terested in the project, while Australia will launch a national RBP program in February (see sidebar).

The program has been lauded by observers such as the National Forum on Health, which said that "only the BC approach is actually aimed at reducing drug costs and improving prescribing appropriateness."

However, it is being denounced by others, including a pharmaceutical lobby that launched an unsuccessful attempt to sue the BC government over it. Others argue that RBP encroaches on physicians' freedom to determine treatment options that are best for their patients.

"What we are arguing about is the principle," says Judy Erola, president of the Pharmaceutical Manufacturers of Canada (PMAC). "Doctors ought to be able to prescribe what they say is the most appropriate therapy — the decision shouldn't be made by anybody else. When governments decide what will be prescribed, based on financial criteria, then we are all in trouble."

BC's 5 referenced categories are nonsteroidal anti-inflammatory drugs (NSAIDs), angiotensin-converting enzyme inhibitors, calcium-channel blockers, nitrates and H_2 antagonists. A number of effective drugs that vary widely in price are available for all categories. Of the more than 20 NSAIDs available, for example, acetaminophen, enteric-coated ASA and naproxen are the referenced drugs; all other NSAIDs must receive special authority from before being prescribed.

RBP affects only those covered by Pharmacare, such as people on welfare. Recipients are allowed to pay the difference between the price of a reference drug and a more expensive one if special authority is declined.

"We stress that this is a reference price, not a reference product," says Hudson. "If drug companies want to lower the price of a medication, we will be happy to list them in our formulary." This has already occurred. When generic transdermal nitrate patches were introduced, they entered as the reference price, and prices for similar products then dropped. Along with products within the 5 classes of drugs, doctors must receive special authority before prescribing some new, second-line medications such as alendronate.

Bob Nakagawa, a pharmacist who chairs the government's RBP advisory committee, says drug companies have opposed RBP because "the $74 million Pharmacare has saved has come directly out of their profits."

Reaction to the program among BC physicians has spanned the spectrum. Some oppose RBP because it marks the first time the concept of "prospective adjudication" has arisen in BC: doctors must ask for permission before following their clinical judgement. "We know that it raises fears of [having to dial] 1-800 for an Aspirin and the terrible excesses of some of the HMOs in the US," explains Hudson, who insists that RBP does not herald widespread prospective adjudication.

Dr. Granger Avery, president of the British Columbia Medical Association, says most doctors agree that when a new medication is being prescribed it is appropriate to try the lower-priced drugs first. "But if patients are on an established regimen and it is working for them, we do not support fiddling around with their medication solely for financial reasons. That is not good medicine."

Hudson stresses that decisions on whether to remove patients from established regimens is left to physicians. "If a doctor says a patient needs a certain drug, we will not challenge him. If he has just spent 2 years to get frail old Mrs. McGillicuty to take her medication properly and he doesn't want to mess with her meds, we say fine. We rely on the doctor's clinical judgement."

Avery says it isn't always that simple. "I have had to ask for 3 or 4 times for special authority for certain patients. Sometimes you have to be very persistent — you can get the feeling they just aren't listening to you."

Many BC doctors acknowledge the need to control a

Australia set to follow BC's lead

Australia won't put a national reference-based drug-pricing strategy (RBP) in place until next month, but a public-relations war has been raging in the country's media since the program was announced last September.

The Australian plan, which is based loosely on the British Columbia model, was announced by the country's minister of health during the 1997 annual meeting of the Australian Pharmaceutical Manufacturers Association (APMA). Full-page advertisements denouncing the RBP as dangerous soon began appearing in the country's major newspapers.

The ads claimed that BC residents are dying because of the policy and that most of its residents were against the program. They also claimed that the CMA was officially opposed to RBP. (Although an editorial that was critical of RBP has appeared in *CMAJ* [Woollard RF. Opportunity lost: a frontline view of reference-based pricing. *Can Med Assoc J* 1996;154:1185-8], the CMA has taken no official stance on it. — Ed.)

Australia is referencing 6 categories of drugs, including H_2 antagonists and selective serotonin reuptake inhibitors.

In its ads, the APMA claimed that Canadians are being denied access to 20 new drugs because of BC's RBP program. "We are trying to correct all the misinformation," says Dr. Rick Hudson of the BC Ministry of Health.