

## Executive Summary

Unabated rises in health spending are threatening to push healthcare systems to their limit. The cause of these increases is a combination of shifting demographics and an escalation in the cost of providing medical treatments. At present, policymakers appear keener to focus on the latter, since they are mostly powerless to do much about the former. Yet in doing so, they have tended to focus their cuts mostly on the cost of pharmaceuticals.

In most developed countries, spending on pharmaceuticals represents around 16% of total spending on health. Certainly, this is no small amount but OECD data suggests that contrary to what is commonly assumed, more recent increases in health spending are not necessarily caused primarily by increases in spending on pharmaceuticals. In fact, since 2005 the contribution towards total increases in health spending accurately attributed to pharmaceuticals is 17.3% in Canada, 13.8% in France, 15.1% in Germany, 5.6% in Italy, 14.0% in Spain, 5.4% in the United Kingdom and 10.9% in the United States.<sup>1</sup> While real-term rises in pharmaceutical spending should not be ignored, it indicates that focusing on pharmaceutical expenditure alone is unlikely to achieve significant cost savings. Although it may be more convenient and less politically sensitive, particularly in European systems where the government is often the main purchaser of such products, patients are likely to derive greater benefit from a holistic approach to cost-containment.

The current approach has seen the development of regulations around the prices that manufacturers may set for their pharmaceutical products. These are regulations separate to the appropriately robust controls around the manufacture and licensing of medicines, which are justified by the harm that could arise from unregulated access to medicines. Price regulations are designed to contain pharmaceutical costs by allowing health authorities to control prices. These regulations are mostly enforced in a heterogeneous way across the developed world, with different approaches reflecting distinct national policy priorities. The consequence can be an artificial price differentiation for pharmaceuticals between countries that reflects each government's willingness to pay for pharmaceuticals or more accurately their desire to get a "good deal" from pharmaceutical manufacturers. The consequence can be a race to the bottom between contending payers who seek to force low prices upon manufacturers with little consideration of the market within which they are being employed. Such rent-seeking is particularly apparent within the

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<sup>1</sup> Health Data 2010 – Frequently Requested Data, Total expenditure on health/capita, US\$ purchasing power parity, and Total expenditure on pharmaceuticals and other medical non-durables/capita, US\$ purchasing power parity.

European Union where prices for pharmaceuticals vary wildly, by up to 25%, regardless of a common market with relative similarity in demand and sensitivities.

In attempting to understand this price differentiation, it is possible to identify a pricing spectrum that has developed as a result of payers' attempts to establish what they deem to be fair prices. This spectrum ranges between the prices that are established within a controlled pricing environment by payers and the prices that are established within a market-based pricing environment by manufacturers. Whilst very few systems can be accurately described as absolutely controlled or absolutely market-based, most systems can be located somewhere on the spectrum. The idea that some sort of perfect price can be agreed through this process is unrealistic, particularly given the current healthcare and economic environment.

The controlled pricing end of the spectrum showcases a number of different mechanisms, most of which are designed to control pharmaceutical prices from the supply side, for example, through price negotiations, profit controls and cross-country comparisons. There are also price controls from the demand side, such as internal referencing. In all of these, payers are ultimately establishing a "controlled price", which reflects the value of a pharmaceutical as well as the need to contain costs. In market-based pricing, pharmaceuticals are priced based more closely according to the fluctuation of market conditions. Whilst manufacturers are still required to oblige with all the relevant safety, efficacy and quality requirements, when it comes to pricing they are able to establish a more or less "market-based price" for their product.

What becomes apparent when studying this pricing spectrum is that market-based pricing encourages greater medical innovation, by expanding the incentives for manufacturers to invest in research and development. This is no more evident than in the United States, which is the most profitable and productive pharmaceutical market by far. Yet, the drawback for this innovation appears to be higher pharmaceutical prices, which is perhaps unsurprising given that most price regulations are designed to bring prices down. As a result, it can reasonably be asserted that the US is getting "more for more" when comes to its approach to pharmaceutical pricing. Europe, on the other hand, is getting "more for less", given the extent of innovative products being imported from freer markets such as the US.

Although it may not seem so initially to European policymakers, this is ultimately problematic. Firstly, it puts European nations in a position where they can be accused of "free-riding" on patients in the US and thus not paying their fair share towards the current cost of developing medicines that are of value to the entire globe, not least to their own patients. Secondly, it means that European nations have surrendered

some autonomy over their healthcare systems by placing the burden for medical innovation on the shoulders of others, whilst leaving themselves susceptible to changes in pharmaceuticals regulations over which they have no authority.

Pricing policy should not be a race to the bottom. Whilst payers do have a duty to manage their budgets in an effective manner, they should take care when contemplating price controls and consider them as part of an overall approach, which understands the efficiency of healthcare systems in a dynamic way. Short-term measures to reduce pharmaceutical prices artificially are, firstly, unlikely to deal with rising healthcare budgets but are also likely to hamper innovation further down the road.