COMMENTARY:
Proton pump inhibitors under Alberta government sponsored programs

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COMMENTARY: PROTON PUMP INHIBITORS UNDER ALBERTA GOVERNMENT SPONSORED PROGRAMS

BACKGROUND

“On October 1, 2016, Alberta government sponsored drug programs introduced Maximum Allowable Cost (MAC) pricing for eligible proton pump inhibitors (PPI) with the MAC price based on the lowest cost PPI. Given the clinical evidence\(^1\) that all PPIs are therapeutically similar and equally effective in the majority of patients, this change will ensure health dollars are spent wisely.”\(^2\)

Proton pump inhibitors are a group of drugs which are the most clinically effective agents in producing a long-lasting reduction of gastric acid production. PPIs are among the most widely sold drugs in the world, and the first one, omeprazole, launched in 1988, is on the WHO Model List of Essential Medicines.\(^3\)

These drugs are used in the treatment of many conditions, such as:

- Dyspepsia
- Peptic ulcer disease
- As part of Helicobacter pylori eradication therapy
- Gastroesophageal reflux disease
- Barrett's esophagus
- Eosinophilic esophagitis
- Stress gastritis and ulcer prevention in critical care
- Gastrinomas and other conditions that cause hypersecretion of acid including Zollinger–Ellison syndrome

In Alberta, Alberta Health is responsible for government-sponsored drug plans and the Alberta Drug Benefit List. The plan in question is administered on behalf of Alberta Health by Alberta Blue Cross.

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\(^1\) [https://www.cadth.ca/proton-pump-inhibitor-therapy](https://www.cadth.ca/proton-pump-inhibitor-therapy)

\(^2\) [https://www.ab.bluecross.ca/pdfs/pharmacy-benefacts/pharmacy-benefact-639.pdf](https://www.ab.bluecross.ca/pdfs/pharmacy-benefacts/pharmacy-benefact-639.pdf)

Prescribers may continue to prescribe and/or plan members may continue to choose any brand name or generic variety of the PPI; however, effective February 1, 2017, Alberta government sponsored drug programs will only pay up to the MAC price and the plan member will be responsible for paying the difference. Pharmacists may choose to switch patients to the MAC priced PPI and submit for an adaptation fee. Patients currently using a PPI that is not the MAC product will be granted a transition period until January 31, 2017, to have their prescription changed to pantoprazole magnesium or rabeprazole sodium, if appropriate.

MAC pricing will be applied as follows:

<table>
<thead>
<tr>
<th>Active ingredient</th>
<th>LCA/MAC price</th>
</tr>
</thead>
<tbody>
<tr>
<td>LANSOPRAZOLE 15 MG</td>
<td>$0.1204</td>
</tr>
<tr>
<td>OMEPRAZOLE 10 MG</td>
<td></td>
</tr>
<tr>
<td>RABEPRAZOLE SODIUM 10 MG</td>
<td>MAC pricing has been applied based on the LCA price for Rabeprazole Sodium 1 X 10 mg enteric-coated tablet.</td>
</tr>
<tr>
<td>LANSOPRAZOLE 30 MG</td>
<td>$0.1875</td>
</tr>
<tr>
<td>OMEPRAZOLE 20 MG</td>
<td></td>
</tr>
<tr>
<td>PANTOPRAZOLE MAGNESIUM 40 MG</td>
<td>MAC pricing has been applied based on the LCA price for Pantoprazole Magnesium 1 X 40 mg enteric-coated tablet.</td>
</tr>
<tr>
<td>PANTOPRAZOLE SODIUM 40 MG</td>
<td></td>
</tr>
<tr>
<td>RABEPRAZOLE SODIUM 20 MG</td>
<td></td>
</tr>
</tbody>
</table>

**THE ISSUE FOR PATIENTS**

The purpose of drug benefit programs, especially publically funded programs, is to remove financial barriers to patients allowing them to obtain appropriate medication to maintain or improve their health. This is a major contributor to health status and also reduces the need for other health services.

The proposed program change to using the lowest cost product in a therapeutic category does not meet this objective. The main objective is to help the drug budget - and even that needs to be balanced by the shift of expense to the health system and patient.

POINT - COUNTERPOINT

1. “Evidence shows all these medications are equally effective”

There is no evidence that all these medications are equally effective in all patients.

When two clinical trials for similar products provide similar results it cannot be generalized that the two populations will respond exactly the same to both products. Some patients will get effective results, others will not; the issue is what proportion will respond and how many will need to try a different drug.

If we have 100 patients who are effectively controlled and they are moved to another medication not all will get the same level of benefit; if only 1% of Albertans on PPIs do not, then 2,000 patients would be affected. But based on the documented variation on drug response of 10% or more, 20,000+ patients will be affected.

2. “If you are currently on a different medication and need to switch you are to discuss this with your physician or pharmacist”

Your physician or pharmacist can shift you to another medication but will not have information or authorization to assist you to have it covered if the drug does not work. If you wish to remain on a drug that is effective you will have to pay a substantial difference in cost. Only if you have a severe allergic reaction will the doctor be able to request an exemption. This will result in thousands of patients having to pay for their medication.

While the savings are estimated for those able to switch, there are no calculations for those that would have to pay. In the seniors population the level of disposable income may preclude many from obtaining appropriate and effective medication. Again, there are no estimates of the down side of the program only a rosy picture of good health and large savings for everyone.

3. “If you choose to use lower cost medication you will have a lower copayment; if you choose not to, your costs will be higher”

Choosing a medication is based on its effectiveness. Patients do not choose the level of effectiveness, the drug decides that. If your drug decides not to work for you, you have no choice. If your government program decides not to provide effective medication you have no choice.
“Putting patients first”, as Alberta claims, means that patients should have a choice.

4. “Patients are advised to read about the drugs in Choosing Wisely Canada”

There is some general information that is not specifically helpful in this situation. It does recommend short term usage of PPIs though - the policy of Alberta Health is to provide a 3 month supply to save on dispensing fees.

5. “There are significant price differences between medications; the Canadian Agency for Drugs and Technologies in Health (CADTH) claims that all medications for acid reflux are considered therapeutically similar and equally effective”

While this is generally true for groups of patients, it is not true for all individual patients. The clinical studies used by CADTH show some patients do not respond. There are no studies comparing the same patients on different drugs. The clinical trials are on a younger different population than those in the Alberta Seniors Drug Benefit Program and there is no evidence that the results can be generalized.

6. “Blue Cross is administering the program and you can phone them for information”

Blue Cross can only repeat the conditions set out by government. If you change to a medication that doesn’t work they will tell you that you will have to pay for a medication that does work.

7. “The Government has estimated the cost savings from these changes”

There is no information on the additional cost from physicians’ visits, emergency department visits for adverse reactions, or additional administrative costs to Blue Cross.

The projected savings from a similar initiative in British Columbia were not realized. In fact, expenses exceeded savings. Savings were to have been $42 million with minimum impact on patient health. In fact, as a direct result of PPI therapeutic substitution in BC there were $24.65 million spent on additional physician services, $9.75 million for additional hospital services, and $9.11 million in increased PPI utilization, for a total of more than $43.5 million. Indirect costs of lower patient quality-of-life and poorer health outcomes, inconvenience and stress for an already vulnerable population, opportunity costs, administrative and bureaucratic change costs, and so on would raise this figure even higher if calculable.
In Alberta no such study has been, or is planned to be, conducted. Why don’t Canadian provinces talk amongst themselves and learn from each other’s experiences? If evidence based decision making was the basis for this policy change, this information should be made public.

Was tendering used to establish a new contract for the administrator of the plan?

Pharmacists will have a major role in helping patients but there is no mention of additional payment or additional information to assist them in this.

There has been no discussion with any stakeholders (patients, pharmacists, physicians, private insurance companies) about any of this. Certainly The Cameron Institute was not asked to conduct an economic analysis but the authors have made a quick calculation. The Alberta government claims that shifting patients on PPIs to the cheapest generic will save $3 million in the first year. About 200,000 patients are on these products in Alberta. If half of the patients have their doctor change their medication the physician fee of $37 would create an expense of about $3.7 million. Pharmacists could adapt the prescription order at a cost of only of $20.

There was an assumption that somehow physicians and pharmacists would work things out.

8. “How will patients be notified of the change in program?”

Most patients will find out that their drug is no longer a benefit when they arrive at a pharmacy to obtain a prescription renewal. In most cases they will not have much medication on hand during the period they must shift to the cheaper drug. In cases where they have tried the cheaper drug and then been placed on their current, more effective medication there is no option to remain on the current therapy unless they pay full price less the price of the cheaper drug.

Placing the onus on patients, especially elderly patients, to sort out the program change instead of arranging it through health professionals is sloppy, lazy public administration. Alberta Health, through Blue Cross, has the names of patients, prescribers and dispensers of each product but, seemingly, no willingness to help patients.
CONCLUSION

This program change puts over 20,000 patients at risk and there is no attempt to measure offset costs or harm.

The move to therapeutic substitution is the latest initiative in a persistent misguided attack on drug prices. The Canadian Institute for Health Information has shown that utilization, not prices, is the main cost driver of drug spending. In this case, management of utilization would consist of ensuring patients only use the drug for short periods which could be done in cooperation with pharmacists.

Access to affordable, effective medication is the main priority for patients. This program change, as with others, restricts access and the number of products available and does not lead to better health.

Best practices in the use of medication would indicate a very different program design.

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