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## Poor pricing progress

Price disclosure isn't  
the answer to high drug prices

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This report was written by Stephen Duckett, Grattan Institute Health Program Director and Peter Breadon, Health Fellow. Leah Ginnivan made substantial contributions to the report and Jonathan Nolan assisted with research.

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## Overview

Grattan Institute's March 2013 report, *Australia's bad drug deal*, showed that Australians paid more than \$1 billion a year too much for prescription drugs.<sup>1</sup> The problem is how the government sets prices. Vested interests are involved in price negotiations, there is no cap on expenditure, and the price cuts when a drug goes off patent are far smaller than in many other countries.

The problem hasn't gone away. Current policies aren't doing nearly enough to bring prices down. In December, the Commonwealth Government's "price disclosure" policy led to price cuts for seven generic drugs. Price disclosure tracks discounts that manufacturers and wholesalers give to pharmacies. Then the government cuts prices to reflect what pharmacies actually pay.

The price cuts in December averaged 34 per cent. In three cases the cuts were big enough to reduce out-of-pocket costs for patients. As a result patients without a concession now save around \$5 for each box of pills.

That sounds like a lot. But this report compares prices *after* these cuts with prices in the UK, New Zealand and the Canadian province of Ontario. On average, Australian prices remain almost 16 times higher than the best price in these three places. Our prices are more than 14 times higher than those in the UK.

High prices are very costly for taxpayers and for consumers. Many Australians pay both through their taxes and then at the pharmacy.

Once again, benchmarking against prices in other countries would get a much better deal. Of the seven drugs that had their prices reduced in December, patients would pay less for all of them, instead of just three. The out-of-pocket saving would also be much higher, averaging more than \$21 per drug.

The money we spend on high drug prices could be much better spent. But this isn't just about saving money. Almost one in 10 Australians don't take their prescribed medicine because of the cost. Better prices would help more people to buy the medicine they need.

The Government should take three steps to cut the extremely high prices we pay for generic drugs. First, it should ask the Department of Health to release annual international comparisons of Australia's drug prices. Everyone would then be able to see whether we are getting value for money.

Second, when the current pricing agreement expires in July next year, there should be one-off benchmarking to get fair market prices. Finally, an independent drug pricing body should be established to make sure prices stay low in the future.

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<sup>1</sup> See [Australia's bad drug deal](#).

## High prices

Australian medicine prices are many times higher than in other countries. Unnecessarily inflated prices have cost patients and taxpayers billions of dollars.<sup>2</sup>

In particular, Australians pay far too much for generic drugs. When new drugs are first introduced, they are covered by patents. In the main it's a sensible system: protection from competition allows high prices to reward companies for research and development.

But once this protection expires, any company can market 'generic equivalent' drugs. Generics can usually be manufactured for a tiny fraction of the price the originator drug sells for and many companies can compete to supply them. While Australians pay high prices, the same drug companies are selling the same drugs for much less overseas. There is no reason we should pay more.<sup>3</sup>

Our prices are high because we buy drugs in the wrong way. The Pharmaceutical Benefits Scheme (PBS) budget is uncapped. Representatives of drug companies and cabinet ministers, instead of independent experts, are involved in the pricing and listing of medicines. There are no strong incentives to make tough choices about putting drugs on the PBS or setting prices. Prices are set by negotiation, not by looking at the prices that are paid overseas. The result: prices that are far too high.

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<sup>2</sup> In March 2013, Grattan Institute estimated the excess cost from high prices was at least \$1.3 billion in 2012-13. For other discussion of high prices and the limitations of price reduction, see Clarke (2012).

<sup>3</sup> Justifications for inflated prices are discussed in detail in a previous report, our previous report, [Australia's bad drug deal](#). More information on price disclosure and other policy settings are also in the report.

## Price disclosure

The Commonwealth Government sets a wholesale price for each drug on the PBS. Patients pay pharmacists up to \$36.10 (which includes dispensing and other fees). If the wholesale price for a drug isn't covered by patients, the Government pays pharmacists the remainder.

But manufacturers and wholesalers often give large discounts to pharmacists. Before 2007, these discounts weren't taken into account when the Government set prices. This meant the Government often paid pharmacists much more than the actual wholesale cost of their drugs.

In 2007 a policy called "price disclosure" was introduced to fix this and cut the price of generic drugs (Figure 1 shows where price disclosure fits in the overall pricing process).

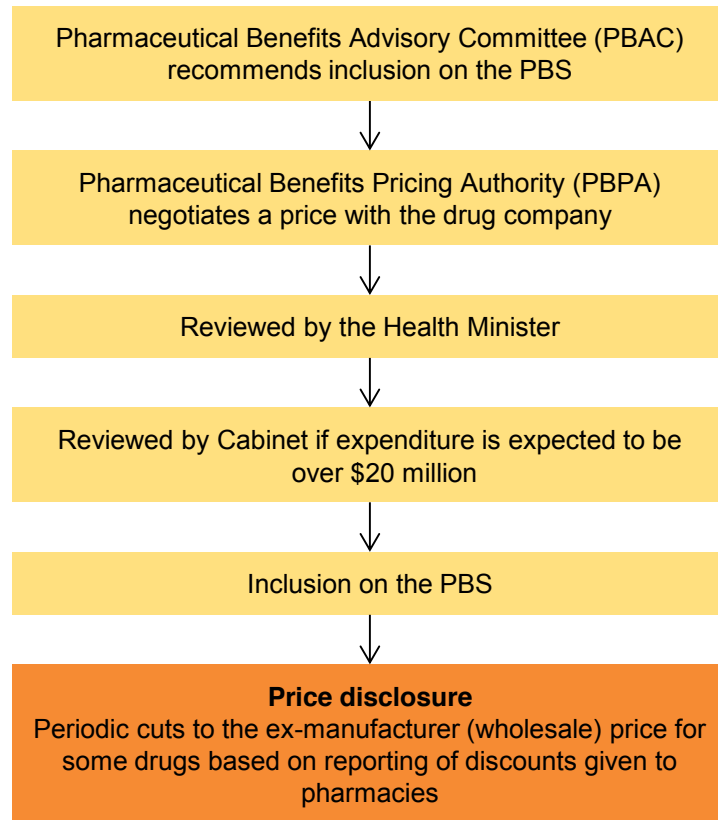
Under price disclosure, drug companies collect information about how much pharmacies actually pay for generic medicines over a 12-month period. Over the next six months, this information is used to calculate the average price after discounts. The Department of Health then uses this average to adjust the PBS price.

Since 2012, price disclosure has cut the price of about 150 medicines, sometimes by more than 50 per cent. In August this year the then Finance Minister announced that from mid-2014 the process would be sped up from 18 months to one year, saving an estimated \$830 million over four years.<sup>4</sup>

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<sup>4</sup> Bowen and Wong (2013). The current Government will implement the reduction in the price disclosure cycle and will also reduce the number of annual rounds and

**Figure 1: The PBS pricing process**



Source: Pharmaceutical Benefits Pricing Authority (2009)

Price disclosure has cut the price of many drugs. In the last six months there have been two rounds of reductions. In August the prices of 39 drugs came down by an average of 26 per cent. December reductions bring down the prices of seven drugs by an average of 34 per cent.

Nevertheless, while some progress has been made, the price disclosure policy has many flaws:

- A long price disclosure process means that falling prices do not benefit consumers until at least a year later.
- A loophole excludes the first month of the data collection period from the calculation of the reduced price. This loophole is being exploited, with drug companies offering 'specials' on medicines during this time, and pharmacists buying months' worth of medicine without fear of a lower profit margin later.<sup>5</sup>
- Another loophole specifies that prices won't be reduced if the potential price reduction is less than 10 per cent. This means that even over cumulative rounds of reductions, many medications might not drop in price if the difference between current subsidy and the average price is relatively small.
- Pharmacists can also receive in-kind gifts instead of direct discounts, such as shop fit-outs, flights or conference tickets. These could disguise the true purchase price of medicines, especially as suppliers and pharmacists adapt to the policy.

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the number of days when price reductions occur, Commonwealth of Australia (2013).

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<sup>5</sup> For example see The Pharmacy Guild of Australia and Ranbaxy (2013)

- The process requires extensive reporting, creating red tape for businesses.<sup>6</sup>

Most importantly, price disclosure hasn't brought most prices anywhere near the prices paid in many other countries. There are still huge disparities between Australian and international prices, at great cost to taxpayers and patients.

There have been calls to continue with price disclosure, to expand its scope, or to shorten the cycle of data collection to three months.<sup>7</sup> Yet while price disclosure is better than nothing, there is no sign it will bring drug prices close to the low prices paid elsewhere any time soon. Every day this is costing taxpayers and patients – we need a new approach.

### Benchmarking is better

Grattan Institute's 2013 report, *Australia's bad drug deal*, proposed another way to reduce the cost of pharmaceuticals on the PBS.<sup>8</sup> It suggested an independent drug pricing body with a fixed budget and medical expertise. It also recommended sharp cuts in the price of new generic medicines entering the market.

Most importantly, the new body would look at the prices paid elsewhere to determine what the PBS should pay. Many countries

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<sup>6</sup> The complexity helps hide what a bad deal taxpayers get, a phenomenon summarised in Teles (2013): "Policy complexity is valuable for those seeking to extract rents from government because it muddies the waters, making it hard to see just who is benefitting and how, and so obscuring the actual mechanism of political action that it is difficult to mobilize against it".

<sup>7</sup> For example, Philip Clarke has suggested that there is scope to adopt England's three-month price disclosure cycle, Consumers Health Forum, *et al.* (2013).

<sup>8</sup> Duckett, *et al.* (2013)

look overseas to help set prices. Twenty-five out of 27 EU member countries, along with Canada, New Zealand and Japan, use some form of benchmarking.<sup>9</sup> The UK is often used in these comparisons, with 11 countries using it as a benchmark.

The model proposed in *Australia's bad drug deal* would have an independent pricing authority set a price (based on an international benchmark) and allow many drug companies to sell at that price. This model would still allow choice for consumers, just as the current system does – any manufacturer would still be free to sell the drug.

To contrast benchmarking with price disclosure, we compared prices in the UK, New Zealand and Canada's largest province, Ontario. We only looked at drugs that have had their prices cut in the December round of price disclosure reductions.<sup>10</sup> Even *after* these cuts, Australia's prices are an average of 15.8 times higher.<sup>11</sup> The PBS doesn't have the lowest price for any of these drugs.

These comparisons are conservative. Most countries benchmark against many others: Germany, for instance, looks at the prices paid in 15 different countries before setting its own.<sup>12</sup> We only looked at the best prices in three jurisdictions. Furthermore, where

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<sup>9</sup> Espin, *et al.* (2011); Ruggeri and Nolte (2013). Many other countries outside the EU also use reference pricing. It has a varying degree of influence on pricing in different countries. We propose that it be at the centre of pricing decisions.

<sup>10</sup> This comparison uses ex-manufacturer prices (before retail mark-ups and dispensing fees).

<sup>11</sup> All comparisons are based on a nominal dose. See the methodological appendix for more information.

<sup>12</sup> Espin, *et al.* (2011)



there were multiple prices within NZ, the UK or Ontario, we always chose the most expensive one for comparison.

As Figure 2 shows, even this conservative benchmarking dwarfs the savings from price disclosure. The height of the bars shows how many times greater the price for a drug is here compared to the lowest price in the UK, New Zealand or Ontario (using wholesale prices). The lighter bars show how many times more expensive our prices were before the price disclosure cuts. The darker bars show the situation now.

Even after price disclosure cuts, our prices are a very bad deal. For three of the seven drug doses we looked at, Australia's prices are well over 20 times higher than the best price in the UK, New Zealand or Ontario.

**Box 1: Atorvastatin – still costing far too much**

Atorvastatin (formerly sold only under the brand name Lipitor) is a drug that lowers cholesterol. It is one of the most commonly prescribed drugs, with nearly 10 million scripts issued each year.<sup>13</sup>

On 1 December the ex-manufacturer price of a box of 30 40mg pills falls from \$38.69 to \$19.32. This sounds like a big drop, but the ex-manufacturer price in the UK is the equivalent of \$2.84. In New Zealand it is only \$2.01 cents.

For this drug alone, the massive premium paid in Australia costs taxpayers tens of millions of dollars a year. Many Australians are paying for these high prices twice – once through their taxes and then again at the pharmacy.

After pharmacy mark-ups the December price reduction will save patients without a concession about \$7 per box of pills.<sup>14</sup> But if we had the UK's wholesale prices, the saving would be up to almost \$19 greater, and almost \$20 more with New Zealand's wholesale prices. Patient savings from benchmarking are discussed further below.

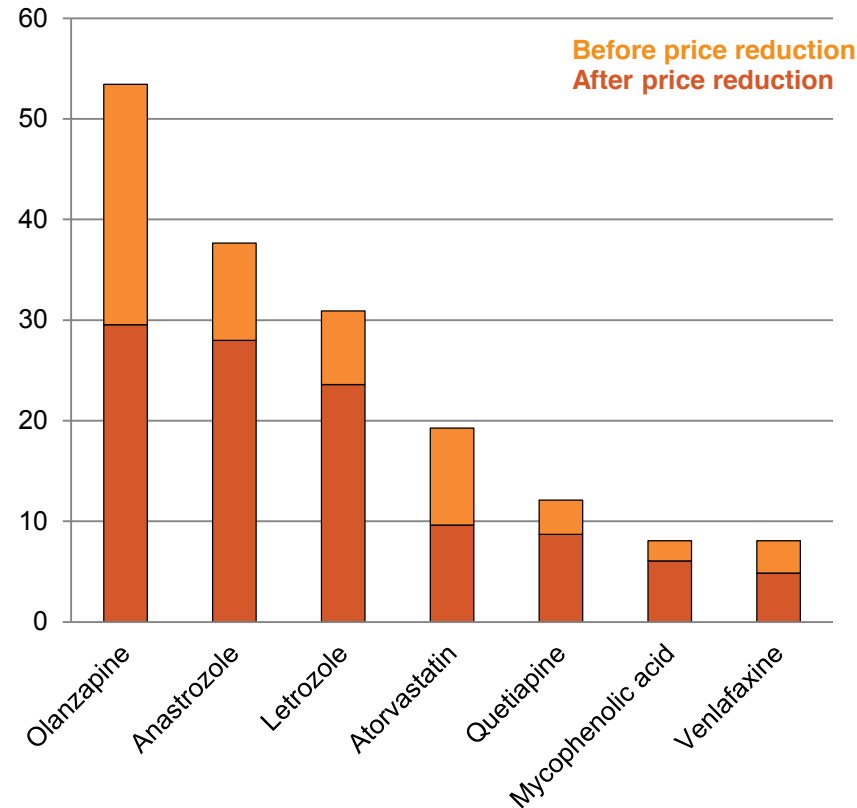
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<sup>13</sup> Department of Health and Ageing (2013)

<sup>14</sup> All out-of-pocket cost comparisons are for non-concessional patients above the Safety Net threshold. See the appendix for more detail on our assumptions.

Figure 2: PBS prices as multiples of the lowest price in NZ, UK or Ontario before and after price reductions

PBS ex-manufacturer prices as multiples of benchmark prices



Notes: Based on nominal doses. Australian prices before reductions are approximate. See methodological appendix for more detail.  
Source: Grattan Institute

### Not just beaten by “third world” New Zealand

There have been criticisms of comparing of Australian and New Zealand drug prices. In response to our report, Brendan Shaw, CEO of pharmaceutical industry group Medicines Australia, said that adopting drug pricing policies from New Zealand would give Australia the health system of a “third world country”.<sup>15</sup> He also claimed that New Zealand is a “basket case” in terms of access to medicine, and is the last place we should be looking for ideas.

Dr Shaw’s criticisms are mostly related to patented medications, which are not the subject of this report.<sup>16</sup> New Zealand does have a more limited range of subsidised drugs than Australia. Its low prices are also partly due to a sole-supplier model, which we don’t recommend. But these criticisms are a distraction from Australia’s sky-high prices. It’s not just New Zealand that has much better prices. Many countries that have similar access to the wide range of subsidised drugs available in Australia also have fairer prices.

To prove this, we did a second comparison against the UK and Ontario. Neither has a sole-supplier model. According to the same reports used to criticise access to medicines in New Zealand, over the last five years the number of subsidised drugs

<sup>15</sup> Shaw, Brendan. Pressure on Market Access in Australia, Speech to Medicines New Zealand Conference, 9-oct-2013, Auckland.

<sup>16</sup> Patented medicines are not subject to price disclosure. Because any company can produce and sell generic drugs, internationally competitive prices are not a real risk to supply. If a company refuses to sell for a price similar to prices that are profitable overseas, another company is very likely to take the opportunity to do so.

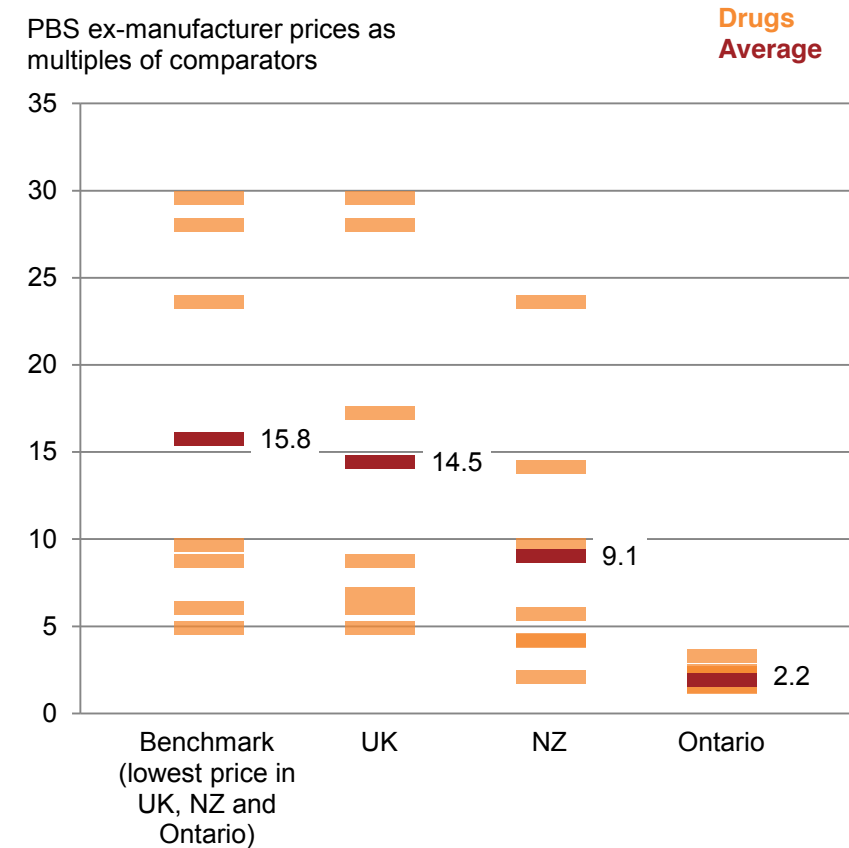


in the UK is 14 per cent higher than in Australia.<sup>17</sup> Recent Ontario data is not available, but Australia had a similar level of drug availability to Ontario for the three years to 2010.<sup>18</sup>

Our wholesale prices are 14.5 times higher than the UK's and more than double Ontario's. As just one example, the breast cancer drug anastrozole (Arimidex) costs \$92 for a box of 30 1mg tablets on the PBS but a mere \$3.30 in the UK. These are wholesale prices, but high prices often flow through both to patients at the pharmacy and to taxpayers, as detailed below.

As Figure 3 shows, while New Zealand's prices are the lowest, we still lag far behind the UK and Ontario. Australia's small size is no excuse for the prices we pay – both New Zealand and Ontario are much smaller markets (with populations of around 4.5 million and 13 million).

Figure 3: PBS prices as multiples of NZ, UK and Ontario prices, following December price disclosure reductions



Note: Based on nominal doses  
Source: Grattan Institute

<sup>17</sup> Based on Canadian, pharmaceutical industry-funded reports cited by Dr Shaw to characterise access to drugs in New Zealand, Shaw (2013). The measure of access is the proportion of the drugs available in Canada that have a public subsidy in other countries. On this measure, access in the UK is comparable to Australia. However, it is not a good measure of access to medicines. Firstly, the list of drugs in different countries varies, so no country has all of Canada's drugs, and some subsidised drugs in other countries are excluded. Secondly, it doesn't take account of how often drugs are used. Finally, price is a barrier to access and this measure ignores costs to consumers. On this measure, in the five years to 2011-12 Australia only had lower 'access' than the UK in 2011-12, by 11% (the full range of variation is 70%), Wyatt Healthcare (2007-2012).

<sup>18</sup> Wyatt Healthcare (2007-2012)

### High costs for patients

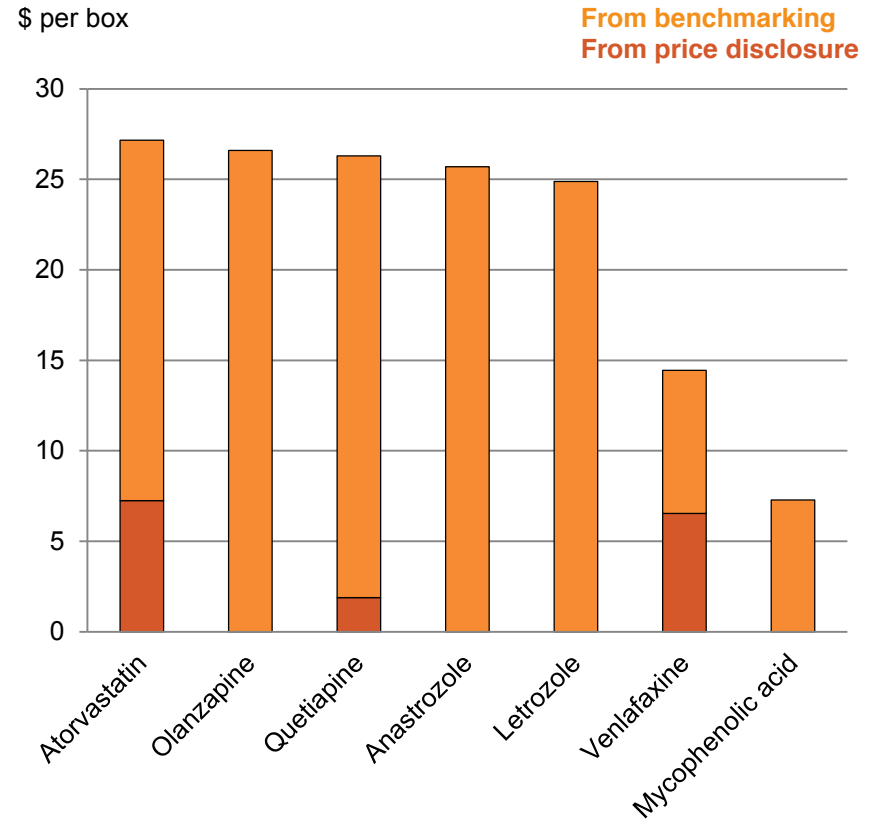
High prices cost patients as well as taxpayers. In fact, patients pay a growing share of the cost of drugs on the PBS, rising from 23 to 30 per cent in the six years to 2010-11.<sup>19</sup> The results of high prices are serious. An estimated nine per cent of Australians don't fill their medicine prescriptions because of the cost.<sup>20</sup>

Price disclosure is having some impact. It is bringing the price of some drugs below \$36.10, the maximum price paid by patients who don't have a concession and are below the Safety Net threshold. For the doses we compared, the December reductions range from around \$2 to \$7 a pack, for three different drugs.<sup>21</sup>

Yet benchmarking would do much more. It would cut out-of-pocket costs for all seven drugs, not just three. The savings are much bigger, averaging up to nearly \$22.

The impact on an individual can be big, especially if they take several drugs. Ivan (not a real person) is a 55-year old who takes atorvastatin for high cholesterol and venlafaxine for mild depression. On these drugs alone, benchmarking could save him up to almost \$350 a year.<sup>22</sup>

Figure 4: Savings to non-concessional patients from price disclosure and benchmarking



Note: Savings are for non-concession patients above the Safety Net. Based on nominal doses. See appendix for more detail.  
Source: Grattan Institute

<sup>19</sup> Includes payments at and below copayment threshold, Harvey (Forthcoming).

<sup>20</sup> ABS (2012).

<sup>21</sup> All calculations refer to non-concessional patients below the Safety Net threshold. See the appendix for more detail.

<sup>22</sup> At current prices Ivan's costs are below the Safety Net, see the appendix.

### A better policy for a better deal

Benchmarking against the best international prices is a much better policy than price disclosure.

- It is faster, as benchmarking does not have the lengthy data collection period used in price disclosure
- It is less administratively complex for both government and drug companies, and would close the loopholes that exist in price disclosure
- It can easily be applied to a larger number of drugs, including drugs that are not generics
- Most importantly, benchmarking would result in far greater savings for the government and patients

Price disclosure is bringing down the excessively high prices of Australian generic medicines. But we would do a lot better if we compared our prices against the lowest prices in comparable countries. The flawed price disclosure process will not bring down costs far enough, or fast enough. There are no prizes for having the 'most improved' price – not when the price started out being astronomically high.

By contrast, benchmarking would allow huge reductions in price, while maintaining choice and certainty of supply.<sup>23</sup>

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<sup>23</sup> For more information, see Duckett, *et al.* (2013)

As a first step, the Commonwealth Government should ask the Health Department to publish price comparisons with several countries each year.<sup>24</sup> Even supporters of current policies should agree with more transparency and accountability about how Australia's prices compare.

There is also an opportunity to do a one-off price reduction in mid-2014, when the Government's commitment to current pricing arrangements expires.<sup>25</sup> In the longer-term, an independent pricing body should be established, as our previous report proposed. In practice, benchmarking would need to leave a buffer for exchange rate fluctuations. But our estimates of savings are very conservative and this buffer is unlikely to reduce them by much.

Better prices would significantly reduce income for community pharmacies.<sup>26</sup> This is a real challenge. But there are ways to address it without giving up on fair prices. One option could be expanding the services that pharmacists can provide, giving them new sources of income.<sup>27</sup> Other options are direct, transparent subsidies to community pharmacies in locations where viability may be an issue, or taking steps to make the sector more

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<sup>24</sup> We suggest, at a minimum, that the comparators for this report be included.

<sup>25</sup> Pricing is governed by a Memorandum of Understanding between the Government and the pharmaceuticals industry group Medicines Australia.

<sup>26</sup> Primarily from the windfall profits from paying prices below the government approved ex-manufacturer price, and partly because pharmacies charge a mark-up which increases with drug prices, their income will decline when prices fall. Lower prices would also have a small financial impact on hospitals that dispense drugs using PBS prices.

<sup>27</sup> We propose this in the context of rural workforce shortages in a previous report, [Access all areas](#).

competitive and efficient. But these costs need to be weighed against the huge benefits of getting a better deal on drug prices. With nearly 200 million individual scripts a year filled, lower prices on essential medicines would create big savings for patients. It would also free up a significant proportion of the health budget.

Advocates of price disclosure might argue that it will eventually achieve the same price as benchmarking. For this to be true, manufacturers would have to discount to international benchmark prices. Then those discounts would need to be fully captured by price disclosure reporting. Even then, patients and taxpayers would keep paying higher prices while price disclosure reporting and analysis is carried out.

High drug prices waste millions of dollars a day. This doesn't just put pressure on the health budget and on taxpayers, it means more people can't afford to buy medicine that a doctor has prescribed. There is a much better way to set drug prices. To get a fair deal on medicines, Australia needs to keep up with the rest of the world.

## Methodological appendix

Data about price reductions was sourced from the Pharmaceutical Benefits Scheme website. Information on volume of prescriptions was generated through the PBS item reports. International pricing data were retrieved from the following websites:

Canada <https://www.healthinfo.moh.gov.on.ca/formulary/>

UK <http://psnc.org.uk/funding-and-statistics/structure-of-pharmacy-funding/drug-tariff-reimbursement/>

NZ <http://www.pharmac.govt.nz/Schedule>

When multiple prices were available overseas, we chose the more expensive option. A price reduction occurs on all forms of a drug – for example, a 20 per cent reduction on atorvastatin will apply to the prices for a box of 10, 20, 40 and 80mg tablets. We made comparisons on one dose of medicine only, a ‘nominal dose’ – for example, a pack of 30 40mg Atorvastatin tablets. Prices were adjusted for pack size and dose if necessary. The average exchange rate for the year to the end of September was used: NZ\$1.21; £0.64; CA\$1.01. Two and three-year averages are higher (resulting in greater savings) than the values we used.

Comparisons involving multiples of the benchmark price do not include pharmacy mark-ups, but apply only to the ex-manufacturer price.

When calculating out-of-pocket savings for patients, we added pharmacy mark-ups. Pharmacy mark-ups were calculated using the fees set out in the *Fifth Community Pharmacy Agreement*.<sup>28</sup> These calculations are approximate because we assumed that only the Pharmacy Mark-up and the Ready Prepared Fee were applied. All out-of-pocket cost comparisons are for patients that do not have concessions and are above the Safety Net threshold.

For the fictitious example of Ivan the daily doses are: atorvastatin, 40mg; and venlafaxine, 37.5mg. Currently, the total annual out-of-pocket cost of these drugs (using the same assumptions described above) is \$567, well below the Safety Net threshold of \$1,390.60. With benchmarking, out-of-pocket costs would fall to \$222.<sup>29</sup>

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<sup>28</sup> Department of Health and Ageing and the Pharmacy Guild of Australia (2010)

<sup>29</sup> These figures represent average annual expenditure and savings (pack sizes, such as 30 pills, do not exactly align with the length of months or years).

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