Reimbursement policies for out-patient medicines in countries of the WHO European Region: which practices best protect vulnerable groups?

Manuel Alexander Haasis[1,*], Guillaume Dedet[2], Janice Lam[2], Hanne Bak Pedersen[2], Sabine Vogler[1]

[1] WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies, Gesundheit Österreich GmbH (Austrian Public Health Institute), Austria;
*correspondence: alexander.haasis@goeg.at

[2] World Health Organization, Regional Office for Europe, Denmark

Background and objectives

- Policy-makers face important challenges when implementing pharmaceutical policies that aim to achieve affordable, equitable and sustainable access to medicines.
- High out-of-pocket payments (OOPs), including co-payments for publicly subsidized medicines, increase the risk of foregoing care or delaying treatment which can lead to poor health outcomes. Evidence on which reimbursement policies could be considered best-practice models to ensure access to medicines is lacking.
- The study aims to provide a comparative review and analysis of the different reimbursement policies for medicines applied by selected countries in the WHO European Region, and to identify practices that best protect vulnerable groups from excessive OOPs.

Methods

- Nine countries at different stages of progress towards Universal Health Coverage (UHC) were chosen as case studies: Azerbaijan, Finland, Greece, Kyrgyzstan, Republic of Moldova, Netherlands, Scotland, Spain and Turkey. Information on specific reimbursement policies and access to selected medicines was collected in these countries using a mixed methods approach to identify potential impacts on affordable access to medicines:
- **primary data collection** and **qualitative interviews** with competent authorities and researchers to survey information of reimbursement policies and its nuances in study countries
- a **literature review** to investigate evidence available on reimbursement models, systems and practices that could best protect vulnerable groups from excessive OOPs on medicines

Results

- All countries have put mechanisms in place to grant some type of access to medicines to their populations (**Table 1**).

Table 1. Comparative analysis of study countries.

Azerbaijan (AZE) • Made progress towards UHC by introducing compulsory health insurance (currently in pilot stage). • Price regulation, in place since 2015, has helped to reduce medicine prices.	**Finland (FIN)** • Reimbursement system requires high co-payments and OOPs and does not account for social status or income. • Committed to promoting generics as strategy to lower prices with mandatory generic substitution and reference price system.	**Greece (GRC)** • In response to global financial crisis, price cuts and measures to promote the uptake of lower-priced medicines (including generic substitution and INN prescribing) were introduced. • Patients are charged percentage co-payment plus prescription fee for most medicines. Exemptions for patients with defined diseases.
Kyrgyzstan (KGZ) • Mandatory health insurance system covers approx. 75% of population but outpatient reimbursement list is limited and not fully aligned with WHO EML. Minimum co-pay of 50%. • High medicine costs due to lack of price regulation; high informal payments pose further financial burden.	**Republic of Moldova (MDA)** • Progress in increasing affordability of outpatient medicines for non-communicable diseases are partially due to mandatory health insurance, but high co-payments continue to impact affordability.	**Netherlands (NLD)** • No percentage reimbursement rates applied, deductible only. • In 2009, measures introduced to contain costs and improve rational use of medicines. Indication based reimbursement resulting in variable coverage for different benzodiazepines indications.
United Kingdom (GBR) • In Scotland, a coordinated approach in pharmaceutical policy guidance across outpatient and hospital sectors resulted in joint lists of recommended medicines developed based on input of both primary care and hospital care physicians on the drug and therapeutics committee.	**Spain (ESP)** • During the global financial crisis, policy measures to reduce public pharmaceutical expenditure resulted in significant savings. • Number of reimbursed medicines reduced, mainly for minor ailments. In addition, co-payments were introduced (pensioners) or raised (non-pensioners above certain income).	**Turkey (TUR)** • Health care reforms steadily increased health insurance coverage, and OOPs have decreased over the years. Turkey has been working on different aspects of the reforms (such as price regulation to reduce pharmaceutical prices and alternative reimbursement agreements for high-priced products).

Discussion and conclusion

- In three Commonwealth of Independent States (CIS) countries (AZE, KGZ, and MDA), the reimbursement lists for outpatient medicines are limited. **Coverage through mandatory social health insurance (SHI) or a national health service (NHS)** provides a supportive framework but **does not automatically ensure financial protection** for patients.
- Case studies from CIS countries and TUR confirmed the need to address different aspects of reimbursement and price regulation. In AZE and TUR, **price regulation effectively reduced medicine prices benefiting both public payers and patients**. TUR further emphasized the need for better tools to assess therapeutic benefit (e.g. HTA).
- **Use of generic, biosimilar and further lower-priced medicines should be fostered** to address the challenge of high OOPs for patients. In FIN, mandatory generic substitution in combination with a reference price system helped to reduce prices, making medicines more accessible to patients while contributing considerable savings to the statutory health insurance system. The Finnish example also emphasizes the necessity of a “strategic design” of the policy framework, with ongoing changes where needed.
- **Cost-containment measures** implemented in GRC and ESP have resulted in reductions in both public pharmaceutical expenditure and medicine consumption. It remains to be seen whether patients decided to forego needed medication (as shown for other health services in GRC) or whether high consumption before the crisis was also attributable to some inefficiencies. In NLD, a **reimbursement restriction** has reduced unnecessary prescribing and suggests its effectiveness.
- **Co-payments and OOPs for outpatient medicines remain an issue** in countries across the WHO European Region, since there are often no co-payments in hospitals. Differences in the provision and coverage of medicines between the outpatient sector and hospitals may further lead to equity issues for patients. In developing **joint reimbursement lists and guidelines**, Scotland was able to improve coordination between the two sectors.

The findings of this study clearly show that there is **no “one size fits all” reimbursement policy model**, and policy-makers have developed a balanced mix of pharmaceutical options. It is imperative to continuously monitor, adapt and refine these policies given the changes in the political and economic environment.