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Why BC Pharmacare won't pay for your insulin

History of insulin

Insulin was first isolated from animal sources in 1921-22 by Drs Banting and Best in Toronto, Ontario. The first commercial insulin was from bovine and porcine sources. Subsequent advances allowed the addition of chemical substances to regular insulin, changing its duration of action. Animal source insulins were exclusively available until 1983. Beginning at that time, human insulin became available. Currently available human insulins do not always closely replicate endogenous insulin secretion. Beginning in the early 1996, various insulin analogues became available for sale in Canada. There are currently four approved insulin analogues. Insulin aspart (NovoRapid®) and insulin lispro (Humalog®) are rapid-acting products. Insulin glargine (Lantus®) and insulin detemir (Levemir®) are extended long-acting products. The kinetics of each of these products is significantly different from all currently available human insulin products (regular, NPH, lente, ultralente).

Insulin and BC Pharmacare

At this time, none of the insulin analogues are fully reimbursed by BC Pharmacare. The Canadian Diabetes Association Clinical Practice Guidelines (CDA CPG) of 2003 recommend insulin aspart and insulin lispro to help people with diabetes control their blood sugar, especially after meals, while minimizing hypoglycemia (low blood sugars). Insulin aspart and insulin lispro have been reviewed by BC Pharmacare and rejected as full Pharmacare benefits largely because of recommendations received from the Therapeutics Initiative (TI). Members of the TI purport to use "evidence based medicine" in making their recommendations. The TI purports to be independent of government although it receives its funding from the BC Ministry of Health. It also claims not to be responsible for Pharmacare decisions. Some of the members of the TI are on record as saying that blood glucose lowering has never been proven to be of benefit in the treatment of type 2 diabetes. This is so contrary to known science as to be laughable. Unfortunately, it is from this sort of individual that BC Pharmacare has chosen to receive recommendations. Insulin aspart and insulin lispro have been deemed by TI to be only a "convenience" to people with diabetes and therefore not worthy of being a full benefit. I really need someone to explain to me how insulin, especially when given 4 or more times per day, could ever be a convenience.

More recently, the Canadian Expert Drug Advisory Committee (CEDAC) recommended that provinces not list insulin glargine. BC Pharmacare is required to follow this recommendation. This is despite the fact that, according to CEDAC itself 4 of 6 clinical trials of glargine in patients with type 1 diabetes and 6 of 8 trials in patients

with type 2 diabetes demonstrated fewer episodes of nocturnal (over-night) hypoglycemia (CCOHTA website, accessed 1 Nov 2005). The CDA CPG recommends insulin glargine for patients who have problems with overnight hypoglycemia. Unfortunately, members of CEDAC are on record as saying to “avoid (all) CPG like swampland”. Again you have to wonder about who is making recommendations to Pharmacare. Insulin detemir has not yet been reviewed by CEDAC.

The CDA CPG have been positively received by Health Ministers from across the country, including the then BC Health Minister, Colin Hansen. The CDA CPG form the basis of the BC Diabetes Care Guidelines distributed to all physicians in BC by the Ministry of Health and the British Columbia Medical Association. So the people in TI and CEDAC advising BC Pharmacare are clearly of a minority opinion yet their recommendations, usually to not cover the cost of drugs, are what BC Pharmacare follows. Neither TI nor CEDAC open their discussions to public viewing nor do they invite true experts to the table as part of their discussions. Their processes are neither open, nor transparent, and their decisions do not reflect the views of the majority of health care providers, including individuals like myself who see upwards of 1000 patients per year with diabetes.

I can tell you that patients benefit from these new insulin products and they are used by almost all of my patients who can afford them. The coverage of the cost of pharmaceuticals is an example of true “two tier” medicine in Canada. Those who can afford the cost get the best, those who can’t afford the cost don’t. How can the province of British Columbia justify not paying for insulin? How can they hide behind the minority scientific opinion held by members of TI and CEDAC? These decisions potentially affect over 200,000 people in BC with diabetes, a number expected to grow to 325,000 by 2010.

Conclusions

BC Pharmacare receives advice from groups whose sole purpose seems to be to save BC Pharmacare money. This short-sighted approach shifts costs to individuals with diseases like diabetes and to other parts of the health care system like hospitals and clinics. If you have been affected by the decisions made by BC Pharmacare based on the recommendations of the TI or CEDAC, I would encourage you to communicate with the Executive Director of BC Pharmacare, your local MLA and the BC Minister of Health.

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Disclaimer: I am an endocrinologist in private practice. I have received remuneration for consulting work done on behalf of the pharmaceutical industry, the Vancouver Island Health Authority and the BC Ministry of Health. I am a volunteer of the CDA. The views expressed are my own.