COMMENTARY

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Ongoing initiatives in the Republic of Srpska to enhance prescribing efficiency; influence and future directions

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Dr Brian Godman reviews the paper by Markovic-Pekovic et al. regarding recent reforms in the Republic of Srpska. These include prescribing restrictions where concerns with the value of products and measures to obtain low prices for generics, which is important given the rhetoric.

Keywords: Demand-side measures, generics, renin-angiotensin inhibitor drugs, Srpska, statins, supply-side measures

Pharmaceutical expenditure has risen rapidly in the past decade, rising by more than 50% in real terms between 2000 and 2009 among OECD countries [1-5]. This has been driven by well-known factors including ageing populations, rising patient expectations and the continued launch of new premium priced drugs [1-6]. This has resulted in multiple supply- and demand-side measures across Europe to maintain the ideals of comprehensive and equitable health care [1-5]. Supply-side measures incorporate those to lower generics prices. They include prescriptive pricing policies, compulsory international nonproprietary name (INN) prescribing, compulsory generics substitution, transparency in the pricing and distribution of generics and reference pricing (ATC Level 5) with patients covering the additional costs themselves for a more expensive product than the referenced one. Demand-side initiatives incorporate those to encourage the prescribing of generics versus originators and patented products in a class or related class. They include guidelines, formularies, academic detailing, prescribing targets, financial incentives as well as prescribing restrictions [1-5]. The Republic of Srpska, which is one of the two constitutive entities of Bosnia and Herzegovina with a population of 1.43 million, is no different [7].

A reference price system was introduced for generics in the Republic of Srpska in May 2008, with the Health Insurance Fund (HIF) only reimbursing the lowest priced molecule. Patients are required to cover the additional costs themselves for a more expensive molecule than the current reference priced one [7]. This is similar to a number of other European countries [8]. Demand-side measures captured under the 4Es [2, 9] include: **Education:** Formularies, standard treatment guidelines and encouraging INN prescribing through e-prescribing initiatives; **Engineering:** Pharmacists obliged to offer patients the cheapest product once generics are available, monitoring the performance of healthcare institutions against prescribing and financial targets; **Economics:** Financial measures to encourage rational prescribing including INN prescribing; 100% co-payment if the indication prescribed for a drug is different to the permitted one; **Enforcement:** Rejection of the cost of prescriptions by HIF if the indications are different to the permitted ones (payment either by the pharmacist or patient) [7]. This includes prescriptions with missing indications.

There was decreasing expenditure/defined daily dose (DDD) in each of the three classes studied (proton pump inhibitors (PPIs), statins and renin-angiotensin inhibitor drugs) of up to 82% between 2004 and 2010. This was less for the PPIs as they were only reimbursed in 2008 with the new pricing system for generics. The various measures restricting the prescribing of angiotensin-receptor blockers (ARBs) to patients experiencing unwanted side-effects from angiotensin converting enzyme inhibitors (ACEIs), and only on specialist recommendation, were successful with ARBs constituting only 1.7% of total renin angiotensin inhibitor drug utilisation in 2010 [7]. This was appreciably lower than seen in Austria and Croatia, which also restricted ARB prescribing [5]. This suggests the greater monitoring of ARB prescribing in the Republic of Srpska further reduced their utilization.

Reimbursed expenditure/DDD for omeprazole, simvastatin and enalapril, as well as fixed dose combination (FDC) ACEIs, were similar in the Republic of Srpska to a number of European countries and regions with varying population sizes [7]. There were also similar precentage reductions in expenditure/DDD for the statins and enalpril in the Republic of Srpska compared with other European countries [7]. This, together with the recent findings from Lithuania [10], provides further evidence to counteract claims that countries with smaller populations have difficulties obtaining considerable price reductions for generics [10, 11]. This is an important observation as resource pressures grow with more standard drugs becoming available as generics [1-3].

A number of further measures are planned in the Republic of Srpska following this analysis. These include potentially restricting more expensive generic esomeprazole and pantoprazole to second line; alternatively prescibing targets for omeprazole and lanzoprazole as a percentage of all PPI prescriptions. In addition, potentially restricting the prescribing of FDC ACEIs to patients who

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have reached their blood pressure target on a combination of single ACEIs and diuretics and pertinent FDC ACEIs are available and reimbursed [7].

In conclusion, this study shows that a country with a small population can introduce a range of supply- and demand-side measures to enhance prescribing efficiency in classes where the products are similar in all or nearly all patients. As a result, providing a stimulus to other European countries to continue to introduce additional measures to maintain comprehensive and equitable healthcare in their countries.

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