A STATUS REPORT ON
The National Pharmaceuticals Strategy: A Prescription Unfilled
January 2009
FOREWORD FROM THE CHAIR

The National Pharmaceuticals Strategy was established in 2004 to develop nationwide solutions to some of the concerns about the safety and affordability of prescription medications in Canada. Individual governments have various programs to improve the accessibility, safety, and affordability of prescription medications, but there are limits to what they can do on their own. This patchwork of different initiatives across the country also means that not all Canadians have the same advantages.

The strategy was part of the 2004 health accord, the First Ministers’ 10-Year Plan to Strengthen Health Care, in which participating* governments agreed to make a variety of improvements to their health care systems, accompanied by additional annual payments from the federal government.

* Quebec has its own pharmacare program and is not part of the development of the National Pharmaceuticals Strategy, but the province shares information and best practices.
In the accord, the prime minister and premiers (First Ministers) gave the federal, provincial, and territorial ministers of health the job of collectively addressing a number of priority areas in pharmaceutical reform (see *The nine elements of the National Pharmaceuticals Strategy*, page 14).

In lay terms, the strategy was intended to:

- develop options for *catastrophic drug coverage* to ensure that Canadians don’t face undue financial hardship to pay for prescription medications they need, regardless of where they live (*catastrophic* refers to the impact on a person’s finances, not to his or her medical condition);
- find ways to reduce the costs of prescription medications to governments and individual Canadians;
- improve patient safety by helping health care professionals provide the most appropriate and safest prescriptions for their patients, and by implementing electronic prescribing to reduce medication errors;
- improve the way medications are monitored after they are released onto the Canadian market to protect patients from unanticipated side effects;
- ensure that all Canadians have access to the same prescription drugs through their government drug plans, based on a common national drug formulary; and
- provide faster access to new emerging drugs for unmet health needs.

In this report, we look more closely at some of the problems the National Pharmaceuticals Strategy was intended to solve, and its progress more than four years later. Our commentary on these findings can be found in a companion document, *A Commentary on the National Pharmaceuticals Strategy: A Prescription Unfilled*, available at www.healthcouncilcanada.ca.

We have also used this report as an opportunity to educate Canadians about the importance and complexity of pharmaceutical reform. This area has not received the same level of public interest as changes to other areas of the health care system, perhaps because the concerns about prescription medications are not well known or understood. In the following section, *Why pharmaceutical reform matters*, we provide compelling data and a snapshot of some of the significant challenges related to the use of prescription drugs in Canada. It’s important to note that the National Pharmaceuticals Strategy was designed to address some, but not all, of these concerns.

When we began this report, the economic climate was much more favourable. Now, as more Canadians lose their jobs and associated health benefits, more people are likely to need help with the costs of their medications. The work of the National Pharmaceuticals Strategy is more important than ever. It has become even more critical to find ways to reduce the costs of prescription drugs, and to ensure that Canadians continue to have access to safe and appropriate medications.

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Why pharmaceutical reform matters
Canadians take a lot of prescription medications. In two independent 2007 surveys of Canadian adults, half (51-53%) said they take at least one prescription drug, while approximately 15% said they take four or more. (See Figure 1.) The numbers climb much higher for those with chronic diseases (37% take four or more prescriptions) and seniors (40% take four or more).\(^1\)\(^2\)

In addition, the use of prescription drugs has soared in the last decade: The number of prescriptions filled each year in Canadian pharmacies nearly doubled over a recent 10-year period, from approximately 234 million in 1996 to more than 422 million in 2006.\(^3\)

In most respects, these are positive developments. Prescription medications are often the best and most cost-effective treatment for many diseases, and are increasingly used in place of other interventions. But as the use and price of pharmaceuticals have increased, so have issues and concerns—particularly about the safe and appropriate use of medications, and the challenge of the increasing financial burden to Canadians and governments.

**Safety and appropriate use**

Canadians may assume they are receiving safe and effective medication for their conditions, but this isn’t always the case. While most Canadians take their medications without incident, too many people receive an inappropriate prescription. The medication may not be right for them or their condition, may be the wrong dose, or may react with other prescription drugs and treatments in ways that cause unforeseen complications and health problems. Sometimes people are not given a prescription when they need one, which can also have negative effects on their health.

The main causes of problems have been shown to be inappropriate prescribing, the underuse or incorrect use of medications by patients, and the lack of continuous and adequate tracking of problems.\(^4\)\(^5\)\(^6\)

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**FIGURE 1**

**Half of all Canadian adults take at least one prescription medication**

In an international survey of seven countries, 53% of Canadian respondents said they take at least one prescription medication: more than one third (38%) take between one and three prescriptions, and one in seven (15%) takes four or more. The percentage of adults in other countries who take at least one prescription medication ranges between 46% and 59%.

Question: “How many different prescription medications are you currently taking?”

Note: Percentages may not add up to 100% due to missing, refusal, and “don’t know” responses.

Who can prescribe?

Although the majority of prescriptions are issued by medical doctors, other health professionals can prescribe medications in a more limited way. All dentists, for example, can prescribe medications for pain relief. And in some provinces and territories, health professionals such as pharmacists, nurse practitioners/extended practice nurses, midwives, podiatrists, and optometrists can prescribe certain medications. The trend to extend prescribing authority to more health professionals means that more prescribers need accurate, current, and comprehensive information on medications and patients’ histories.
MEDICATION ERRORS ARE FAR TOO COMMON

In the years since the National Pharmaceuticals Strategy was established, research has begun to highlight the extent of medication errors in Canada:

> A 2008 study of a busy Vancouver hospital showed that 12% of emergency department visits by adults were related to problems with medications.8

> In a 2007 international survey, 6% of Canadian respondents said that they had either been given a wrong medication or wrong dose in the past two years. This survey also showed that 10% of Canadians who have two or more chronic health conditions reported experiencing a medication error.2 (See Figure 2.)

> In another 2007 survey, 4% of Canadian respondents said they had been given a wrong prescription at a pharmacy and 18% of those said it caused a very serious health problem.1

> A 2007 study showed that between 8-12% of seniors in four provinces (Alberta, Saskatchewan, Manitoba, and New Brunswick) had a long-term prescription for a high-risk drug on the Beers List, an internationally recognized list of drugs that are identified as potentially inappropriate to prescribe to seniors due to an elevated risk of adverse effects.9

> A 2005 study at a Moncton hospital showed that 40% of patients had inconsistencies or omissions in their prescription medication treatment plan at the time they were discharged from the hospital.10

> A 2004 study by an Ottawa hospital showed that 72% of the adverse events reported by patients in the 14 weeks after leaving the hospital were caused by medication errors.11

> A 2004 study showed that 7.5% of adult patients in Canada experience some kind of adverse event in the hospital, and the second most common cause is medications.12

![Figure 2](image_url)

**Six percent of Canadians report medication errors**

In an international survey of seven countries, 6% of Canadian adults said they were given the wrong medication or wrong dose when filling a prescription or while hospitalized in the past two years. Ten percent of those who have two or more chronic health conditions said they experienced this type of medication error. Canada is not alone in struggling with this issue; the results were similar in other countries.

Question: “In the past 2 years, have you ever been given the wrong medication or wrong dose by a doctor, nurse, hospital or pharmacist when filling/collecting a prescription at a pharmacy or while hospitalized?”

Many unexpected and often preventable incidents involving medication are severe enough to require hospitalization. Others happen to patients who are already in the hospital. Patients are also at risk for experiencing medication-related problems during transitions of care, such as when they are discharged from a hospital, as noted in the 2005 Moncton hospital study cited earlier. In the 2004 Ottawa hospital study, the medication errors reported after discharge were related to a lack of ongoing monitoring. These findings indicate that too many Canadians are at risk for problems with their medications.

Many medication-related problems and deaths internationally are preventable. In a review of studies conducted worldwide, health problems related to medication accounted for an estimated 3-9% of hospital admissions. Of all these, 50% were judged to be preventable. This helps to illustrate the significant impact of medication-related incidents on people’s health, as well as the strain on health care systems everywhere.

Seniors are a particularly vulnerable population, as they are often on multiple prescriptions and may be more sensitive to medications and their interactions. A review of international studies found that up to 88% of medication-related hospitalizations of seniors are preventable. A study in one Canadian hospital showed that 41% of admissions among seniors involved problems with medication, 97% of these were potentially preventable, and most involved frequently prescribed medications. Although there is little research on the costs of all medication-related problems in Canada, one study estimates that preventable medication-related incidents and deaths in seniors alone cost approximately $11 billion annually.

PATIENTS LACK GOOD INFORMATION

Many Canadians don’t use their medications correctly, which can lead to health problems or missed health benefits. Although there are no comprehensive data on the scope of this problem, the 2008 Vancouver hospital study cited earlier provides some insight: more than one-quarter (28%) of the medication-related visits by adults to the emergency department were because patients had not taken their prescribed medication, or had taken it incorrectly.

A lack of appropriate and clear information for patients—about side effects, drug interactions, and how to take a medication—can have very serious consequences. Yet two 2007 surveys indicate that Canadians are not getting the information they need about their medications.

In the 2007 Canadian Survey of Experiences with Primary Health Care, 39% of Canadian adult respondents said that their doctor or pharmacist had rarely or never reviewed and discussed all their different medications in the last 12 months. And in the Commonwealth Fund 2007 survey, 15% of Canadian adult respondents who were hospitalized in the past two years said they did not receive counselling about their prescription medications before they were discharged.
Steps and stages of safe and effective medication use

In an ideal situation:

- the patient receives a timely and correct diagnosis;
- the health professional has full knowledge of the patient’s condition (e.g. co-morbidities, allergies, competency to properly use the medication), prescribes appropriately, and has a measurable objective for the patient’s health for each prescription;
- the medication is effective and has an acceptable safety profile;
- the patient can afford the prescribed medication or is covered by insurance (if he can’t, he may not fill the prescription);
- the pharmacist dispenses the medication correctly and the patient receives appropriate advice on how to take the medication;
- the patient takes it as prescribed or has someone who can assist to see that it is taken properly;
- the patient’s condition is monitored appropriately, and his medication use is reviewed regularly;
- there is access to full patient information;
- the health professionals responsible for the patient’s care communicate regularly with each other; and
- public and private payers look for trends in medication use and prescribing.

Research shows that at least one of these steps is missing for most patients.
Health professionals play a vital role in educating patients about their prescriptions. Patients don’t always know what they should be asking about medication. A US study showed that 91% of patients attending a guided counselling session asked about the potential side effects of a new medication, but only 21% asked about medication interactions and 19% asked how to take the medication.18

Although there is a great deal of written information for patients about diseases and treatments, including medications, much of this information is conflicting, inaccurate, or poorly written.19,20 Research shows that patients want more information about the side effects of medications than they currently receive.21

**MEDICATIONS CAN CREATE UNEXPECTED HAZARDS**

Before medications can be approved for distribution on the Canadian market, drug manufacturers must show the effectiveness and potential side effects through clinical trials. But these studies often examine a limited number of patients under very defined conditions over a limited amount of time and generally only for the intended use of the medication. Still, clinical trials are considered a “gold standard” in scientific research.

When a medication enters the market and is prescribed for a large number of patients in “real-world” settings, unforeseen, serious side effects sometimes arise for some patients or in certain circumstances.

Canadians may remember the worldwide withdrawal of the widely used pain medication rofecoxib (VIOXX®) in 2004, which was found to be associated with an unacceptable increased risk of heart attack and stroke.22,23

**Financial burden of prescription drugs**

Prescription medications can be prohibitively expensive for both Canadians and their insurers, particularly governments and employers. Many Canadians struggle to pay for their medications, an added stress when they may already be vulnerable because of illness or unemployment.

The rising cost of prescription drugs is significantly straining government health budgets, raising serious questions about sustainability. Governments say that drug plan expenditure growth squeezes out other health department priorities, and that overall health budget growth crowds out other government priorities including education and public infrastructure.24

**CANADIANS PAY TOO MUCH FOR MEDICATIONS**

In a 2007 international study, 6% of Canadian adults said that their families spent more than $1,000 in the past year out of their own pockets (not covered by insurance), a higher percentage of respondents than the other seven countries in the survey, except for the US.2

In a 2008 international survey of adults described as “sicker” (those who experienced some specific health challenges—see below), 11% of respondents said that their families spent more than $1,000 in the past year out of their own pockets (not covered by insurance). Many more Canadians with chronic conditions such as diabetes or arthritis had high drug costs: 17% of Canadian adults who have one chronic health condition and 21% who have two or more said they paid more than $1,000 a year out-of-pocket.25

Note: The 2008 Commonwealth Fund survey identified sicker adults as those “who met at least one of four criteria: rated their health as fair or poor; reported that in the past two years they had a serious illness, injury, or disability requiring intensive medical care; had major surgery; or had been hospitalized.”
Each province and territory, as well as the federal government, offers prescription medication benefit plans to cover the costs borne by Canadians. In fact, there are often many different benefit plans within one jurisdiction, offering coverage based on criteria such as age (e.g. for seniors), income (e.g. for people on social assistance), type of health condition, or other factors. Many jurisdictions also offer coverage for the high prescription costs of people who fall between the cracks of other plans. But not all jurisdictions choose—or can afford—to offer the same kinds of benefit plans, and the criteria vary widely. As a result, not all Canadians have the same access to affordable medications; someone may be eligible for a government drug plan in one province, but have to pay out-of-pocket if he or she moves to another.26,27

Between 60% and 75% of Canadians have private insurance coverage for prescription drugs, and on average about 25% (ranging from 9% to 43%) qualify for government reimbursement.27,28 But even those with private coverage can struggle to pay when their medication costs are high. When insurance companies are faced with the increasing costs of prescriptions, eventually they look to their beneficiaries to contribute more to the total cost through higher premiums, larger deductibles, and co-payments. Insurance companies might also opt to drop coverage of some medications. In some cases, private plans will pay for prescription costs only to a yearly or lifetime maximum, or will not cover certain medications at all. And the loss of a job that includes private insurance coverage can catapult someone with high prescription costs into a financial crisis, placing undue stress on patients and their families.

**TOO MANY CANADIANS CAN’T AFFORD THEIR PRESCRIPTIONS**

When out-of-pocket medication costs become too high to manage, some people cut corners in ways that can compromise their health.29,30 In the Commonwealth Fund 2007 survey, 8% of Canadian respondents said they had not filled a prescription or had skipped a dose in the past year because of the cost.2

Other research confirms that patients who can’t afford medications often fail to get their prescriptions filled, cut back on the dosage without telling their doctor or pharmacist,29 or share the medications of family or friends.31

High prescription costs now pose a similar financial threat to some Canadians that hospital care and doctors’ fees once posed in the days before these services were funded by governments. This isn’t acceptable to Canadians: In a 2006 public opinion survey, 83% of Canadians said that governments should ensure there is a limit to how much individuals should personally pay for the costs of their prescription medication. Even more respondents (90%) said that if a medication is covered by one province, it should automatically be covered by other provinces.32
SOARING COSTS STRAIN THE BUDGETS OF INDIVIDUALS, INSURERS, AND GOVERNMENTS

The money spent on pharmaceuticals is consuming an increasing size and proportion of health care dollars, and the costs are escalating faster than the rate of inflation. Spending on prescription medication in Canada grew at an average annual rate of 10.6% between 1985 and 2005, compared with total health spending which grew at an average annual rate of 6.5%. In 2006, total drug expenditures were $25.3 billion. (This includes both prescription and non-prescription medications, but not drugs used in hospitals.) This amount was expected to reach $29.8 billion in 2008. Governments pay approximately 40% of these costs through government drug plans, while individual Canadians and private insurers pay the remaining 60%. They also feel the impact of rising drug costs.

The annual growth in spending largely represents increases in price and use, rather than inflation or changes in population size.

Governments have said that they are increasingly stretched to pay for pharmaceuticals and are diverting resources from other areas of their budgets. Governments also struggle with complicated issues of ethics and funding that surround new, exceedingly expensive drugs to treat rare genetic diseases.

MEDICATIONS ARE TOO EXPENSIVE

One of the major issues is that prescription medications in Canada could be—and should be—less expensive.

Canadians and their governments pay more for medications than many other Western countries. We pay more for generic prescription medications compared to 11 other countries. We also pay more for patented and non-patented branded prescription medications (see below) than most other countries studied (except for Switzerland and the US). (See Figure 3, page 12.)

While generic prescription drug prices dropped in all countries studied in 2005, Canada’s prices dropped by only 0.3% compared to drops of between 1.2% (France) and 32.4% (UK). Similarly, for non-patented branded prescription drugs, Canada’s prices rose by 3.4% whereas most other countries saw a drop in their prices.

These data come from Canada’s Patented Medicine Prices Review Board (PMPRB), which monitors the international prices of patented medications and regulates prices that companies can charge for these drugs based on international comparisons.

Note: As defined by the PMPRB, a patented drug is a drug that is subject to PMPRB price review; a generic drug is sold under the name of its principal ingredients; and a branded drug is sold under a particular trade name.
If Canadian prices had been kept in check and not exceeded international median prices in 2005, spending on non-patented prescription drugs could have been reduced by an estimated $1.47 billion in that year alone.\(^{36}\)

In addition, a recent report from the Competition Bureau states that Canadians could save up to $800 million a year if changes are made to the way private plans and provinces pay for generic drugs.\(^ {37}\)

**SUMMARY**

This is by no means a full picture of the concerns and complexities surrounding the use of pharmaceuticals. But the information presented clearly shows that Canadians face a high risk of preventable problems with their medications. And both Canadians and their insurers (governments and employers) pay a great deal more for prescription drugs than in other countries, straining personal budgets, business competitiveness, and a sustainable approach to financing our health care system.

The National Pharmaceuticals Strategy, established in 2004, was intended to be the vehicle for provinces, territories, and the federal government to collectively address some of these issues. In the next section we will look at what governments agreed to do through the national strategy and the result of their efforts more than four years later.

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**FIGURE 3**

**Canadians pay more than they should for prescription medications**

Canadians pay more for patented, generic, and non-patent branded prescription medications than people in many Western nations studied (six of these countries are shown).

The foreign-to-Canadian price ratios shown in this figure indicate how much less (or more) people pay for their medications in other countries. A foreign-to-Canadian price ratio of 1.0 means that average prices in that country are on a par with Canada; less than 1.0 means the medications have a lower average price than in Canada, and higher than 1.0 means that the average price is higher.

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A closer look at the National Pharmaceuticals Strategy
The National Pharmaceuticals Strategy
Key developments, 2003 to 2008

“No Canadian should suffer undue financial hardship for needed drug therapy.”
2003 First Ministers’ Accord on Health Care Renewal

GROUNDWORK IN 2003
The prime minister and premiers (First Ministers) signed a health accord to increase access to many health care services, including necessary prescription medication. Governments all agreed that no one should suffer undue financial hardship to pay for prescription medications.

This 2003 First Ministers’ Accord on Health Care Renewal committed governments to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage by the end of 2005/06. (Catastrophic refers to the effect on a patient’s finances, not the nature of his or her health condition.)

The First Ministers also agreed that one of their priorities would be to collaboratively promote use of the best practices in prescribing medications. They also pledged to better manage the costs of all prescription medications, including generic medications, and to ensure that medications are safe, effective, and accessible in a timely and cost-effective fashion.38

“Affordable access to drugs is fundamental to equitable health outcomes for all our citizens.”
10-Year Plan to Strengthen Health Care

STRATEGY LAUNCHES IN 2004
The First Ministers recommended a National Pharmaceuticals Strategy as part of their 10-Year Plan to Strengthen Health Care. The accord stated that “no Canadian should suffer undue financial hardship in accessing needed drug therapies. Affordable access to drugs is fundamental to equitable health outcomes for all our citizens”.39

THE NINE ELEMENTS OF THE NATIONAL PHARMACEUTICALS STRATEGY
The First Ministers directed their health ministers to establish a ministerial task force that would develop and implement a National Pharmaceuticals Strategy with the following nine action items:

1) Develop, assess, and cost options for catastrophic pharmaceutical coverage;

2) Establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness;

3) Accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process;

4) Strengthen evaluation of real-world drug safety and effectiveness;

5) Pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines;

6) Enhance action to influence the prescribing behaviour of health care professionals so that drugs are used only when needed and the right drug is used for the right problem;

7) Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record;

8) Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and

9) Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.39

DEVELOPMENTS IN 2005
Ministers of health met and reaffirmed their commitment to the National Pharmaceuticals Strategy. At that time, they asked their officials to:

› accelerate work on catastrophic drug coverage;

› expand the scope of the Common Drug Review (CDR) to consider all medications, not just the new ones considered after the CDR began its work in 2003. (The CDR is a process that involves evaluating the cost-effectiveness of drugs and making recommendations to governments about whether medications should be funded through their drug plans.);

› work towards a common national formulary (a listing of medications approved as benefits under the various government-funded drug plans) so that all Canadians have access to public funding for the same drugs;
give the Patented Medicine Prices Review Board the additional responsibility to monitor and report on the prices of non-patented prescription medications; and

undertake time-limited research programs on treatments for the rare conditions Fabry disease and MPS1-Hurler Schie syndrome on a risk-shared basis with manufacturers.40

CHANGES IN 2006
The premiers directed the ministerial task force to release a progress report on the National Pharmaceuticals Strategy and to “continue to work on key elements … with a special focus on the catastrophic drug program”.

In a progress report later that year, the ministerial task force stated that the following items of the National Pharmaceuticals Strategy would be given “short to medium term focus”:

- catastrophic drug coverage;
- expensive drugs for rare diseases;
- common national formulary;
- pricing and purchasing strategies; and
- real world drug safety and effectiveness.

A comment in the report stated that this was done to “facilitate timely and concrete results for Canadians”. Several elements of the original 2004 strategy were not given any particular focus and were therefore essentially marginalized:

- accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process;
- enhance action to influence the prescribing behaviour of health care professionals so that drugs are used only when needed and the right drug is used for the right problem; and
- broaden the practice of e-prescribing through accelerated development and deployment of the electronic health record.36

2009: WHERE THE NATIONAL PHARMACEUTICALS STRATEGY STANDS NOW
The first few years of the National Pharmaceuticals Strategy involved “unprecedented”41 collaboration between federal and provincial/territorial governments. But then governments changed, and progress slowed.

Work has continued on various elements by both the federal government and provincial/territorial governments, although not necessarily collectively under the auspices of the National Pharmaceuticals Strategy ministerial task force.

No further public information was available about the strategy until September 2008. The provinces and territories had developed a list of decision points that they made public following their annual meeting that month. This signalled the provincial and territorial ministers’ intent to raise the profile of the National Pharmaceuticals Strategy and to negotiate some elements of it with the federal government:

- Establishing a national standard of pharmacare coverage for all Canadians. The proposed funding agreement would protect the flexibility and autonomy of provinces and territories to define programs for their populations, ensure that prescription drug costs will not exceed 5% of the net income base for their respective populations, and recognize shared responsibility by allocating the cost of catastrophic drug coverage 50/50 between the federal government and the provinces or territories;

- Creating a Canadian Access Program for Drugs for Rare Diseases. The proposed program would involve a centralized, transparent decision-making model with public involvement, a 50/50 split of the cost of these medications between the federal government and provinces or territories, and would require participation in research and monitoring; and

- Supporting a federally funded program to enhance the degree to which drugs are monitored and ensure real-world safety and effectiveness.

The provincial and territorial ministers of health also indicated that from their perspective:

- the intent of a common national formulary has been met through the Common Drug Review process; and

- a nationwide approach to savings in pricing and purchasing is not realistic at this time, but interprovincial collaborations should be separately pursued.24

As of January 2009, there had not been any further public information on the status of these discussions with the federal government, or on the National Pharmaceuticals Strategy.
What was promised and what has happened

In 2008, the Health Council of Canada conducted a review of the National Pharmaceuticals Strategy to monitor how it had progressed in the four years since it was launched.

We compiled a review of its stated progress as of January 2009 through the use of publicly available documents, information from representatives in the jurisdictions, and discussions with experts and academics who work in health policy and pharmaceuticals management.

CATASTROPHIC DRUG COVERAGE

“Develop, assess and cost options for catastrophic pharmaceutical coverage”

The high cost of medications can be financially devastating – catastrophic – for Canadians who don’t meet the criteria for existing public drug plans and who lack health insurance.

Contrary to public perception, it isn’t only people with illnesses such as HIV or cancer who need help with high costs; someone with chronic health conditions and multiple prescriptions could also have difficulty making ends meet.

Governments have agreed – especially in the 2004 health accord – that no one should suffer financial hardship to pay for medication that they need to care for their health.39

Some jurisdictions have programs that specifically address catastrophic drug expenses. Others have drug benefit programs that their residents can access depending on income and whether they have access to private plans to cover their high drug costs.26 Eligible First Nations and Inuit people who are not insured elsewhere may be covered for drug expenses under Health Canada’s Non-Insured Health Benefits program.42

Plans vary in their criteria and in the out-of-pocket costs that residents must pay. In addition, each jurisdiction has a drug formulary or a list of drugs that are covered and the lists in each jurisdiction differ. An expensive drug might be covered in one province, but not another. Atlantic Canada in particular has struggled with the affordability of catastrophic drug coverage.26,43

One element of the National Pharmaceuticals Strategy was to reach common criteria for catastrophic drug coverage – and to determine how much it would cost.39

In the 2006 progress report from the National Pharmaceuticals Strategy ministerial task force, governments said they were looking at consistent nationwide criteria – such as a percentage of income – that Canadians would need to pay for their medications before they would be eligible for catastrophic drug coverage.36

No further public information was released for more than two years. Then, in September 2008 at their annual meeting, the provincial and territorial ministers of health issued a public statement about the National Pharmaceuticals Strategy, saying they held a “common view that Catastrophic Drug Coverage is as essential to Canadians as physician and hospital coverage” and that the “federal government has a funding responsibility to establish a minimum standard of drug coverage for all Canadians”.24 They indicated their intent to pursue this issue with the federal government.
The provincial and territorial governments indicated that they want to establish a mutually agreeable funding formula with the federal government to support a “national standard of pharmacare coverage for all Canadians”. Provinces and territories hope to introduce and/or maintain a program designed to best meet the needs of their residents where, on average, prescription drug costs will not exceed 5% of the net income base for their respective populations. They propose that the federal government share responsibility for catastrophic drug coverage 50/50 with the provinces and territories.24

As of January 2009, no further public statements had been made about catastrophic drug coverage.

**OF NOTE**
Some jurisdictions have made prescription medications more accessible and affordable for their residents in the last few years or have announced their intention to do so: Alberta,44 Newfoundland and Labrador,45 Nova Scotia,46 Prince Edward Island,47 and Saskatchewan.48

**EXPENSIVE DRUGS FOR RARE DISEASES**
“Undertake research on expensive medications for rare diseases”

In 2005, the ministers of health added another area of focus to the National Pharmaceuticals Strategy: the issue of funding costly medications for patients with rare diseases. Governments are facing increasing public pressure to pay for these medications—often without sufficient scientific evidence to support the decision.40

With rare diseases, it’s often very difficult to identify enough patients to conduct an appropriately sized scientific clinical trial that will determine whether new medications help or harm patients—or whether they are sufficiently effective to warrant funding. Governments agreed to undertake time-limited research programs on treatments for Fabry disease and MPS1-Hurler Schie syndrome on a risk-shared basis with manufacturers.36,40 The Canadian Fabry Disease Initiative study was launched in 2006, a three-year research study to gather information on the real-world effectiveness of two forms of enzyme replacement therapy for Fabry disease. The study is being funded by federal and provincial governments and two drug companies that developed the enzymes.49,50

Governments identified that this issue needed a collaborative approach under the National Pharmaceuticals Strategy because of the extremely high cost of these therapies (e.g. $263,000–$290,000 per year to treat Fabry disease51) and the domino effect that can occur if one jurisdiction decides to fund these medications. Other governments are immediately under public pressure to follow suit, and patients from other parts of Canada might understandably want to move to the jurisdiction that funds the drug.

In September 2008, the provincial/territorial health ministers indicated their intent to approach the federal government to establish a Canadian Access Program for Drugs for Rare Diseases. The program would involve centralized, transparent decision-making with public involvement, with the cost of these medications split 50/50 between the federal government and the provinces or territories.24 As of January 2009, no further information was available about this proposal.

**OF NOTE**
In December 2008, Alberta announced its intention to fund expensive medications for people with rare genetic conditions if they have lived in the province for at least five years.44
BREAKTHROUGH DRUGS

“Accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process”

All new prescription medications must be approved as safe and effective by Health Canada before they can be offered to Canadians. But new “breakthrough” medications can be temporarily distributed (with restrictions) for compassionate reasons, such as new medications for conditions such as HIV and cancer.

The goal of the National Pharmaceuticals Strategy in this area was to speed access to breakthrough drugs through improvements to policies and regulations that influence the drug approval process. However, this item was not on the list of priorities in the 2006 progress report on the National Pharmaceuticals Strategy. Even basic elements such as establishing a clear definition for the term “breakthrough drug” have not been completed.

OF NOTE
There have been efforts in some jurisdictions such as Ontario (see Bill 102—Bold legislation in Ontario aims to reduce costs and improve access, page 19) to monitor Health Canada’s review process for promising new therapies so that when a medication is approved, the province does not then need to take additional time to decide whether or not to fund it. This enables patients to receive the medication more quickly.

PRICING AND PURCHASING

“Pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines”

“Accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs”

Governments spend a significant amount of money on medications prescribed in hospitals and through public drug plans. They will spend even more when they extend catastrophic drug coverage nationwide or provide access to highly expensive drugs for rare diseases, making it increasingly important for them to find savings from within their budgets for prescription medications. As noted earlier, Canadians and their governments pay more for medications than many other Western countries.

In 2005, as part of their work on the National Pharmaceuticals Strategy, health ministers asked the Patented Medicine Prices Review Board (PMPRB) to track domestic and international prices of non-patented medications. The PMPRB now does this—but it doesn’t regulate the prices as it does with patented drugs.
Bill 102 – Bold legislation in Ontario aims to reduce costs and improve access

In June 2006, the Ontario legislature passed Bill 102, the Transparent Drug System for Patients Act. According to the Ontario Ministry of Health and Long-Term Care, the government expects to save up to $277 million per year as a result of the new legislation.

The Act includes:

- achieving significant savings by striking the best possible deals when purchasing medications for the government’s Ontario Drug Benefit Program, which currently spends $3.4 billion on medications each year;
- closing loopholes that lead to unacceptable price increases for drugs;
- improving patient access to drugs. The government will permit rapid funding decisions for breakthrough drugs for life-threatening diseases. And if a drug is not approved, the government will tell patients and manufacturers the reasons;
- listening to the views of Ontarians through a new Citizens’ Council that will advise the Ministry on the social aspects of drug policies and priorities;
- strengthening transparency by giving patients a role in drug listing decisions of the Committee to Evaluate Drugs;
- recognizing the valuable role of pharmacists in patient care by paying them for enhanced patient counselling and other professional services;
- using the expertise of Ontario’s pharmacists through a new Pharmacy Council to advise the Ministry and the Executive Officer of the public drug programs; and
- freeing doctors of the burden of paperwork associated with Exceptional Access drugs (drugs that require special authorization/approval by physicians in order for the prescription to be eligible for government reimbursement).
National Prescription Drug Utilization Information System (NPDUIS)

This valuable database can be used to track and analyze prescription medications provided through publicly funded drug benefit plans in participating jurisdictions. It was established with the support of all ministers of health in 2001, as a collaborative effort between the Canadian Institute for Health Information (CIHI) and the Patented Medicine Prices Review Board (PMPRB). The objective was to provide analysis of price, utilization, and cost trends so that Canada's health system has more comprehensive and accurate information on how prescription drugs are being used, as well as the sources of cost increases. In addition, doctors and pharmacists have better information from which to provide care to patients.54,55

In 2004, Health Canada awarded CIHI additional funding to explore opportunities to include data about the prescription drugs funded by the private sector (i.e. insurance companies and out-of-pocket payers).

Over time, analysis of data in the NPDUIS database is expected to help drug plan managers to: 1) access standardized drug product information and comparable data on publicly funded drug formularies across the country; 2) measure and analyze drug utilization; and 3) better understand the difference between drug plans and the impact on drug utilization. The NPDUIS database should enable managers to monitor their cost management strategies and to identify best practices based on comparisons between jurisdictions.

As of November 2008, 11 jurisdictions (federal, provincial, and territorial) were participating in varying degrees. Six are providing claims data, 10 are providing drug plan coverage data, and all jurisdictions are providing information on program policies. Data sharing agreements for claims data are under discussion in three jurisdictions. For NPDUIS to reach its goal of tracking and analyzing prescription medication use through publicly funded drug plans, it needs comprehensive data to be submitted from all participating jurisdictions.56 For more information, visit www.cihi.ca/drugs.
In 2006, the ministerial task force said that options for a comprehensive national pricing and purchasing framework were being considered. They also recommended that Canada take a “business-management approach” regarding the pricing of medications, with a priority on generic medications because of their high cost to Canadians.\(^{36}\)

In September 2008, the provincial and territorial ministers of health said that, in their view, a “national approach to achieving pricing and purchasing savings is not realistic at this time, given the economic development and legislative/policy considerations within individual jurisdictions”. However, they recommended that “interprovincial collaborations should be separately pursued and evaluated outside of a National Pharmaceuticals Strategy”. Essentially they have recommended that this commitment be undertaken by jurisdictions alone or through interprovincial collaborations.\(^{24}\)

**OF NOTE**

Ontario,\(^{53}\) Quebec,\(^{57}\) and Newfoundland and Labrador\(^{58}\) have used legislation to create major shifts in their approach to pricing and purchasing. Some jurisdictions, such as British Columbia and Alberta, have joined forces to look at purchasing medications together.\(^{59}\)

**ANALYZING COSTS**

“Enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies”

Governments can save money on their drug plans through strategies such as tighter management, more cooperation among jurisdictions, and improved prescribing behaviour on the part of health professionals. A key part of reducing costs involves looking closely at the reasons costs are rising, such as: prescribing trends and the intensification of drug use in medicine overall; rising prices for drugs; inappropriate prescribing; and demographic trends. It also involves looking at successful strategies in other jurisdictions and countries.

The National Pharmaceuticals Strategy has not taken direct action in this area, but has noted that work is partially underway through the National Prescription Drug Utilization Information System (NPDUIS).

**INFLUENCING PRESCRIBING**

“Enhance action to influence the prescribing behaviour of health care professionals so that drugs are used only when needed and the right drug is used for the right problem”

With thousands of prescription medications on the market and more being added all the time, it’s a challenge for health care professionals to be well informed about all the options and potential side effects of new drugs, as well as the interaction risks of each and every treatment choice. With patients often receiving prescriptions from more than one health care professional, the challenge increases.

Yet current and consistent information is critical to helping a patient receive a safe and effective prescription, tailored to his or her specific needs. For example, an elderly patient may need a lower dose or a different medication than would be prescribed for a younger adult.
Physicians frequently learn about medications from drug company representatives. The pharmaceutical industry has been criticized for over-emphasizing the positive elements of studies and downplaying the adverse effects of drugs. Health professionals who prescribe and dispense prescription medicines benefit from easily accessible, evidence-based information about the proper use and risks of each medication, as well as from education about the most cost-effective options for patients.

In 2006, the ministerial task force assured Canadians that two efforts were under way to help influence prescribing behaviour, but neither is under the umbrella of the National Pharmaceuticals Strategy. The two initiatives were the National Prescription Drug Utilization Information System (NPDUIS), and the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS), which produces tools and strategies to help physicians prescribe the most appropriate medications. COMPUS was established in 2004 by the deputy ministers of health and is funded by Health Canada to support all jurisdictions.

Like the electronic health record, both COMPUS and NPDUIS have long-term potential to help influence prescribing behaviour, but they need the committed participation of all jurisdictions.

This commitment to influence prescribing behaviours was not slated as a priority in the National Pharmaceuticals Strategy 2006 progress report. The ministerial task force stated that progress would be monitored and links would be formed where appropriate to influence prescribing.

The Health Council of Canada has been concerned about this gap, and in response hosted a 2007 policy symposium called Safe and Sound: Optimizing Prescribing Behaviours. A summary report on the main themes and insights is available at www.healthcouncilcanada.ca. Experts recommended a number of other efforts that would help with appropriate prescribing, such as providing more one-on-one educational sessions to physicians (see Academic detailing: Getting the right information to prescribers, page 23).
Academic detailing: Getting the right information to prescribers

One initiative under way in several provinces is called academic detailing, in which physicians and other prescribers are provided with the latest academic evidence on medications and recommended prescribing practices.

The academic detailer is most commonly a pharmacist who provides doctors with evidence-based information about specific medications or classes of medications in order to promote optimal prescribing. These efforts are intended to counterbalance information from the representatives of pharmaceutical companies, a common way that physicians receive information about medications.

There is considerable evidence that academic detailing programs are effective at changing physicians' prescribing patterns. In 2008, only four provinces had these programs (British Columbia, Nova Scotia, Saskatchewan and Manitoba). British Columbia’s academic detailing program was recently expanded from one academic detailer to 10 full-time pharmacists, aimed at supporting up to 2,000 physicians and other health care professionals in the province. Alberta’s provincial-level program has been discontinued, but academic detailing initiatives in the province continue at the regional level.

The total academic detailing workforce in Canada is estimated to be small. In contrast, the pharmaceutical industry employs 5,500-6,000 detailers in Canada.
E-health and medication safety

Millions of dollars are being invested across the country in the infrastructure to support electronic health records and drug information databases. These tools are essential for many aspects of the medication-use system, from improving the way medications are prescribed and safely used to tracking and analyzing data that can help to shape policy.

While Canada Health Infoway does not specifically fund e-prescribing initiatives, the electronic health record infrastructure designed and funded by Infoway will support e-prescribing activities throughout Canada. Infoway has allocated $250 million in funding towards the development of drug information systems across the country that allow prescriptions to be sent, viewed and confirmed electronically. When in place, these systems will identify drug-to-drug interactions automatically, adding this information to the patient’s drug profile to warn of potential danger.

Implementation targets are to “electronically capture and store approximately 75% of dispensed medication information by 2010 and 95% by 2016 and provide approximately 50% of retail pharmacies with access to patients’ medication profiles by 2010 and 100% by 2016.” As of March 2008, drug information systems had been deployed for 50% of the population in British Columbia, Manitoba, and Ontario, and are in the adoption phase for 100% of the population in Alberta, Prince Edward Island, and Saskatchewan. With the exception of the Northwest Territories, which has yet to initiate a plan towards implementing a drug information system, the remaining provinces and territories are in the planning and implementation phases. In addition, family physicians must be linked to these systems; many of them must pay to provide the computer infrastructure that links them to electronic health records and databases.

Of note
Many jurisdictions have moved ahead with implementing drug information systems. In British Columbia, the government has operated a computerized pharmacy database called PharmaNet since 1995. PharmaNet links all pharmacies in the province to the database. It is key to reducing the risks of medication-related problems: pharmacists and other authorized health professionals at hospitals or in the doctors’ offices can log on to PharmaNet for the latest information about a person’s prescriptions. Among its many features, the system helps health professionals to flag potential side effects and dangerous drug-to-drug interactions.
E-PRESCRIBING

“Broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record”

Writing prescriptions on a computer and sending them electronically to a pharmacy reduces the odds of medication errors at the pharmacy from misinterpreting bad handwriting,68 and speeds the dispensing of a patient’s prescription.

In 2006, the progress report of the National Pharmaceuticals Strategy ministerial task force said that two steps had been made towards this commitment:

1) Health Canada and Canada Health Infoway, on behalf of participating provinces and territories, had collaborated to identify a technical standard and protocol that could be used across Canada to ensure the accuracy of electronic prescriptions; and

2) During consultations in 2005, stakeholders agreed upon the proposed standard and support was given to amend any regulations needed to enable electronic prescribing, which Health Canada was pursuing.36

However, the National Pharmaceuticals Strategy ministerial task force made no recommendations for the future related to this commitment; the 2006 progress report commented generally on the integration of e-prescribing with other existing and emerging electronic systems, and with current modes of practice and promotion of e-prescribing.36

COMMON NATIONAL DRUG FORMULARY

“Establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness”

The list of prescription drugs that a government has decided to fund through its public drug plans is called a formulary. Each province and territory, as well as the federal government, currently has its own formulary. The purpose of establishing a common national drug formulary is to ensure that the same prescription medicines are funded by each jurisdiction.

Prior to 2003, provincial governments conducted their own assessments of the clinical effectiveness and costs of medications, which is partly why the formularies were so different. But since then, governments (except Quebec) have been using one central drug review process—the Common Drug Review—to make these assessments. Experts conduct objective, rigorous analysis of medications, and then recommend which prescription drugs governments should provide through their public plans.

The final decision is still made independently by each jurisdiction. But the Common Drug Review has been viewed as a major step forward in collaboration and cooperation among governments, saving each jurisdiction the expense and time of assessing medications on its own.69,70 However, the Common Drug Review has not been without growing pains, as there have been some criticisms of both process and effectiveness.71

In 2006, the National Pharmaceuticals Strategy ministerial task force recommended a staged expansion of the Common Drug Review to increase the similarity of public plan formularies, and continued discussions on the design of a common national formulary. The ministerial task force also recommended expanding the Common Drug Review to include medications not in its original mandate, and to look at the feasibility and benefits of a common review process for cancer medications36 (which began in 2007).
Although there are some inequities in the coverage of prescription medications across the country,²⁷ provincial and territorial ministers of health said in September 2008 that in their view, a common national formulary is no longer needed. They said there is greater than 90% commonality between jurisdictional plans (although some experts believe this number is much lower).²⁴ Still, this would mean that 10% of medications, which may include newer and/or more expensive medications, are inconsistently offered across the country. Canadians need to know what these medications are, as well as the governments’ plans to work to close that 10% gap.

**REAL-WORLD DRUG SAFETY AND EFFECTIVENESS**

“Strengthen evaluation of real-world drug safety and effectiveness”

The risks and benefits of medications are usually identified in clinical trials (research involving patients) before they are approved for market. But sometimes new and potentially dangerous side effects are identified once a product is put on the market and used by many more people in real-world conditions.

Information about the positive and negative impact of prescribed medications changes over time, as does knowledge about drug interactions. In order to ensure patient safety, countries need proactive strategies to collect and interpret information about the real-world experiences of people who take medications. Countries also need policies and protocols so that they can take appropriate action when it is warranted.

One of the challenges of real-world safety and effectiveness is being able to learn about unexpected hazards as quickly as possible, so that steps can be taken to protect patients.

In July 2008, the federal government announced an intention to invest $1 million to support the establishment of the Drug Safety and Effectiveness Network (DSEN) as a component of the Food and Consumer Safety Action Plan. The network will create the link between research centres of excellence and coordinate a common research agenda. The linked centres will conduct research to address the agenda developed by a national oversight body. This will help to increase knowledge about the safety and effectiveness of drugs based on their use in the real world, outside the controlled experimental environments of clinical trials.³³

In January 2009, the federal minister of health announced a commitment of a further $31 million to the network over the next four years, and $10 million per year after that.³⁴

**OF NOTE**

The MedEffect program, launched in 2005 as part of Canada’s Therapeutic Access Strategy, provides centralized access to health product safety information as soon as it becomes available. MedEffect provides health professionals and patients with information, and a simple, fast way to obtain and file information about adverse reactions to medications.³⁵ (Visit [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect) for more information.)

Proposed new federal legislation could also make a significant difference to the real-world safety of medications (see Bills C-51 and C-52, page 27).
Bills C-51 and C-52

In April 2008, the federal government tabled Bill C-51, An Act to Amend the Food and Drugs Act and introduced Bill C-52, the Canada Consumer Product Safety Act to the legislature.

If the acts are reintroduced and passed into law, the government will be able to put new terms and conditions on prescription drugs when they are authorized to be marketed in Canada. As one example, the government might require a drug company to track and report on any health problems that arise with the use of the drug. The government will also have the power to require more stringent product labels about potential health risks, and will be able to disclose information to the public about the risks and benefits that are associated with a drug. The federal government would gain the power to suspend or revoke a company’s authorization to market the drug under specific conditions. In addition, health care institutions such as hospitals will be required to provide information about adverse reactions from therapeutic products.

Canadians may be surprised to learn that the federal government does not already have these powers. Although this proposed legislation is promising, there are concerns that it does not go as far as it could. While it indicates that no person shall advertise a therapeutic product unless they are authorized by the regulations to do so, it does not call for a ban on all forms of direct-to-consumer advertising of prescription drugs. There is reliable evidence that this type of advertising does not protect the interests of patients and in fact may cause harm as physicians are more likely to prescribe an unnecessary medication in response to a patient’s request for an advertised brand.

In 2004 and 2006, both the parliamentary Standing Committee on Health and the Health Council of Canada considered the evidence for and against direct-to-consumer advertising and then called for strengthening of legislation to ban all forms of it. The proposed legislation also does not adequately establish mechanisms to gather the types of information needed by governments to execute its new authorities. While it indicates that governments will establish and maintain a publicly accessible register to keep information about therapeutic products, which is a good idea, it provides no mechanism to require researchers or pharmaceutical companies to disclose confidential business information, even if it were valuable information about the safety of a prescription drug, or data collected from people who agreed to be research subjects.

Bill C-51 introduces a definition of commercial confidentiality into the Food and Drugs Act for the first time. This definition broadly includes any information that firms do not wish to disclose and have not disclosed publicly, and that might affect profitability if disclosed. Information indicating inadequate effectiveness or a safety concern can affect a company’s share price and sales.

While the legislation has great promise, it must be noted that there are concerns in the health care community about these and other flaws.
In summary
Making the necessary changes to our highly complex pharmaceutical system is not easy. It requires exceptional cooperation among the provincial, territorial, and federal governments to resolve complicated issues of regulations, ethics, and financing.

Provinces, territories, and the federal government can move ahead with pharmaceutical reforms on their own, and many have. But there are interdependencies and limitations to what individual jurisdictions can achieve on their own. That’s why the premiers and the prime minister decided in 2004 that the National Pharmaceuticals Strategy is essential. It is through this collective action, as well as through changes in each jurisdiction, that all Canadians will benefit.

REFERENCES


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The analyses and conclusions of this report do not necessarily reflect those of external contributors or the organizations with which they are affiliated.

About The Commonwealth Fund

The 2007 International Health Policy Survey of the General Public’s Views of their Health Care System’s Performance in Seven Countries was sponsored by The Commonwealth Fund with Harris Interactive as the surveyor. Co-funding of the Canadian sample was provided by the Health Council of Canada; the Dutch sample by The Dutch Ministry of Health, Welfare and Sport and The Centre for Quality of Care Research (WOK), Radboud University Nijmegen; and the German sample by the German Institute for Quality and Efficiency in Health Care.

The 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults, conducted by Harris Interactive, assessed health care system performance and responsiveness from the perspective of sicker adults. Conducted in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, the United States, and France, the study explored the experiences and views of adults with health problems with a focus on key aspects of access, quality, patient-centeredness, and efficiency, including safety, waiting times, communication, care coordination, administrative burden, and financial barriers. The Commonwealth Fund provided core funding for the eight-country international survey. In addition, co-funding of the country-specific sample was provided by the Health Council of Canada, the Quebec Health Commission, the Ontario Health Quality Council, the Health Foundation (UK), the German Institute of Quality and Efficiency, and the Dutch Ministry of Health, Welfare and Sport.
ABOUT THE HEALTH COUNCIL OF CANADA

Canada’s First Ministers established the Health Council of Canada in the 2003 Accord on Health Care Renewal and enhanced our role in the 2004 10-Year Plan to Strengthen Health Care. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

The Council’s vision
An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council’s mission
The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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