



TRANSCRIPT

Minister for Health and Ageing
Leader of the House of Representatives

Tony Abbott MHR

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E&OE

Abbott

OK, well thanks everyone for coming along today. I hope you've all had a chance to read the documentation because while I don't think it is conceptually too difficult, there is quite a lot of detail. I think the department has been pretty good at simplifying it in ways that intelligent lay people can understand and I'll do my best to try to put it in my own words now.

First of all, I want to say that these are important long-term structural changes to the PBS but they certainly won't disadvantage patients. If anything, they should moderately advantage patients by over time, bringing the price of more drugs below the co-payment and thus enabling more patients to get more access to cheaper drugs.

But essentially these changes are about ensuring that taxpayers get better value for their PBS spending. We want to do that in ways that continue to make it reasonably easy to get new medicines on to the Pharmaceutical Benefits Scheme.

There are two basic problems that these changes seek to address. The first is that historically we have been spending too much money for the generics in the system. To give you one example, the common cholesterol-lowering drug simvastatin, which currently costs the PBS about \$300 million a year, we here in Australia pay more than \$50 for this drug. In the UK, they pay less than \$10 for that drug. Now the difference in price under our system as it currently stands is mostly accruing to pharmacists by way of discounts and so what we are trying to do with these changes is to harvest most of those discounts for the benefit of taxpayers.

The other issue which has only become apparent recently is that the interaction of reference pricing with the recently introduced mandatory 12.5 per cent price cut for the first new generic on the system has meant that some patients are potentially exposed to large premiums for the PBS drugs that they need. To give you one example, there is a drug, Alimpta, which fairly recently came on the PBS. It's still on patent but it's reference priced with drugs that came off patent recently. When their price dropped by 12.5 per cent, the company insisted on a very large patient premium, about \$450 from memory. We have taken measures to ensure that patients that really need Alimpta can get it without that premium but it's cumbersome, and that kind of system was not going to be sustainable into the future.

So these were the two problems – overpricing to government and therefore to taxpayers of generics, and the difficulties of reference pricing in the new system of mandatory price cuts. These were the two problems that these changes are designed to address.

We are essentially doing two things. First of all, we are dividing drugs on the PBS into two categories - Formula 1 and Formula 2.

Formula 1 drugs will essentially be drugs on patent, drugs for which there is a single brand.

Formula 2 drugs are essentially drugs off patent, drugs for which there are multiple brands. Now reference pricing arrangements, as they have traditionally operated, will not operate in F2 and there are new arrangements for the pricing of drug . . . sorry, will not operate in F1 and there are new drugs, new arrangements for the pricing of drugs in F2.

Formula 2 we are essentially dividing into two categories. Category 1 are off-patent drugs for which there is little price competition at this time. These drugs will be cut by 2 per cent in price in three successive years before moving to a system of price disclosure and the government will pay after a particular time the disclosed price.

The other category of drugs in Formula 2 are drugs which have been identified in discussions between the Government and the Pharmacy Guild as being drugs where there are already large discounts available. These drugs will have their price cut by 25 per cent and then they will move after a certain period to time to a disclosed price. These drugs, which will be subject to an additional 25 per cent price cut, are quite a large segment of our market. In fact about \$2 billion a year, or a third of the PBS, is comprised of these drugs.

Now, you'll want to know what savings we're going to make. We think that these changes will produce gross savings over the forward estimates period in the order of \$1.7 billion. We think they will produce gross savings over the next 10 years of about \$3 billion. I'm now going to move to . . . sorry, net savings over the 10 year period of \$3 billion. In the forward estimates period, they will produce net savings of about \$600 million. The reason for the difference between the gross save and the net save is that there will be a significant adjustment to the funding that the Government provides to pharmacists.

There are essentially four changes that we're making here. There will be a modest increase in the dispensing fee; there will be a modest increase in the mark up, particularly for very high cost drugs; there will be a \$1.50 incentive payment per dispensed script that does not involve a patient premium; and there will be a 40 cent per script incentive to use PBS online.

All of those will cost \$1.1 billion over the forward estimates period and they will essentially ensure that the position of pharmacists for the life of the current agreement is as it would otherwise have been.

The only other change that I want specifically to mention is an improvement to the authority required prescribing system for about 200 drugs which are regularly prescribed on a long-term basis for things like diabetes. Doctors will no longer have to ring Medicare Australia for a formal authorisation. I think this is an important change, it's an important reduction in red tape and I hope it will be welcomed by the profession.

I want to address a couple of issues that I know you will be interested in. The first is this question of why should pharmacists get so much compensation for these changes. Pharmacists are being compensated, I believe fully compensated, for the changes as they will impact on pharmacy over the life of the current agreement. But they aren't being compensated for changes that will flow from this policy in the years after the current agreement expires. I think that's fair and I want to congratulate the Pharmacy Guild for the way they have cooperated constructively with the Government in this period of consultation and negotiation.

The other matter that I should briefly touch on, the Generics Medicine Industry Association is not, as I understand it, especially happy with these changes. It believes that these changes will make it harder for them to maintain market share by removing the scope for them to offer discounts to pharmacists.

I make a couple of points in response. First of all, I point out that 70 per cent of the Australian generics market is occupied by companies which are not members of the Generic Medicines Industry Association, they are in fact members of Medicines Australia. They are the manufacturers and marketers of innovative patented drugs as well as of off-patented drugs.

The other point I make is that we are, as part of these changes, ruling out a tendering system and I think that the whole sector, including GMIA, should be pleased that we are not going down the New Zealand path.

The final point I would make is that by removing the gross discounts from the system, we should ensure that domestic generic manufacturers are less at risk from predatory newcomers such as some of the Indian generic drug manufacturers.

I should say that I think there is something in this for everyone. There are substantial savings for taxpayers. There is some opportunity for lower-priced drugs for patients. Certainly there should be continued availability of a wide range of drugs to Australian patients. There is a recognition of the importance of innovative patented drugs for Medicines Australia. There is compensation for community pharmacy and there is, as I said, a certain amount of systemic protection I believe provided to the domestic generic manufacturing sector.

Finally – and I apologise for this rather long introduction, but because this is a complex area, I thought it was important to give you a bit more than is normally the case at occasions like this – I want to say that my department has done an extraordinary amount of work. Jane Halton and her team, particularly Rosemary Huxtable, one of our First Assistant Secretaries who is here today, have done a really remarkable job of painstaking dialogue with a complex and diverse sector on what is really a very complex and at times a difficult issue, and I think that what we have seen emerge from this whole process is a good illustration of how the Australian system of governance does work well to address difficult problems to the long-term benefit of our nation. OK.

Reporter

Are you essentially saying that, under the current system, pharmacists are just gaining too much in that through the discounts and giving them four years to restructure so that that can be taken out of the system?

Abbott

Well, I'm not saying that pharmacists are doing anything wrong because, as some of you would remember, pharmacy offered some significant savings to the Government as part of the recently renegotiated guild-Government agreement. But the savings that the Government, that the pharmacists offered to the Government, depended or were based on certain assumptions about how their businesses would work and I suppose one of the assumptions was the discounts that they get from selling generic or off-patent drugs; and if we were going to make major changes to their access to those discounts, it was only fair and proper that we should give them appropriate compensation.

So I'm not saying that pharmacists were ripping anyone off. I'm certainly not saying that. But their business model built these discounts in and if we're going to take these discounts out and make them available to taxpayers, we have to provide a certain amount of compensation, which is what we've done.

Reporter

So can you just clarify that that's the point that you want ... this will make the Government to have the discounts rather than the pharmacists?

Abbott

That's correct, that's correct.

Reporter

Can you please sum it up for us?

Abbott

Sure, what we are on about is harvesting for the benefits of taxpayers these discounts, which have historically been going to pharmacists, and in so doing, it's only fair that there should be some compensation arrangements, which the Government has put in place.

Reporter

So the pharmaceutical companies weren't dropping their prices as much as getting the discount, that's the issue.

Abbott

That's not a bad way of putting it. The real price to pharmacists will become the real price to Government for these off-patent drugs.

Reporter

So [inaudible] when will patients start to benefit in the sense [inaudible]?

Abbott

Okay, well, the further mandated price cuts, Peter, will start on 1 August 2008 and once patients – once drugs fall below the co-payment price, then patients will start to benefit from lower prices in the pharmacy.

Reporter

Just quickly, I understand that you are not pointing a finger at pharmacists but clearly their operations are based on the big discounts. Would you expect that, after four years, when the next agreement is negotiated, that their loss of these discounts and, at that time, the loss of your adjustment money will have to be reflected in the new agreement?

Abbott

Well, the \$3 billion figure for net saves over the next 10 years assumes that the changes announced today, including the compensation package, flow forward into that period. So if the changes that I announced today by way of compensation to pharmacists are built in to the next agreement, there will still be \$3 billion worth of net saves to taxpayers over the decade. That is what I am told by my statistical experts and modellers.

The reason why the savings to government become much more significant in five years' time and beyond is because there are about 100 major drugs that are coming off patent in that time and we are compensating pharmacists, we are explicitly compensating pharmacists for the loss of discounts over the next four years; but we are not explicitly compensating them for the much greater impact of the loss of discounts in the subsequent five and more years.

Reporter

Would you expect that the pharmacists would, acknowledging that the old system is passing, that based on trying to readjust their own businesses so that four years from now, there won't be such problems for them?

Abbott

Well, look, we don't control how pharmacists run their business. All we do is agree to pay them a certain amount for doing certain things. Now, obviously, pharmacy will adjust in all sorts of creative ways to these changes. The important thing is are we harvesting discounts, which are currently going to pharmacists, for taxpayers in ways which are fair – and I believe we are.

Reporter

What I was trying to get earlier was, as these savings start to come in government and therefore taxpayer dollars, what happens to the co-payment contributions in the years to come?

Abbott

Well...

Reporter

Why would that not be reduced as the benefits start to flow on?

Abbott

Yeah. The Government has no plans to change current co-payment arrangements, Peter, and the savings that these changes will produce, we believe, will be available to put new and innovative drugs on the PBS.

For instance, since August alone, we have added drugs to the PBS, Herceptin for early stage breast cancer for HER2 positive women, Lantus and Levemir for people with diabetes. We have made statins more widely available. Now, the changes that we have made to the PBS since August alone will add \$1 billion to our estimated spend over the forward estimates.

Gardasil is almost certainly going to be on the National Immunisation Program in the not-too-distant future, so it will not strictly be in the PBS but, nevertheless, if it comes on to the National Immunisation Program at more or less the current price with more or less the current target group, that is going to cost something like \$600 million over the forward estimates period.

So there are all these very expensive new drugs and vaccines marching towards us. They ought to go into the system if they are cost-effective, and in order to keep the system sustainable, it is important to pay no more than is absolutely necessary for drugs which are off-patent, and that is what we are trying to do with these changes.

Reporter

[Inaudible] that will be achieved, that more and more drugs will become available under the PBS as this marches on?

Abbott

That's my strong expectation, Peter. I mean, under our system, if an applicant company can demonstrate that a drug is cost-effective, it will almost certainly come on to our system regardless of how much it costs.

For instance, Herceptin costs something like \$50,000 per patient per year and that's gone on our system, at \$29.60 or \$29.50, I think, for non-concessional patients and \$4.70 for concessional patients because the PBAC judged, and the Government agreed, that it was cost-effective even at that price.

So yeah, look, we will continue to pay very high prices for some drugs because we believe they are cost-effective and that is why it is important to get the best possible prices for drugs which are no longer on patent.

Reporter

And that would mean future drugs that fall into the Gardasil category will go on to the National Immunisation Program, that the benefit accrues there as well. So even if ...

Abbott

Yeah, the \$3 billion that we estimate we will save over 10 years is not strictly hypothecated to particular new drug applications. But nevertheless, by achieving lower prices for off-patent drugs, we believe that we will be in a much better and stronger position to pay whatever it is that we need to pay to bring cost-effective patented drugs on to the system.

Reporter

So more Gardasil's (inaudible)

Abbott

Well, there are ... I mean, there are certainly a lot more expensive drugs, targeted drugs that are coming into our system, and if they are genuinely cost-effective, they ought to be there, even at very high prices.

Reporter

[Inaudible] medication ... it says here that some medicines under \$29.50 will be cheaper. Do you know which medicines are most likely to be changed?

Abbott

Well, I don't have those particular drugs at my fingertips but obviously off-patent drugs that are currently priced, you know, at \$35 or thereabouts, if they had a 25 per cent price cut, they would suddenly come below the co-payment. So they're the sorts of drugs that we would be looking at and I might see if I can get people in my department to offer to run through the system and see if they can give you some names.

Reporter

Can the Government stop pharmaceutical companies from charging such (inaudible)? And they do make massive profits.

Abbott

But they also provide massive benefits, and I'm not against profit. The Government certainly isn't against profit and, in fairness to the companies, we have to remember that for every blockbuster drug that they make squillions on, they've probably invested an enormous amount of money in dozens, if not hundreds of other drugs which for all sorts of reasons never get to the market.

So look, I think it's easy to run a populist line against the drug companies, and I accept that they are very profitable businesses, but I do think that they do a lot of work to justify those profits and, as I said, for every drug that they make a large fortune on, there are probably dozens where they invest a lot of money without any significant return.

Reporter

What was the [inaudible] offering these discounts to pharmacists? What was their motivation?

Abbott

Well, under our system, which is as you know a managed market system, everyone pays the same price for drugs that are over the co-payment, and what tended to happen in this country was that we got relatively good prices for on-patent drugs but because of the kind of market dynamic in this country, we got relatively poor prices for off-patent drugs.

Now Medicines Australia, which represents both on-patent and off-patent manufacturing businesses, but which is probably most focused on innovative manufacturing on-patent drugs, thought that the gains in terms of reference pricing were worth the cost in terms of mandatory discounts. Why particular companies offered such large discounts to pharmacists is an issue that you really should raise with them.

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