



Prescription pricing demystified

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Summary

Patient status, premiums, special contributions and safety nets all affect the cost of prescription medicines. Depending on their status, patients pay different co-payments for subsidised prescription drugs. Extra costs may be added by the manufacturer and the dispensing pharmacist.

Key words: bioequivalence, cost of drugs, Pharmaceutical Benefits Scheme.

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Introduction

Many patients are unsure about the price of their Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (RPBS) prescriptions and often ask their doctor 'How much will my prescription cost?'. The final price paid by the patient for these prescription medicines can be broken down into various components and depends on the following (see Fig. 1):

- their status as a patient (general, concessional or repatriation)
- whether a brand price premium, therapeutic group premium or a special patient contribution applies
- the patient's safety net status.

The pricing of 'private' prescriptions that fall outside the PBS and RPBS is not influenced by any Australian government subsidy or pricing restrictions.

Patient co-payments

For the 2009 calendar year, the co-payments payable by patients are as follows:

General patients	up to \$32.90
Concessional and repatriation patients	\$ 5.30

These amounts are indexed on 1 January each year in accordance with the Consumer Price Index in the previous 12 months. The *National Health Act 1953* precludes pharmacists from discounting the patient co-payment that applies on government-subsidised PBS medicines.

Premiums and special contributions

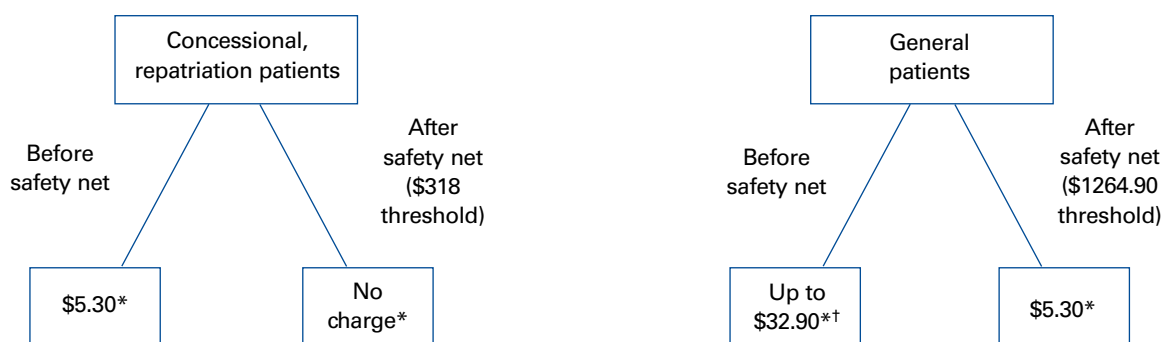
In certain instances the pharmaceutical manufacturer may choose to apply an additional charge for their product which the patient is obliged to pay. These can be a brand price premium, a therapeutic group premium or a special patient contribution. While these extra charges are paid to the pharmacist at the time of dispensing, they are passed on to the manufacturer.

Brand price premiums

Since 1990, manufacturers have been able to set their own prices on PBS medicines in particular circumstances. The policy operates when there are a number of therapeutically equivalent brands available. The government subsidises each of the available brands to the level of the cheapest brand. This means that patients have to pay extra for the more expensive brands – those with a brand price premium.

Fig. 1

Doctor, how much will my prescription cost?



* Plus any premium (brand price premium or therapeutic group premium) or special contribution that may apply

† Actual cost depends on manufacturer price and allowable pharmacist fees and charges

These amounts apply during the 2009 calendar year

Unless the prescribing doctor has specifically indicated otherwise on the prescription, a pharmacist can dispense another bioequivalent brand at the patient's request. In this way, patients can avoid paying the brand price premium. However, when the brand price premium applies, it cannot be discounted by the pharmacist and the patient must pay it in full.

In August 2008, 334 of the approximately 3000 brands listed on the PBS attracted a brand price premium. The average brand price premium was \$2.69 and ranged from \$0.08 to \$75.30. The majority of brand price premiums were in the range of \$1.00–\$4.00.

Therapeutic group premiums

Since 1998, a therapeutic group premium policy has applied to specifically defined groups of drugs which have similar safety and health outcomes. Within these groups, the drugs can only be interchanged by the prescriber. The government subsidises all drugs within a group to the level of the lowest priced drug. The difference in price between the lowest priced drug and the highest priced drugs within the group is called a therapeutic group premium. This is paid by the patient and goes to the manufacturer, not to the pharmacy or the government.

The principle is that there is always at least one drug within each therapeutic group of drugs that does not have the therapeutic group premium. In addition, when a patient is only able to take a drug with a therapeutic group premium for medical reasons, the prescribing doctor can request an exemption from the therapeutic group premium from Medicare Australia. Where there is no exemption, the patient has to pay the therapeutic group premium in full.

In August 2008, there were four groups of drugs affected by the therapeutic group premium policy. These were angiotensin converting enzyme (ACE) inhibitors, calcium channel blockers, proton pump inhibitors, and the H₂ receptor antagonists. Of the many items within these therapeutic groups, only eight attracted therapeutic group premiums ranging from \$1.52 to \$4.02. The prices of items in these groups are reviewed by the Pharmaceutical Benefits Pricing Authority each year, as are all drugs listed on the PBS.

Special patient contributions

For certain expensive medicines where the government and the manufacturer cannot negotiate a mutually acceptable price, the government makes a part contribution towards the manufacturer's price. In these instances the patient pays their normal co-payment plus a special patient contribution. This is the difference between the government's part contribution and the actual cost of the supplied medicine.

The special patient contribution cannot count towards the safety net, nor does it apply to RPBS prescriptions, so veterans only pay their normal co-payment contribution and the Department of Veterans' Affairs pays the rest.

In August 2008, there were 11 items on the PBS attracting a special patient contribution, which ranged from 61 cents to \$437.01 (bleomycin sulfate).

Other charges for the patient

A significant number of PBS items are priced below the maximum co-payment for general patients of \$32.90. As no government subsidy applies to these items, the patient pays the full cost for these medicines.

The amount the patient pays for these items will depend not only on the manufacturer's price for the item, but also on the fees and charges the pharmacist is entitled to apply. The online version of the PBS Schedule (accessible at www.pbs.gov.au) includes a 'price to consumer' column which lists the price the consumer can expect to pay, including the allowable fees and charges. There is also a column showing the 'maximum recordable value for safety net' – this is the maximum amount that can be recorded on the patient's 'prescription record form' to count towards the safety net for that patient. It does not necessarily equate to the amount the patient pays which could well be higher due to the additional fees and charges that do not count for safety net purposes.

The allowable extra fees and charges the pharmacist can apply to items priced under the maximum co-payment of \$32.90 include the following:

Additional fee for safety net recording	\$1.03
Allowable additional patient charge	up to \$3.79

The additional fee (\$1.03) can be charged for the extra work involved in recording the prescription details on the prescription record form. It may take the form of a part charge to take the cost up to \$32.90. It is not compulsory for the pharmacist to charge the patient, but if the fee is charged it should be added to the PBS dispensed price recorded on the patient's prescription record form. Only one fee is payable per medicine, even if there are multiple quantities dispensed. It does not apply to prescriptions dispensed for concessional and repatriation patients.

The allowable additional patient charge (up to \$3.79) applies where the PBS dispensed price is below the general patient contribution of \$32.90. It is added to the PBS dispensed price in lieu of charging private prescription rates. The charge is agreed between the Pharmacy Guild and the government and has been in place since 1991 (when it stood at \$2). This charge is optional and it can be discounted by the pharmacist. It may only be added to general patients' prescriptions and cannot be entered on the prescription record form as part of the cost of the medicine.

Some pharmacies discount below the base price of the medicine. Such pricing practice is usually associated with pharmacies offering a low-overhead, low-service model of care which may not be geographically convenient for some patients.

The maximum amount that may be charged to a general patient is \$32.90 so this charge cannot be applied if the total cost (including the additional fee and this allowable extra charge) takes the amount over \$32.90. However, this allowable additional patient charge may take the form of a part charge to take the cost up to \$32.90.

The PBS reforms that took effect on 1 August 2008 lowered the prices patients pay for many items priced below the maximum patient co-payment – the prices of more than 1000 medicines have fallen by between 20 cents and \$4.65. There is a \$1.50 government incentive payment to pharmacists for dispensing substitutable, premium free prescriptions. This only applies to subsidised items and is not paid by the patient.

Patient safety nets

Since the late 1980s, a PBS safety net has been in place to protect patients and their families (particularly those who may be using large quantities of medicines) from the high cumulative cost of prescription medicines.

Two safety nets apply – one for pensioner, concessional and repatriation patients, and the other for general patients. The thresholds for each safety net are adjusted each year in line with the Consumer Price Index. For the 2009 calendar year the respective safety net thresholds are as follows:

General	\$1264.90
Concessional and repatriation	\$318 (equivalent to 60 prescriptions at \$5.30)

The thresholds do not take into account brand price premium, therapeutic group premium or special patient contribution charges, or the allowable additional patient charge.

After reaching the threshold of \$1264.90, general patients are issued with a safety net concession card that entitles them to pay the concessional co-payment (\$5.30 per prescription) for the rest of that calendar year. These patients are still required to pay any relevant brand price premium, therapeutic group premium or special patient contribution charges.

After concessional patients have reached the threshold of \$318, they are issued with a safety net entitlement card that allows them to receive their prescriptions free of charge for the remainder of that calendar year. However, these patients are still required to pay any relevant brand price premium, therapeutic group premium or special patient contribution charges.

Patients can keep a record of their accumulating expenditure on PBS/RPBS medicines on a prescription record form. This form is available from community pharmacies and can either be kept by the patient or the pharmacist. If kept by the patient, the form needs to be handed to the pharmacist on every occasion a PBS prescription is dispensed. Many patients (particularly those who use only one pharmacy) leave it to the pharmacist to keep their accumulating prescription usage on the dispensary computer.

Conclusion

There are many variables that need to be considered before a definitive answer can be given to patients about their prescription costs, including the patient's entitlement status (concessional, repatriation, general, safety net), whether a premium or special contribution applies and whether (for general patients) the amount falls below the maximum patient co-payment. In simple terms, Fig. 1 provides a useful summary of the likely cost, taking into account these variables.

Conflict of interest: none declared

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