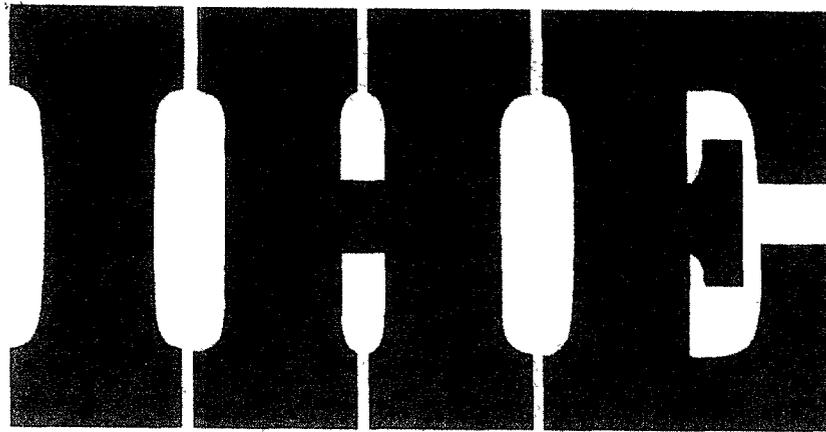


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INSTITUTE FOR HEALTH ECONOMICS

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Parallel trade in drugs in Sweden – an economic analysis

Why does such a thing as parallel trading exist in the first place, and what are its pros and cons? How does it affect the actions of operators in Swedish health care, and in what ways does it influence pharmaceutical costs and prices? At the request of the National Corporation of Swedish Pharmacies, the Association of Parallel Importers, the Federation of County Councils, and the Pharmaceutical Industries Association, IHE's *Ulf Persson, Anders Anell, and Malin Persson* analyse the Swedish parallel trade in a recent study.

In January 1997, the first parallel-imported pharmaceutical became available in Sweden. Today there are about 140 parallel-imported drugs in the Swedish market, and some ten businesses are trading in this area.

In 2000, drugs of this kind accounted for just under nine per cent of total sales in Sweden.

Parallel trading accounts for approximately one per cent of the total pharmaceutical market in Europe.

Parallel imports mean income losses for pharmaceutical manufacturers. For instance, the annual cost of gastric-ulcer drugs would, according to calculations presented in the study, have been SEK 188 million higher if parallel imports had not taken place.

The chief cost-cutting factor is found in the actions of the direct im-

porter: first, the price of Losec is lowered; second, the new Losec MUPS is introduced at the same price as parallel-imported Losec. The reduction of expenditure owing to parallel importation corresponded to just under 20 per cent of the costs of omeprazole and lansoprazole.

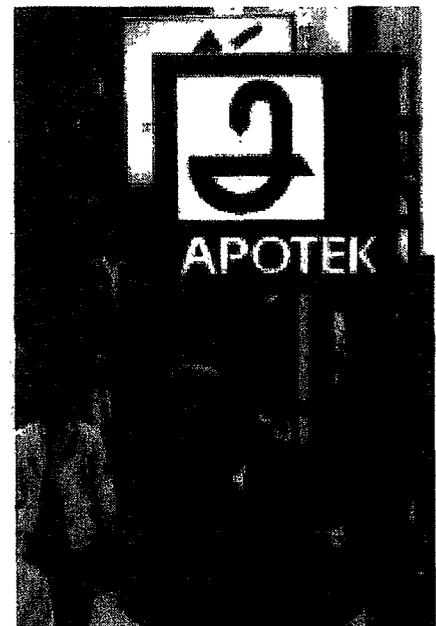
However, parallel imports entail higher costs for pharmacies, mainly in connection with storage, remaining-stock records, and extra information to patients. In respect of some drugs, the additional costs to pharmacies exceed the savings made on cheaper parallel imports.

In 1999, the ten best-selling parallel-imported drugs accounted for 74 per cent of the total sales value of all parallel-imported preparations in Sweden.

In other words, most parallel-imported drugs engender relatively modest sales and cannot, generally speaking, be expected to yield savings, although their price is set at least 10 per cent below that of the originally imported drug.

In view of the extensive opportunities of parallel importation, and the fact that costs vary, future assessments must be based on more explicit calculations regarding benefits and costs.

A decision to use the drugs with the lowest prices only does not amount to an optimal utilisation of resources. That applies both to the selection of



In the Netherlands, the UK, Ireland, and Norway, pharmacies are able to increase their profits by switching to parallel-imported drugs. In these countries, too, the proportion of parallel imports is relatively large.

pharmaceutical therapy in a general sense and in the situation where a choice has to be made between a directly imported drug and a parallel-imported one.

Other aspects must be taken into consideration, too, such as packaging, extra information, reliable deliveries, additional costs of storage, and the danger of poorer compliance. These

costs have not yet been satisfactorily elucidated. The choice of therapy and drug should be made on the basis of the total costs and gains which arise in consequence of different choices.

Since the Swedish market is so small, Swedish regulations, prices, and the occurrence of parallel importation are of very limited significance when it comes to encouraging the global pharmaceutical industry to do more research leading to new drugs.

Even so, innovation is not only a matter of coming up with entirely new drugs; it may be associated with new packages, modified dosage, specially adapted information, and so on. The interest among direct importers in developing new package sizes or information and training geared to the Swedish market may be assumed to decrease in proportion to an increase in parallel imports. This constitutes another cost which should be taken into account in decision-making.

In the health services of the future, in which responsibility and accountability for the cost of drugs will have been decentralised, there will be a range of options when it comes to making general and local assessments of the costs and gains associated with parallel imports.

One straightforward option consists in letting pharmacies make the assessments involved, which means that (part of) the price difference goes into the calculations of pharmacies, as an income. Another option entails passing the decision on to the health services, in which case the extra costs to pharmacies must – obversely – be accounted for within the framework of health-care expenditure. Both these options come with disadvantages as well as advantages, and the study reviews them all.

The general debate over the parallel trade in drugs is concerned with finding a balance between temporary monopolies, promoting long-term innovation, and competition, which insists that products be priced on the basis of marginal costs.

The pharmaceutical industry, with massive overheads going into research and development, is operating with a cost structure which should, if everything worked according to plan, entail large differences in prices between countries as well as between health-

Effects of deregulating the – Experiences from Iceland



Parallel imports are uncommon in Iceland, as the additional costs of packaging and marking would not be offset by sales in this small market. Another contributing factor is an extensive domestic manufacture of generics.



care systems, depending on the ability to pay. Marginal costs in manufacturing are low; and the main issue, if anything, is how the financing of fixed costs – overheads – should be distributed among the countries involved.

Advocating that the Swedish health services utilise parallel trade within the EU/EEA as wisely as possible thus does not amount to defending its existence from a global, or even a European, perspective. If price differences become indefensible within a future integrated EU/EEA, it will become all the more important to uphold this principle at the global level. That is to say, countries that are – relatively speaking – wealthy will assume the responsibility for funding research and development, thereby helping to make new drugs available to poor countries as well.

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For more information
Persson U, Anell A & Persson M,
Parallellhandel med läkemedel i Sverige – en ekonomisk analys, IHE
Monograph 2001, may be
ordered from IHE.

Pharmacies in the Nordic countries have traditionally been one-person businesses, run by privately operating pharmacists and strictly controlled by public authorities in respect of establishment and pricing – with Sweden as the exception to the rule. In Iceland, Norway, and Denmark, this system was placed under scrutiny in the 1990s; and questions as to how pharmacies should be set up and who should own them have been debated, just as they have been in this country. In Iceland and Norway, these investigations have led to tangible changes. IHE's Anders Anell and Jonas Hjelmgren discuss the background of these changes, as well as the effects seen so far, in a new report.

In Iceland as well as in Norway, ownership of pharmacies is unrestricted following deregulation, with the exception of individuals or companies associated with the pharmaceutical industry and prescribers. One condition has not changed, though: only qualified pharmacists are allowed to run pharmacies. In practice, the new legislation on pharmacies in both countries has introduced almost complete freedom when it comes to setting up shop as a pharmacist.

In both countries, the role of the state is conditioned by a desire to avoid under-establishment in, for instance, sparsely populated areas. In addition, pharmacies are permitted to compete in

operation of pharmacies Norway, and Denmark

pricing. The role of the authorities is limited to fixing the maximum prices of prescribed drugs.

It may seem odd that Iceland and Norway, which have chosen to remain outside the EU, have gone to the greatest lengths when it comes to deregulating pharmacies. Part of the reason may be found in the efforts made in the 1990s to make the public sector more efficient and to gain control of expenditure. Joining the EEA was also a significant factor in this context, as the EEA insists on competition in the wholesale pharmaceutical trade.

Another essential factor in both countries is a debate concerning the income levels of pharmacists, above all the distribution of income between pharmacists in urban districts and sparsely populated areas. Both the Icelandic and the Norwegian state have stated that such dissimilarities in income constitute an especially clear sign of inefficiency.

A common feature is that deregulation quickly led to the setting up of new pharmacies, and alongside this development pharmacy businesses amalgamated into chains. These changes were swift, and today 3-4 chains compete for the pharmacy market in each of the two countries.

In addition, Norway has a system of co-operation agreements between pharmacy chains and wholesalers, and in several cases wholesalers have their own pharmacies. As yet, the Norwegian experience has not been able to tell us a great deal about the functioning of these new constellations. The changes are recent; and so far, the most striking outcome is a struggle for power among pharmacies and wholesalers eager to secure the most advantageous positions.

In Iceland the corresponding changes were implemented in 1996. Hence, there are now several years' experience of how the new pharmacy chains behave, for instance when negotiating discounts from wholesalers and offer-

ing to cut those charges that customers are required to pay out of their own pockets.

Reykjavik pharmacies are far more apt to give customers discounted charges than rural ones, and in respect of certain disorders and drugs pharmacies have granted 100-percent discounts. Consequently, the state has to some extent lost control of the subsidising system.

At least one of the chains has expressed the opinion that price competition has had its day, and that future competition will focus on quality differences as regards service, availability, and accessibility.

Both Iceland and Norway have witnessed the gradual emergence of demands for supplementary deregulations/regulations. In both countries competition authorities have created regulations intended to counteract power concentration and private monopolies.

Among the additional changes now discussed in Iceland is the possibility that certain drugs may not in future be available from pharmacies run in conjunction with outpatient health centres.

In Norway, a decision to the effect that OTC drugs should be on sale in pharmacies only will be reconsidered.

There are some important differences as well. In Iceland, new rules concerning the orientation and quality of pharmacy operations have been introduced gradually. In Norway, price competition and freedom of establishment were introduced together, in a decisive step which would seem to create opportunities for massive changes.

On the other hand, the Norwegian department of health has stated that the profile of pharmacies should remain the same, and it does not as yet allow

pharmacies whose operations are solely geared to Internet sales. Nor does it permit the sale of OTC drugs outside pharmacies.

Deregulation in Iceland and Norway was carried out with a comparatively low level of involvement on the part of the health services, or of prescribers. Nor was there a strategy in the respective departments as to how a connection between drugs dispensing and health care might be achieved, or how the new conditions for pharmacies

might lead to a better utilisation of drugs.

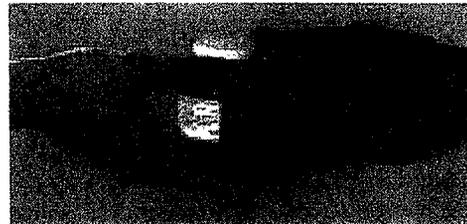
The drugs-dispensing profession played rather an insignificant part in pre-deregulation investigations.

As a result, the departments of health were the

prime movers and designers of the relevant schemes.

The situation in Sweden differs from the one in Norway and Iceland in a number of ways. One major difference is the pharmaceuticals reform, which transfers the responsibility for costs to health-care authorities. If the national price-control scheme regarding drugs is abolished, and health-care authorities are able to negotiate directly with pharmaceutical companies, there will be no need for a powerful negotiating party in the form of integrated pharmacies/wholesalers.

Instead, the main questions we face when contemplating the choice of system for wholesale and pharmacy trading are: How can distribution be made to function efficiently; and how will pharmacies be able to promote the proper utilisation of drugs and become a natural part of the health services regarded as a whole? *IHE*



In Norway, the patient and the pharmacy split the price difference between the costlier directly-imported drug and the cheaper parallel-imported drug between them.

For more information
Anell A & Hjelmgren J. *Effekter av avreglering i apoteksväsendet. Erfarenheter från Island, Norge och Danmark*, IHE Working Paper 2001:3, may be ordered from IHE.