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In Health Care, Cost Isn't Proof of High Quality

"For most consumers, the fact that there is no connection between quality and cost is one of the dirty secrets of medicine," said Peter V. Lee, the chief executive of the Pacific Business Group on Health, a California group of employers that provide health care coverage for workers. Many of my Medicaid patients refuse generic medications, insisting "they just don't work as well". In a recent study conducted in 2002 by AARP, 22 percent of those surveyed indicated they thought that generic drugs might be less effective or of poorer quality than brand-name drugs. Many physicians appear to have the same mindset, prescribing the newest anti-hypertensive agent or the newest oral hypoglycemic agent that is often more expensive than a generic and has no associated proven outcomes benefit (quality). Why? Perhaps because we feel obliged, since the pleasant drug rep brought us lunch or dinner. However, the Food and Drug Administration approves generic drugs that contain the same active ingredients as brand-name pharmaceuticals, and the agency says that generic drugs meet the same quality standards as brand-name drugs.

In this *Heartbeat* we'll present a rational of why you should 'jump onto the generic bandwagon'.

A quiet coup is taking place in American medicine cabinets. Prescription bottles bearing catchy brand names like Zocor, Coreg, Toprol XL and Lotrel are being pushed aside by tongue-twisting generics like simvastatin, carvedilol, metoprolol succinate extended release tablets and amlodipine besylate/benazepril.

This is happening because patents are expiring on many of the drugs that were introduced during the late 1980s and early 1990s, an unusually productive era of research and development for the pharmaceutical industry. Physicians using generics as standard care, could divert some of the $30 billion spent on direct-to-consumer and physician advertising to research for adding new beneficial drugs to the pipeline.

As frequently happens when generics appear, sales of the name-brand drop—Ambien plunged to $91 million in the second quarter, from $420 million in the same period last year. Generics already account for 60 % of prescriptions in this country, and we are just at the beginning of the trend. The rise of generics has helped slow spending increases for prescription medications over all, even though an aging population is consuming more drugs and even as new

medicines enter the market. *It's an exciting time when we can offer the same or better quality at decreased cost.* This is especially true in cardiology, with most patients on Medicare with limited incomes taking multiple drugs for a myriad of complex medical conditions. The guideline recommended drug classes for most of the major cardiac disease states now have generic choices.

Don't fall into the trap of prescribing the newest drugs. The classic drug rep line about this is, "It's covered by the insurance plan." But who's paying for the insurance? –You, our patients and I. All of our rates will continue to go up by double digit percentages instead of the single digit increases anticipated if we use more generics. "Better compliance" is another sales pitch (Coreg SR—one dose daily—was just released to recoup losses from the now generic coreg—two doses daily), but you should give your patients the choice. Most of mine prefer saving the $40 to $50/prescription and will be compliant taking two pills a day rather than one. Or if compliance is *really* an issue, generic Toprol XL (also 1 dose daily) remains a choice.

The pharmaceutical industry is very clever—new formulations come out just as old ones go generic. Exforge (a combo of amlodipine besylate [Norvasc] and valsartan [Diovan]) was released by Novartis when Lotrel went generic. The only reason to use Exforge instead of generic Lotrel would be for patients with cough or angioedema secondary to an ACE inhibitor (< 10%)—same as for use of generic ACEs for cardioprotection in HF, T2DM and CAD as opposed to an angiotensin receptor blocker (no generics available). Cost is the tiebreaker when benefits are equal.

"A statin is a statin." Use generics (lovastatin, pravastatin and zimvastatin) wherever possible to get your patients to appropriate LDL-C goals. Do not short-change your patient. There is a place for Crestor 40mg, Lipitor 80mg and Vytorin 10/40mg and 10/80mg to assist in getting patients to those difficult to reach < 70mg/dL optional goals. (FYI per my research, Vytorin is cheaper than a generic statin and ezetimibe (Zetia) when you happen to need this combination therapy to reach a specific goal).

After comparing the various strengths of statins (Table 1), you really don't have to use Lipitor Crestor or Vytorin in their less potent doses. Comparable strength generics can be substituted, obviously unless they're not tolerated. Further savings can be had by prescribing a larger dose statin and having the patient break the tablet in half or taking it every other day when possible to get to the appropriate therapeutic LDL-C.

Table 1.Comparative efficacy of available statins

Comparative Efficacy of Statins

Available Statins	Dose	% LDL-C reduction
rosuvastatin (Crestor)	5mg	
simvastatin/ezetamibe (Vytorin)	10/10mg	
atorvastatin (Lipitor)	10mg	
simvastatin (generic)	20mg	~ 33-39%
lovastatin (generic)	40mg	
pravastatin (generic)	40mg	
fluvastatin (Lescol)	80mg	

Remember LDL-C level is key. In the PROVE-IT study comparing atorvastatin 80mg with pravastatin 40mg, outcomes were significantly improved with reaching LDL-C levels < 70mg/dL and obviously the more potent statin (atorvastatin) was superior. But when pravastatin got the LDL-C to less than 70mg/dL the outcome benefits were equal.

I believe that we, as physicians, are an important part of the healthcare system. We are advocates for our patients and all of the people who need medical care. If we can decrease our patients' cost and the cost to the whole health system, regardless of who's paying, and still deliver high quality care, we should. I think that compliance with our multiple drug treatment plans can be significantly improved by decreasing cost which will improve quality.

With the so-called *Walmart effect* ($4/ 30 day prescription for up to 2400 generic drugs planned next year) and the Three Democratic candidates — Hillary Rodham Clinton, John Edwards and Barack Obama — having included generics in their health care proposals, folks are seeing generics as more acceptable than they previously had.

We can't fix the entire "broken" healthcare system, but we can help. Hopefully some of the dollars saved will enable patients with coverage to obtain better coverage and patients without coverage to get some. In reality, we'll have to leave getting coverage for the 50 million without and improving coverage to those with poor coverage to Universal Healthcare and another *Heartbeat.* Hopefully at that time those in charge of the healthcare system will be able to negotiate for reduced pharmaceutical prices as do all the other industrialized countries.

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