

**FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE:
PEER-TO-PEER LEARNING WORKSHOP
FINDING SOLUTIONS TO COMMON CHALLENGES**

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Financial Protection and Improved Access to Health Care: A Spotlight on Pharmaceuticals

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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



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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 medicines^b
- 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



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Medicines Account for 3 out of 10 Sources of Inefficiencies in Health Systems

Sources of Inefficiencies^a

- 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

Source: WHO-2010

Inefficiencies account for

30%-40%

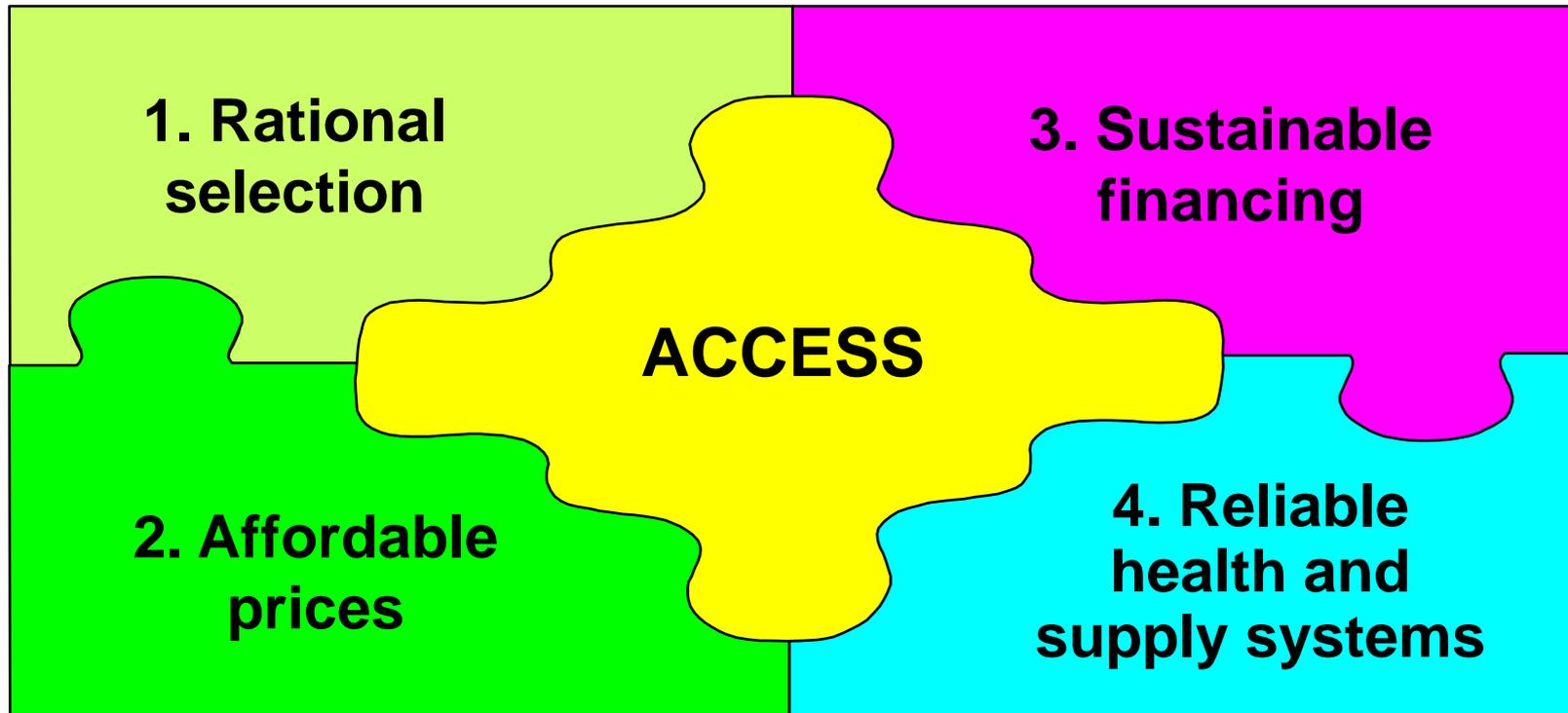
of all health expenditures



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Access to Essential Medicines and UHC^a



a WHO



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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.^a

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.^b

a Velasco-Garrido et al, 2006

b MSH 2014



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Medicines Benefits Design Key Considerations

Static components (although regularly updated)

Dynamic processes

Reimbursement list:
which medicines are
covered

Reimbursement rates,
prices, discounts,
budget caps, etc.

Assessment and
decision making on
inclusion of new
technologies

Patient eligibility (sub-
population, condition,
age, gender, etc.)

Patient co-
payment:
exemptions, limits

Case management
for high-cost
patients

Set information
systems to capture
data

Compensation for
distributor,
pharmacist;
substitution rights

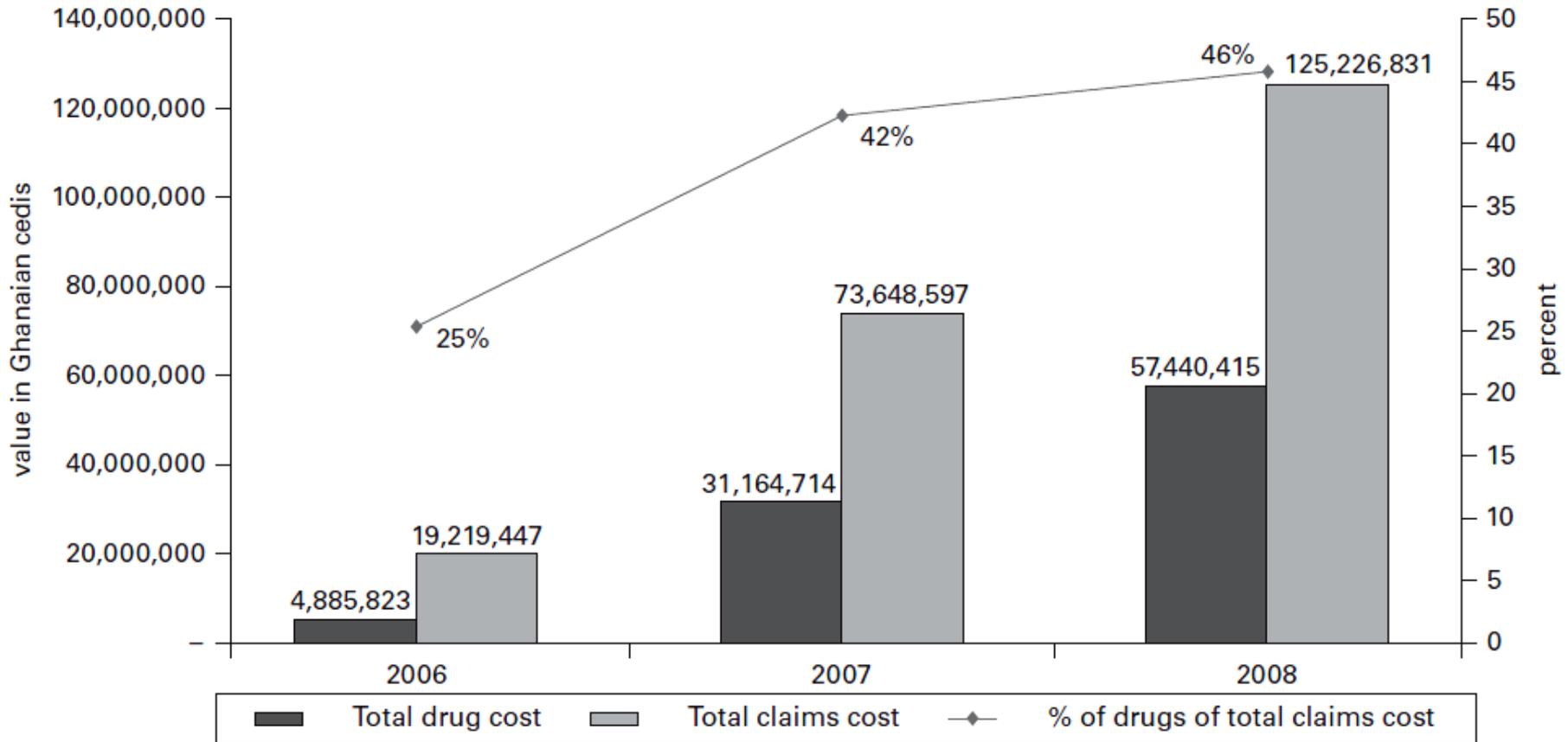
Negotiation
strategies for deals
with industry



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Coverage and Medicines Cost in Ghana



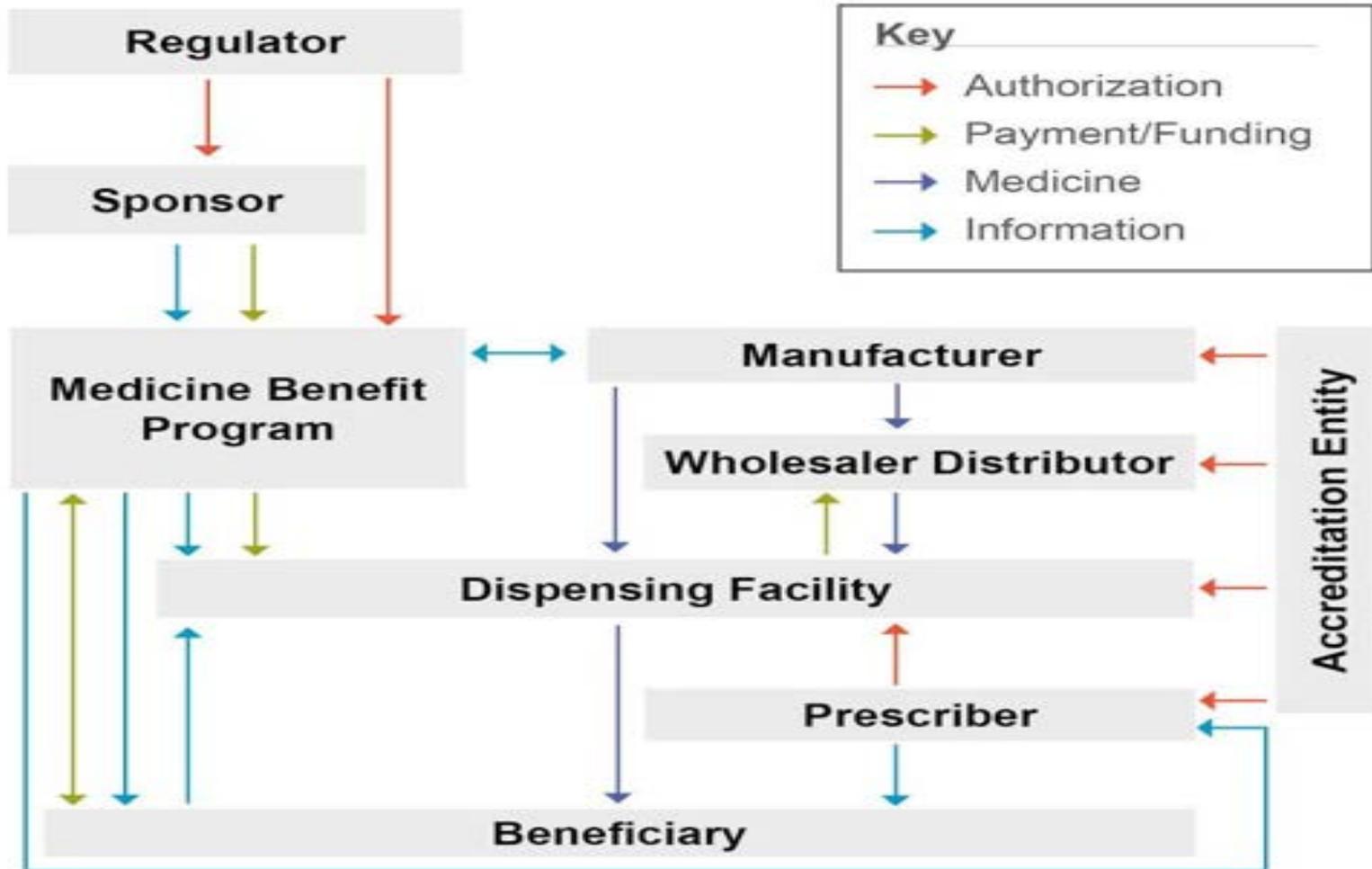
Source: Roberts and Reich, 2011, data from Mensah and Acheampong 2009



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How the Insurance System Interacts with the Pharmaceutical System



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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

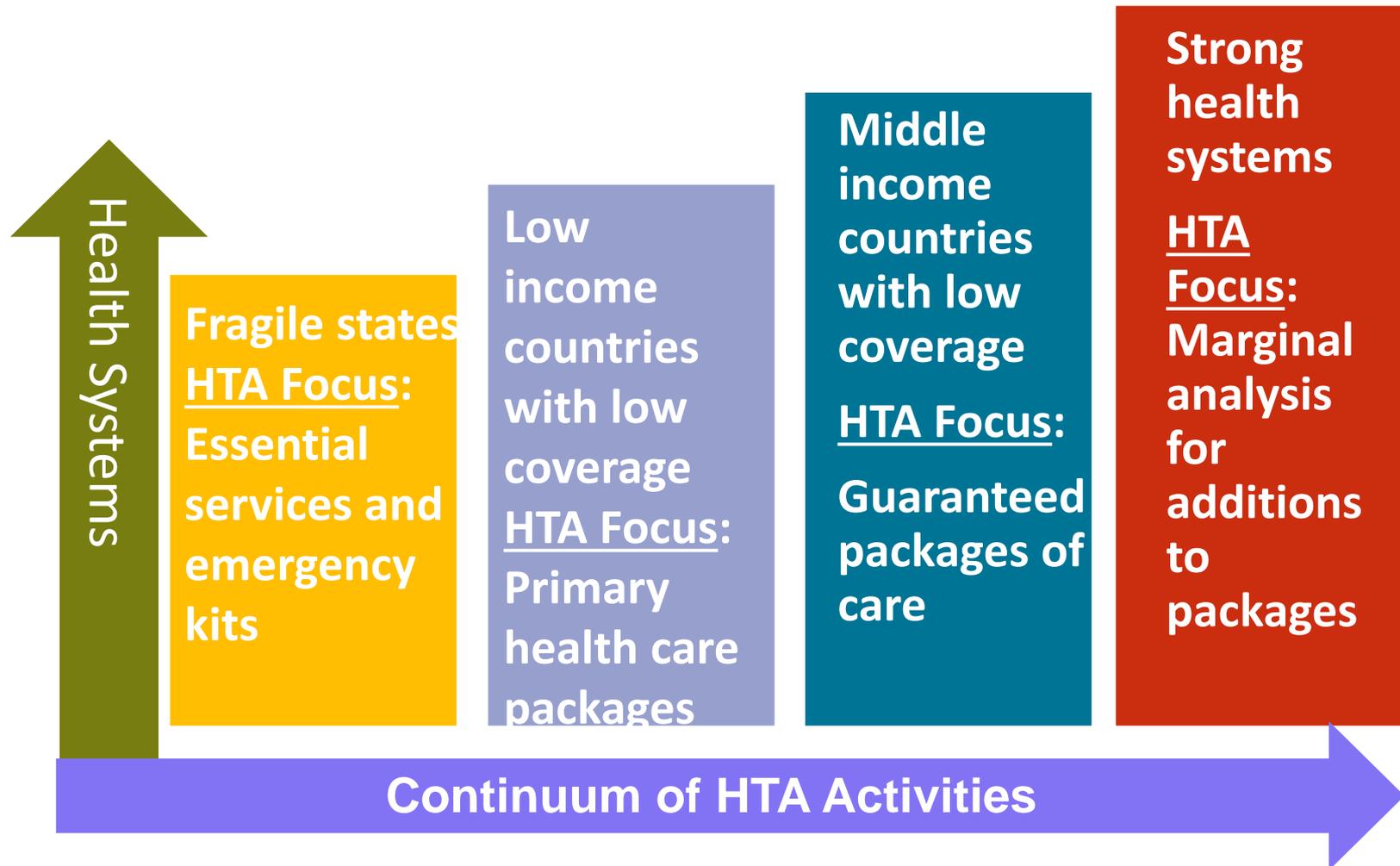
- Estimate likely medicine consumption over the period.
- Explore price volume arrangements with suppliers in the face of volume uncertainty
- Manage the risk of currency fluctuation and changes in the input costs that may affect suppliers



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How Health Technology Assessment is Used for Selection of Medicines



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Pricing and Reimbursement of Dispensers

Approaches

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

Mechanisms

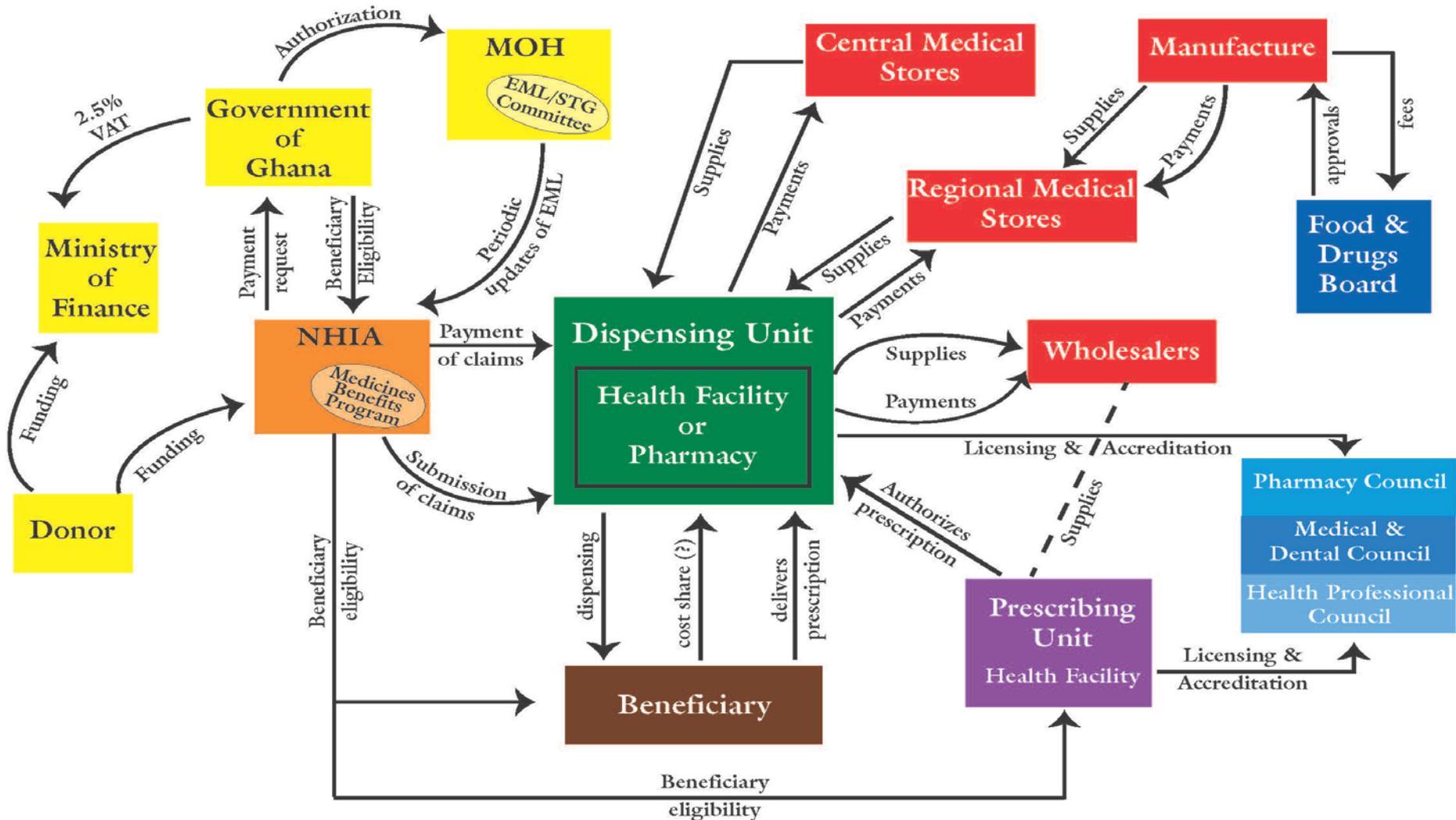
- Fee for Services
Risk of over-servicing, no incentive not to dispense medicine, rewards process rather than outcomes
- Case-Based
Less incentive to over-serve, no incentive not to dispense, some opportunity to reward outcomes.
- Capitation
No incentive to over-serve



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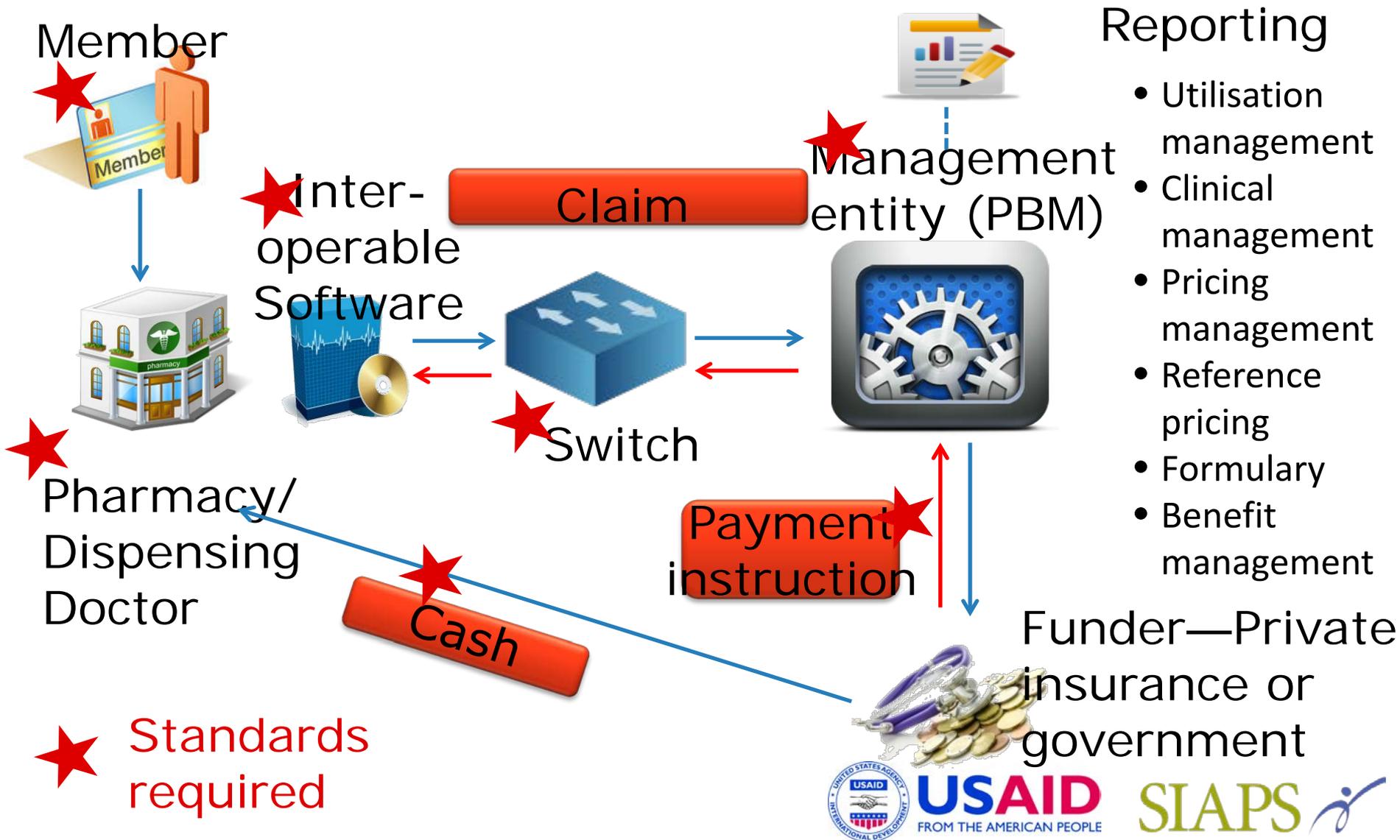
Ghana Medicines Benefits Program



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How Computers can Improve Efficiency of Claims Management for Medicines



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Managing cost by Analyzing Routine Pharmaceutical Monitoring Indicators

Performance Measures	<ul style="list-style-type: none"> • Cost • Utilization • Quality of care • Adherence
Cost	<ul style="list-style-type: none"> • Avg. cost per member per month (PMPM) • Avg. net cost per dispensing per month
Utilization	<ul style="list-style-type: none"> • Avg. no. of dispensings PMPM • Total no. of dispensings per therapeutic class
Quality of Care	<ul style="list-style-type: none"> • % of patients with ARI receiving antibiotics • % of patients discharged from hospital with acute myocardial infarction receiving beta blockers
Fraud, Abuse	<ul style="list-style-type: none"> • No. of prescriptions of opioids per provider • No. of dispensings per member



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Achieving UHC and Access to Medicines Requires Balancing Competing Objectives

Ensure Availability of Quality Products

both generic and novel products

Encourage Appropriate Use

of needed, safe, and effective medicines taken properly



Improve Equitable Access
particularly for the poor and near-poor

Keep Costs Affordable
for households and health system

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.



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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



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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



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THANK YOU



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