

**Speaking points Anita Vegter
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Pharmaceutical markets and consumers

Thank you. It has been a very interesting discussion. This UNCTAD meeting is unique in terms of the range of the delegates in attendance, and the opportunity for us to learn from each other's experiences. I would like to tell you about a problem that we had to deal with recently at the Netherlands Authority for Consumers and Markets.

ACM is a multi-functional authority, that combines competition law oversight with consumer protection and regulation of energy, telecommunications, post and transport markets. One of ACM's priorities is Consumers of Health Care.

ACM aims to promote options and opportunities for consumers and business. Spending on health care in the Netherlands accounts for 12 % of GDP. As is the case in all of your countries, public attention for health care is high.

Problem

In 2014, ACM closed a case investigating price differences between the price charged for a specific branded drug depending on whether this was for use in hospital, or for sale in pharmacies. The patented drug was being sold very cheaply inside hospitals. In fact, it was given away for free. The same drug when sold outside of hospitals was far more expensive. There were generic equivalents available for this drug. However, they were not prescribed by the specialists in the hospitals, because in the hospitals the branded drug was cheaper. The patients leave the hospital with a prescription for this patented drug. And the family doctor is naturally inclined to prescribe the same brand as the hospital specialist prescribed. So even though some of those patients could switch to a cheaper generic alternative, many of them continue to take that expensive drug for the rest of their lives.

ACM had to close the investigation in this case. We did not establish a dominant position on this post-hospital market of "bound" users of the patented drug and therefore found

no violation of the Dutch Competition Act.

Consumers are not paying for their own drugs in the Netherlands. The hospital pays for the drugs, and the health insurance provider pays for the drugs. Consumers are frequently unaware of the price of the drugs they take.

Competition law could not help us. So we did two things. Firstly, we turned to advocacy, and secondly, we turned to consumer empowerment.

Advocacy

ACM published a paper, in January 2015, "Pharmacy under the Microscope". In this paper, ACM focuses on two reasons for the high level of drug costs in the Netherlands.

The first cause is the way drug costs are reimbursed in the Netherlands. The current patent system, in combination with the funding system, results in incentives for brand-name drug manufacturers to focus primarily on drugs with relatively limited added value, and to focus less on new drugs.

A second cause lies in the prescription behavior of physicians, which is another reason why these strategies can be so successful. Medical specialists within the hospital, and doctors outside hospitals prescribe relatively expensive, patented brand-name drugs, whereas cheaper (generic) drugs often turn out to be just as good.

When it comes to preventing such practices, ACM looks at the way in which drug costs are funded and reimbursed in the Netherlands. Health insurance providers play an important role in keeping the price of drugs low. Under law, the insurance provider can state that they will only reimburse the costs of a drug, if it is the cheapest form of the drug available on the market. This has had a huge effect on drug prices of the most popular generic drugs, reducing their prices by up to 90%. However, patented drugs are protected from this policy. Because, for patented drugs where there are no generic alternatives, the policy cannot have a price-lowering effect.

In the paper, we suggest ways in which the funding mechanism for drugs in the Netherlands could be altered in order to deter evergreening. That is the practice of making minor changes to branded drugs in order to extend the right to exclusivity. For example, if the government could link the reimbursement system to the therapeutic added value of the drug, this might reduce the incentive to evergreen.

In relation to prescription behaviour, we see that the drug that is prescribed to a patient by a specialist in a hospital, has a strong position in relation to the drug that is prescribed to the patient, once he or she leaves the hospital. The specialist in the hospital tends not to think of the long-term consequences of their prescribing behaviour. This leads to large price differences between drugs sold to hospitals, and drugs sold to pharmacies. ACM believes that the problem could be greatly reduced if physicians were to take (more so than now) the cost aspects of the drugs they prescribe (for use outside the hospital) into consideration.

The paper also gives insight on the behaviour of pharmaceutical companies. It explains why they spend so much on marketing to promote branded drugs, and to discredit alternatives.

Another factor explained in the paper is that this is a highly dynamic market. Today the profits are being made in low volume very high cost medicine. Producers have moved from chemical medicines to biological medicines. The question is whether the same or similar behaviour will be seen here as with chemical medicines. The development of biologicals may be even more expensive than chemical medicines. Biosimilars may not be very much cheaper.

The question is what is the most appropriate tool to use in these dynamic contexts? The ACM paper suggests that competition policy rules may not always be the most suitable instrument. Alternatives that address the incentives for the pharmaceutical industry to innovate may lead to a quicker resolution.

Consumer protection

As I said already, the high costs of drugs are often not visible to consumers. The insurance providers pay the costs. But if we can empower consumers to force the insurance providers to compete, then we can lower health care costs and the cost of medicines.

ACM conducted investigations into switching barriers in the health insurance market. The switching rate is about 10%. The investigation revealed that of the consumers who in 2013 did not switch, 60% had not done so because they found switching too much trouble. Or because consumers perceive little difference in terms of price and quality between health insurers. 1 in 10 of those consumers said they found the health insurance market too complex.

In 2014, we followed up this investigation with a deeper inquiry into the difficulties experienced by consumers in switching. From a behavioural economics perspective, we see that consumers experience loss aversion. They find comparisons difficult between different policies. There is a real need for comparison websites in this market.

ACM is a multi-functional authority, and we were able to combine the expertise of our consumer and competition experts to set up a campaign, together with the health care authority, to help people through the switching process. We also had experience with switching difficulties because of our work in energy switching. We developed a 5 step plan to help consumers to understand their rights and obligations. This with the aim of empowering consumers to make a well-founded choice for a health insurance provider.

Switching and even the possibility that consumers may switch encourages the insurance providers to do their best to find the best hospital, to find the best drugs, for their consumers, for a reasonable price.