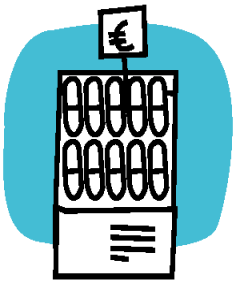
Unit 3: Are medicines an economic good like any other ?



6. Generic drugs in France (2): Government efforts for a market with price competition

Hello. I am Étienne Nouguez head of research at the Center for the Sociology of Organizations. This video will be about generic drugs and how they pertain to price competition. This second part of my presentation will focus on the role played by the actors involved in the demand that creates price competition namely physicians, pharmacists, and patients. In France, up until the mid-1990s none of these three actors benefited from prioritizing generic drugs be they physicians, pharmacists or patients. We will cover how the drug companies on the one hand and the government on the other hand tried to push these actors either towards generic or originator drugs. Pharmacists: primary actors behind developing generics. Let's start with pharmacists who were the main drivers for the development of generic drugs in France. Up til the mid-1990s pharmacists were against generic drugs. They did not push them for two reasons: one, they were not allowed to substitute generic drugs for original drugs except in a few rare cases for therapeutic reasons two, their profit margins were based on drug prices. Selling cheaper products lowered their margins thus they had little interest in selling generic drugs. In 1998, what the government did was give substitution rights to pharmacists, which meant a pharmacist could dispense generic drugs instead of the prescribed originator drugs if the generic medication was listed on the official Repertoire. Then, the French government gave to pharmacists preferential margins on generic drugs which mean margins on generic medication were then equal to margins on the originator drug. After that substitution rights gave an edge to pharmacists who bought from the ten labs selling generic drugs. They sold the same drugs. The only way to get ahead was to start competing on prices to the favor of pharmacists. Large commercial discounts were created – supplier rebates – and pharmacists started having much better profit margins when selling generic drugs instead of originator ones so they began substitution regularly. Physicians: second actor behind developing generics like pharmacists physicians were rather hostile to the development of generic drugs in the mid-1990s for several reasons. One, they were against substitution rights that they felt were an intrusion from pharmacists on their sole prescription authority. Two, they did not like health insurers intruding on the patient-doctor bond which could make prescriptions not about the patient's well-being but about the savings of the insurer. Mostly, though, in France since physicians' wages are not related to their prescriptions they are not related to drug prices unlike in many other countries prescribing generic drugs did not benefit physicians. They had three ways of interfering with the development of generic drugs. The first way was to not write prescriptions using International Nonproprietary Names (INN) also known as generic names. INN prescriptions have barely inched up especially for specialists who rarely ever use INN. Second, physicians could write do not substitute in a script comment to avoid use of generics a practice reserved in theory for only special cases. A 2009 study by the French health insurance system showed that about 4% of prescriptions bore this indication. What physicians generally did to avoid prescribing generic drugs was to prescribe innovative ones for which no generic versions existed yet. I mentioned in my first video those pseudo-innovations which physicians started prescribing more to make sure that what they prescribed would not be switched out. Why did they do that? One, they think generic drugs are not as good and that these new drugs, in turn have to be better. Drug companies also played a role, of course: promotional encounters with physicians flourished in order to persuade doctors to favor these new drugs. Consider also the influence of experts and key opinion leaders who prescribed the new drugs. General practitioners sometimes lacked the willpower to make changes to prescriptions of specialists.

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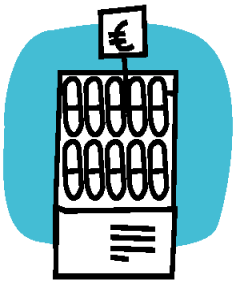

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The health insurance system thus tried to push all doctors towards generic drugs. They implemented several measures and in stages. The first was to threaten them financially as part of the Juppé and Aubry plan in the 1990s. Physicians rejected these sanctions and the Council of State voided them. From the beginning of the 2000s onward a new strategy was implemented one based on communication with prescription profiles and health insurance delegates to show physicians the need for generic drugs. Since the end of the 2000s a new performance-based payment method was implemented: if physicians achieve a number of objectives including generic drug prescriptions they received individual bonuses on top of their basic fees. That was enough for some physicians but the results remain mixed. The development of generic drugs is still mostly stalled by physicians who do not prescribe them enough. Patients: third actor behind developing generics. There is another player to consider: the patients. When developing generic drugs, the state ran into an issue: in the substitution rights talks it was established that patients could refuse substitutions without giving a reason due to informed consent considerations. Since they got the same kind of refund for generic and original drugs that is in full in most cases when they had a health mutual fund there was no reason to favor the generic medication. The state attempted to rally patients without taking away their freedom of choice. They relied on the prescription-makers: physicians and pharmacists had to convince their patients to choose generic drugs. Then they launched awareness campaigns appealing to civic engagement: If you want to save public health care use generic drugs. That only worked on some patients. So the state attempted to change the way reimbursements were issued first, using a reference price reimbursement system (TFR) where reimbursement only covered the generic drug's price. If there was a difference between generic and originator prices the patient paid it. That worked wonders. Faced with a price difference, the majority refused to pay more and took the generic drugs. Some labs who sold original drugs then decided to match TFR prices. Since there was no more difference between the two kinds the generic drug lost its competitive edge. TFR also drew the ire of pharmacists because with TFR margins were not anchored to originator drug prices but to generic drug prices so they were losing money. The government thus had to limit the use of TFR only in sectors where substitution could not expand without it. The alternative came in 2006 with the idea of a third-party payer in exchange for generics: i.e. the medication costs are advanced by the third payer if the patient takes a generic. This policy had significant effects. In the areas where this was implemented substitution rose by 15-20% in a few months. My research focuses on the factors that do or do not contribute to the dissemination of generic drugs. When considering the map on generic drugs there is a clear divide between the countryside where generic drugs are now widely in use and in cities and very urban spaces where dissemination was much slower. The map confirms that urban patients who are ready to pay more for the best medication found practitioners ready to sell them that medication due to a commitment to medical excellence and to justify higher fees. In the countryside, however patients did not always want the drug that was judged best and they talked to professionals who were not trying to prescribe original drugs at any costs.