

# Purchasing Prescription Drugs in Canada: Hang Together or Hang Separately

## L'achat de médicaments sur ordonnance au Canada : tous ensemble ou séparément



MICHAEL R. LAW AND STEVEN G. MORGAN

*Centre for Health Services and Policy Research*

*School of Population and Public Health*

*University of British Columbia*

*Vancouver, BC*

### **Abstract**

Canada's provincial and territorial governments have expressed an interest in bulk purchasing prescription drugs for many years. We propose they start by purchasing selected generic drugs for the entire population and provide them for little or no cost to patients. This politically popular strategy would significantly reduce drug expenditures and improve population health.

### **Résumé**

Depuis plusieurs années, les gouvernements territoriaux et provinciaux canadiens s'intéressent à l'achat en vrac de médicaments sur ordonnance. Nous leur proposons de commencer par l'achat de certains médicaments génériques pour la population entière et de les fournir aux patients à faible prix ou sans frais. Cette stratégie politiquement populaire réduirait sensiblement les dépenses en médicaments et améliorerait la santé de la population.

**P**ROVINCIAL PREMIERS AND TERRITORIAL LEADERS HAVE RECENTLY AGREED TO FORM a pan-Canadian purchasing alliance for prescription drugs. A purchasing alliance is tantamount to a strategy of “hanging together instead of hanging separately” in the multi-billion-dollar business of purchasing prescription drugs for Canadians. The argument that coordinated drug purchasing would reduce prices is sound, and calls for such a policy have been repeatedly echoed by prominent government commissions (Members of the National Forum on Health 1997; Romanow 2002; F/P/T Ministerial Task Force 2006). Estimates place the potential savings from bulk purchasing in the billions of dollars (Morgan et al. 2007).

Given that bulk purchasing would reduce prices, it will encounter significant resistance from pharmaceutical manufacturers, as it has when recommended in the past (Morgan et al. 2007). In light of these politics, we believe that the current effort should focus on cost-saving and health-improving purchases that would benefit patients as much as government. A program that can achieve these goals in tandem has the potential to overcome this resistance.

Specifically, governments should implement a Priority Drug Program (PDP) that would cover carefully selected drugs for the entire population at little or no cost to the patient: a first-dollar pharmacare program for specific medications. A PDP would combine coordinated bulk purchasing with coverage expansion on a class-by-class and drug-by-drug basis. By moving slowly and by starting with generic drugs, we believe the political resistance would be substantially reduced.

Cholesterol-lowering and anti-hypertensive medications are prime examples of the types of drug that should be covered under such a program. These are the most commonly dispensed drugs in Canada (IMS Health Canada 2009). They treat conditions that are among the leading causes of death in Canada (Statistics Canada 2010). And expanded coverage for the best of these drugs has been estimated to be cost-effective, even at prevailing prices (Dhalla et al. 2009). But prices of drugs covered by a PDP would fall – dramatically so.

### **Benefit 1: Cost Savings**

Canada has amongst the highest generic drug prices in the world (Competition Bureau Canada 2007). While this factor hasn't been as important in the past, a huge number of very popular drugs have lost, or are about to lose, their patent protection. For example, the highest-selling drug in the world, the cholesterol-lowering atorvastatin (brand name Lipitor), became available as a generic last year and is now sold by more than 10 different manufacturers in Canada. Other countries leverage this breadth of suppliers to drive down prices through fierce competition for contracts. In return, suppliers are often guaranteed market exclusivity for that medicine and a particular volume of purchases (Morgan et al. 2007). The result: prices at modest mark-ups over manufacturing and distributing costs.

Instead of harnessing competition as our peers do, Canada sets generic prices at an arbitrary percentage of the equivalent brand-name drug. Changing these percentages has been

highly political and contentious, such as when Ontario capped its prices at a nationwide low of 25% in 2010. However, this method of pricing ignores the fact that some generic drugs are purchased elsewhere for substantially less. For example, Ontario now pays 62.5 cents a pill for the popular cholesterol-lowering drug simvastatin (20 mg) (MOHLTC 2010). In comparison, the United States Department of Veterans Affairs (VA) pays just 3.1 cents (USDVA 2010). Similarly, while Ontario pays 20 cents for the popular antihypertensive ramipril (5 mg), the VA pays 5.3 cents (MOHLTC 2010; USDVA 2010). Compared to our international peers, even Ontario is considerably overpricing these popular drugs.

Moving to VA-level prices for just these two cardiovascular drugs would save Canadian governments tens of millions of dollars. Adding further drugs with similar price differences would save millions more. For many cardiovascular medicines, we suspect that Canadian governments could save enough through bulk purchasing to cover everyone in their provinces, give the drugs away for free and still save money. These are the drugs that the PDP should target first.

## **Benefit 2: Improved Population Health**

Not only would a PDP save money, it would also improve health. Out-of-pocket costs for prescription drugs remain a problem for many Canadians: 18% of those with a chronic condition report not taking a drug or skipping doses because of cost (Commonwealth Fund 2008). In the case of cardiovascular medicines, fewer than half of Canadian patients adhere to therapies, including high-risk patients with established coronary disease (Jackevicius et al. 2002). One analysis found that providing free medications to patients after a heart attack in Canada would increase their life expectancy by a full year (Dhalla et al. 2009). A PDP would remove the cost barrier for a range of medications – probably the single most modifiable determinant of drug adherence (Goldman et al. 2007) – and improve health as a result.

The medical consequences of cost-related non-adherence ultimately fall upon patients who cannot afford their medicines. Ironically, the financial consequences of the expensive hospital and physician services that result fall squarely upon provincial healthcare budgets. The evidence indicates that making cardiovascular medications free for patients would improve health and reduce hospital and physician costs for expensive procedures that provinces cover in full (Choudhry et al. 2008; Dhalla et al. 2009).

## **Benefit 3: Politically Popular**

Linking changes in the way government purchases drugs to an expansion in coverage also makes the policy change much more politically saleable. Average Canadians would rightfully see the PDP as an attempt not just to cut costs, but also to expand access to necessary medicines and reduce their increasing out-of-pocket costs. By starting with cardiovascular medicines, the benefits of lower co-payments would be immediately apparent to millions of Canadians every single time they visited a pharmacy. In the future, there are several other drug classes that could be added to the program, making the numbers that benefit even larger. As two-thirds of Canadian households have out-of-pocket expenditures on drugs every year, the

benefits are likely to be widespread (Statistics Canada 2009).

In sum, our governments should use this round of bulk purchasing negotiations to provide universal, first-dollar coverage of a large selection of generic cardiovascular drugs at lower cost than they currently pay now under existing seniors-only or income-based drug plans. “Hanging together” would save costs, improve population health and mark the end to the previously unsuccessful attempts at harnessing bulk purchasing power. It’s time that Canada was successful in gaining better prices for drugs, and this is the logical place to start.

### *Acknowledgements*

Dr. Law receives salary support through a New Investigator Award from the Canadian Institutes of Health Research and an Early Career Scholar Award from the Peter Wall Institute for Advanced Studies.

*Correspondence may be addressed to: Michael R. Law, UBC Centre for Health Services and Policy Research, 201–2206 East Mall, Vancouver, BC; V6T 1Z3; e-mail: mlaw@chspr.ubc.ca.*

### REFERENCES

- Choudhry, N.K., A.R. Patrick, E.M. Antman, J. Avorn and W.H. Shrank. 2008. “Cost-Effectiveness of Providing Full Drug Coverage to Increase Medication Adherence in Post-Myocardial Infarction Medicare Beneficiaries.” *Circulation* 117(10): 1261–68.
- Commonwealth Fund. 2008. *2008 Commonwealth Fund International Health Policy Survey of Sicker Adults*. Retrieved April 6, 2011. <<http://www.commonwealthfund.org/Content/Surveys/2008-Commonwealth-Fund-International-Health-Policy-Survey-of-Sicker-Adults.aspx>>.
- Competition Bureau Canada. 2007 (October). *Generic Drug Sector Study*. Retrieved April 6, 2011. <<http://competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/02495.html>>.
- Dhalla, I., M. Smith, N. Choudhry and A. Denburg. 2009. “Costs and Benefits of Free Medications after Myocardial Infarction.” *Healthcare Policy* 5(2): 68–86.
- Federal/Provincial/Territorial (F/P/T) Ministerial Task Force. 2006. *National Pharmaceuticals Strategy: Progress Report*. Retrieved April 6, 2011. <<http://www.hc-sc.gc.ca/hcs-sss/pubs/pharma/2006-nps-snpp/index-eng.php>>.
- Goldman, D.P., G.F. Joyce and Y. Zheng. 2007. “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health.” *Journal of the American Medical Association* 298(1): 61–69.
- IMS Health Canada. 2009. “Top 10 Dispensed Therapeutic Classes in Canada.” Retrieved April 6, 2011. <[http://www.imshealth.com/deployedfiles/imshealth/Global/Americas/North%20America/Canada/StaticFile/Top10DispensedTherapeuticClasses\\_En\\_10.pdf](http://www.imshealth.com/deployedfiles/imshealth/Global/Americas/North%20America/Canada/StaticFile/Top10DispensedTherapeuticClasses_En_10.pdf)>.
- Jackevicius, C.A., M. Mamdani and J.V. Tu. 2002. “Adherence with Statin Therapy in Elderly Patients with and without Acute Coronary Syndromes.” *Journal of the American Medical Association* 288(4): 462–67.
- Members of the National Forum on Health. 1997. *Canada Health Action: Building on the Legacy*. Retrieved April 6, 2011. <<http://www.hc-sc.gc.ca/hcs-sss/pubs/renewal-renouv/1997-nfoh-fnss-v1/index-eng.php>>.
- Ministry of Health and Long-Term Care (MOHLTC). 2010. *Ontario Public Drug Programs – Formulary/Comparative Drug Index*. Retrieved April 6, 2011. <[http://www.health.gov.on.ca/english/providers/program/drugs/odbf\\_elformulary.html](http://www.health.gov.on.ca/english/providers/program/drugs/odbf_elformulary.html)>.
- Morgan, S., G. Hanley, M. McMahon and M. Barer. 2007. “Influencing Drug Prices through Formulary-Based Policies: Lessons from New Zealand.” *Healthcare Policy* 3(1): 121–40.

Romanow, R. 2002. *Building on Values: The Future of Health Care in Canada*. Saskatoon, SK: Commission on the Future of Health Care in Canada.

Statistics Canada. 2009. "CANSIM Table 109-5012." Retrieved April 6, 2011. <<http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&searchTypeByValue=1&id=1095012#TFtn>>.

Statistics Canada. 2010. "Table 1-1: Ten Leading Causes of Death by Selected Age Groups, by Sex, Canada – All Ages." Retrieved April 6, 2011. <<http://www.statcan.gc.ca/pub/84-215-x/2010000/tbl/t001-eng.htm>>.

United States Department of Veterans Affairs (USDVA). 2010. *Pharmaceutical Catalog – National Acquisition Center's Socioeconomic Contract Catalog*. Retrieved April 6, 2011. <[http://www1.va.gov/nac/index.cfm?action=search&template=Search\\_Pharmaceutical\\_Catalog](http://www1.va.gov/nac/index.cfm?action=search&template=Search_Pharmaceutical_Catalog)>.



***Do you get it?***

*Ideas, Policies, Best Practices and Learning Events.*

**Longwoods.com/newsletters**