Patented Medicine Prices Review Board

Conseil d'examen du prix des médicaments brevetés

www.pmprb-cepmb.gc.ca

PATENTED MEDICINE PRICES REVIEW BOARD

Annual Report 2012

Canada

The mandate of the Patented Medicine Prices Review Board is to ensure that prices at which patentees sell their patented medicines in Canada are not excessive; and to report on pharmaceutical trends of all medicines and on R&D spending by patentees.

Statistical Highlights 2012

REGULATORY MANDATE

Compliance

- 82 new patented drug products for human use reported to the PMPRB
  - 57 were within Guidelines
- In total, 1,328 patented drug products for human use were under the PMPRB's jurisdiction

Enforcement

Up to May 31, 2013:

- 15 Voluntary Compliance Undertakings accepted; price reduction and a total of $34.5M excess revenues offset by way of payment to the Government
- Four hearings were completed: Copaxone (redetermination) on price; Pentacel and Quadracel on remedy; Sandoz Canada Inc., on failure to file; and Tactuo on price
- There are no decisions pending
- Two matters remain before the Board: Apotex Inc. and Apo-Salvent CFC Free

REPORTING MANDATE

Sales Trends

- Sales of patented drug products declined slightly by 0.3% to $12.8 billion
- The share of patented drug products as a percentage of total sales rose from 58.6% in 2011 to 59.3% in 2012
- Antineoplastics and immunomodulating agents made the largest positive contribution to sales growth

Patented Drug Price Trends

- Prices of patented drug products sold by patentees, as measured by the Patented Medicines Price Index, increased, on average, by 0.6% and the Consumer Price Index rose by 1.5%.
- Canadian prices were the 4th highest among the seven comparator countries, lower than prices in Switzerland, Germany and the US.

Research and Development

- Patentees reported total R&D expenditures of $894.8 million, a decrease of 9.8% over 2011
- Rx&D members reported $782.8 million in R&D expenditures, a decrease of 13.1% over 2011
- R&D-to-sales ratios decreased slightly in 2012:
  - all patentees, from 5.6% in 2011 to 5.3%
  - Rx&D members, from 6.7% in 2011 to 6.6%

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Patented
Medicine Prices
Review Board

Conseil d'examen
du prix des médicaments
brevetés

May 31, 2013

The Honourable Leona Aglukkaq, P.C., M.P.
Minister of Health
House of Commons
Ottawa, Ontario
K1A 0A6

Dear Minister:

I have the pleasure to present to you, in accordance with sections 89 and 100 of the *Patent Act*, the Annual Report of the Patented Medicine Prices Review Board for the year ended December 31, 2012.

Yours very truly,

Chairperson

Canada

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Chairperson's Message

December 2012 marked the 25th anniversary of the Patented Medicine Prices Review Board. In the past two decades there have been significant changes in the pharmaceutical landscape. As the environment continues to evolve, the PMPRB remains committed to protecting consumer interests and contributing to the Canadian healthcare system by ensuring that the prices of patented medicines sold in Canada are not excessive and by reporting on pharmaceutical trends and R&D spending by patentees.

Early in the year we embarked on a comprehensive program evaluation to assess the PMPRB's performance and relevance, and initiated an action plan based on the results. The main objectives of the evaluation were to determine whether we are achieving our outcomes and whether our allocated resources are appropriate for the effective delivery of our mandate.

The Program Evaluation Report found the PMPRB programs appropriate for delivery by a federal agency and well-aligned with both government-wide priorities and our Strategic Outcome. It also found that we are achieving our expected outcomes. According to the evaluation, the incremental funding that was received in 2008–2009 was effectively used and has achieved the results for which it was approved.

In our Management Action Plan, we addressed the recommendations outlined in the Evaluation Report through examining ways to (i) expedite processes and further simplify the Guidelines, (ii) decrease regulatory burden, and (iii) make effective use of the PMPRB's resources, all without compromising its consumer protection role.

To that end, we initiated consultation with stakeholders on proposed regulatory burden reduction initiatives. Also, the Monitoring and Evaluation Plan for the Major Changes in the Guidelines remains an excellent platform for continued dialogue with patentees and other stakeholders, enabling us to make appropriate, timely adjustments to the Guidelines.

We have made a commitment to ensuring that our studies and reports are available to policy decision makers in the timeliest manner. Through the National Prescription Drug Utilization Information System (NPDUIS) program, we have expanded our exchanges with stakeholders and increased our participation in discussions and conferences.

As Chair of the Board, it is my objective to ensure that our framework continues to have a positive impact for consumers while recognizing the value that innovative medicines offer to patients. Our pricing framework makes reference to countries including Germany and the United Kingdom. As changes in drug reimbursement policies internationally continue to evolve, we will be following the progress with interest and assessing its significance.

Throughout the year, I have had the opportunity to work with dedicated colleagues on the Board and Staff. I wish to thank Tim Armstrong for his invaluable contribution to the advancement of the organization's mandate during his 10-year tenure on the Board. As well, I thank Anne Warner La Forest for her commitment to the ideals of the PMPRB. I am pleased to welcome two new Board Members, Normand Tremblay and Richard Bogoroch. Experts in their respective fields, their commitment to the PMPRB mandate will complement the Board's continued efforts to effectively serve Canadians.

I also take this opportunity to recognize the late Robert G. Elgie, former Chairperson of the PMPRB, who passed away in April. A remarkable man, Dr. Elgie believed in the PMPRB's role of protecting consumer interests and worked tirelessly at ensuring that it met its public service commitments.

On behalf of my colleagues, I reiterate our commitment to continue to effectively deliver the PMRPB mandate of serving Canadians.

ABOUT THE PATENTED MEDICINE PRICES REVIEW BOARD

About the Patented Medicine Prices Review Board

The Patented Medicine Prices Review Board (PMPRB) is an independent, quasi-judicial body established by Parliament in 1987 under the *Patent Act*.

The PMPRB protects the interests of Canadian consumers by ensuring that the prices of patented medicines sold in Canada are not excessive. It does this by reviewing the prices that patentees charge for individual patented drug products in Canadian markets. If a price appears to be excessive, the Board can hold public hearings and order price reductions and/or the offset of excess revenues. The PMPRB is also responsible for reporting on trends in pharmaceutical sales and pricing for all medicines and for reporting research and development (R&D) spending by patentees.

The Minister of Health is responsible for the pharmaceutical provisions of the *Patent Act* (Act) as set out in sections 79 to 103. The PMPRB is part of the Health Portfolio, which also includes Health Canada, the Public Health Agency of Canada and the Canadian Institutes of Health Research. The Health Portfolio supports the Minister of Health in maintaining and improving the health of Canadians.

Although part of the Health Portfolio, the PMPRB carries out its mandate at arm's length from the Minister of Health. It also operates independently of other bodies such as Health Canada, which authorizes the sale of drugs in Canada after their assessment for safety, efficacy and quality; federal, provincial and territorial public drug plans, which are responsible for listing reimbursement decisions for their respective plans; and the Common Drug Review, administered by the Canadian Agency for Drugs and Technologies in Health, which provides listing recommendations to participating public drug plans based on cost-effectiveness.

JURISDICTION

Regulatory

The PMPRB is responsible for regulating the prices that patentees charge for prescription and non-prescription patented drugs sold in Canada to ensure that they are not excessive. It includes sales to wholesalers, hospitals, pharmacies or others for both human and veterinary use. The PMPRB regulates the price of each patented drug product. This includes each strength of an individual, final dosage form of a medicine.

The Board's jurisdiction is not limited to drug products for which the patent is on the active ingredient. Rather, the Board's jurisdiction also covers drugs for which the patents relate to, but are not limited to, the processes of manufacture, the delivery system or dosage form, the indication/use and any formulations.

Patented drug products are not limited to brand-name products. A number of generic companies fall under the Board's jurisdiction by virtue of being licensees selling the same drug product as the brand company or because of manufacturing or processing patents, which various generic companies also hold.

The PMPRB has no authority to regulate the prices of non-patented drugs and does not have jurisdiction over prices charged by wholesalers or pharmacies, or over pharmacists' professional fees. Also, matters such as whether medicines are reimbursed by public drug plans, their distribution and prescribing are outside the purview of the PMPRB.

Under the Act, patentees are required to inform the PMPRB of their intention to sell a new patented drug product. Upon the sale of such a patented drug product, patentees are required to file price and sales information at introduction and, thereafter, twice a year for each strength of each dosage form of each patented drug product sold in Canada.

Although patentees are not required to obtain approval of the price before a drug is sold, they are required to comply with the Act to ensure that the prices of patented drug products sold in Canada are not excessive. In the event that the Board finds, after a public hearing, that a price is or was excessive in any market, it may order the patentee to reduce the price and take measures to offset any excess revenues it may have received.

Reporting

The PMPRB reports annually to Parliament through the Minister of Health on its activities, on trends relating to the sales and prices of medicines, and on R&D spending by patentees.

Through the National Prescription Drug Utilization Information System (NPDUIS) program, the PMPRB provides critical analyses of price, utilization and cost trends in Canada to support decision making by participating federal, provincial and territorial public drug plans.

GOVERNANCE

The Board consists of up to five members who serve on a part-time basis. Board Members, including a Chairperson and a Vice-Chairperson, are appointed by the Governor-in-Council. The Chairperson is designated under the Act as the Chief Executive Officer of the PMPRB, with the authority and responsibility to supervise and direct its work.

The Members of the Board, including the Chairperson, are collectively responsible for the implementation of the applicable provisions of the Act. Together, they establish the guidelines, rules and other policies of the Board as provided by the Act and consult, as necessary, with stakeholders including the provincial and territorial Ministers of Health and representatives of consumer groups, the pharmaceutical industry and others.

As of May 31, 2013, there was one vacancy on the Board.

MEMBERS OF THE BOARD

Chairperson

Mary Catherine Lindberg, BSP

Mary Catherine Lindberg was first appointed Member and Vice-Chairperson of the Board in June 2006. On May 19, 2010, Ms. Lindberg assumed the powers and functions of the Chairperson while the office was vacant. She was officially appointed Chairperson of the Board on March 3, 2011.

From 2002 to 2009, Ms. Lindberg was Executive Director of the Ontario Council of Academic Hospitals, an organization of 25 Academic Hospitals that are fully affiliated with a university and its Faculty of Medicine. Previously, she was the Assistant Deputy Minister, Health Services, with the Ontario Ministry of Health and Long-Term Care. Her responsibilities included the Ontario Health Insurance Plan (OHIP) and the Ontario Drug Programs.

Ms. Lindberg has a degree in pharmacy from the University of Saskatchewan and holds a pharmacist license in both Saskatchewan and Ontario.

Vice-Chairperson

Mitchell Levine, BSc, MSc, MD, FRCPC, FISPE

Dr. Mitchell Levine was appointed Member and Vice-Chairperson of the Board on March 3, 2011.

Dr. Levine is a professor in the departments of Clinical Epidemiology & Biostatistics and Medicine in the Faculty of Health Sciences at McMaster University in Hamilton, Ontario. He is also Director of the Centre for Evaluation of Medicines at St. Joseph's Healthcare in Hamilton.

Dr. Levine received his medical degree from the University of Calgary in 1979, which was followed by postgraduate training in Internal Medicine (FRCPC) and Clinical Pharmacology at the University of Toronto (1981–1987). He received an MSc degree in Clinical Epidemiology from McMaster University in 1988.

Prior to his appointment to the Board, Dr. Levine had been a member of the PMPRB's Human Drug Advisory Panel. He acts, on an ad hoc basis, as a clinical pharmacology consultant to the Ontario Ministry of Health and Long-Term Care. In addition, he is the Editor-in-Chief of the *Journal of Population Therapeutics and Clinical Pharmacology* and is an Associate Editor of the *ACP Journal Club: Evidence-Based Medicine*.

Normand Tremblay, ASC, MSc, Adm.A, C.M.C

Normand Tremblay was appointed Member of the Board in May 2012.

Mr. Tremblay teaches at the Université du Québec in Trois-Rivières, in the area of strategic management. He brings to the Board a vast experience in strategic and operational planning and organizational development.

Mr. Tremblay served as member of the National Research Council of Canada from 2007 to 2010. He is a member of the Order of Certified Administrators of Québec.

Richard Bogoroch, LL.B.

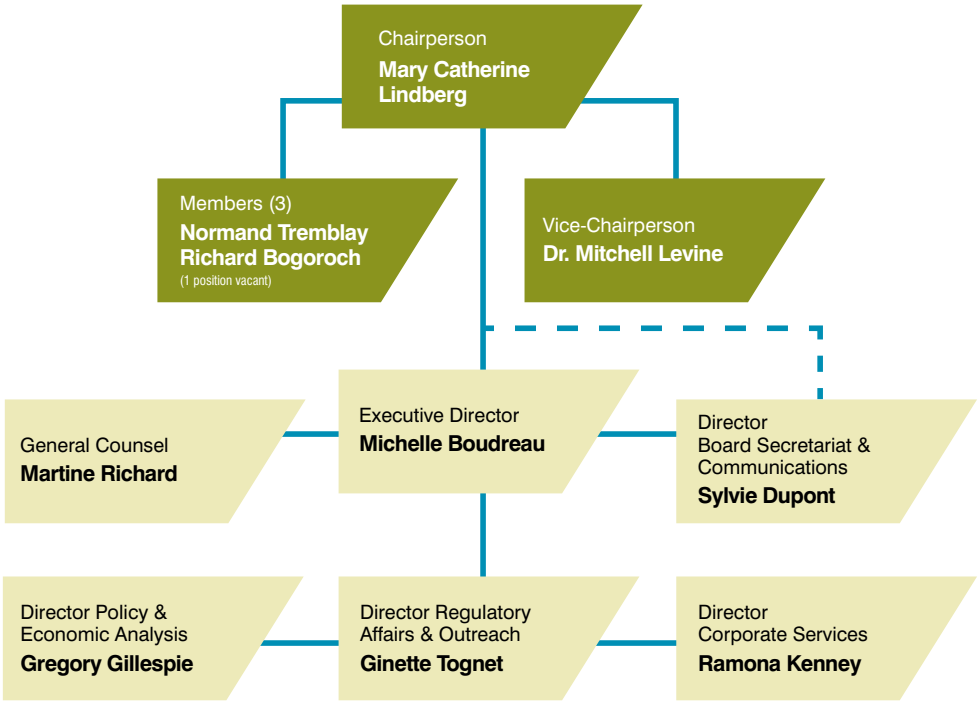
Richard Bogoroch was appointed Member of the Board in December 2012.

Mr. Bogoroch is a leading personal injury and medical malpractice lawyer actively involved in the legal community. He is a past Director of the Ontario Centre for Advocacy Training and a past Director of the Advocates' Society. Mr. Bogoroch is also a member of the Toronto Lawyers Association, the Medico-Legal Society of Toronto, the Association of Trial Lawyers of America, the American Bar Association, the Advocates' Society and the Ontario Trial Lawyers Association. He has lectured and written extensively on many aspects of personal injury and medical malpractice litigation for Continuing Legal Education Programmes organized by the Law Society of Upper Canada, the Advocates' Society, Osgoode Hall Law School and others.

Mr. Bogoroch graduated from McGill University Law School with a B.C.L. in 1978 and an LL.B. degree in 1979. He was admitted to the Alberta Bar in 1980 and called to the Ontario Bar in 1983. In 1993, he was certified by the Law Society of Upper Canada as a Specialist in Civil Litigation.

In 2012, the terms of appointment of Thomas (Tim) Armstrong and Anne Warner La Forest, who served the Board for ten and five years respectively, ended. They both made significant contributions to the PMPRB.

ORGANIZATIONAL STRUCTURE AND STAFF



Executive Director

The Executive Director is responsible for advising the Board and for the leadership and management of the Staff.

Regulatory Affairs and Outreach

The Regulatory Affairs and Outreach Branch reviews the prices of patented drug products sold in Canada to ensure that they are not excessive; encourages patentees to comply voluntarily with the Board's Guidelines; implements related compliance policies; and investigates complaints into the prices of patented medicines. This Branch also informs and educates patentees on the Board's Guidelines and filing requirements.

Policy and Economic Analysis

The Policy and Economic Analysis Branch develops policy advice and recommendations on possible changes to the Board's Guidelines and on other policy issues, as required; conducts research and economic analysis on pharmaceutical trends and prepares reports; and conducts studies both in support of compliance and enforcement and as directed by the Minister of Health.

Corporate Services

The Corporate Services Branch provides advice and services in relation to human resources management, facilities, health, safety and security, information technology and information management. It is also responsible for strategic and financial planning and reporting, audit and evaluation, and liaising with federal central agencies on these topics.

Board Secretariat and Communications

The Board Secretariat and Communications develops and manages the PMPRB's communications program, media relations and public enquiries; manages the Board's meeting and hearing processes, including the official record of proceedings; and coordinates activities pursuant to the *Access to Information Act* and the *Privacy Act*.

General Counsel

The General Counsel advises the PMPRB on legal matters and leads the prosecution team in proceedings before the Board.

BUDGET

In 2012/13, the PMPRB had a budget of $11.058 million and an approved staff level of 76 full-time equivalent employees.

TABLE 1

Budget and Staffing

	2011/12	2012/13	2013/14
Budget	$11.832 M	$11.058 M	$10.944 M
Salaries	$7.034 M	$7.034 M	$6.920 M
Operating	$1.698 M	$1.554 M	$1.554 M
Special Purpose Allotment*	$3.100 M	$2.470 M	$2.470 M
FTEs	76	76	74

* The Special Purpose Allotment is reserved strictly for external costs of public hearings (legal counsel, expert witnesses, etc.). Any unspent funds are returned to the Consolidated Revenue Fund.

COMMUNICATIONS AND OUTREACH

The Communications Program is responsible for planning and managing the PMPRB's external communications activities, as well as raising the organization's visibility and engaging with stakeholders. Information is exchanged in different forms, and through a variety of media, with consumers, provincial/territorial partners, industry and other stakeholders. The program's main activities include media relations; responding to public inquiries; and informing the public through publishing updates of Board proceedings and decisions and research results.

The Communications Group focuses on adapting to the changing requirements of the PMPRB's operating environment by evaluating its effectiveness and constantly exploring alternate communications products.

As a reliable, impartial source of comprehensive, accurate information on drug prices, the PMPRB is committed to developing and maintaining on-going collaboration with its stakeholders.

Industry stakeholders are consulted and informed of changes in the operating environment and are promptly informed of any updates to the regulatory process. To facilitate patentees' access to information, the Regulatory Affairs and Outreach Branch conducts regular outreach sessions.

Publications

In addition to regular publications, including the Annual Report and the quarterly *NEWSletter*, the PMPRB publishes NPDUIS research reports in response to program and corporate requirements.

The PMPRB is continuing to move toward electronic-only publication formats to reduce costs and decrease the environmental impact of printing. It is placing a greater reliance on its website and social media for collaboration with its stakeholders.

The PMPRB remains committed to meeting its objectives with openness and transparency.

Program Evaluation Report and Management Response

In 2008/09, the Treasury Board Secretariat approved an increase in funding for the PMPRB to help it to effectively deliver its mandate. As a provision of receiving this ongoing increase in resources, the PMPRB agreed to conduct a complete evaluation of its programs in 2011/12. The goal of the evaluation was to assess the PMPRB's relevance, efficiency and effectiveness, and the extent to which the increased resources helped it achieve its objectives.

In 2012, the PMPRB began the program evaluation process. Both the Patented Medicines Price Regulation Program and the Pharmaceutical Trends Program were found to be appropriate for delivery by a federal agency and were well-aligned with government-wide priorities and with PMPRB's Strategic Outcome. The review also concluded that the PMPRB achieved its expected outcomes.

According to the evaluation, the incremental funding that was received in 2008/09 was effectively used and has achieved the results for which it was approved.

In early 2013, the PMPRB released the Evaluation Report, along with its Management Response and Action Plan to address the considerations proposed in the Evaluation Report:

- expedite all PMPRB processes
- further simplify the Guidelines
- expand plain language use throughout all PMPRB communications
- expand the target audience for outreach efforts (strong focus on public payers, third party payers and patient advocacy groups).

The Management Response and Action Plan provides details on the initiatives and activities the PMPRB has undertaken or will be undertaking to address these considerations.

As it moves forward, the PMPRB will continue to improve its programs by monitoring the impact of the Guidelines and clarifying, adjusting and amending them as appropriate. It will also seek opportunities to make its studies and reports available to policy decision-makers in a timely manner.

REGULATING PRICES OF PATENTED MEDICINES

Patented Medicine Prices Review Board

Regulating Prices of Patented Medicines

The PMPRB protects the interests of Canadian consumers by ensuring that the prices of patented medicines sold in Canada are not excessive. It does this by reviewing the prices that patentees charge for each individual patented drug product to wholesalers, hospitals and pharmacies.

REPORTING REQUIREMENTS

Patentees are required by law to file information pertaining to the sale of their drug products in Canada. The *Patent Act* (Act) along with the *Patented Medicines Regulations* (Regulations) set out the filing requirements, and Board Staff reviews the pricing information on an ongoing basis to ensure that the prices are not excessive until all patents pertaining have expired.

There are several factors used for determining whether a drug product is excessively priced, as outlined in section 85 of the Act. The *Compendium of Policies, Guidelines and Procedures* (Guidelines) details the price tests used by Board Staff to determine whether the price charged by a patentee falls within the maximum allowable price. The Guidelines were developed in consultation with stakeholders including the provincial and territorial Ministers of Health, consumer groups, and the pharmaceutical industry. When an investigation determines that there is a problem with the price of a patented drug product, the patentee is offered the opportunity to voluntarily lower its price and/or refund its excess revenues through a Voluntary Compliance Undertaking (VCU). If the patentee disagrees with the results of the investigation and chooses not to submit a VCU, the Chairperson of the Board may issue a Notice of Hearing (NOH). A patentee may submit a VCU after the NOH has issued, or the matter may go to a public hearing. After hearing the evidence, if the Board finds that the price is indeed excessive, it can issue an Order to reduce the price and/or refund the excess revenues.

Copies of the Act, the Regulations, the Guidelines and the *Patentee's Guide to Reporting* are posted on the PMPRB's website.

Failure to Report

The PMPRB relies on the patentees' full and timely disclosure of any and all patented drug products being sold in Canada to which a patent pertains. In 2012, 12 drug products were reported to the PMPRB for the first time even though they were patented and sold prior to 2012. In addition, nine drug products previously reported to the PMPRB and for which the patent had expired, were reported again as having another patent pertaining.

Table 2 lists the drug products that were patented and sold in Canada prior to being reported to the PMPRB.

TABLE 2

Failure to Report the Sale of Patented Drugs

Currently sold by	Brand name	Generic name	Year medicine came under PMPRB's jurisdiction	Year medicine came under PMPRB's jurisdiction with subsequent patent
Baxter Corporation	Hemofil-M	Factor VIII		2005
EMD Serono Canada Inc.	Gonal-F (10 drug products)	Follitropin alpha	1999 (2), 2001 (1), 2002 (1), 2003 (3), 2005 (3)	
GlaxoSmithKline Inc.	Arepanrix	Split influenza virus, inactivated, containing antigen equivalent to A/California/7/2009 (H1N1) v-like strain	2009	
Novo Nordisk	Novolin ge (8 drug products)	Insulin, human biosynthetic		2009
Orion Corporation	Simdax	Levosimendan	2011	

Failure to File Price and Sales Data (Form 2)

Failure to file refers to the complete or partial failure of a patentee to comply with the regulatory filing requirements outlined in the Act and the Regulations. There were no Board Orders issued for failure to file in 2012.

SCIENTIFIC REVIEW

Human Drug Advisory Panel

All new patented drug products reported to the PMPRB are subject to a scientific evaluation as part of the price review process. The Human Drug Advisory Panel (HDAP) was established by the Board to provide independent expertise and advice to Board Staff. HDAP conducts a review when a patentee makes a claim regarding therapeutic improvement. HDAP reviews and evaluates available, appropriate scientific information, including any submission by a patentee with respect to the proposed level of therapeutic improvement, the selection of drug products to be used for comparison purposes and comparable dosage regimens.

HDAP members base their recommendations on current medical and scientific knowledge and clinical practices. The members of HDAP are as follows:

- Dr. Jean Gray, Professor Emeritus of Medical Education, Medicine and Pharmacology at Dalhousie University
- Dr. Adil Virani, Director of Lower Mainland Pharmacy Services in Vancouver and Associate Professor in the Faculty of Pharmaceutical Sciences at the University of British Columbia
- Dr. Fred Y. Aoki, Professor of Medicine, Medical Microbiology and Pharmacology & Therapeutics, Faculty of Medicine, at the University of Manitoba
- Dr. Jacques LeLorier, Professor, Departments of Medicine and Pharmacology at the University of Montréal, and Chief, Pharmacoepidemiology and Pharmacoeconomics, Centre de recherche du CHUM (CRCHUM)
- Dr. Muhammad Mamdani, Director of the Applied Health Research Centre, Li Ka Shing Knowledge Institute at St. Michael's Hospital, Toronto, and Professor in the Department of Health Policy, Management and Evaluation (Faculty of Medicine) and the Leslie Dan Faculty of Pharmacy at the University of Toronto

PRICE REVIEW

The PMPRB reviews the average price of each strength of an individual dosage form of each patented medicine. In most cases, this unit is consistent with the Drug Identification Number (DIN) assigned by Health Canada at the time the drug is approved for sale in Canada.

New Patented Drug Products Reported to the PMPRB in 2012

For the purpose of this report, a new patented drug product in 2012 is defined as any patented drug product first sold in Canada, or previously sold but first patented, between December 1, 2011, and November 30, 2012.

There were 82 new patented drug products for human use reported as sold in 2012. Some are one or more strengths of a new active substance and others are new presentations of existing medicines. Of the 82 new patented drug products, 10 (12.2%) were being sold in Canada prior to the issuance of the Canadian patent that brought them under the PMPRB's jurisdiction. The table below shows the year of first sale for these drug products.

TABLE 3

Number of New Patented Drug Products for Human Use in 2012 by Year First Sold

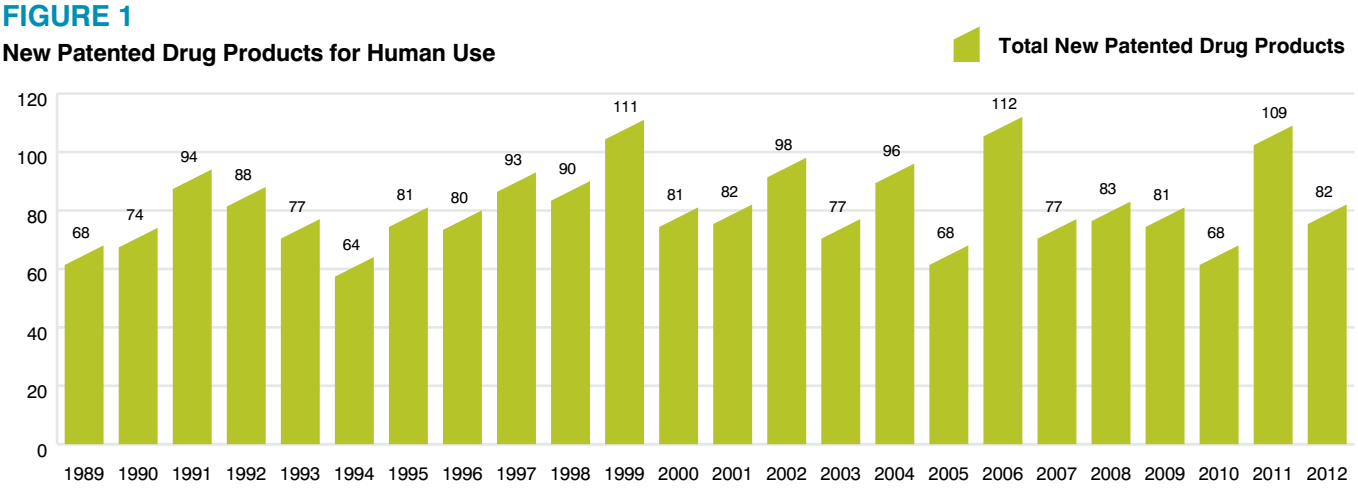
Year first sold	No. of drug products
2012	72
2011	3
2010	6
2009	1
Total	82

The list of New Patented Medicines Reported to the PMPRB is available on the website under Regulating Prices. This list includes information on the status of the review (e.g., whether the medicine is under review, within the Guidelines, under investigation, or subject to a VCU or Notice of Hearing).

Figure 1 illustrates the number of new patented drug products for human use reported to the PMPRB from 1989 to 2012.

FIGURE 1

New Patented Drug Products for Human Use



Source: PMPRB

Of the 82 new patented drug products:

- the prices of 82 had been reviewed as of March 31, 2013:
  - 57 were found to be within the Guidelines
  - 9 were at levels that appeared to exceed the Guidelines by an amount that did not trigger the investigation criteria
  - 15 were priced at levels that appeared to exceed the Guidelines and investigations were commenced
  - 1 was the subject of a Voluntary Compliance Undertaking

A complete list of the 82 new patented drug products and their price review status appears on the PMPRB website.

Price Review of Existing Patented Drug Products for Human Use in 2012

For the purpose of this report, existing patented drug products include all patented drug products that were first sold and reported to the PMPRB prior to December 1, 2012.

At the time of this report, there were 1246 existing patented drug products:

- 1033 were priced within the Guidelines
- 130 exceeded the Guidelines by an amount that did not trigger the investigation criteria
- 44 were the subject of investigations:
  - 1 was opened as the result of introductory pricing in 2011
  - 43 were opened on the basis of year-over-year prices
- 7 were under review
- 30 drug products were the subject of Voluntary Compliance Undertakings
- 2 drug products were the subject of a price hearing under section 83 of the Act (see *Hearings*)
- 1 additional drug product remains the subject of a hearing although no longer patented in 2012

A summary of the status of the price review of the new and existing patented drug products for human use in 2012 is provided in Table 4.

TABLE 4

Patented Drug Products for Human Use Sold in 2012—Status of Price Review as of March 31, 2013

	New drug products introduced in 2012	Existing drug products	Total
Total	82	1,246	1,328
Within Guidelines	57	1,033	1,090
Under Review	0	7	7
Does Not Trigger Investigation	9	130	139
Under Investigation	15	44	59
Voluntary Compliance Undertakings	1	30	31
Price Hearings	0	2	2

Update from the 2011 Annual Report

- Reviews of all drug products for human use reported as Under Review in the 2011 Annual Report have been completed
- 64 of the 68 investigations reported in the 2011 Annual Report resulted in one of the following:
  - the closure of the investigation where it was concluded that the price was within the Guidelines
  - a Voluntary Compliance Undertaking (VCU) by the patentee to reduce the price and offset excess revenues through a payment and/or a reduction in the price of another patented drug product (see *Voluntary Compliance Undertakings*)
  - a public hearing to determine whether the price was excessive, including any remedial Order determined by the Board (see *Hearings*)

Patented Over-the-Counter Drug Products and Patented Drug Products for Veterinary Use

Board Staff will only review the price of a patented over-the-counter drug product or a patented veterinary drug product when a complaint has been received. No complaints were received in 2012.

VOLUNTARY COMPLIANCE UNDERTAKINGS AND HEARINGS

Board Staff reviews the prices of all patented drug products sold in Canada. When it finds that the price of a patented drug product appears to exceed the Guidelines, and the circumstances meet the criteria for commencing an investigation, Board Staff will conduct an investigation to determine if the price of the patented drug product in fact exceeds the Guidelines. An investigation could result in one of the following:

- its closure where it is concluded that the price was within the Guidelines
- its closure when it is the Chairperson's opinion that it is not in the public interest to issue a Notice of Hearing
- a Voluntary Compliance Undertaking (VCU) by the patentee to reduce the price to a non-excessive level and offset excess revenues obtained as a result of excessive prices—excess revenues may be offset through a payment and/or an additional price reduction of the patented drug product or a price reduction of another patented drug product
- the issuance of a Notice of Hearing by the Chairperson to hold a public hearing into the price of a patented medicine

Voluntary Compliance Undertakings

A VCU is a written undertaking by a patentee to adjust its price to conform to the Board's Guidelines. Under the Guidelines, patentees are given an opportunity to submit a VCU when Board Staff concludes, following an investigation, that the price set forth by the patentee for a patented drug product sold in Canada appears to have exceeded the Guidelines. A VCU can also be submitted by a patentee after a Notice of Hearing is issued.

In 2012, the Chairperson accepted 11 VCUs covering 24 drug products. In addition to price reductions for certain drug products, excess revenues totalling $27,264,768.52 were offset by way of payments to the Government of Canada.

In 2013, to date, the Chairperson accepted 3 VCUs covering 10 drug products. Excess revenues totalling $6,828,178.77 were offset by way of payment to the Government.

Patentees are to ensure that the prices of their patented drug products remain within the Board's Guidelines in all periods in which the drug products remain under the PMPRB's jurisdiction.

TABLE 5

Voluntary Compliance Undertakings in 2012 up to May 31, 2013

Patented drug product	Therapeutic use	Patentee	Date of approval	Offset of excessive revenues	
				Price reduction	Payment to the government
VCUs in 2012					
Thalomid (3 drug products)	Multiple myeloma	Celgene Corporation	Jan.		$10,000,000
Dovobet (1 drug product)	Psoriasis	LEO Pharma Inc.	Jan.		$32,019.98
Precedex (1 drug product)	Sedation	Hospira Healthcare Corporation (Canada)	March	Price reduction of Docetaxel – $807,490	
Diflucan (1 drug product)	Fungus infections	Pfizer Canada Inc.	April	✓	$30,951.51
Trileptal® (3 drug products)	Seizures	Novartis Pharmaceuticals Canada Inc.	May	✓ $2,471,084.02	$1,000,000.00
Pariet (1 drug product)	Gastric secretion	Janssen Inc.	May	✓	$225,122.07
Avonex PS (1 drug product)	Multiple sclerosis	Biogen Idec Canada Inc.	July		$76,347.23
Banzel (2 drug products)	Seizures (LGS)	Eisai Limited	Oct.		$30,905.80
Lyrica (1 drug product)	Fibromyalgia; diabetic nerve pain; pain after shingles; partial onset seizures	Pfizer Canada Inc.	Nov.		$63,981.64
Halaven (1 drug product)	Breast cancer	Eisai Limited	Dec.		$47,822.80
Procytox (6 drug porducts)	Lymphoproli-ferative and neoplasms	Baxter Corporation	Dec.		$6,520,381.87
Uromitexan (1 drug product)	Urinary tract toxicity				$5,834,001.29
Ifex (2 drug products)	Soft tissue sarcoma, pancreatic and cervical cancers				$3,403,234.33
VCUs in 2013, up to May 31					
Novolin® (8 drug products)	Diabetes mellitus	Novo Nordisk Canada Inc	April	✓	$6,503,426.81
Mavik (1 drug product)	Hypertension	Abbott Laboratories Limited	April	✓	$118,168.48
Airomir (1 drug product)	Asthma	Graceway Canada Inc.	April		$206,583.48
Tactuo (1 drug product)	Acne	Galderma Canada Inc.	April		Board Order: $419,468.12
Overall total					$34,512,415.41

Hearings

In the event that the price of a patented medicine appears to be excessive, the Board can hold a public hearing. If it finds that the price is excessive, it may issue an order to reduce the price and to offset revenues received as a result of the excessive price. Board decisions may be subject to judicial review in the Federal Court of Canada.

In 2012, the Board issued decisions and/or orders effectively completing three matters: Copaxone (redetermination) on price; Pentacel and Quadracel on remedy; and Sandoz Canada Inc. on failure to file.

The Board issued one Notice of Hearing in 2012, in the matter of Galderma Canada Inc. and the medicine Tactuo. The Hearing Panel accepted a Voluntary Compliance Undertaking to offset excess revenues of $419,468.12 by way of a payment to the Government of Canada. The panel issued a Board Order in April 2013, concluding the matter.

Two matters remain before the Board: Apotex Inc. and Apo-Salvent CFC Free.

Summary

Excess revenues totalling $39,826,577.68 were offset by way of payments to the Government of Canada through VCUs and Board Orders in 2012 up to May 31, 2013.

Since 1993, a total of 93 VCUs have been approved and 26 public hearings initiated. These measures resulted in price reductions and the offset of excess revenues by way of additional price reductions and/or payments to the Government of Canada. Approximately $146 million have been collected through VCUs and Board Orders by way of payments to the Government of Canada and/or to customers such as hospitals and clinics.

TABLE 6

Status of Board Proceedings in 2012 up to May 31, 2013

Patented drug product	Therapeutic use	Patentee	Issuance of notice of hearing	Status
Apo-Salvent CFC-Free	Asthma	Apotex Inc.	July 8, 2008	Ongoing
Copaxone – Redetermination	Multiple sclerosis	Teva Canada	February 2010: New panel struck	Board Order: February 23, 2012 Payment of excess revenues: $2,801,285.00 Federal Court decision: April 30, 2013—*Application allowed; Board decision quashed; matter returned to new panel for redetermination*
Pentacel and Quadracel	Immunization	sanofi pasteur Limited	March 27, 2007	Board Order—Following reconsideration of the remedy as instructed by the Federal Court: June 14, 2012 Payment of excess revenues: $2,512,877.74
ratio-Salbutamol HFA	Asthma	ratiopharm Inc. (now Teva Canada)	July 18, 2008	Board decision: May 27, 2011 Board Order: October 17, 2011 Applications for judicial review filed with the Federal Court June 27, 2011; hearing scheduled for Nov. 4–6, 2013
Tactuo	Acne	Galderma Canada Inc.	Sept. 26, 2012	Board Order: April 24, 2013 VCU—Payment of excess revenues: $419,468.12

TABLE 6 (continued)

Status of Board Proceedings in 2012 up to May 31, 2013

Patentee	Issue	Date of Notice of Application	Status
Apotex Inc.	Failure to file (jurisdiction)	March 3, 2008	Ongoing
ratiopharm Inc. (now Teva Canada)	Failure to file (jurisdiction)	August 28, 2008	Board Order: June 30, 2011; amended: October 17, 2011 Application for judicial review filed with the Federal Court July 29, 2011; hearing scheduled for Nov. 4–6, 2013
Sandoz Canada Inc.	Failure to file (jurisdiction)	March 8, 2010	Board Order: August 1, 2012; re-issued October 1, 2012 Application for judicial review filed with the Federal Court August 31, 2012; hearing date to be announced

Matters before the Federal Court

Three Board decisions are currently subject to judicial review by the Federal Court for the following: ratio-Salbutamol HFA (T-1058-11; T-1825-11); ratiopharm Inc. (now Teva Canada) (T-1252-11); and Sandoz Canada Inc. (T-1616-12). The ratiopharm matters are scheduled to be heard by the Court on November 4 to 6, 2013, while the Sandoz matter has not yet been scheduled.

The Federal Court heard the Copaxone Redetermination (T-586-12) case on February 5, 2013. The Court released its decision on April 30, 2013, allowing the Teva application, quashing the Board's February 23, 2012, decision and returning the matter to a different hearing panel of the Board for redetermination.

Implementation of the Guidelines

The PMPRB is committed to making the price review process open and transparent to all stakeholders. The *Compendium of Policies*, *Guidelines and Procedures* (Guidelines) provides guidance to patentees and Board Staff on the application of factors set out in the *Patent Act* and the *Patented Medicines Regulations* to determine if the price of a patented drug product sold in Canada is excessive.

In 2010, the PMPRB implemented new Guidelines. Since then, the PMPRB has been monitoring and evaluating the application and impact of the changes to the Guidelines on an ongoing basis. In June 2011, the PMPRB published the *Monitoring and Evaluation Plan for the Major Changes to the Guidelines*. The Board was presented with the second annual assessment under this Plan in December 2012, and a table summarizing the results was published in January 2013.

As patentees and Board Staff gain experience working with the new Guidelines, and as the monitoring and evaluation process proceeds, new issues will continue to be identified. Clarifications are promptly communicated through the quarterly *NEWSletter*, and stakeholders are consulted on proposed amendments to the Guidelines through the Notice and Comment process. A revised version of the Guidelines, reflecting all changes is released annually in June.

Regulatory Burden Reduction

In alignment with the Government's Red Tape Reduction Plan and the Economic Action Plan as well as in response to the considerations identified in the 2012 PMPRB Program Evaluation, the PMPRB committed to examining its price review process to identify possible ways to reduce the regulatory burden on patentees without adversely affecting its mandate to protect consumers.

To date, the PMPRB's internal review has focused on two regulatory burden reduction initiatives to examine:

- the PMPRB's Consumer Price Index (CPI) Adjustment Methodology, and
- the feasibility of changing to one regulatory filing per year for existing patented medicines by patentees and modifying the requirement for patentees to submit information for the first day of sales of new patented drug products.

These initiatives have been identified as priorities by the Board in its *Report on Plans and Priorities* and in the *Management Response and Action Plan* published recently in response to the *2012 Program Evaluation of the PMPRB*.

The Board is consulting on those initiatives as it wishes to strike a balance between the certainty, flexibility, feasibility and efficiency of the price review process while reducing the regulatory burden on patentees.

The PMPRB has also developed new Service Standards that clarify expectations and increase predictability in the federal drug price regulatory system, more specifically for the scientific review of new patented medicines and the price review of new and existing medicines.

These initiatives are aimed at decreasing the patentees' regulatory burden and increasing the efficiency of the price review process while protecting the PMPRB's core mandate of protecting consumer interests.

KEY PHARMACEUTICAL TRENDS

Patented Medicine Prices Review Board

Key Pharmaceutical Trends

The PMPRB is responsible for reporting on trends in pharmaceutical sales and pricing for all medicines and for reporting research and development spending by patentees. In addition, the PMPRB undertakes studies and conducts analysis on a variety of topics related to pharmaceutical pricing and costs.

TRENDS IN SALES OF PATENTED DRUG PRODUCTS

Patentees are required under the *Patented Medicines Regulations* (Regulations) to submit detailed information on their sales of patented drug products, including quantities sold and net revenues received for each product by class of customer in each province and territory. The PMPRB uses this information to analyze trends in sales, prices and utilization of patented drug products.[1] This section provides key statistical results from this analysis.

Sales and Prices

Canadians spend much more today on patented drug products than they did a decade ago, but it is important to understand that an increase in drug spending does not in itself imply rising drug prices. The PMPRB's Annual Reports from 1995 through 2003 noted that sales of patented drug products grew at annual rates consistently exceeding 10%, while average annual rates of change for prices were less than 1%. In these instances, sales growth was driven by changes in the volume and composition of drug utilization.

A variety of factors can produce such changes. These include:

- increases in total population
- changes in the demographic composition of the population (for example, shifts in the age distribution toward older persons with more health problems)
- increases in the incidence of health problems requiring drug therapy
- changes in the prescribing practices of physicians (for example, shifts away from older, less expensive drug products to newer, more expensive medications, or a shift toward higher or more frequent dosages)
- increases in the use of drug therapy instead of other forms of treatment
- the use of new drug products to treat conditions for which no effective treatment existed previously

Sales Trends

Table 7 reports patentees' total sales of patented drug products in Canada for 1990 through 2012. In 2012, sales of patented drug products declined to $12.8 billion from $12.9 billion in 2011, a decrease of 0.3%. By comparison, the annual growth in sales was 27.0% in 1999 and remained in double-digits until 2003.

The last column of Table 7 gives sales of patented drug products as a share of overall drug sales. This share rose from 43.2% in 1990 to a peak of 72.7% in 2003. It has generally declined since 2003, implying that sales of non-patented brand and generic drug products have grown faster than sales of patented drug products in recent years.

TABLE 7

Sales of Patented Drug Products, 1990–2012

Year	Patented drug products		Sales of patented drug product share of all drug sales (%)*
	Sales ($billions)	Change (%)	
2012	12.8	-0.3	59.3
2011	12.9	4.0	58.6
2010	12.4	-3.8	56.0
2009	12.9	2.4	59.2
2008	12.6	2.4	61.7
2007	12.3	3.4	63.2
2006	11.9	3.5	67.8
2005	11.5	4.5	70.6
2004	11.0	7.8	72.2
2003	10.2	14.3	72.7
2002	8.9	17.5	67.4
2001	7.6	18.9	65.0
2000	6.3	16.7	63.0
1999	5.4	27.0	61.0
1998	4.3	18.9	55.1
1997	3.7	22.6	52.3
1996	3.0	12.8	45.0
1995	2.6	10.8	43.9
1994	2.4	-2.1	40.7
1993	2.4	9.4	44.4
1992	2.2	14.0	43.8
1991	2.0	13.1	43.2
1990	1.7	—	43.2

* The denominator in this ratio comprises sales of patented, non-patented brand and generic drug products. Starting with the estimate for 2005, this value is derived from data contained in IMS Health's MIDAS database. In previous years, IMS data were used to calculate sales of generic drug products only, while sales of non-patented brand products were estimated from data submitted by patentees. This approach was abandoned because of anomalies related to year-to-year changes in the set of companies reporting to the PMPRB. Ratios reported for years before 2005 likely overstate the patented share, but by only a small amount. This small bias in no way invalidates the strong upward trend evinced by the results for the years 1990 through 2003.

Sources: PMPRB and MIDAS©, 2005-2012, IMS Health Incorporated or its affiliates. All rights reserved.[2]

Drivers of Sales Growth

Table 8 decomposes the sales growth that occurred between 2011 and 2012 into distinct elements reflecting the impacts of:

- previously patented drug products that have gone off-patent or left the Canadian market ("exiting drug effect")
- patented drug products introduced to the Canadian market in 2012 ("new drug effect")
- changes in prices among patented drug products with sales in Canada in both 2011 and 2012 ("price effect")
- differences in the quantities of such drug products sold in the two years ("volume effect")
- interactions of price and quantity changes ("cross effect")

The first row of Table 8 gives these impacts as dollar amounts. The second row expresses the impacts as proportions of the overall change in sales between 2011 and 2012. For the sake of comparison, the third row provides average year-over-year proportionate impacts for 2007 through 2011.[3]

The results in this table show that the decline in sales that occurred between 2011 and 2012 was the result of drug products going off-patent; all other components contributed negatively toward the overall decrease in sales. The growth in new drugs, along with the price and volume effect, was not large enough to offset the negative effect of the exiting drugs on the overall sales.

The pronounced decline in rates of sales growth over the last few years is a striking development. Figure 2 breaks down 2012 sales of patented drug products according to the year in which the product was first sold in Canada. Throughout the latter part of the 1990s and early 2000s, sales growth was largely driven by a succession of new "blockbuster" products that ultimately achieved very high sales volumes. Despite the recent patent expiries (patent cliff), these products still accounted for a substantial share of sales in 2012. Since the beginning of the 2000s, changes in the Canadian pharmaceutical environment, along with a reduction in the rate of introduction of new high-volume products, has resulted in decreased growth.

TABLE 8

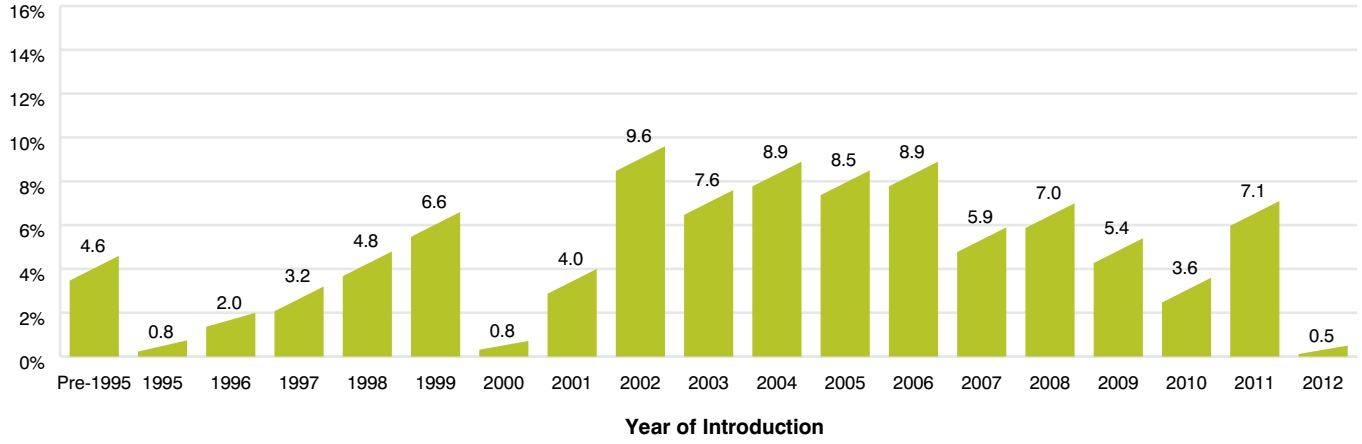
Decomposition of Changes in Sales of Patented Drug Products

	Total change	Exiting drug effect	New drug effect	Price effect	Volume effect	Cross effect
Sales impact, 2012/2011 ($millions)	-27.25	-317.82	282.07	43.22	37.68	-72.40
Proportion of total change, 2012/2011 (%)	100.00	1,166.33	-1,035.13	-158.60	-138.29	265.69
Average proportion of total change, 2007–2011 (%)	100.00	168.02	-122.76	-21.94	38.27	38.40

Source: PMPRB

FIGURE 2

Share of 2012 Sales of Patented Drug Products by Year of Introduction



Source: PMPRB

Sales by Therapeutic Class

The PMPRB classifies drug products according to the World Health Organization's (WHO) Anatomical Therapeutic Chemical (ATC) system when it conducts analyses at the level of therapeutic class. This is a hierarchical system that classifies drug products according to their principal therapeutic use and chemical composition. At its first level of aggregation (Level 1), the ATC system classifies drug products according to the element of human anatomy with which they are primarily associated.

Table 9 breaks out sales of patented drug products in Canada in 2012 by major therapeutic class, defined by ATC Level 1. The table gives the 2012 sales for each class, the share of the total sales this represents and the rate at which sales grew relative to 2011. Values in the last column represent the component of overall sales growth attributable to drug products in the corresponding therapeutic class.[4] By this measure, antineoplastics and immunomodulating agents made the largest positive contribution to sales growth. This contribution was more than offset by the declining sales of patented drug products related to the cardiovascular system and, secondarily, the blood and blood forming organs.

TABLE 9

Sales of Patented Drug Products by Major Therapeutic Class, 2012

Therapeutic class	2012 sales ($millions)	Share: 2012 sales (%)	Growth: 2012/2011 ($millions)	Growth: 2012/2011 (%)	Impact on change in expenditure (%)
A: Alimentary tract and metabolism	1,263.7	9.8	148.5	13.3	-390.1
B: Blood and blood forming organs	826.9	6.4	-126.7	-13.3	332.8
C: Cardiovascular system	1,342.8	10.5	-682.4	-33.7	1,792.4
D: Dermatologicals	108.1	0.8	25.4	30.7	-66.6
G: Genito-urinary system and sex hormones	555.8	4.3	8.0	1.5	-21.1
H: Systemic hormonal preparations	55.3	0.4	-18.2	-24.7	47.7
J: General antiinfectives for systemic use; and P: Antiparasitic products*	1,446.5	11.3	80.9	5.9	-212.5
L: Antineoplastics and immunomodulating agents	3,259.4	25.4	451.7	16.1	-1,186.5
M: Musculo-skeletal system	420.4	3.3	-11.6	-2.7	30.5
N: Nervous system	1,941.1	15.1	134.2	7.4	-352.3
R: Respiratory system	1,062.8	8.3	-101.0	-8.7	265.4
S: Sensory organs	505.2	3.9	57.6	12.9	-151.2
V: Various	54.8	0.4	-4.4	-7.5	11.6
All therapeutic classes	12,842.9	100.0	-38.1	-0.3	100.0

* These groups have been combined for reasons of confidentiality.

Source: PMPRB

End Notes

[1] All statistical results for patented drug products reported in this chapter are based on data submitted by patentees as of April 2013. On occasion, patentees report revisions to previously submitted data or provide data not previously submitted. New data of this sort can appreciably affect the statistics in this chapter. To account for this possibility, the PMPRB has adopted the practice of reporting recalculated sales figures (see *Trends in Sales of Patented Drug Products*), price and quantity indices (see *Price Trends and Utilization of Patented Drug Products*) and foreign-to-Canadian price ratios (see *Comparison of Canadian Prices to Foreign Prices*) for the five years preceding the current Annual Report year. All such recalculated values reflect currently available data. Consequently, where data revisions have occurred, values reported here may differ from those presented in earlier Annual Reports.

[2] Although based in part on data obtained under license from the MIDAS IMS database, the statements, findings, conclusions, views and opinions expressed in this Annual Report are exclusively those of the PMPRB and are not attributable to IMS AG.

[3] Under the scheme applied here, the "exiting drug effect" is the amount of 2012 sales generated by drug products that were under the PMPRB's jurisdiction in 2011 but not in 2012. The "new drug effect" is the amount of 2012 sales generated by drug products that were under the PMPRB's jurisdiction in 2012 but not in 2011. Other effects are derived by means of the relationship:

$$\Sigma\, p^{2012}(i)\, q^{2012}(i) - \Sigma\, p^{2011}(i)\, q^{2011}(i) = \Sigma\, [p^{2012}(i) - p^{2011}(i)] q^{2011}(i) + \Sigma\, p^{2011}(i)\, [q^{2012}(i) - q^{2011}(i)] + \Sigma\, [p^{2012}(i) - p^{2011}(i)]\, [q^{2012}(i) - q^{2011}(i)]$$

$p^y(i)$ is the price of drug i in year y, $q^y(i)$ is the physical volume of drug i sold in year y and (signifies summation over the set of drug products that were under the PMPRB's jurisdiction in both 2011 and 2012. The left-hand-side of this equation represents the change in total sales of such products between 2011 and 2012. The three terms of the right-hand-side define the volume, price and cross effects, respectively, reported in Table 8.

[4] This is obtained as the ratio of the year-over-year change in the dollar value of sales for the therapeutic class in question to the change in sales across all patented drug products.

PRICE TRENDS

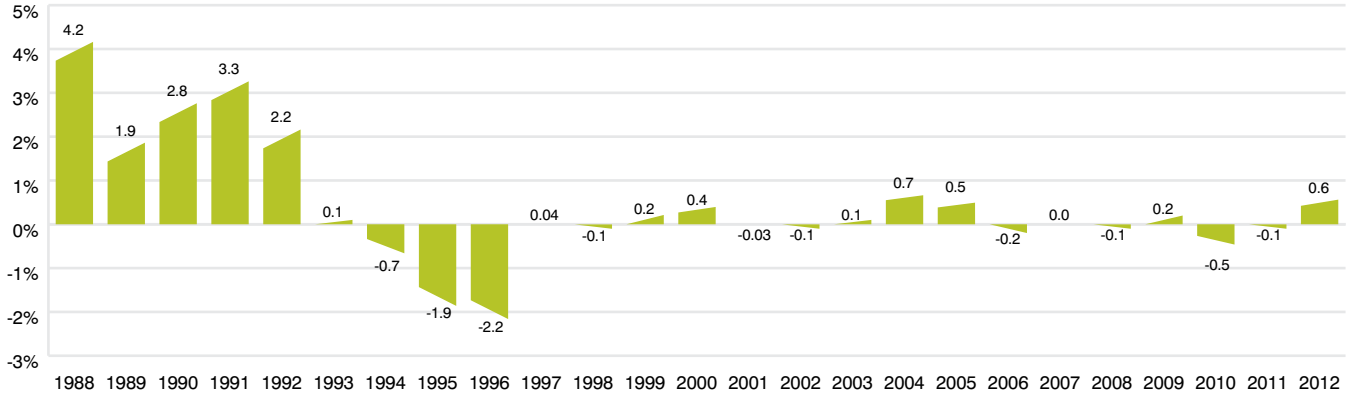
The PMPRB uses the Patented Medicines Price Index (PMPI) to monitor trends in prices of patented drug products. The PMPI measures the average year-over-year change in the ex-factory prices of patented drug products sold in Canada. The index is constructed using a formula that takes a sales-weighted average of price changes observed at the level of individual drug products.[5] This is similar to the approach Statistics Canada uses to construct the Consumer Price Index (CPI). The PMPI is updated every six months using price and sales information submitted by patentees.

It is important to understand the conceptual relationship between the PMPI and drug costs. The PMPI does not measure changes in the utilization of patented drug products; a quantity index, the PMQI, is calculated for this purpose (see *Utilization of Patented Drug Products*). The PMPI does not measure the cost impact of changes in prescribing patterns or the introduction of new medicines. By design, the PMPI isolates the component of sales growth attributable to changes in prices.

Figure 3 provides year-over-year changes in the PMPI for the years 1988 through 2012. As measured by the PMPI, prices of patented drug products increased slightly, on average, by 0.6% between 2011 and 2012.

FIGURE 3

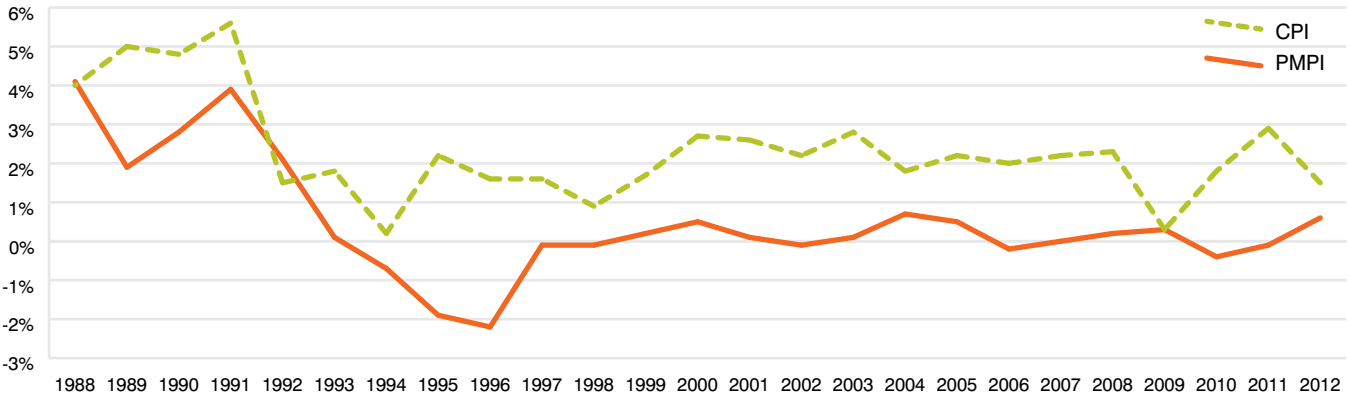
Annual Rates of Change, Patented Medicines Price Index (PMPI), 1988–2012



Source: PMPRB

FIGURE 4

Annual Rate of Change, Patented Medicines Price Index (PMPI) and Consumer Price Index (CPI), 1988–2012



Sources: PMPRB; Statistics Canada

The *Patent Act* requires the PMPRB to consider changes in the Consumer Price Index (CPI), among other factors, in determining whether the price of a patented drug product is excessive. Figure 4 plots year-over-year rates of change in the PMPI against corresponding changes in the CPI. General price inflation, as measured by the CPI, has exceeded the average increase in patented drug prices almost every year since 1988. In 2012, the CPI rose by 1.5%, while the PMPI on average increased slightly by 0.6%.

It is not surprising that the PMPI has seldom kept pace with the CPI. The PMPRB's Guidelines allow the price of a patented drug product to rise by no more than the CPI over any three-year period. (The Guidelines also impose a cap on year-over-year price increases equal to one-and-one-half times the current year rate of CPI inflation.) This effectively establishes CPI inflation as an upper bound on the amount by which individual prices may rise over any period of three years.[6] Increases in the PMPI normally do not reach this upper bound because many patentees do not raise their prices by the full amount permitted under the Guidelines, or choose to reduce their prices.

Price Change by Therapeutic Class

Table 10 provides average rates of price change among patented drug products at the level of major therapeutic classes. Results in this table were obtained by applying the PMPI methodology to data segregated by their ATC Level I class. The last column provides a decomposition of overall PMPI change, with each entry representing the component of the overall change attributable to drug products in the corresponding therapeutic class. By this measure, slight increase in PMPI (0.6%) reflects a general state of price stability across therapeutic classes. Note that all the therapeutic classes except alimentary tract and metabolism, musculo-skeletal system and systemic hormonal preparations saw an average rate of price change below the rate of CPI inflation.[7]

TABLE 10

Change in the Patented Medicines Price Index (PMPI), by Major Therapeutic Class, 2012

Therapeutic class	Share: 2012 sales (%)	Price change: 2011 to 2012 (%)	Contribution: change in PMPI (%)
A: Alimentary tract and metabolism	9.8	3.8	0.4
B: Blood and blood forming organs	6.4	0.0	0.0
C: Cardiovascular system	10.5	0.5	0.1
D: Dermatologicals	0.8	0.3	0.0
G: Genito-urinary system and sex hormones	4.3	0.9	0.0
H: Systemic hormonal preparations	0.4	1.6	0.0
J: General Antiinfectives for systemic use; and P: Antiparasitic products*	11.3	-0.7	-0.1
L: Antineoplastics and immunomodulating agents	25.4	-0.4	-0.1
M: Musculo-skeletal system	3.3	2.0	0.1
N: Nervous system	15.1	0.9	0.1
R: Respiratory system	8.3	0.8	0.1
S: Sensory organs	3.9	0.4	0.0
V: Various	0.4	-0.9	0.0
All therapeutic classes	100.0	0.6	0.6

* These groups have been combined for reasons of confidentiality.

Source: PMPRB

Price Change by Class of Customer

Figure 5 presents average rates of price change by class of customer.[8] These results were obtained by applying the PMPI methodology separately to sales data for hospital, pharmacy and wholesale customers.[9] The 2012 rates of price change for these classes were, respectively, -1.2%, -0.8% and 1.3%.

Price Change by Province/Territory

Figure 6 presents average annual rates of price change by province/territory, obtained by applying the PMPI methodology to sales data segregated by the province/territory in which the sale occurred. These results indicate that, between 2011 and 2012, prices of patented drug products in the Yukon fell on average. The largest average price increase occurred in New Brunswick (2.0).

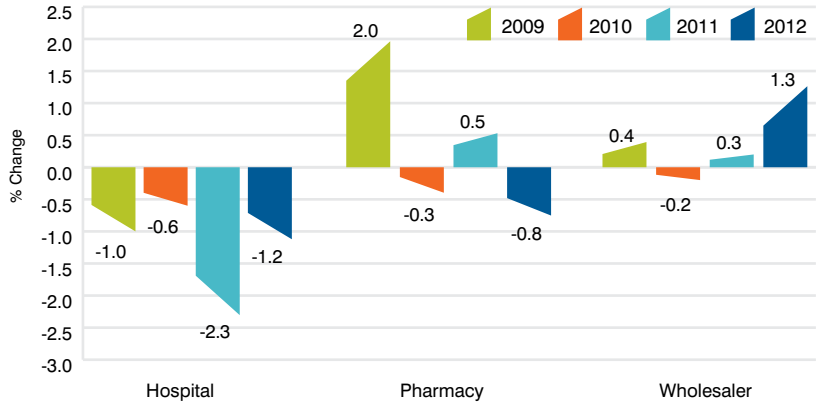
Price Behaviour After Introduction

Does the price of a typical patented drug product change much in the years after it enters the Canadian market? To answer this question, Figure 7 provides the average ratio of the 2012 price to introductory price (the price at which the drug product was sold in its first year on the Canadian market).

The results in Figure 7 imply no consistent tendency for prices to either rise or fall after introduction, with the 2012 price of a typical patented drug product being within a few percentage points of its introductory price, regardless of when it was introduced to the Canadian market.[10]

FIGURE 5

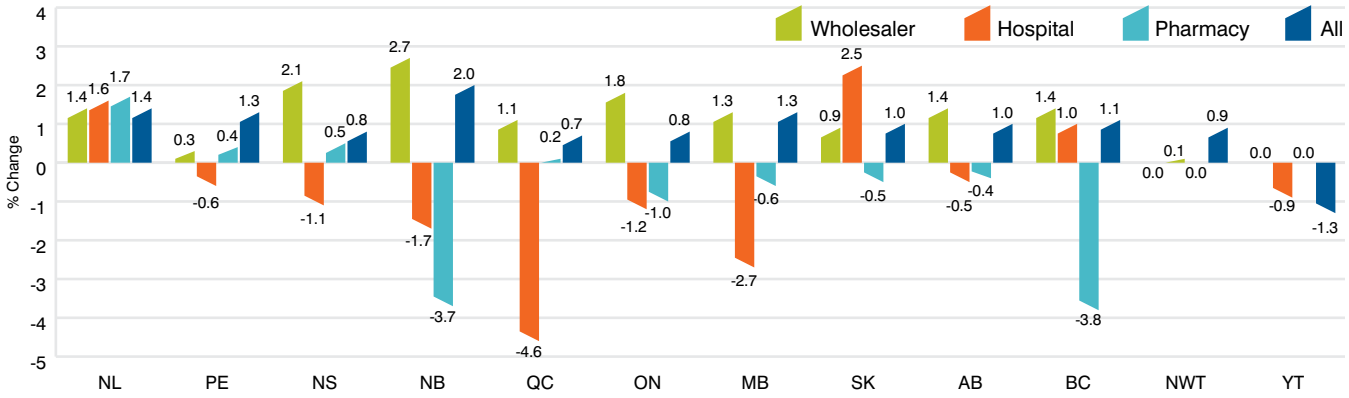
Annual Rate of Change, Patented Medicines Price Index (PMPI), by Class of Customer, 2009–2012



Source: PMPRB

FIGURE 6

Annual Rate of Price Change, by Province/Territory* and Class of Customer **, 2012

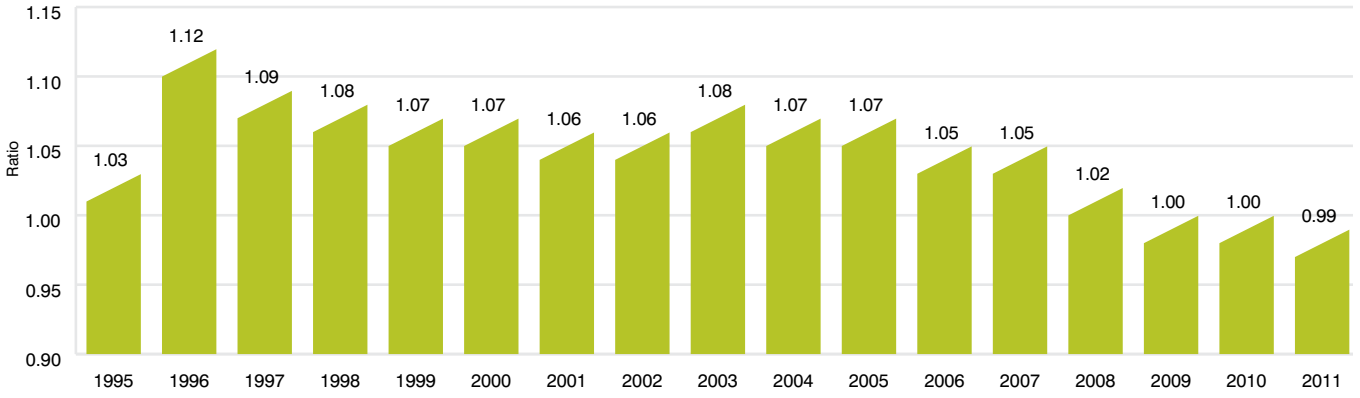


* Values for Nunavut are included in the Northwest Territories (NWT).
** Results for "All" in Figure 6 include the class of customer "other".

Source: PMPRB

FIGURE 7

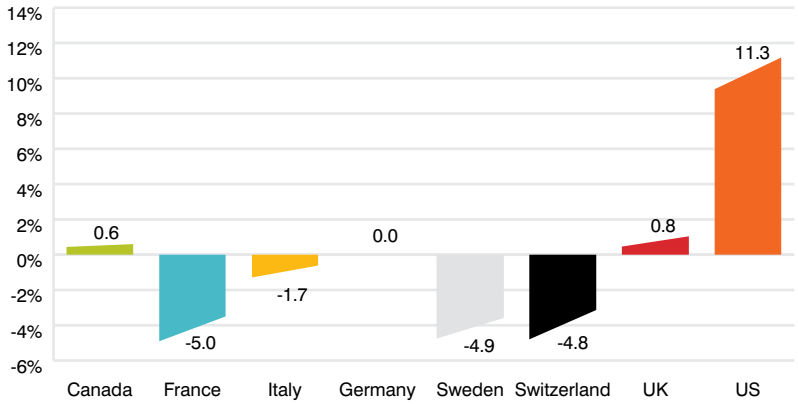
Average Ratio of 2012 Price to Introductory Price, by Year of Introduction



Source: PMPRB

FIGURE 8

Annual Average Rates of Price Change, Canada and Comparator Countries, 2012



Source: PMPRB

Price Change by Country

In accordance with the Act and the Regulations, patentees must report publicly available prices of patented drug products for seven foreign comparator countries: France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States.

The PMPRB uses this information to:

- conduct the international price comparison tests specified in its Guidelines
- compare the Canadian prices of patented drug products to those prevailing in other countries

Figure 8 gives the average annual rates of price change for Canada and each of the seven comparator countries. These results were obtained by applying the PMPI methodology (with weights based on Canadian sales patterns) to the international price data that patentees have submitted to the PMPRB. Note that results for the United States are based on prices that incorporate prices from the US Federal Supply Schedule (FSS).[11]

The results in Figure 8 indicate that in 2012, the United States saw prices rise on average at a rate of 11.3%. United Kingdom saw much more modest average price increases, while prices in France, Italy, Switzerland and Sweden declined.

End notes

[5] These calculations are performed at the level defined by Health Canada's Drug Identification Number (DIN). Each DIN represents a unique combination of active ingredient(s), dosage form, strength(s), brand and manufacturer.

[6] It is possible for individual prices (or, for that matter, the PMPI) to rise by more than the CPI in a given year. This can occur when patentees have banked price adjustments in the preceding years. It can also occur when the forecast rate of CPI inflation exceeds the actual rate. To allow patentees to set prices in advance, the CPI-Adjustment Methodology provides for the calculation of the CPI-adjustment factors based on forecast changes in the CPI. This raises the possibility of price increases exceeding CPI inflation whenever forecast CPI inflation exceeds actual CPI inflation. Note that this will not be a permanent gain as the patentee is expected to comply with the actual CPI in all subsequent reporting periods.

[7] Suppose R represents the overall rate of change in the PMPI. Suppose there are N therapeutic classes, indexed by 1, 2 … N. Let $R(i)$ represent the average rate of price change in major therapeutic class i obtained by means of the PMPI methodology. Using the fact that R is a sales-weighted average of price changes taken over all patented drug products, it is easy to derive the following relationship:

$$R = w(1) \times R(1) + w(2) \times R(2) + \ldots + w(N) \times R(N),$$

where $w(i)$ represents the share of therapeutic class i in the sales of patented drug products. This relationship provides the basis for the decomposition in the last column of Table 10. Each term on its right-hand-side multiplies the average rate of price change for a given therapeutic class by its share of overall sales. The resulting value is readily interpreted as the contribution of the corresponding class to the change in the overall PMPI. Note that the size of this contribution depends on both the rate of price change specific to the class and its relative importance, as measured by its share of sales.

The decomposition in Table 10 is approximate. This is because the weights used to calculate the contribution of each therapeutic class are based on annual sales data, whereas rates of price change (whether overall or by therapeutic class) are calculated from data covering six-month reporting periods. The resulting discrepancy is normally small.

[8] Sales of patented drug products are dominated by sales to wholesalers, which accounted for 78.2% of all sales in 2012. Sales to hospitals accounted for another 8.4%, while direct sales to pharmacies accounted for 5.1%. The pharmacy share has fallen precipitously since 2001, when it stood at 20.1%.

[9] Results for a fourth class of customer, "Others", are not provided. This class accounted for about 8.3% of patented drug sales in 2012. Buyers in this class are principally health care institutions other than hospitals, such as clinics and nursing homes. It also includes direct sales to governments. The composition of this class is thought to vary substantially from one year to the next, rendering any analysis of price change in this class of limited value.

[10] It must be emphasized that this statement refers to the behaviour of prices on average. There may be instances where individual prices have risen or fallen substantially since introduction.

[11] The pharmaceutical industry in the US has argued that the publicly available prices in that country do not reflect actual prices because of confidential discounts and rebates. Effective January 2000, and following public consultation, the PMPRB began including prices listed in the US Federal Supply Schedule (FSS) in calculating the average US price of patented drug products. The FSS prices are negotiated between manufacturers and the US Department of Veterans' Affairs. They are typically less than other publicly available US prices reported to the PMPRB by patentees.

COMPARISON OF CANADIAN PRICES TO FOREIGN PRICES

Tables 11 and 12 provide detailed statistics comparing the foreign prices of patented drug products to their Canadian prices. Each table provides two sets of average price ratios. These are differentiated according to the method by which foreign prices were converted to their Canadian dollar equivalents. The tables also give the numbers of drug products (DINs) and the volume of sales encompassed by each reported price ratio.[12]

The average price ratios given in Tables 11 and 12 are sales-weighted arithmetic means of price ratios obtained for individual drug products, with weights based on Canadian sales patterns. Average price ratios constructed in this way provide exact answers to questions of the type:

How much more/less would Canadians have paid for the patented drug products they purchased in 2012 had they paid Country X prices rather than Canadian prices?

For example, Table 11 states that the 2012 average French-to-Canadian price ratio was 0.76. This means Canadians would have paid 24% less for the patented drug products they purchased in 2012 had they bought these products at French prices.

For many years, the PMPRB has reported average foreign-to-Canadian price ratios with foreign prices converted to their Canadian dollar equivalents by means of market exchange rates. (More exactly, the 36-month moving averages of market rates the PMPRB normally uses in applying its Guidelines.) Table 11 also reports foreign-to-Canadian price ratios with currency conversion at purchasing power parity (PPP). The PPP between any two countries measures their relative costs of living expressed in units of their own currencies. In practice, cost of living is determined by pricing out a standard "basket" of goods and services at the prices prevailing in each country. Because PPPs are designed to represent relative costs of living, they offer a simple way to account for differences in overall national price levels when comparing individual prices, incomes and other monetary values across countries. When applied to the calculation of average foreign-to-Canadian price ratios they produce statistics answering questions of the type:

How much more/less consumption of other goods and services would Canadians have sacrificed for the patented drug products they purchased in 2012 had they lived in Country X?

Questions of this type cannot be answered by simply comparing drug prices. Rather, one must first calculate what each price represents in terms of goods and services foregone. PPPs are designed for such purposes.

Bilateral Comparisons

Table 11 provides bilateral comparisons of prices in each of the PMPRB's seven comparator countries to corresponding Canadian prices. Focusing on the results with currency conversion at market exchange rates, it appears that, as in previous years, Canadian prices were typically within the range of prices observed among the comparator countries. Canadian prices were roughly in line with Swiss prices. Prices in France, Italy, the United Kingdom and Sweden were appreciably lower than Canadian prices, while those in Germany were substantially higher. As in previous years, prices reported for the United States were much higher than prices in Canada or any other comparator country.

Average price ratios obtained with currency conversion at PPPs tell a somewhat different story. When international differences in cost of living are accounted for, it appears Canadians incurred a substantially larger consumption cost for the patented drug products they purchased in 2012 than did residents of every other comparator country except Germany and the United States.

Figure 9 puts these results in historical perspective. In 2005, Canadian prices were, on average, approximately equal to or below corresponding prices in all comparators other than Italy. By 2012, Canadian prices were decidedly above prices in the United Kingdom, France, and Italy and somewhat higher than prices in Sweden.

TABLE 11

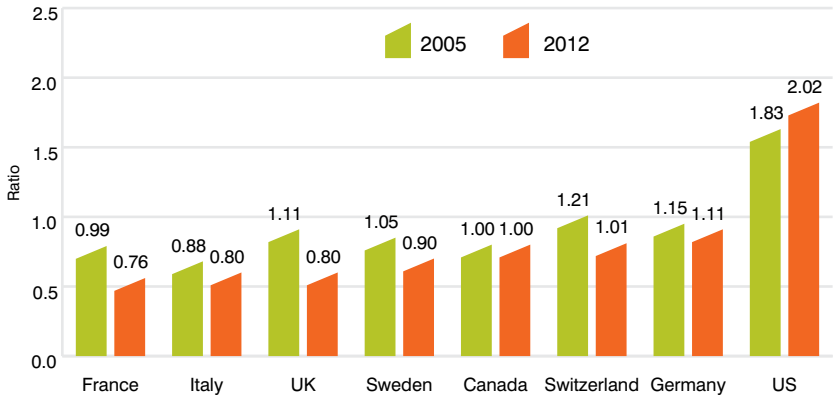
Average Foreign-to-Canadian Price Ratios, Bilateral Comparisons, 2012

	Canada	France	Italy	Germany	Sweden	Switzerland	United Kingdom	United States
At Market Exchange Rates								
Average price ratio 2012	1.00	0.76	0.80	1.11	0.90	1.01	0.80	2.02
Average price ratio 2011	1.00	0.84	0.84	1.20	0.95	1.03	0.82	1.98
At Purchasing Power Parities								
Average price ratio 2012	1.00	0.79	0.91	1.24	0.84	0.82	0.89	2.42
Average price ratio 2011	1.00	0.81	0.89	1.27	0.88	0.81	0.91	2.28
Number of patented drug products	1,264	736	809	903	870	842	864	1,070
Sales ($millions)	12,842.9	10,262.5	10,389.8	11,023.8	10,828.0	10,768.9	10,794.9	12,083.6

Source: PMPRB

FIGURE 9

Average Foreign-to-Canadian Price Ratios: 2005, 2012



Source: PMPRB

Multilateral Price Comparisons

Table 12 provides average foreign-to-Canadian price ratios using several multilateral measures of foreign prices. The median international price (MIP) is the median of prices observed among the seven comparator countries. Other multilateral price ratios compare the minimum, maximum and simple mean of foreign prices to their Canadian counterparts.

Focusing again on results at market exchange rates, the average MIP-to-Canadian price ratio stood at 1.07 in 2012. (The corresponding value for 2011 was 1.05.) Note that mean foreign prices produce higher foreign-to-Canadian price ratios than do MIPs. This is readily explained by the influence of US prices, which are typically much higher than prices elsewhere. Although US prices nearly always figure importantly in determining mean foreign price, they almost never emerge as median international prices.

Figure 10 puts these results in historical perspective, giving a history of the average MIP-to-Canadian price ratios from 2001 to 2012. Although there has been considerable movement in the ratio over this period, it has remained above parity.

TABLE 12

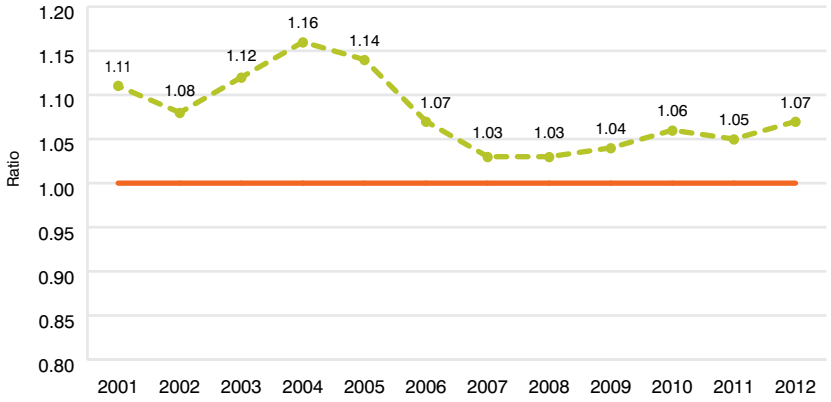
Average Foreign-to-Canadian Price Ratios, Multilateral Comparisons, 2012

	Median	Minimum	Maximum	Mean
Average price ratio at market exchange rates	1.07	0.78	2.07	1.19
Average price ratio at purchasing power parities	1.09	0.84	2.44	1.29
Number of patented drug products	1,204	1,204	1,204	1,204
Sales ($millions)	12,614.0	12,614.0	12,614.0	12,614.0

Source: PMPRB

FIGURE 10

Average Ratio of Median International Price (MIP) to Canadian Price, At Market Exchange Rates, 2001–2012

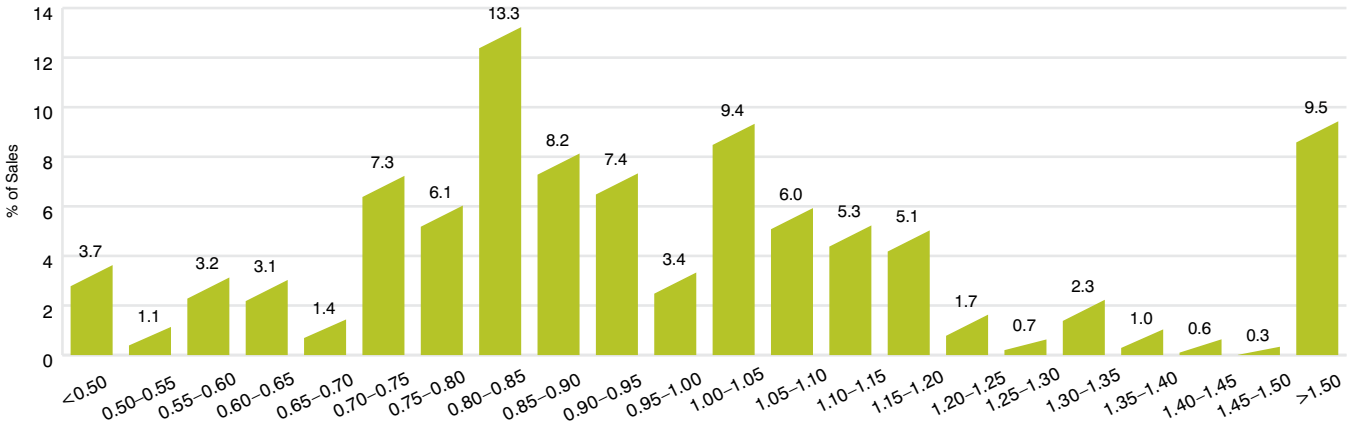


Source: PMPRB

Figure 11 offers more detail on the product-level MIP-to-Canadian ratios underlying the averages reported in Table 12. This figure distributes the 2012 sales of each patented drug product according to the value of its MIP-to-Canadian price ratio (more exactly, according to the range into which the ratio fell).[13] These results show substantial dispersion in product-level price ratios: while patented drug products with MIP-to-Canadian price ratios between 0.90 and 1.10 accounted for 26.2% of sales, those with ratios less than 0.90 accounted for 47.4% of sales, and products with ratios exceeding 1.10 accounted for 26.4%.

FIGURE 11

Range Distribution, Sales, by MIP-to-Canadian Price Ratio, 2012



Source: PMPRB

End Notes

[12] The number of drug products and sales these ratios encompass vary because it is not always possible to find a matching foreign price for each patented drug product sold in Canada. Note that all of the bilateral average price ratios reported in Table 11 combined represent at least 80% of 2012 Canadian sales, while the multilateral ratios in Table 12 cover over 98%.

[13] To produce the results represented in this figure, foreign prices were converted to their Canadian-dollar equivalents at market exchange rates.

UTILIZATION OF PATENTED DRUG PRODUCTS

The price and sales data used to calculate the PMPI also allow the PMPRB to examine trends in the quantities of patented drug products sold in Canada. The PMPRB maintains the Patented Medicines Quantity Index (PMQI) for this purpose. Figure 12 provides average rates of utilization growth, as measured by the PMQI, from 1988 through 2012. These results confirm that in recent years, growth in the utilization of patented drug products has declined significantly, with rates of utilization growth roughly tracking sales growth. This tracking pattern continued in 2012, with the utilization of patented drug products, on average, remaining unchanged (0.0%) between 2011 and 2012 and sales decreasing by 0.3%.

Utilization Growth by Therapeutic Class

Table 13 provides average rates of utilization growth among patented drug products at the level of major therapeutic classes. The results in this table were obtained by applying the PMQI methodology to data segregated by ATC Level I class. As in Table 10, the last column provides an approximate decomposition of overall PMQI change into contributions attributable to each therapeutic class.

In 2012, levels of utilization did not increase in six therapeutic classes. Modest growth in general alimentary tract and metabolism products, antineoplastics and immunomodulating agents, and nervous system products accounted for most of the growth in overall utilization. Drug products in the cardiovascular system and blood and blood forming organs classes declined.

TABLE 13

Change in the Patented Medicines Quantity Index (PMQI), by Major Therapeutic Class, 2012

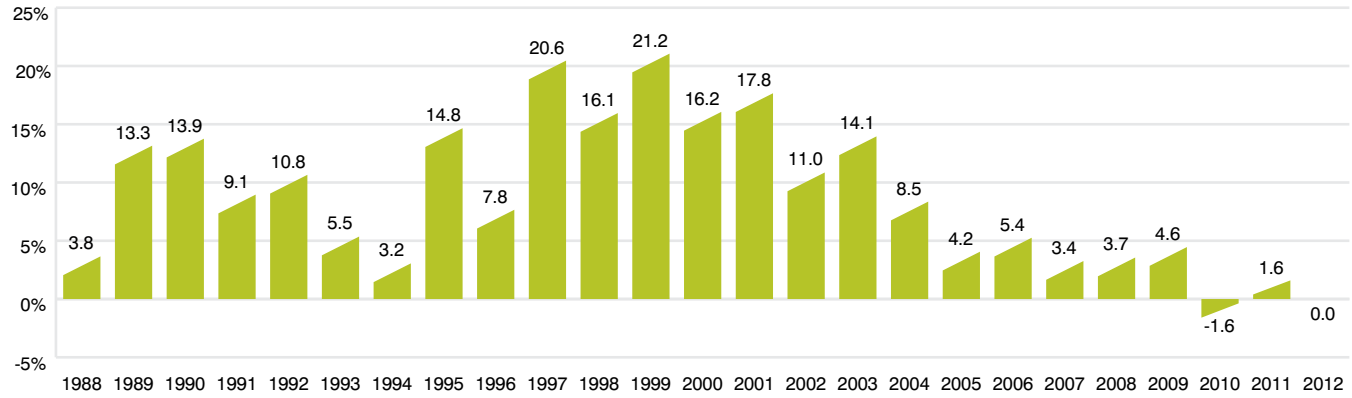
Therapeutic class	Share: 2012 sales (%)	Quantity change: 2011 to 2012 (%)	Contribution: Change in PMQI (%)
A: Alimentary tract and metabolism	9.8	20.8	2.0
B: Blood and blood forming organs	6.4	-13.8	-0.9
C: Cardiovascular system	10.5	-34.7	-3.6
D: Dermatologicals	0.8	12.4	0.1
G: Genito-urinary system and sex hormones	4.3	3.5	0.2
H: Systemic hormonal preparations	0.4	2.9	0.0
J: General antiinfectives for systemic use and P: Antiparasitic products*	11.3	9.7	1.1
L: Antineoplastics and immunomodulating agents	25.4	8.4	2.1
M: Musculo-skeletal system	3.3	2.4	0.1
N: Nervous system	15.1	11.0	1.7
R: Respiratory system	8.3	-2.6	-0.2
S: Sensory organs	3.9	12.2	0.5
V: Various	0.4	9.9	0.0
All therapeutic classes	100.0	0.0	0.0

* These groups have been combined for reasons of confidentiality.

Source: PMPRB

FIGURE 12

Annual Rate of Change, Patented Medicines Quantity Index (PMQI), 1988–2012



Source: PMPRB

CANADIAN DRUG EXPENDITURES IN THE GLOBAL CONTEXT

IMS Health[14] regularly reports on drug sales across a large number of countries. Based on sales data from this source, Figure 13 provides shares of global sales for Canada and each of the seven comparator countries that the PMPRB considers in conducting its price reviews.[15] The Canadian market accounted for 2.6% of the global market in 2012.

Figure 14 provides Canada's share of global sales for each of the years 2005 through 2012. The Canadian share has remained between 2.4% and 2.7% throughout this period.

Figure 15 gives the average annual rate of growth in total drug sales for Canada and the seven comparator countries, individually and collectively. From 2005 to 2012, drug sales in Canada rose at an annual average rate of approximately 4.0%. Drug sales among the seven comparator countries rose at an annual average rate of 3.3% over the same period.

Figure 16 compares rates of year-over-year growth in drug sales in Canada and the comparator countries combined. In 2012, for the second consecutive year, sales grew at a slower rate in Canada than in the comparator countries.

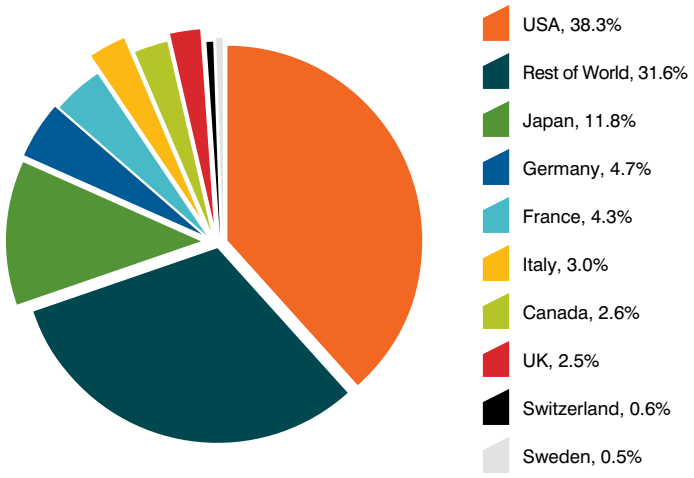
The proportion of national income allocated to the purchase of drug products provides another way to compare drug costs across countries.[17] Figure 17 gives drug expenditures as a share of Gross Domestic Product (GDP) for Canada and the seven comparator countries based on data for 2010. Drug expenditures absorbed between 1.1% and 2.1% of the GDP in the seven comparators. The Canadian value (1.9%) lies near the upper end of this range.

Table 14 provides historical perspective on the expenditures-to-GDP ratio. Between 2000 and 2010, drug expenditures in Canada grew at approximately twice the rate of GDP growth.

Table 15 gives the composition of patentees' sales by therapeutic class for Canada and the seven comparator countries, individually and as an aggregate.[18] These results imply a remarkable degree of similarity across countries.

FIGURE 13

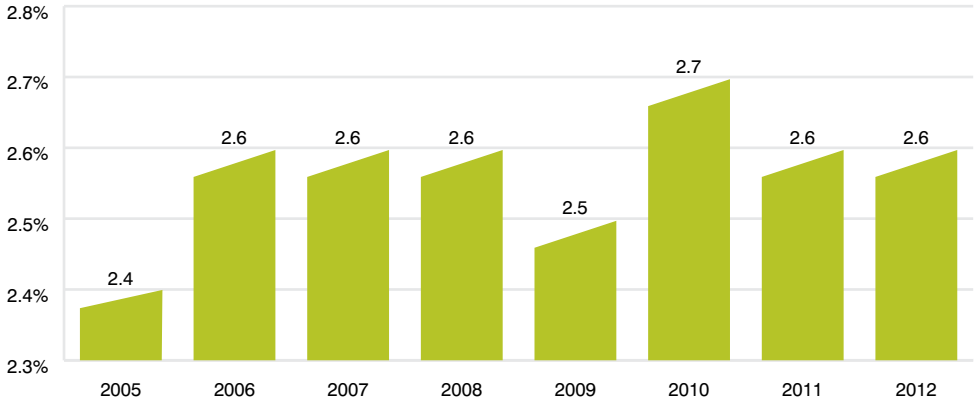
Distribution of Drug Sales Among Major National Markets, 2012



Source: MIDAS©, 2005–2012, IMS Health Incorporated or its affiliates. All rights reserved.[16]

FIGURE 14

Canada's Share of Drug Sales, 2005–2012



Source: MIDAS©, 2005–2012, IMS Health Incorporated or its affiliates. All rights reserved.[16]

FIGURE 15

Average Rate of Growth, Drug Sales, at Constant 2012 Market Exchange Rates, by Country, 2005–2012

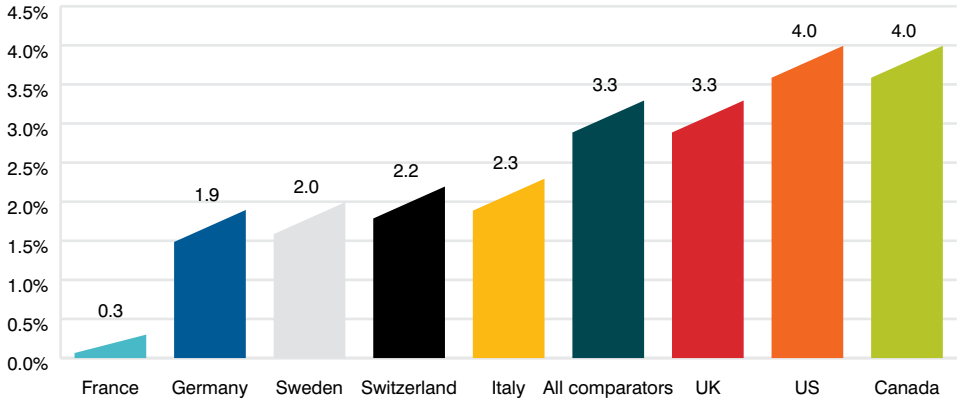


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FIGURE 16

Average Annual Rate of Change in Drug Sales, at Constant 2012 Market Exchange Rates, Canada and Comparator Countries, 2006–2012

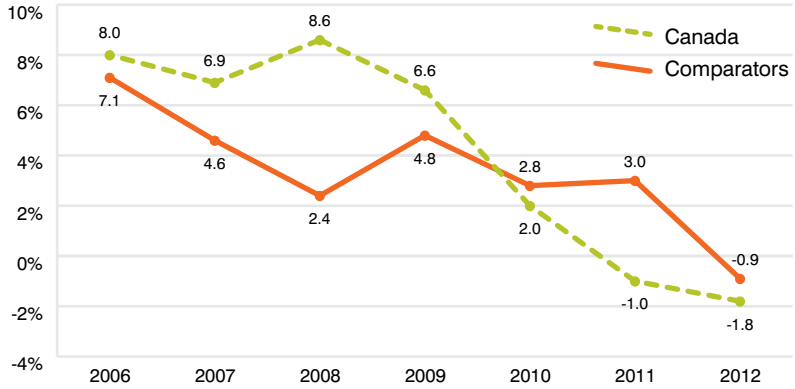

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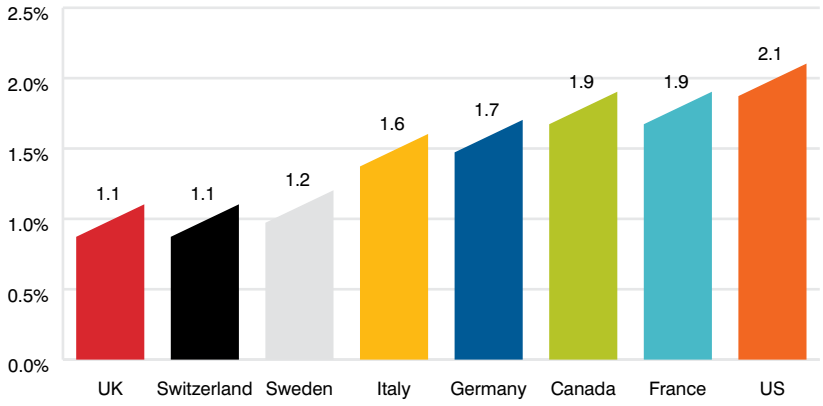
FIGURE 17

Pharmaceutical Expenditure as a Share of GDP, 2010



Source: OECD

TABLE 14

Drug Expenditures as a Share of GDP, 2010

	Share: Drug expenditures/ GDP, 2010 (%)	Share: Drug expenditures/ GDP, 2000 (%)	Growth: Drug expenditures, 2000–2010 (%)	Growth: GDP 2000–2010 (%)
Canada	1.90	1.42	150.30	86.69
France	1.86	1.81	74.74	70.41
Germany	1.72	1.43	97.65	64.63
Italy	1.60	1.74	65.98	80.55
Sweden	1.21	1.18	57.35	53.50
Switzerland	1.11	1.11	58.17	58.77
United Kingdom	1.13	1.14	51.87	52.84
United States	2.09	1.46	111.89	47.71

Source: OECD

TABLE 15

Distribution of Drug Sales (%) by Major Therapeutic Class for Canada and Comparator Countries, 2012

Therapeutic class	Canada	Comparators	France	Italy	Germany	Sweden	Switzerland	United Kingdom	United States
A: Alimentary tract and metabolism	12.6	12.2	10.6	11.2	11.5	10.1	11.1	11.0	12.6
B: Blood and blood-forming organs	4.1	5.6	7.4	8.2	5.6	7.7	4.8	4.2	5.3
C: Cardiovascular system	14.3	10.7	12.9	13.6	9.6	6.2	12.1	8.9	10.5
D: Dermatologicals	3.1	2.7	2.4	2.1	2.7	2.5	3.6	3.2	2.8
G: Genito-urinary system and sex hormones	5.2	5.0	3.3	3.9	3.8	5.0	4.6	4.7	5.4
H: Systemic hormonal preparations	1.1	1.8	1.8	1.9	2.0	2.5	1.5	2.1	1.7
J: General antiinfectives for systemic use	7.3	10.6	12.2	12.9	10.1	7.8	10.7	10.4	10.4
L: Antineoplastics and immunomodulating agents	15.6	16.7	16.7	16.6	20.6	21.4	19.8	16.4	16.1
M: Musculo-skeletal system	3.7	3.1	3.4	3.9	3.7	3.0	5.0	2.6	3.0
N: Nervous system	18.6	17.5	14.7	12.1	15.2	18.4	15.7	18.5	18.5
P: Antiparasitic products	0.2	0.2	0.2	0.0	0.1	0.2	0.1	0.3	0.2
R: Respiratory system	7.2	7.8	6.3	5.8	6.7	9.1	6.2	10.2	8.1
S: Sensory organs	3.1	2.5	2.9	1.9	2.6	2.6	3.1	3.3	2.4
V: Various	4.0	3.6	5.2	5.8	5.9	3.5	1.8	4.2	3.0
All therapeutic classes*	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Values in this column may not add to 100.0 due to rounding.

Source: MIDAS©, 2005-2012, IMS Health Incorporated or its affiliates. All rights reserved.[16]

End Notes

[14] Most of the statistical results presented in this section are based on sales data from MIDAS©, 2005–2012, IMS Health Incorporated or its affiliates. All rights reserved.[16] These data cover the pharmacy and hospital sectors.

[15] The results given in Figures 13 through 16 are based on estimates of ex-factory sales revenues encompassing patented, non-patented branded and generic drug products. These estimates have been converted to Canadian-dollar equivalents at annual average market exchange rates. Fluctuations in these rates can substantially influence these shares.

[16] Although based in part on data obtained under license from the MIDAS IMS database, the statements, findings, conclusions, views and opinions expressed in this Annual Report are exclusively those of the PMPRB and are not attributable to IMS AG.

[17] Comparisons made on this basis will reflect international differences in prices, overall utilization and patterns of therapeutic choice, as well as differences in national income.

[18] Note that the data used to produce Table 15 encompass patented, non-patented branded and generic drug products. Hence, the results reported here for Canada are not directly comparable to those reported in Table 9, which encompass only patented drug products.

ANALYSIS OF RESEARCH AND DEVELOPMENT EXPENDITURES

The *Patent Act* (Act) mandates the PMPRB to monitor and report on pharmaceutical research and development (R&D) spending (while giving the PMPRB no regulatory authority to consider the amount or type of patentees' research spending in the context of its price regulation). This chapter provides key statistics on the current state of pharmaceutical research investment in Canada.

Data Sources

The statistical results presented in this section were entirely derived from data that patentees have submitted to the PMPRB.

The Act requires each patentee to report its total gross revenues from sales of all drugs for human or veterinary use (including revenues from sales of non-patented drug products and from licensing agreements) and R&D expenditures in Canada related to medicines (both patented and non-patented for human or veterinary use). Patentees transmit this information to the PMPRB by means of its Form 3 (*Revenues and Research and Development Expenditures Provided Pursuant to subsection 88(1) of the Patent Act*).

The *Patented Medicines Regulations* (Regulations) require that each submitted Form 3 be accompanied by a certificate stating the information it contains is "true and correct". The Board does not audit Form 3 submissions, but it does review submitted data for anomalies and inconsistencies, seeking corrections or clarifications from patentees where necessary. To confirm that PMPRB Staff has correctly interpreted the data submitted, each patentee is given the opportunity to review and confirm the accuracy of its own R&D-to-sales ratio before that ratio is published.

Failure to File

It is a patentee's responsibility to ensure a complete and accurate Form 3 is filed within the time frame set out in the Regulations. Where a patentee fails to meet these filing requirements, the Board may issue an Order demanding compliance. There were no such Board Orders issued for the 2012 reporting period.

Coverage

Note that companies without sales of patented medicines need not report to the PMPRB on their R&D expenditures. This has two implications.

First, the statistical results reported below should not be taken to cover all pharmaceutical research conducted in Canada. For example, a company may sell only non-patented drug products but may still perform considerable research in Canada. Similarly, a company may conduct research and have no product sales at all.[19] The results presented below will not reflect the R&D expenditures of firms in either situation.

Second, as new patented drug products come onto the Canadian market and existing patents expire, the number and identity of companies required to file R&D data may change from year to year. A total of 85 companies reported on their R&D activity in 2012. Of these, 35 were members of Canada's Research-Based Pharmaceutical Companies (Rx&D).

Definition of Sales Revenues

For reporting purposes, sales revenues are defined as total gross revenues from sales in Canada of all drug products and from licensing agreements (e.g., royalties and fees accruing to the patentee related to sales in Canada by licensees).

Definition of R&D Expenditures

Pursuant to section 6 of the Regulations, patentees are required to report R&D expenditures that would have qualified for an investment tax credit in respect to scientific research and experimental development (SR&ED) under the provisions of the Income Tax Act that came into effect on December 1, 1987.[20] By this definition, R&D expenditures may include current expenditures, capital equipment costs and allowable depreciation expenses. Market research, sales promotions, quality control or routine testing of materials, devices or products and routine data collection are not eligible for an investment tax credit and, therefore, are not to be included in the R&D expenditures reported by patentees.

Total Sales Revenues and R&D Expenditures

Table 16 provides an overview of reported sales revenues and R&D expenditures over the period 1988 through 2012.

Patentees reported total 2012 sales revenues of $16.8 billion, a decrease of 5.8% from 2011. Sales revenues reported by Rx&D members were $11.9 billion, accounting for 71.0% of the total. (Less than 1% of reported sales revenues were generated by licensing agreements.)

Patentees reported R&D expenditures of $894.8 million in 2012, a decrease of 9.8% over 2011. Rx&D members reported R&D expenditures of $782.8 million in 2012, a decrease of 13.1% over last year. Rx&D members accounted for 87.5% of all reported R&D expenditures in 2012.

TABLE 16

Total R&D Expenditures and R&D-to-Sales Ratios of Reporting Companies, 1988–2012

Year	All Patentees					Rx&D					
	Number of companies reporting	R&D expenditures by all patentees ($millions)	Change from previous year (%)	Sales revenues ($millions)	Change from previous year (%)	R&D expenditures by Rx&D patentees ($millions)	Change from previous year (%)	Sales revenues by Rx&D patentees ($millions)	Change from previous year (%)	R&D-to-sales ratio: all patentees (%)	R&D-to-sales ratio: Rx&D patentees (%)
2012	85	894.8	-9.8	16,754.4	-5.8	782.8	-13.1	11,896.1	-11.5	5.3	6.6
2011	79	991.7	-15.8	17,798.8	4.7	901.2	-9.9	13,446.1	10.7	5.6	6.7
2010	82	1,178.2	-7.4	17,000.0	-0.3	1,000.2	-11.7	12,149.0	-11.8	6.9	8.2
2009	81	1,272.0	-2.9	17,051.9	4.5	1,132.9	-3.4	13,780.0	4.6	7.5	8.2
2008	82	1,310.7	-1.1	16,316.7	2.0	1,172.2	-1.0	13,178.2	-1.4	8.1	8.9
2007	82	1,325.0	9.5	15,991.0	7.3	1,184.4	24.8	13,359.8	20.0	8.3	8.9
2006	72	1,210.0	-1.9	14,902.0	4.7	949.0	-8.8	11,131.2	-5.8	8.1	8.5
2005	80	1,234.3	5.5	14,231.3	0.5	1,040.1	3.9	11,821.4	0.0	8.7	8.8
2004	84	1,170.0	-2.0	14,168.3	4.0	1,000.8	0.8	11,819.0	8.8	8.3	8.5
2003	83	1,194.3	-0.4	13,631.1	12.8	992.9	-3.6	10,865.7	5.2	8.8	9.1
2002	79	1,198.7	13.0	12,081.2	12.5	1,029.6	10.1	10,323.8	16.8	9.9	10.0
2001	74	1,060.1	12.6	10,732.1	15.3	935.2	14.7	8,835.4	14.3	9.9	10.6
2000	79	941.8	5.3	9,309.6	12.0	815.5	4.0	7,728.8	11.6	10.1	10.6
1999	78	894.6	12.0	8,315.5	19.2	784.3	9.9	6,923.4	22.8	10.8	11.3
1998	74	798.9	10.2	6,975.2	10.9	713.7	8.6	5,640.2	10.6	11.5	12.7
1997	75	725.1	9.0	6,288.4	7.4	657.4	10.3	5,098.2	4.9	11.5	12.9
1996	72	665.3	6.4	5,857.4	9.9	595.8	6.5	4,859.5	8.7	11.4	12.3
1995	71	625.5	11.5	5,330.2	7.5	559.5	9.8	4,468.8	1.4	11.7	12.5
1994	73	561.1	11.4	4,957.4	4.4	509.5	10.4	4,407.2	2.0	11.3	11.6
1993	70	503.5	22.1	4,747.6	14.0	461.4	24.0	4,321.4	14.4	10.6	10.7
1992	71	412.4	9.6	4,164.4	6.9	372.1	9.0	3,778.4	6.5	9.9	9.8
1991	65	376.4	23.2	3,894.8	18.1	341.4	24.7	3,546.9	19.5	9.7	9.6
1990	65	305.5	24.8	3,298.8	11.0	273.8	25.8	2,967.9	10.5	9.3	9.2
1989	66	244.8	47.4	2,973.0	9.4	217.6	34.7	2,685.5	7.3	8.2	8.1
1988	66	165.7	—	2,718.0	—	161.5	—	2,502.3	—	6.1	6.5

Source: PMPRB

R&D-to-Sales Ratios

Table 16 also provides ratios of R&D expenditures to sales revenues. It should be noted in this context that, with the adoption of the 1987 amendments to the Act, Rx&D made a public commitment to increase their annual R&D expenditures to 10% of sales revenues by 1996.[21] This level of R&D expenditure was obtained by 1993, in some years exceeding 10%. However, since 2003, R&D-to-sales ratios for all patentees and for Rx&D members have declined.

The ratio of R&D expenditures to sales revenues among all patentees was 5.3% in 2012, down from 5.6% in 2011. These values are close to figures last observed in 1988. The overall R&D-to-sales ratio has been less than 10% for the past 12 consecutive years.

The corresponding R&D-to-sales ratio for members of Rx&D was 6.6% in 2012, down from 6.7% in 2011.[22] These values are close to figures last observed in 1988. The Rx&D ratio has been less than 10% for the past 10 consecutive years.

Table 21 in Appendix 2 provides details on the range of 2012 R&D-to-sales ratios. Of the 85 companies reporting in 2012, 83.5% had R&D-to-sales ratios below 10%.

New Developments

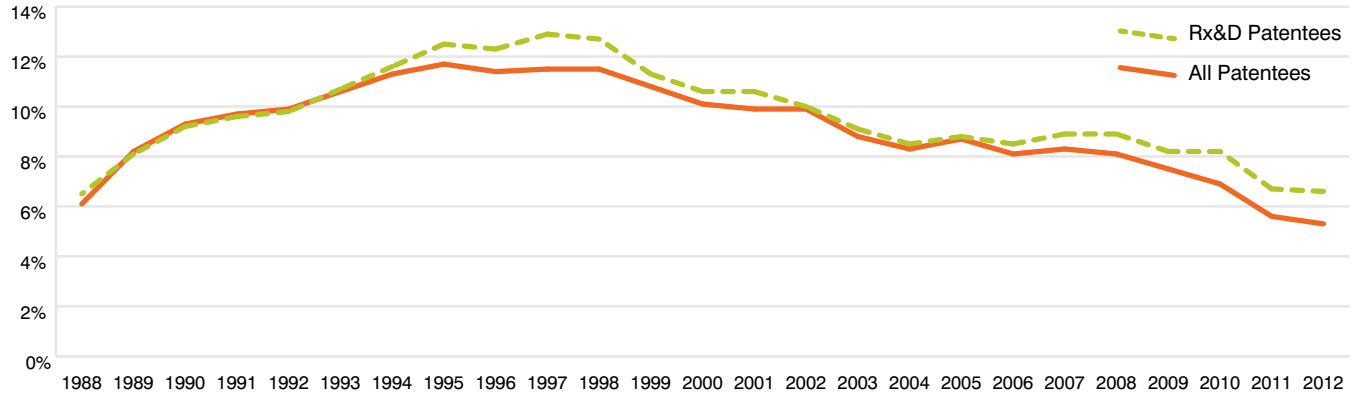
In 2012, Rx&D engaged KPMG to update the results from the 2010 report entitled *Summary of Pharmaceutical Survey Findings on R&D Spending and Investments by Rx&D Members*. The updated survey followed the same methodology as the one that was initially jointly funded by Rx&D and the Canadian Institutes for Health Research (CIHR). The original survey, using 2010 data, was developed as part of an Industry Canada led Steering Committee that was formed to examine current levels of R&D investment by members of the Rx&D in Canada. Both the PMPRB and CIHR participated in the Steering Committee.

Current Expenditures by Type of Research

Table 17 and Figure 19 (as well as Figure 21 in Appendix 2) provide information on the allocation of 2012 current R&D expenditures[23] among basic and applied research and other qualifying R&D.[24] Patentees reported spending $114.6 million on basic research in 2012, representing 13.2% of current R&D expenditures and a decline of 30.5% over the previous year. Patentees reported spending $520.9 million on applied research, representing 60.2% of current R&D expenditures. Clinical trials accounted for 69.4% of applied research expenditures.

FIGURE 18

R&D-to-Sales Ratio, Pharmaceutical Patentees, 1988–2012



Source: PMPRB

TABLE 17

Current R&D Expenditures by Type of Research, 2012 and 2011

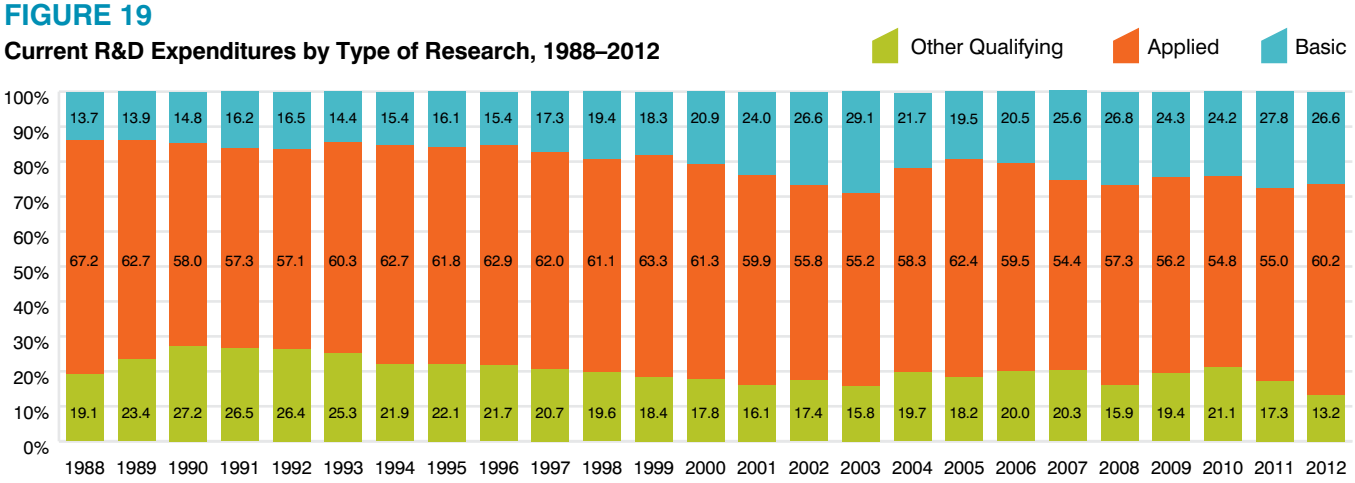
Type of research	Expenditures: 2012 ($millions)	Share: 2012 (%)	Expenditures: 2011 ($millions)	Share: 2011 (%)	Annual change in expenditures (%)
Basic	114.6	13.2	164.9	17.3	-30.5
Chemical	78.3	9.1	99.4	10.4	-21.2
Biological	36.3	4.2	65.5	6.9	-44.6
Applied	520.9	60.2	525.1	55.0	-0.8
Manufacturing process	82.2	9.5	77.4	8.1	6.2
Pre-clinical Trial I	35.7	4.1	16.9	1.8	111.2
Pre-clinical Trial II	41.5	4.8	35.7	3.8	16.2
Clinical Trial Phase I	34.3	4.0	29.8	3.1	15.1
Clinical Trial Phase II	82.1	9.5	83.0	8.7	-1.1
Clinical Trial Phase III	245.1	28.3	282.3	29.5	-13.2
Other qualifying R&D	230.1	26.6	265.2	27.8	-13.2
Total	865.6	100.0*	955.3	100.0*	-9.4

* Values in this column may not add to 100.0 due to rounding.

Source: PMPRB

FIGURE 19

Current R&D Expenditures by Type of Research, 1988–2012



Source: PMPRB

Current R&D Expenditures by Performer

Patentees report expenditures on research they conduct themselves (intramural) and research performed by other establishments, such as universities, hospitals and other manufacturers (extramural). Table 18 shows that 49.1% of 2012 current research expenditures were intramural. Research performed by other companies on behalf of patentees was 25.3% of current expenditures, while research conducted in universities and hospitals accounted for 15.1%.

Current R&D Expenditures by Source of Funds

Table 19 provides information on the sources of funds used by patentees to finance their R&D activity. Internal company funds remained by far the single largest source of funding in 2012, accounting for 86.8% of current expenditures. Funds received from government amounted to 2.7% of current expenditures.

TABLE 18

Current R&D Expenditures by R&D Performer, 2012 and 2011

R&D performer	Expenditures: 2012 ($millions)	Share: 2012 (%)	Expenditures: 2011 ($millions)	Share: 2011 (%)	Annual change in expenditures (%)
Intramural					
Patentees	425.3	49.1	496.1	51.9	-14.3
Extramural					
Universities and hospitals	131.0	15.1	151.7	15.9	-13.7
Other companies	218.6	25.3	196.9	20.6	11.1
Others	90.7	10.5	110.6	11.6	-18.0
Total	865.6	100.0*	955.3	100.0*	-9.4

* Values in this column may not add to 100.0 due to rounding.

Source: PMPRB

TABLE 19

Total R&D Expenditures by Source of Funds, 2012 and 2011

Source of funds	Expenditures: 2012 ($millions)	Share: 2012 (%)	Expenditures: 2011 ($millions)	Share: 2011 (%)	Annual increase in expenditures (%)
Company funds	777.1	86.8	879.2	88.6	-11.6
Federal/provincial governments	23.8	2.7	28.7	2.9	-17.1
Others	93.9	10.5	83.8	8.5	12.1
Total	894.8	100.0*	991.7	100.0	-9.8

* Values in this column may not add to 100.0 due to rounding.

Source: PMPRB

Current R&D Expenditures by Region

Table 20 (as well as Table 23 and Table 24 in Appendix 2) show current R&D expenditures by region. As in previous years, current expenditures were heavily concentrated in Ontario and Quebec in 2012, with these provinces accounting for 83.6% of total expenditures. While current R&D expenditures decreased at a year-over-year rate of 1.8% in Western Canada, they also declined in Ontario by 8.5% and in Quebec by 13.8%.

TABLE 20

Current R&D Expenditures by Region, 2012 and 2011

Region	Expenditures: 2012 ($millions)	Share: 2012 (%)	Expenditures: 2011 ($millions)	Share: 2011 (%)	Annual increase in expenditures (%)
Atlantic provinces	21.9	2.5	17.9	1.9	22.1
Quebec	354.8	41.0	411.8	43.1	-13.8
Ontario	368.6	42.6	403.0	42.2	-8.5
Western provinces	120.3	13.9	122.5	12.8	-1.8
Territories	0.0	0.0	0.0	0.0	-100.0
Total	865.6	100.0*	955.3	100.0*	-9.4

* Values in this column may not add to 100.0 due to rounding.

Source: PMPRB

The Global Context

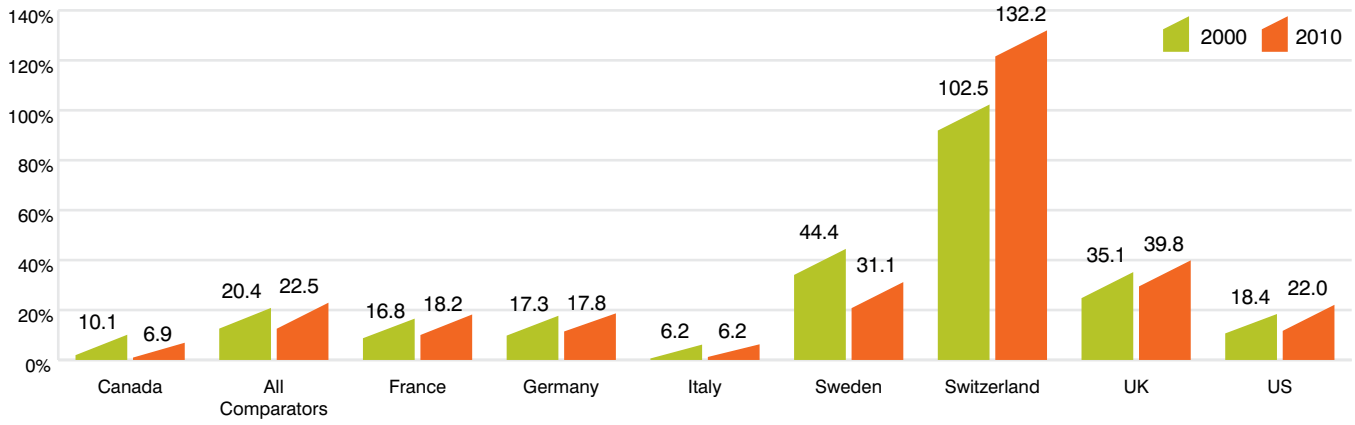
Figure 20 compares Canadian pharmaceutical R&D-to-sales ratios for the years 2000 and 2010 to those in the PMPRB's seven comparator countries.[25] Canada's ratio stood at 10.1% in 2000. Only Italy, at 6.2%, had a lower ratio in that year, while Switzerland had the highest ratio at 102.5%.

A similar pattern emerges in the ratios for 2010. Italy remained at the bottom of the range at 6.2%, with Canada second lowest at 6.9%. Ratios in all other comparator countries remained well above Canada's ratio. The ratio obtained by aggregating R&D spending and sales across all seven comparator countries was 22.5%, three and a half times the value obtained for Canada.

The R&D-to-sales ratios represented in Figure 20 may be compared to the average bilateral price ratios reported in Table 11 (see *Comparison of Canadian Prices to Foreign Prices* section). Several comparator countries, which have patented drug prices that are, on average, substantially less than prices in Canada, have achieved R&D-to-sales ratios well above those in Canada. Increasingly, the impact of the prices of medicines on companies' decisions on where to locate investment or conduct research is being questioned. Other factors such as where companies can find the best science base at reasonable cost, taxation incentives, flexible labour markets and economic stability are seen as being important.[26]

FIGURE 20

R&D-to-Sales Ratio, Canada and Comparator Countries



Source: PMPRB, European Federation of Pharmaceutical Industries and Associations (EFPIA): *The Pharmaceutical Industry in Figures 2012, PhRMA 2012 profile*

End Notes

[19] This is likely the situation for much of Canada's biotechnology sector. Note, however, that if a patentee commissions research from another company specializing in biotechnology research, the patentee should normally include this among the research expenditures that it reports to the PMPRB.

[20] Budget 2012 proposed reductions to the Scientific Research and Experimental Development (SR&ED) tax credit and new restrictions on deductions. It also introduced new measures to support innovation and R&D. As per the Regulations, the PMPRB defines R&D based on the 1987 SR&ED definition.

[21] As published in the Regulatory Impact Assessment Statement (RIAS) of the Patented Medicines Regulations, 1988, *Canada Gazette*, Part II, Vol. 122, No. 20 – SOR/DORS/88-474.

[22] The R&D-to-sales ratios presented in Table 16 include research expenditures funded by government grants. If the government-funded component is excluded, the ratios for all patentees and for the members of Rx&D in 2012 are 5.2% and 6.4%, respectively.

[23] Current R&D expenditures consist of non-capital expenses directly related to research, including (a) wages and salaries; (b) direct material; (c) contractors and sub-contractors; (d) other direct costs such as factory overhead; (e) payments to designated institutions; (f) payments to granting councils; and (g) payments to other organizations. These elements are described in more detail in Form 3 (*Revenues and Research and Development Expenditures*) available from the PMPRB website under the heading Act, Regulations and Guidelines/Patentee's Guide to Reporting. Current R&D expenditures accounted for 96.7% of total R&D expenditure in 2012, while capital equipment costs and allowable depreciation expenses made up 1.4% and 1.8%, respectively.

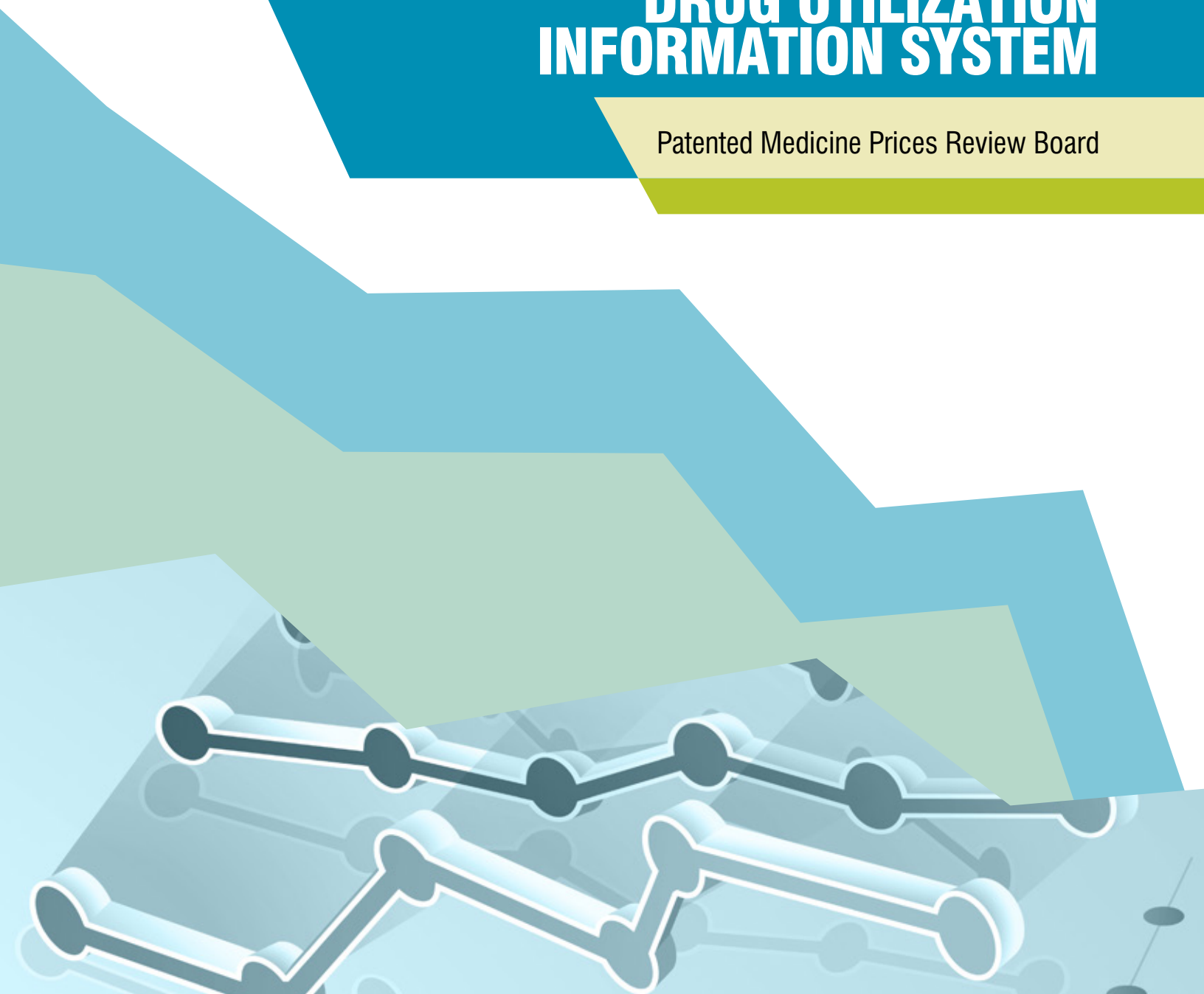
[24] "Basic research" is defined as work that advances scientific knowledge without a specific application in mind. "Applied research" is directed toward a specific practical application, comprising research intended to improve manufacturing processes, pre-clinical trials and clinical trials. "Other qualifying research" includes drug regulation submissions, bioavailability studies and Phase IV clinical trials.

[25] Sales in Figure 20 represent domestic sales and do not include exports.

[26] NERA Economic Consulting, *Key Factors in Attracting Internationally Mobile Investments by the Research-Based Pharmaceutical Industry*. Cited by Medicines, Pharmacy & Industry Group. Government response to consultation. London: UK DoH; 2011.

NATIONAL PRESCRIPTION DRUG UTILIZATION INFORMATION SYSTEM

Patented Medicine Prices Review Board



National Prescription Drug Utilization Information System

The National Prescription Drug Utilization Information System (NPDUIS) is a research initiative established by federal, provincial, and territorial Ministers of Health in September 2001.

The purpose of NPDUIS is to provide policy makers and public drug plan managers with critical analyses of price, utilization and cost trends, so that Canada's health care system has more comprehensive and accurate information on how prescription drugs are being used and on sources of cost increases.

The PMPRB's authority to conduct work under the NPDUIS initiative is based on a formal request by the federal Minister of Health under section 90 of the *Patent Act*, and is consistent with the PMPRB's mandate to report on pharmaceutical trends.

The NPDUIS Steering Committee advises the PMPRB on its research agenda and on individual studies. The Committee is composed of representatives from public drug plans in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon, and Health Canada.

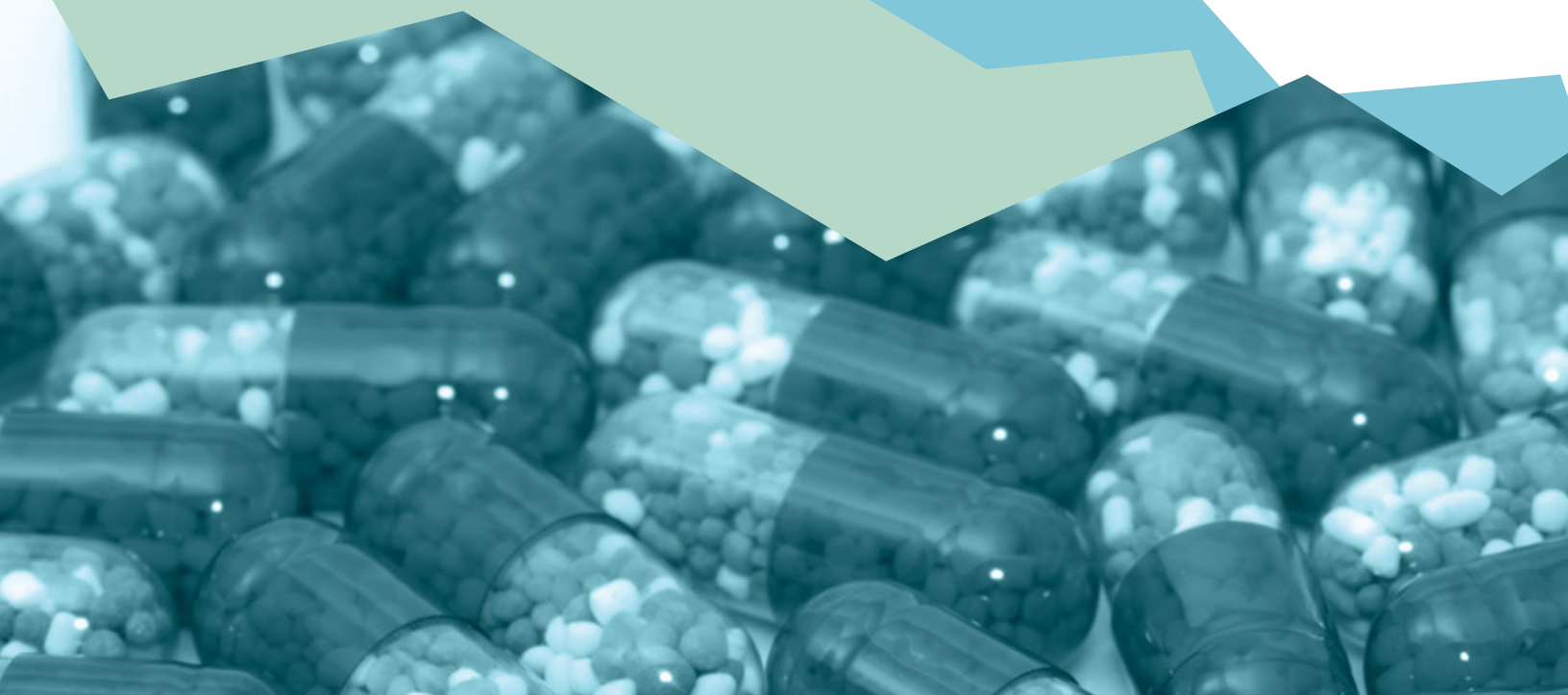
PUBLICATIONS

The latest NPDUIS reports released are the *New Drug Pipeline Monitor—Fourth Edition* and *The Use of Blood Glucose Test Strips in Select Public Drug Plans, 2008*.

A number of NPDUIS reports are anticipated for publication in the latter part of 2013 while other studies are currently under development. The NPDUIS Forward Agenda provides detailed information on ongoing analytical studies.

APPENDICES

Patented Medicine Prices Review Board



Appendix 1: Glossary

For more detailed information and definitions please refer to the *Patent Act*, the *Patented Medicines Regulations*, the PMPRB *Compendium of Policies, Guidelines and Procedures*, and the *Food and Drug Regulations*, or contact the PMPRB.

ACTIVE INGREDIENT: Chemical or biological substance responsible for the claimed pharmacologic effect of a drug product.

ADVANCE RULING CERTIFICATE (ARC): A non-binding advance ruling certificate may be issued pursuant to subsection 98(4) of the *Patent Act* at the request of a patentee when the Board is satisfied that the price or proposed price of the medicine would not exceed the maximum non-excessive price under the Board's Guidelines.

ATC: Anatomical Therapeutic Chemical (ATC) classification system, developed and maintained by the World Health Organization (WHO) Collaborating Centre for Drug Statistics Methodology, divides drugs into different groups according to their site of action and therapeutic and chemical characteristics. This system is used by the PMPRB as a guide for selecting comparable medicines for purposes of price review.

DEDICATION OF PATENT: A practice whereby a patentee notifies the Commissioner of Patents that it has surrendered its rights and entitlements flowing from the patent for the benefit of the public to use and enjoy. NB: As of January 30, 1995, the Board does not recognize dedication of patent as a means to remove the medicine from its jurisdiction.

DRUG IDENTIFICATION NUMBER (DIN): A registration number (drug identification number) that the Health Products and Food Branch of Health Canada assigns to each prescription and non-prescription drug product marketed under the *Food and Drugs Regulations*. The DIN is assigned using information in the following areas: manufacturer of the product; active ingredient(s); strength of active ingredient(s); pharmaceutical dosage form; brand/trade name; and route of administration.

DRUG PRODUCT: A particular presentation of a medicine characterized by its pharmaceutical dosage form and the strength of the active ingredient(s).

FAILURE TO FILE: The complete or partial failure of a patentee to comply with regulatory filing requirements pursuant to the *Patent Act* and the *Patented Medicines Regulations*.

FAILURE TO REPORT: The complete failure of a patentee to have reported a patented drug product being sold in accordance with regulatory filing requirements pursuant to the *Patent Act* and the *Patented Medicines Regulations*.

GENERIC PRODUCT: A drug product with the same active ingredient, strength and dosage form of a brand name drug product.

LICENSE, VOLUNTARY: A contractual agreement between a patent holder and a licensee under which the licensee is entitled to enjoy the benefit of the patent or to exercise any rights in relation to the patent for some consideration (i.e., royalties in the form of a share of the licensee's sales).

MEDICINE: Any substance or mixture of substances made by any means, whether produced biologically, chemically, or otherwise, that is applied or administered in vivo in humans or in animals to aid in the diagnosis, treatment, mitigation or prevention of disease, symptoms, disorders, abnormal physical states, or modifying organic functions in humans and or animals, however administered. For greater certainty, this definition includes vaccines, topical preparations, anaesthetics and diagnostic products used in vivo, regardless of delivery mechanism (e.g., transdermal, capsule form, injectable, inhaler, etc.). This definition excludes medical devices, in vitro diagnostic products and disinfectants that are not used in vivo.

NOTICE OF COMPLIANCE (NOC): A notice in respect of a medicine issued by the Health Products and Food Branch of Health Canada under section C.08.004 of the *Food and Drugs Regulations*. The issuance of an NOC indicates that a drug product meets the required Health Canada standards for use in humans or animals and that the product is approved for sale in Canada.

PATENT: An instrument issued by the Commissioner of Patents in the form of letters patent for an invention that provides its holder with a monopoly limited in time, for the claims made within the patent. A patent gives its holder and its legal representatives, the exclusive right of making, constructing and using the invention and selling it to others to be used.

PATENTED MEDICINE PRICE INDEX (PMPI): The PMPI was developed by the PMPRB as a measure of average year-over-year change in the transaction prices of patented drug products sold in Canada, based on the price and sales information reported by patentees.

PATENTEE: As defined by subsection 79(1) of the *Patent Act*, "the person for the time being entitled to the benefit of the patent for that invention and includes, where any other person is entitled to exercise any rights in relation to that patent other than under a license continued by subsection 11(1) of the *Patent Act* Amendment Act, 1992, that other person in respect of those rights;"

PENDING PATENT: An application for a patent that has not yet been issued.

RESEARCH AND DEVELOPMENT (R&D): Basic or applied research for the purpose of creating new, or improving existing, materials, devices, products or processes (e.g., manufacturing processes).

RESEARCH AND DEVELOPMENT—APPLIED RESEARCH: R&D directed toward a specific practical application, comprising research intended to improve manufacturing processes, pre-clinical trials and clinical trials.

RESEARCH AND DEVELOPMENT—BASIC RESEARCH: R&D defined as work that advances scientific knowledge without a specific application in mind.

RESEARCH AND DEVELOPMENT —OTHER QUALIFYING: Includes eligible research and development expenditures that cannot be classified into any of the preceding categories of "type of research and development". It includes drug regulation submissions, bioavailability studies and Phase IV clinical trials.

RESEARCH AND DEVELOPMENT EXPENDITURES: For the purposes of the *Patented Medicines Regulations*, in particular Sections 5 and 6, research and development includes activities for which expenditures would have qualified for the investment tax credit for scientific research and experimental development under the *Income Tax Act* as it read on December 1, 1987.

CURRENT RESEARCH AND DEVELOPMENT EXPENDITURES: Consist of the following non-capital expenses that are directly related to research work: (a) wages and salaries, (b) direct material, (c) contractors and subcontractors, (d) other direct costs such as factory overhead, (e) payments to designated institutions, (f) payments to granting councils, and (g) payments to other organizations. These elements are described in greater detail in the *Patentees' Guide to Reporting*—Form 3, available from the PMPRB Website under Regulatory Filings.

SPECIAL ACCESS PROGRAMME (SAP): A program operated by Health Canada to give practitioners access to drugs that are not approved or otherwise available for sale in Canada.

VOLUNTARY COMPLIANCE UNDERTAKING (VCU): A written undertaking by a patentee to adjust its price to comply to the Board's Guidelines. The Chairperson may accept a VCU in lieu of issuing a Notice of Hearing if it is in the public interest. A VCU can also be submitted following the issuance of a Notice of Hearing. A VCU submitted at this point must be approved by the Board Hearing Panel struck to hear the matter. The Board reports publicly on all VCUs accepted by the Chairperson or the Board.

Appendix 2: Research and Development

TABLE 21

Range of R&D-to-Sales Ratios by Number of Reporting Companies and Total Sales Revenue

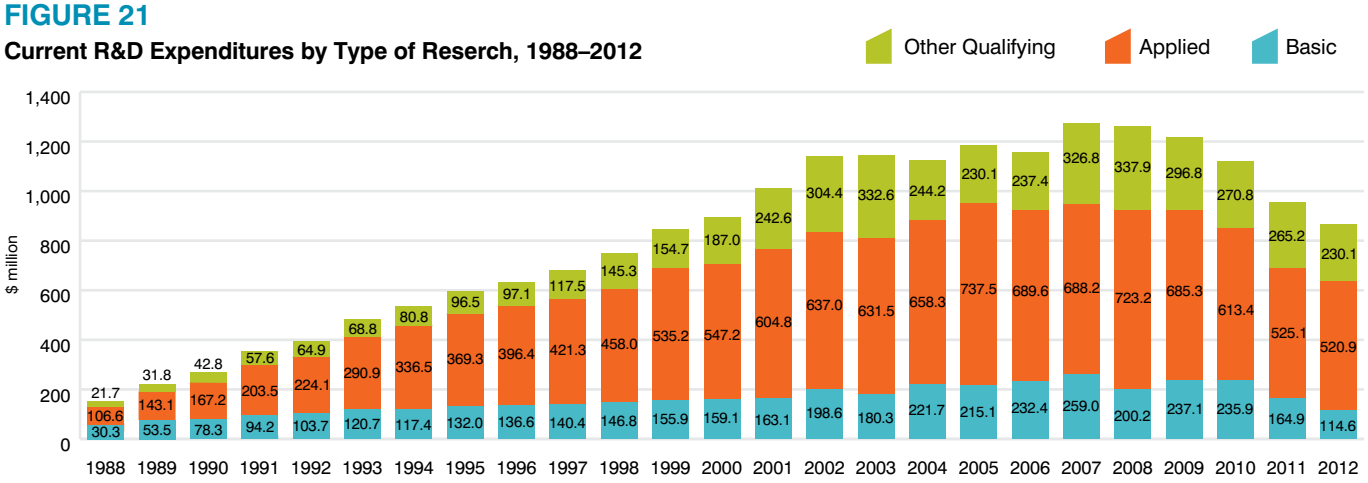
Range: R&D-to-sales ratio	Number of reporting companies: 2012	Sales revenues: 2012 ($millions)	Share: 2012 (%)	Number of reporting companies: 2011	Sales revenues: 2011 ($millions)	Share: 2011 (%)
0%	32	1,596.4	9.5	30	1,625.4	9.1
⩽ 10%	39	11,794.4	73.2	37	12,995.1	73.0
> 10%	14	3,363.6	17.3	12	3,178.3	17.9
Total	85	16,754.4	100.0*	79	17,798.8	100.0*

* Values in this column may not add to 100.0 due to rounding.

Source: PMPRB

FIGURE 21

Current R&D Expenditures by Type of Reserch, 1988–2012



Source: PMPRB

TABLE 22

Ratios of R&D Expenditures to Sales Revenue by Reporting Patentee[1], 2012 and 2011

Company	R&D-to-sales ratio (%)	
	2012	2011
Abbott Laboratories, Ltd.[2,3]	1.0	1.1
AbbVie Corporation.[2,4]	1.9	—
Actelion Pharmaceutiques Canada Inc.[2]	4.4	5.9
Alcon Canada Inc.	0.1	0.1
Alexion Pharmaceuticals Inc.[3]	0.0	0.0
Allergan Inc.	5.3	6.1
Alveda Pharmaceuticals Inc.[5]	0.0	—
Amgen Canada Inc.[2,3]	6.9	6.8
Astellas Pharma Canada Inc.[2,6]	5.3	6.3
AstraZeneca Canada Inc.[2,3]	1.8	3.5
Bausch & Lomb Canada Inc.	0.0	0.0
Baxter Corporation[3]	0.2	0.3
Bayer Inc., Healthcare Division[2]	4.4	3.3
Biogen Idec Canada Inc.[3]	12.5	10.2
BioMarin Canada Inc.[3]	52.3	27.9
Biovitrum AB	0.0	0.0
Boehringer Ingelheim (Canada) Ltd.[2]	11.3	12.6
Bracco Diagnostics Canada Inc.[2]	0.0	0.0
Bristol-Myers Squibb Pharmaceutical Group[2,3]	13.1	8.0
Celgene Canada[3]	1.8	2.9
CSL Behring Canada Inc.[5]	0.8	—
Duchesnay Inc.	6.4	3.2
Eisai Limited[2,3]	172.5	0.0
Eli Lilly Canada Inc. (includes Provel Animal Health Division)[2,3]	10.0	11.1
EMD Serono Canada Inc.[2]	7.2	9.7
Ferring Inc.	3.1	1.0
Fresenius Medical Care Canada	0.0	0.0
Galderma Canada Inc.	0.0	0.0
GE Healthcare Inc. (Amersham Health Inc.)	0.0	0.0
Genzyme Canada Inc.[2,3]	0.9	1.3
Gilead Sciences Inc.[2,3]	24.6	19.8
GlaxoSmithKline Inc.[2]	10.6	10.6
Grifols Canada Ltd (Talecris Biotherapeutics Ltd.)[3]	0.9	0.9
Hoffmann-La Roche Ltd. Canada[2]	3.9	3.7
Hospira Healthcare Corp.	0.0	0.0
INO Therapeutics[2]	0.0	0.0
Intermune Canada Inc.	0.0	0.0
Iroko International LP	0.0	0.0

Janssen Inc.[2,3]	3.3	5.1
Johnson & Johnson Inc.	0.0	0.0
Johnson & Johnson Medical Products	0.8	0.0
Lantheus MI Canada Inc.	0.0	0.0
LEO Pharma Inc.[2]	2.1	1.8
Lundbeck Canada Inc.[2]	0.7	0.6
Lundbeck Inc. (Ovation Pharmaceuticals Inc.)	0.0	0.0
McNeil Consumer Healthcare Canada	2.6	2.6
Medical Futures Inc.[5]	0.0	—
Medicis Canada Ltd.[5]	0.0	—
Merck Canada Inc.[2,3]	3.3	1.7
Merz Pharma Canada Ltd.	6.5	19.6
Novartis Pharmaceuticals Canada Inc.[2,3]	12.6	11.4
Novo Nordisk Canada Inc.[3]	1.7	2.2
Optimer Pharmaceuticals Canada Inc.[5]	0.0	—
Osiris Therapeutics Inc.[5]	372.2	—
Otsuka America Pharmaceuticals[2]	17.4	0.0
Paladin Laboratories Inc.[2]	0.02	0.2
Pfizer Canada Inc.[2,3]	6.0	7.6
Pharmascience Inc.	8.6	7.4
Purdue Pharma[2]	2.4	2.0
Ranbaxy Pharmaceuticals Canada Inc.	0.0	0.0
Rare Disease Therapeutics Inc.	0.0	0.0
sanofi pasteur Ltd.[2,3,7]	53.4	46.0
sanofi-aventis Pharma Inc.[2,3,8]	5.8	8.2
Santhera Pharmaceuticals Canada Inc.[3]	2.7	2.5
Sandoz Canada Inc.	1.2	—
Seattle Genetics Inc.[5]	14.7	—
Sunovion (Sepracor Pharmaceuticals Canada Inc.)[2]	0.0	0.01
Servier Canada Inc.[2]	5.4	3.8
Shire Canada Inc.[2]	0.1	0.2
Shire Human Genetic Therapies[3]	2.5	1.7
Sigma Tau Pharmaceuticals Inc.	0.0	0.0
Sopherion Therapeutics Canada Inc.	0.0	0.0
Takeda Canada Inc.[2,3]	0.0	5.9
Teva Canada Ltd. (Ratiopharm)	0.0	0.0
Teva Canada Innovation GP[3]	2.1	7.4
Tribute Pharma Canada Inc.[5]	0.0	—
Triton Pharma Inc.	0.0	0.0
Tyco Healthcare Group Canada Inc.	0.0	0.0
UCB Pharma Canada Inc.[3]	9.7	12.3
Unither Biotech Inc.	0.0	0.0
Valeant Canada Ltd.[3,9]	0.0	0.0

Vertex Pharma Canada Inc.[5]	26.4	—
VIIV Healthcare ULC.[2]	0.0	0.0
Warner Chilcott Canada Inc.[2]	0.1	0.3
Watson Pharma Co.[5]	0.0	—

[1] To avoid double counting of sales revenues, revenues from royalties are included in calculating each company's ratio but not included in calculating industry-wide ratios. Federal and provincial government grants are subtracted from the R&D expenditure in calculating individual R&D-to-sales ratios but are included in calculating industry-wide ratios. Differences between the list of firms filing data on prices and those filing R&D data are due to differences in reporting practices of patentees and their affiliates or licensees. Note as well that some veterinary patentees (i.e., those without revenue from sales of products for human use) are required to file information on R&D expenditure but not price and sales information.

[2] Member of Rx&D.

[3] Member of BIOTECanada.

[4] Spin off of Abbott's proprietary products division into a separate legal entity effective Oct. 31, 2012.

[5] Not a patentee in 2011.

[6] Formerly known as Fujisawa Canada Inc.

[7] Formerly known as Aventis Pasteur Ltd.

[8] Formerly known as Aventis Pharma Inc.

[9] Formerly known as ICN Canada Ltd.

TABLE 23

Current R&D Expenditures by Province/Territory, 2012

Province	Expenditures: All patentees ($000)	Regional share (%)	Expenditures: Rx&D ($000)	Regional share (%)
Newfoundland	5,308.33	0.613	4,379.63	0.577
Prince Edward Island	51.32	0.006	51.32	0.007
Nova Scotia	14,673.60	1.695	13,643.39	1.798
New Brunswick	1,882.83	0.218	1,354.22	0.178
Quebec	354,793.95	40.986	297,461.97	39.198
Ontario	368,642.16	42.586	331,874.77	43.733
Manitoba	6,491.07	0.750	5,361.41	0.707
Saskatchewan	2,413.53	0.279	1,701.77	0.224
Alberta	70,108.02	8.099	66,082.45	8.708
British Columbia	41,278.92	4.769	36,954.88	4.870
Territories	0	0.000	0	0.000
Canada	865,643.73	100.0*	758,865.81	100.0*

* Values in this column may not add to 100.0 due to rounding.

Source: PMPRB

TABLE 24

Current R&D Expenditures by Performer and Province/Territory, 2012

Province		Patentees	Other companies	University	Hospitals	Others
Newfoundland	$000	644.0	2,326.3	1,208.1	131.0	998.9
	%	12.1	43.8	22.8	2.5	18.8
Prince Edward Island	$000	0.0	30.4	0.0	21.2	0.0
	%	0.0	59.3	0.0	41.3	0.0
Nova Scotia	$000	1,628.4	2,632.5	6,787.4	1,441.2	2,184.1
	%	11.1	17.9	46.3	9.8	14.9
New Brunswick	$000	208.3	903.9	0.0	388.6	382.0
	%	11.1	48.0	0.0	20.6	20.3
Quebec	$000	186,355.5	96,333.7	10,953.7	16,577.7	44,573.2
	%	53.8	25.4	3.2	4.8	12.9
Ontario	$000	168,651.7	90,854.3	20,607.3	56,746.1	31,782.7
	%	45.7	24.6	5.6	15.4	8.6
Manitoba	$000	1,863.7	1,828.7	107.6	1,341.1	1,350.0
	%	28.7	28.2	1.7	20.7	20.8
Saskatchewan	$000	477.1	845.5	671.9	278.9	140.2
	%	19.8	35.0	27.8	11.6	5.8
Alberta	$000	49,488.7	8,612.2	4,192.0	3,544.9	4,270.2
	%	70.6	12.3	6.0	5.1	6.1
British Columbia	$000	15,953.3	14,265.4	2,229.2	3,782.9	5,048.1
	%	38.6	34.6	5.4	9.2	12.2
Territories	$000	0.0	0.0	0.0	0.0	0.0
	%	0.0	0.0	0.0	0.0	0.0
Canada	$000	425,270.3	218,632.9	46,757.64	84,253.6	90,729.5
	%	49.1	25.3	5.4	9.7	10.5

Notes:

- The percentage under each R&D category gives the percentage of all money spent in that category in that province/territory.
- Expenditures as a percentage of total means percentage of R&D expenditures in that province compared to total R&D in Canada.
- Rows and columns may not equal totals due to rounding.
- Current expenditures plus capital expenditures (equipment + depreciation) = total R&D expenditures.

Source: PMPRB