By Leendert van der Ent

A Shared Drive: Securing Patient Access to High-Cost Medicines

In order to contain rising costs for oligopolistic medicines, a joint initiative in the Netherlands has been launched by hospitals, hospital pharmacists, health insurers and hematologists. As of January 1, 2018, Dutch hospitals will jointly procure 1 out of 3 comparable drugs against chronic myeloid leukemia. In this pilot project, 75% of new second-line therapy patients will receive the preferred medicine. This is the first cluster for which a national agreement could be reached. More clusters could follow this attempt to secure patient access to high-cost medicines.

During the decade preceding 2014, medicine costs in the Netherlands remained within the range of 4.5 to 5 billion euros. Lately, however, prices of many new drugs have soared. This trend poses an increasing threat to the financial sustainability of the health care system. The real “threat” still lies ahead, disguised in the blessing of ever more effective new drugs becoming available. The potential boost in length and quality of patients’ lives sometimes comes at breathtaking prices. These new drugs exist, but will they become “available”?

“A trend like this can lead to change,” says Peter Roos, hospital pharmacist at Erasmus Medical Center Rotterdam and program manager for high-cost drugs at NFU, the Dutch Federation of University hospitals. “It inspired a sense of urgency in the boards of both Academic Medical Centers and the health insurance companies. Both parties are not accustomed to direct communication on the highest level, but now found each other in the shared conviction that something had to be done about soaring drug prices.”

Bart Benraad, program manager high-cost drugs at Dutch Health Insurers (Zorgverzekeraars Nederland, ZN): “Respect for each other’s interests helps to remove inflated profit from the pharmaceutical column. It was a fine accomplishment that we managed to get rid of bottlenecks and found each other on mutual interests, which are in fact national interests.”

Competition rules

A steering committee and a work group on the subject were established, in which apart from the learning hospitals of the NFU also the nonlearning hospitals were represented on behalf of the NVZ, the Dutch Association of Hospitals. This work group, of which both Roos and Benraad are members, analyzed what goes wrong in drug procurement. Roos: “Both parties were transparent about their own role and agreed to a pilot project for the collective procurement of a certain category of drugs to stimulate the market mechanism.”

How can you stimulate the market in this way, and does the “competition watchdog” allow that? “The legal issues regarding the Authority for Consumers and Markets (ACM) were our first concern,” says Roos. Benraad: “Together with our lawyers we meticulously defined what would be within the boundaries. The ACM saw no legal objections.” The pivotal point is that although the health insurers are involved as facilitators, they only receive information on a general level, being the total sum to be reimbursed.

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Funding/support: nothing to disclose.
The authors have indicated they have
no potential conflicts of interest to
disclose.

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from the journal.
HemaSphere (2017) 1:1(e9)
<http://dx.doi.org/10.1097/HS9.000000000000009>

Hematology pilot

When regarding the drug market, there is a base of cheap, generic medicines. Then comes a large group of not particularly expensive drugs. In the Netherlands, these are procured by approximately 6 procurement combinations. On the extreme end of the spectrum, there are the vastly expensive monopolistic drugs. The Minister of Health directly negotiates with pharmaceutical companies about their price. Roos: “We target the category in between: oligopolistic drugs, 16 percent of total drug turnover. These are advanced medicines for which some competitors have comparable substances on the market.”

A small dossier was selected for the pilot project: medicines against chronic myeloid leukemia, with a list price of 30 million euros. “Instrumental in this choice was Nicole Blijlevens, chair of the Dutch Hematology Association and treasurer of HOVON,” Roos indicates. “She had the courage to align the specialists in her field and to speak out: ‘all three medicines are for treatment of the same indication and are safe’.” Blijlevens: “We can treat three quarters of new secondary care CML patients with one of these three comparable drugs—and we will. There is no obligation, however. The different drugs have particular side effect profiles. An estimated 25 percent of patients will need—and get—one of the other two drugs.”

Benraad: “Without this support of physicians we are not getting anywhere. They know about the financial bottleneck, and are willing to contribute to a solution.” Blijlevens: “We can only serve patients if the proper means remain available. As specialists,

we can indicate where we see room for a pilot. It is the only way to set this fixed market segment in motion.”

Truly unprecedented

The fact that practically all relevant patients are represented by their insurers and hospitals is a great achievement. Benraad: “This unity on a national level is truly unprecedented.” At present the full list price is paid for oligopolistic drugs. The pilot project can change that, thanks to economy of scale. The choice between all or nothing should make it attractive for a pharmaceutical company to make a sharp price offer. Blijlevens can already mention a candidate for a sequel project: multiple myeloma. Discussions about pilot projects in lung disease and oncology are ongoing. “It can be done in any cluster with oligopolistic drugs,” Benraad concludes.

Roos and Benraad are convinced that the present pilot project will have an important signaling function to suppress excesses. Blijlevens thinks this is only the beginning. “We can also look at other categories, such as that of drugs just below the presently targeted price, and even the monopolistic drugs. In this last category, developments cannot continue the way they are going.”

It would be worthwhile to lift this initiative to the European level as well, says Blijlevens. “EMA now only considers effectiveness and safety. It would be great if cost effectiveness and affordability would also be taken into account for European market access. I am aware of the huge differences between the health-care systems in Europe. It will be very hard, but the issues of accessibility and affordability make it worth trying.”