Preparing for the rising tide of price disclosure

KEY POINTS

- Profits from generics are short-lived with the price disclosure mechanism designed to inevitably claw back pharmacy margins and profitability of generics suppliers.
- Eventually pharmacy will receive less remuneration per script than when government began the PBS reform process, including price disclosure, in 2007 while business costs continue to rise with inflation.
- Price disclosure has a big impact on suppliers of substitutable medicines and may lead to decisions such as discontinuing some low-volume and unprofitable molecules.
- The future is still positive for those pharmacies that can adapt to the changing remuneration model or have already.

PROFITABILITY FROM GENERICS IS A SHORT-TERM BONUS THAT SHOULD BE INVESTED IN PREPARATION FOR LEANER TIMES, WRITES **MARK NICHOLSON**.*

While the atorvastatin and rosuvastatin 25% price reduction on 1 December 2012 was not technically a weighted average disclosed pricing (WADP) reduction it has increased awareness and heightened concern about the WADP price reductions that will occur every four months (1 April, 1 August and 1 December).

Up until the atorvastatin and rosuvastatin price reduction, the impact of the advised price reductions at each start date has been more than offset by new profit streams resulting from new patent expiries (ie. substituting new generic medicines for originator medicines). Patent expiries will of course continue but, once the high-volume molecules reach their end point in the price reduction process, pharmacy's average gross profit dollars per script will decline from where it is today.

This article is designed to help owners and managers forecast the impact of these cuts on their business and encourage them to invest in changes required to ensure their ongoing viability, growth and profitability.

GENERICS AND THE PBS

The government's recently released 2012 annual report on PBS expenditure and prescriptions notes a PBS spend of more than $7.5bn for about 195 million scripts. Table One shows the top 10 drugs by government cost, together with an indication of which medicines are currently off patent and when their next price cut is due.

The top 10 drugs account for more than 30% of the PBS expenditure and there are only three that are currently off patent. Atorvastatin is comfortably the highest funded molecule followed by rosuvatatin. It is not known when rosuvastatin will be off patent but when it does it will be warmly welcomed by pharmacy as the generic equivalent will provide short-term gross profit dollars to offset the future price cuts to atorvastatin and other key molecules.

One of the often stated reasons by government to implement the WADP mechanism is to create headroom for new PBS listings. Table Two details the new drugs listed on the PBS from 1 December 2012. It appears the new listings to be dispensed by community pharmacies are alternatives to drugs already listed, while new medicines that represent a new cost to the PBS are hospital-based medicines. While this is good news for health consumers and taxpayers, if this trend continues over time and no new 'blockbusters' are listed on the PBS, community pharmacy's share of the PBS spend may well decrease.

The WADP process

Price disclosure started in August 2007 as a long-term response to the market price of medicines coming off patent. Under the Australian system of remuneration, the Federal Government pays pharmacies a fixed price for a particular Pharmaceutical Benefits Scheme (PBS) medicine by molecule and strength. The pharmacy, in turn, pays the medicine's purchase price to the manufacturer/wholesaler.

When medicines come off patent generic manufacturers compete for market share by offering competitor brands to pharmacy for a lower price than the list price paid to the originator.

Weighted average disclosed pricing (WADP) was designed to ensure the majority of this price difference was clawed back by the government on behalf of the Australian taxpayer and health consumer with both the generic and originator manufacturers being paid less for their product over time.

Under this price disclosure regime, medicine manufacturers submit sales information (net of discounts) to the government which then calculates the weighted average price. Based on that information, government reduces the price paid (ex-manufacturer) for those medicines to the average market price (subject to a minimum 10% difference). This is an ongoing process with the cycle from patent expiry to first price-cut taking about 18 months (maximum 21 months) and then subsequent price cuts occurring annually.

TABLE ONE: **Top 10 drugs by government cost – 2012. PBS (excludes RPBS)**

	Drug	Product	Condition treated	No. Prescriptions	Government Cost	Avge Govt Payment/Rx	Patent Expiry Date	Next Price Cut date
1	Atorvastatin	Lipitor	High Cholestorol	10,507,613	593,307,859	$56.46	Off Patent	1/12/13
2	Rosuvastatin	Crestor	High Cholestorol	6,729,477	359,207,846	$53.38	Future	
3	Ranibizumab	Lucentis	Vision loss	145,018	307,816,693	$2,122.61	Future	
4	Adalimumab	Humira	Autoimmune disease	111,611	198,802,937	$1,781.21	Future	
5	Esomeprazole	Nexium	Ulcers, reflux	5,677,991	168,095,363	$29.60	Future	
6	Fluticasone with Salmeterol	Seretide &	Asthma & anti-inflammatory	3,007,412	169,267,494	$56.28	Future	
7	Olanzapine	Zyprexa	Anti-psychotic	938,882	159,545,861	$169.93	Off Patent	1/08/13
8	Clopidogrel	Plavix	Heart disease	2,427,196	133,172,362	$54.87	Off Patent	1/08/13
9	Etanercept	Enbrel	Autoimmune disease	72,658	127,752,968	$1,758.28	Future	
10	Tiotropium Bromide	Spiriva	Pulminary disease	1,695,976	117,857,405	$69.49	Future	
					2,334,826,788			

THE RISE AND FALL OF GENERIC PROFITS

The molecules coming off patent in 2013 include irbasartan (Avapro), irbasartan/HCTZ, montelukast sodium (Singulair), candesartan cilexetil (Atacand), and candesartan cilexetil + hydrochlorthiazide (Atacand Plus). The current total PBS spend on these molecules is estimated at around $245m compared to the $885m spend on the top three PBS medicines that are now off patent: atorvastatin ($593m), olanzapine ($159m) and clopidogrel ($133m).

These three molecules which now have generic alternatives are among the top 10 list in Table One. Table Three calculates the average number of scripts (all strengths) processed in each of the estimated 5,250 pharmacies across Australia. Of course, some pharmacies will do more and some less so you may want to review your own pharmacy's data and use it as a reference against the calculations in the subsequent tables.

Table Four provides an estimate of the current differences between the costs to pharmacy of the generic drug versus the historical amount funded by the government (ie. the cost of the originator's drug).

Much has been made of these short-term windfall differences by various commentators, but little commentary discusses:

- **the short-term profit incentive that ensures pharmacy does the government's initial 'heavy lifting' by converting patients to generic medicines;**
- **the eventual significant savings to government through an orderly but aggressive price-reducing mechanism (ie. WADP) that capitalises on the high conversion rates and the low costs of generic manufacturers within a reasonably short period of time;**
- **government achieve savings via reduced mark-up payments to pharmacy on many medicines as the price paid by government is reduced; or**
- **pharmacy's eventual net funding per prescription for medicines with generic equivalents will be less than received before the introduction of generics. More on this below.**

Accurately forecasting profit reduction is difficult due to the number of variables impacting the final price reduction.

TABLE TWO: **New PBS listings from 1 December 2012**

	Condition	Community pharmacy	Alternatives previously available
Aflibercept	Eye	Yes	Yes
Paraffin compound eye ointment	Dry eye syndrome	Yes	Yes
Sodium hyaluronate	Dry eye syndrome	Yes	Yes
Atenolol	High Blood Pressure	Yes	Yes
Ezetimibe	High Cholestorol	Yes	Yes
Naloxone hydrochloride	Opoid overdose	Yes	Yes
Rivaroxaban	Deep vein thrombosis	No	?
Aprepitant	Chemotherapy related	No	?
Temozolomide	Brain cancer	No	?
Mycophenolate sodium	Lupus related kidney inflammation	No	?

ESTIMATING PROFIT REDUCTION BY SCRIPT

Accurately forecasting profit reduction is difficult due to the number of variables impacting the final price reduction. These include:

- **each manufacturer's sell price and volume;**
- **manufacturer's off-invoice incentives;**
- **the volume purchased by pharmacy in the first month following the listing of a competitor brand as this is excluded from calculations; and**
- **the mix of different volumes and prices attached to each product strength for each molecule.**

Nonetheless, Table Five provides an indicative estimate of how significant the price reductions will be and the extrapolation of total profit reduction, using the script numbers derived on an average basis within Table Three. Hence, across the three molecules the annualised loss of profit for the respective script volumes totals $70k. Bear in mind that atorvastatin's price cut will not be until December 2013 and will therefore not be truly felt until 2014.

Additionally, the cuts will continue annually until the difference between the price the government pays and the average price pharmacy pays is less than 10%.

Table Six forecasts how these ongoing price cuts may unfold and what the annualised loss of

TABLE FOUR: **Example Discount Calculation**

	Atorvastatin 40mg	Olanzapine 7.5mg	Clopidogrel 75mg
Current List Price (excl. premium free incentive)	$51.00	$124.71	$50.15
Less:			
Dispense fee	$6.52	$6.52	$6.52
Mark-up	$4.50	$10.74	$4.50
Funded price to pharmacy for medicine cost	$39.98	$107.45	$39.13
Estimated generic purchase price discount %	75%	80%	70%
Estimated generic purchase price discount $	**$29.99**	**$85.96**	**$27.39**
Example generic price to pharmacy for medicine cost	$10.00	$21.49	$11.74

TABLE THREE: **Scripts per pharmacy — Averaging Calculation**

	Atorvastatin	Olanzapine	Clopidogrel
Total scripts funded by government	10,507,613	938,882	2,427,196
Number of pharmacies in Australia	5,250	5,250	5,250
Average number of scripts per pharmacy p.a.	2,001	179	462

TABLE FIVE: **Estimated profit reduction using script volume from Table Two**

	Atorvastatin 40mg	Olanzapine 7.5mg	Clopidogrel 75mg
Estimated generic substitution rate	80%	50%	60%
Estimated generic purchase price discount (per Table Three)	$29.99	$85.96	$27.39
Date of next price reduction	1/12/13	1/08/13	1/04/13
Possible price reduction *	$23.99	$42.98	$16.43
Example number of scripts per pharmacy p.a.	2,001	179	462
Example annualised total profit reduction per pharmacy based on above script volume	$48,000	$7,693	$7,593
		Total = $63,286	

* Price reduction estimate calculated by multiplying substitution rate by price discount.
The above is illustrative only and eventual price reductions could be less or more.

profit is by the third price cut. At this time (2015) the Pharmacy Guild of Australia will hopefully have negotiated a new five-year agreement with the government of the day, hence the remuneration variables may change.

It should be noted that the forecast calculations assume that there will not be further improvements in trading terms (ie. generics buy-prices will remain static). Competition among generics manufacturers may bring further price improvements which will help pharmacy owners but it also means future cuts will be greater and, in turn, accelerated the claw-back of wholesaler discounts.

As an aside, this will ultimately exert significant pressure on local manufacturing operations which carry higher costs than their overseas counterparts. Not unlike the low-price warehouse pharmacies in a price-centric market, the eventual winners in the generics price game will be those with the lowest costs and supply chain control (unless government provides subsidies similar to motor vehicle manufacturers). Hence, over time it is possible that high-cost manufacturers could withdraw products in low-volume molecules if they become unprofitable and may contemplate moving manufacturing operations to low-cost countries (eg. New Zealand and Pharmac).

TABLE SIX: **Estimated profit reduction timeline using assumptions in Tables Four and Five**

	Forecast price movement based on assumptions					
	Atorvastatin 40mg		Olanzapine 7.5mg		Clopidogrel 75mg	
Date	Price	Reduction	Price	Reduction	Price	Reduction
30/11/12	$67.54					
1/12/12	$51.00	$14.92	$124.71		$50.15	
1/04/13						
1/08/13			$78.41	$46.30	$22.70	$27.45
1/12/13	$24.91	$26.09				
1/04/14						
1/08/14			$54.00	$24.41	$16.12	$6.57
1/12/14	$19.39	$5.52				
1/04/15						
1/08/15			**$43.26**	$10.75	**$13.49**	$2.63
1/12/15	**$18.29**	$1.10				
Total Estimated reduction including mark-up due to WADP and 25% non WADP reduction on 1/12/2012		$47.63		$81.46		$36.66
Average number of scripts from Table Three		2,001		179		462
Example forecast annual loss by 1 December 2015 from 30/11/2012		**$95,329**		**$14,580**		**$16,948**

1. Price excludes premium-free incentive and future increases to the dispensing fee.
2. Price reduction estimates are inclusive of mark-up loss and assumes current net into store price remains constant.
3. Price reduction estimate calculated with reference to variables arising from previous examples.
4. Average number of scripts is for all strengths rather than just the specific strength listed hence the total loss on molecule calculation should not be relied upon.
5. The above is illustrative only and eventual price reductions and loss per individual pharmacy could be less or more.

SCRIPT PROFIT DECLINE

Table Seven compares the price and gross profit pharmacy made on atorvastatin/Lipitor before WADP in 2007, then immediately prior to its availability as a generic in March 2012, and finally against the forecast position from Table Six after the expected December 2015 price cut.

This table highlights that pharmacy owners will eventually make less per script in dollar terms for medicines with generic alternatives than they achieved in 2007 before the introduction of WADP. For many this will comprise the dispense fee ($6.52 but indexed annually), the premium-free incentive ($1.62) and the mark-up of 15%. Hence, as the approved price comes down then so does the mark-up component.

TABLE SEVEN: **Comparison of Pharmacy Gross Profit – Atorvastatin 40mg**

	Atorvastatin originator (Lipitor) 40mg 2007	Atorvastatin originator (Lipitor) 40mg 31/03/2012	Atorvastatin generic estimated 1/12/2015
Dispense value including dispense fee	$78.07	$67.54	$18.29
Premium free incentive		$1.62	$1.62
Total	$78.07	$69.16	$19.91
Estimated net purchase cost including wholesaler discount	$62.72	$53.70	$10.00
Gross Profit $	**$15.35**	**$15.46**	**$9.92**
Gross Profit %	20%	22%	50%

Therefore, over an eight-year period (2007–2015) the average remuneration per script will have fallen in real terms while business costs continue to rise with inflation. Clearly, pharmacy owners should not get carried away with the short-term benefits flowing from generics and understand it is an immediate and one-off opportunity to reduce debt and invest in business innovation to ensure long-term sustainability.

Equally, any consideration to buy a pharmacy business should take into account the future profits and cashflows of the business rather than what has been produced historically.

A NEW PERSPECTIVE—NOW AND BEYOND

Having strategies to combat the negative impact of WADP is essential for all pharmacies. These strategies will vary, should be specific, achievable and uncomplicated. Consider the following as a guide:

1. **All good businesses are underpinned by efficient and effective reporting systems that allow strategic change to be measured and managed.**
2. **Financial success is defined by good sales/profit per square metre (sq m) and appropriate expenses per sq m. If sales are inadequate then growth is required (organic or through acquisition/merger/medical centre) or space reduced. If sales are okay but profit is low then margins, product mix, store layout, staff skill-set and so on will require reviewing.**
3. **Growth strategies for most community pharmacies will revolve around service innovation, training and marketing of specialty categories and services, whether as a branded pharmacy or an independent.**
4. **Use capable advisers who understand your business and industry to stress test your chosen market position, strategies to get there and your action plan.**

Therefore, over an eight-year period (2007–2015) the average remuneration per script will have fallen in real terms while business costs continue to rise with inflation.

WADP is a systemic change to the Industry which is now only just starting to be felt and properly understood by pharmacy owners. Despite the significant price cuts in the future for key molecules, the underlying remuneration per script compares favourably with many foreign countries (eg. NZ). Hence, WADP should be viewed more as an eventual 'resetting of the base' rather than the creation of a base that is structurally unsustainable.

At JR Pharmacy we are working with clients on strategies to replace an estimated loss of $2.00 per script by December 1, 2015 across the pharmacy's total script volume (ie. for 60,000 prescriptions, this equals $120,000) while also considering the inevitable inflationary rise in overheads.

Business models that are already structurally unstable through low net profit to sales (<7%), high debt, high rent to gross profit dollars or both may inevitably fail if they are unable to adapt to the changing prescription remuneration model.

But for those that can adapt or already have, then the future should be positive and full of opportunity. Some strategies, such as investing in pharmacists, may seem counter intuitive (ie. possible increase in wages costs) but this can ensure government-funded program income, health solution services income and scheduled medicines sales are maximised while differentiating against warehouse discount models.

Ageing and overweight populations with complex health problems need support with health solutions in the form of both medicines and advice, while healthy ageing Australians want assistance to stay that way.

For those pharmacies that can meet the changing expectations of Australian consumers in a changing retail and PBS landscape, the future can be as bright as the past. ■

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