Ingelheim Pharmaceuticals (Pty) Ltd

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ATT: Competition Commission

5 March 2015

INQUIRY INTO PRIVATE HEALTHCARE

COMPETITION COMMISSION OF SOUTH AFRICA

Response by Ingelheim Pharmaceuticals (Pty) Ltd trading as Boehringer Ingelheim in relation to factual inaccuracies in submissions

5 March 2015

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1. Two allegations are levelled specifically against Boehringer Ingelheim ("BI"), and this response is limited to addressing the inaccuracies of those submissions, and the context within which price differentiation and the pricing regulations should be viewed.

2. In relation to our product pricing in Switzerland, viz. that Actilyse is 92% cheaper than the South African price is inaccurate. The Published price of Actilyse in Switzerland is as follows:
   - Ex-Manufacturers Price excluding VAT in Switzerland: Actilyse 50 mg 1 vial is 644.59 Euro
   - Ex-Manufacturers Price excluding VAT in South Africa: Actilyse 50mg 1 vial is R5,532.95. At the present Rand Euro exchange rate of

R13.10, the Euro price would be € 422.36.

In essence therefore the South African price is € 222.23 cheaper than Switzerland, in other words Switzerland is 52.6% more expensive.

3. It must be noted that the SEP regulations does not allow for any private sector pricing flexibility as is the case in other countries' private sectors.

4. In any event, benchmarking of prices across countries is complex and fraught with difficulty (e.g. as to which markets are being compared). Even the local legislative mandate for international benchmark pricing acknowledge that country-specific factors must be considered when deciding on an appropriate methodology. Furthermore, it would be easy for each stakeholder to pick a country, and for the whole pharmaceutical sector to be subjected to cherry-picked price comparisons, instead of a rational, well-designed and fair system (if indeed that would be necessary, given the fact medicines is not a cost driver, and all medicines increases granted, and those taken, have been well below CPI since 2005.

5. In terms of the allegations made by Transpharm that BI exploits the logistics fee system, BI regards it as speculative. BI have consistently acted within the requisite legal framework, and, to date, logistics fees are subject to market forces between manufacturers and logistic service providers. Due to these variations, the published logistics fee is a weighted average between several distributors and wholesalers. Variations in logistics fees are negotiated with various suppliers based on their Service Quality and product offering designed to improve stock management, stock-outs, write-offs due to Expiry dates and minimizing the effect of excess Product being tied up in the distribution Channel.

6. It must be noted that an aspect to be investigated by the Panel, namely managed care, might bear responsibility for cost increases, in particular

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increased specialist and hospitalisation costs. This is because the managed care mechanisms, and in particular pharmaceutical benefit management, are run as a stand-alone or silo activity. Its sole aim, and, so we understand, incentives, is to keep costs as low as possible, irrespective of patient outcomes and downstream costs. There are, to the best of our knowledge, no appetite to measure what happens with patients of whom motivations for care have been declined, and how the hospitalization and other costs associated with that patient, looks.

7. There is also a fundamental conflict of interests between Administrators and Medical Schemes, which also drives healthcare expenditure. Administrators offer costly administration models to trustees, without such trustees being in a position to assess the offerings, or its impact on members. The main driver of these are cost-savings, in which, as one administrator submission acknowledge, they profit-share.

8. There is also competition law concerns where administrators establish their own wholly owned Designated service providers, like Postal Pharmacies and wholesalers, and unless suppliers “play ball” they face exclusion from significant portions of the market. The cost of care is increased through the payment of increased logistics fees and data fees to these entities.

9. Undue influence is also placed on healthcare professionals. In return for compliance with specific financial limits (e.g. no prescription above a certain Rand value) or adherence to certain protocols, professionals received higher remuneration. This done without evaluating the appropriateness of such care being limited on patients.

10. The non-adherence to reimbursement regulations of PMB- and non-PMB conditions by managed healthcare companies results in patients being out

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of funds during the year. These patients are unable to all approach the Council for Medical Schemes, and even where one patient wins a case, that has no impact on the scheme's behaviour or other patients in his/her shoes. This means that every single patient at that scheme must use formalized complaints procedures to protect his/her rights.

11. Many complaints relating to PMBs could be resolved quite successfully if the PMBs had been subject to the reviews as envisaged in the law. Furthermore, ensuring that all algorithms are placed, as the law requires, on the basis of evidence-based medicine, would assist patients in ensuring adequate and appropriate care. Inadequate and inappropriate care are expensive care.

12. The restrictive nature of the Single Exit Price legislation (i.e. there is no room for, for example, good risk-sharing models) creates a perception that prices in South Africa's private sector. It also encompasses a massive administrative bureaucracy embarked upon each year, at great cost to companies and the Department of Health.

13. We believe that the focus on Pharmaceutical prices by the Administrators of Medical Schemes is misplaced. Valuable resources are spent on sophisticated system designed to keep costs at a minimum, with little regard with an integrated view on patient outcomes.

Regards,

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