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Collective purchasing of (expensive) medicines

Wolf Sauter and Susan van Velzen

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ACM Healthcare Taskforce, 8 March 2016 – wolf.sauter@acm.nl

Outline

- Social and economic context
- Parallel public and private action
- Collective purchasing
- Proposed approach
- Conclusions/questions

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Social and economic context

- Netherlands ‘new’ healthcare system since 2006
  - Fully private healthcare provision and insurance*
  - Mandatory insurance for basic package of care
  - Open enrollment but risk equalisation system
  - For profit, contributions set in competition

  \+ Governmental efforts at cost control

- Increasing importance of medicines for which there are few substitutes – biologicals, small populations

→ Rising prices of (expensive) medicines
  - 9% of total healthcare expenditure
  - 7,4% of hospital care in 2013 (2011: 3,8%)

  \+ 10% annual prices growth v total scope 1% after inflation

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The NL healthcare triangle*

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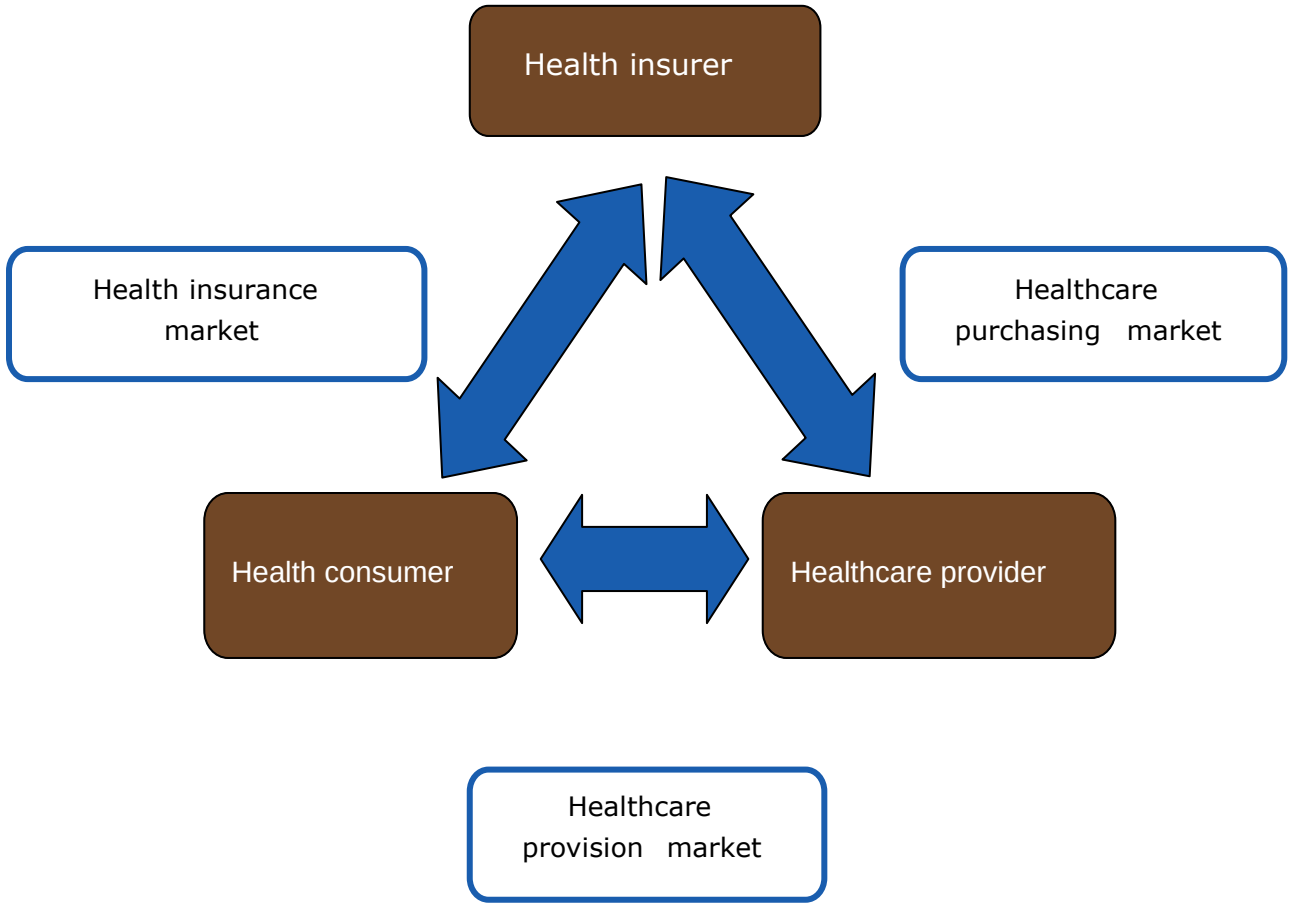

Parallel public and private actions

- Extramural drugs: direct price negotiations between insurers and pharmaceutical companies
  - Drugs for which generics are available
  - Preferential/selective purchasing: 15-20% discount

  → Global annual cost savings 600-900 € mn on 4.2-4.5 bn €

- Intramural (hospital) drugs: cost problems remain
  - Generally drugs with few substitutes
  - NL only 2% global market

- Governmental initiatives
  - Conditional access to reimbursement → discounts
  - Putting insurers in charge of access?
  - Pooling Benelux purchasing efforts
  - Opening debate at EU level

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Collective purchasing

1. By private insurers (4x joint 90% market share)
2. By hospitals (84 of which 8 academic)
3. By combination of (1) and (2)

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- Can this work where there are no competitive constraints on pharmaceutical producers?
  - Potential competition and competitive overlap

- What are the limits on collective purchasing?
  - Framework under Article 101 TFEU and national law
  - 2011 Guidelines on horizontal agreements

Proposed approach

Relevant markets

National: purchasing medicines; basic health insurance

Local: hospital care

Proposed approach and conditions

a. If purchasers not in same market: no issue

b. <15% joint market share: safe haven

c. < [5-20%] shared costs no competition concerns if

- No hardcore restraints
- Limited maximum duration of contracts [1-3 years]
- Transparent, non-discriminatory, objective criteria entry & exit
- Freedom to purchase outside collective purchasing group

d. > [5-20%] shared costs: individual assessment

- Only problematic in case of market power

Conclusion and questions

- Competition concerns
  1. Buying power: desirable if benefits are passed on
     → Differentiate between insurers [5%] and hospitals [20%]?
  2. Exclusion: addressed by ‘FRAND’ entry and exit
  3. Collusion: dampening downstream competition addressed by cap on shared costs

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- Hence focus on shared costs as driving competition concerns instead of market share:
  - Effective and legitimate approach?
  - Can be squared with Commission guidance?
  - Problems if approach is generalised to other sectors?