



June 2010

Follow-Up Questions and Answers

CADTH Webcast: Health Information — Is it a Public Good?

Webcast Held March 30, 2010

These questions were received by email after the event, and the presenters have kindly offered to provide answers for sharing on the CADTH website.

Question for Lloyd Sansom: What proportion of consumer groups in Australia are funded by the pharmaceutical industry, and do you think such funding makes a difference to their advocacy positions?

Lloyd Sansom: I do not know exactly how many consumer organizations receive financial support from the pharmaceutical industry. While it can be argued that any funds are untied donations, nonetheless there is a perception that such funding in some way makes the organizations responsible to the funder in some direct or indirect way – for example, the perception is that any criticism of a donor's behaviour would be seen to be biting the hands that feeds them and it would be likely to be muted or, at least, toned down.

Whilst it is appreciated that without industry funding many of these organizations would not function, industry funding is a potential issue if patient groups are to be seen as truly independent. In Australia, the issue of government funding to replace industry money has been raised but has not been implemented.

Linda Wilhelm: The Best Medicines Coalition (BMC) accepts the majority of its funding from the pharmaceutical industry and I will make no apologies for that, for a number of reasons:

- We would be happy to accept money from anywhere, but we are an advocacy organization and there are strict rules about gaining charitable status and the amount of advocacy an organization can do. Without charitable status, one cannot fundraise.
- If government would like to provide us with sustainable funding, we would be happy to refuse funding from the pharmaceutical industry.
- Despite the fact that BMC receives funding from this source, it is unrestricted and we decide our priorities and they often are different than the industry's; two examples being direct-to-consumer advertising (we oppose it strongly) and stronger post-market surveillance of medications, and increased cost recovery for drug reviews.
- All of our members are volunteers; we receive no compensation for the time we dedicate to get the patient perspective heard. In fact, I am often not covered for out-of-pocket expenses. I spend a great deal of time volunteering!



- No one questions the money physicians receive from the pharmaceutical industry (well, more now than before, but physicians continue to receive money) or the money that universities receive. Does the public believe this money makes the views of doctors and researchers any less credible?
- I would rather see an independent organization like BMC receive funding from this industry than have them spend their money on developing their own websites to educate patients, like Pfizer's "More Than Medication" or Amgen's site "Inside RA." This speaks directly to the exchange of information and patients not knowing what information they can trust. Personally, I don't trust information from a website that is developed by a drug company.

I know my opinion was not solicited and you can tell I have strong beliefs on this topic. I'm sure there will be attempts by the industry to coerce patient groups into lobbying for them. This is why BMC has provided input into the CADTH process for patient input into the CDR. We felt there should be a two-step process. If patient organizations feel there might be a time that they will want to provide input, they could pre-apply to CADTH declaring conflict of interest on an annual basis, similar to Health Canada's process, which CADTH could keep on file. This process would discourage bogus patient organizations that form to lobby on behalf of a drug company or at least make it easier to weed them out without penalizing the legitimate groups.

Question for Lloyd Sansom and Judith Glennie: How do you balance access to medications and confidential pricing arrangements that do not allow for public disclosure?

Lloyd Sansom: In regard to lack of transparency of pricing issues, this is a matter of concern. However, the most important issue for me is whether we can make available to the public a cost-effective drug. In Australia, the independence of the PBAC [Pharmaceutical Benefits Advisory Committee] and the requirement that a drug must be considered to be cost-effective by the PBAC for PBS listing and the fact that reasons for listing are in the public domain minimizes my concern regarding special pricing arrangements.

In many cases, governments do not release the results of tender arrangements except the tender winner(s). The decision by the PBAC is determined by the actual price the government will pay, so the cost-effectiveness is based on the real price and not on the price which may appear in the public domain. That special pricing arrangements re declaration of the actual price apply is designated within the relativity sheets as "special pricing arrangements apply." If a sponsor wishes to seek listing on a cost minimization basis against a drug with such arrangements, then that sponsor will find out the actual price of the comparator after the PBAC considers the matter.

Judith Glennie: A number of public payers in various jurisdictions around the world have been undertaking pricing agreements with pharmaceutical companies (both innovators and generic firms) for a number of years. Payers are continually challenged in balancing patients' needs for access to medications and financial pressures. These pricing agreements are one means by which they have strived to achieve this balance.

Question for All: Please discuss the March 26 CBC report of Pfizer hiding internal studies on gabapentin's effectiveness and the resultant \$142 million US fine.

Judith Glennie: I can't comment on this. As of April 15th, I have not seen the report being referred to and do not know the details of the example that is cited.