BIG PHARMA VS EVERYONE

CANADA'S DRUG COSTS ARE AMONG THE HIGHEST IN THE WORLD AND OUR HEALTH PLANS ARE CRACKING UNDER THE STRAIN. HOW CAN WE GET COSTS UNDER CONTROL BEFORE IT'S TOO LATE?

BY PAUL CHRISTOPHER WEBSTER

ILLUSTRATION BY RAYMOND BIESINGER

On the 20-minute drive between Sault Ste. Marie Airport and Jim Rennie's office at the Essar Steel Algoma plant, I spotted five pharmacies. When I mentioned this to Rennie, who is vice-president of human resources at Essar, he checked his "heat map," which locates each of the city's 27 pharmacies and highlights their sales to the 22,000 people covered by Essar's health plan. "By my count, you actually drove past 15 pharmacies, and there were another seven within a block of you at various points," Rennie calculated with a chuckle. "If it was a pub crawl, you wouldn't have made it here."

Rennie's interest in pharmacies isn't academic. When, in 2010, he became a VP at Essar—which, with 2,800 employees, is the largest employer in the Soo and is currently under creditor protection—he took a hard look at the company's drug costs. He calculated that each of the city's pharmacies was selling about $1-million worth of prescriptions annually, on average, to Essar's health plan beneficiaries. About half of these charges are paid by Essar, and half by Ontario's public drug plan. With its population of 75,000, Sault Ste. Marie has

Concerned about drug costs at Essar Steel Algoma, Jim Rennie (left) hit upon the idea of building an employer-owned pharmacy. Here he looks over blueprints with developer Joe Ruscio

a pharmacy for every 2,778 people—a ratio 26% higher than the national average. Rennie soon began to wonder whether there were savings to be had on Essar's drug bills. So he brought in Mike Sullivan, a Toronto-based health-data analyst whose company, Cubic Health, specializes in probing corporate drug plans for inappropriate billings, waste, fraud and other inefficiencies.

It didn't take long for Sullivan, who is a pharmacist himself, to conclude that Essar and its beneficiaries were being dramatically overcharged in numerous perfectly legal ways by many local pharmacies—mostly through over-enthusiastic application of "dispensing fees," as well as big markups. "Sault Ste. Marie is a kind of geographical island," Rennie explains. "Pharmacists here have a captive market. And nobody was challenging their bills."

To start bringing down Essar's health costs, Rennie strong-armed many local pharmacies into paring down their charges and joining a "preferred provider network" that Essar's beneficiaries are firmly encouraged to patronize. That step has reduced Essar's share of the drug costs by 23%—from more than $15 million in 2010 to $11.5 million in 2015. But secrecy around the actual costs that pharmacies pay for drugs still rankles Rennie, who thinks there is a lot more money to be saved.

One evening over a Scotch with Sullivan, Rennie hit upon a novel idea.

"How would it be," Rennie asked Sullivan, "if we just set up our own pharmacy?"

From his perch in a Bay Street office tower, Tim Clarke, who is chief innovation officer at human-resources and insurance consultants Aon Hewitt, sees Rennie's revolt as part of a broader health cost containment revolution getting under way across corporate Canada, which is home to an estimated 100,000-plus group insurance contracts. "All sorts of companies are testing ways to contain their health-care costs," Clarke says. "Essar's not the only company that has considered building its own pharmacy."

Over the past decade, Clarke estimates, company health-plan costs have doubled. Frustration with these costs—driven partly by pharmacists' fees and markups, and partly by quickly rising drug prices—is becoming acute, says Clarke. "The main driver of these cost increases is a small category of high-cost drugs," he says. To illustrate his point, he singles out Sovaldi, a treatment introduced in 2014 for hepatitis C. The drug costs at least $55,000 to treat a virus that is estimated to infect as many as 400,000 Canadians.

Some 63% of all new drugs approved by Health Canada in 2013 were high-priced specialty drugs such as Sovaldi. Some of them are biotech-based "biologic" drugs, often for rare disorders once considered untreatable. Others are non-biologics used to treat diseases such as cancer. Some of them can cost patients up to $1 million annually. Thanks to generous patent protections designed to encourage pharmaceutical companies to invest in research, these drugs' extreme profitability is guaranteed for a dozen years or more.

Meanwhile, the prices of numerous less-innovative drugs have also exploded—most famously in the case of pyrimethamine, a 60-year-old drug used to treat toxoplasmosis in immunocompromised patients. Turing Pharmaceuticals, which purchased American sales rights to the drug in August, 2015, immediately raised its price more than 50-fold.

A 2014 report from the Canadian Institute for Health Information (CIHI) spelled out the effect of rising drug costs. It noted that the proportion of public drug-program spending on the most expensive beneficiaries—those for whom a program paid $10,000 or more annually—nearly doubled to almost 30% between 2008 and 2013. This has erased savings stemming from the introduction of scores of low-cost generic drugs as the patents on numerous drugs expired in recent years, says CIHI.

But drug-makers' cost-inflating tactics aren't the only problem, says Mike Sullivan. "Employers are on the hook, but by and large they don't have a clue what's going on," he opines. "All they know is that there's a pharmacy on every street corner."

And those pharmacies are not hurting. In Canada, they have consolidated over the past decade into a handful of powerful national and regional chains. While Canadian data on their revenue is scarce, one indication of their profitability comes from an analysis by Bloomberg of 39 medicines with sales of more than $1 billion a year. It found that in the United States, "30 of them logged price increases of more than double the rate of inflation from 2009 to 2015....Only six drugs had price increases in line with or below inflation."

The pain of rising drug costs is shared three ways. First, there are the public plans managed by the provincial, territorial and federal governments, which foot 42% of Canada's $35-billion annual drug bill. Then there are the private employers and their insurers, which pay 36% of national drug costs. Finally, individuals paying out of their own

PHOTOGRAPHS ALLEN AGOSTINO

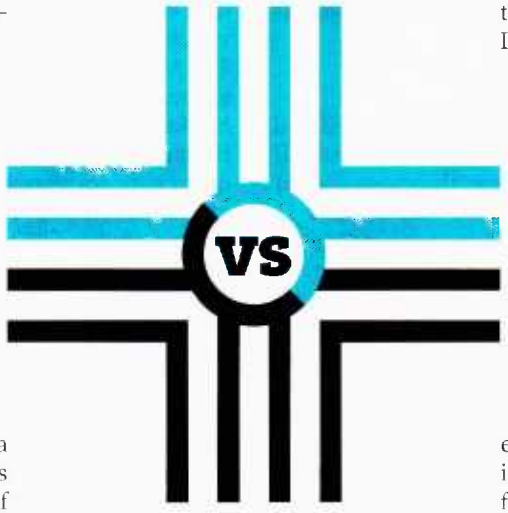
pockets account for the remaining 22%. Canada's per capita drug spending is the world's highest after the U.S., and almost twice as high as Sweden's. Canadian drug expenditures almost doubled between 2000 and 2012, says Carleton University analyst Marc-André Gagnon. He notes that a 2012 study by benefits manager Express Scripts Canada pinpointed another influence on rising costs: It estimated that "poor patient decisions" result in about $5 billion in overspending annually by private drug plans.

In extreme cases, pharmacy markups can be as high as 240% on a prescription for a chronic-care drug that gets renewed indefinitely, says Sullivan. And the price of a drug often varies by 40% to 50% depending on where it is bought. "When an employer pays $130,000 for a drug claim—as is increasingly the case—you can be paying $20,000 to a pharmacist for taking a couple bottles of pills out of a drawer."

(Asked to respond to concerns that pharmacists are driving up drug costs, a spokesperson for the Canadian Pharmacists Association said she could not comment "because we are not involved in the actual business of pharmacy.")

COST FOR A TWO-MONTH SUPPLY OF SOVALDI IN EGYPT

$800



COST FOR A TWO-MONTH SUPPLY OF SOVALDI IN CANADA

$55,000

Then there's the cut that goes to a category of companies known as claims benefits managers. The two largest of these intermediaries between pharmacies and insurers are Express Scripts Canada and a branch of telecom giant Telus. These costs—which are passed along to payers—are buried in the intermediaries' contracts with pharmacies. These contracts are secret. Tellingly, however, Anthem, a major American health insurer, is suing Express Scripts in the U.S. for about $15 billion (U.S.) for alleged drug overcharging. In its lawsuit, Anthem claims it was paying "massively excessive prices," and generating "an obscene profit windfall" for Express Scripts—claims that the benefits manager denies.

And then there's the fee of 10% or more on all employee claims charged by the insurers, Sullivan fumes. "The insurance companies," Sullivan argues, "have been able to get away with telling employers almost nothing about what's going on. But when you sift through their employee claims data and tell employers how much they are overpaying, they all have heart attacks."

When Sullivan turns to the pharmaceutical industry's profits, he can no longer remain in his seat. Pacing his boardroom, he notes that generic drug manufacturers as a group charge 18% of the price of the brand-name equivalents to their products—and are still profitable. "It makes you wonder like hell how much the pharmaceutical industry makes," he says fiercely. "When you think about bullshit drug pricing, it's crazy."

Worldwide, the market for pharmaceuticals is worth an estimated $1.1 trillion (U.S.). As of 2009, almost a fifth of the entire health-care budget across the countries within the Organization for Economic Co-operation and Development, which includes many rich countries like Canada, is spent on medicines. In many emerging economies like Vietnam, China, Chile and Saudi Arabia, drug market growth is 8% or more annually.

Powered by ironclad patent protections entrenched in international trade agreements, successful drugs deliver massive profits for their owners. The widely prescribed anti-cholesterol drug Lipitor, for example, generated about $150 billion (U.S.) for its manufacturer, Pfizer, between its launch in 1997 and the end of 2015. (The cost of developing such a "blockbuster" drug has been put at $2.6 billion (U.S.) by the Tufts Center for the Study of Drug Development.) After Lipitor's patent expired in 2011, Pfizer's revenues from it began dropping as patients switched from $5-a-pill patented versions of the drug to 31-cent versions made by generic drug manufacturers.

The variation in drug prices between provinces and countries can be extreme—as in the case of Sovaldi, marketed by U.S.-based Gilead. Egypt has the highest prevalence of viral hepatitis C in the world, and, in 2014, it was the first low- or middle-income country to negotiate preferential pricing with Gilead. The result is that the same two-month-long treatment course that costs $55,000 in Canada is just $800 in Egypt.

In the U.S., where the drug costs even more, a public-interest-research group called the Initiative for Medicines, Access & Knowledge (I-MAK) has evaluated Gilead's patent portfolio and concluded that, "based on U.S. and international patent law, Gilead does not deserve any of its 27 patents for Sovaldi" because "the base and secondary patents for the drug are based on old science and commonly known techniques." I-MAK is challenging Gilead's patents, and its prices, in Argentina, Brazil, China, India, Ukraine and Russia.

If the patents were removed, says I-MAK director Priti Radhakrishnan, "people in the U.S. could access far cheaper versions of the same drug as soon as 10 years earlier." This

could open access to treatment for millions of people in the U.S., she adds, "saving patients and payers like Medicare and Medicaid $5 billion (U.S.) over an eight-year period."

The roots of the extreme pricing lie in Gilead Sciences Inc.'s acquisition of the drug's developer, Pharmasset, for $11 billion (U.S.) in the fall of 2011. Pharmasset's chief executive made an estimated $255 million (U.S.) on the deal, and its 82 employees each averaged an estimated $3.3 million (U.S.). Gilead has hauled in more than $30 billion (U.S.) on sales of Sovaldi and another hepatitis drug, Harvoni, so far.

Asked to respond to I-MAK's critique, Gilead's public affairs director, Mark Snyder, emphasized that Gilead itself invested in hepatitis C research before buying Pharmasset—an acquisition, he said, that carried "considerable risk." While he did not directly reply to a question about disparity in the price of Sovaldi, Snyder said, "We appreciate the importance of making health-care accessible for all patients living with hepatitis C....Gilead employs a multi-pronged approach to make treatment more affordable to the developing world, including flexible, tiered pricing based on a country's local economic conditions, as well as disease burden."

The advent of a new generation of specialized drugs like Sovaldi, which are hundreds of times more expensive than the mass-market blockbusters of yesteryear like Lipitor, is straining the long-standing compact between employers, insurers, pharmacists, drug makers and the claims-processing companies that help manage drug claims for pharmacists and insurers. "The old insurance model is breaking down," warns Aon Hewitt's Tim Clarke. "We're at the point where we need new solutions," he says.

In the past, Clarke explains, the role of health insurance companies that manage private health plans—the likes of Manulife, Sun Life Financial, Great-West Life and Green Shield—was largely limited to helping employers adjudicate and pay for claims with flow-through funding from the employer. Their role as insurers per se was limited to providing insurance for catastrophic costs.

With the advent of many new ultra-expensive drugs, and the growing numbers of beneficiaries using them, employers face an increasingly expensive dilemma, Clarke says: Do they continue "self-insuring" and paying for employees' medicines as part of their operating costs, or do they increase their spending on expensive catastrophe insurance? Spending on the latter has doubled or tripled in many cases, and in some instances it's increased to 7% of companies' total health bill, Clarke estimates. "We are seeing occurrences of individual beneficiaries in plans whose drug bills run over half a million dollars annually," he says. "If my employee loses the genetic lottery, it suddenly means a lot to me. Cost containment is top of mind with virtually everyone we talk to."

Clarke says employers and insurers are testing a basket of measures ranging from closer management of beneficiaries' health problems to greater scrutiny of formularies (which list approved drugs), to requiring that beneficiaries obtain prior authorization for expensive prescriptions. "We're seeing some knee-jerk reactions—'We won't cover biologics and we won't cover anything over $10,000.'"

Both insurers and employers as a group are starting to take tentative steps to confront the crisis. In September, 2015, Manulife launched a "DrugWatch" program, which, it tells employers, "closely monitors the drug landscape and analyzes the effectiveness and financial impact of new medications, to ensure you receive value for your drug benefit dollars."

The program is described by PDCI Market Access, Canada's leading drug pricing and reimbursement consultancy, as the first time a major private payer in Canada is placing significant emphasis on the public-sector expertise provided by the Canadian Agency for Drugs and Technologies in Health, which makes price recommendations to public drug plans. The Manulife program also prioritizes "expert negotiation" to seek the best possible drug prices for their clients, PDCI Market Access reported. "This could mark a sea change in the private payer landscape, depending upon how other major carriers respond to this initiative."

Another strategy focuses on drugs one at a time. According to a study of 27 manufacturers, insurers and pharmacy benefits managers by PDCI Market Access and H3 Consulting, 41% have negotiated at least one product-listing agreement (PLA), by which drug makers agree to grant preferential pricing for a product.

Among private insurers, Sun Life was among the first to reveal in 2014 that it had negotiated a discount price for the arthritis drug Remicade. But as PDCI noted in a September, 2015, report, "some agreements prohibit the parties from revealing even the existence of the PLA."

The need to maintain secrecy is an important theme in PDCI's analysis, which notes that "maintaining confidentiality may become challenging since private payers are likely to want to advise their market partners, clients, and distribution channels that lower prices are available through PLAs. To the extent that plan members are to benefit from lower prices on cost-shared medicines, those prices may need to be transparent in the retail or specialty pharmacy as well."

Jean-Michel Lavoie, assistant vice-president of product development, group benefits, at Sun Life, Canada's largest provider of group benefits, describes the Remicade deal as part of an effort that includes the establishment of a preferred provider network of 2,500 pharmacies for high-cost drugs. Another new measure is that Sun Life requires prior authorization of individual claims for expensive drugs, based on the recommendations of a team of newly hired in-house pharmacists dedicated to supervising the most expensive claims. "We want to use our market share as leverage," Lavoie said about the company's efforts. "We're in the business of managing risks, and we only see costs going upwards. We're concerned about our ability to pay, and our clients' ability to pay."

The growing chorus of opposition to high drug prices includes Helen Stevenson of the Reformulary Group and analyst Mike Sullivan of Cubic Health, who himself is a pharmacist

At Aon Hewitt, Tim Clarke says the drug price crisis is producing a range of innovative responses by employers and insurers. He could not delve into specifics, citing client confidentiality. But he did acknowledge that the options include probing the underlying costs of the drugs. "And, yes, building your own pharmacy."

Which is exactly what Jim Rennie at Essar Steel Algoma now aims to do. In partnership with the Sarnia-based Hogan Pharmacy chain, Rennie plans to build a pharmacy where clinical pharmacists will consult with customers on matters such as drug interactions and maximizing drugs' therapeutic benefit. He hopes the facility will evolve into a "wellness centre" where employees can also see nurses and other health professionals. The idea is to orchestrate better and faster health care for employees, given a patchwork public-health system that often leaves employees off work and awaiting care for long periods. "We want to bring down Essar's health costs as a whole," Rennie enthuses, "not just our drug costs."

Helen Stevenson, who is the founder and CEO of a Toronto-based drug plan management company called the Reformulary Group, agrees with Tim Clarke at Aon Hewitt that spending on specialty drugs is starting to break private and public drug plans. "Where else in the world would you see a system like this?" she asked about Canada's drug plan patchwork while chairing a debate on the merits of a national pharmacare plan in Toronto recently.

Stevenson's views on the costs drug makers are inflicting on both public and private drug plans are incisive. They stem from her 2007-2010 stint as head of Ontario Public Drug Programs, which currently spends well over $4 billion annually on drugs for groups such as seniors and low-income beneficiaries.

Stevenson and her team are credited with saving $1.5 billion by challenging costs charged by pharmacies and drug makers as well as the suitability of their products for Ontario's drug formulary, which lists more than 4,300 drugs. Since leaving the Ontario government, she's been busy reality-checking drug costs at Reformulary.

The fight to reduce public drug plan costs has been hard fought, and is far from over, Stevenson says. Drugs are the second-largest health-care expense after hospitals, she notes. In a 2011 analysis, "An End to Blank Cheques," Stevenson said Ontario's push to rein in costs was "met with huge resistance by pharmacy and pharmaceutical companies."

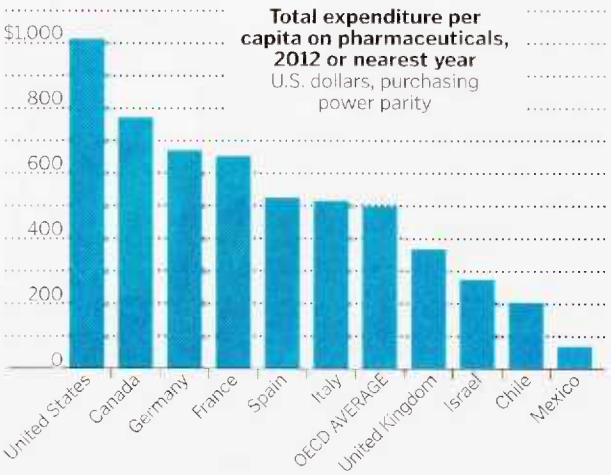
At least one drug maker is willing to make government pushback into a constitutional issue. The case concerned the cost of the drug Soliris, which comes to either $500,000 or $700,000 annually, depending on which of two diseases is being treated. The drug generated nearly all of manufacturer Alexion's $2.6 billion (U.S.) in revenue last year.

The Patented Medicine Prices Review Board, the Canadian drug-price review agency, told Alexion to lower its price and repay excess revenues generated by the drug from 2012 through the first half of 2014. Alexion responded by challenging the agency's legal power to impose pricing caps. A federal court dismissed the challenge last June, but hearings into the issue of price are ongoing.

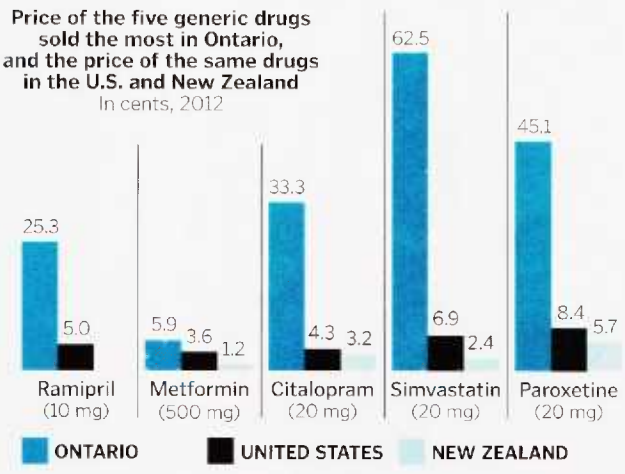
The public sector's growing success in confronting drug costs is a rare example of governments exhibiting greater fiscal prudence than their private-sector counterparts. In Stevenson's view, the private plans would be wise to start emulating the public plans. Between 2005 and 2009, private-sector drug-plan spending grew at almost twice the rate of public-sector spending, Stevenson noted in "An End to Blank Cheques." In her assessment, "employer drug plans appear to have been managed very lightly," and employers "have historically been slow to take action" to manage costs. The problem is "not necessarily complacency," she argues. "Rather, it is a lack of awareness."

To drive home her message, Stevenson highlights studies revealing that the vast majority of newly introduced high-priced medicines are "me-too" knockoffs offering little or no therapeutic benefit over older, cheaper drugs. But private drug plans seldom question this profit-seeking tactic,

CANADA LAGS ONLY THE U.S. IN PER-CAPITA DRUG SPENDING...



IN PART BECAUSE SOME POPULAR DRUGS COST FAR MORE HERE THAN ELSEWHERE...



Stevenson observes. She recommends insurers and employers seek outside advice from experts like, well, Reformulary Group, which uses an independent expert committee of physicians and pharmacists to devise cost-effective formularies. At Sun Life, Jean-Michel Lavoie says Reformulary is now part of the company's efforts to curb drug costs.

While she was with the provincial government, Stevenson also called out pharmacies for inconsistent charges and dispensing fees, and for "questionable practices" around drug company rebates—which have since been banned in Ontario. Her doubts were well-founded: Both the brand-name and generic wings of the pharma industry have a history of offering incentives to doctors and pharmacists to favour their products.

Some of these rebates have been identified as hidden revenue streams by Canada Revenue Agency, which revealed in July, 2016, that more than 1,000 Canadian retail pharmacists and their corporations received gift cards, travel vouchers, prepaid credit cards and other "incentives," totalling $58 million, from generic drug firms but failed to pay the taxes on these unreported benefits.

Stevenson is also critical of brand-name pharma's technique of pushing so-called co-pay, coupon or pharmacy benefit cards that encourage patients to request brand-name medications rather than cheaper generics. In exchange, drug companies make up the difference in price. "The problem here is that these cards circumvent good formulary practice and provide incentives for patients to choose a medication that is often more costly for their employer or health plan," says Stevenson. "Coupon cards also run dramatically counter to a well-established trend in Canada, which is that for the past 60 years, every province has required that generic drugs be substituted for brands in the provincial drug programs. This is called generic substitution, and by all accounts, it has been a true success story in bringing lower-cost versions of brand-name drugs to Canadians."

Sometimes, drug makers go beyond what's legally allowed: According to a 2016 report from Transparency International, a U.K.-based anti-corruption action group, dubious promotional schemes are problematic in the global pharmaceutical sector.

The report, which was co-authored by Jillian Kohler and Martha Martinez of the Leslie Dan Faculty of Pharmacy at the University of Toronto, notes that "Since 1991, the [pharmaceutical] industry has paid $30 billion (U.S.) in criminal fines in the U.S. for Medicare fraud, unlawful promotions, kickbacks, monopolistic practices and failure to disclose clinical trial data." Elsewhere, the report says that in the U.S., "The pharmaceutical industry spends an estimated $42 billion (U.S.) on promotional activities that target doctors annually, which is equal to $61,000 (U.S.) per doctor on average." The practice can back expensive medicines that have no therapeutic advantage over existing alternatives, the report explains.

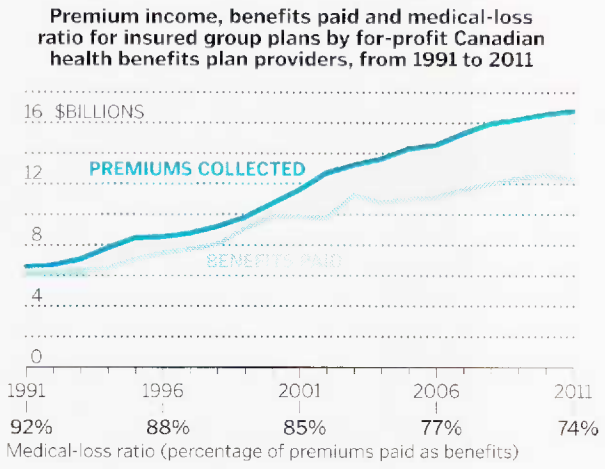
The Transparency International report calls for greater transparency in drug procurement procedures and prices, so comparisons can be easily made on prices paid by different entities for the same medicine. "Ideally," it suggests, "these measures will help curb price-gouging, price manipulation and overpayments."

Not surprisingly, the pricing practices of the pharmaceutical companies that impose the world's highest drug prices on American patients have become a mainstream political controversy in the U.S. Twenty-eight states have passed laws to compel private health insurance companies to make data on drug and other health costs transparent. The New York and Massachusetts attorneys general have launched investigations into major pharmaceutical companies' and insurers' drug-pricing policies and strategies. And numerous states have considered laws to force drug makers to reveal the real costs of drug development.

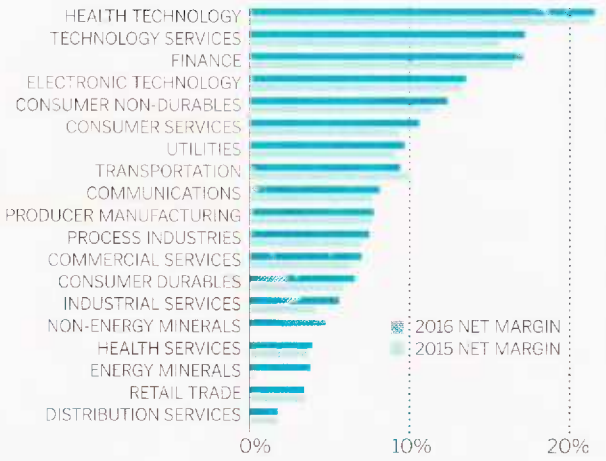
Similarly concerted government efforts are getting under way in Canada. Following on from Stevenson's success in wringing price concessions from companies whose drugs are included on Ontario's formulary, five federal government drug plans and all of the 13 provincial and territorial plans have gradually gelled in a national bargaining organization called the pan-Canadian Pharmaceutical Alliance

CHART SOURCE (1) CIHI/OECD; (2, 3) CANADIAN MEDICAL ASSOCIATION JOURNAL; (4) FORBES

BUT WHILE HEALTH PLANS FEEL THE PAIN, INSURERS DO NOT...



AND PHARMA RANKS AS THE MOST PROFITABLE INDUSTRY IN THE U.S.



(pCPA). So far, the pCPA has negotiated well over 100 drug-pricing deals with pharmaceutical companies. For generic drugs, the pCPA reduces prices for all Canadian purchasers. For patented drugs, the pCPA negotiates confidential lower prices that only apply to Canadians covered under a government plan, leaving those with private coverage or no coverage stuck with the much higher list prices.

Just as in the case of the private-sector equivalent—product-listing agreements achieved by the likes of Sun Life—the deals the pCPA reaches are secretive. Established in 2010, the pCPA still has no website. The public has no way of knowing whether the public plans in Canada are still being soaked compared with international comparators, as in the case of Solvadi.

Reassuringly, however, the pCPA has revealed that its deals are saving public plans $712 million annually—an achievement that has prompted Stephen Frank, senior vice-president for policy at the Canadian Life and Health Insurance Association, to suggest that private drug insurers should be included in the Alliance. "Having Canada's insurers in the pCPA would allow negotiators to leverage the volumes of the entire Canadian market when negotiating lower patented drug prices," Frank says. "Critically, this will ensure that all Canadians are paying the same lower price and improve the financial position of all plans over time."

Health economist Colin Busby, who is associate director of research at the C.D. Howe Institute in Toronto, agrees with Frank. The same governments that are negotiating lower drug prices for the public drug plans employ an estimated 3.6 million people, almost all of whom are privately insured, he observes. "For this reason alone," says Busby, "governments should get behind the push to drive down drug costs for private insurers." Busby also supports "an expanded federal role not only in financing, but also in drug pricing, formulary design, and in the creation of a drug strategy for rare and high-cost diseases."

The brand-name pharmaceutical industry's national lobby group, Innovative Medicines Canada (formerly called Rx&D), rejects efforts to challenge drug costs. In a statement issued in late September, the group's interim president, Elaine Campbell, complained that "discussions around new medicines in our publicly funded health-care system have focused on narrow cost containment policies that will only result in short-term savings that ultimately reduce the flow of new medicines in the system and eliminate patient and physician choice."

Canada is at a turning point, Campbell warned. "If we limit ourselves to focus only on costs in one area of the health-care system," she argued, "we will miss out on the grander opportunities that the promise of science and innovation offer for improved health."

A request made to Innovative Medicines Canada for an interview to delve further into the impact of drug pricing on health plans was declined.

In Ottawa, researcher Marc-André Gagnon insists that the public plans need to double down on drug costs through the pCPA. Recalibrating the catastrophic costs borne by public and private insurance schemes risks seeing the private plans dumping their costliest liabilities on the public plans, he warns.

In a 2014 study, Gagnon concluded that whereas the administrative costs (including the insurers' profits) for private drug plans run to 16%, these costs amount to 2% among the public plans. Including the private plans within the public plans' collective purchasing negotiations, as recommended by the Canadian Life and Health Insurance Association and the C.D. Howe Institute, would likely fracture the united front the public plans now present in their negotiations with drug companies, he argues.

Instead of tinkering around the margins with administrative adjustments, Gagnon suggests a far bolder strategy for governments and employers intent on reining in the insurers and the drug companies. "Canada is the only OECD country with universal public health care that does not also have a pharmacare plan," Gagnon observes. "If we want sustainable public drug plans, and affordable drugs for everyone, we should join them."

Feedback

A friendly letter from Big Pharma

In our November issue, award-winning writer Paul Christopher Webster investigated the soaring cost of prescription drugs and the threat they pose to our public and corporate drug plans. Soon after, we received an eight-page letter from Innovative Medicines Canada, a lobby group backed by some of the world's largest pharmaceutical companies.

The lobby group took issue with almost every fact in the story, making 42 separate complaints (a few of which were valid—see the correction below). The group's main argument was that drug prices could not possibly be out of control, since patented drugs are regulated by the federal government's Patented Medicine Prices Review Board (PMPRB). How could prices be out of control, the lobbyists argue, when regulators dictate that they can't rise faster than inflation?

Seemed like a fair point, but when we looked into it, we found it didn't hold up.

For starters, the regulations only apply to drugs that are still under patent. As drug policy researcher Joel Lexchin noted in a 2010 medical journal article, the government regulators at the PMPRB have no jurisdiction over generic drugs, many of which have ballooned in cost.

Secondly, the regulators freely admit that they are failing to keep even patented drug prices in check. In a discussion paper released this past June, the PMPRB wrote that the impact of its current policies "has been the opposite of what was intended," and that "Canadian patented drug prices have been steadily rising relative to prices in the seven countries to which Canada compares itself." It seems that the regulations are simply not working. When it comes to prescription drugs, "Canada spends more per capita and as a percentage of GDP than most other countries," the regulator notes.

Innovative Medicines Canada demanded a "full and complete retraction of the article," but we stand by it. In case you missed it, you can find our story online at **tgam.ca/bigpharma**

CORRECTION

In our November feature on drug costs ("Big Pharma vs everyone"), we cited $55,000 as the cost of a two-month supply of Sovaldi in Canada. In fact, that is the cost of a 12-week course of treatment. As well, we stated that Canada's governments cover 42% of Canada's $35-billion annual drug bill. We should have written that they cover 42% of Canada's $29-billion annual prescription drug bill. Finally, we should clarify that the prices cited for Lipitor were American prices stated in U.S. dollars, and that while the pan-Canadian Pharmaceutical Alliance has no stand-alone website, it does have a section within the Council of the Federation website (www.canadaspremiers.ca).

TAKE OUR ADVICE (OR NOT)

In our December issue, an investment banker asked Corporate Governess for some advice on whether to take paternity leave after the birth of his first child. The Governess's answer: absolutely. The commenter consensus: heck no. **You have been given some well-meaning but terrible advice,** wrote one, ahem, traditionalist. **Your career path is more cutthroat than almost any other. Be realistic rather than idealistic. Take a week off like the rest of us do, go home early when you can and come in a little later than usual for a while. Sacrifice and do whatever it takes to keep your job. It is an inconvenient truth, but that will be better for your family in the long run than ruining your career.**

KEYNES VS. CAPITALISM

In an interview with Paul Waldie, U.K.-based economist Mariana Mazzucato ("Mariana trenchant," December) made the case for government intervention in the economy. Reaction was predictably mixed. **This is a progressive Keynesian economist that thinks governments can plan and execute better than capitalism. Never has worked, and never will,** commented one reader. **Many people are happy to live off the fruits of government research,** scoffed another. **They then amuse themselves by denigrating the people whose work has made them prosperous. They posture and preen. People clap. And we all sit around blathering about the evils of big government and waiting for the next fruits to drop into our greedy little mitts.**

The last word goes to this reader: **Capitalism doesn't really work either, but that's life. Stumble, fall, get up, try again. Compared to economies 80 years ago, all our developed economies are "socialist." Things change.**

BOOM OR DOOM?

In the same issue, we featured five manufacturers producing transportation-related equipment—from train doors to satellites—here in Canada ("We built that"). Readers reacted in vastly different ways. **That's great and all,** one said, **but this feel-good story loses a bit of its lustre when the average Canadian goes home at the end of the day. ...Then it dawns on them that the tablet, the TV and just about all of the consumer goods in their home came from a cargo container from India or East Asia.**

This reader, however, was optimistic: **I suspect we have a lot more going for us than we think, but need to have a bit of uplifting news. I know I will be looking at some of these five to see if there is an investment opportunity here. I would love to put my few pennies to work here in Canada."**

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