An Independent Review of OFT's evaluation of its 2001 abuse of dominance case against Napp Pharmaceuticals

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1. To avoid any confusion on terminology, I distinguish below between the original **intervention** (by OFT in 2001); the **evaluation** (the main document to which this is annexed) and this, my **review**.

2. I saw my main role in this review to be an independent assessor of the evaluation. However, I have already provided various comments on earlier working drafts of this evaluation, in which I have commented on: (i) the broad methodology employed, (ii) the detailed analysis, and (iii) the conclusions drawn. Many of these earlier comments have now been incorporated into the evaluation, and now I only have three remaining issues to raise.

The purpose and methodology of evaluation

3. I believe that the main objectives of evaluations such as this are: (i) to provide an ex-post estimate of the savings resulting from the intervention, and (ii) to assess the quality of analysis and assumptions employed in that intervention.

4. As a matter of general good practice and clarity, evaluations should emphasise and explain up front:

   - What were the precise objectives of the original intervention.
   - The analytical methods (and, where appropriate, the theory) which will be used in the evaluation to assess success in achieving those objectives.
   - The counterfactual(s)? How one assesses what **would** have happened without the intervention.

5. The final draft of this particular evaluation now goes some way to achieving this. However, I would still have liked a separate section (to appear fairly early on in the paper), devoted to a discussion of the choice of counterfactual. This would include (i) a standard general explanation of the central role of the counterfactual in any evaluation, (ii) a discussion of any potential problems in identifying a plausible counterfactual in the particular case (in this instance, one such problem is that, even absent the

intervention, there would have been some changes in the market because of the increased tendency to generic prescribing); and (iii) a discussion of the practicability of various different methods for populating the counterfactual (in this instance, an explanation that a difference-in-differences approach employing international comparisons was infeasible for data availability reasons.) The bottom line is that, as always, any particular counterfactual inevitably entails assumptions, and these need to be discussed and evaluated.

A central assumption

6. In the chosen counterfactual, it is not assumed that there would have been no changes in the market absent the intervention. Rather, between 2004 and 2010, the proportion of SRM prescriptions that was generic rose from 30% to 50%. It is assumed that this would have occurred anyway, and that the ensuing savings to the NHS from this source should not be attributed to the intervention. Instead, by implication and on the advice of the Department of Health (DoH), it is attributed to the DoH, who explained to the OFT that it 'has proactively sought to influence the way in which GPs prescribe for a number of years; particularly, they have encouraged generic prescribing (para 1.16.)

7. Ideally, I think this issue would have merited closer examination. As it stands, this assumption is based merely on the advice of the DoH, without any supporting evidence. Yet, it is surely possible that the intervention might have contributed to this increased generic prescription – not only because it 'shone a light' on the exclusionary pricing of NAPP, but also because NAPP's hospital prices subsequently rose as a result of the intervention, and this may have encouraged doctors to prescribe generically.

8. While I accept that this assumption is in the spirit of making a **conservative** evaluation of the effects of the intervention, it should not necessarily be accepted as fact. Some more general evidence is surely needed on the extent and efficacy of the DoH's exhortations to prescribers – not least because

procurement in the NHS remains a generally open issue (see below).

Deterrence

9. As is often the case, a key issue is the extent of any deterrent effect – if large, then the intervention is certainly justified. This is briefly acknowledged, and we are told that some stakeholders believe that there might have been a large deterrent effect. But, without more discussion, information and referencing, this is difficult to assess. Again, as a matter of general practice, and given the current state of our ignorance on the magnitude of the deterrent effect competition policy in general, specific case studies such as this are potentially an opportunity to drill down more deeply into how deterrence might work, and quantitatively important it is.

10. In summary, in my opinion, given the time and data constraints faced by the authors, this evaluation is commendable in many respects. I particularly like the passages on the role of procurement, which I believe is crucial. Data collection has been extensive.

11. The bottom line estimate of impact itself seems sensible and plausible. It raises higher level issues such as 'does this magnitude of saving justify all the costs incurred in the intervention itself?' On the other hand, the estimates are deliberately conservative, and I would expect that, with less conservatism, the estimated impact could be much larger.

Other conclusions

12. I would also like to use this opportunity to also offer my opinion on the original intervention, and some broader conclusions on some lessons to be learned for both future evaluations and interventions.

    - It is worth contemplating whether the eventual fine of only £2.2 million was appropriate if the abuse was costing the NHS **at least £1.5 million per annum**.

- Even if the intervention might be judged as a success in its own terms, coming to the current state of this market as an outsider, I would question whether it can now be 'signed off' as a market which is now 'competitive'? At best, near monopoly has been replaced by 'near duopoly'. While just two firms can sometimes be associated with intensive competition, it remains the case that the price charged to the Community Sector is much higher than that charged to hospitals. Why? It also remains the case that the dominant firm is able to charge a higher price than its rivals in both sectors. Given that the product is apparently homogeneous, what is the explanation for this?

- The report correctly shines a light on the significance of procurement practices in the NHS. If I may exceed my brief, I wonder whether OFT is considering further, more general, work on this?[1]

[1] See the conclusions of the recent NAO report: "The procurement of consumables by NHS acute and Foundation trusts" (2011).