

Quarterly Economic Commentary

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Pharmaceuticals: Getting Better Value for Money

Paul K. Gorecki, Anne Nolan, Aoife Brick and Seán Lyons¹

The Irish health-care system is under severe budgetary pressure. Pharmaceutical expenditure is no exception. During the 2000s Ireland experienced one of the highest annual growth rates in pharmaceutical expenditure of any OECD country. In 2009 Ireland spent more on pharmaceuticals per capita than any other OECD country (with the exception of the US, Canada and Greece).

The onset of the financial crisis has seen a number of austerity budgets, which will continue until at least 2015. Public expenditure is being tightened. Households, whose incomes are being squeezed, are likely to be asked to make greater out-of-pocket contributions towards pharmaceuticals. Budget 2012, for example, raised the monthly threshold for the Drug Payment Scheme by €12 to €132 and retained the 50c charge per prescription item for medical card patients, which was introduced in October 2012.

Nevertheless, significant progress has been made in recent years in reducing the cost of delivery of pharmaceuticals in Ireland, both to the Health Services Executive (HSE) and the cash paying customer. For example, wholesale margins have been reduced and pharmacy mark-ups have declined, at least for pharmaceuticals paid for by the state. However, more can and needs to be done to take these reforms forward.

The Health Service Executive asked the ESRI to undertake a study of the pharmaceutical delivery system with a view to ensuring better value for money, while assuring security of supply. The report, *Delivery of Pharmaceuticals in Ireland. Getting a Bigger Bang for the Buck[†]*, made a wide ranging set of recommendations and suggestions on how Ireland can obtain better value for money in its pharmaceutical expenditure. These recommendations covered all stages in the delivery system from the manufacturer through to the pharmacist and the prescriber. In this Research Bulletin some of the major recommendations are highlighted.

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The expiry on 1 March 2012 of the agreement between the state and the Irish Pharmaceutical Healthcare Association, which represents the international research-based pharmaceutical firms, provides an opportunity to set lower ex-factory prices for new pharmaceuticals. The ex-factory price is that charged by the manufacturer at the factory gate, while new pharmaceuticals are those recently introduced pharmaceuticals subject to patent protection with no direct competition. The ex-factory price of new pharmaceuticals is currently set as the average across a basket of nine EU Member States: Belgium, Denmark, France, Germany, Netherlands, Spain, the UK, Finland, and Austria. If instead of the average the lowest price was used, then the ex-factory would be reduced by between 20 to 25 per cent. Other Member States typically use the lowest rather than the average price.

The Department of Health is to introduce the Health (Pricing and Supply of Medical Goods) Bill later in 2012 which is designed to encourage generic substitution and reference pricing. Generic substitution allows the pharmacist to select a different, usually lower priced, product from that prescribed. A reference price sets for brands of the same pharmaceutical which have been certified as interchangeable pharmaceutical products, the ex-factory price for that particular group. For high volume interchangeable pharmaceutical products the reference price should be set by competitive tendering. The winner of the tender (i.e. the lowest priced bid) would set the reference price and supply the market. If the prescriber decides to select a different – usually the higher-priced originators – brand for the patient, then the prescriber would be required to: (i) specify the medical reason for their decision; and (ii) write in their own hand 'no substitution' on the prescription. This should provide valuable feedback on the implementation of generic substitution and reference pricing.

The pharmacy market is marked by a lack of information available to patients on not only pharmaceutical prices, mark-ups and dispensing fees, but also the services supplied by pharmacists. These services have been expanding with the administration of the seasonal influenza vaccine and the dispensing of emergency hormonal contraception. In other professions such as dentistry and medicine in Ireland, as well as pharmacy in other jurisdictions, patients are provided with information that assists them in deciding which provider to choose. Despite the marked reluctance of the industry regulator, the Pharmaceutical Society of Ireland, the same should apply for pharmacy in Ireland. Dispensing fees, services offered and mark-ups should be posted in pharmacies, and pharmacists should have the option of using media to disseminate such information. New forms of retailing such as the internet should – under the appropriate regulatory conditions – be considered by the HSE, perhaps on a trial basis. The result should

be a more competitive, efficient and vibrant pharmacy sector that is more responsive to patient preferences and needs.

The prescriber, typically the family doctor, acts on the patient's behalf in making decisions concerning the appropriate course of treatment in addressing the patient's condition. This may involve selection of a pharmaceutical. In writing a prescription the international non-proprietary name (INN) – atorvastatin, rather than Lipitor, fluoxetine rather than Prozac – should be used by the prescriber. The INN identifies the pharmaceutical substance or active pharmaceutical ingredient. Each INN is a unique name that is globally recognised and is public property. A non-proprietary name is also known as a generic name. INN prescribing is safer as it reduces the potential for confusion when prescribing or when seeking to identify a pharmaceutical that a patient has been taking. There are likely to be exceptions to INN prescribing such as that referred to above in the discussion of no-substitution prescriptions. The evidence suggests low levels of INN prescribing in Ireland.

In designing ways of achieving better value for money, the recommendations are based on evolution, rather than revolution. In part this approach has been driven by the observation that variation within health care systems is much greater than between them. Thus, by reforming the current model of pharmaceutical delivery, better value for money can be realised, while at the same time the costs and unintended consequences of large changes can be prevented. This minimises the chances that there will be an adverse impact on security of supply.

The recommendations contained in the ESRI report commissioned by the HSE are designed to ensure that taxpayers get better value for money from the €1.9 billion public pharmaceutical budget, but also that the cash paying patients benefits too. They are also designed to ensure that patients, irrespective of whether or not the state pays for the pharmaceutical, receive safe and effective pharmaceuticals without interruption to supply.

[†]Paul K. Gorecki, Anne Nolan, Aoife Brick and Seán Lyons, *Delivery of Pharmaceuticals in Ireland. Getting a Bigger Bang for the Buck*. Research Series Number 24, Dublin: ESRI. January 2012.