Collective purchasing of (expensive) medicines

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Outline

• Social and economic context
• Parallel public and private action
• Collective purchasing
• Proposed approach
• Conclusions/questions
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
The NL healthcare triangle*

- Health insurer
- Health insurance market
- Healthcare purchasing market
- Health consumer
- Healthcare provider
- Healthcare provision market
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
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)

• 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

• 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?