

Drug Prices in Canada and the United States: Another Opinion

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The commentary by Graham and Walker analyzing drug prices in Canada and the United States is an example of the triumph of ideology over fact.(1) Both authors work for the right-wing Fraser Institute which has long campaigned against government intervention in the economy. Therefore, their conclusion that differences between drug prices in the two countries does not come from government price controls should come as no surprise. Instead they postulate that whatever differences exist are the result of a widening gap in purchasing power parities (PPPs) and from a surcharge that manufacturers add on to their prices in the U.S. to cover the costs of legal liability protection.

In reaching these conclusions the authors ignore inconvenient facts that do not fit their preconceived ideas, they fail to differentiate between drug price indices and the cost of a prescription and finally, they do not consider the consequences of high prescription prices on vulnerable segments of the American population.

Graham and Walker claim that one-third to one-half of any pharmaceutical price differentials in 1990 were due to the higher cost of legal liability protection in the U.S. However, there was a consistent gap of about 15% in favor of Canada in the price of single source products, that is those without generic competition, going back as far as 1968, long before there were astronomical liability suits in the U.S.(2) That gap remained roughly the same through the early 1980s despite any changes in the cost of law suits.

Does a widening PPP account for the fact that American prices for patented drugs went from 36% higher in 1988 to 60% higher in 1999? To begin with, when Graham and Walker cite changes in PPPs they appear to be referring to the PPP for all items not just the PPP for pharmaceuticals. It is a mistake to assume that changes in the general PPP would be reflected in prices for pharmaceuticals without taking into account factors that might differentially impact the overall cost of goods and the cost of drugs specifically. Furthermore the use of PPPs in the context of pharmaceutical prices has been questioned by a senior official with the National Economic Research Associates: "It would not be appropriate . . . to use PPPs in the context of an international pharmaceutical price index."(3)

In dismissing the role of Canada's Patented Medicine Prices Review Board (PMPRB) in controlling drug prices Graham and Walker ignore changes in the Canadian Industrial Product Price Index [IPPI (pharma)] and the U.S. Product Price Index [PPI(pharma)]. Between 1982-87

the Canadian IPPI(pharma) went up 9.0% annually versus 7.1% for the American index. Over the period 1988-99 the Canadian IPPI(pharma) only grew at 1.9% per year against 5.1% for the U.S. PPI(pharma). A graph of year-by-year changes in the two indexes shows them crossing in the 1986-88 period, the time of establishment of the PMPRB.(4)

The PMPRB is not the only factor in government control over drug prices in Canada. PMPRB regulations permit the prices of patented drugs to rise at the level of the Consumer Price Index (CPI), but for most of the past decade pharmaceutical manufacturers have not taken advantage of this opportunity; price rises for patented drugs have lagged behind the CPI.(4) The monopsony buying power of provincial drug programs is a large part of the explanation for this "restraint" on the part of the manufacturers. The province of Ontario spends well over CAN\$1 billion annually on prescription drugs and if drugs do not get listed on the provincial formulary they tend to be generally ignored by doctors. This dominance in the marketplace gives the province considerable room to bargain with companies over prices. Finally, Graham and Walker do not deal with the price of a prescription which, after all, is what affects consumers most directly. They do correctly note that generic products in the United States tend to be less expensive than those in Canada, reflecting the greater number of companies marketing generic drugs in the U.S. But while roughly 35-45% of drug units dispensed in either country are for generic drugs they account for a small minority of the total expenditures, about 8-9% in both countries.(4,5) There is a substantial difference in the cost of a prescription for a generic versus a brand name product. In Canada, in 1997 a prescription for a generic drug was between CAN\$10.02 and CAN\$31.44 depending on whether the drug was marketed before or after 1993 versus a range of CAN\$37.66 and \$61.82 for a brand name drug.(6) 1994 figures for the U.S. are US\$22.40 for a generic product and US\$43.00 for a brand name one.(7)

If U.S. consumers were getting prescriptions filled generically they would probably be no worse off than their Canadian counterparts, but the most vulnerable segment of the American population, the elderly amongst whom about one-third lack any form of prescription drug insurance, are not getting prescriptions for generics. This age group suffers from a host of chronic medical problems such as cardiovascular disease, elevated cholesterol, depression and diabetes. In the case of products for depression, drugs introduced after 1991 accounted for over US\$3.6 billion out of a total expenditure of US\$7.1 billion, and the price of a prescription for an antidepressant rose by more than 60% between 1993-98. Figures for new oral hypoglycemic agents for diabetes were US\$1.6 billion out of a total of US\$2.5 billion, with a rise in the price of a prescription of 34%.(5)

These newer, more expensive drugs are the ones that are being prescribed to the elderly in the U.S. and they are precisely the ones that have their prices regulated in the Canadian market by a combination of the actions of the PMPRB and the provincial governments.

Price controls have been successful in restraining Canadian prices and if the U.S. government is interested in protecting the elderly from the price of prescription drugs, it would do well to look to the Canadian model.

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