Pharmaceutical Privatization and Reform Program in Kazakhstan

Larry Barenbaum, R.Ph.

In late 1991, the dissolution of the Soviet Union ended the Cold War and set in motion profound changes in the Central Asian States, including Kazakhstan, an area northwest of China but southwest of Siberia with a population of over 17 million. The sudden imposition of market reforms in the larger economy, accompanied by unstable social conditions, has burdened a rather poor government in its attempt to resurrect some sort of systematic structure from the previous dominance of Soviet health care.

AMCP board member Larry Barenbaum was hired by BHM Consulting to review the technical assistance provided by an American agency aiding the Kazakhstan Ministry of Health in its monumental move toward privatization. At the 1993 Vancouver Summit by President Bill Clinton and Russian President Boris Yeltsin, the U.S. agreed to send professional and technical assistance to the newly created nations resulting from the breakup of the Soviet Union. The U.S. Agency for International Development (USAID) set up missions and contracted for expertise needed to implement the strategy and arrange for needed tools, intensive demonstration sites, and technical training programs. Dr. Barenbaum’s assignment was to review the progress of the privatization of pharmacy services.

The overwhelming structure of the previous Soviet health system has been difficult to dislodge as new forms of ownership, new ways of organizing services, and new means of manufacturing and distributing products are being implemented.

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Contributing Editor

The Central Asian States still look to Russia when it comes to health care. The States remain a highly centralized society, and strong forces are working against adequate access to rural health care. Obstacles to overcome include: deteriorating quality of life; concerns about privatization; relationships between the national sector and the oblasts (states) which must be improved for necessary authority over the various facilities; and chronic under-funding. Other obstacles include hospitals that only have a single-specialty expertise, a nonexistent preventive care process, difficulty accepting consumer responsibility of autonomy and choice, and a new health insurance program created and funded through a mandated employer add-on tax, which falls far short of the care provided through the previous entitlement process. One of the most difficult tasks, however, is taking on all components to create a single change.

WASHINGTON, D.C. BRIEFING

After flying into Washington, D.C. on Tuesday, briefing sessions began Wednesday, comprised of introductions to BHM Consulting (the contractor for this task force hired for the evaluation) and an explanation of all the different units involved. These units included USAID, the ABT Technical Consulting contractor, BHM Consulting. We received extensive background on the project, dubbed Zdrav Reform or Health Care Reform, to add to the 18-inch stack of paper sent to me previously.

Our first day of briefing included a limited historical overview of the project from the USAID deputy director. We heard that New Independent States (NIS) were looking at various options and systems from other governments and offering simultaneous opportunities in all areas of interest. The commitment made by President Clinton to President Yeltsin is being carried out through USAID for multiple projects with a major focus on health care reform. We heard how the privatization of pharmacies and wholesale drug distributors went along with the formation of HMOs. Capitation payment is in place in selected sites with primary care and specialty referral. New financial systems are being put in place to support the process, along with the introduction of management information systems (MIS). The implementation of seven Intensive Demonstration Sites (IDS) shows actual intensive technical training programs in action. Additionally, for the pharmacy component, a full complement of training programs, legislative strategies, facility restructuring, alternative provider payment methods, and quality and
management information systems are being provided through USAID's accumulative efforts.

At the offices of ABT Technical Consulting in Bethesda, Maryland, we heard a different view of the program. ABT gave us the history, as well as an overview of the difficulties the organization has encountered while putting the program in place. Most such obstacles are created by countries not familiar with a market approach and uneasy about making major shifts, not only in ideology but in processes and paradigms as well. Also in play were agenda differences between the contractor and the contractees concerning the operational expectations and the values received for the funding. We also received a site-by-site update by project and additional statistics of this two-and-a-half year program. The strengths and successes were listed along with the disappointments. We heard several times how huge the program was and how much had been accomplished in a short time. It appeared that in spite of both real and perceived roadblocks, a giant leap forward has been taken.

Finally, we were prepared. We departed from Dulles International Airport in Virginia to begin our mission in earnest.

THE SITE VISIT INTERVIEWS

Once in Kazakhstan, the time had come to get to work and site visit interviews were my responsibility. I had several specific topics to address. What follows is a summary of the results of my interviews and discussions.

DRUG POLICY

Success of the national drug policy needs full support from the appropriate host government agencies, the drug distributors, the pharmacies, and the health care principals. Such support is paramount to the success of the privatization process. Recognizing other elements of the economy also is in order, not only to sustain the program but to catalyze the process throughout the economy.

In my interview with Professor Kelesbeck Abdullin of the Department of Control Quality and Licensing and Medical Equipment, I found that he was satisfied with the current 80% privatization of the pharmacy industry. The areas we discussed and he commented on included the implementation and expansion of the World Health Organization (WHO) Essential Drug List, the formulary process that has been and still is being propagated, the drug procurement tenders (bids) process that has been introduced, the drug information compendium expected out in November to support the Essential Drug List, the reimbursement structure that is being introduced, the proposed and soon-to-be-instituted drug system management training program, and the recommendations for quality control.

This key government agency supports the current status of the process. Professor Abdullin indicated that the process will prevail as there seems to be a solid structure in place; however, continued help in reforming minds in tandem with the system is crucial, as is exposure to new concepts with supportive technical training.

ESSENTIAL DRUG LIST

The formation of this list was crucial to the system. Containing over 700 listings with 3,000 items, the list represents products covered by entitlement programs designated for large portions of the population. With government funding cut in half and Gross Domestic Product (GDP) allocation dropping from 6% to 3%, quality control was in question, as was the availability of appropriate generics. Narrowing the list and improving the quality has enhanced the concept of accountability and competition as exemplified by the acceptance of formularies, price reductions, and the tender or contracting procurement process as developed in Kazakhstan.

The Essential Drug List was adopted by national decree in February 1996. Dr. Abdullin expressed his pleasure that the recommendations were to set the standard, capitalizing on the use of the WHO drug listing as a base model (but which only represents 18% of the national list). He also indicated that it is much easier to procure the items now than it was a year ago and that significantly lower prices are available because of competition from multiple sources.

The process of allowing exceptions will be under the guidance of a committee similar to the Pharmacy and Therapeutics Committees in the U.S., for which there is currently a starting point in the Ministry. The seven committees currently in operation within this Ministry Department that could be

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A several-hour layover in Frankfurt, Germany at a busy airport with few comfortable chairs, to grab a nap was long and tiring, but uneventful. We finally arrived in Almaty, Kazakhstan in the wee hours of the morning. Following several delays, a long and arduous passport check, and lost luggage headaches, we arrived at the hotel at 5 a.m. The Hotel Otrar, located in the heart of this city of 1.5 million people, was quite austere. I looked forward to a prolonged rest, but my phone rang at 10:30 a.m.

The first order of business was a visit to the ABT offices, a block from the hotel. We then proceeded to the U.S. Embassy for appointments with the mission director and the USAID director. We later returned to the ABT offices for a reception.

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the springboard to standardization are those addressing equipment, nutrition, cosmetics, narcotics, pharmacopeia, pharmacology, and production.

**DRUG BENEFITS**

I saw no specific assessing of drug benefits. My interview with Dr. Zhanna Sakenova, chief of staff at the Almaty Pediatric Hospital, touched on current inconsistencies such as the public entitlement drug benefit program not providing free coverage to ambulatory patients over the age of one. Dr. Abdullin of the Ministry of Health said that his agency "will be able to support public funding through the Mandatory Health Insurance (MHI) Fund but it is anticipated to be a two- to three-year conversion." It appears that the drug benefit will be easier to administer by changing the overall health care system, rather than the specific benefit design. In the meantime, higher quality and lowering product costs through competition will keep a lid on the benefit.

**DRUG PROCUREMENT**

A system of tender courts a competitive process instituted through the wholesale distributors, but not brought down to the retail level yet. The first bid resulted in 90% being awarded to the private sector and 10% to the state-owned facility. This process allows for a major purchase of Essential Drug List products to be available to the state program through the hospitals, state pharmacies, and private pharmacies at more affordable prices. I wasn't apprised of any other active elements in this area.

**DRUG INFORMATION**

It appeared that the sequence of events leading to a drug information system was fully supported by the host players. But first, there was an obstacle in the form of Medstandart, a somewhat independent organization with a minimal connection to both the Ministry of Health and the National Standards Bureau. Medstandart had its own drug information data, along with computer capability and the capacity to publish this information. This agency was determined to protect its position and took an uncooperative approach. The situation was alleviated by absorbing Dr. Abdullin's department into the Ministry Department.

An ABT-formulated drug information compendium for the industry was slated for November 1996, and was to be provided in hard copy initially. The expectation is for complete distribution nationally to all health care facilities, physicians, pharmacists, and other caregivers. It will be revised regularly with updates and deletions. The ultimate plan is to create a computer data bank, but this appears to be years away. The construction of the data has been undertaken by ABT staff, following the established Essential Drug List. A structure has been created that conforms to established standard formats from recognized current national compendia. The goal is to translate everything into Russian.

**DRUG REIMBURSEMENT**

The drug reimbursement system has been limited thus far. Many mixed messages exist, causing concern for the design, implementation, technical assistance, and ultimate success of the attempt. A plan for pharmacy reimbursement that seemed to be tied to the whole health care system reform process was unveiled at the ABT site briefing. In my view, the operational aspects would be beyond the comprehension of the host and certainly beyond the capability of the systems in place. The implied sophistication of the plan would have to be incorporated into the total working health care system reform program. Amid major concern for the embryonic stage of the pharmacy privatization program and the slow speed of change that can be expected, trying to change too many other elements could cause confusion.

Talker Imanbayev, general director of the National Offices of the MHI Fund in Almaty, commented that his agency has no current interest in the reimbursement program for pharmacy and may not find it to be an issue for MHI at all. The Fund's only interest in pharmacy concerns the diversity of pricing that could be regulated through claims criteria. In the oblasts, such as Semeypalatinsk, the local MHI Fund covers more facets of health care reimbursement and pharmacy. According to Imanbayev, "the local MHI Funds are free to try the process with approval from the National Fund."
The ABT senior associate pharmacy privatization expert indicated that two oblasts would attempt to handle reimbursement in a limited capacity. This pilot project would incorporate treatment for tuberculosis, which is widespread in the country. Three to four drugs identified from the Essential Drug List would be used, with the following associated criteria: number of patients in a given area; recipient's card number, number of participating pharmacies; number of medical providers with prescriptions; incentives to eliminate over/under prescribing; and creation of co-payment guidelines and development of capitation parameters.

The ABT senior expert reported that the State views reimbursement as a black-and-white issue, and not interactive. Encouraging, and perhaps complementing, a host-derived design rather than a ready-made U.S. version not easily replicated, understood, or endorsed should be the ultimate goal.

In the Semyepalatinsk interviews, Marina Rakishov, director of the local MHI Fund, said that in this oblast they are making pharmacy reimbursements at 50% of the cost of drugs at retail outpatient pharmacies for two classes of patients—pensioners and army veterans. She indicated that this unique reimbursement was going to be taken over by the national MHI Fund in the near future.

**DRUG SYSTEM MANAGEMENT**

Drug system management has had limited exposure thus far, but the work plans seem quite ambitious. An as-yet-unimplemented "Business Management Assistance to Private Pharmacies Work Plan" is to be a collaborative program with ABT Associates' Zdrav Reform Program, Carana Corporation's Small-Scale Privatization and Enterprise Support Programs, and The Futures Group.

Carana Corporation has been the main technical advisor to the Kazakhstan government for small-scale privatization. Carana is beginning to analyze the effect of privatization in the pharmacy sector, comparing retail and wholesale prices in state-owned pharmacies (those still operating) and privately-owned pharmacies. Some of their price comparisons represent reductions of up to 150% in product prices from the previous system.

The Futures Group, through its SOMARC Project, is developing a national market for contraceptive products, as well as working with individual pharmaceutical importers, distributors, and retailers to strengthen regional and national distribution chains for contraceptives. The Futures Group's regional manager for Central Asian Republics relayed that a franchising program in pharmacy would be feasible. In addition to building chain-type identity, the individual owners would benefit from group purchasing power, thus reducing overall costs of general merchandise, advertising, and purchased services.

A senior consultant with the pharmacy sector of International Executive Services Corps, working through The Futures Group, indicated that a technical training and initiation program is available to pharmacy owners to begin business management and marketing training and theory. This will not only enhance the retail skills of the new owners and contribute to the general knowledge base, but encourage them to support the SOMARC contraceptive initiatives as well.

**QUALITY ASSURANCE**

This last measurable task item has not been addressed formally yet, but is scheduled to be activated as an ancillary function of the current re-engineering. Quality assurance's permanent place through appropriate criteria will have to achieve a long-term, viable credibility to support the reform program.

**PHARMACY SITE VISITS**

I visited a number of actual pharmacies to assess the various phases of the privatization process. The first was a modern new pharmacy located in the center of Almaty. The visit was unannounced, as were most, and therefore it was somewhat difficult to obtain nonofficial interviews. I was impressed with the retail private facility until I learned it was owned by the wife of a very influential Almaty politician. The facility was well-staffed and had excellent merchandising techniques, a wide variety of products, and many prescription-type products openly displayed under glass. The inventory was well integrated with different specialty sections and large amounts of shelving; both counter and wall advertising was evident.

The next pharmacy I visited was a state-owned facility that was austere; everything was either hidden behind closed

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Following a meeting at the National Office for Mandated Health Insurance Fund with the director general and other key staff we headed back to the ABT offices and began to pull together our notes and summary reports for our team leader. We also held a debriefing to determine if there was a general consensus of opinions and observations. While we didn't agree on every issue, we all felt that this was a great personal experience, a worthwhile project, a vehicle for exposure to things and people not otherwise available to us, an enlightening professional experience, and a great adventure. I only hope I have the time and opportunity to pursue similar opportunities in the future.
KYTRIL®
(Granisetron hydrochloride) Injection and Tablets
See complete prescribing information in SmithKline Beecham Pharmaceuticals literature. The following is a summary table.

INDICATIONS AND USAGE: Kytril is indicated for the prevention of nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy including high-dose cisplatin.

CONTRAINDICATIONS: Kytril is contraindicated in patients with known hypersensitivity to the drug or any of its components.

PRECAUTIONS: Granisetron does not induce or inhibit the cytochrome P-450 drug-metabolizing enzyme system. There have been no definitive drug-drug interaction studies to evaluate pharmacokinetic or pharmacodynamic interaction with other drugs, but in humans, granisetron has been safely administered with drugs containing benzodiazepines, neuroleptics and anti-scorbutic medications commonly prescribed with antineoplastic treatments. Kytril Injection also does not appear to interact with parenteral antineoplastic chemotherapeutic reactions. Because granisetron is metabolized by hepatic cytochrome P-450 drug-metabolizing enzymes, inducers or inhibitors of these enzymes may change the clearance and/or concentration of granisetron.

Carbohydrate, Fat, Protein, Impairment of Fertility: In a 24-month carcinogenicity study, rats were treated orally with granisetron 1, 5, or 50 mg/kg/day, 8, 30, or 1250 mg/mL/day. The 50 mg/kg/day dose was reduced to 75 mg/kg/day prior to the 25 mg/kg/day dose due to toxicity for a 50 kg person of average height (1.64 m body surface area). These doses represent 18, 81, and 405 times the recommended IV clinical dose (0.37 mg/kg IV or IV) or 0.37 mg/kg or a body surface area basis. There was statistically significant increase in the incidence of hepatocellular carcinomas and adenomas in males treated with 5 mg/kg/day (38 mg/kg/day, 97 times the recommended IV human dose based on body surface area) and females treated with 50 mg/kg/day (800 mg/kg/day, 405 times the recommended IV human dose) and 101 times the recommended oral human dose based on body surface area). No statistically significant increase in the incidences of hepatocellular carcinomas and adenomas in males treated with 25 mg/kg/day (125 mg/kg/day, 507 times the recommended IV human dose) and 16 times the recommended oral human dose based on body surface area) in males and 5 mg/kg/day (35 mg/kg/day, 73 times the recommended oral human dose based on body surface area) in females. In a 24-month oral toxicity study, treatment with granisetron 100 mg/kg/day (8000 mg/kg/day, 1252 times the recommended IV human dose and 405 times the recommended oral human dose based on body surface area) in female rats resulted in a significant increase in the incidences of hepatocellular carcinomas and adenomas in males and females. No statistically significant increase in the incidence of hepatocellular carcinomas and adenomas in males treated with 25 mg/kg/day (125 mg/kg/day, 507 times the recommended IV human dose) and 16 times the recommended oral human dose based on body surface area) in males and 5 mg/kg/day (35 mg/kg/day, 73 times the recommended oral human dose based on body surface area) in females. In a 12-month oral toxicity study, treatment with granisetron 100 mg/kg/day (8000 mg/kg/day, 1252 times the recommended IV human dose and 405 times the recommended oral human dose based on body surface area) in animals was found to cause weight loss, a decrease in the food consumption of male and female rats.

Pregnancy Category B: Reproduction studies have been performed in pregnant rats at IV doses of 2.5 mg/kg (54 mg/kg), 140 times the recommended human IV dose based on body surface area) and oral doses of 100 mg/kg (800 mg/kg/day, 405 times the recommended oral human dose based on body surface area) and pregnant rabbits at IV doses of 2.5 mg/kg (35 mg/kg, 50 times the recommended human IV dose based on body surface area) and fetal development was found to be normal and did not affect rates of performance of male and female rats.

ADVERSE REACTIONS: Events observed in clinical trials—Single-Day Chemotherapy

Percentage of Patients with Event

<table>
<thead>
<tr>
<th>Event</th>
<th>Kytril Injection</th>
<th>Comparator*</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>4% (1/25)</td>
<td>7% (2/28)</td>
<td>7% (3/42)</td>
</tr>
<tr>
<td>Asthenia</td>
<td>5% (1/20)</td>
<td>6% (1/17)</td>
<td>4% (1/24)</td>
</tr>
<tr>
<td>Somnolence</td>
<td>4% (1/25)</td>
<td>6% (1/17)</td>
<td>6% (1/17)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>8% (2/25)</td>
<td>10% (2/19)</td>
<td>10% (2/19)</td>
</tr>
<tr>
<td>Constipation</td>
<td>3% (1/32)</td>
<td>6% (2/28)</td>
<td>3% (1/24)</td>
</tr>
</tbody>
</table>

1. Events were also recorded over 7 days post-Kytril injection administration.
2. Incentives provided to investigators for each Kytril-treated patient and comparator.

In over 5,000 patients receiving Kytril injection (7 to 150 mg/kg) in single-day and multiple-day clinical trials with emetogenic chemotherapeutic regimens, other than those described above, no additional adverse events were observed. These events are not considered to be drug-related and are unlikely to result in any therapeutic difficulties.