (CDR) recommending to the nine participating provinces not to list a badly needed HIV drug on public drug reimbursement plans because it is not a pharmacoeconomically wise decision (meaning it costs more than other drugs in its class so drug budgets shouldn't pay for it). Will this continue as more, and probably more expensive drugs become available for market in Canada?

Let's hope that pharmaceutical companies recognize that there is only so much money to go around; that CDR revamps its processes to make better informed decisions; and that public and private payers recognize the importance to overall health and other budgets for keeping people healthy and productive. That really would be something "new" for 2005. ■

## BOARD OF DIRECTORS

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## 2004 FUNDERS

Health Canada

Abbott Laboratories • Boehringer Ingelheim

• Bristol-Myers Squibb • Gilead Sciences •

GlaxoSmithKline in partnership with Shire

BioChem • Hoffmann-La Roche • Pfizer

Canada, Agouron Division • Schering

Canada • Ward Health Strategies

## 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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## MEMBERSHIP

Membership applications are available by contacting the CTAC office or by visiting the CTAC web site at [www.ctac.ca/english/membership.html](http://www.ctac.ca/english/membership.html).

### 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

## CONTACT US

### Canadian Treatment Action Council (CTAC)

P.O. Box 116, Station "F"  
Toronto, Ontario M4Y 2L4

Phone

and Fax: (416) 410-6538

Email: [ctac@ctac.ca](mailto:ctac@ctac.ca)

Website: [www.ctac.ca](http://www.ctac.ca)

## 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

## PUBLICATION CREDITS

**This newsletter is a quarterly publication.**

**Editorial Board:** Daryn Bond / Françoise Grothé / Enrico Mandarino (Chair) / Ken Monteith

### Editorial Committee:

Ron Rosenes / Michelle Marchione

### Editorial Co-ordination:

Michelle Marchione and Joanne Acri

**Translation:** Alain Boutilier

**Printing:** The Printing House

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