The economic impact of the introduction of prescription control in the Greek social security funds

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OBJECTIVES: Due to the financial crisis Greece was forced to implement hard cost containment measures almost in all fiscal sectors. The objective of the study is to investigate the economic impact emerging from the initiation of controls in prescriptions implemented in the Greek social security funds as of 1st January 2010 to 30th April 2010. METHODS: The data derive from the drug reimbursement database of the three biggest social security funds of Greece from January to April 2010 compared with the same period of the previous year. The three security funds of the analysis cover about 90% of the Greek population with almost 10 million fully insured members. The security funds in scope were: IKA which covers the private sector with 6.3 million insured members; OPAD covering the public sector with 1.5 million insured members and OGA for agriculture with 2 million insured patients. RESULTS: In the first four-month period of 2010 form the initiation of the prescription control scheme the pharmaceutical expenditure was the following: for IKA €474 million in comparison to 716 million in the same period of the previous year, a reduction of 4.2%, for OPAD 172 million for 2010 while with in 2009 the expenditure was 203 million, with savings of 15% and for OGA in 2010 was 310 million and the same period in 2009 the amount reimbursed for medicines was €288 million with 7.64% growth. It should be highlighted that although for IKA and OGA the pharmaceutical expenditure is higher in 2010 in comparison to 2009, still the growth of expenditure follows a downward slope, 2008–2009 14.82% for IKA and 11.64% for OGA respectively. CONCLUSIONS: The new cost containment measures implemented in the Greek health care sector started presenting results. Other cost containment implemented measures were price cuts for all medicinal products in May 2010 and reduced supply prices for sanitary products.

VALUE BASED PRICING IN THE UK: A PRICE-QUANTITY MODEL

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OBJECTIVES: In the wake of the 2007 Office of Fair Trading (OFT) Pharmaceutical Price Regulation Scheme (PPRS) request on value based pricing (VBP), market study there is a debate whether the UK should switch to a value-based pricing (VBP) scheme. The OFT VBP system has its aim to price pharmaceuticals in line with their clinical effectiveness. METHODS: The switch from the traditional PPRS system to a VBP scheme in the UK was investigated with regards to the two main PPRS objectives: cost containment and value for money. This was carried out by modifying and applying a price quantity setting model (Das, 1980) regarding to the two main PPRS objectives: cost containment and value for money. RESULTS: The current PPRS system was seen as very beneficial with high transparency and stability, nevertheless lacking mechanisms promoting price competition when compared to the VBP system. The main concern with a switch to a VBP system was the risk of a global price lock-in. Since the UK is directly or indirectly influencing pricing decisions within about 25% of global pharmaceutical consumption, the industry might delay drug launch in the UK, to maintain global price flexibility (e.g. in the adjudging set). Risk-sharing agreements were found to be one possible solution to maintain global price flexibility for the industry, while securing the NHS pays a fair price. The interviewed were unanimous about establishing an organization separate from any political influences needs to handle the pricing decision to avoid conflicting incentives. It was suggested to offer a price premium for pharmaceuticals with well documented cost-effectiveness. A premium would incentivise the industry and reduce reimbursement decision uncertainty. CONCLUSIONS: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VBP system in the UK.

VALUE BASED PRICING IN THE UK: A SURVEY-BASED APPROACH

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Conclusions: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VBP system in the UK.

THE QUALITY AND OUTCOMES FRAMEWORK INFLUENCED PRIMARY CARE DATA RECORDING

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OBJECTIVES: The Quality and Outcomes Framework (QOF) was introduced in the UK in April 2004. The scheme financially rewards practices for providing quality care and this is evaluated based on electronic medical records. This study therefore evaluated whether data recording changed after QOF was introduced. METHODS: Patients were selected from The Health Improvement Network (THIN) database, which holds longitudinal anonymised primary care records from >450 UK practices. Patients were grouped according to whether they ever had 1 or 15 chronic QOF diseases. Percentages of patients with ≥1 general practice (GP) visit, smoking status, blood pressure (BP) and weight record were estimated throughout nine 12-month time periods (January 4, 2009–January 4, 2009). Results compared mean percentages before and after QOF introduction (January 4, 2004). RESULTS: Percentage of QOF patients ranged from 26.6% to 32.9% over time and non-QOF patients from 67.1% to 73.4%. The average percentage of QOF patients with a GP visit was 80.5% (standard deviation (SD):3.2) before QOF and 84.5% (SD:0.9) after QOF (p = 0.086). These percentages were 57.5% (SD:3.2) and 62.0% (SD:0.9) (p = 0.082) for non-QOF patients. The average percentages for smoking recording were 26.8% (SD:12.9) versus 55.9% (SD:3.0) (p = 0.018) for QOF patients and 10.9% (SD:8.5%) versus 22.3% (SD:2.9) (p = 0.007) for non-QOF patients. For BP recording, 53.6% (SD:6.7) versus 68.1% (SD:4.8) (p = 0.013) for QOF patients and 20.5% (SD:2.9) versus 24.2% (SD:0.9) (p = 0.084) for non-QOF patients. For weight recording, 25.5% (SD:5.4) versus 40.4% (SD:3.2) (p = 0.006) for QOF patients and 9.8% (SD:1.7) versus 14.8% (SD:1.7) (p = 0.008) for non-QOF patients. Overall, the QOF has a greater chance of being recorded directly or indirectly influencing pricing decisions within about 25% of global pharma 

METHODS: Interviews were carried out with experts from the industry, academia and the government comparing the traditional PPRS with the proposed VBP system. The interviews focused on the regulatory effectiveness, competition, launch delays, pharmaceutical pricing, risk-sharing agreements and uncertainty premium of the two systems. A systematic literature review was also carried out for all the above mentioned topics. RESULTS: In the interviews the current PPRS system was seen as very beneficial with high transparency and stability, nevertheless lacking mechanisms promoting price competition when compared to the VBP system. The main concern with a switch to a VBP system was the risk of a global price lock-in. Since the UK is directly or indirectly influencing pricing decisions within about 25% of global pharmaceutical consumption, the industry might delay drug launch in the UK, to maintain global price flexibility (e.g. in the adjudging set). Risk-sharing agreements were found to be one possible solution to maintain global price flexibility for the industry, while securing the NHS pays a fair price. The interviewed were unanimous about establishing an organization separate from any political influences needs to handle the pricing decision to avoid conflicting incentives. It was suggested to offer a price premium for pharmaceuticals with well documented cost-effectiveness. A premium would incentivise the industry and reduce reimbursement decision uncertainty. CONCLUSIONS: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VBP system in the UK.

VALUE BASED PRICING IN THE UK: A SURVEY-BASED APPROACH

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OBJECTIVES: A survey was carried out to investigate the economic impact of a switch from the traditional Pharmaceutical Price Regulation Scheme (PPRS) system to a value-based pricing scheme (VBP), as proposed by the Office of Fair Trading (OFT). The OFT VBP system has its aim to price pharmaceuticals in line with their clinical effectiveness. METHODS: Interviews were carried out with experts from the industry, academia and the government comparing the traditional PPRS with the proposed VBP system. The interviews focused on the regulatory effectiveness, competition, launch delays, pharmaceutical pricing, risk-sharing agreements and uncertainty premium of the two systems. A systematic literature review was also carried out for all the above mentioned topics. RESULTS: In the interviews the current PPRS system was seen as very beneficial with high transparency and stability, nevertheless lacking mechanisms promoting price competition when compared to the VBP system. The main concern with a switch to a VBP system was the risk of a global price lock-in. Since the UK is directly or indirectly influencing pricing decisions within about 25% of global pharmaceutical consumption, the industry might delay drug launch in the UK, to maintain global price flexibility (e.g. in the adjudging set). Risk-sharing agreements were found to be one possible solution to maintain global price flexibility for the industry, while securing the NHS pays a fair price. The interviewed were unanimous about establishing an organization separate from any political influences needs to handle the pricing decision to avoid conflicting incentives. It was suggested to offer a price premium for pharmaceuticals with well documented cost-effectiveness. A premium would incentivise the industry and reduce reimbursement decision uncertainty. CONCLUSIONS: This survey indicates that a transparent and stable pricing process with proper risk-sharing agreements would increase the probability of a successful implementation of a VBP system in the UK.