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

1. Patented Medicine Prices Review Board. *The impact of federal regulation of patented drug prices*. Ottawa: The Board; 1997. PMPRB Study Series S-9708.
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-