Regulation in the Italian generics sector: state of play and prospects for future legislation

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Foreword

It is widely recognised by the relevant decision-makers (AIFA, Ministry of Health, Ministry of the Economy and Finance) that the use of generics can give a significant contribution to the financial sustainability of the national healthcare service (NHS) – in particular, the view is generally held that the savings generated by the uptake of generics can significantly help the NHS to provide patients with access to the costly, innovative pharmaceuticals that will enter the market in the next years.

Nevertheless, the generics market is **underdeveloped** in Italy compared to other major EU Member States. In particular:

- The **market share** of generics (roughly 13% of the overall spending for retail pharmaceuticals reimbursed by the NHS) is lower than the EU average
- The **price** of generics is relatively higher - which is surprising, in a country where on-patent drugs have relatively low prices in the EU context, and parallel exports are a widespread practice precisely for this reason.

This report will briefly examine the possible reasons for this state of affairs, particularly by analysing the flaws in the generic reference pricing system which has been in force in Italy since 2001. A focus will be devoted to the issue of financial incentives to pharmacies.

The report will then give a brief account of the measures taken over the last years to improve the reference pricing system and correct the market distortions it had generated.

Finally, we will give an overview of the policy actions that are being considered/debated by the relevant decision-makers to improve the generics market.

1. Generic reference pricing and its flaws

In general terms, the reimbursement price of all pharmaceutical products which are offered to patients at the expense of the NHS are negotiated by the manufacturer with AIFA.

Under the generic reference pricing system established in 2001[1], whenever two or more pharmaceutical products containing the same (off-patent) active ingredient are available in the regional distribution chain, the NHS is only entitled to reimburse the price of the lowest-priced product available, irrespective of which product is actually purchased by the patient in a pharmacy. This means that:

- Whenever a doctor prescribes a product containing an off-patent active ingredient, the pharmacist is bound to offer to the patient the lowest-priced product available in the regional distribution chain (which, of course, is not necessarily the product prescribed by the doctor)
- If the doctor states in the prescription that the product indicated is *"non-substitutable"*, or if the patient insists to purchase the prescribed product, then the difference between the price of the prescribed product and the price of the lowest-priced one is paid by the patient.

As mentioned above, this system has failed to generate the expected penetration of generics in the Italian market and the expected fall in the price of off-patent products. The reasons for this include:

[1] Decree-Law n. 347/2001, art. 7.

- **Prescription behaviour**. Generic products have met the skepticism of both doctors and patients, particularly as regards their quality. Doctors have proved extremely reluctant in prescribing generic products and information to patients has been poor, especially in the first few years after the introduction of the reference pricing system
- **Distorted incentives to the distribution chain (wholesalers and pharmacies)**. It must be recalled that the **remuneration of wholesalers and pharmacies** for the sale of reimbursed pharmaceuticals is regulated by the national law; it is set as a fixed percentage of the reimbursement price. This means that both wholesalers and pharmacies have no explicit incentive to offer cheaper reimbursed products, because the higher the reimbursement price, the higher their remuneration will be in absolute terms. In the view of both the regulatory Agency (AIFA) and many observers, this regulatory framework leads the interests of pharmacies and those of the manufacturers of off-patent originators to converge (since off-patent originators are typically more expensive than the relevant generics). Since reimbursed retail drugs can only be sold by pharmacies[2], the latter act as **a bottleneck in the distribution chain**, thus having a considerable **market power**
- **Lack of competition**, both among producers and among pharmacies. Price competition among manufacturers of reimbursed generic medicines is mitigated by the circumstance that **their price is negotiated with AIFA**. The latter includes all off-patent medicines, including the originator, in the so-called (regularly updated) "transparency lists", where the products are grouped according to their active ingredient. Competition among pharmacies is severely limited by the legal restrictions to their number and (to date) their ownership. Also, there is **no such thing as competition "for the market" in the retail drugs sector**, in the sense that any attempt to introduce tenders for the purchase of off-patent pharmaceuticals have been thwarted by the joint opposition of pharmacies and the industry of generics.

Due to price formation mechanisms (i.e. negotiation for inclusion in transparency lists) and restrictions to competition, the price dynamics of off-patent products follows a peculiar pattern in Italy, compared to other large EU Member States such as the UK and Germany:

- Taking into account the average price of all products containing off-patent active ingredients, including the originator, the price typically drops significantly in the first year after the patent expiry: the average price index is 0.751 after one year (assuming 1.000 at the moment the patent expires), vs. 0.731 in Germany and 0.858 in the UK. However, the price only decreases moderately in the following years: four years after the patent expiry**, the average price index is considerably higher in Italy (0.550) than in the UK (0.358) and Germany (0.356)**[3]
- **Price dispersion in Italy is much lower** than in the other 2 Member States considered. In other words, the price of the originator decreases more than in the UK and Germany: 4 years after the patent expiry, the originator price index is 0.603 vs. 0.749 in Germany and 0.852 in the UK. From another perspective, while in Italy the

[2] We deliberately use the word "pharmacies", not "pharmacists": all medicines that require a medical prescription (irrespective of being reimbursed by the NHS or not) can only be sold in a pharmacy. Medicines that do not require a medical prescription can also be sold by a professional pharmacist in other stores (s.c. para-pharmacies and supermarkets).

[3] These data refer to the 2002-2011 period.

average price of generics is roughly 70% the price of the relevant originator 4 years after the patent expiry, the ratio is approx. 50% in Germany and approx. 22% in the UK.

To sum up, the reference pricing system did not result in the expected drop in NHS spending for the reimbursement of off-patent retail drugs. Prices remained higher than in other major EU Member States, and since there was only a limited shift in demand (medical prescriptions, patients' preferences) from the originator to generics, the result of the reference pricing system was to **shift part of the burden from the NHS to patients** (because the difference between the price of the originator and the reference price is paid by the patient).

2. Focus: discounts to pharmacies

As we have seen, the legislation in place which disciplines the remuneration of wholesalers and pharmacies provides for no financial incentive to offer lower-priced generics instead of more expensive off-patent originators.

It is a widely held view that the generics manufacturers have tried to improve this state of affairs, by making **extensive use of discounts to the distribution chain** in the last decade. In practice, this resulted in the following consequences:

- Profit shares on the sale of reimbursed generics were considerably altered: manufacturers accepted to cut their profit share
- Symmetrically, discounts resulted in a higher profit share for wholesalers and pharmacies, but
- The final price did not change: **discounts did not mitigate the financial burden over the NHS and/or patients**

Discounts were not disciplined by the law until 2009. The spreading of such a commercial practice provided decision-makers with further evidence that the reference pricing system was ineffective in generating the expected reduction in pharma spending.

3. Action taken over the last years

In 2009-2012, reforms were passed to address the above mentioned flaws.

Decision-makers focused their effort on three areas:

1. **Generics Price cut**, to ensure a proper pass-through of discounts granted by the industry on the final price reimbursed by the NHS. This happened in 2 steps:
   a. A temporary 12%[4] / 12.5%[5] **cut** to the price of all generics (**not** including off-patent originators), combined with a 1,4% discount imposed by the NHS on pharmacies[6], *"as a compensation for the extra discounts granted by pharmaceutical companies"* in the previous years
   b. **A reform of the reference price system**. In 2010[7], AIFA was given the mandate to set a ***"maximum reimbursement price"*** for every off-patent active ingredient/dose, basing on the assessment of prices in place in other EU Member States. AIFA did so in 2011, by updating its transparency list and bringing reference prices down on the basis of a comparison with average

[4] In April-December 2009 (Decree-Law n. 39/2009, art. 13)
[5] In July-December 2010 (Decree-Law n. 78/2010, art. 11)
[6] In April 2009-April 2010 (Decree-Law n. 39/2009, art. 13).
[7] Decree-Law n. 78/2010, art. 11.

prices in UK, Germany, France and Spain. Thus, the reference price for each off-patent active ingredient, which was originally set at the level of the lowest price negotiated by AIFA with the relevant manufacturer, was modified (i.e. reduced) unilaterally by AIFA: typically, generics manufacturers agreed to reduce the price of their products accordingly. Whenever the new reference price is lower than the lowest price available, the difference is paid by the patient.

2. **Limitation to discounting**. The practice of discounts to wholesalers and pharmacies was integrated in the regulatory framework on profit shares. The profit share reserved to the industry was reduced from 66.65% to 58.65%, while the legal shares reserved to wholesalers and pharmacies remained unchanged. The remaining 8% share was left free to be allocated to wholesalers and pharmacies out of pure market dynamics; please note that in this case as well, the reform applies to generics only, i.e. not to off-patent originators.

   Extra-Discounts over 8% of the drug's price were banned. This means, in practical terms, that manufacturers are not allowed to earn less than 58.65% of the drug's reimbursement price, while pharmacies are not allowed to earn a profit share higher than 38.35% on the sale of a generic product (the legal minimum share 30.35%, plus 8%). The Italian law now foresees that failure to respect the above mentioned rules on profit shares results in:

   - 20% price cut, to be implemented by AIFA by means of an administrative act (50% in case of reiterated extra-discount on the same product)
   - Obligation on the wholesaler to pay a sum to the NHS, equaling two times the excess profit earned
   - Obligation on the pharmacy to pay a fine, in the range of €500-3,000. In case of reiterated breach of the rules on profit shares, the pharmacy may be shut down for no less than 15 days.

3. **Medical Prescriptions**. A legislative provision was introduced, according to which a doctor who treats a patient for a disease for which two or more equivalent drugs are available, **shall indicate in the prescription the name of the active ingredient** contained by the drug, either alone or on top of the commercial name of the product. The doctor is still free to indicate that the prescribed product is *"non-substitutable"*, but he shall now add a *"brief motivation."* These provisions are obviously intended to discourage doctors from making extensive use of the "non-substitutable" clause and to encourage pharmacists to offer lower-priced generics instead of the more expensive off-patent originator. However, as far as retail equivalent drugs are concerned, rules on medical prescriptions are not going to generate any direct financial benefit for the NHS, because, as already said, any difference between the price of the product purchased by the patient in pharmacies and the reference price set by AIFA is paid by the patient, not by the NHS.

As shown by this brief account, the measures taken over the last years have resulted in lower reimbursement prices and a moderate increase of the market share of generics. However, these results have been achieved **through administrative measures, not through a more competitive environment**. The flaws in the reference pricing system and the distribution chain's remuneration system remained untouched. What lawmakers did was

basically to correct its most blatant distortive effects, but the pricing&reimbursement system for generics was never actually reformed.
Generics certainly gave a significant contribution to keeping the NHS retail drug expenditure under control. The relevant spending threshold, set by the national law for retail pharma expenditure as a percentage of the overall NHS budget, has not been exceeded for the last 4 years despite having been gradually cut from 13.3% to 11.35% of the NHS budget.
However, there is a widespread sense among decision-makers that patent expiry and generics market entry have so far allowed the NHS to save less than expected.

4. What's coming next?

In view of the forthcoming admission to reimbursement of costly, innovative medicines, in a context where the financial resources allocated by the Government are increasingly scarce[8], the pressure on the NHS to achieve savings from generic competition is expected to lead decision-makers to take renewed action in this field.

a) Therapeutic reference pricing

One major measure already agreed by the Government with Regional Administrations, and now in the process of being approved by the Parliament, is the extension in scope of the reference price system, which is set to evolve into a **therapeutic reference price system**. AIFA will have the mandate to renegotiate the price of reimbursed medicines with the relevant MA holders (within September 2015), by setting a reference price for each group of medicinal products that are "therapeutically comparable" and have the same intensity of treatment. This means that reference prices will apply to pharmaceuticals (either on-patent, off-patent or generics) containing different active ingredients. AIFA will have the power to negotiate *"selected reimbursement price cuts"* with manufacturers of drugs included in a given group. The final amount of savings to be achieved through the price renegotiations shall not be lower than the sum of the difference between the current reimbursement price of each of the *"comparable"* products included in a group and the lowest price available in that group, multiplied by the consumption volumes recorded in 2014. In case AIFA fails to reach an agreement with a MA holder, the Agency is entitled to either order the company (through an administrative act) to pay an equivalent sum to the NHS, through a pay-back mechanism, or to exclude the relevant products from reimbursement.
Once again, decision-makers have chosen to exploit generic entry as a negotiating tool to force originators' manufacturers into price renegotiation; in this case, this mechanism is going to impact on on-patent products as well as off-patent ones.

b) Retail tenders? Very unlikely

Still, no measure is being considered to achieve savings through enhanced competition. In theory, a possible way forward in this direction would be to introduce tenders (e.g. at the regional level) for retail distribution[9]. Assuming that a tender process is held for the procurement of every off-patent active ingredient, this would mean, in practical terms, to have more price competition and only one supplier for each active ingredient at the end of

[8] The NHS budget for 2015 was cut by €2.35bn in the course of the year, and the level of budget available for the coming years is, to date, unpredictable.

[9] Tenders are currently in place for the procurement of goods, including pharmaceuticals, for hospital use.

the process (i.e. whoever offers the lower price, most likely a generic producer). This would also imply **limited freedom of prescription for medical doctors** and **limited market power (and restricted profit margins) for pharmacies**[10], compared to the current state of affairs.

The sense we gathered is that **not only originators' MA holders, but also generic manufacturers would oppose the introduction of tenders**, as well as pharmacies. This is, in fact, what happened in 2013 when the PD (centre-left) group in the Healthcare Committee of the Senate proposed the introduction of regional tenders for the procurement of retail drugs: both AssoGenerici (generics business association) and FederFarma (association of pharmacies) lobbied against that legislative proposal, which was eventually repealed.

Other measures are being negotiated in a **stakeholder working group**, established within the Ministry of Economic Development. Participants to discussions include other Ministries (Minister of Health), AIFA, Regions, the industry (including AssoGenerici), representatives of the distribution chain (wholesalers, pharmacists), Unions. The aim of the working group is to formulate shared policy proposals in the field of pharmaceuticals, from both a healthcare policy and an industrial policy perspective, that can be then taken into account by the Government when drafting the **2016 Budget Law**[11].

c) Stakeholders' working group at the Ministry of Economic Development

Proposals being considered by the working group include:

- **Export provision**: under the proposed amendment to the Industrial Property Code, manufacturers of generic products based in Italy would be allowed to produce active ingredients (API) and medicinal products that are still covered by a supplementary protection certificate, with the sole purpose to either:
  a. Stock them, with a view to ensuring swift market entry in Italy or other EU Member States as soon as the certificate expires,
  or
  b. Export them towards non-EU countries where the relevant patent law already allows generics to be marketed.

  This proposed measure is obviously intended to attract investments in the production of generics in Italy. It could also encourage prompter generic entry in the domestic market.
- A **reform of pharma spending governance**. Here, shared policy proposals are still far from being identified. However, the reform of the governance should include the introduction of a fund, dedicated to finance the purchase of innovative medicines. Savings from generics and biosimilars entry would be automatically allocated to this fund. Such a mechanism, by making the link between generic entry and the purchase of innovative products explicit, could increase pressure on the NHS to enhance generic competition in the future. But it is not possible to formulate any prediction at this stage on how such pressure will impact on future legislation on generic drugs.

[10] Under a regional tender, regional contracting authorities would enter an agreement with the MA holder which offers the lowest price. Pharmacies (and wholesalers) would then be granted a fee for retail distribution, but would no longer be in the position to negotiate discounts with the industry.

[11] The 2016 draft Budget Law shall be introduced in Parliament within mid-October.

No further measures are expected in the field of discounts/other financial incentives granted by the industry to pharmacies.

This does not mean, however, that the issue of distorted incentives to the distribution chain is not recognised as a critical one by relevant decision-makers: but rather than focusing on punishing illegal practices, decision-makers have started a process towards a structural solution to this issue, by means of a **comprehensive reform of the remuneration** of wholesalers and pharmacies.

A 2012 provision[12] entrusted AIFA to agree on a new remuneration mechanism with the relevant business associations, basing on the *"fee for service"* principle: in other terms, pharmacies would no longer be remunerated according to a fixed percentage of the reimbursement price of each product, but they would be granted a **fixed fee for every product**, plus a percentage of the price (obviously lower than the current one). The aim of such a mechanism would be to **remove the current implicit incentive to purchase and offer higher-priced products.** A preliminary agreement was signed by AIFA and the relevant business associations in October 2012. It introduced a **fixed remuneration to pharmacies** (€2 for every product), **plus a premium fee (€0.10 for every product) for off-patent products** and a 3.30% share of the product's price. A similar mechanism would apply to wholesalers: a fixed remuneration would be granted for every product (€0.25 for products whose price does not exceed €25, €0.35 for products whose price exceeds €25), on top of a 0.55% share of the price.

However, the agreement was rejected by the Government, because the above-described mechanism would have implied an additional financial burden on the NHS for lower-priced pharmaceuticals. In turn, the associations of pharmacists rejected the Government's counter-proposals, which entailed lower fixed fees. Therefore, the reform process was blocked and the deadline for the new remuneration scheme to come into force, originally set on 1 January 2013, gradually **postponed until 1 January 2016.** The sense we got is that even though the issue is being considered by the stakeholders working group, an agreement is yet to come, and a further extension of the deadline cannot be ruled out.

[12] Decree-Law n. 95/2012, art. 15.