Putting a price on drugs

The Pulse article "Regulating the price of patented drugs", (*Can Med Assoc J* 1997;156:1512), by Lynda Buske, included an excerpt from a recently released report from the Patented Medicine Prices Review Board (PMPRB) showing a marked decline in average prices for patented drugs since the inception of the board in 1988. The PMPRB report goes on to claim that, from 1988 to 1995, federal regulation of patented drug prices has saved the Canadian health care system between $2.9 billion and $4.2 billion.[1]

However, since the PMPRB has been operating, provincial governments have also taken independent initiatives to limit drug prices. For instance, in the fiscal year 1992–93 the Ontario Ministry of Health established a guideline of 2% for drug price increases, and the next year it imposed a price freeze on formulary drugs.

One way of separating the effects of the PMPRB from the measures taken by the provincial governments is to look at what happened to the prices for nonpatented drugs. The PMPRB regulates only the prices for patented drugs, whereas provincial controls should have affected patented and nonpatented products alike. The PMPRB study makes this comparison by constructing a nonpatented medicine price index (NPMPI) and comparing the annual change in this index to the index for patented medications (PMPI). According to the PMPRB, the NPMPI went up at a rate of 4.25% annually between 1988 and 1995 whereas the PMPI went up only 1.63% annually over the same period. The difference, 2.62% per year, is attributed to the effects of the PMPRB regulations. This difference translates into total savings of $3.68 billion.

However, on the basis of a different approach to calculating a NPMPI, taken from a study done for the Federal/Provincial/Territorial Pharmaceutical Policy Committee, prices of nonpatented drugs had an annual growth of only 0.7% between 1989 and 1994, a lower rate of growth than for patented drugs.[2]

Even if we accept the PMPRB study at face value, we still need to ask whether the PMPRB could be doing more to keep prices down. The key here is the control over introductory prices. Even if price increases are indexed to inflation, a high introductory price guarantees continuing high prices. The PMPRB does not have the capability to determine whether introductory prices truly reflect research and development costs. Instead, one of the main measures that it uses to determine this is the relation between Canadian and "international" prices. But under the PMPRB regulations "international" has a specific meaning: the price in 7 other Organization for Economic Cooperation and Development (OECD) countries — France, Germany, Italy, Sweden, Switzerland, the UK and the US. Are these countries representative of the OECD as a whole? To answer this question we need to turn to an economic measure called purchasing power parities (PPPs), rates of currency conversion that equalize the purchasing power of different currencies. When they are used to compare drug prices in the 7 reference countries that the PMPRB uses with those in all 24 OECD countries, it turns out that prices are more than 6% higher in the PMPRB's reference group of countries.[3]

Provincial government actions may have done as much or more than the PMPRB to reduce drug costs. Even if the board has had an effect, introductory prices are kept artificially high because of the PMPRB's definition of an international price.

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References

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2. Brogan Consulting Inc., WN Palmer & Associates. *Review of prescription nonpatented drug prices in Canada using public and private drug plan data 1989–1994*. Ottawa: Federal/Provincial/Territorial Pharmaceutical Policy Committee; 1995.
3. Organization for Economic Co-operation and Development. *Purchasing power parities and real expenditures: GK results. vol. 2, 1993*. Paris: The Organization; 1996: Table 2.9

Foreign specialists need not apply

David Square has raised some interesting issues in his article "Storm of protest greets motion to restrict specialty exams" (*Can Med Assoc J* 1997;157:1188-9). The motion that was recently considered by the Royal College of Physicians and Surgeons of Canada (RCPSC) is quite challenging, but makes me curious. Is the accreditation process applied by the RCPSC very different from that applied in most other countries? Are there any formal studies looking at competency or performance of trainees from different specialty-training programs around the world?

Although the motion may affect small numbers of physicians, this is not the issue: this should be an issue of principle. Do we have good reasons to deny foreign-trained specialists the right to challenge our examinations? Even though only a handful of specialists might be affected, this would translate into thousands of Canadians who might be denied quality care, especially in remote ar-

eas. Even though foreign specialists will not provide the ultimate solution to Canada's maldistribution problems, they are and will likely continue to be an important element of any solution.

I realize the act of accreditation involves tremendous responsibility and that authorities must ensure that only competent and capable specialists are allowed to practise. However, can we really exclude, carte blanche, entire groups of trainees from some countries? It seems arrogant to suggest that our training programs are of higher calibre than similar programs in Germany, France or Japan. It would be fascinating to see the data supporting this notion.

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Patient confidentiality and the law

It is a pleasure to see that a medical student and practising physician are sufficiently interested in the ethical issues surrounding patient confidentiality to write a paper. However, the article "From Hippocrates to facsimile" (*Can Med Assoc J* 1997;156: 847-52), by Daniel Y. Dodek and Arthur Dodek, should not be considered a comprehensive guide to patient confidentiality in Canada. Some of the authors' conclusions are so general they are misleading and must not be taken at face value.

The authors based their article on the premise that patients have a right of "inviolate confidentiality" with respect to their medical records. No such absolute right exists. They seem to acknowledge this fact by citing the CMA *Code of Ethics*, which provides that patient confidentiality is to be respected except where it might conflict with the law or would result in harm to the patient or others. These significant limitations have become increasingly common, and they should not be regarded as minor aberrations. They must be recognized and respected by the profession.

Likewise, subpoenas requiring the release of patient records may eventually conflict with the confidentiality that would otherwise attach to patient records. However, the subpoena does not oblige the physician to turn medical records over immediately to the person requesting them but merely to bring them to court, where it will be determined whether they should be released. Therefore, complying with a valid subpoena will not automatically violate a patient's confidentiality.

The same problem exists concerning the mandatory-reporting obligations cited by the authors. They write that reporting AIDS, but not HIV infection, is mandatory in the US and in Canada. This is inaccurate. Although it may be true in some jurisdictions, there is strong authority that it does not apply, for example, in Ontario. The policy of the Ontario medical officer of health is that, pursuant to Ontario's Health Promotion and Protection Act, physicians are required to report cases of HIV infection. Likewise, rules on mandatory reporting of child abuse vary across the country. Finally, gunshot and knife wounds are *not* subject to mandatory disclosure. It may apply in the specific context of a criminal investigation or a coroner's inquiry for which a subpoena or a warrant has been issued, but the bold statement that all gunshot and knife wounds must be reported is unfounded.

The authors also state that the physician should ask whether there is any information the patient wishes to keep absolutely confidential. This is highly questionable advice. Keeping 2 sets of charts will create obvious record-keeping problems. Moreover, even though a patient and doctor have deemed something "absolutely confidential," it can still be produced under court order.

It is difficult to imagine when it would be in a physician's interest to consent to not documenting or deleting certain findings or medical information. Failure to record all relevant information will make it difficult to establish the facts upon which advice or treatment was based, and could lead to inappropriate treatment when someone relies upon the incomplete record. The evidentiary consequences in a malpractice action against a physician could serve to destroy an otherwise strong defence.

Finally, if a patient requests that only a portion of the chart be provided to a third party, the physician should let the party know that a portion has been withheld at the patient's request. For example, a patient with a heart condition who applies for life insurance might request than an expurgated version of the chart to be sent to the insurance company. If the company pays out a claim because of this, it could bring a civil action against the physician to recover its losses.

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[The authors respond:]

We appreciate Margaret Ross's comments. The article was not meant to be a comprehensive guide to patient confidentiality but rather a selection of the many direct and indirect ways in which patient confidentiality can be betrayed.

There are some very specific legal limitations on patient confidentiality, and physicians certainly must abide by them. We wanted to point out how easy it is to violate patient confidentiality.