

## Medicine price, availability, affordability and price component survey undertaken in Mongolia, 2012

A field study to measure the price, availability, affordability and price components of selected medicines in Mongolia was undertaken in late 2012 using a standardized methodology developed by the WHO and HAI. The survey manager was Ch. Munkhdelger, Ministry of Health.

### Method

Data was collected from a total of 31 public sector medicine outlets and 35 private pharmacies in the capital Ulaanbaatar and five regions i.e. Darkhan city, Bulgan aimag, Dornod aimag, Umnugobi aimag and Uvs aimag. Data was also collected from a total of 20 Revolving Drug Fund (RDF) outlets in Bulgan, Dornod, Umnugobi and Uvs. Government procurement (tender) prices and prices from local private wholesalers were also collected in each area. Fifty medicines were surveyed, each with a specified strength and dosage form. Of these, 47 were on Mongolia's Essential Medicines List (EML). For each medicine, data was collected for the originator brand and most sold generic equivalent (products identified centrally) and lowest priced generic equivalent (generic product with the lowest price at each outlet). Prices are expressed as median price ratios (MPR) to an international reference price i.e. 2011 Management Sciences for Health's International Drug Price Indicator Guide. Using the salary of the lowest-paid unskilled government worker, affordability was calculated as the number of days' wages this worker would need to purchase standard treatments for common conditions. Data was also collected on price components (mark-ups, taxes etc.) for 5 medicines in the private sector supply chain in Ulaanbaatar.

### Key findings

#### *Availability of medicines in the public and private sector:*

- Mean availability of generics was sub-optimal in all sectors i.e. public sector 42.8% (EML meds only), private sector 73.0% (all meds) and RDF outlets 60.0% (EML meds only). For originator brands, the mean availability was 4.3%, 22.4%, and 9.2% in the public, private and RDF sectors respectively.
- Despite being on the EML, some important NCD medicines had low availability in all three sectors and were far below WHO's target of 80% availability e.g. salbutamol inhaler (max. 35%), beclometasone inhalers (0%), gliclazide (max. 28%) and atorvastatin (max. 20%).

#### *Public sector procurement prices:*

- The government was procuring generics via tenders but many had high prices. Overall, lowest priced generics had a median MPR of 2.24 (i.e. 124% more than the international reference prices). Only one originator brand was procured (salbutamol inhaler).
- Lowest priced generics were about 20% higher priced when purchased from local private wholesalers compared to tender prices.

#### *Public sector patient prices:*

- Patient prices for MSGs and LPGs were also high at 2.25 and 2.11 times international reference prices respectively.
- Public sector patient prices for generic medicines were very similar to procurement prices.
- There was little variation in price between most sold and lowest priced generics (paired analysis).

#### *Private sector patient prices:*

- Patient prices in private pharmacies had a median MPR of 7.23 (only 4 meds), 4.37 and 4.59 for OBs, MSGs and LPGs respectively.
- Patients pay 7% more for originator brands than lowest priced generics (however this was based on only a few medicines). There was little variation in price between most sold and lowest priced generics (paired analysis).
- Generics were about 85% higher priced in the private sector compared to the public sector.

*RDF sector patient prices:*

- Patient prices for MSGs and LPGs in RDF outlets were high at 5.53 and 4.73 times international reference prices respectively.
- Most sold generics were 5% higher priced than lowest priced generics (paired analysis).
- Patient prices of MSGs and LPGs were substantially higher (95.1% and 106.7% respectively) in the RDF sector compared to the public sector.

*Affordability of standard treatment regimens:*

- Some treatments would be unaffordable even when purchasing lowest-priced generics e.g. treating hypercholesterolaemia with simvastatin or atorvastatin would require 2.6-4 days wages, and a course of co-amoxiclav tablets requires over 2 days salary (in all three sectors). Many people earn far less than government workers, and co-morbidities would be unaffordable.

*Price components in the private sector:*

- For imported products, cumulative mark-ups for originator brands were about 67% and 90%, and generics were 74% and 115%. For the locally produced generic, the cumulative mark-up was 74%. 10% VAT is applied to medicines.
- The manufacturer's selling price was the main contributor to the retail price. Wholesale mark-ups were about 4-29% and retail mark-ups were 36%-44%.

**Recommendations of the investigator**

- Increase the budget, allocate it in an optimal manner, and provide stable financing
- Accurately estimate consumption based on demand and prevent shortages
- Use international reference prices as a benchmark when procuring medicines in the public sector
- Strengthen the centralized bidding mechanism (tenders) to achieve lower prices in the public sector.
- Develop a medicine pricing policy that ensures transparency, uniformity, and predictability in the pricing of medicines. Incorporate the pricing policy into the National Drug Policy.
- Develop a medicines price index and monitor prices, availability and affordability on a regular basis.
- Develop a pricing system with a view to improving availability and affordability
- Monitor manufacturer's prices with a view to improving access of medicines
- Promote the acceptance of generics in the community and among health professionals.
- Provide training for doctors to improve prescribing of cost-effective generics.
- Exempt VAT on essential medicines and consider recouping lost revenue by increasing taxes on unhealthy goods such as alcohol, cigarettes and sugary drinks.