

Spend less on older therapies and the new ones will be more affordable

August 29 2011, By Philip Clarke



New medicines and therapies place significant financial pressure on the PBS.

Australians are living longer largely due to a remarkable trend that appeared about 40 years ago.

While [life expectancy](#) increased dramatically in the early part of the 20th century, it remained relatively stable for several decades. However, since the 1970s it has been increasing by about a year each decade, mainly due to declines in cardiovascular disease.

While this reduction can be attributed to many factors, including changes in diet and a drop in smoking rates, it is also due to widespread

use of drugs to reduce [high blood pressure](#) and cholesterol. Several million [Australians](#) use these medications daily.

All this has come at a cost. Government expenditure on the Pharmaceutical Benefits Scheme, which provides subsidies for many commonly used medications, has almost doubled in real terms during the past decade.

An important driver of PBS expenditure has been a succession of blockbuster drugs, particularly for treating cardiovascular disease. What popularised them was evidence from large studies demonstrating substantially reduced risk of heart attacks and strokes.

But about 10 years ago, clinical studies started to find something unexpected. One of the first was the ALLHAT study involving different types of blood pressure treatment: its results showed newer medications were no more effective than older, cheaper ones.

Since then several studies of [new drugs](#) have failed to demonstrate benefit or in some cases showed them to be harmful. The wave of innovation in [cardiovascular medications](#), at least for the moment, seems to have reached a high-water mark.

With no new blockbuster drugs for cardiovascular disease emerging, the innovative end of the [pharmaceutical industry](#) has focused on other diseases such as prevention and [treatment of cancer](#). Here there have been important developments, including Gardasil, the Australian-developed vaccine for preventing [cervical cancer](#). New drugs create pressures on the PBS; for example, the cost of providing this vaccine is more than \$400 million.

Where can governments find the money to continue to list new medications on the PBS that are shown to be cost-effective? There is a

strikingly obvious answer -- pay less for the older generation of medications.

This solution is particularly relevant now, as many blockbuster drugs are coming off patent and so should be subject to dramatic price cuts. Most of the high cost of newer drugs arises not because they are expensive to manufacture, but time-consuming to develop. Hence, when a drug patent expires, its price should fall by up to 95 percent.

Not only will these price reductions benefit consumers, they are a necessary driver of structural change in the pharmaceutical industry. Resources need to be shifted from treatments for [cardiovascular disease](#), where we can increasingly rely on cheap generic medications, to diseases such as cancer, where there has been innovation. New cancer treatments can be very expensive, because they are for relatively fewer patients, providing a limited market to offset development costs.

Australia has had few effective mechanisms to bring about price reductions in drugs once their patent expires, and consequently pays some of the highest prices in the world for many generics. Take the cholesterol-lowering simvastatin, the patent of which expired in 2005. In Australia the PBS and consumer payments amount to \$30 for a month's supply, while in Britain the equivalent cost is only \$3, and \$1.50 in New Zealand.

Last year the Department of Health and Ageing entered into a four-year pricing agreement with Medicines Australia, the peak body representing larger pharmaceutical companies. This agreement involved modest initial price cuts and then a system of price disclosure from 2012, where the subsidy for older drugs will be based on average wholesale prices.

Unfortunately, this agreement is more likely to entrench rather than solve Australia's generic pricing problem. The all-time blockbuster

cholesterol treatment atorvastatin has cost Australian taxpayers more than \$5.7 billion since its listing in the late 90s. When it goes off patent next year, its initial price reduction will be only 16 percent, while Canada has just cut its price by 75 percent.

I have previously estimated that paying above world prices will cost about \$1.7bn across the next four years for statins alone. Failure to deal with this appears to be symptomatic of broader policy atrophy. Treasury in its first Intergenerational Report argued PBS spending was a key long-term driver of outlays, but it has been unable to lead effective reform. It's also hard to understand why the government has not referred it to the Productivity Commission.

The key challenge for the government is not to find extra funds for new therapies, but to spend less on existing ones. Sometimes less is more.

Provided by University of Sydney

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