FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE:
PEER-TO-PEER LEARNING WORKSHOP
FINDING SOLUTIONS TO COMMON CHALLENGES
FEBRUARY 15-19, 2016
ACCRA, GHANA

Day II, Session V.
Financial Protection and Improved Access to Health Care:
A Spotlight on Pharmaceuticals

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February 16, 2016
Learning Objectives

- **Coverage of Medicines.** Understand how countries have selected drugs to be covered under their medicines benefit packages
- **Management of Pharmaceuticals.** Learn how countries have successfully managed pharmaceuticals- a driver of UHC program expenditures
- **Threats to Access.** Understand the threats to achieving access to medicines benefits
- **Design of Medicines Benefits.** Explore best practices for designing medicines benefits
Why Focus on Medicines?

• Medicines save lives and improve health, but they can be costly to health systems, and can impoverish individuals.a
• Between 20% and 60% of health expenditures in LMICs goes to medicinesb
• In low- to middle-income countries (LMICs), up to 80% to 90% of medicines are purchased out-of-pocket as opposed to being paid for by health insurance schemes
• Problems with access—average availability of selected generic medicines in LMICs:
  • Public sector less than 42%
  • Private sector almost 72

a Managing Access to Medicines and Health Technologies, MSH
b WHO 2010
Medicines Account for 3 out of 10 Sources of Inefficiencies in Health Systems

Sources of Inefficiencies

- Underuse of generic medicines and overuse of brand medicines
- Use of substandard and counterfeit medicines
- Inappropriate or ineffective use.
- Overuse or supply of equipment, investigations, and procedures.
- Inappropriate or costly staff mix, unmotivated workers

Inefficiencies account for 30%-40% of all health expenditures

Source: WHO-2010
Access to Essential Medicines and UHC

1. Rational selection
2. Affordable prices
3. Sustainable financing
4. Reliable health and supply systems

a WHO
Universal Health Coverage—Benefit Package Definitions

A medicines benefit program is a component of the UHC Benefit Package that covers some or all medicines prescribed and dispensed to beneficiaries. It is drawn after the minimum or optimal health benefit package is defined.¹

Medicine Benefits Management is the set of rules, controls, and enforcement tools that define how eligible beneficiaries can obtain payment for prescription medicines under a public budget or funded health care program.²

¹ Velasco-Garrido et al, 2006
² MSH 2014
Medicines Benefits Design Key Considerations

Static components (although regularly updated)

Dynamic processes

- Reimbursement list: which medicines are covered
- Patient eligibility (sub-population, condition, age, gender, etc.)
- Set information systems to capture data
- Reimbursement rates, prices, discounts, budget caps, etc.
- Patient co-payment: exemptions, limits
- Compensation for distributor, pharmacist; substitution rights
- Assessment and decision making on inclusion of new technologies
- Case management for high-cost patients
- Negotiation strategies for deals with industry

Static components (although regularly updated)
Coverage and Medicines Cost in Ghana

Source: Roberts and Reich, 2011, data from Mensah and Acheampong 2009
How the Insurance System Interacts with the Pharmaceutical System
Addressing cost through appropriate Medicines Supply Management

Selection

- Burden of disease
- Effectiveness
- Safety and quality
- Appropriateness

Procurement

Procurement strategy must appreciate the risk of stock-outs and mitigate against this risk

Costing and Financing

- Estimate likely medicine consumption over the period.
- Explore price volume arrangements with suppliers in the face of volume uncertainty
- Manage the risk of currency fluctuation and changes in the input costs that may affect suppliers
How Health Technology Assessment is Used for Selection of Medicines

Fragile states
HTA Focus: Essential services and emergency kits

Low income countries with low coverage
HTA Focus: Primary health care packages

Middle income countries with low coverage
HTA Focus: Guaranteed packages of care

Strong health systems
HTA Focus: Marginal analysis for additions to packages

Continuum of HTA Activities

Health Systems
Pricing and Reimbursement of Dispensers

**Approaches**
- Internal or External Reference Pricing
- Single Exit Pricing
- Traditional Margin or Mark-Up Pricing

**Mechanisms**
- Fee for Services
  Risk of over-servicing, no incentive not to dispense medicine, rewards process rather than outcomes
- Case-Based
  Less incentive to over-service, no incentive not to dispense, some opportunity to reward outcomes.
- Capitation
  No incentive to over-service
How Computers can Improve Efficiency of Claims Management for Medicines

Member

Inter-operable Software

Pharmacy/Dispensing Doctor

Switch

Claim

Member

PBM

Payment instruction

Cash

Standards required

Reporting

- Utilisation management
- Clinical management
- Pricing management
- Reference pricing
- Formulary
- Benefit management

Funder—Private insurance or government

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## Managing cost by Analyzing Routine Pharmaceutical Monitoring Indicators

| Performance Measures | • Cost  
|                      | • Utilization  
|                      | • Quality of care  
|                      | • Adherence  
| Cost                | • Avg. cost per member per month (PMPM)  
|                     | • Avg. net cost per dispensing per month  
| Utilization         | • Avg. no. of dispensings PMPM  
|                     | • Total no. of dispensings per therapeutic class  
| Quality of Care     | • % of patients with ARI receiving antibiotics  
|                     | • % of patients discharged from hospital with acute myocardial infarction receiving beta blockers  
| Fraud, Abuse        | • No. of prescriptions of opioids per provider  
|                     | • No. of dispensings per member  |
Achieving UHC and Access to Medicines Requires Balancing Competing Objectives

Ensure Availability of Quality Products both generic and novel products

Improve Equitable Access particularly for the poor and near-poor

Encourage Appropriate Use of needed, safe, and effective medicines taken properly

Keep Costs Affordable for households and health system

Wagner et al, BMC Health Services Research, 2014
Examples of Active Interventions

**South African and Namibia**—Pricing introduced at regulator level. Price = single exit price + logistics fee + dispensing fee (dispensing fee varies with cost of medicine).

**China**—Reimbursed patients only for medicines listed on the formulary, capped hospital revenue from medicine sales, and raised provider service fees.

**South Korea**—Separated prescribing and dispensing services.
Common Threats to Achieving Access to Medicines Benefits

- Inability to manage competing political and policy goals
- Inappropriate benefit design
- Inefficient use of resources.
- Absence of efficient data systems and human capacity to generate information.

- Failure to routinely monitor benefit policy effects on access, use, health
- Failure to adapt technology to assist in adjudication of medicines claims
- Failure to adapt policies to changing system context
- Failure to communicate with public, patients, providers
- Failure to negotiate with industry, and suppliers
Best Practices in Designing Medicines

Benefits

- “Smart” therapeutics—inpatient and outpatient medicines coverage of essential medicines, medicines on clinical guidelines
- Increased efficiency—appropriate generic/therapeutic substitution, efficient procurement and distribution systems
- Introduction of disease management program for chronic disease and coverage of high cost medicines
- Reliable partners—accredited health providers and dispensing outlets, competitive sourcing from quality assured suppliers
- Performance management—robust management systems for inventory management, claims management and drug use review, fraud detection
- Patient, provider, public education—on UHC, medicines, value
- Culture of adaption—routine monitoring, evaluating, learning
- Revise benefits -- Make appropriate decisions using a carve-in or carve-out approach
THANK YOU