

Current experience with differential pricing of HIV/AIDS related drugs in Uganda

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Based on experience from UNAIDS Drug Access Initiative



Background (1)

- Estimated population of 21 million people (1998)
- Average HIV prevalence is 7%.
- An estimated cumulative number of 2,276,000 to have been infected since the onset of the epidemic in 1982
- 1,438,000 estimated to have died.
- GNP per capita: \$310 (1998).

Background (2)

- HIV-related drugs in several categories
 - STI drugs provided to patients through STIP
 - Basic drugs for treatment of opportunistic infections
 - TB drugs
 - Basic drugs for pain relief & symptom control
 - Antiretrovirals & sophisticated drugs for opportunistic infections – patient meets full cost

The UNAIDS/MOH D.A.I.

UNAIDS/MOH HIV Drug Access Initiative.

- Goal: to increase access to HIV-related drugs and care.

Two major mechanisms:

- Adequate healthcare infrastructures
- Differential pricing and responsive distribution system

D.A.I.: Implementation

Pilot Program initiated in June 1998.

- Access to antiretroviral drugs initiated 1 Aug.1998.
- National Advisory Board to oversee activities.
- Mechanism for negotiations, procurement and distribution for ARVs established
- Treatment centres for access to ARVs accredited.
- Training of health providers in correct use of drugs conducted
- Patients pay for ARV medications and medical visits

ARV Price Analysis - Objectives

Carried out in December 2000 with the following objectives:

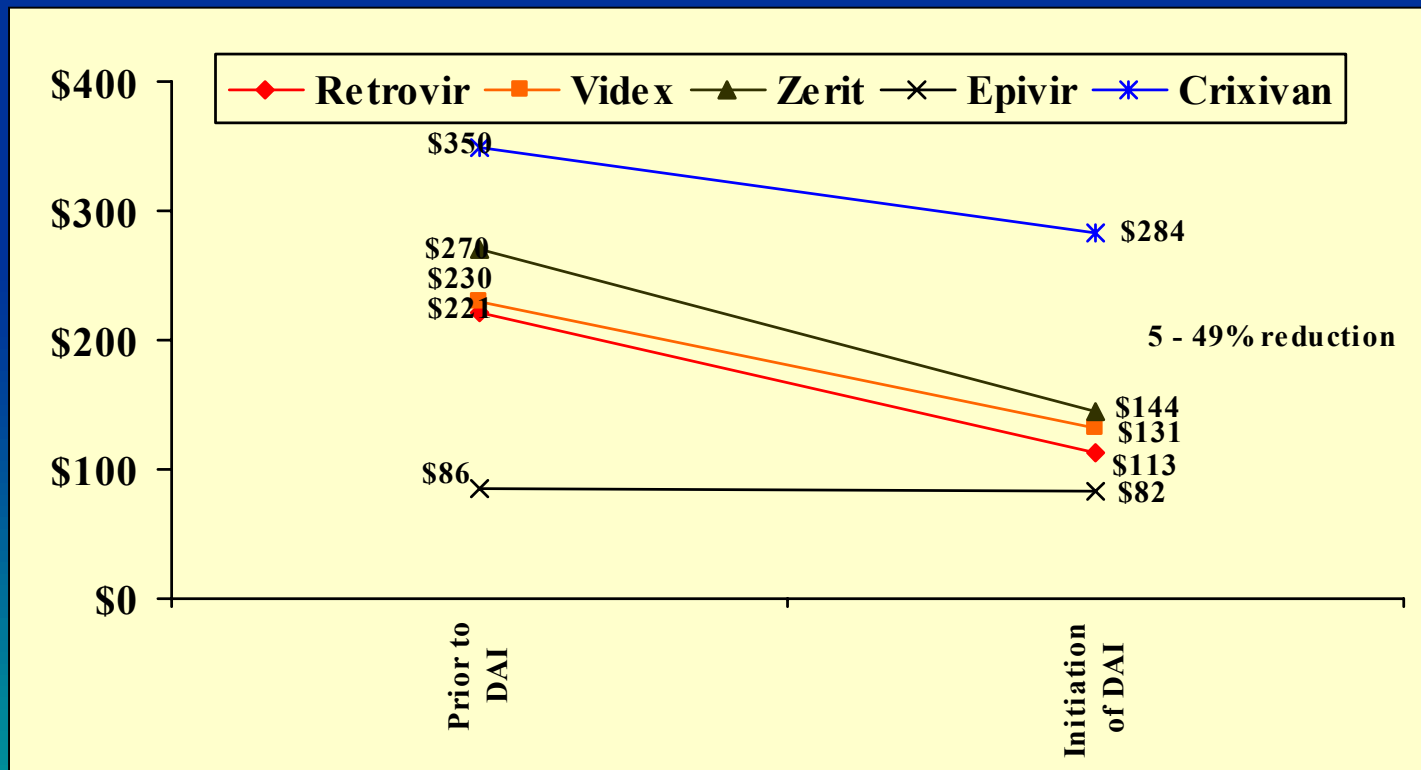
- Describe the cost of ARV drug combinations to patients in Uganda.
- Describe reasons for price fluctuations of ARV to patients in Uganda.
- Quantify the price reductions as at end of 2000.

Method

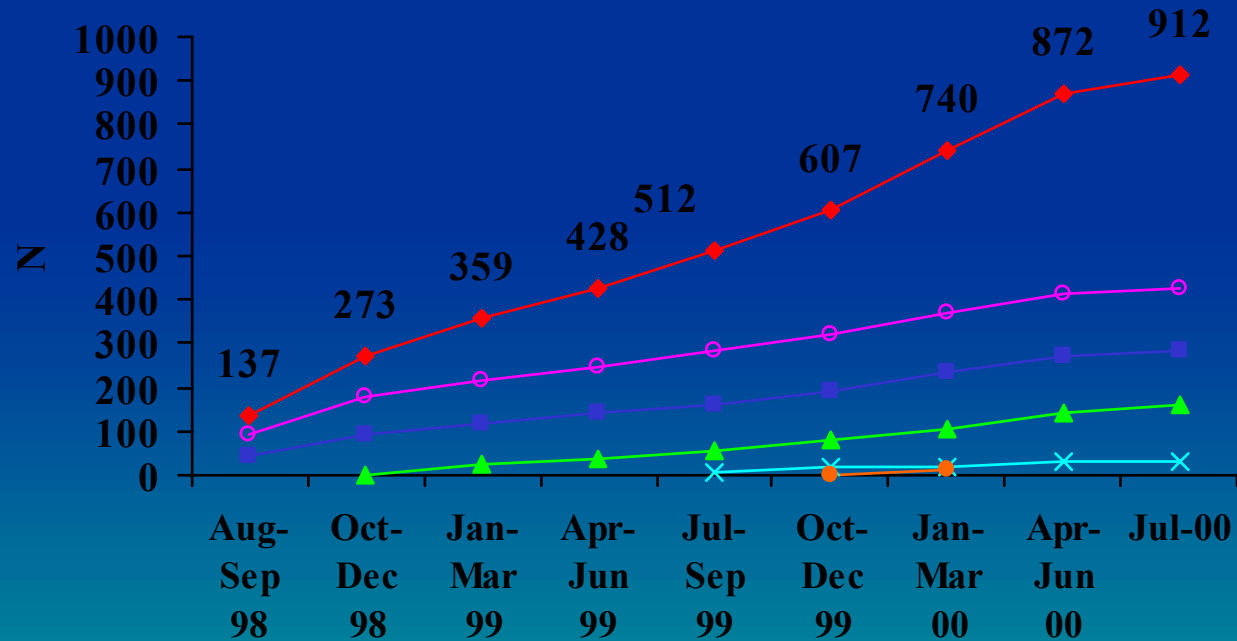
- Information on cost of ARV gathered from medical Access (U) Ltd.
 - From August 1998 – December 2000.
 - Costs of drugs purchased in foreign currency 7 converted to Ugandan shillings
- Information on costs of drugs to patients gathered from treatment centres.
 - = cost of drug to medical access plus small mark-up

ARV price reduction in Uganda

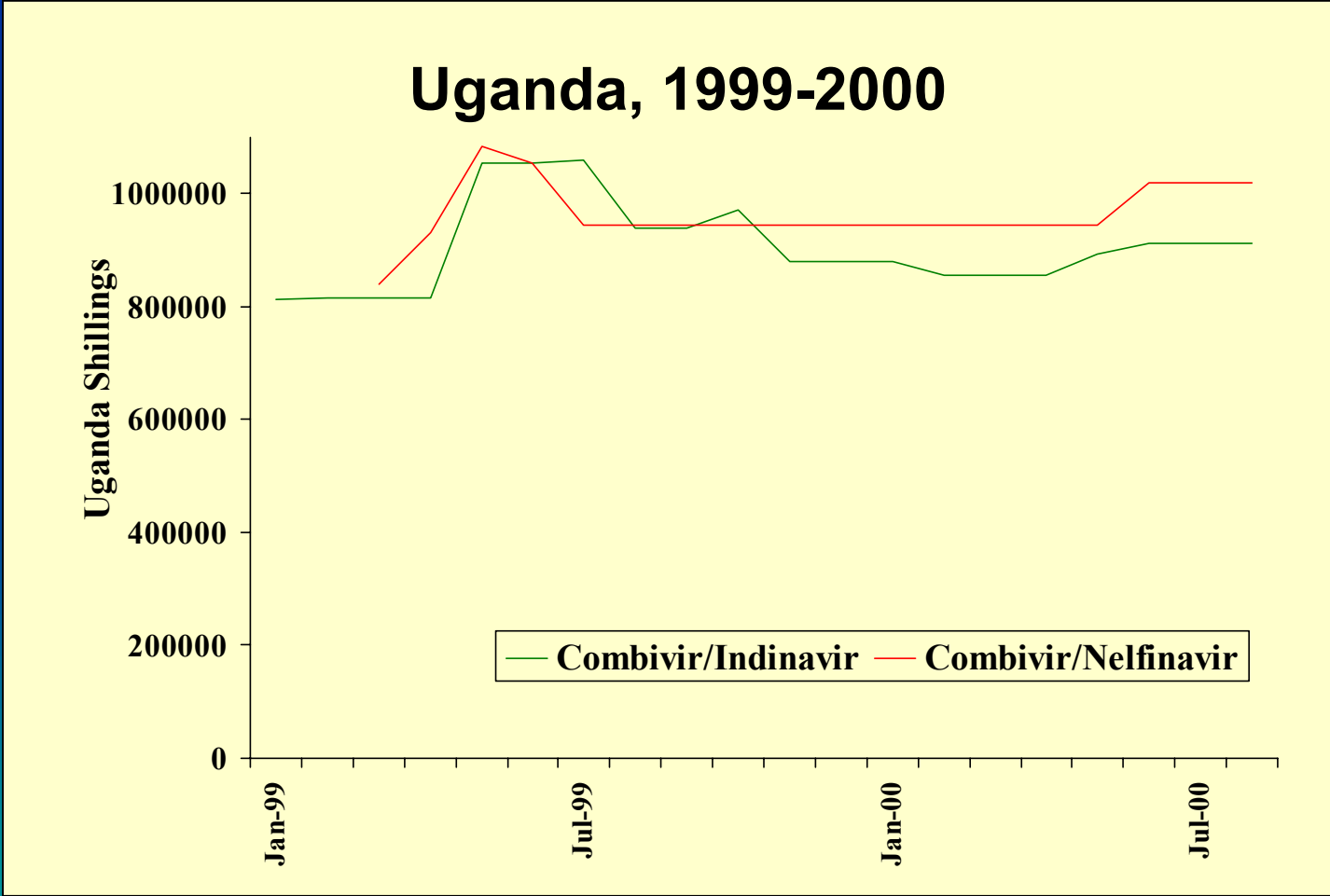
at initiation of DAI – August 1998



Cumulative enrollment - DAI



ARV costs in response to Currency Valuation & Price Changes



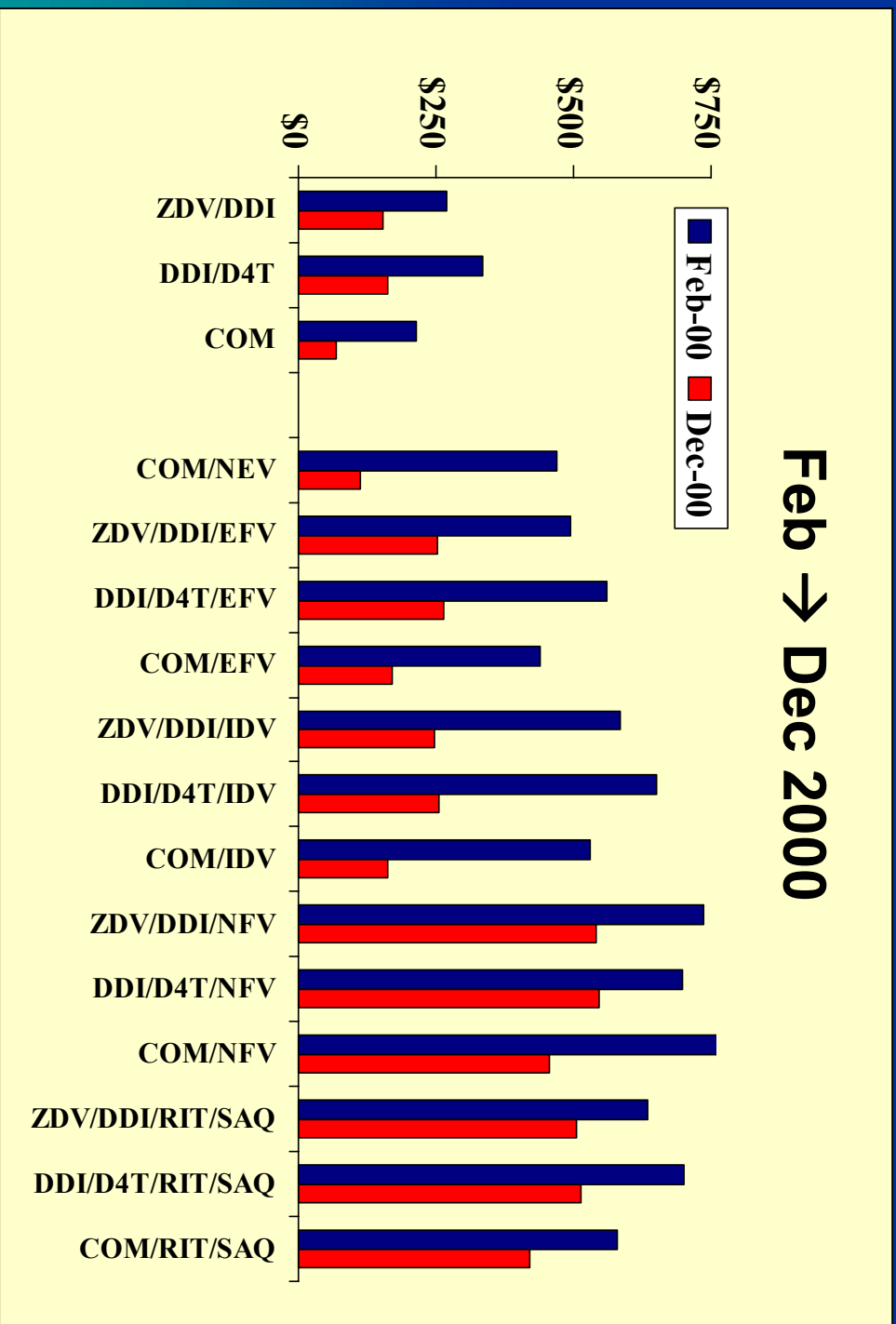
Reasons for recent price reductions

- Negotiated reductions in the prices of some drugs from multinational pharmaceutical manufacturers
- Pressure from Governments, PWAs and other activists in developed countries on multinational companies

May 2000 announcement: Further Price Reductions

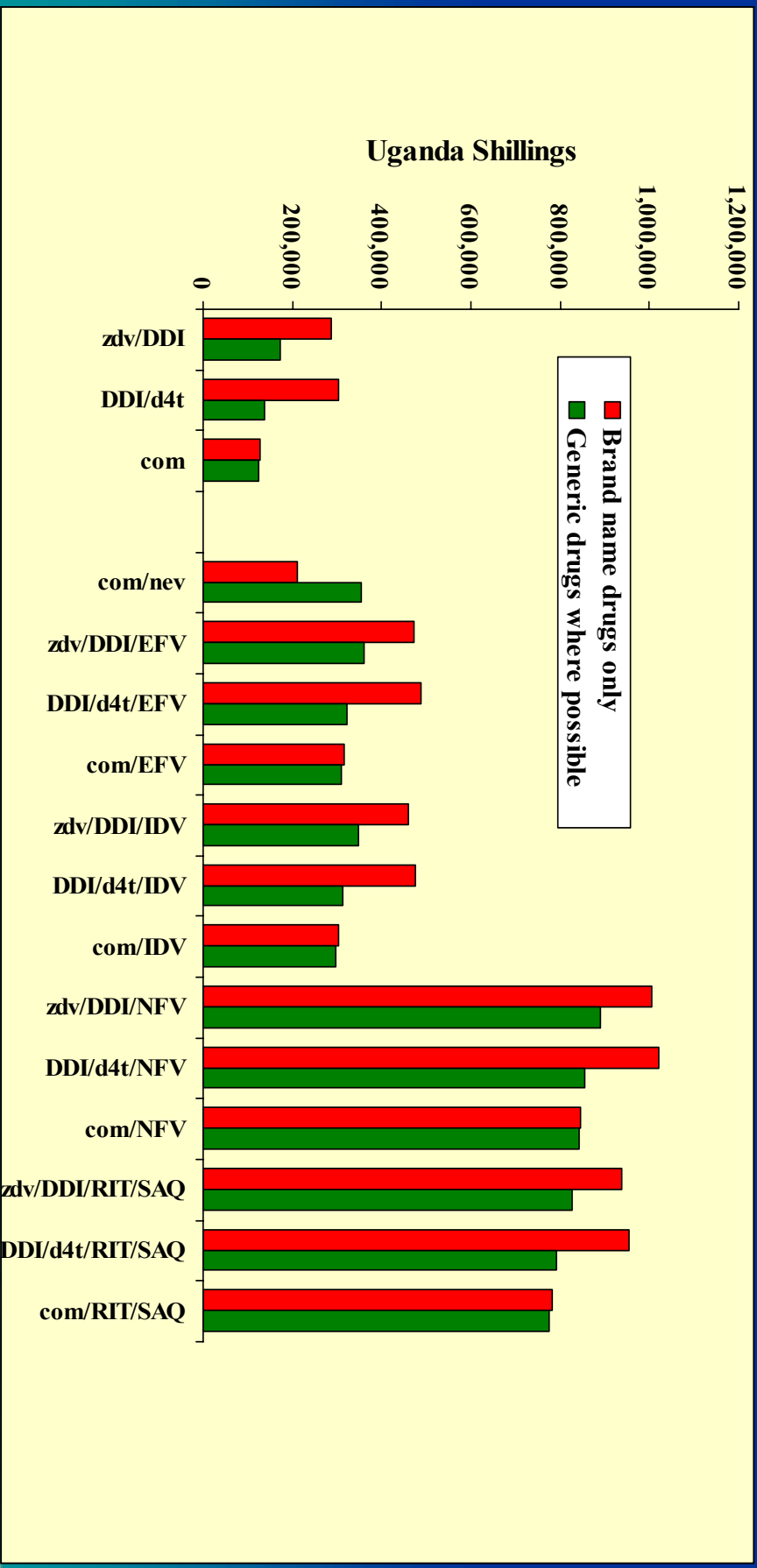
- 5 pharmaceutical companies/5 UN Agencies pledged to substantially reduce prices for developing countries.
- Effected in Uganda – November-December 2000.
- Price reductions for individual products 0-83% compared to Feb 2000 prices.
- Price reduction not same for all drugs (>50% for 6 drugs, 25-50% for 2 and <5% for 6 drugs).

Cost of 30 days supply of Combinations of ARVs in Uganda



Cost of 30 days supply of Combinations of ARVs in Uganda

Using Generic Vs. Brand Name Drugs - Dec 2000



ENROLMENT AFTER NEW PRICE REDUCTIONS

CENTER	START DATE	JUL-2000	DEC-2000	JAN 01
* JCRC	01-Aug-98	423 (46%)	452	512
Nsambya	06-Aug-98	286 (31%)	305	345
Mildmay	05-Oct-98	158 (17%)	167	189
Mulago	21-Jun-99	33 (4%)	41	41
Mengo	02-Jan-00	12 (1%)	12	12
Total		912	977	1099

* Additional 536 patients started purchasing ARVs before August 1998 or had no clinical records at the center

Lessons learned (1)

- The cost of ARVs is only one aspect of total cost of providing HIV/AIDS care.
- Few HIV/AIDS individuals have adequate financial resources to purchase ARVs – majority cannot afford even at current reduced costs.

Lessons learned (2)

- Need more public funding to enhance healthcare infrastructure and subsidize further drug costs.
- Depreciation of local currency may affect patients purchasing power, and therefore quality of care.
- Further price reductions will enable more of those previously on dual therapy to access HAART.

Conclusions

- Differential pricing can be looked at from two perspectives: the health care provider and the care seeker.
- In developing countries most care seekers cannot meet the costs. The provider to some extent is under obligation to fill the gap.
- We have recently seen important efforts for differential pricing. What are care providers prepared to do?