

Effect of co-payment ceiling on prescription drug consumption

PRELIMINARY

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Abstract

This study estimates the impact of the patient co-payment ceiling on prescription drug consumption in Finland. In 2009, the Finnish Health Insurance covered an average of 51% expenditures on prescription drugs until an annual expenditure ceiling is reached. After exceeding the ceiling, all drug consumption is covered apart from a small prescription fee. This creates exogenous variation in the drug prices faced by the patient that is utilised in the analysis. The identification is based on comparison of patients who have exceeded the ceiling to those with similar drug consumption history except the differences in timing of the purchases. The analysis data include prescription drug purchases for all Finnish patients in 2006–2010. Based on preliminary results, the reaching the co-payment ceiling increases consumption by 22%.

Keywords: Prescription drugs, co-payment, matching estimator

JEL: H51, I11, I18

1 Introduction

Expenditure on drugs has been growing rapidly during the last decades in most OECD countries. This has contributed to increasing financial strain caused of health care services because prescription drug expenditures are typically partly reimbursed by publicly funded health insurances. On average, drug expenditures accounted for 1.5% of GDP in OECD countries with around 0.8% of GDP financed publicly (OECD 2013). In Finland, the total expenditure on prescription drugs was 1.9 million euros in 2012 and it has grown at an average annual rate

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of 7.6% since 1995. The cost increase has led the Finnish government to implement several changes in the insurance scheme to curb the public expenditure growth. However, there is only limited evidence on how changes in the insurance scheme impact the demand for prescription drugs, and without this information it is difficult to implement a socially optimal insurance scheme.

This study analyses the demand for prescription drugs by estimating the effect of patient co-payment ceiling on individual level drug consumption in Finland. During the analysis period, the National Health Insurance covered an average of 51% of prescription drug costs until an annual co-payment ceiling is reached. After exceeding the ceiling, all drug consumption is covered apart from a 1.5 euros prescription fee. Similar policies, where the out of pocket expenditure share decreases with the level of consumption, are in use in several countries.

The co-payment ceiling may have significant behavioural effects on drug purchases. After exceeding the ceiling, patients have practically no monetary incentives to limit their drug consumption. This may induce excess drug consumption from society's view or even lead to inappropriate drug use. As the ceiling is determined annually, reaching the ceiling causes a hoarding effect at the end of the year. Poor and liquidity constrained individuals may harvest drugs because they may not afford to pay co-payments for their drugs after turn of the year. If exceeding the co-payment ceiling has large behavioural effects, reforming the reimbursement scheme could help to curb drug reimbursement costs. On the other hand, if there is evidence that liquidity constrained individuals increase their consumption after reaching the ceiling, it may indirectly indicate under-consumption of drugs which may have detrimental health effects.

The National Health Insurance in Finland covers most prescription drug purchases. Drugs are subject to three different reimbursement rates. The basic rate is 42% of the price and the lower special reimbursement rate is 72% while the higher special rate is 100% with fixed 3 euros co-payment. Drugs with special reimbursement rates are used for treatment of certain severe, long-term diseases. The annual co-payment ceiling was 675 euros in 2011 and after reaching the ceiling patients pay fixed 1.5 euros co-payment. The co-payment ceiling is relatively high and only 3.3% of the patients exceeded the ceiling.

The co-payment ceiling creates a very large drop in drug prices faced by the patient. The fact that the ceiling is annual provides exogenous variation in the prices for patients with similar consumption histories. However, the key question in the identification of the effect of co-payment ceiling is how to construct a valid comparison group. This analysis utilises the differences in timing of purchases between patients to estimate the causal effect of the co-payment ceiling. The comparison group is constructed by selecting individuals who have the same cumulative co-payments as the treatment group but a large share of these purchases are done in a

previous year.

The analysis data are constructed by linking prescription register to population and tax registers for years 2006–2011. The prescription register of the Social Insurance Institution of Finland includes detailed information on all reimbursed prescription drug purchases in Finland. All permanent Finnish residents over 15 years of age who had drug purchases in the analysis period are included in the analysis. The population register includes several background characteristics for the patients and the tax register provides information on patients' annual income.

Estimation is done using a propensity score matching combined with exact matching on key variables. Exact matching is done with respect to gender, cumulative co-payments and drug expenditure in the pre-treatment period. The results show that the level of drug consumption increases by 133 euros in the three months follow-up period after the co-payment ceiling is reached. When compared to the level of consumption in the control group, the estimate implies a 22% increase in the consumption. Given that patients face approximately 94% decrease in the prices, this corresponds to the price elasticity of -0.23. The estimated effect is larger for females and for working-aged patients. Also consumption increases more for drugs with the basic reimbursement rate which is expected due to their lower initial reimbursement rate.

The structure of the paper is the following. The next section reviews previous literature on cost-sharing in health insurance schemes and co-payments for prescription drugs. The section 3 describes the analysis data and discusses Finnish health insurance system. The descriptive statistics are presented in the section 4 and estimation strategy is discussed in the section 5. The section 6 presents results and the final section concludes.

2 Previous studies

Economic discussion on co-payments for prescription drugs is closely related to a wider topic of the optimal design of health insurance. Most of the literature is focused on the US markets where health care costs have been rapidly increasing while part of the population has remained outside health insurance system. Studies analysing European countries, where public drug reimbursement system are common, are relatively scarce. Some Scandinavian studies exist while Finnish literature on drug reimbursement system is very limited. A Cochrane review by Austvoll-Dahlgren et al. (2008) provides a comprehensive review on the recent literature.

The RAND Health Insurance Experiment is a famous US randomized experiment conducted in the late 1970s that studied the effect of different health insur-

ance plans with varying cost-sharing schemes. The study included members of participating families below 62 years of age and their drug usage was covered on the same cost-sharing scheme as other use of medical services. Using the data from the experiment, Manning et al. (1987) estimate that the average price elasticity of demand for medical services is around -0.20 which means that people are modestly responsive to the cost of health care. The analysis of drug consumption data from the study gives similar results, i.e. individuals with more generous insurance bought more prescription drugs Leibowitz et al. (1985).

Chandra et al. (2010) study the effects of increase in cost-sharing for retired public employees in California and they estimate similar elasticities as those in the RAND experiment. However, they find evidence that higher hospitalization rates may offset the direct savings obtained from increase in cost-sharing as supplemental insurer has no incentives to take into account the costs that accrue to Medicare. Also a Canadian study by Contoyannis et al. (2005) find relative low elasticities for prescription drug consumption ranging from -0.12 to -0.16. They exploit non-linearities in the price schedule that are created by cost-sharing in the public insurance program.

Policy reforms and non-linearities in the price schedules have been exploited also in European studies on demand for prescription drugs. Winkelmann (2004) analyses the 1997 reform in Germany where co-payments for prescription drugs where increased and finds that it lead to substantial decrease in doctor visits. A Danish study by Simonsen et al. (2010) utilise the variation in prices that arises from the kinked cost-sharing scheme. They are able to utilize a rich register based dataset and estimate the effect for different subpopulations. The results suggest that the average price elasticity is between -0.08 and -0.25 while low-income individuals are more responsive and essential drug usage is less sensitive.

3 Data and health insurance in Finland

The analysis data are constructed by linking prescription register to population and tax registers for years 2006–2011 (note: current analysis is based on 2009 data only). The prescription register of the Social Insurance Institution of Finland includes information on all reimbursed prescription drug purchases in Finland. The population register is used to define the analysis population. All permanent Finnish residents over 15 years of age who had drug purchases in the analysis period are included in the analysis. The population register also includes several background characteristics for the patients and the tax register includes information on patients' annual income.

Data from the prescription register include detailed information on the drug

purchases. The variables used in the analysis are the date of purchase, the cost of drug, the sum of reimbursement, the reimbursement category and the Anatomical Therapeutic Chemical (ATC) classification of drugs. However, the register does not cover drugs used in inpatient care, institutional care or drugs available without a prescription from doctor.

Background information is linked for the patients at the end of previous year. The variables in the analysis data are age, gender, indicators for being married and Finnish nationality and taxable income.

The National Health Insurance in Finland covers most prescription drug purchases. Also some skin creams and clinical nutrients prescribed by doctor are covered by the insurance. Preventive medicines are not covered and for some drugs the reimbursability is limited for the treatment of specific diseases. The Pharmaceutical Pricing Board confirms the reimbursement status for each drug.

Drugs are subject to three different reimbursements rates. The basic rate is 42% of the price and the lower special reimbursement rate is 72% while the higher special rate is 100% with fixed 3 euros co-payment. Drugs with higher reimbursement rates are used for treatment of certain severe, long-term diseases.

The reimbursement covers drug purchases up to a price that is confirmed reasonable by the pricing board and only the amount needed for three months use can be bought at a time. Typically pharmacies are able to credit the reimbursement directly to the patient. Otherwise patients can claim the reimbursement within six months from Kela. When the non-covered expenses exceed the annual co-payment limit, the exceeding expenses are fully covered by the additional reimbursement apart from 1.5 euros fixed co-payment. In 2009, the ceiling was 672 euros and it is adjusted annually by the consumer price index. Kela informs patients by mail when the co-payment ceiling is reached.

4 Descriptive statistics

The impact of drop in drug prices after patients exceed the co-payment ceiling can be illustrated by examining weekly drug consumption. Figure 1 presents mean individual drug costs by their current level of cumulative co-payments. The mean weekly drug costs are computed for patients in 10 euro bins. The co-payment ceiling is denoted by dotted vertical line. This demonstrates that co-payment ceiling has an evident effect on the level of consumption. After the ceiling the weekly consumption starts to increase and then it stabilises to a higher level. However, this analysis does not allow for causal interpretations about the consumption rates because it does not take into account the timing of purchases. It is possible that patients increase the amount of drugs purchased at a time but do not increase their

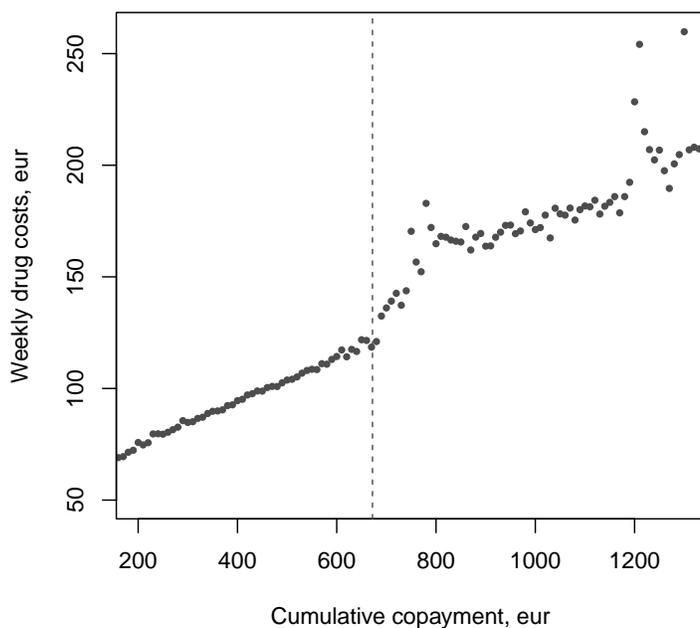


Figure 1: Weekly drug costs by the cumulative co-payments in 2009. Mean costs are computed for patients with co-payments in 10 euro categories.

overall consumption.

Figure 2 shows the average monthly expenditure on drugs for all patients and the expenditure for those exceeding the co-payment ceiling in 2009. The left panel illustrates the monthly variation in the drug purchases. The expenditure is relatively stable around 40 euros per month but there are two points that should be taken into account. First, there is a quarterly pattern in the purchases. This arises from the regulation that patients are allowed to purchase drugs at most for three months use. The pattern is even more evident when data are examined at individual level. Second, the purchases are higher in December which is due to the fact that patients who have exceeded the co-payment ceiling have incentive to hoard drugs at the end of the year.

The right panel in Figure 2 shows the average drug expenditure before and after the month that patients have exceeded the co-payment ceiling. The expenditure is computed only for those who reach the ceiling between April and September in

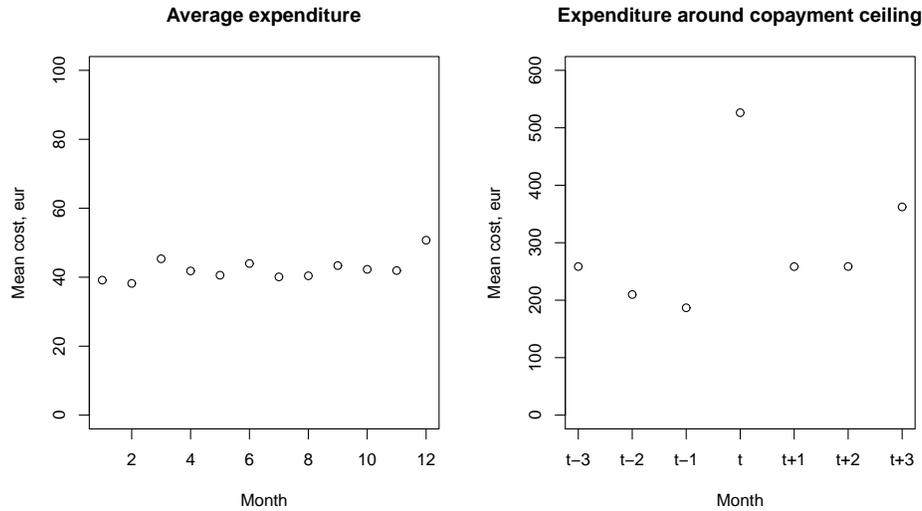


Figure 2: Average expenditure for all patients and for patients who exceeded the ceiling between April and September in 2009.

order to follow their expenditure level for three months using 2009 data. The expenditure level is much higher for them, 300 euros per month on average. The expenditure is highest when the ceiling is reached as all these patients have purchases in that month. Also similar three-monthly consumption pattern is apparent as for all drug users.

The number of patients exceeding the ceiling and their monthly expenditure is illustrated in Figure 3. The left panel shows that the number of patients increases steadily over the course of year from less than 1000 patients in January to over 5000 in December. This reflects the fact that there are relatively few patients with very expensive drugs that accumulate the co-payment ceiling rapidly. Also some patients may have bought their medication at the end of previous year and their next purchase will be in March. The right panel shows the annual expenditure on drugs by the month patients have exceeded the ceiling. The annual costs decline quickly for those in the first quarter and then fall fairly linearly for other patients. This indicates that patients exceeding the ceiling in the first quarter have very different medication from others.

Background characteristics for all patients and for those who have exceeded the ceiling are presented in Table 1. Those who have exceeded the ceiling are more often elderly and female than other patients. Their median annual income is below 15 000 euros which is related to the age distribution. Also they have high

Table 1: Patient characteristics in 2009

		Ceiling exceeded	Other patients
Age	15–59	0.365	0.732
	60–79	0.423	0.224
	80–	0.212	0.044
Gender	Male	0.376	0.489
	Female	0.624	0.511
Married	No	0.530	0.549
	Yes	0.470	0.451
Nationality	Finnish	0.991	0.972
	Other	0.009	0.028
Income, eur	0–999	0.240	0.248
	10 000–14 999	0.281	0.145
	15 000–19 999	0.152	0.110
	20 000–29 999	0.170	0.219
	30 000–	0.156	0.277
Drug costs in 2008, eur	0–49	0.019	0.501
	50–499	0.061	0.335
	500–999	0.109	0.098
	1000–	0.811	0.066
Ceiling exceeded in 2008	No	0.333	0.988
	Yes	0.667	0.012
N		34029	1060032

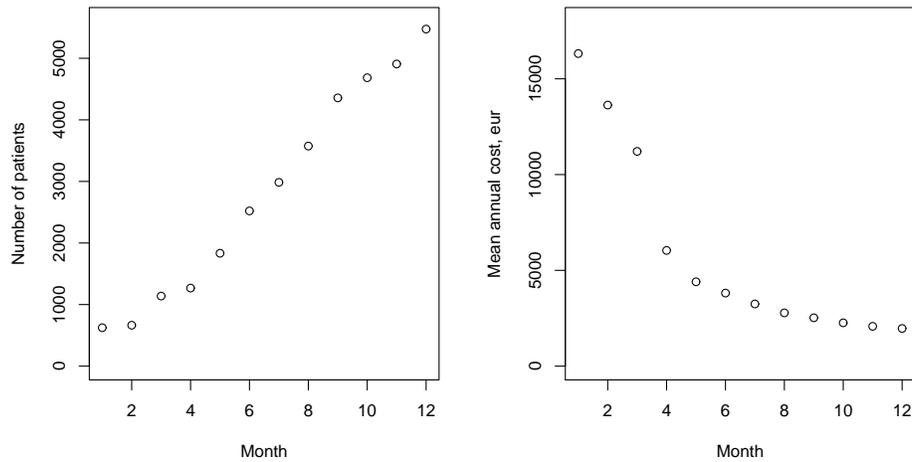


Figure 3: Number of patients and their average expenditure by the month when the ceiling is exceeded in 2009.

drug expenditure in previous year which likely relates to poor health and lower earnings. Two-thirds of these patients have exceeded the co-payment ceiling also in the previous year. Only around 12 000 of the patients who did not exceed the co-payment ceiling in 2009 did so in the previous year.

5 Estimation strategy

A key question in the identification of the effect of co-payment ceiling is how to construct a valid comparison group. Simple comparison of individuals who have exceeded the payment ceiling to those with less drug expenditures is subject to fundamental selection problem because those with low expenditures are likely to have better health. Individuals with good health may also have a more elastic demand for health care. Thus, the comparison of patients who have exceeded the co-payment ceiling, and therefore have high drug consumption, to those with lower drug expenditure gives biased and unmeaningful estimates.

The fact that the payment ceiling is annual provides exogenous variation in the probability of exceeding the payment ceiling. Some patients have similar drug consumption histories but differences in timing of their purchases. This analysis utilises these differences in timing in the identification of the causal effect of the

co-payment ceiling. The comparison group is constructed by selecting individuals who have the same cumulative co-payments as the treatment group but a large share of these purchases are done in previous year.

The construction of the comparison group is complicated by two important aspects of the analysis setting that were discussed in Section 4. Firstly, there is variation in the level of treatment because patients with very high drug expenditure exceed the co-payment ceiling early in the course of year. Therefore, different comparison groups need to be constructed based on the rate that the treated patients have accumulated their co-payments. Another aspect that complicates the analysis setting is a need for a meaningful follow-up period. A longer follow-up period means that purchases in the comparison group needs to be lagged more. Because the control group should have a similar rate of purchases as the treated patients before reaching the ceiling, patients in the control group are also expected to reach the co-payment ceiling at some point in time.

Based on the three-monthly consumption pattern observed in Figure 3, the follow-up period is defined to be three months. This should capture the purchases of different drugs that patients are using. The length of the follow-up period means that patients who exceed the co-payment ceiling between October and December are excluded in the analysis as it is not possible to follow them for three months before the end of year. The follow-up period also means that the patients in the control group need to be selected in such a way that their expected accumulation of co-payments remains below co-payment ceiling. Therefore, it is not possible to find controls for those who reach the co-payment ceiling in the first three month of the year.

Control group could be constructed individually based on the date when the co-payment ceiling is exceeded. However, to simplify the analysis setting, the drug consumption data is analysed on monthly level. The restrictions following from the three-month follow-up period lead to six different treatment groups running from April to September. The pre-treatment period is defined to be until the end of the month which includes the last purchase without eligibility to increased reimbursements and the follow-up period begins from the following month. The monthly analysis may imply either a upward or downward bias in the estimates depending on patients' timing of purchases after the co-payment ceiling.

Estimation is done using a propensity score matching combined with exact matching on the key variables. Exact matching is done with respect to gender, cumulative co-payments and drug expenditure in the pre-treatment period. Exact gender comparison is important to capture differences in gender specific health problems and drug usage patterns. Exact matching on cumulative co-payments (in ten euro bins) ensures basically that controls have the same rate of consumption as treated in the pre-period. Controlling for expenditure ensures that patients using

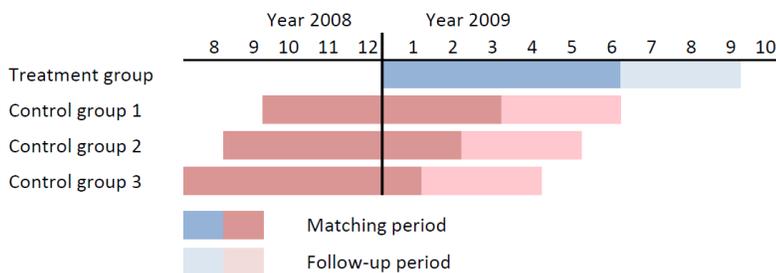


Figure 4: Example of alternative control groups for the June treatment group.

similar drugs are compared because drugs in different reimbursement categories result very different accumulation of co-payments.

Monthly analysis provides several different control groups for most treatment months. Figure 4 illustrates available control groups for the June treatment group. The first control group is lagged three months and the third group is lagged five months. A lag of three months is the shortest possible as otherwise the expected rate of consumption would mean that this control group would reach co-payment ceiling in the follow-up period. In this case, a lag of five months is the longest possible that splits the follow-up period between two years. Considering the different treatment months, only one control group is available for April while six groups are available for September.

It is not obvious which ones of the different control groups should be preferred over the others. Therefore, available controls are randomised before matching using equal weights for alternative control groups. As the objective in the analysis is to provide an average treatment effect, the main estimation is done jointly for the different treatment months. The results are also estimated separately by treatment month because heterogeneous effects can be expected with respect to drug consumption rate in the pre-treatment period.

The propensity score is estimated using logit regression. The controlled variables are age, age squared, being married, being native and four level income category. Alternative matching specifications will be tested later.

6 Results

This section presents results from the matching estimation. First the results are presented for the main estimation where the effect of all treatment months is estimated jointly. This is followed by the monthly estimation which shows how the

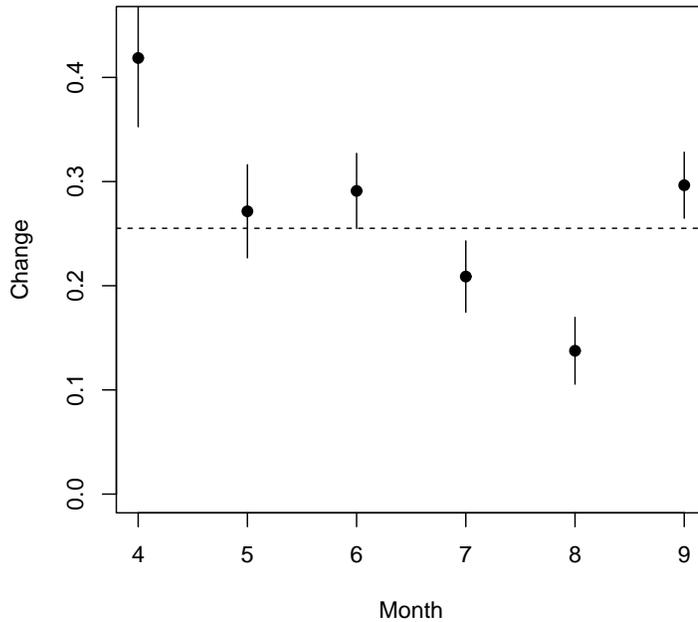


Figure 5: The effect of exceeding co-payment ceiling by month (dashed line shows the average effect, 2009 data)

treatment effect varies by the month the co-payment ceiling is reached. Then estimates for each reimbursement category are discussed. Finally the heterogeneity of the treatment effect is studied by the main background characteristics. The matching balance is presented in the appendix.

The level of drug consumption is estimated to increase 133 euros in the three months follow-up period after the co-payment ceiling is reached. When compared to the level of consumption in the control group, the estimate implies a 22% increase in the consumption. Given that patients face approximately 94% decrease in the prices, this corresponds to the price elasticity of -0.23.

Figure 5 shows the effect of exceeding the co-payment ceiling by the treatment month. The effect is largest for the April treatment group and smallest for the August treatment group. The September treatment group has surprisingly higher estimate than the August group. This is probably explained by the fact that December is included in the follow-up period for the September group. Increased consump-

Table 2: Effect by reimbursement category (2009 data)

	Change	Estimate	S.E.	N treated	Reference level
Main result	0.255	133	4	14880	521
Basic rate (42%)	0.325	90	3	14880	277
Restricted (42%)	0.226	22	2	14880	99
Lower special (72%)	0.252	22	2	14880	86
Higher special (100%)	-0.022	-1	2	14880	59

Table 3: Heterogeneity of the effect of the co-payment ceiling (2009 data)

		Change	Estimate	S.E.	N treated	Reference
Main result		0.255	133	4	14880	521
Age	15—59	0.387	189	8	4632	488
	60—79	0.200	115	6	6362	577
	80—	0.118	62	6	3886	523
Gender	male	0.227	125	7	5443	553
	female	0.289	145	5	9437	500
Income	—9999	0.187	101	8	3891	539
(in 2008)	10 000—19 999	0.250	138	10	2350	551
	19 999—29 999	0.378	184	10	2242	486
	—29 999	0.342	161	11	1957	470

tion in December is due to the hoarding effect shown in Figure 3.

Table 2 presents the matching estimates separately for different drug reimbursement categories. The price change is highest for drugs with basic reimbursement rate and therefore it is expected that also the change in the level of consumption is highest when the ceiling is exceeded. The consumption increases 32.5% which is clearly higher than the 25.5% increase for all drugs. The drugs with restricted reimbursability includes drugs that are reimbursed only in case of specific medical condition listed by Finnish Social Insurance institution. These drug are typically fairly expensive and require additional medical certificate. Their demand increase ten percentage points less than regular drugs in the same reimbursement category which could be explained by the more controlled availability. The estimate for the drugs with lower special rate is 25.2% that is close to the main estimate. The price change for these drugs is much smaller than for drugs with basic rate. Finally the drugs with 100% reimbursement rate do not show any statistically significant change in their demand which is not surprising because for their prices drops from 3 euros to 1.5 euros for patients.

Heterogeneity of the effect with respect to the patient characteristics is ana-

lysed by estimating the matching model separately for subpopulations defined by age gender and previous year income. The results are presented in Table 3 which shows that the estimates are much lower for elderly patients. The working-aged patients increase their consumption by 38.7% while those over 80 years increase consumption only by 11.8%. Also males and females show slightly differing responses as males increase their consumption only by 22.7%. When patients are analysed by their previous year income, low income patients increase their consumption much less than middle income patients. This is in line with the result for working-aged patients. The average income level in this population is low mainly due to a large share of elderly patients.

7 Conclusions

Expenditure on prescription drugs has been growing rapidly and has contributed significantly to the overall cost growth in health care in most OECD countries. In Finland, this has led to a need curb the cost growth, and recently several cuts has been implemented that have changed the National Health Insurance scheme. However, to reform the instance scheme in socially optimal way information is needed how patients respond on cost sharing rules. This paper estimates the effect of patient co-payment ceiling on prescription drug consumption using individual level data on all Finnish patients.

The National Health Insurance covered an average of 51% of patients' prescription drug costs until an annual co-payment ceiling is reached. After the ceiling is exceeded all costs are covered by the insurance apart from small fixed fee. Similar policies, where the out of pocket expenditure share decreases with the level of consumption, are in use in several countries. The identification strategy used in the analysis utilises the fact that patients with similar drug consumption histories face different prices depending on the timing of their purchases. The comparison group includes patients with the same cumulative co-payments as those who have exceeded the co-payment ceiling but a large share of their purchases are done in previous year and therefore they are not eligible for increased reimbursements.

Results are based on exact matching with respect to gender, cumulative co-payments and drug expenditure history. In addition, propensity score matching is used for other individual characteristics. The results show that the level of drug consumption increases by 133 euros in the three months follow-up period after the co-payment ceiling is reached. When compared to the level of consumption in the control group, the estimate implies a 22% increase in the consumption. Given that patients face approximately 94% decrease in the prices, this corresponds to the price elasticity of -0.23. The result is in line with previous studies from the

US and Europe that have examined the effect of cost sharing on use of medical services and prescription drug consumption. The fiscal impacts of changing the Finnish insurance scheme could be predicted more accurately using the results of this study and also higher elasticity among employed patients can be taken into account when considering socio-economic impact of the such reforms.

References

- Austvoll-Dahlgren, A., Aaserud, M., Vist, G., Ramsay, C., Oxman, A., Sturm, H., Kösters, J. & Vernby, A. (2008), 'Pharmaceutical policies: effects of cap and co-payment on rational drug use.', *Cochrane database of systematic reviews (Online)* (1).
- Chandra, A., Gruber, J. & McKnight, R. (2010), 'Patient Cost-Sharing and Hospitalization Offsets in the Elderly', *The American Economic Review* **100**(1), 193–213.
- Contoyannis, P., Hurley, J., Grootendorst, P., Jeon, S. & Tamblyn, R. (2005), 'Estimating the price elasticity of expenditure for prescription drugs in the presence of non-linear price schedules: an illustration from Quebec, Canada', *Health Economics* **14**(9), 909–923.
- Leibowitz, A., Manning, W. & Newhouse, J. (1985), 'The demand for prescription drugs as a function of cost-sharing', *Social Science & Medicine* **21**(10), 1063–1069.
- Manning, W., Newhouse, J., Duan, N., Keeler, E. & Leibowitz, A. (1987), 'Health insurance and the demand for medical care: evidence from a randomized experiment', *The American Economic Review* **77**(3), 251–277.
- OECD (2013), Health at a glance 2013 - OECD indicators. OECD Publishing.
- Simonsen, M., Skipper, L. & Skipper, N. (2010), Price Sensitivity of Demand for Prescription Drugs: Exploiting a Regression Kink Design. Economics Working Papers, School of Economics and Management, University of Aarhus.
- Winkelmann, R. (2004), 'Co-payments for prescription drugs and the demand for doctor visits—Evidence from a natural experiment', *Health Economics* **13**(11), 1081–1089.

Appendix

Table 4: Matching balance (2009 data)

	Before matching				After matching			
	Treated	Controls	SMD	p	Treated	Controls	SMD	p
Age	66.402	65.652	4.434	0.000	66.402	65.272	6.685	0.000
Age2	4695	4599	4.662	0.000	4695	4575	5.816	0.000
Married	0.443	0.462	-3.830	0.000	0.443	0.435	1.531	0.164
Immigrant	0.007	0.009	-2.215	0.028	0.007	0.009	-2.729	0.027
Income 10000-14999	0.298	0.290	1.738	0.073	0.298	0.290	1.911	0.097
Income 15000-19999	0.158	0.159	-0.176	0.856	0.158	0.148	2.599	0.023
Income 20000-29999	0.151	0.166	-4.149	0.000	0.151	0.150	0.151	0.893
Income 30000-	0.132	0.140	-2.469	0.012	0.132	0.135	-1.112	0.332
Expenditure in 2008	2422	2639	-14.457	0.000	2422	2410	0.816	0.265
Co-payments in 2008	1144	1246	-15.357	0.000	1144	1141	0.465	0.266
Female	0.634	0.647	-2.579	0.008	0.634	0.634	0.000	1.000
Treatment month	7.246	7.314	-4.407	0.000	7.246	7.246	0.000	1.000
Co-payment category	9.454	13.295	-52.283	0.000	9.454	9.454	0.000	1.000

Note: SMD stands for standardised mean deviation.