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Health Sector Reforms and the Memorandum of Understanding

- Implementation of reforms has progressed substantially from March to November 2012 and today stands in the middle of a long way (see Table below)
- Prescription by active substance and compulsory lowest priced medicines substitution began in late November 2012
- Consolidation of all existing health insurance in a single universal social health insurance organisation expected to be finalized by December 2012
- Fees for medical services outsourced to private providers and expenditure to private clinics and diagnostic services has gone out of control in the second semester of 2012
- Introduction of automatic claw-back mechanism (quarterly rebate) on the turnover of pharmaceutical producers has not yet been implemented due to pharmaceutical companies' initiation of legal action on some aspects of the system.

Health Sector Reforms' Implementation and Progress from March to November 2012

Health Sector Reforms	Implementation Index (0 to 5)		Reforms' Progress
	NOVEMBER 2012	MARCH 2012	NOV-MAR 2012
Pharmaceutical spending reduction	**3**	**0.5**	**2.5**
claw back quarterly rebate mechanism	1	0	1
new price mechanism for medicines	3	1	2
prescription by active substance	5	0	5
increasing use of generics	3	1	2
reduction of profit margins for medicines	3	1	2
prescription budget for each doctor and average cost of prescription per patient	1	0	1
centralised procurement	3	0	3
Adopt a code of good conduct to restrict promotional activities	**1**	**0**	**1**
Review of prices in diagnostic services	**1**	**0**	**1**
Consolidation of EOPYY	**3**	**1**	**2**
Electronic prescription	**4**	**2**	**2**
Accounting and control + monthly report	**3**	**1**	**2**
Hospital computerisation and monitoring system	**3**	**1**	**2**
Average implementation index	**2.5**	**1**	**1.5**

INDEX: 0=not implemented & 5= fully implemented

Source: The Second Economic Adjustment Programme for Greece-First Review-December 2012, Eurobank Research

Overview

Health sector reforms are a crucial component of fiscal consolidation efforts given the high share of public expenditure that is spent on healthcare[1]. The comprehensive reform on the health care system started in 2010 with the objective of keeping public health expenditure at or below 6% of GDP. In 2011, delays were already observed in the implementation of policy measures since the institutional setup remained fragmented. Strong resistance by vested interests, combined with the lack of timely data and effective monitoring mechanisms, has made health sector reforms difficult. This study aims at assessing the reforms' progress and the related policy measures' implementation. For this, we constructed an implementation index. This index takes into account the degree and the timely implementation of each policy measure and shows that the reforms' implementation stands in the middle of a long way.

Implemenation of reforms in the middle of a long road

Implementation of reforms has progressed substantially from March to November 2012 and today stands in the middle of a long road (see Table above). In order to assess the reforms' progress we constructed an implementation index. This index takes into account the degree and the timely implementation of each policy measure. It is based on the assessment of compliance with the Memorandum of Understanding on specific policy measures made on the Second Economic Adjustment Programme for Greece (December 2012). This assessment takes into consideration the ongoing process of reforms implementation and the related legislated measures. Implementation index ranges from 0 to 5 with zero (0) corresponding to not implemented policy-measure and five (5) corresponding to fully implemented. Index equals to 1 describes a policy which has just started and only some initial work has been done. Index equals to 4 portrays a policy close to completion. Index equals to 3 means that the policy has started and there are clear signs of progress in implementation but still there is long way to conclusion. Implementation index equals to 2 refers to a policy which is ongoing with some work already done. In addition, we formed the difference of the implementation indexes for March and November 2012 to show the reforms' progress.

The Table shows that the average implementation index stands at 2.5 meaning that the implementation of reforms stands today in the middle of the way. In March 2012, the average implementation index stood at 1 revealing the strong resistance by vested interests to health reforms. A substantial progress has been observed especially on reforms related to pharmaceutical spending reduction over the last months. More precisely, the claw back quarterly rebate mechanism has been reactivated; a new price list for medicines was published; the doctors' prescription by active substance was made compulsory; the use of generics has been increased; profit margins for medicines were readjusted; centralised procurement for pharmaceuticals was introduced. Furthermore, a significant progress has been made on electronic prescription and on consolidation of all existing health insurance in a single universal social health insurance organisation- EOPYY. On the other end of the spectrum, there are major reforms on health sector which has not progressed such as the review of prices for medical services outsourced to private providers and the adoption of good conduct regarding the interactions between pharmaceutical industry, doctors, patient, pharmacies and other stakeholders.

Reforming pharmaceutical sector

There were costly delays in policy implementation especially in the pharmaceutical sector. Expected measures yielding savings on pharmaceuticals of at least €2bn relative to 2010 level were only partially implemented. The negligible reduction in spending was mainly due to a one-off-across-the-board cut in prices and entry fees for the positive list[2]. However, some more permanent measures to reduce spending were implemented in late 2011, such as the abolishment of 0.4% contribution of wholesale pharmaceutical prices to Pan-Hellenic Pharmaceutical Association. Additional measures were legislated in March 2012

[1] Public expenditure on health accounted for 11% of total public expenditure in 2009.

[2] The positive list is the list of reimbursed medicines using the reference price system developed by EOF (National Organization for Medicines).

which aimed at reducing the volume (through controlling the over-prescription and fraud) and prices. Namely,

I. Implementation of the claw back mechanism

Authorities introduced (through legislation) an automatic claw-back mechanism (quarterly rebate) on the turnover of pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure does not exceed budget limits. The law and the ministerial decree were adopted, the system has been activated (albeit with delay) and the value to be clawed back has been requested. However, pharmaceutical companies have initiated legal action on some aspects of the system, resulting in zero claw-back collection until end Q3-12 and the risk of budgetary slippages by the end of the year. Finally, in late November 2012, following a number of legislative steps and a related decision by the High Court, the mechanism has been reactivated after the deadlock period. The authorities adopted legislation which activates contingency measures (including a cross-the-board cut in prices) if, for any reason, the claw-back is not able to achieve the target. In addition, through Ministerial decree, it was set the new-claw back threshold for 2013 (€2.4bn for outpatient pharmaceutical).

II. New pricing mechanism for medicines

In November 2011, the authorities were committed to update and complete, on a quarterly basis, the new price list for medicines in the market, using the new pricing mechanism based on the three EU countries with the lowest prices. With a significant delay, in Q3-12, the number of medicines in the positive list was reduced and aligned with the experience in other countries. Medicines were moved to the negative list (non-reimbursed medicines list). Moreover, a reference price of reimbursement was introduced. The new price list for medicines was published with delay in November 2012 and thus will produce only limited savings in 2012. Yet, with the new price bulletin the authorities expect a reduction of 12% in prices starting in Q4-2012.

III. Prescription by active substance - Compulsory lowest-priced medicines substitution

Since the last quarter of 2011, the authorities made it compulsory for physicians to prescribe by international non-proprietary name for an active substance, rather than the brand name, so as to avoid wrong incentives to doctors, over-prescription and outright fraudulent prescription behaviour. Although the measure was legislated in March 2012 as a prior action in the 2nd adjustment programme, there was strong resistance from doctors and authorities to implement it. Finally, it was implanted in late November 2012 since when any reference to brand name in the e-prescription is not accepted.

Since the beginning of 2012, the authorities mandated the substitution of prescribed medicines by the lowest-priced of the same active substance in the reference category by pharmacies. This measure legislated in March 2012 but it was not implemented until the end November 2012 where the authorities committed to send a circular to all pharmacies to ensure proper implementation.

In other words, until recently, doctors continued to prescribe by brand name, and therefore more expensive medicines, while patients were only reimbursed the cheapest medicine in each active substance group. Implementing such a reimbursement system without proper prescription by active substance, without enforcing mandatory generic substitution with cheapest medicines (as also legislated) and without full control of doctors' prescriptions led to shift the burden of adjustment onto citizens/patients with risk of access to health care.

IV. Increasing the use of generic medicines

Additional measures were taken to promote the use of generic medicines by setting the maximum price of generics to 50% of the branded (originator patented) medicine with similar active substance at the time its patent expired. The price was set in December 2011, but it was still a fixed price not a maximum price. As a result, there was no competition in this market that could lead to lower prices over time. In Q4-12, the price of generics was revised and a new price list was published. The authorities expect a reduction of 12% in the prices of generics compared to Q1-12 list.

Moreover, the authorities took further measures to ensure that at least 40% of the volume of medicines used by public hospitals is made up of generics with a price below that of similar branded products and off-patent medicines. Besides, all public hospitals compulsory procure pharmaceutical products by active substance. In Q4-12, a circular sent to all hospitals.

V. Reduction of profit margins for medicines

Starting from 2012, the pharmacies' profit margin were readjusted and a regressive margin was introduced – a decreasing percentage combined with a flat fee of €30 on the most expensive medicines (above €200)- with the aim of reducing the overall profit margin to no more than 15%, including the most expensive drugs. The Law adopted in March 2012, yet it was not implemented and only since the end September 2012 it was removed the 6%, 7% and 8% of profit margin of pharmacies for medicines above €200. Furthermore, the Government is committed to produce an implementation report on the impact of the new profit margins by Q1-2013. If it is shown that this new model to calculate profit margins does not achieve the expected result, the regressive margin should be further revised.

Moreover, the current provision of the law which hampered the collection of the rebate from pharmacies in case of delays in payments on the part of EOPYY was repealed.

What's more, starting from Q1-2012, the wholesalers' profit margins are reduced to converge to 5% upper limit.

In addition, the authorities decided a number of the most expensive medicines currently sold in pharmacies, to be sold in hospitals or EOPYY pharmacies, so as to eliminate the costs with outpatient distribution margins, and to allow for a strict control of the patients who are being administered the medicines.

VI. Prescription budget for each doctor

The authorities agreed that if the monthly monitoring of expenditure shows that the reduction in pharmaceutical spending is not producing expected results; additional measures will be promptly taken in order to keep pharmaceutical consumption under control. These include a prescription budget for each doctor and a target on the average cost of prescription per patient, and if necessary, across-the-board further cuts in prices and profit margins and increases of co-payments. Even though pharmaceutical expenditure has gone out of control, the authorities so as to deliver the target have legislated contingency measures which include only the entry fee to positive list.

VII. Centralised procurement

Centralised procurement of pharmaceuticals and medical goods introduced with the aim of increasing substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures. Some tenders have been launched already and the authorities expect important savings.

Reforming other areas of health sector

Reforms on the health sector continued and an important policy impetus took place in March 2012; yet, it was only partially implemented. Progress has been observed in areas such as hospital accounting and centralised procurement, leading to some savings in the hospital sector. What's more, improvement has been observed in electronic prescription. More precisely,

I. Electronic prescription

The tender for e-prescription was launched with significant delays. Recently it has been strengthened and in late November 2012, electronic prescription constituted more than 90% of all prescriptions. The system can provide real-time information for continuous monitoring and assessment of prescription behaviour and pharmaceutical spending by EOPYY and the Ministry of Health.

II. Accounting and control

Internal controllers have been assigned to most but not all hospitals. A monthly report published for the first time in late September. Yet, its structure and content needs to be substantially improved. The report is supposed to include analysis and description of detailed data on healthcare expenditure by all social security funds with a lag of three weeks after the end of the respective month. Moreover, it should make possible a detailed

monitoring of the budget execution, by including both expenditure commitments/purchases (accrual basis) and actual payments (cash basis). It should describe performance of entities on execution of budget and accumulation of arrears. It should highlight any defaulters and recommend remedial actions to be taken.

III. Hospital computerisation and monitoring system

Throughout 2012, measures were taken to improve the accounting, book-keeping of medical supplies and billing systems through the introduction of analytical cost accounting systems (double-entry accrual accounting) and the regular annual publication of balance sheets in all hospitals. However, only a minority of hospital have started the analytical cost accounting. On the other hand, the calculation of stocks and flows of medical supplies in hospitals using the uniform coding system has been implemented and covers 80% of the producers.

IV. Consolidation in EOPYY

The consolidation of all existing health insurance in a single universal social health insurance organisation -EOPYY- has started since the beginning of 2012. While most health insurance schemes, including the four largest were merged into EOPYY, already in April 2012, some health insurance schemes had refused to join the single fund, delaying the overall consolidation process. To fix this problem, the authorities have recently legislated that all remaining health insurance schemes should join EOPYY by December 2012. The only fund left out was the Journalists' fund which will be transformed into private fund.

Furthermore, health contributions have not been equalised across all population groups, hindering equity in financing and access to care. Most recently, OGA's contributions to EOPYY have been doubled, but they remain far below the average contributions paid by other population groups of EOPYY. The process of equalisation of contributions legislated by end-2011, implemented in January 2012 and will be completed in 30 months.

V. Adoption of code of good conduct

The authorities, pharmaceutical companies and physicians was supposed to adopt a code of good conduct (ethical rules and standards) regarding the interactions between pharmaceutical industry, doctors, patient, pharmacies and other stakeholders. This code would impose guidelines and restrictions on promotional activities of pharmaceutical industry representatives and would forbid any direct (monetary and non-monetary) sponsorship of specific physicians. Sponsorship should be attributed through a common and transparent allocation method based on international best practice. This code is supposed to be adopted since Q2-2012, but it has not been implemented yet. There has been only some initial work by EOF in mid-October 2012 which needs to be substantially improved.

VI. Pricing and use of diagnostic services

Fees for medical services outsourced to private providers were supposed to be reviewed with the aim of reducing related costs by at least 15% in 2012. But, only limited reduction in the price of services contracted to private providers has been realised in 2012. This revision of prices is urgent and even more necessary now in view of the emerging large deficit of EOPYY in 2012. Instead, the expenditure to private clinics and diagnostic services has gone out of control in the second semester of 2012. In mid-November 2012, authorities have legislated substantial increases in co-payments and revision of contractual arrangements with providers leading to substantial cuts in fees and prices. It remains to be seen whether the additional measures will be fully implemented.

Conclusions

Health sector reforms started in 2010 aiming to modernise the healthcare system, strengthen its governance, improve health policy coherence, reduce fragmentation in the purchasing of health services and reduce administrative costs. But, strong resistance by vested interests and lack of political will led to significant delays in policy implementation. Takinfg into account our implementation index, the reforms' implementation stands in the middle of a long way. Nonetheless, there has been a catching-up over the past few months. Reforms related to pharmaceutical

spending reduction have started to be implemented and there is important progress since the beginning of 2012. Legislated measures were put into practice: There is a revised and updated positive list of reimbursed medicines; it is compulsory for physicians to prescribe by active substance; there is a significant reduction of profit margins for medicines. The measure related to the quarterly rebate mechanism (claw-back) on the turnover of pharmaceutical producers is on going. In other areas improvement has been observed in hospital accounting and centralised procurement. Moreover, the consolidation of all existing health insurance in a single universal social health insurance organisation should be finalized by end-2012, albeit with delay. Major policy efforts are still necessary in several areas such as the revision of prices for medical services outsourced to private providers which went out of control the second semester of 2012.

To sup up, after a long period of slow progress and delay, the set of legislated measures has started to bear fruit. More precisely, pharmaceutical spending in 2012 will likely not exceed €3.1bn, corresponding to about €1bn in savings as compared to 2011 (about €4.1bn). Regarding the hospital sector, 2012 will see a reduction in operation costs of more than 8%. The authorities re-affirmed their commitment to address vested interests in the sector in order to achieve agreed targets and limit unnecessary increase in the burden to patients. Commitment must now turn into practice and the authorities must ensure the implementation of the policies just legislated.

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