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Bulk purchasing for innovative pharmaceuticals – proceed with caution

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Further centralization of purchasing power will yield diminishing returns and risk unintended consequences, including delayed access to new therapies, and reduced therapeutic choice, particularly for single-source products.

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COMMENT

The promise of substantial additional cost savings from so-called "bulk purchasing" has long underpinned the push toward a national pharmacare program. But the promise may be fleeting. Federal, provincial and territorial (FPT) governments already exercise significant monopsony buying power through the pan-Canadian Pharmaceutical Alliance (pCPA) – the agency that negotiates confidential rebates for all publicly funded pharmaceuticals in Canada. It is unlikely there are significantly more savings to be had.

Although sometimes used by the media and politicians to describe the current pCPA process, the term "bulk purchasing" is, in fact, a misnomer, as governments do not actually purchase the prescription drugs listed on their drug plan formularies; instead, they reimburse eligible drug costs incurred by patients. Actual bulk purchasing involves centralized buying and volume commitments from purchasers - practices inconsistent with Canada's current reimbursement-based system.

The CDA Advisory Panel recommends a semantic change, replacing "bulk purchasing" with "pooled procurement." Regardless of terminology, the result is what economists consider a monopsony, where a single buyer (or several buyers acting together) has the power to drive down the prices of multiple sellers.

Despite some prominence in recent legislation and Canada's Drug Agency (CDA) Advisory Panel work, "bulk purchasing" remains undefined in Canadian policy. A recent expert roundtable hosted by Life Sciences Ontario suggests that the implications of centralized purchasing, particularly for innovative medicines, are far more complex than they appear.

The current pCPA process is both sophisticated and complex. The pCPA negotiates rebated prices, which are used to calculate rebates (i.e., the difference between the list price and the confidential rebated price, multiplied by the volume reimbursed). These rebates are generally payable quarterly by manufacturers to each of the participating FPT governments.

Confidential rebated prices are based primarily on a percentage reduction off the public list price. In addition, rebated prices may be tiered (price-volume agreements) and may include caps on patient costs or the total amount reimbursed annually for a particular drug. Less often, patient outcomes can also inform rebates such that the manufacturer covers or rebates the drug cost of patients who do not respond to their therapy. These "pay-for-performance" models are relatively rare as they often require considerable administrative oversight and rely on outcomes data that may not be readily available.

By comparison, bulk purchasing envisages centralized purchasing of large quantities of drugs, warehousing them, and then distributing them as needed. This model has some application for hospital buying groups, as well as for blood products and public health vaccines, but not for prescription drugs dispensed at community pharmacies.

Traditional bulk purchasing typically relies on tendering, which involves declaring one or two winners who supply the market for a specified period (usually two years). At the same time, losers are shut out, with limited or no revenue for their product unless a private market exists.

Internationally, bulk purchase tendering is used in some jurisdictions for multi-source drugs (including generics and biosimilars), but it is impractical for single-source innovative drugs. Contracting (rather than tendering) for innovative drugs focuses on value for

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money, taking into account clinical and cost-effectiveness. In principle, this is the Canadian model for innovative medicines, where the pCPA negotiates a term sheet that is, in turn, reflected in contracts between the manufacturer and each of the public drug plans.

As described above, Canada's public drug plans, working together through the pCPA, already exercise monopsony power, securing significant price reductions averaging 48.1 percent of total plan-paid patented drugs cost excluding dispensing fees, copayments/deductibles and markups according to the most recent analysis published by the Canadian Health Policy Institute (Skinner 2025). The confidential rebates negotiated by the pCPA process have generated billions of dollars in savings to the FPT governments; however, the demands by the pCPA to extract significant cost reductions are increasingly not commercially viable for manufacturers, resulting in prolonged delays in listing innovative therapies on formularies.

Further centralization of purchasing power will yield diminishing returns and risk unintended consequences, including delayed access to new therapies, and reduced therapeutic choice, particularly for single-source products.

Lower prices may also destabilize the fragile supply chain infrastructure supporting drug distribution, especially in rural and remote areas. Distributors operate on narrow margins, and further compression could threaten their viability. Tendering for generics and biosimilars will reduce supplier diversity, increasing the risk of shortages that already plague several drug categories.

There is also a practical perspective. Healthcare is a provincial responsibility, and some provinces may refuse to cede control to a national bulk purchasing entity. Furthermore, the nascent state of national pharmacare is based on bilateral federal-provincial pharmacare agreements that vary widely, raising concerns of inequities and fragmented implementation. In addition, political shifts since the passage of the federal Pharmacare Act have complicated attempts to use bulk purchasing to further lower prices. The 2025 federal budget mentions pharmacare only once, and in passing.

Expanding public coverage will erode the role of private insurers, which currently reimburse higher prices. Revenues from higher prices in the private market factor into a manufacturer's calculus when negotiating with the pCPA, allowing manufacturers to offer greater rebates to public plans. A shift to a public-first or public-only model risks destabilizing this balance and may inadvertently increase public sector costs.

A national monopsony may provoke trade tensions, particularly with the United States. Canada's regulatory and market access environment is already under pressure, as the Trump administration is pressuring Canada and other countries to allow higher drug prices to help pay their "fair share" of the research and development costs for new medicines. Bulk purchasing could exacerbate these concerns. Moreover, the 2025 federal budget is focused on fostering innovation across all sectors. Regulatory proposals that aim to lower prices and restrict market access to innovative medicines are antithetical to innovation.

There has long been concern that the pCPA process is too slow and typically only begins after Health Canada and subsequent reviews by the CDA and INESSS in Quebec are complete. There are ongoing projects that help expedite the process, including aligned and parallel reviews by Health Canada and the HTA agencies, as well as newer price negotiation initiatives such as the international Project Orbis and Ontario's Funding Accelerated for Specific Treatments (FAST) program. The latter programs are in the early stages and, for now, focus primarily on cancer treatments. Any shift toward a bulk purchasing model will upset the modest efficiency gains in the negotiation process and further delay patient access to new therapies.

Before moving forward further on bulk purchasing for innovative pharmaceuticals, federal and provincial governments, as well as arm's length organizations such as Canada's Drug Agency, the pan-Canadian Pharmaceutical Alliance should:

- Acknowledge that the primary objective of bulk-purchasing (cost savings) is already achieved through the pCPA process
- Assess whether the current pCPA process is now over-reaching in some cases by placing cost savings ahead of patient access
- Expedite the pCPA process such that reimbursement coverage is in place as soon as drugs are approved by Health Canada, particularly for high-priority drugs
- Clearly define the scope, mechanisms and implications for any new bulk purchasing initiatives or any changes to the pCPA process.
- Assess economic trade-offs, including innovation impacts and supply chain risks.
- Develop governance models that respect provincial autonomy.
- Consider the role of private insurers and broader implications for access.
- Evaluate international trade consequences.

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Skinner, B. J. (2025). Net direct public expenditure on patented medicines in 10 Canadian provinces in 2023. Canadian Health Policy, DEC 2025. www.canadianhealthpolicy.com.