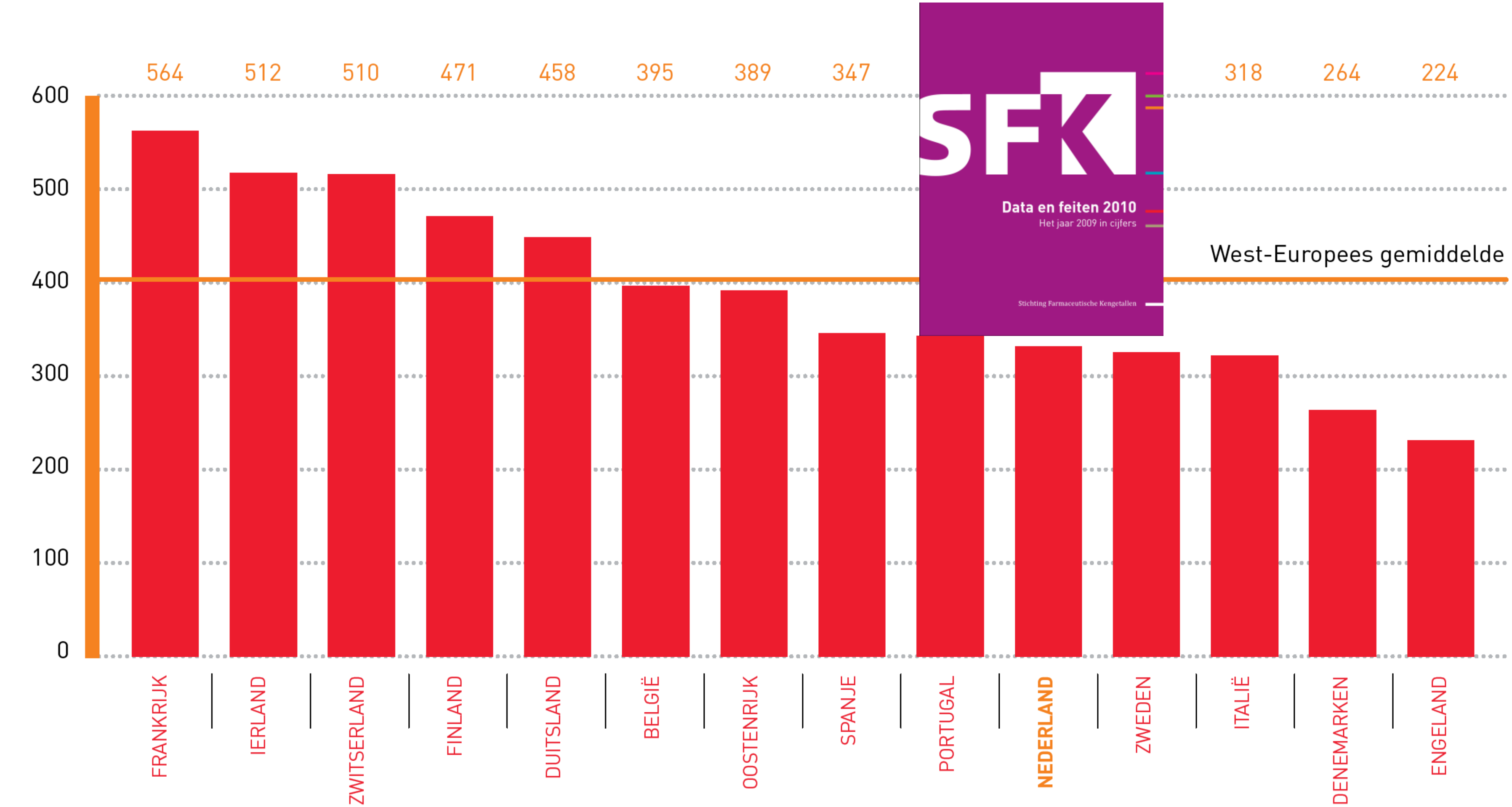
Generics-the Dutch experience

Martin van der Graaff PhD| Wien | 22 März 2011

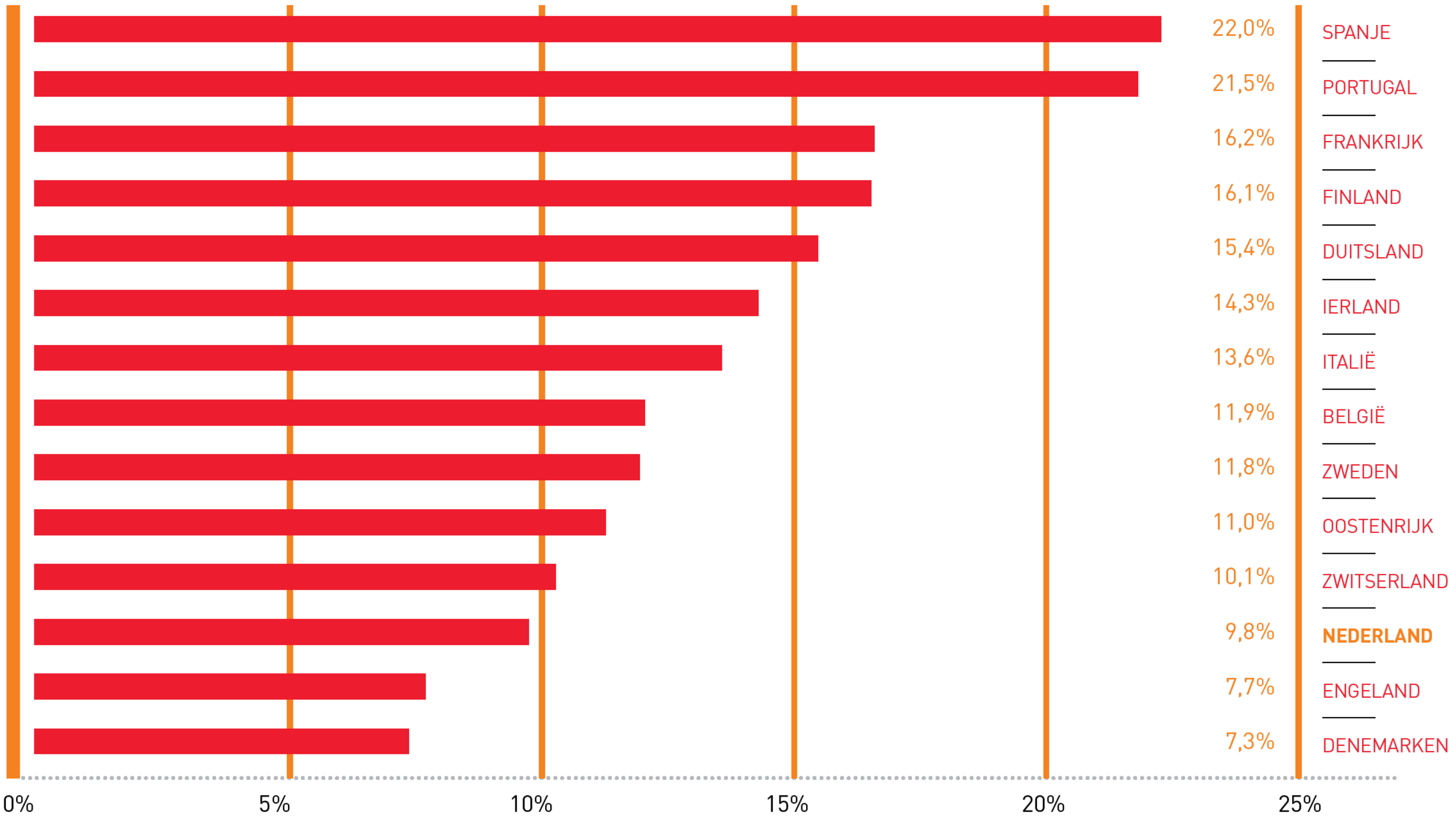
1.12 Geneesmiddelenuitgaven via apotheekhoudenden per hoofd van de bevolking in 2008



De geneesmiddelbestedingen in Nederland zijn van een vergelijkbaar laag niveau als die in de van oudsher zuinige Zuid-Europese landen en Denemarken. Engeland heeft de laagste uitgaven per hoofd van de bevolking, echter dit is exclusief dure geneesmiddelen.

Bron: Stichting Farmaceutische Kengetallen

1.13 Uitgaven farmaceutische hulp via apotheekhoudenden als aandeel in de uitgaven aan gezondheidszorg in 2008



Nog geen 10% van de totale zorguitgaven in Nederland komt voor rekening van geneesmiddelen. Nederland behoort hiermee tot de hekkensluiters in West-Europa.

Bron: Stichting Farmaceutische Kengetallen

History of Cost Containment (1)

- Reimbursement system GVS introduced in 1991 based on clustering with reimbursement limits
- 1983 to 1989: copayment max. Hfl 2,50 (~ € 1): “medicijnenknaak”.
  - Result: more units per prescription
- Eighties: pharmacists keep 1/3rd of price diff. generics and brand products; doctors to use INN names on prescriptions.
- Early nineties: Pharmacists to negotiate their own rebates. Start of golden age.
  - 1998 clawback 4,8 %, 2000 increased to 6,8%

Reimbursement in clusters

- Reimbursement is maximized by cluster limit
- Cluster contains different active substances
- Average price in clusters is determined by weighted average of list prices of brands and generics (brands having a higher weighting factor)
- Reimbursement limit is set at the price of a product the closest below the average.
- Result: all prices tend towards the average and are close to reimbursement limit: system failure!
- Consequence: fake list prices, large rebates, rebates not ploughed back in system but ……..

History of Cost Containment (2)

- No listing of unique new products (list 1B) from 1993 to 1999 except for great medical need
  - Finally replaced in 2005 by system with FE
- 1996: Pricing Law Pharmaceuticals (WGP): max price = av. of FR, BE, UK, GE
- Early 2000’s: advent of voluntary agreements (Convenant), blown up by generics association after breakthrough of preferential policies.

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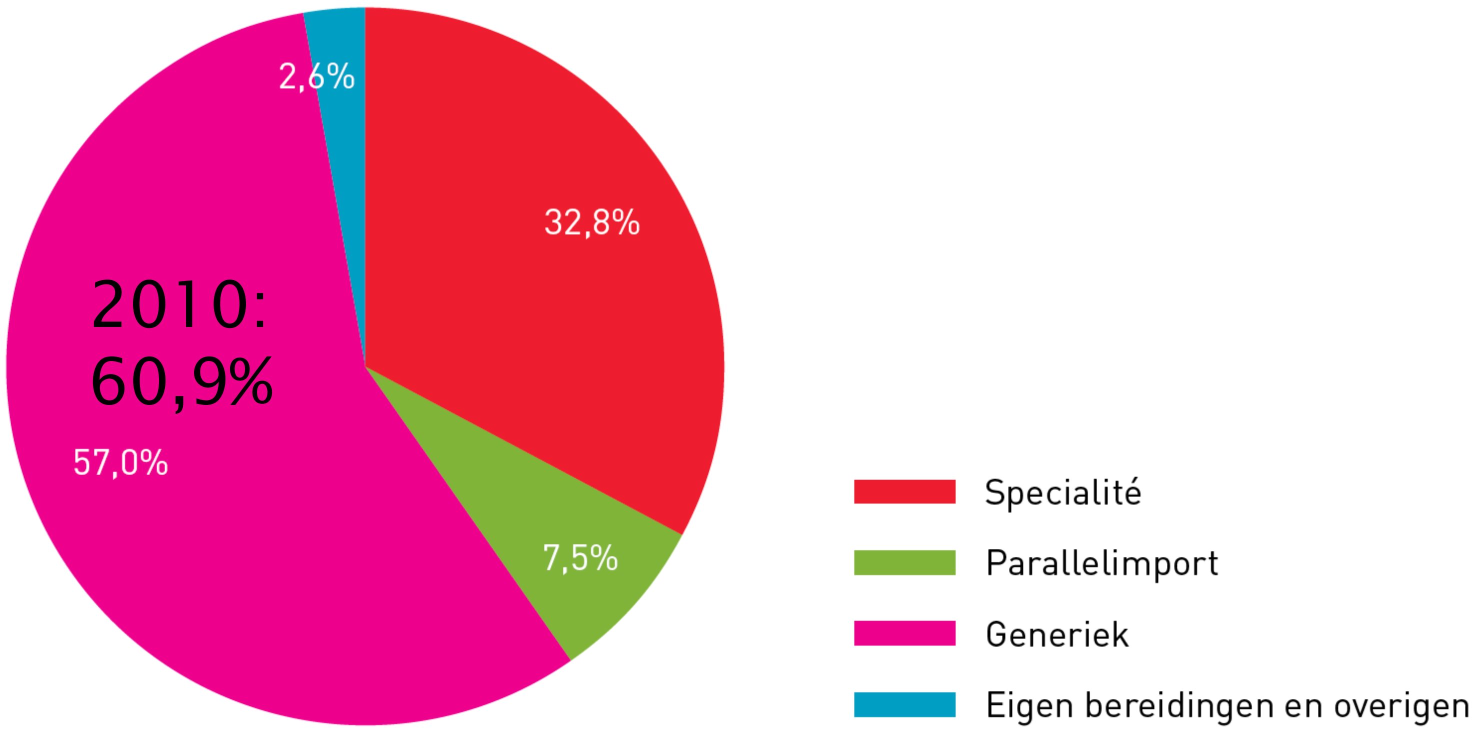
1.9 Gebruik van geneesmiddelen naar productgroep: voorschriften 2009

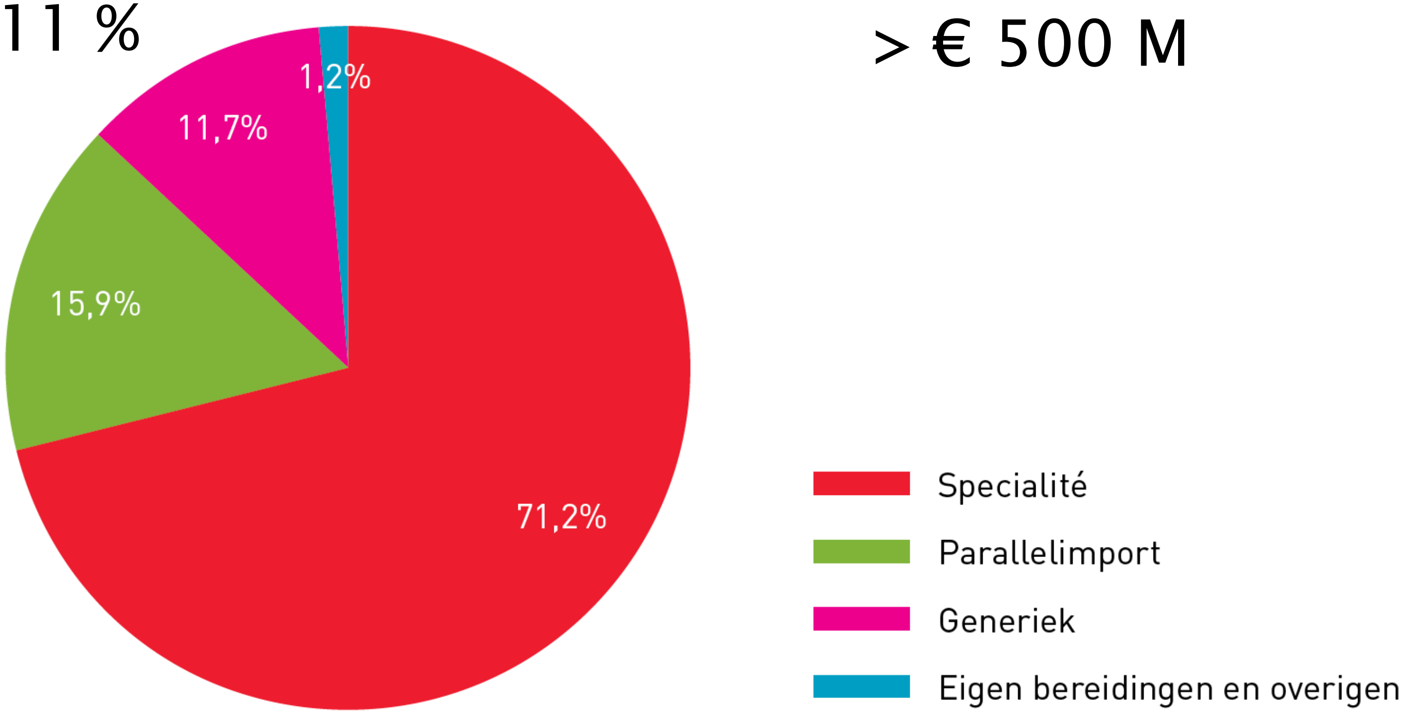


Bron: Stichting Farmaceutische Kengetallen

1.10 Gebruik van geneesmiddelen naar productgroep: geneesmiddelenkosten 2009

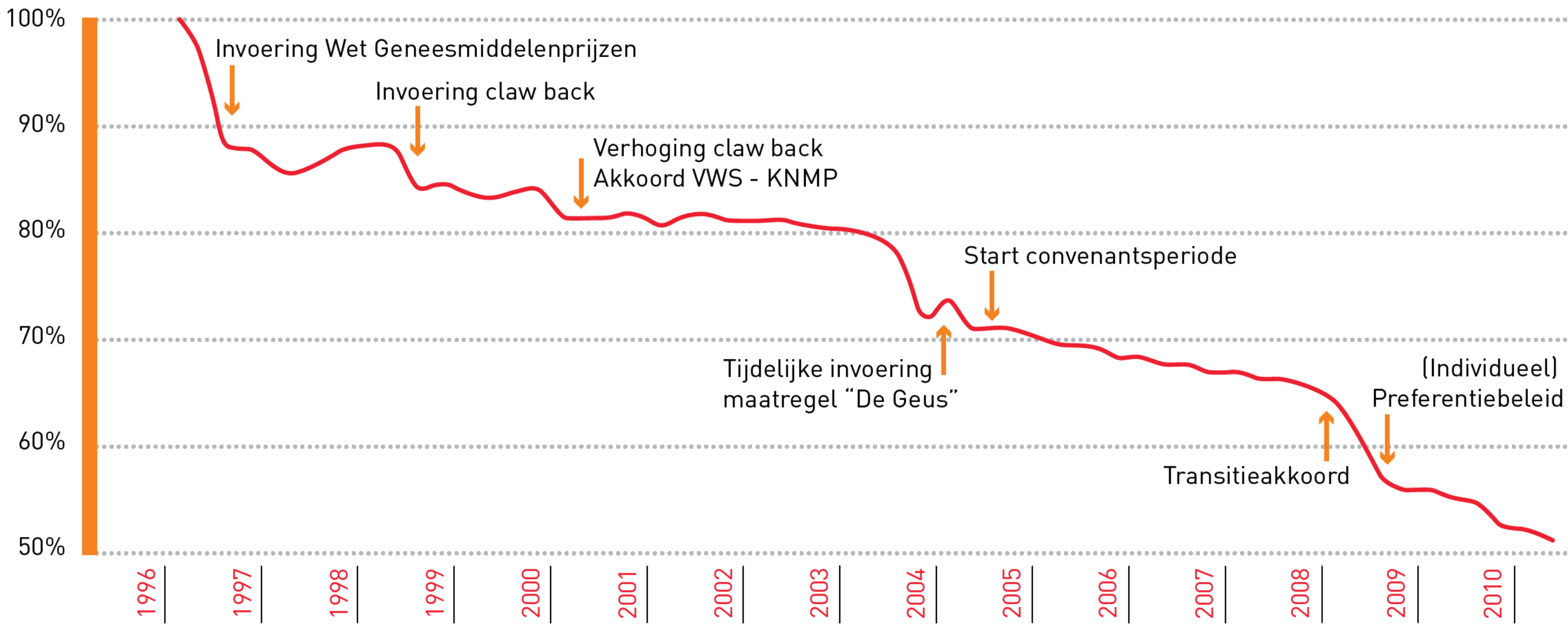
2010:
11 %

Overall: € 4950 M
> € 500 M



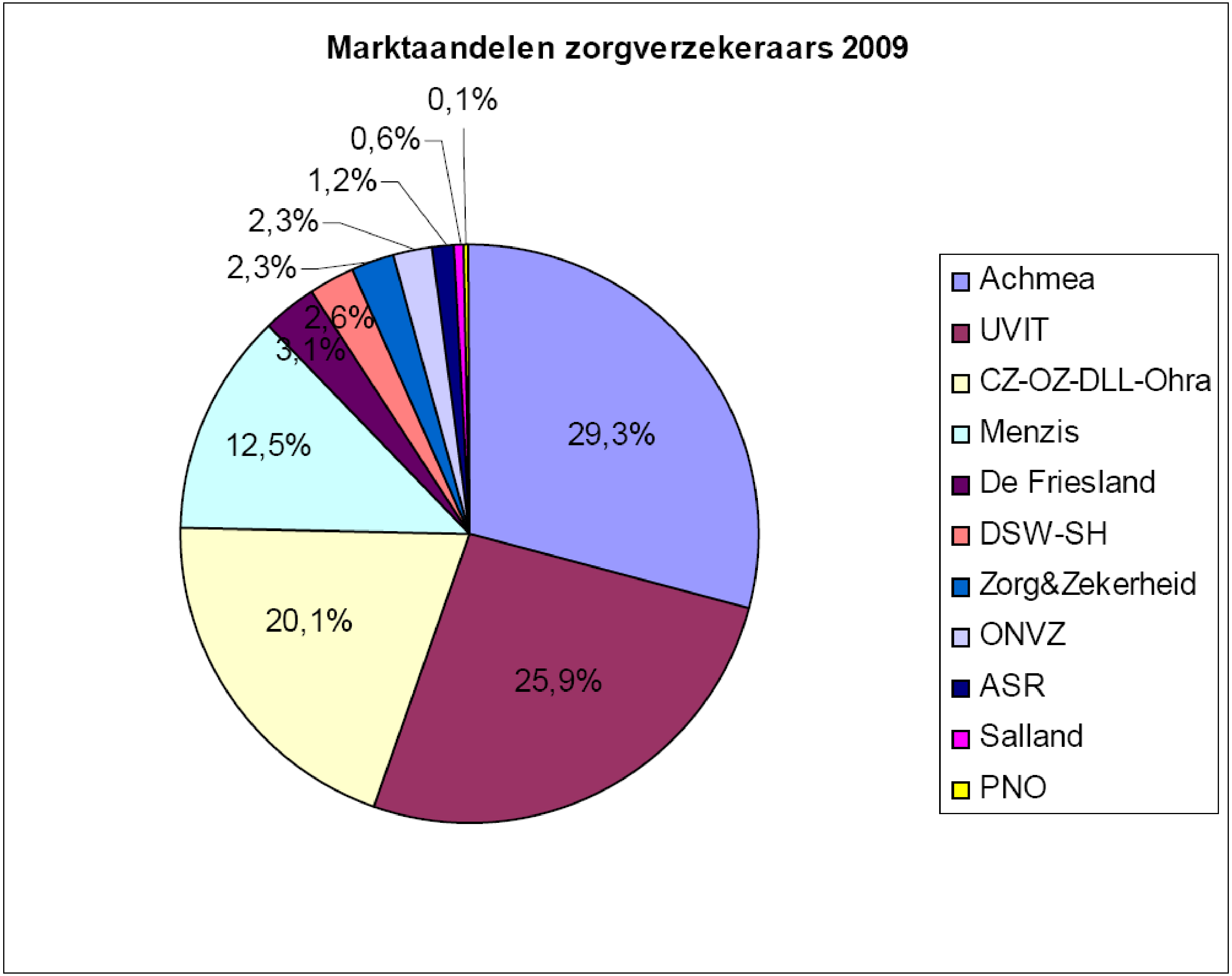
Bron: Stichting Farmaceutische Kengetallen

1.8 Prijsontwikkeling receptgeneesmiddelen op basis van de SFK prijsindex (januari 1996 = 100), afzet gewogen gemiddelde



Bron: Stichting Farmaceutische Kengetallen

Figuur 4. Marktaandeel zorgverzekeraars basisverzekering 2009



History of preference policies

- 2005: First attempts by Agis, Menzis, CZ, Univé, VGZ
  - 3 drugs only: pravastatin, simvastatin, omeprazol
  - All companies stayed within price band of 5 % of cheapest
  - A failure
- 2007: Breakthrough by Focus Pharma (unjoined company!!): obtain exclusivity for simvastatin
  - 15 % cheaper
- 2008 : Individual insurers start own policies. In the middle of transition armistice as covenant follow-up: Generics association BOGIN quits, prices slump.

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The facts

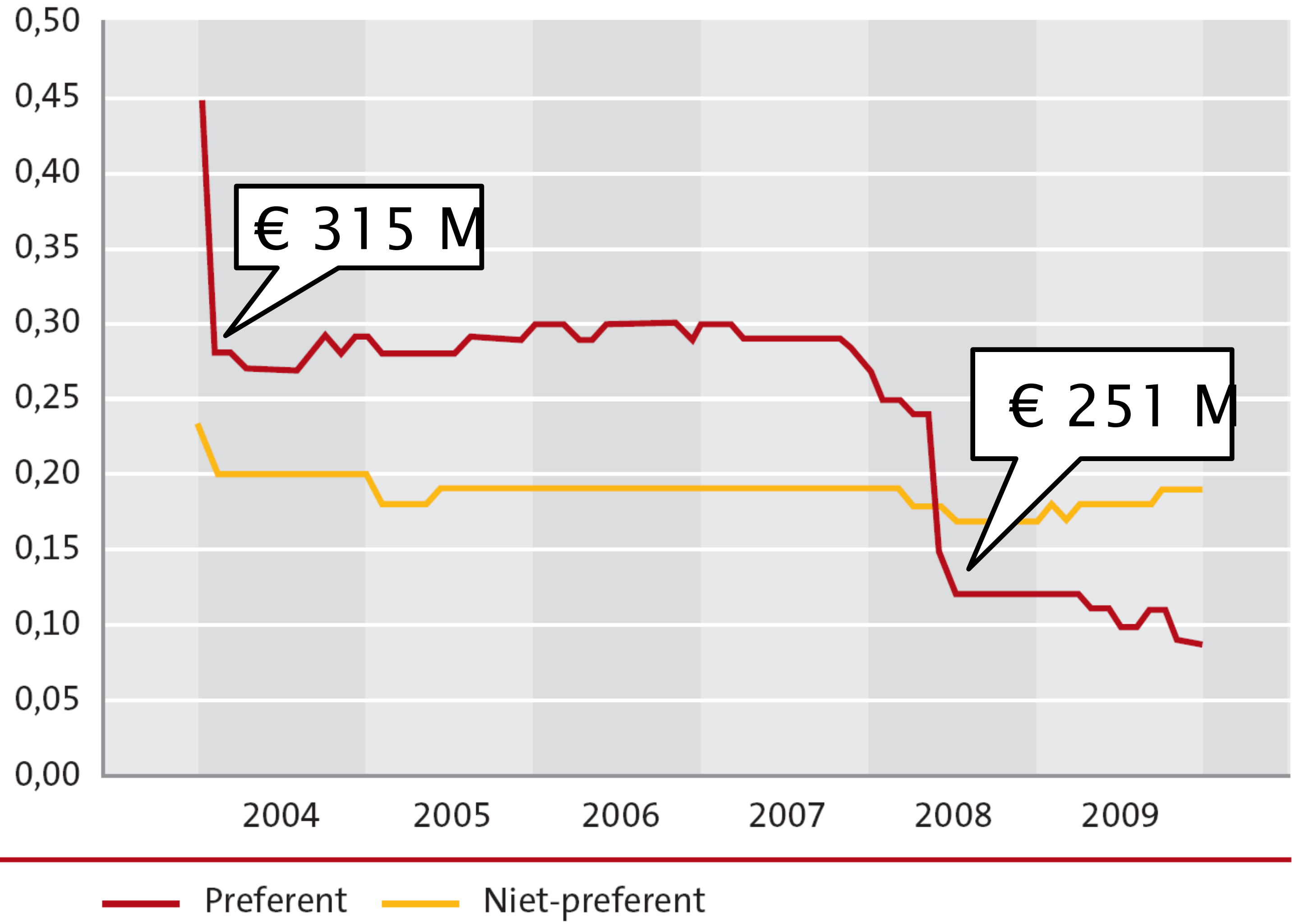
- Private entities: tenders not subject to the EU rules for public tenders.
- Supplier status granted for 6 or 12 months
- 2007: very limited, few groups of medicines:
  - statins (preferred substance: simvastin),
  - proton-pump inhibitors (omeprazole or pantoprazole)
  - medicines like β-blockers (metoprolol),

Tabel 7. Overzicht uitvoering preferentiebeleid zorgverzekeraars

Zorgverzekeraar	Aantal stofnamen	Aantal ZI-nummers	Periode aanwijzing 2010 (maanden)
UVIT	54	147	12/13 (v.a. 1 juni en 1 juli 2009)
Achmea/Agis	129	249	11 (vanaf 1 februari)
Menzis	30	74	12 (vanaf 1 november)
CZ	39	92	12 (vanaf 1 januari)
De Friesland	3	27	12 (vanaf 1 januari)

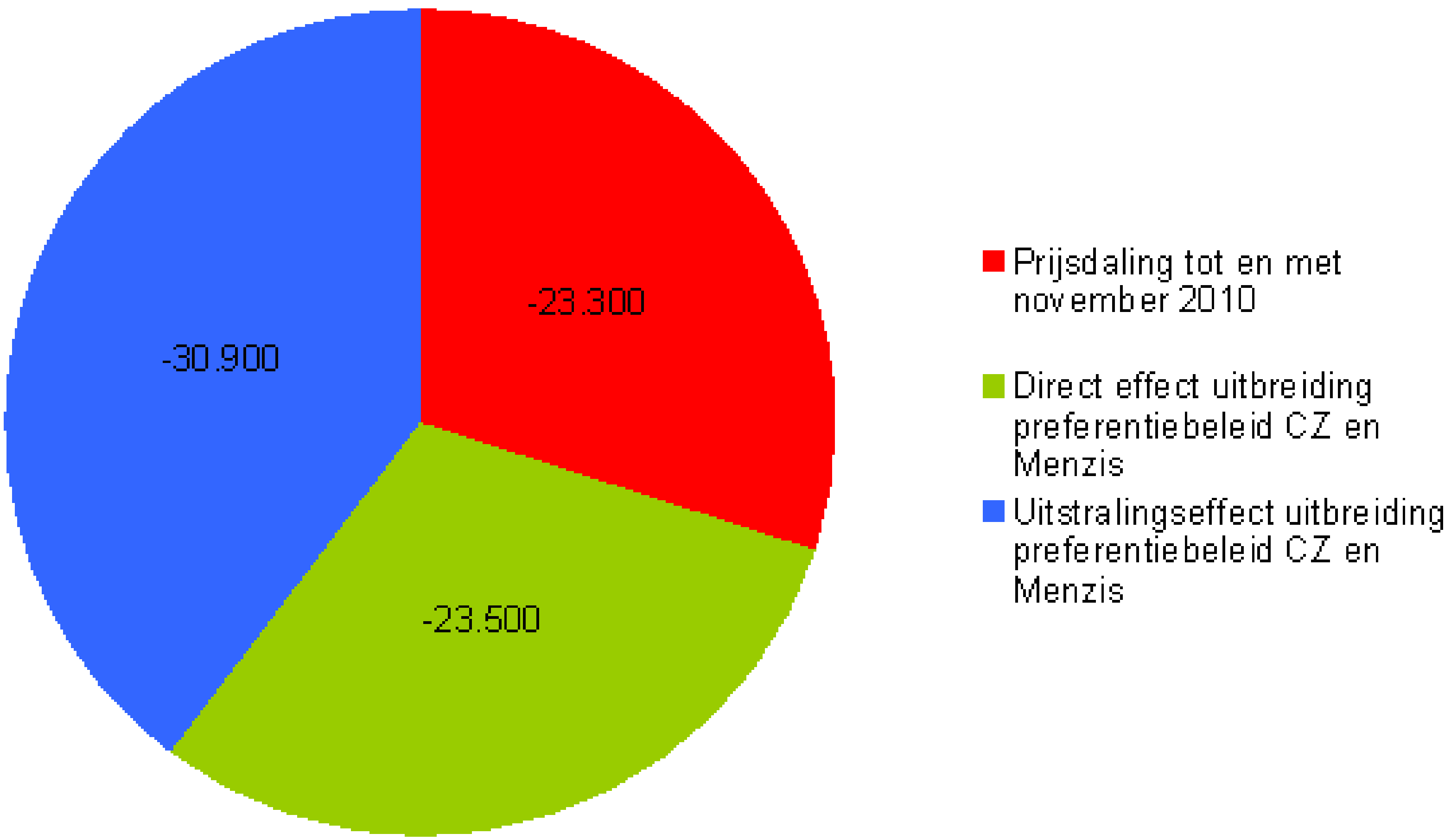
FIGUUR 4.1 | PRIJS PER DDD GENERIEKE GENEESMIDDELEN, PER MAAND 2004-2009

1 = 1 EURO



figuur 1: Verwachte omzeteffecten prijsdaling generieke geneesmiddelen op jaarbas

Price cuts lead to turnover loss of ~€ 77.700 per pharmacy Av. annual turnover ~€ 2.5 M



IDEA (pakjesmodel)

Higher basic fee for service

No enforced preferential products

Fixed price per DDD

No clawback on rebates

Risky but potentially rewarding

Pharmacists 74 %

Preferential policy

Standard fee for service

Preferential products enforced

Clawback on rebates on multisource products

Less risky but logistic nightmare

Pharmacists 24 %

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Pro’s

- Highly effective instrument in reducing reimbursement costs
- Lower costs of health insurance policies
- Ends excessive margin profits made by manufacturers, wholesalers and pl

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Con's

- Intransparant process and accountability
- Severe disruption of market manufacturers and wholesale logistics (winner takes all effect, short-terms of awarded preferency contracts).
- Pharmacies deprived of legally-entitled share margin
- Logistic nightmare pharmacies in area's without dominant health care insurer
- Economic risks with the pharmacies, wholesalers and manufacturers, not with the health insurers
- Producers only start manufacturing when awarded contract
- Many leave market leading to perverse effect: the few remaining will increase price
- Risks to safety and patient compliance

Conclusion

- Mix of policies has been successful
- Insurers have taken the lead in managing expenditure
- There is still willingness to pay for real innovations

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