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Canadian policy makers' views on pharmaceutical reimbursement contracts involving confidential discounts from drug manufacturers

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ABSTRACT

Pharmaceutical policy makers are increasingly negotiating reimbursement contracts that include confidential price terms that may be affected by drug utilization volumes, patterns, or outcomes. Though such contracts may offer a variety of benefits, including the ability to tie payment to the actual performance of a product, they may also create potential policy challenges. Through telephone interviews about this type of contract, we studied the views of officials in nine of ten Canadian provinces. Use of reimbursement contracts involving confidential discounts is new in Canada and ideas about power and equity emerged as cross-cutting themes in our interviews. Though confidential rebates can lower prices and thereby increase coverage of new medicines, several policy makers felt they had little power in the decision to negotiate rebates. Study participants explained that the recent rise in the use of rebates had been driven by manufacturers' pricing tactics and precedent set by other jurisdictions. Several policy makers expressed concerns that confidential rebates could result in inter-jurisdictional inequities in drug pricing and coverage. Policy makers also noted un-insured and under-insured patients must pay inflated "list prices" even if rebates are negotiated by drug plans. The establishment of policies for disciplined negotiations, inter-jurisdictional cooperation, and provision of drug coverage for all citizens are potential solutions to the challenges created by this new pharmaceutical pricing paradigm.

1. Introduction

Pharmaceutical policy makers are increasingly negotiating reimbursement contracts as a condition of drug coverage [1–4]. Such contracts come in many forms but commonly include confidential rebates paid directly from the manufacturer to the drug plan. These rebates may be simple discounts on the list price of medicines or more complex forms of compensation based on the volume, appropriateness, or outcomes of medicine use. Though such contracts may offer a variety of benefits, including the ability to tie payment to the actual performance of a product, they may also create potential policy challenges.

There has been relatively limited documentation of payers' views of reimbursement contracts [5,6]. This is not simply because of the confidentiality of negotiation outcomes; it also stems from the relative novelty of these policies in many countries. We sought to document policy considerations related to the use of reimbursement

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Table 1
Statistics on Canada's provinces and territories.

	Population (2011)	Gross domestic product per capita (CAD$, 2010)	Prescription drug spending per capita (CAD$, 2011)	Share of prescription drug spending financed by provincial or territorial governments (2011)
Canada (total)	34,482,779	$47,000	$788	38%
Ontario	13,372,996	$46,000	$785	43%
Quebec	7,979,663	$40,000	$912	33%
British Columbia	4,573,321	$44,000	$575	36%
Alberta	3,779,353	$70,000	$725	45%
Manitoba	1,250,574	$43,000	$710	34%
Saskatchewan	1,057,884	$60,000	$799	38%
Nova Scotia	945,437	$38,000	$985	34%
New Brunswick	755,455	$39,000	$937	26%
Newfoundland and Labrador	510,578	$55,000	$920	32%
Prince Edward Island	145,855	$34,000	$791	31%
Northwest Territories[a]	43,675	$108,000	$587	20%
Yukon (territory)[a]	34,666	$67,000	$677	38%
Nunavut (territory)[a]	33,322	$53,000	$573	14%

Sources: Authors' analysis of data from Canadian Institute for Health Information and Statistics Canada.
[a] Less than 1% of Canada's population lives in Canada's vast, sparsely populated territories in which Federal drug programs play a particularly important role; as such, provinces are the focus of this paper.

contracts in Canada, a federation of heterogeneous provinces, some of which have begun using reimbursement contracts in recent years. Using data collected from key informant interviews, we analyze motivations for and challenges associated with reimbursement contract use in Canada. Several generalizable lessons emerge regarding factors that affect the adoption and outcomes of reimbursement contracts for pharmaceuticals.

1.1. Canada's policy context

Reimbursement contracts in Canada are referred to as product listing agreements (PLAs). Their use is shaped by a number of economic, demographic, and institutional factors. The first is that Canadian health care is formally the responsibility of the ten provinces, which are heterogeneous in both population size and income. As shown in Table 1, provincial populations vary from 145,855 in Prince Edward Island to 13,372,996 in Ontario; average per capita incomes vary from CAD$34,000 in Prince Edward Island to CAD$70,000 in Alberta.

National standards for the provincial health insurance programs that publicly finance virtually all costs of medical and hospital care are maintained by way of significant federal cost-sharing. Federal contributions for qualifying provincial insurance programs include mechanisms for resolving disparities in provincial GDP such that all provinces can afford to maintain national standards [7]. Prescription drugs used outside of hospitals are excluded from this federally-supported 'medicare' system. The federal government only funds prescription drug coverage for veterans, status Indians, and other specific populations that fall under its jurisdiction. This accounts for 2% of total prescription drug costs in Canada.

Provincial governments fund between 31% and 45% of prescription drug costs in their provinces through drug benefit programs that vary considerably in terms of eligibility and cost-sharing requirements [8]. All provinces require a majority of residents to fund medicines out-of-pocket or through private insurance. In Quebec, all residents are required to purchase private insurance if they qualify [9]. Private insurance is voluntary in all other provinces and, as a result, many Canadians are either uninsured or underinsured for pharmaceutical costs.

All provinces except Quebec participate in a Common Drug Review (CDR) for appraising new drugs for coverage decision-making. Manufacturers that wish to have a product listed on provincial formularies must submit an application to the CDR which then appraises evidence and makes a coverage recommendation [10]. The recommendations from the CDR are just that: recommendations. Final coverage decisions remain under the authority of each provincial government. Most provincial drug plans cover virtually all medicines in high-volume, primary care drug classes – such antihypertensives, statins, and antidepressants [11]. Provincial drug plans do vary, however, with respect to the timeliness and extent of coverage for specialized medicines [12,13].

The prices of medicines in Canada are determined by a combination of federal regulation and provincial negotiation, the relative importance of which will vary depending on the product. The federal Patented Medicine Prices Review Board sets limits on allowable prices based on the median of list prices found in seven comparator countries: France, Germany, Italy, Sweden, Switzerland, the United Kingdom, and the United States [14]. The province of Quebec also requires that manufacturers guarantee private and public drug plans in Quebec the best available prices in Canada [15]. Other provinces exert influences on drug pricing by way of negotiations concerning formulary listings; however, in the past, provincial governments seldom (if ever) negotiated confidential rebates with manufacturers seeking coverage for new medicines [16–18]. Instead, decision-making by provinces was historically a function of simple "yes" or "no" decision-making concerning coverage of drugs at list prices. Manufacturers thereby had incentive to ensure that the list prices rendered their products cost-effective in Canada, which often resulted in list prices