Balancing access with cost and quality

The paper on Medscheme's generic medicines reference pricing initiative reported in this issue of the *SAMJ*[1] (p. 183) raises several questions. At the time of introduction, the merits and demerits of the so-called 'Medicine Price List' were hotly debated in the lay press, on radio and even on national television.

Has this initiative influenced quality of care in a positive or negative way? If quality of care is defined as the appropriate, cost-effective use of resources within the limits of what is affordable, evidence seems to indicate a positive effect.

Did this initiative have a deleterious effect on the financial livelihood of any of the stakeholders in health care? The answer is difficult to quantify, but it seems as if the competition introduced between manufacturers of generic equivalent drugs was healthy and patients were better off. Because of the lower price paid by consumers for generically equivalent drugs, their benefits or budgets could stretch further. This also made life easier for doctors and pharmacists.

The more serious question, however, is the way forward. The way in which medicine is allowed to be practised by a society is influenced by a complex interplay of economic, social and political factors. The volatility and sensitivity of the current South African situation is demonstrated by the recent march on parliament of a representative group of doctors.

The patient's perspective on health care into the future is the most important. Simply put, it is the common and collective duty of all stakeholders to find a way to balance access with cost and quality for the entire population. Self interest is less important. Confrontation and adherence to outdated policies, practices and procedures are counterproductive.

Rapidly promulgated new legislation and regulation addresses key issues of equity and community. Government will not allow a system that provides the poor, elderly and chronically sick (both in the public and private sectors) with inferior funding and therefore services. When measured in terms of standards of delivery against cost, the social-democratic measures being introduced are aimed at being more efficient for the larger population. The economically strong will share with the less fortunate to guarantee efficiency and equity.

While medical leaders (of all categories of 'providers' of care) are negotiating with government, practitioners are feeling desperately squeezed between the advance of these social-democratic measures, the demands of patients, and the ever-dwindling benefits that these patients (in private practice) can afford, despite contribution increases that outstrip the consumer price index. In order to manage this situation, medical schemes are prioritising benefits, which means that reimbursement rules (for many options) are complex, placing an administrative function on practitioners.

Another important focus of disquiet involves limitation on access to new technology, due to financial constraints. In order for practitioners to pursue their modern-day trade optimally, they need access to sophisticated equipment and medicines. Short of banning research and development, growth of costly advances will not be contained. Some of these advances are also cost-effective in absolute terms; in other words, total health care costs will decrease due to their (expensive) use. Others are relatively cost-effective; good value for money, but still unaffordable in the bigger scheme of things.

These complex issues and questions can, however, be resolved. In many instances they are already being addressed.

A policy of patient-focused prioritisation of benefits as the basis for reimbursement rules provides the solution.

These rules have to be explicitly transparent and defensible on scientific, financial and ethical grounds.

The true answer lies in collaboration of stakeholders, including government and pharmaceutical industry.

Large pools of quality data are analysed to assess clinical and financial risk of relevant South African populations. Results are used to introduce appropriate delivery and funding models. Meaningful risk-sharing and strategic partnerships are essential.

The depth of clinical and actuarial resources in our country must be utilised to balance costs with access to, and quality of, patient care.

The cost issue has been squarely addressed by the Medicines Control Amendment Act (Act 90 of 1997), but with the fundamental aim of providing access to the same medicines at a lower price. To this end a Pricing Committee was set up in 2003 to develop a system to support and enhance the requirements of the Act. Recently published recommendations of the Committee were:

- the introduction of a single exit price for all medicines and scheduled substances
- determination of an appropriate dispensing fee to be charged by pharmacists or any person licensed to do so in terms of the Act
- determination of an appropriate fee to be charged by the wholesalers or distributors or any person selling medicines that do not require a prescription.

The draft Regulations introducing these measures were published by the Department of Health on 16 January 2004. These regulations are open for public comment for a period of 3 months as from 16 January 2004 and are to be enacted, with

adjustments, on 2 May 2004.

It is expected that the proposed single exit price, pegged at a minimum of 50% of the manufacturer's net price, will be vigorously contested by the pharmaceutical manufacturers. However, while there may well be adjustments to this figure, the costs of medicines will almost certainly decrease with this new legislation. The draft Regulations also regulate price increases, thereby hedging traditional risk due to year-on-year medicines price increases, and not only will price increases be regulated against CPI and PPI figures, but local prices will be also be compared to international equivalent prices and comparator products. The Regulations do not make any reference to control in terms of launch price of new products introduced into the market, but the originator product at 50% of the current cost would effectively 'ceiling' the price for generic entries post patent expiry.

The proposed legislation fixes the price of a product and pack size for one year (only downward adjustments are allowed in this time), but large price variations are expected to remain for groups of products used to treat a disease. The likelihood is that the Act and proposed Regulations, while promoting generic substitution, will still permit substitution by the highest priced equivalent, and where the mark-up is expressed as a percentage of the manufacturer's exit price one can expect to see dispensing of the product which will maximise dispenser's margins.

Taking the above into account, the question might be asked whether medicine management programmes will still be relevant within the medical schemes environment. Reference to the paper by Kanavos[2] which is summarised in this issue of the *Journal*[1] suggests that there is indeed a place for supply-side management as well as for demand and proxy-demand management. The managed care programmes introduced to medical schemes address cost and utilisation factors, both of which remain relevant for the future. As a result, the generic medicines reference pricing model, as described in this issue of the *Journal*,[1] will most likely remain as an option selected by trustees of medical schemes.

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1. Rothberg AD, Blignault J, Serfontein T, *et al*. Experience of a Medicines Reference Pricing model. *S Afr Med J* 2004; **94:** 183-188 (this issue).
2. Kanavos P. Financing pharmaceuticals in transition economies. *Croat Med J* 1999; **40:** 244-259.