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# **Paying for Essential Medicines for PHC**

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## **Paying for Essential Medicines for PHC - Conference version**

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## INTRODUCTION

After decades of progress in increasing coverage with a range of needed health services, the COVID-19 pandemic moved the world backwards. WHO now estimates that by 2023, 840 million of the one billion people who should be covered in 2030 to reach the SDG targets will not be covered – up from the earlier estimate of 730 million that did not take account of the impact of the pandemic (WHO 2022a). There are multiple reasons, but an important deterrent to coverage is the need to make out-of-pocket payments (OOPs) to obtain health services, medicines and health products (Neelsen and O’Donnell 2017; World Bank 2019; Rahman et al. 2022; WHO 2022b). Further, almost a billion people who do access and pay for health services, medicines and health products suffer severe financial hardship, as a result, defined as a financial catastrophe, sometimes requiring them to go into debt, sell assets, or take children out of school (Saksena, Hsu and Evans 2012; World Bank 2016; WHO and World Bank 2021).<sup>1</sup> An estimated 70 million are pushed into extreme poverty because of OOPs, and 435 million are further into poverty (WHO and World Bank 2021).

OOPs in health, therefore, limit progress in both arms of universal health coverage (UHC): coverage with needed health services, without financial hardship caused by OOPs (financial protection). Recognizing this has led to a consensus in health financing policy that the predominant source of funding for health needs to come from obligatory pre-paid contributions which can then be pooled – to spread the financial risks of ill-health across the population, thereby allowing people to use the health services (and medicines and health products) that they need without the fear of financial catastrophe or impoverishment. The preferable sources of financing for health, therefore, are pre-paid contributions (i.e., taxes, obligatory levies and charges including health insurance premiums) rather than OOPs (World Bank 2016; World Bank 2019; Kurowski et al. 2022; WHO 2022c).

### 1. Paying for medicines

There is growing evidence that OOPs for medicines are responsible for a considerable share of overall out-of-pocket health spending – over 50% and as high as 80% - in a range of countries spanning Europe, Latin America and the Caribbean, South and East Asia, and Africa (Alsan et al. 2015; Thomson, Cylus

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<sup>1</sup> These estimates refer to 2017, the latest available. Financial catastrophe here is defined as OOPs accounting for 10% or more of total household expenditures.



and Evetovits 2019; World Bank 2020; Cid et al. 2021; Goginashvili, Nadareishvili and Habicht 2021; WHO and World Bank 2021; Evetovits T. and the BAR team 2022).<sup>2</sup>

Presumably, therefore, reducing these expenditures would reduce the incidence of financial catastrophe and impoverishment linked to OOPs, and accelerate progress on both arms of UHC. In fact, in some countries, there is already direct evidence that medicines account for a majority of catastrophic OOP episodes. For example, in India, it has been estimated that out of the 17.9% of households incurring catastrophic OOPs in 2011-12, over half of 11.2% were attributable to medicine OOPs (Selvaraj et al. 2018).<sup>3</sup>

## 2. Why are OOPs for medicines high

Understanding the cause of high OOPs for medicines is an important first step to developing the appropriate policies that would reduce these payments. Table 1 summarizes the four broad reasons why that people purchase medicines, although they are not mutually exclusive. For example, patients might consume more than necessary, and pay too much for each medicine at the same time.

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<sup>2</sup> A number of additional country reports have been published by the Barcelona Office on Health System Strengthening of the European Regional Office of WHO between 2019 and 2022 using the same format as Thomson, S., Cylus J., Evetovits T. (2019): including on Albania, Austria, Cyprus, Ireland, Spain, Sweden. The most recent is for Austria (Czypionka, Röhring and Six 2022).

<sup>3</sup> It is possible that such studies overestimate the relative impact of medicine OOPs on financial catastrophe. Common metrics of financial protection annualize the reported OOPs in household surveys and, therefore, no distinction is drawn between (for example) 12 monthly payments of \$10 for drugs throughout the year versus a one-time hospital bill of \$120. In reality, the latter case is likely to represent a greater financial shock to the household due to liquidity constraints, including by triggering sub-optimal coping strategies such as borrowing, distressed asset sales, or decreases in human capital investments.

**Table 1: Reasons and contributing factors to high OOPs for medicines**

Reasons	1. The medicines people pay for are not covered, or only partially covered, by pre-paid and pooled funds (either through a national health system or social health insurance)	2. Medicines are supposed to be available in the public sector or covered by insurance, but are not, forcing patients to purchase privately or the medicines are available but patients seek care elsewhere due to other public sector shortcomings	3. The prices paid by patients are higher than they should be	4. The volume consumed by patients is higher than it should be
Contributing factors	<ul style="list-style-type: none"> <li>○ High co-payments, official or unofficial, for medicines that are covered</li> <li>○ Patients purchase medicines that are not covered</li> <li>○ Insufficient funds to cover the range of medicines patients either need or use</li> </ul>	<ul style="list-style-type: none"> <li>○ Supply chain or funding problems: medicines not in stock</li> <li>○ Government doctors send patients to private pharmacies (possibly for kickbacks) or to their own private practices during off-hours</li> <li>○ Patients bypass public sector because of perceived poor quality, staff absenteeism, inconvenient opening hours, long waiting times (even if medicines are available)</li> </ul>	<ul style="list-style-type: none"> <li>○ Market distortions inflate prices/mark-ups (e.g., import/wholesale cartels, regulatory barriers)</li> <li>○ Import duties on essential medicines</li> <li>○ Preference for brand name vs. generics (supply or demand side)</li> <li>○ Multiple small purchasers in the country cannot obtain the best price</li> <li>○ Poor negotiation skills or corruption of purchaser(s)</li> </ul>	<ul style="list-style-type: none"> <li>○ Polypharmacy</li> <li>○ Overuse of the right medicines (supply or demand side)</li> <li>○ Use of inappropriate medicines (mostly demand, but can be supply side)</li> </ul>

### 3. Options for reducing medicine OOPs

Medicines are a critical component of primary health care (PHC), not just for curative care but also for forms of secondary prevention. The objective is not to reduce the appropriate consumption of medicines. In fact, many people do not yet receive the medicines they require in lower-income settings. The main objective is to reduce OOPs relating to medicines while allowing the consumption of essential medicines to increase as appropriate. As argued above, the consensus in health financing is that the bulk of funding should come from obligatory pre-paid sources that are subsequently pooled so that, ideally, funding for essential PHC medicines should be funded from these pools.

This would mean incorporating more medicines into the guaranteed package (e.g., WHO Europe 2019; WHO and World Bank 2021). There are three qualifiers to this conclusion.

First, the medicines that seem essential for PHC on technical grounds might not correspond well to the medicines that people purchase out-of-pocket so their inclusion in a package might not result in a great fall in OOPs. A study in India found that unnecessary or harmful treatments were prescribed for 55% of unstable angina cases and 63% of asthma cases (Das et al. 2012). WHO estimates that half of all medicines are prescribed, dispensed or sold inappropriately (WHO 2022d). Pressures for overuse and misuse can come from both provider and patient (Lopez, Sautmann and Schaner 2022).

The question of overuse and misuse is complex. One component consists of medicines that have little clinical effect: these should not be included in a guaranteed package even if patients currently purchase them. Another component related to essential PHC medicines is that are either used more than necessary or used for the wrong indications. This problem would remain even if they become part of an essential package. OOPs would fall, but the government or health insurance would end up paying for a higher level of consumption than necessary. The solution to this problem is to find ways to reduce inappropriate or unnecessary use. In fact, the absence of high-quality, patient-centered primary care may be a root cause that prompts patients to self-treat (and incur associated OOPs): improving the quality of PHC might then act as a key tool to reduce the consumption of unnecessary or inappropriate medicines (or appropriate medicines that are purchased OOP because public services cannot be conveniently accessed), thereby reducing OOPs and the medicine costs paid from pooled funds.

Second, many countries pay too much for the medicines they provide as part of a package, and people face higher prices than necessary when paying OOP (WHO 2010). Paying too much for the PHC medicines to be included in a guaranteed package stretches pooled resources unnecessarily. Their inclusion would reduce OOPs to an extent, but the pooled funds achieve only a part of what they could do if medicine prices fell.



Other types of interventions would be necessary to address this problem, and some of the solutions (such as addressing market distortions) would also reduce OOPs for the medicines that remain outside the package.

Third, pooled funds are severely constrained in low- and lower-middle-income countries (LICs and LMICs). In health accounts, the term current government health expenditure (GHE) is used to describe health spending from general government revenues and obligatory health insurance contributions combined. In LICs, GHE per capita is typically lower than US\$10 annually: in 2019, the last year for which health expenditure data are available, per capita GHE was \$6.42 in the Central African Republic, \$7.54 in the Democratic Republic of Congo, and \$8.09 in Madagascar for example (WHO 2022e). This included spending by all levels of government and development assistance for health channeled through government budgets.

Moreover, the second update of the “From Double Shock, Double Recovery: Health Financing in the time of COVID-19” work of the World Bank shows that four LICs (including the three countries named above) and 14 LMICs are projected to see declining, not increasing, levels of real general government expenditure (GGE) per capita through to 2027, with levels in 2027 remaining below those of 2019, pre-COVID-19 (Kurowski et al. 2022). They are part of the group of “GGE contraction” countries. Another 10 LICs and 20 LMICs are expected to see overall government expenditure increase, but only slowly, to 2027: part of the “GGE stagnation” countries.

It will be particularly difficult, though not impossible, for the LICs and LMICs in the contraction countries to increase GHE per capita in the coming years. It will be difficult for them to spend more on medicines from pooled sources when overall GGE is projected to fall. It will be less difficult, though still complex, for the stagnation countries to do so, particularly compared to the remaining 8 LICs and 18 LMICs that comprised part of the “GGE expansion” group of countries.<sup>4</sup> But certainly, it would not be possible for them to immediately incorporate all the medicines that households currently purchase into a guaranteed package.

So, what can they do? The following steps are useful to consider.

- First, develop plans for the progressive inclusion of essential medicines into guaranteed packages covered by pooled funds. This needs to be accompanied by macroeconomic policy to redress the decline or stagnation in GGE per capita, and to increase the share of GHE going to health and to PHC, something that was the focus of Plenary 2 at this Forum.
- Second, better understand why OOPs on medicines are high in absolute or relative terms.

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<sup>4</sup> Data were available to do the projections for 177 countries in total.



- Develop interim strategies to address these causes, reducing current medicine OOPs even while the guaranteed package is being expanded over time. Many of these strategies will improve the efficiency of purchasing from pooled funding as well, both now and in the future.

A detailed review of the range and effectiveness of these interventions is beyond the scope of this background note, but table 2 provides a picture of the type of interventions that have been implemented in different settings – although even then, there are multiple versions of the interventions that are mentioned.



**Table 2: Selected interventions to address reasons 2, 3 and 4 from table 1**

Reasons	2. Medicines are supposed to be available in the public sector or covered by insurance, but are not, forcing patients to purchase privately <i>or</i> the medicines are available but patients seek care elsewhere due to other public sector shortcomings	3. The prices paid by patients are higher than they should be	4. The volume consumed by patients is higher than it should be
Contributing factors	<ul style="list-style-type: none"> <li>○ Supply chain improvements, including in the private sector</li> <li>○ Improve legislation, regulation and enforcement of pharmaceutical kick-backs and dual practice</li> <li>○ Improve quality and patient-centredness of PHC facilities, including addressing absenteeism, the quality of medical advice, and non-clinical aspects such as opening hours and waiting times</li> </ul>	<ul style="list-style-type: none"> <li>○ Legislate/regulate to reduce the power of cartels/oligopolies</li> <li>○ Eliminate import duties on essential medicines</li> <li>○ Generic substitution policy, information, clinical guidelines</li> <li>○ Centralize purchasing to use the purchaser's power</li> <li>○ Better information on medicine prices elsewhere, better public financial management to reduce corruption</li> </ul>	<ul style="list-style-type: none"> <li>○ Multiple interventions to reduce overuse; underuse, misuse on both supply and demand sides (see WHO 2022d).</li> </ul>



## 4. Plenary session objective

The session seeks to explore the experience of countries that have used some of these approaches to try to reduce OOPs related to medicines. The strategies discussed range from incorporating more medicines into a guaranteed package, improving the supply chain to reduce prices, the introduction of a generic medicines policy to reduce prices, and the steps a single purchaser can take to reduce price and volume.

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