Evaluation of the social welfare part of the Hungarian drug provision system

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Background and objectives

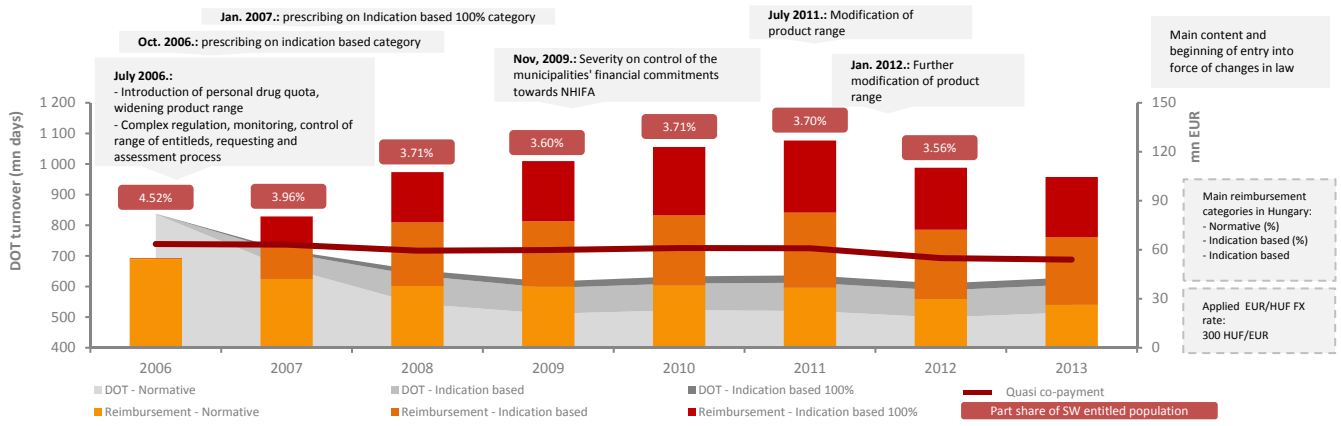

Figure 1. Turnover data, number of entitled persons of the Hungarian social welfare drug provision system, and the most relevant law changes concerning the SW segment

The social welfare (SW) part of the Hungarian reimbursed pharmacy drug provision system is a subsidy item granted by the state in order to decrease the acute and chronic drug expenditures of socially underprivileged people, which means the overtaking of co-payment expenses up to the personal drug needs, which is verified by the general practitioners, and the patients' monthly drug quota is set up based on this process. This overtaken amount of co-payment by the state called „quasi co-payment". This kind of subsidy can be applied based on subjective rights (eg. state-cared people, disabled people) or the extent of the monthly income and drug expenses. The maximum monthly limit of the chronic drug quota is 40 EUR, the available quota for acute diseases is 20 EUR per year. The authorities continuously keep a record of the entitlement and drug quota of the entitled persons.

The regulation and financing way of the SW drug provision system has changed several times in different extents since 2006. The purpose behind the clarification of the former soft legal regulating environment was to shift the system to a more efficient and more transparent state. Changes in law with the most significant impact were introduced in 2006-2007, whereby among others patients' drug quota was established, available product range was widened both in quantity and in reimbursement categories, the application and decision making process and its control were clarified and tightened.
Market position of SW segment within the whole reimbursed pharmacy drug market is significant considering both manufacturers' and the Fund's point of view. Part share of SW turnover in reimbursement outflow increased from 2006 level 4,5% to 11,1% in 2013, considering the (ex-factory price) sales turnover the proportion is similar, it increased from 2006 level 6,8% to 11,5% in 2013. Considering the absolute turnover data 123.4 mn EUR sales turnover and 104.5 mn EUR reimbursement outflow realized in SW segment in 2013. In point of the number of entitled persons the trend is in inverse ratio to turnover data, part share of SW entitled persons within the whole Hungarian population decreased from 2006 level 4,5% to 3,5% in 2012, which resulted a more than 100 thousand capita decrease in SW entitled segment.

From the Fund's and the legislators' aspect it is a legitimate claim, that financing the overtaken co-payment expenses of socially underprivileged persons' drugs refilled for chronic diseases should be implemented in the most effective way. Based on the narrow drug budget resources it is reasonable, that in point of view of the effective operation of the system, only really socially underprivileged patients should be entitled for SW provision, and these patients should have access only to their disease based therapies. Judgement of access to SW provision, and setting up the drug quota extent is a key factor in course of optimal resource allocation. From patient right and moral aspects it may be a relevant factor that underprivileged patients also should have the right to access to innovative therapies.
Changes in legal environment in recent years regulated the SW provision in a complex way. The main goal is the optimal utilization and reallocation of resources in case of patients who are suit for legal conditions. To assess the efficiency of the SW system, a bigger and comprehensive picture may be set up in course of analysing together the market trends in the SW segment and the legal changes came into force in a given time period.

Methods

Time series and aggregated market turnover data (trends in demand, reimbursement outflow, sales and quasi co-payment turnover) derives from the monthly published data by the National Health Insurance Fund Administration (NHIFA). Number of SW entitled persons (public data available until 2012) derives from the databases of the Hungarian Central Statistical Office (KSH) and the KSH-TeIR (Territorial Information System). Real world data concerning the demography and monthly refillings patterns derives from the financing database of the NHIFA. To assess changes and breaking-points in SW market trends, changes in law may serve as explanations to make conclusions. SW system is regulated by Act III. of 1993. and Act XCVIII. of 2006. In course of the study calculations we applied 300 EUR/HUF FX rate.

Results

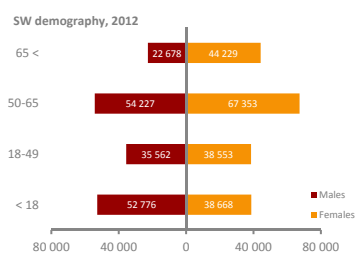

Figure 2. Demography of SW population in 2012

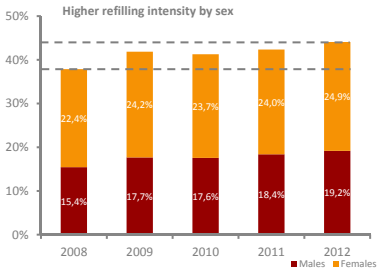

Figure 3. Patients with higher intensity pattern (10-12 months per year)

Figure 2. displays the age structure diagram of SW population in 2012. Considerable part share of entitled persons under 18 age may derive from the above mentioned subjective right. Figure 3. displays the part share of those patients, who had refillings at least 10 different months in each years, this pattern can be considered as a higher refilling intensity. The intensity shows an improving trend, in addition considering the decreasing number of entitled persons, it may lead to the assumption, that those persons remained in the system, who had larger needs the SW subsidy in point of regularity. In case of females the intensity level is higher.

Number of SW entitled persons decreased after regulating in law the application, assessment and decision making process, the implementation of registry system, continuous monitoring and control of claim of entitled persons and the prescribing patterns of general practitioners, then it stagnates from 2008.

On Figure 1. it can be observed, that aggregated demand (DOT turnover) decreased by continuous decrease of number of entitled persons, while the quasi co-payment amount did not change significantly. Reimbursement outflow shows considerable growth. Average quasi co-payment per capita remained under the 40 EUR upper limit of monthly drug quota in spite of the significant product range widening (both in range and reimbursement category). The huge expansion of product range did not implied similar growth in quasi co-payment amounts. Turnover shifted to the more expensive products with higher reimbursement category, which is mostly due to the availability of SW prescribing on indication based and indication based 100% reimbursement categories after 2006-2007. Decreases in value in reimbursement outflow from 2012 reflects the severity in reference pricing system regulations, when after 2006-2007 the available SW product range modified again, and as an impact of new items of reference pricing in 2012-2013, radical price cuts were implemented in case of most concerned active substances.

Conslusions

2006	TOP10	2013
C08CA01 (amlodipine)	1.	R03AK07 (formoterol and budesonide)
A02BA03 (famotidine)	2.	V06D (other nutrients)
C09AA04 (perindopril)	3.	R03AK06 (salmeterol and fluticasone)
C09AA02 (enalapril)	4.	R03BB04 (tiotropium bromide)
C09BA02 (enalapril and diuretics)	5.	N05AX08 (risperidone)
N06BX18 (vinpocetine)	6.	A10AB01 (insulin (human))
C01DA14 (isosorbide mononitrate)	7.	L04AD02 (tacrolimus)
C01DA02 (glyceryl trinitrate)	8.	L04AA06 (mycophenolic acid)
N07CA01 (betahistine)	9.	A10AE04 (insulin glargine)
M03BX04 (tolperisone)	10.	N05AX13 (paliperidone)

Table 1. TOP10 act. subst. by reimbursement outflow

Based on changes in laws and regulations, and the observed SW market trends it may be encouraging, that SW system began to move to a more optimal state after 2006. From the patients' aspect the available product range expanded. Considering the list of TOP10 active substances, generating the highest reimbursement outflow, the order totally changed from 2006 to 2013. While in the year of introduction of SW legislation reforms products from C01, C08 and C09 ATC categories (cardiovascular, antihypertension drugs) appeared in the TOP list, until then in 2013 a different range of active ingredients was included in TOP10, particularly respiratory, antipsychotic and insulin therapies. The list reflects that to the end of that period patient's access to more innovative therapies was provided.

SW prescribing possibilities of these products implied additional burden to the Fund due to the increased reimbursement outflow besides the quasi co-payment. To refine the objectivity of a bigger picture of SW system, there is an opportunity to get a more complex overview of SW patients' (and persons, who lost the entitlement) refilling patterns based on real world data (financing database of NHIFA) studies: compliance, specialists' prescribing patterns, therapy switches, co-morbidity, cluster analysis. It may be worth comparing the Hungarian system with other European subsidy systems to discover the international best practice. In course of analysing patient paths on patient level may serve more information for healthcare decision makers to optimize reallocation of resources, also considering patient rights.

References

Legislation source:
1. Act III. of 1993 on Social Administration and Social Benefits
2. Act XCVIII. of 2006 on the General Rules for the Safe and Economical Supply of Medicines and Medical Equipment and the Distribution of Medicines ("Medical Care Act")
3. Decree No. 32/2004. (IV.26.) ESzCsM on the Reimbursement of Medicinal Products ('Reimbursement Decree')

Source of data: NHIFA, KSH, TeIR

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