Prescribing patterns drive up health care costs

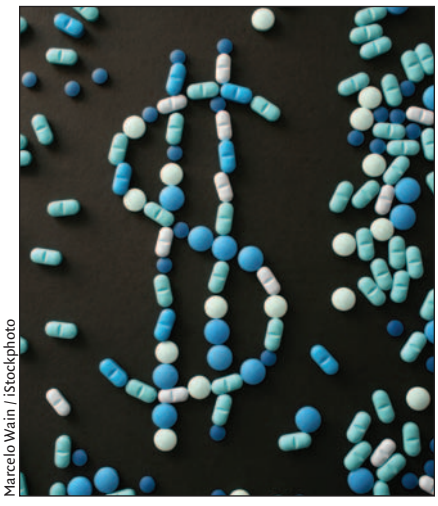
In the wake of a controversial Industry Canada–commissioned report, a thorny debate has surfaced over the responsibility of physicians to consider cost as well as efficacy while making prescriptions, as part of the national effort to contain health care costs.

The report, completed by IMS Consulting Inc. in February but released in October through an Access to Information Act request from Canadian Press, suggested that doctors do not consider cost when making prescriptions and typically prescribe more expensive brand names when generics would do.

No comprehensive survey has ever been undertaken to determine whether any provinces require their physicians to put more weight on cost as a consideration in prescribing, so it isn't apparent whether any doctors are now under obligation to do so in the manner of say American health maintenance organizations, which often dictate to doctors which drugs they can prescribe.

That's confirmed by *CMAJ* interviews with 2 of the largest provincial Colleges of Physicians and Surgeons, which say they haven't any policies mandating doctors to take cost into account in the interest of the overall health budget.

"We don't usually get down to the day-to-day positions in a doctor's office, so we don't have a [drug cost] position about you shall, you must," says Kelly Eby, communications department manager of the College of Physicians and Surgeons of Alberta. "We are interested in the best interest of patients ... not that level of detail."



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Canadian doctors often fail to take cost into account when prescribing, an independant health consulting firm says.

The Ontario College of Physicians and Surgeons, which refused to be interviewed except through written email questions, indicated that their members are in a similar position. "Issues related to specific drugs, how new drugs are introduced to doctors, and drug costs, in general, are not within our regulatory framework, and we do not take public positions [on] them," wrote Kathryn Clarke, the college's senior communications coordinator.

The Canadian Medical Association weighed in on the debate in the form of a letter to the editor to newspapers across the country from President Dr. Brian Day, arguing that effectiveness "and not expense" is now the primary consideration of physicians.

But knowledge of drug costs "is part of optimal prescribing," Day acknowledged. "Ideally, doctors and patients take cost into account, along with clinical suitability, when making decisions about drug treatment."

The latter was ignored by the IMS Consulting study as it focused on prescription numbers rather than individual physician behaviour, he added.

As an example of prescription patterns, the IMS report presented data on simvastatin, a cholesterol-lowering drug, between 2002 and 2006 in the United States and the United Kingdom, and an unspecified 4-year period in Canada.

The United States and United Kingdom already take cost into prescription decisions, the report states, and generic drug prescriptions increase rapidly once they become available.

Health maintenance organizations in the United States, which deliver prepaid health care services to enrolled members, will often pick a generic drug over the brand name since generics are cheaper to make. In the United Kingdom, general practitioners manage their own budgets.

Nothing comparable exists in Canada, although some provinces let pharmacists practise therapeutic substitution of a generic for a brand name drug.

"Pharmacists see patients more often than a physician does, and are in a better position to assess whether the patients are getting the best drug or not," says Jeff Poston, executive director of the Canadian Pharmacists' Association.

Physicians want to prescribe the proper drug for a patient's needs and in some cases, a more expensive brand name is a better formula than the generic, Poston adds. "I think what there is a tendency for is for physicians to use the newer drugs rather than the older drugs, because they're heavily promoted. [But] some of the newer drugs may be more convenient, like you might take it once a day as opposed to twice or three times a day."

Neither the Ontario nor Alberta college has a position on therapeutic substitutions, but several provinces, including Alberta, have moved to give pharmacists more prescriptive authority in hopes of bringing down drug costs (*CMAJ* 2007;176[9]:1295-96). In Ontario, therapeutic substitution falls into a legal grey area. The province's Drug Interchangeability and Dispensing Fee Act, amended last year, does not forbid the practice. But it states, "nothing in this Act shall be construed to permit therapeutic substitution."

Quebec pharmacists are allowed to "adjust" prescriptions, but the report states generics penetrate that province's market more slowly than any other. This happens because pharmacists receive a full reimbursement of brand name drugs if they dispense those products during the first 15 years after generics become available, the report says.

Poston noted that some provinces use other mechanisms to reduce drug costs, like allowing provincial drug plans to determine generic prices or negotiating business agreements with manufacturers to reduce costs.

"What we focus on more in Canadian drug plans is access," Poston said.

Informed prescription decisions cut into drug costs, since patients become healthy and require fewer drugs to live well, he added. "I think we know that proper pharmaceutical practice is cost-effective." — Elizabeth Howell, *CMAJ*

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