Reference-based pricing: Will other provinces follow the BC lead?

Features

Chroniques

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In brief

REFERENCE-BASED PRICING has had a major impact on medical practice in British Columbia. Anne Mullens discusses the new system's first 2 years. She says physicians outside BC should pay attention, because RBP may be heading their way. It is set to land in Australia next month.

En bref

L'IMPOSITION DE MÉDICAMENTS DE RÉFÉRENCE a eu d'importantes répercussions sur la pratique médicale en Colombie-Britannique. Anne Mullens présente les deux premières années du nouveau régime. Selon elle, les médecins des autres régions du Canada doivent être attentifs à ce qui se passe en C.-B., car cette méthode de contrôle des coûts risque fort d'apparaître sous peu chez eux. L'Australie compte adopter ce régime dès le mois prochain.

For the last 2 years doctors in British Columbia who want to prescribe a drug within 5 separate medication categories have either had to write a script for the cheapest drug available or ask the government for permission to prescribe a more expensive one. Predictably enough, the government loves the program while physicians' responses remain far from enthusiastic. Regardless, doctors in the rest of Canada should pay close attention to the BC experience with reference-based pricing (RBP). The message has already been heard in Australia and eventually may spread across Canada.

The controversial program is BC's way of pulling in the reins on a Pharmacare budget that had doubled to $400 million in 5 years. Other provinces have tried to curtail costs by increasing deductibles, taking drugs off the formulary or making people ineligible for coverage. BC looked to evidence-based medicine for answers, and using 5 categories of drugs began to treat all medications within a category as "therapeutically equivalent." When drugs are known to be equally safe and effective, Pharmacare now pays for the least expensive one — the reference drug — within the category. It will pay for more expensive ones if the reference drug fails or is inappropriate.

The ministry says RBP has saved $74 million since the program was launched in October 1995, but it has also irritated some doctors. "Properly handled, reference-based pricing could have been a small start toward mutual trust and the eventual resolution of conflict," Dr. Robert Woollard wrote in a 1996 *CMAJ* editorial (154:1185-8). "As it is, it represents just another incoming volley. . . ."

"It must be stressed that reference-based pricing is about *first-line* prescribing for common conditions," says Dr. Rick Hudson, director of the Ministry of Health's Clinical Support Unit. "Peer-reviewed studies predict how the majority of first-time users will react to a drug, but they can't predict how the individual will react. That is why we created special authority. We just want the doctor to document that the first-line was tried first, or for some patient-specific reason was inappropriate. [RBP] is a speed-bump, not a wall."

BC was first to introduce an RBP model of this type and its experience is being watched across the country and around the world. Newfoundland is said to be in-

Dr. Granger Avery: "you can get the feeling they just aren't listening"

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.

Pharmacare budget that jumped to $407 million in 1995 from $196 million in 1990, and many accept the "therapeutic-equivalent" rationale behind the scheme. Unfortunately, most also find the new program bureaucratic and irritating because it forces them to complete yet more forms and places yet more demands on their time.

"Frustrating," "annoying" and "a pain in the neck" are some typical comments BC doctors have offered about RBP, particularly the special-authority process that forces them to fax or phone Pharmacare for permission to prescribe a different drug. Since special authority can expire in 6 months to a year, they may have to go through the same application process many times.

"I agree in principle with the idea but at times it is a real headache, particularly if you have to keep renewing a special authority for a patient who has a problem with the referenced drug," says Dr. Allison Ferg, a Victoria family physician. Her comments were echoed by every physician interviewed for this article.

"It is a lot more work on doctors' shoulders and the paperwork is an irritation and an obligation," adds Dr. Jim Rhodes, president of the Society of General Practitioners of BC.

Five full-time pharmacists handle the 400 special-authority requests that arrive each day, entering the permission directly on the province's Pharmanet computer system. The ministry says the turnaround time is 24 to 48 hours, but doctors say it can take up to a week for patients to receive approval.

Some medical disorders and specific medical specialties are automatically exempted from the special-authority process. Cardiologists, nephrologists and internists specializing in cardiology don't have to seek special authority for unreferenced calcium-channel blockers, and rheumatologists don't need special authority to prescribe higher-priced NSAIDs. The ministry has created a reference list of exclusions for all 5 drug categories.

Rhodes says the exclusions irritate many FPs. "They leave the impression that the government thinks GPs can't be trusted to prescribe appropriately. But GPs aren't ignorant."

Like most doctors, he would have preferred an education program that encouraged appropriate, cost-effective prescribing rather than the firm fist of policy. Hudson agrees that would have been preferable but claims that education alone would not change prescribing behaviour enough to make a difference in the Pharmacare budget, especially when government efforts would be pitted against the overwhelming amount of information doctors receive from drug companies.

When RBP was introduced, the PMAC and 7 drug firms sued the province, arguing that the health minister lacked authority to implement the scheme and that RBP contravened both doctors' confidentiality provisions and the Food and Drug Act. The arguments were rejected by both the BC Supreme Court and BC Court of Appeal.

Despite the losses, Erola claims the PMAC won a "moral victory" because the appeal court judge, Mary Newbury, wrote that she dismissed the case "with some reluctance" because the "RBP policy is not administered in a manner that can inspire confidence on the part of health professionals, much less those less fortunate classes of patients who are affected most directly by it." That, says Erola, is "a pretty clear condemnation of the program."

Data indicate that the policy has had an impact. For the 5 months from Oct. 1, 1995, to Feb. 29, 1996, the number of prescriptions for Nitrong SR, which costs $77.86 a month, fell to 10 345 from 21 180. Meanwhile, the number of prescriptions for isosorbide dinitrate, which costs $4.62 a month, increased to 18 492 from 5 405. Still, many critics claim that although RBP may save money by lowering drug costs, overall costs will increase because there will be more visits to physicians and more hospitalizations because of adverse reactions.

Pharmacare has monitored sentinel illnesses before and after the introduction of RBP, using data on hospital deaths and discharges and records of services provided in hospital and for certain diagnostic codes.

The data show that among seniors who switched nitrates because of RBP, hospitalization rates for syncope and myocardial infarction were unchanged. The average number of hospitalizations for syncope was 73.5 per week for the 2 years before the policy and 72.2 per week for the 6 months after nitrates were referenced. For heart attack the average rate was 73.1 hospitalizations per week before RBP was introduced, compared with 68.8 in the 5 months after its introduction. Rates of hospitalization were unchanged for GI bleeding among seniors who switched NSAIDs, with 49.9 hospitalizations per week before referencing was introduced and 49.8 in the first 4 months afterwards.

The figures don't impress Dr. Bill McArthur, a visiting fellow in health policy at the Fraser Institute who criticizes RBP because it was introduced without pilot studies and with no evaluation process in place. He is creating a strict, peer-reviewed design protocol to evaluate RBP; 3 other groups are also said to be considering evaluation projects.

Hudson welcomes this. "We are committed to an open, peer-reviewed evaluation process and we will ensure that its results are made public, no matter what the findings." ?