WHO webinar series on country pharmaceutical pricing policies

Sharing prescription costs
Country policies on patient co-payments for medicines and their implications

This webinar will start shortly

Use Q&A window to post questions (not “Chat”)
- “Q&A” to send your questions to the panellists
- “Chat” ONLY when sharing comments or documents with all participants

Please keep all comments respectful and constructive

The session is recorded for viewing on demand
- Slides and recording will be shared after the session
Today’s Panelists

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The association of prescription drug insurance and cost-sharing with drug use, health services use, and health

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WHO webinar series
on country pharmaceutical pricing policies
November 22, 2022
A systematic umbrella review of the association of prescription drug insurance and cost-sharing with drug use, health services use, and health

With Tooba Fatima, Sophiya Garasia, and Kimia Khoee – McMaster University
Carley Hay – Ontario Ministry of Health

The associations of prescription drug insurance and cost-sharing with drug use, health services use, and health – a systematic review of Canadian studies

With Erica Stone, Riya Trivedi, Sophiya Garasia, Kimia Khoee – McMaster University
Alexia Olaizola – Stanford University
Carley Hay – Ontario Ministry of Health

Funding: Canadian Institutes of Health Research

Competing interests: none

>>> Implications for Canadian pharmacare <<<
Canadian health care systems

The Canada Health Act legislates universal coverage for medically necessary physician and hospital services (including prescription drugs administered in hospitals) without any cost-sharing.

Other services viewed by many as equally medically necessary, such as prescription drugs are excluded. Financing of these services largely relies on a patchwork of public and private supplementary health insurance.

- Québec: public/private universal pharmacare
- British Columbia: income-based public pharmacare
- Ontario: age-based public pharmacare (Ontario Drug Benefit \([\geq 65 \text{ years}, \text{OHIP+/-} [< 25 \text{ years}])\)
- About 2/3 of Canadians report private drug insurance (most often employer-sponsored)
Research questions

Intervention:
— Insurance, cost-sharing (copayments, user charges, deductibles, ...), delisting, ...

The association between prescription drug coverage (primary and supplementary), as well as varying types and levels of cost-sharing, and:

1. the **utilization of prescription drugs** (i.e., own-price effects on drug use);
2. **population health outcomes** (i.e., own-price effects on health outcomes);
3. the **utilization of healthcare services** (i.e., cross-price effects on the use of healthcare services such as physician and inpatient services);
4. The degree to which the associations identified in 1–3 above differed across levels of socioeconomic status (SES, e.g., income, education), populations of differing health status such as the chronically ill, age, and sex
Methods – protocol, search

1. A review protocol was prepared in advance and registered with PROSPERO.

2. Search:
   
   2.1. Five electronic bibliographic databases (MEDLINE, Embase, Scopus, EconLit, and Health Systems Evidence);
   
   2.2. Grey literature via the New York Academy of Medicine Grey Literature Report, Open Grey, Google, and Google Scholar;
   
   2.3. ‘Hand-searched’ eight specialty journals (BMC Health Services Research, Health Affairs, Healthcare Policy, Health Economics, Journal of Health Economics, Health Economics, Policy and Law, Health Services Research, and Medical Care Research and Review) and two working paper repositories (RePEc, Research Papers in Economics and the National Bureau of Economic Research working paper series);
   
   2.4. Examined references of included reviews and of reviews that cited key studies using Web of Science and Google Scholar;
   
   2.5. The database search was last updated on September 15, 2020;

3. At least two reviewers, using distillerSR, screened titles and abstracts of citations to determine relevance, then full text if relevance was unclear.
Methods – inclusion, exclusion criteria

- Types of studies: all reviews (e.g., narrative, rapid, scoping, systematic, meta-analysis, meta-regression);
- Types of interventions:
  1. Insurance: all studies that examined the expansion of prescription drug insurance, irrespective of the insurance provider (e.g., government, employers, professional associations) and studies that examined partial or full-delisting of prescription drugs from insurance coverage;
  2. Cost-sharing: all studies that examined any form of direct patient payment for prescription drugs including, but not limited to, fixed copayment, coinsurance, ceilings, and caps.
- Types of outcomes: all reviews that included as an outcome any of drug utilization, health services utilization, or health outcomes;
- Time period: all reviews published since January 2000;
- Languages: only studies written in English and French.
- Excluded reviews that focused solely on low- and middle-income countries.
Methods – quality assessment, data extraction

- Assessment of Multiple Systematic Reviews (AMSTAR) tool
- Data extraction:
  - citation
  - type of review
  - population investigated
  - research question
  - outcomes studied
  - whether there was an ‘a priori design’ and duplicate study selection and data extraction,
  - comprehensiveness of the search including if grey literature was searched
  - year/month of last search
  - whether the keywords/search strategy were reported
  - total number of studies included; total number of studies included that focused on drug insurance and/or cost-sharing
  - whether a list of included and excluded studies was provided
  - whether the characteristics of the included studies were provided
  - whether the scientific quality of the included studies was assessed documented, and used appropriately in formulating conclusions
  - whether the methods used to combine the findings of studies were appropriate
  - whether the likelihood of publication bias was assessed
  - whether funding and competing interests were clearly reported
  - key results for each of drug use, healthcare services utilization, and health, and reviews’ conclusion (as stated by the authors)
Results

Of 38 reviews:

- 16 focused on the general population of which,
  - 8 commented on subgroups (e.g., seniors, the poor, and chronically ill)
  - 9 focused on seniors (most often on the US Medicare population)
- 11 focused on the poor and/or chronically ill
- 2 examined drug insurance and cost-sharing among Canadians
- 1 review examined publicly insured populations

Most included reviews were narrative reviews
- 6 meta-analyses (quantitatively pooled estimates)
- 1 meta-regression (attempt to explain heterogeneity in terms of study-level characteristics)
Results – drug utilization

37 reviews:

• Lack of insurance and higher cost-sharing were associated with lower drug use.
  - Own-price $\eta \approx -0.1$ to $-0.6$

• Restriction to reimbursement was associated with decreased drug use, either immediately after policy change or long-term.

• Lack of drug insurance and higher cost-sharing were associated with lower medication adherence and a higher risk of cost-related nonadherence.

• With increased cost-sharing, both essential and non-essential drug use was decreased
  - mixed evidence the decrease was larger for nonessential drugs

• Among seniors, the poor and chronically ill, higher cost-sharing was associated with lower drug use.
Results – health services use

18 reviews:

• Limiting (expanding) drug insurance was associated with an increase (decrease) in the use of health services (emergency department visits, emergency mental health service, hospitalizations, psychiatric hospitalizations, nursing home admissions).

• Higher levels of prescription drug cost-sharing were associated with lower use of health services (outpatient visits, preventative services, emergency department visits, emergency mental health services, hospitalizations, nursing home admissions).

• Among seniors, the poor, chronically ill, and children, lower cost-sharing was associated with higher health services use.
21 reviews:

No consistent evidence of an association between drug insurance or cost-sharing and health

• Evidence on the association between prescription drug cost-sharing and health suggested that higher drug cost-sharing generally lowered health status [3 reviews];

• Evidence on the association between prescription drug cost-sharing and health was limited and/or unclear [8 reviews];

• Evidence on the association between prescription drug insurance and health was limited, but generally indicated a positive association [1 review];

• Some evidence that higher cost-sharing was associated with poorer health among the poor and chronically ill [4 reviews].

• Among seniors, evidence on the association between prescription drug cost-sharing and health was limited and/or unclear [1 review].
Limitations

1. Thirty-eight reviews but considerable overlap between the studies that were included in each review;

2. Confident about the direction of the associations, but difficulties commenting on the precise magnitude of associations;

3. Did not examine reviews that focused specifically on an alternative cost-sharing design called “value-based cost-sharing” or more generally “value-based insurance design.”
   – The key feature of value-based insurance design is to link the amount of cost-sharing across services with the documented effectiveness and cost-effectiveness of a service, drug or device.
Take-home messages

1. Consistent evidence that having drug insurance and lower cost-sharing among the insured were associated with increased drug use while the lack or loss of drug insurance and higher drug cost-sharing were associated with decreased drug use.

   1.1. Consistent evidence that the poor, the chronically ill, seniors and children were similarly responsive to changes in insurance and cost-sharing.

2. Drug insurance and lower drug cost-sharing were associated with lower healthcare services utilization including emergency room visits, hospitalizations, and outpatient visits.

3. No consistent evidence of an association between drug insurance or cost-sharing and health.

4. No evidence that the association between drug insurance or cost-sharing and drug use, health services use or health differed by socioeconomic status, health status, age or sex.
A systematic umbrella review of the association of prescription drug insurance and cost-sharing with drug use, health services use, and health

G. Emmanuel Guindon, Tooba Fatima, Sophiya Garasia, and Kimia Khoei

Emmanuel Guindon
emmanuel.guindon@mcmaster.ca

Umbrella review can be found at:
https://doi.org/10.1186/s12913-022-07554-w
Effects of copayment increase in Finland: a case study on medicines for type II diabetes (T2D)

Katri Aaltonen, PhD(Pharm), University of Turku, INVEST research centre, sociology
Social Insurance Institution of Finland (on leave)

WHO webinar series on country pharmaceutical pricing policies 22.11.2022
Fig. 4.5 | Co-payments for publicly subsidized outpatient medicines in countries in the WHO European Region, 2017

Finland: 100%: all residents are universally covered for prescription costs through National Health Insurance (NHI)

Finland: NHI reimbursable medicines account for 91% of total outpatient prescription medicine costs (2019)

Finland: NHI paid 71% of the costs of reimbursable prescription medicines (2019)


Sources of Finnish data: Statistics by Finnish institute for Health and Welfare & Social Insurance Institution of Finland
Reimbursements for medicine expenses 2022

You have to pay the first €50 of covered medicines yourself (initial deductible)

Reimbursement is available after meeting the initial deductible

Maximum annual limit on medicine expenses in 2022

After you reach the maximum, you are reimbursed by Kela for any additional medicine expenses you have during the rest of the year

Basic rate of reimbursement: 40%

Lower special rate of reimbursement: 65%

Higher special rate of reimbursement: 100%

You pay €2,50 for each purchase medicine
Disease-based reimbursements

- **Basic reimbursement (co-payment 60% of retail price)** e.g. allergy medicines, antibiotics, migraine, pain
- **Lower special reimbursement (co-payment 35% of retail price)** e.g., Cardiovascular diseases, asthma, rheumatic diseases, IBD
- **Higher special reimbursement (co-payment €4.50 fixed fee)** e.g., Endocrine diseases, cancer
Reimbursements for medicine expenses 2022

2017 reform: Type 2 diabetes medicines (ATC class A10B) shifted higher to lower special reimbursement category

Disease based reimbursements

- **Basic reimbursement (co-payment 60% of retail price)** e.g. allergy medicines, antibiotics, migraine, pain

- **Lower special reimbursement (co-payment 35% of retail price)** e.g., Cardiovascular diseases, asthma, rheumatic diseases, IBD

- **Higher special reimbursement (co-payment €4.50 fixed fee)** e.g., Endocrine diseases, cancers
Reform aims

- Create savings and curb down cost growth
- Shift type 2 diabetes medicines in the same reimbursement category with medicines for cardiovascular diseases
Reimbursable type 2 diabetes medicines (A10B), costs and recipients 2008-2019

Therapeutic shifts in the use of type 2 diabetes medicines (A10B), 2003-2015

Soppi et al, [https://doi.org/10.1016/j.healthpol.2018.09.008](https://doi.org/10.1016/j.healthpol.2018.09.008); [https://tutkimusblogi.kela.fi/arkisto/4702](https://tutkimusblogi.kela.fi/arkisto/4702)

Kela – The Social Insurance Institution of Finland. Statistical registers
Impact on the consumption of type 2 antidiabetics and insulins

→ Co-payment increase in type 2 antidiabetics was associated with decreased consumption.
→ No simultaneous increase in insulin consumption was detected.

Rättö et al. 2021 https://doi.org/10.1016/j.healthpol.2021.05.007.
Impact on glycaemic control (HbA1c – glycated haemoglobin)

Among T2D patients from one region:
→ An estimated increase of 0.81 (95% CI, 0.04–1.58) mmol/mol in average HbA1c levels at the time of the policy change
→ Strongest effects among patients who used only other diabetes medications than insulin or metformin (3.56 mmol/mol, 95% CI 2.50–4.62).
→ Yearly consumption of diabetes medications decreased slightly.
Impact on patient-reported outcomes

→ Increase of co-payment decreased patient-reported satisfaction to diabetes care.
→ It increased the risk to experience financial difficulties to purchase diabetes medications.
→ Also changes in medication use were observed during the follow-up.

Lavikainen et al. 2020  https://doi.org/10.1016/j.healthpol.2020.08.001
Impact on use of last-resort means-tested social assistance

- After the reform, the share of social assistance recipients increased more among type 2 diabetes patients than among the control group not affected by the reform (patients with chronic hypertension or chronic coronary artery disease CAD).
- The effect was even more pronounced among under 65-year-old patients.
- Results demonstrate spill-over effects, i.e., need of social assistance increased.
Financial difficulties in buying prescription medicines

→ Diabetes patients had higher risk of financial burden than other prescription medicine users already before the reform in 2015
→ In 2017, the gap between diabetes patients and other users was 6 percentage points larger than in 2015
→ Similar increases were not observed for other users of prescription medicines with or without long-term illnesses

Opinions on the fairness of reimbursement policies

¬ Individuals with diabetes or another chronic illness were more skeptical about the fairness of the reimbursement system than other respondents
¬ Over time, positive evaluations decreased alongside an increase in negative views
¬ These changes appear to have affected different respondent groups in a relatively similar way
Summary of evidence

• **Longitudinal studies:**
  • Decrease in consumption of T2D medicines (but no increase in consumption of insulins)
  • Worsening glycaemic control
  • Increases in financial difficulties and use of last-resort social assistance
  • Decrease in satisfaction to care

• **Pooled cross-section study:**
  • Increase in financial difficulties in buying medicines among diabetes patients
  • Increasing overall scepticism towards fairness and justness of reimbursement system
Discussion

- Co-payment increases can have negative implications in terms of clinical outcomes, patient reported outcomes, need for other social benefits, and legitimacy.

- Cost containment without increasing access barriers could be achieved by strengthening policies to promote responsible use of medicines through better prescribing, dispensing and supply-side policies.
Original research articles

IMPACT OF USER FEES ON UPTAKE OF HIV SERVICES AND ADHERENCE TO HIV TREATMENT

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Dr. Oladipupo O. Fisher
Public Health Physician
Lagos State AIDS Control Agency
HIV in Nigeria

- Most populous African country (Over 200 million)
- Estimated PLWHA 2.0 million
- 1.7 million currently on treatment
- 4th largest global epidemic
Trend Analysis: Donor Support in Nigeria

- PEPFAR funding to Nigeria peaked in 2011, and has decreased by >$100 million USD since.
- Expectation that the Government of Nigeria would increase financial commitment from 7 to 50%
Trend Analysis:
Global AIDS-Related Deaths

Source: UNAIDS 2019 estimates.
Funding the Global HIV Response

• Success of the global AIDS response has relied heavily on financial investments from multilateral institutions including from the US President’s Emergency Plan for AIDS Relief (PEPFAR).

• Data from the early period of ART scale-up showed that user fees were associated with worse clinical outcomes, and ultimately led to widespread availability of free HIV care in many resource-limited settings.

• Cutbacks in PEPFAR funding has left recipient country governments with greater responsibility to fund their national HIV programs.
Case Study

- Nigerian Institute of Medical Research, PEPFAR-supported HIV Clinic in Lagos, Nigeria
- 7,351 patients enrolled in care
- Fees instituted October 2014
- Children & pregnant women exempted

<table>
<thead>
<tr>
<th>FEE CATEGORIES</th>
<th>YEARLY COST in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Test</td>
<td>$3</td>
</tr>
<tr>
<td>New Patient Consultation</td>
<td>$25</td>
</tr>
<tr>
<td>New Patient Labs</td>
<td>$45</td>
</tr>
<tr>
<td>Follow-up Consultation Fee</td>
<td>$20</td>
</tr>
<tr>
<td>ART</td>
<td>$72</td>
</tr>
<tr>
<td>Routine Labs</td>
<td>$28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$190</strong>*</td>
</tr>
</tbody>
</table>

*82% of Nigerians live on less than 2 USD per day

Ahonkhai et al, PLoS One 2020
Methods

Enrolled Oct 2012 - Sept 2013

Followed for 1 Year
N=1970

Followed for 1 Year
N= 787

Outcomes

Clinic Attendance
ART Initiation
Medication Adherence

Ahonkhai et al, PLoS One 2020
Impact of User Fees on Enrollment & ART Prescriptions

65% decline in new patient enrollment

Ahonkhai et al, PLoS
Impact of User Fees on Enrollment & ART Prescriptions

65% decline in new patient enrollment

75% decline in monthly ART prescriptions

Ahonkhai et al, PLoS
### More High Earners in the User-Fee Cohort

<table>
<thead>
<tr>
<th></th>
<th>PRE-User Fee N=1970</th>
<th>POST-User Fee N=787</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1261 (64%)</td>
<td>492 (63%)</td>
<td>0.446</td>
</tr>
<tr>
<td><strong>Age (mean yrs)</strong></td>
<td>36.4</td>
<td>37.0</td>
<td>0.150</td>
</tr>
<tr>
<td><strong>High Earner</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed and/or tertiary education</td>
<td>474 (24%)</td>
<td>252 (32%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Baseline CD4/uL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median, [IQR]</td>
<td>220, [88-412]</td>
<td>222, [84-387]</td>
<td>0.239</td>
</tr>
</tbody>
</table>

Ahonkhai et al, PLoS One 2020
User Fees Associated With:

- 65% decline in patient enrollment
- 75% decline in no of ART doses dispensed
- 45% decreased risk of missed visits
- 23% decreased risk of loss to follow up
- 28% decreased odds of optimal medication adherence

Ahonkhai et al, PLoS
Change in Clinical Service Provision Across 30 Comprehensive HIV Treatment Centers

<table>
<thead>
<tr>
<th>CLINIC SERVICES PROVIDED</th>
<th>BEFORE Policy Change</th>
<th>AFTER Policy Change</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Line ART</td>
<td>100%</td>
<td>100%</td>
<td>=</td>
</tr>
<tr>
<td>Second Line ART</td>
<td>100%</td>
<td>100%</td>
<td>=</td>
</tr>
<tr>
<td>CD4</td>
<td>100%</td>
<td>100%</td>
<td>=</td>
</tr>
<tr>
<td>Viral Load</td>
<td>92%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>HGB/ALT/Cr</td>
<td>100%</td>
<td>0%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Staff Stipend</td>
<td>72%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Staff Hiring</td>
<td>80%</td>
<td>20%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Patient tracking</td>
<td>100%</td>
<td>44%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Outreach Services</td>
<td>84%</td>
<td>16%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Staff Training</td>
<td>96%</td>
<td>20%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Generator Fuel</td>
<td>100%</td>
<td>28%</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>IT Support</td>
<td>96%</td>
<td>40%</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>
Coping Strategies Implemented

- User Fees [Median $40USD]
  - 96% of APIN sites
  - Patients charged for: Lab monitoring tests (96%), hospital registration (32%), and clinical consultations (20%)
- Donations
- Volunteers
- Creative Task Shifting
  - Counselors used for adherence checks, medication pick-up, and toxicity screening
## Conclusions

<table>
<thead>
<tr>
<th>NEGATIVE</th>
<th>POSITIVE</th>
</tr>
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<tbody>
<tr>
<td>Decreased enrollment</td>
<td>Increased clinic attendance</td>
</tr>
<tr>
<td>Decreased ART coverage</td>
<td>Decreased loss to follow-up</td>
</tr>
<tr>
<td>Worse ART adherence</td>
<td></td>
</tr>
<tr>
<td>Marginalization of poorest patients</td>
<td></td>
</tr>
</tbody>
</table>

Ahonkhai et al, PLoS One 2020
Policy Implications

Continuing to charge clinic-based user fees in this manner may
- decrease access to ART
- undo progress towards achieving UNAIDS 95-95-95 goals
- alienate the poorest patients from treatment
- have negative downstream effects on HIV transmission
Sustainability path

A. Integration of HIV services into the State Health insurance:
   I. Immediate plan
   II. Short-term plan
   III. Long-term plan

B. Improve domestic resource mobilization for HIV/AIDS (a proportion of the 1% State Consolidated revenue for health to be appropriated to HIV response)

C. Policy on exemption for the indigent clients

D. The Country Inaugurated the National HIV Trust fund in February, 2022, to mobilize $150 million, by the private sector (to address the funding gap).
## Acknowledgements

<table>
<thead>
<tr>
<th>Vanderbilt University Medical Center</th>
<th>Massachusetts General Hospital</th>
</tr>
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<tbody>
<tr>
<td>Muktar Aliyu</td>
<td>Ken Freedberg</td>
</tr>
<tr>
<td>Leslie Pierce</td>
<td>Elena Losina</td>
</tr>
<tr>
<td>VIGH Team</td>
<td>Sue Regan</td>
</tr>
<tr>
<td></td>
<td>MPEC team</td>
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</tbody>
</table>

### APIN
- Prosper Okonkwo
- Juliet Adeola
- Bolanle Banigbe [Boston University]

### Funders
- NIH/NIAID K23 AI106406
- MGH Center for Diversity and Inclusion
- Harvard Medical School Center for Diversity, Inclusion, and Community Partnership

### Patients

### NIMR
- Oliver Ezechi
- Nkiru David
- Zaidat Musa
- Ifeoma Idigbe
Outline:

1. Country context
2. Health system overview
3. Country situation on patients' co-payments for medicines
Kyrgyzstan

- Landlocked, mountainous country in Central Asia. The country’s territory comprises about 200,000 square km.
- Population of 7 million in 2022.
- It is a lower middle-income country with a small economy dominated by the extraction of minerals, agriculture, and reliance on remittances from citizens working abroad.
- As a result of the COVID-19 pandemic, GDP declined by 8.6% in 2020. GDP per capita, current $1,275.9. Current health expenditure stood at 4.5% of GDP in 2019.
- Politically, Kyrgyzstan is a presidential republic in which the president, who is directly elected to a maximum of two five-year terms, serves as the head of state and government.
Health system overview

- The average age of the population was 27.7 years in 2020.
- Life expectancy at birth in 2019 was estimated at 71.6 years.
- High burden of both communicable and noncommunicable diseases.
- The maternal mortality rate was estimated at 60 per 100,000 live births in 2019.

Risk factors:

- Alcohol consumption and smoking.
- Unhealthy diets (including over- and undernutrition).
- Lack of physical activity are other challenges.
- Air pollution is one of the main risk factors contributing to mortality.
- Access to water and sanitation is another challenge. Only 68.2% of the population had access to safely managed drinking-water services in 2017.
Country situation on patients' co-payments for medicines

The entitlement of the population to publicly covered health services is set out in the State Guaranteed Benefit Package. The SGBP includes services that are free to all patients (regardless of insurance status), as well as services that require co-payments. It draws on funds from the state budget (raised via taxation) and from mandatory health insurance.

Population coverage by mandatory health insurance was estimated at 69% of the population in 2019.

Mandatory health insurance consists of “basic” and “additional” mandatory health insurance programmes. The “basic” mandatory health insurance programme covers medical and preventive services and pharmaceuticals that are formally free of charge to users and paid through the single payer, the MHIF. The “additional” mandatory health insurance programme covers services that require co-payments by users.
Medicines through State Guaranteed Benefit Package

- For patients with paranoia, schizophrenia, affective disorders, epilepsy, bronchial asthma, and palliative treatment in the terminal stage of cancer

--- Co-payment is around 10% of a centrally calculated reimbursement amount (baseline price)

- The budget is - 55mln KGS – 650,887 USD

Additional Drug Package

- The ADP list is short, and includes 56 items in the outpatient sector
- Focused on the NCD medicines

--- Co-payment is 50% of a centrally calculated reimbursement amount (baseline price)

- The budget is 406,956,330 KGS – 484,800 USD
Medicines procured centrally

- At the outpatient level patients with diabetes, diabetes insipidus, haemophilia, HIV/AIDS, TB receive essential medicines provided free of charge
- The government allocates targeted financial resources for the purchase of these drugs
- The specialized tertiary health care organizations carry out the purchases and the medicines are then delivered to health care organizations as needed
- The budget is not fixed, e.g. in 2022 one billion KGS was allocated
Out-of-pocket payments

- The introduction of the SGBP aimed to reduce the financial burden of health care spending and to replace informal payments. The results of national household budget surveys in 2001–2010 showed that the financial burden of seeking health services had declined.

- However, they also showed that sustaining these improvements over the longer term is a challenge.

- Between 2000 and 2014 the share of households making out-of-pocket payments increased substantially. In 2000, 57% of households reported paying for health services out-of-pocket, while by 2014 this share had risen to 82%.

- The main drivers of out-of-pocket spending are medicines and medical products, which together accounted for more than 50% of household spending on health in 2000–2014.
What are the key gaps in coverage?

1. In 2019 only 69% of the population was covered by mandatory health insurance, a decline from 76% in 2016.

2. The ADP is too small to provide effective coverage for targeted conditions.

3. No regulation at the pharmacy retail level leads to a situation whereby the MHIF pays the fixed prices and patients end up paying more than 50%.

4. Some items in the ADP are not justified based on the latest cost-effectiveness evidence.

5. And the reimbursement processes appear to be lengthy and resource-intensive.
Price regulation

• In 2016 new State Drug policy was approved followed by a revision of the legislation and approval of new law on medicines in 2017

• This law was a major turning point - one of the innovations introduced was the potential to regulate prices for essential medicines.

• Currently the temporary regulation on price control is being piloted

• SGBP and ADP medicines are subject to price control
Next steps

• Considering the results of piloting and sensitivity analysis the permanent regulation to be introduced in 2023

• The list of medicines for price control to be enlarged

• Funding allocated to the ADP will be increased so that more prescriptions will be reimbursed by the MHIF. It is expected that the approved budget will increase by 15% each year; and

• The list of medications covered by the ADP will be revised to better align the Program with evidence-based practices and to maximize coverage for priority conditions, cost-saving, and cost-effective interventions. (PforR project)
Thank you

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Panel discussion
Myth or fact I?

Copayment reduces ‘frivolous’ demand for medicines.

Moral hazard
Overuse of (low value) medicines and care

Behavioral hazard*
Overuse of low value medicines and care
Underuse of highly effective medicines and care

*See https://www.nber.org/papers/w18468 or https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9121790/
Myth or fact II?

User fees are important for the financial health of health systems.

Health systems

Look after me so that I could look after you
? Myth or fact III ?

Increasing number of high-cost medicines is a good justification for increasing co-payment.

We want people to receive the best or the newest medicines available, now.

We want people to pay less.

We don’t want government or insurers to be bankrupt.
Co-payment can facilitate inflation of medicine price over time, because neither the government/insurers nor the patients are bearing the full cost.
What planning or supportive policies are needed when reducing or removing co-payments? And how?

Potential short-term ‘shocks’:
› sudden increase demands on health services / medicines supply to meet previously unmet need
› sudden reduction in fund
› substitution to medicines not covered by the new policy
Q&A with the audience
Announcements

WHO EURO report

Can people afford to pay for health care?

https://www.who.int/europe/publications/i/item/9789289056212

Upcoming webinar
• End of year webinar – Policy quiz (and opening the chat and microphone for you!)


https://www.who.int/news-room/articles-detail/call-for-experts--who-technical-advisory-group-on-pricing-policies-for-medicines
The deadline is 25 November 2022.

Comments and suggestions
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