

Ending Australia's bad drug deal: the three elements of pharmaceutical pricing reform

Australians are paying far too much for prescription drugs, especially drugs that are no longer under patent.

Our pricing system fails at almost every step. There is no drug budget to contain costs and force tough negotiations. The pharmaceutical pricing body includes vested interests and can be overruled by politicians. The policies that try to keep prices in check are timid and ineffective.

The first report from Grattan Institute's Health Program, [*Australia's bad drug deal*](#), makes detailed comparisons with the prices paid in New Zealand, and by public hospitals in two Australian states. It looks at how drug prices are set elsewhere and explains the three steps that will get a much better drug deal for Australia.

[Professor Stephen Duckett](#) discussed the report findings at a [Parliamentary Library Lecture](#) in Canberra on Wednesday 20 March.

Speaker: **Professor Stephen Duckett, Health Program Director, Grattan Institute**

JONATHAN CURTIS: Ladies and gentlemen, my name's Jonathan Curtis, I'm the Assistant Secretary Research Branch. Welcome to the latest of the Libraries Vital Issue Seminars & Lectures.

Our speaker this morning is Professor Stephen Duckett who's talking about opportunities to reduce the cost of the Pharmaceutical Benefits Scheme. On Monday Grattan Institute and Professor Duckett published the report [*Australia's bad drug deal: High pharmaceutical prices*](#) and it certainly appears to be an issue worth some fairly close examination given the, I understand, about \$9 billion in government funding that goes into the Pharmaceutical Benefits Scheme. And I also read that around 194 million prescriptions are subsidised through the PBS amounting to about nine prescriptions per year for each person in Australia.

Professor Duckett probably needs limited introduction. I think he's fairly well-known already, but he's held top operation and policy leadership positions in healthcare in both Australia and Canada, including as Secretary of what's now the Commonwealth Department of Health & Ageing. He studied economics at ANU and health administration at the University of New South Wales. He's also been awarded a Doctor of Science by the University of New South Wales and elected as a Fellow for the Academy of the Social Sciences in Australia.

I'd ask you to join me in welcoming Professor Duckett.

STEPHEN DUCKETT: Thanks very much. And I'd like to start by acknowledging that I'm giving a speech on what was Aboriginal land and that these acknowledgments of the country are really important, especially in talks about the health sector, because still today Aboriginal people have significant difference in life expectancy from non-Aboriginal people. And so when we hear these acknowledgments we need to remember what the dispossession and the disadvantage that has occurred over the centuries has meant.

This report came out of a stream of work we're doing at Grattan Institute on the issue of waste in the health sector and this component was looking at high input prices as an example of waste. It's not the only area we're going to be looking at, but we thought it was timely to start with this one. Please feel free if you wish to interrupt as we go along, but we're going to have time for questions at the end.

We're going to look at five main areas: basically a bit about pharmaceutical costs, but that's mostly known; a bit about what Grattan Institute did and how the current pharmaceutical pricing works; where we think it should change, a better way to purchase; and what some of the reaction to our report has been.

So this graph ([refer presentation](#)) is the graph of total expenditure on the Pharmaceutical Benefits Scheme in real terms. You can see that it's escalating pretty significantly. Most of the spending is by pensioners and healthcare card holders. This other spending includes people who have hit the safety net. And so the scheme in terms of its incidence is actually quite well-targeted and there's also a significant patient contribution. So we're interested in whether there's anything could be done to reduce that total expenditure. And what we see when we look at that is that five years or so ago Australia was amongst the best in the world in negotiating prices for pharmaceuticals. The Productivity Commission did a report back in 2000 which said that we were amongst the best in the world, not quite the best but pretty close to the best. But over the last decade or so we've lost our advantage and from ranking in the top three and everybody basically spending more in terms of prices relative to Australia, we've now dropped to a situation where the European countries especially are now spending less in terms of prices and we're now in the bottom three in terms of rankings.

It's important to recognise that there are two basic markets we're talking about in the pharmaceutical business and these work quite differently. The first is the patented drugs - these are drugs which are still recouping the cost of the investment in the research and development - and off-patent drugs. And in patented drugs they're essentially by definition sole supplier arrangements, there's only one supplier because they're under patent, and there's no patient choice. And when you listen to some of the responses to my report they say "Oh, look our report is going to lead to no patient choice and sole supplier arrangements", well they forget that that's actually part of the market for one sort of drug. The other is of course off-patent drugs where there's the potential for multiple suppliers and very low margin of cost of production, and so you have the potential for competition and the potential for price reductions. The policy issues in the two markets are actually quite distinct. Obviously in the patented drugs there's the listing decision which is whether the incremental benefit is worth it, and that actually continues to be an issue after the drug is introduced and this issue of substitution is a very important one. And of course, what should the subsidised price be? And that is particularly the issue with respect to the off-patent drugs or the generics. So our report is about pricing and we've not addressed a whole lot of issues. We were criticised for not addressing patent law extension and so, but we're essentially about pricing and, as this drug suggests, that's part of the experimental science.

So what did we do? We identified the 50 drugs that are the highest volume on the Pharmaceutical Benefits Scheme and the 50 drugs which are the highest in total spending on the Pharmaceutical Benefits Scheme, and we attempted to compare the prices paid by those by Pharmac in New Zealand, the prices paid for those in Western Australia by the Western Australian public hospitals, and the prices paid in another state in Australia, and we got the data from that second state on the condition of confidentiality so we can't tell you which state it is. There was an overlap. There was an overlap, in the case of New Zealand, 62 identical drugs, in the unnamed state 59 identical drugs, and in Western Australia 39 identical drugs. There are 11 drugs for which we could find substitutes in New Zealand and two drugs which weren't on the schedule in New Zealand at all. And so, again, a criticism as you'll see of our report was that there was reduction in access in New Zealand, and that's actually represented here.

So what did we actually find? This graph shows the difference in multiples of the drugs we could look at. The chart represents 58 identical drug dose combinations and only 39 of those are displayed because there just wasn't room to. On average - and this is comparing what we call the benchmark, that is the best price achieved by either Western Australia or the unnamed state or New Zealand - on average the Pharmaceutical Benefits Scheme pays eight times as much as our benchmark. So if someone says to you that the prices in the Pharmaceutical Benefits Scheme are very good, well they are very good but not necessary for the tax payer or for the consumer. So in this particular case, this is the only case where Western Australia was able to negotiate or tender for or get the cheapest price. For this particular drug Western Australia public hospitals got a particularly good deal or the Pharmaceutical Benefits Scheme got a particularly bad deal. The price on the Pharmaceutical Benefits Scheme was 62 times what Western Australian public hospitals pay compared to an average of eight times for all drugs. And this drug, New Zealand was the cheapest so that is Western Australia, the orange ones are New Zealand are the cheapest, and the black ones are the unnamed state's prices. And so you can see that by and large we're not doing too well.

And so, what are the savings that are achievable from this? If we simply adopted Western Australian prices for exactly the same drugs, no difference in the drug, the generic equivalents and so on, there would be a saving of about \$790million a year. Forget about New Zealand, forget about anything else,

just use Western Australia, we'd save \$790million. If we chose New Zealand as our comparator we'd save \$1.7billion or so, with some of it coming from patented drugs and substitutions but the majority of it coming from generics. But as you see, the majority of the savings that we talk about come from generic drugs.

What's most interesting is that the Pharmaceutical Benefits Scheme performs worst where it's most important. And so if we look at the highest volumes of drugs, for the 10 drugs which are the highest volume on the Pharmaceutical Benefits Scheme we pay on average 12-and-a-bit times of what New Zealand pays. For the next 10 in terms of volume we pay just under eight times what New Zealand pays, and we drop down to the group 40 to 50 paying twice and a bit times what New Zealand pays. The same sort of pattern for the high total cost, for the 10 drugs which are the highest total cost on the Pharmaceutical Benefits Scheme we pay more than 10 times what New Zealand pays. And to give you an example of Atorvastatin using data from October 2012, in Australia the Pharmaceutical Benefits Scheme paid \$51.59 for a box of 30mg/40mg, in New Zealand they paid \$5.80 for a box of 90. Same manufacturer, it's Pfizer in both cases. If the PBS paid the same price as New Zealand you'd save \$1.4million a day. And so too would consumers. If Atorvastatin was listed on the PBS at the New Zealand price then consumers who aren't healthcare card holders, aren't on the safety net, would pay only \$14.10 to get a box of tablets versus the \$36.10 that they pay under the co-payment arrangements now, a saving of \$22 per box of tablets. And the same is true in Western Australia. If a patient in Perth could get the same price as the public hospital in Perth gets they would save \$19 out-of-pocket every time they filled their prescription. And these are the drugs, so you can see there are these six drugs where the saving is more than \$20 and \$15. So there's significant savings on a number of drugs – this is out-of-pocket cost savings for individual consumers.

So what are the problems of the process? Why did we get in this situation? We were so good, we're not now. We think that there are problems with the whole process of setting the prices and there is existing policy called Expanded and Accelerated Price Disclosure which doesn't work terribly well obviously; there's embedded politics, there's an agreement and there's timid price cuts on new generics, which we will explain as we go along. So there is this thing called Expanded and Accelerated Price Disclosure. And the first element of this is that you collect information from the drug companies on their price disclosure and this builds in a minimum delay of 12 months between when a discount is given by the pharmaceutical manufacturers to when the data is collected, and then they collect the price disclosure data and they send it in. Now, bearing in mind that practically all inventory control these days is computerised it doesn't seem to me legitimate to have a 12 month minimum delay. The second component of the so-called Accelerated Price Disclosure is that a consultant is hired to actually get the spreadsheet and turn it into advice and then make a decision, and that takes six months which is another extraordinary delay. So the whole process is proceeding at snail's pace.

So what has been the impact of this Expanded and Accelerated Price Disclosure? Well, here is the price of these drugs as they were in the 2011/2012 schedule and there have been some reductions introduced as a result of price disclosure and they bring the price down actually quite significantly in some cases - in fact in 1½ cases - but not so significantly in other cases. And these drugs are the drugs that were impacted by price disclosure and were in our data set of 75 drugs that we started off with. So when the government and the pharmaceutical industry says that actually price disclosure is bringing prices down, they are actually right. It is and you can see it in this graph. The question is: is it bringing the prices down far enough? And so this diamond here is actually the benchmark price. And so you can see that the proportionate reduction is nowhere near sufficient – except in one case – it's nowhere near sufficient generally getting the prices as a result of price disclosure down to what the benchmark prices ought to be.

What is the current process? It's a complicated process for listing drugs on the Pharmaceutical Benefits Scheme which involves a whole lot of negotiations and prices and submissions and so on, and includes the Pharmaceutical Benefits Scheme Pricing Authority, and I'll come back to that. But at the end of the day the decision is made by a politician, either by the Health Minister or by Cabinet. And so we have politics embedded in the whole process. The Pricing Authority, despite its grandiose title, is in fact a committee of the Department of Health & Ageing which has representatives of the industry actually on the committee, two of the six people. So it's got politics embedded in it and there's politics at the end of the whole process. And the whole framework is governed by a Memorandum of Understanding with Medicines Australia which gives a deal to Medicines Australia which says "The Commonwealth undertake not to implement new policy to generate price-related savings from the PBS

during a five year period". And you'll note that over this five year period Australia's slipped from being one of the best in terms of negotiating good prices to being one of the worst, and it may be because other countries were introducing new policies at the time, as we'll see. Another issue is this timid pricing for new generics. So when a drug comes off patent in Australia there's a 16% mandate reduction just like that when the drug comes off patent. You can compare that with these European countries where 30/40/50% reduction. Nine of the 10 Canadian provinces have just announced an 82% reduction for six generics. And so our 16% is looking quite timid.

So what do we think should happen? What we recommend in our report is getting the politics right; that the government should make a decision about what the budget is and we should have an independent governance process where there's a political decision about the funds available and then the pricing and access decisions are based on clinical value, and that's a decision made by experts. The second stage of our reform was to suggest at least a 50% cut for new generics and benchmark pricing thereafter, and that would generate about \$1.3billion we estimated just on the drugs that we looked at. Those drugs accounted for about 46% of PBS spending, so there may well be bigger savings when you apply that sort of policy across the whole of the Pharmaceutical Benefits Scheme. We suggested wider application of therapeutic premiums for substitute drugs which is likely to generate \$550million. We said this was an indicative estimate because there needs to be further clinical evaluation and assessment of that stage.

So that's what we said and in terms of who is the benchmark? The PBS is the benchmark in actually five of the drugs we looked at, so they can actually negotiate good prices; Western Australian one; unnamed state; but most of the drugs the benchmark was New Zealand. New Zealand and the unnamed state were actually quite close. Most of these savings came from identical pharmaceuticals, so no change in what is actually provided, and most of the savings came from generic drugs. And we suggested a three-stage process, get the framework right, get the organisation right, and you do that before the agreement with Medicines Australia expires. Once the agreement with Medicine Australia expires you can then introduce your new pricing, new policies, cutting the generics especially, price benchmarking, and then sometime after that a third stage of reform broadening the therapeutic premium.

So what were the reactions to our report? Well, one of them was this one: if you want a how-to guide to turning your country into a Third World country, this report will be it. So I was interested in what Third World countries they were thinking we were, so we looked at Third World countries around the world and this is a map of Third World countries. Mostly the green ones are usually considered the Third World, the other ones don't, but Medicines Australia has added Third World, they've added England, Scotland, Ireland, Sweden, Canada and other countries - these of course have been added in - Japan as all Third World countries. New Zealand, of course, we all know that New Zealand has got a lot of problems some of them - not always - associated with being a Third World country. Anyway, so Minister Plibersek said "The idea you can just pick and choose elements of other country's systems and that automatically gives us a better, stronger system is incorrect". So there is a lot of literature about whether countries can learn from each other and so this is an important theoretical issue - which I'll discuss more in my lecture at ANU. But we were selective in what of New Zealand, Western Australia and the other state we actually chose to adopt. So I think it is not true that you can't learn from other countries and I think we can and we should. The Commonwealth can also learn from some of the states, which is probably a bit more difficult than to learn from other countries.

So in Australian public hospitals companies are happy to take a very low price so that when patients go into the community they stay on that particular brand of medicine. Well, there's little evidence that the companies are making a loss doing that and certainly it doesn't explain the lower prices in New Zealand. So the argument of a loss-leader is actually not borne out by the New Zealand evidence nor necessarily by the hospital evidence, because sometimes the patients are on those drugs when they come into the hospital. New Zealand is a basket-case when it comes to access to medicines. It's the last place health policy makers in this country should be looking to for ideas. Now, the issue of access to medicine is only relevant to the patented drugs because with respect to the generics, which is where the vast bulk of our savings are, there's no issue of access because they've got exactly the same access, and so it's not relevant to our proposal, generic pricing. And it is true though that New Zealand does have lower access and a lag time with getting new drugs on the market, that is true. So that component, that this is a policy issue that needs to be addressed and it's partly addressed by where you set the budget, but it's not true that they've had no increase in drugs. And if you look at some of

the major classes of drugs, New Zealand, like Australia, is having significant increase in drug utilisation, but they're doing it cheaply. I said their expenditure is almost flat, but it's important to point out to you there's been a 15% increase in expenditure in real terms.

Then we have Australian suppliers of generic medicines already sell their medicines at international world's best prices. There is a very competitive generic medicines industry in Australia, but our concerns are unfounded as price disclosure ensures that the government benefits. And that simple statement is from the Health Minister and so on. Well, patently that's not true. We see when we actually look at the data that it's just not true and also when we look at our policies it's just not the best practice in the world. And then it is true that New Zealand does get a good price for generic medicines, which is actually inconsistent with that, but they have a great deal less choice for patients. Now of course, the issue is choice by itself here and the argument rhetoric of choice was very important in some of the responses. Choice is in fact not a preeminent value. Just think about patented medicines; you don't have a choice with patented medicines because government across the world has made the decision to trade off choice to reward innovation, which I think is the right thing to do. So you think about choice not being always the best thing. And of course, choice is supposed to be part of the competitive ideal and lead to savings, and it doesn't in this case. Our model does not propose the elimination of choice, but I just put this to you: on the Pharmaceutical Benefits Scheme there are 13 brands of Atorvastatin. All are listed the same price. All are listed in the new list at \$52.62 and so that the patient pays \$36.10, who's not on concession and not safety net. So if you went out and did a survey of patients and said - even patients who are on Atorvastatin: would you prefer to have a choice of 13 types of Atorvastatin or would you prefer to have \$22 savings in your pocket every time you got that box from the pharmacist? I'm not sure whether they would all vote in favour of having 13 brands and no patient benefit versus one or two or three or four or five brands and a \$22 saving.

Other concerns were lower income for retail pharmacists. You'll see the Pharmacy Bill traipse into parliament today advocating greater income for pharmacists. But the retail pharmacy income we'll already disclose from price disclosure, we haven't taken those savings into account but we have said that our savings would impact about \$20,000 per pharmacy. And if this is an issue, and it's unclear to us whether it is, it is going to be an issue particularly in rural Australia in which case you might need to restructure the subsidy arrangements. And there might be a loss of research and development in Australia. It's not at all clear that will be the case but in any case, if you look at the types of research and development that take place in Australia in the drug industry, most of it is in phase III clinical trials compared to the United States where there's about the same amount of investment in phase III clinical trials as there is discovery research. So we've already lost the game and our exposure to phase III clinical trials is, we're highly exposed to that but those other countries develop their capacities in that area. And in any event, there's no evidence that paying high prices in a country influences the choice of where people do clinical trials and it would seem to me that direct strategies to support R&D are preferred to indirect ones.

So what did we recommend? That's what we recommended: start by getting the foundations right; tough rules on generic pricing; promote cost effective choices; certainly with stage one and two we'd save at least \$1.3billion and then possibly \$550million thereafter.

Thank you very much. Are there any questions?

JONATHAN CURTIS: Any questions?

AUDIENCE: I was just wondering, given that MOU expires in 2016, have you spoken to the opposition about your report and the reforms that you've suggested? And, if so, are they critical of the reforms or do they accept the –

STEPHEN DUCKETT: I've briefed the opposition, but I haven't asked them to disclose to me and to the world what their policies are.

AUDIENCE: In terms of the \$1.3billion in savings, have you worked out the proportion that would go the budget and the proportion that would go to individuals?

STEPHEN DUCKETT: The answer is no, we haven't because it's not possible to get that information from what's available. Roughly speaking about 85% of Pharmaceutical Benefits Scheme total spending

is government spending and about 15% consumer spending, but we don't know the distribution of that by drug. But you can guess it's about 85:15 is what we've said that we've expressed our savings in total savings.

AUDIENCE: Just to add to that, that wouldn't necessarily follow though because most of the savings accrue to non-concession card holders who pay that differential amount of \$36 rather than \$5.50. So wouldn't the savings be more so to non-concession card holding individuals?

STEPHEN DUCKETT: I can't tell. One of the problems is some of these drugs, like Atorvastatin, it's a chronic disease sort of drug and so they might have hit the safety net by the end of the year, even if they're above the safety net at the start of the year. So the high volume drugs, which are where the big savings are, may well be skewed towards concession card holders, but it's speculation.

AUDIENCE: Just to continue on that, the general fairly rough rule that I'd applied was that even savings between what a non-concession card holder and a concession card holder is paying out of pocket, about a third of that saving should accrue to those that don't have a concession card as cold hard cash. And the rest of that saving accrues to government, if generic prices have fallen from somewhere between \$36 and \$5.50 it should all be going to government. So in theory I would have argued that a non-concession card holding individual will get a third of the savings. Very broad terms, but most generic drugs would be under \$36 and above \$5.

STEPHEN DUCKETT: Yes, most of the generics under this proposal would go way under the \$36 and could go for the \$5, in which case government would get \$30 benefit on every one in addition to what they get above the \$36.

AUDIENCE: A quarter of the population have a concession card and then for that remainder, assuming that they are equally likely to be on treatment, which is not the case, that would accrue to the individual?

STEPHEN DUCKETT: Yes, exactly. Yes, but in any event it's significant to both.

AUDIENCE: Yes.

STEPHEN DUCKETT: Yes.

JONATHAN CURTIS: Any other questions?

AUDIENCE: I just wondered if you could expand a little bit more on the price disclosure arrangements and what time period do you think would be a better time period to aim for? I think you explained that in total there's about an 18 month time lapse between the initial part of the process and the final part of the process. So how long do you think that should reasonably take? And what sort of savings could we make by accelerating that process further?

STEPHEN DUCKETT: Well, it's difficult to know what sort of savings. The savings depend on the disclosures, but certainly an 18 month period puts a huge lag in the whole process. This minimum of 12 months for –

AUDIENCE: It's basically a price guarantee, isn't it?

STEPHEN DUCKETT: Yes, it is, it's a price guarantee and other discounts might occur after the disclosure date, so you're always playing catch-up. But it seems to me absurd to allow 12 months for a process which involves downloading computer information onto a spreadsheet and sending it off to the Department. So you could easily, in my view, shrink that to three months.

AUDIENCE: Did you look at what other countries do?

STEPHEN DUCKETT: They don't have a process like this and this is the consultant and the Department making a decision. So I thought that you could shrink that whole process down to six months without doing great violence and then you could actually make the announcements twice a

year rather than only once a year as they currently do. So you could really speed it up I think and if you wanted an interim policy solution that would certainly be one.

AUDIENCE: Just on that point, when the legislation was being debated the Greens actually put up an amendment to reduce the timeframe but ended up –

STEPHEN DUCKETT: Did they say what to?

AUDIENCE: I can't remember, but I do remember that there was an amendment that was put up and then withdrawn. And Korea actually had a similar approach, but after about 18 months to two years stopped it and it was just before Australia introduced theirs, which I thought was interesting. Just a question if I may: in terms of calculation of the total drug budget what sort of principles would you envisage guiding that setting of the global budget?

STEPHEN DUCKETT: Well, the budget setting process is always complex, especially with things like the Pharmaceutical Benefits Scheme. At the moment there's no budget, it's just totally and completely open-ended. I know that the hospital pricing system fell into disrepute recently, but it seems to me that you ought to be taking those sorts of things into account; age and sex of the population and how that changes. But also how pricing could be expected to change, which is in the hospital funding formula, plus also a technology factor, which is in the hospital pricing. So you build into the budget setting process the expectation that you are going to be having to respond to new technologies and new drug discoveries, but then you say well, that's what you have to live with. So it shouldn't just be "last year +3%", the COPPA sort of approach, which would be not a good strategy.

AUDIENCE: Being a little ignorant about some of this material I wasn't able to follow your run through some of the counterarguments towards the end, but there was one that attracted my attention, I was just hoping you could step us through in a little more detail, which was a loss-leader argument, sales in public hospitals and sales in the community? Can you step us through how that works and why that's a relevant issue here?

STEPHEN DUCKETT: So public hospitals supply drugs to inpatients, and to some extent outpatients, but supply drugs to inpatients and are not allowed to charge the cost of those drugs against the Pharmaceutical Benefits Scheme. So the public hospital itself has to purchase drugs for use with inpatients. So the public hospitals purchase those drugs and we got data from Western Australia and also from an unnamed state about the prices they paid. So the Minister's argument is this: that one of the reasons that the drug companies would be prepared to give low prices to public hospitals is that if a person goes into a public hospital with a new event, say a heart failure of some kind, and then is placed on a drug in the public hospital, then when they go out of the public hospital they'd be more likely to stay on exactly the same brand of drug that they got in the public hospital, rather than being swapped to a different brand of the same drug. And so the pharmaceutical manufacturers would then have an incentive to lower the price in the public hospitals so they would capture market share when those patients are discharged. So that's what the Minister is arguing here, that the companies are happy to take a very low price so that when the patients get discharged and go back into the community they stay on that particular brand of medicine, thus increasing the market share of the pharmaceutical manufacturer.

AUDIENCE: Okay, your point being that? Sorry, is the implication the Minister is making there, if we were to try and lower the PBS price it would force them to raise the public hospital price?

STEPHEN DUCKETT: No.

AUDIENCE: Is this about a cross-subsidy?

STEPHEN DUCKETT: One of the staff at the Grattan Institute took the view that the pharmaceutical manufacturers were just being generous and charitable to the public hospitals and they were so kind-hearted they were giving low prices, this was his argument. This line of argument would be that the pharmaceutical manufacturers would not be as generous in their negotiations with the Pharmaceutical Benefits Scheme because there was no incentive to expand their market share that they would get. Now, the other weakness that I didn't say here is that the drugs that we compared were generic drugs

basically with Western Australia and so there doesn't seem any reason. And, as I said here, it doesn't explain lower prices in New Zealand. Does that answer your question?

AUDIENCE: I think so

STEPHEN DUCKETT: It's still puzzling.

AUDIENCE: It's a non-argument really.

STEPHEN DUCKETT: Well, that's sort of what we're saying.

AUDIENCE: I guess the other comment is, as you mentioned, that in fact in a lot of cases it's patients going in, particularly with the chronic disease things, they're already using a drug and they go into hospital and while they're in hospital the public hospital is giving them that same drug.

STEPHEN DUCKETT: Many public hospitals would let them bring their tablets in with them, but people might forget or they might run out or whatever and so they just get the public hospital supply. And so this argument in fact doesn't apply for that reason as well.

AUDIENCE: I was just going to ask, when you said they had this agreement that when the drug comes off patent with Medicines Australia, they're 16% lower as a minimum. What stops the pharmacy side of things from taking a lower price? Like, you get warehouse pharmacies as you are competing now. What stops me if I'm a warehouse pharmacy saying "Well, to hell with the 16%, I'll take it down to whatever"?

STEPHEN DUCKETT: Nothing. There's nothing, but only the warehouse pharmacies do that, most of the retail pharmacies don't.

AUDIENCE: So what you're saying is, even though the government – I'm asking Stephen, I'm still a bit blurred on this myself.

STEPHEN DUCKETT: You just gave a speech on this on Monday or Tuesday I thought?

AUDIENCE: I did, yes, but that was not so much on generics, that's where we've got a blockage of novel drugs which is a problem of course. But the reason that blockage was created was the government – and I can understand this – is because the cost of the generics was not getting the sale. So I'm not disputing what you're saying and it's not contrary to what you're saying, it's just a different, or I'm picking the other end up and looking at that, as you know Stephen. But what I'm saying is, even though we said 16% there's nothing to stop really the Pharmacy Guild having an agreement with its pharmacists to charge a much lower rate than they are currently?

STEPHEN DUCKETT: To negotiate a better deal from the suppliers. And many of them are, which is what the price disclosure is about, but the question is they're not passing that on generally to the consumer.

AUDIENCE: Yes, because that's not part of my speech, but that's what I was feeling.

STEPHEN DUCKETT: But my argument is there are a lot of drugs that have been delayed and not coming onto the schedule and it's going to be worse in the future because of the genomics and so on. The \$1.3billion, at least part of it ought to be used to fix up some of the lags and shifting the spending from generic to innovating.

AUDIENCE: Yes, and that's what my speech was more designed, because the new biologics, which are the main new drugs coming through, they're all generally fairly damned expensive and to a narrow audience, they're more designer drugs. And the worry is because we are squandering money on the generics – and I agree totally, I'm not disputing that – but I think we could probably fix it up if the Pharmacy Guild and others had a look at this and said "Look, we'll be dinkum about this and diversify, I don't need the scrutiny of the public so much on these generic drugs". So what do you think of that comment?

STEPHEN DUCKETT: Well there are a couple of points you're making. The first is we should be shifting money from the generics; we're spending too much on the generics. We may be spending too much on the innovators but it's not nearly as much, and we have got drugs that aren't being listed or delayed in listing that we ought to be listing. So I agree with you to that extent. And the second thing is, the trouble is individual consumers would find it hard to put pressure on their local pharmacy. Maybe though, it depends whether they're in a very competitive situation, how close the nearest pharmacy is to say "Are you prepared to do a deal on this particular drug?" Norman Swann on the Health Report on Monday night had a story about a guy in Canberra who went shopping to see what the best prices were and it was a pretty sorry tale. So we might be able to get better deals for the consumers resting on consumer power, but I'm not sure that we could. Can we then trust the Pharmacy Guild to charitably, in a sense, try and reduce the prices? Well, some of the generic suppliers are actually owned by chemist chains, Chemmart and so on, so it might be feasible.

AUDIENCE: Maybe I could just add in, I referred to it as the suicide gene in the PBS in 2005 and this suicide gene is the fact that we pay for a therapeutic outcome in this country; we don't pay a competitive price. So if we've agreed that the price to look after your hypertension is \$56, the PBS, until we had the mandatory price cut under Tony Abbott, was blind to whether it was a generic or an innovator doing that job, it'll pay up to \$56. And this is the issue: why would you negotiate a better price if anything from \$56 down to \$55.50 will be paid for you by the government, whether it's a generic or not? There's simply no incentive to do anything else than take the raw price of the drug and capture everything up to \$55.50 and share that surplus between the person who delivers or manufactures the drug and the person who sells it. So that surplus is simply being divided up in various ways all around the country. So that's the problem.

STEPHEN DUCKETT: And not to the consumer.

AUDIENCE: That's right.

STEPHEN DUCKETT: Or the tax payer.

AUDIENCE: So the question I had for you Stephen was, we've talked a fair bit about what might happen if generic prices were to fall, but the first thing we've discussed is the viability of regional pharmacies, good, that's an important issue. The second one, what would GPs and pharmacists do in the firing line now, because you've removed the incentive for a pharmacist to sell a generic drug because they don't capture any surplus anymore because there is no surplus? So now, what do we have? Potentially we're moving back to using innovators instead because pharmacists cease to push a generic.

STEPHEN DUCKETT: If the price is low, do you care whether it's an innovator or the generic?

AUDIENCE: That's the problem, the pharmacist no longer cares.

STEPHEN DUCKETT: But does the government? If the government gets a really good price deal, I mean if I take New Zealand and Atorvastatin, it's actually Pfizer who supplies in New Zealand at that low price and they were the innovator.

AUDIENCE: And they make a generic version.

STEPHEN DUCKETT: They make a generic version, but should government care whether it's Pfizer or Chemmart, as long as it's getting a good deal and getting a good low price?

AUDIENCE: No, but the point I'm making is that at the moment, when you think about, if there's a \$55 price for an innovator the manufacturer gets most of that. The great overwhelming majority of that is taken by the drug manufacturer and there's not much in it for the pharmacist. But if there's a generic right next to it on the shelf selling for \$54 and the pharmacist gets nearly half that in the pocket, well of course they're going to do what they can to push the generic. So we are currently at about 30-35% generic prescribing, the rest of the developed world is double. So my first question is how do we keep pharmacists interested in using generic drugs once you take away their surplus? And secondly, are we going to start talking to GPs about depressing generic prescribing?

STEPHEN DUCKETT: Well, the latter point is a really important one and how do you do that? Sending out details and so on; local education of GPs hasn't been terribly successful.

AUDIENCE: Financial incentives?

STEPHEN DUCKETT: Yes, the AMR I think would die in the ditch about giving the GPs a drug budget and a financial incentive. And what's the downside in that you might say? I wouldn't say that, but –

AUDIENCE: I just wanted to hear your views on it.

STEPHEN DUCKETT: Yes.

AUDIENCE: So this is like effectively benchmarking generic prescription and identifying who are the high prescribers?

STEPHEN DUCKETT: Well, you could provide them feedback on what their prescribing rights are. It's something we are going to be turning our mind to because this issue of low generic prescribing rates, Australia is a standout as you point out and it's really a very good policy question. I haven't had enough time to turn my mind to what would be the best strategy to actually address that and certainly financial incentives on GPs could work, I need to look at the literature on that. Education hasn't tended to work. Financial incentives for consumers has worked. Yes, so a combination. But, as I said earlier, if the government gets the prices down, and you could say in the Atorvastatin example well, we can still have 13 manufacturers on the list, but you're only going to get \$5.80 or whatever it is and it doesn't seem to matter whether it's a generic brand or a Pfizer brand that they use, as long as the government's getting a good deal and the patient's getting a good deal.

JONATHAN CURTIS: On that note, if we have no final questions let's wrap up this session. Stephen, thank you very much for coming in and giving your presentation and answering the various questions. Thank you very much.

STEPHEN DUCKETT: And our full report is available on the [Grattan website](#). Thank you very much.

End of recording