Econometric studies of Japanese prescribing (Iizuka 2007, 2009)

- Provides some of the first quantitative evidence on the extent to which the integration of prescribing and dispensing distorts prescribing behavior.
- Finds that the doctor is willing to forgo $1 of markup in exchange for a $0.28 reduction in patient cost.
- A counterfactual simulation suggests that expenditures on hypertension drugs are inflated by 10.6% from overprescribing, and another 4.4% from the substitution of more expensive drugs that offer higher markups.

China’s 2009 Health Reforms

Overview by Karen Eggleston
Stanford University Asia Health Policy Program
September 2009

Key features

- Expanding coverage of basic medical care, combining
  - social insurance (demand-side financing, Bismarckian system, ~2/3 of financing) with
  - Direct government provision (supply-side financing, Beveridge system, ~1/3 of financing)
- Expanded population health service benefit package, strengthening primary care, essential drug list, separating prescribing and dispensing, reforming public providers
- “an arduous and long-term task…”

Implementation Plan (2009-2011)

- “The implementation of the five priority reform programs aims at effectively solving the problem of ‘difficult and costly access to health care services’, which arouses intense public concerns.”
- “Making the basic health care system as public goods to the general public…”
- “Reverse the profit-orientated behaviors of public health care institutions and drive them to resume their commonweal nature…”

Expanding public financing

- “Estimates suggest that governmental investment (both central and local) of CNY850 billion (about US$124 billion) will be injected into the health-care system in the coming 3 years, doubling the average annual governmental expenditure compared with 2008” (p.1322).


Karen Eggleston, Stanford 2009

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Several of the **Five Priorities** touch on pharmaceutical policy

1. Expanding basic medical insurance to 90% coverage;
2. National essential drug system;
3. Strengthening grass-roots health services [primary care];
4. “Gradual equalization of basic public health services”;
5. Government hospital reform pilots.

**(2) National essential drug system**

- Improve drug supply: "Bring into full play the role of market forces in pushing forward merger and restructuring of pharmaceutical manufacturing and distributing enterprises…"
- Central government sets "guiding retail prices" of essential medicines.
- Based on the result of tender, provincial governments set the unified purchasing prices within the range of the government-guided prices, with the distribution charge included in the purchasing price.
- "Government-run health care institutions at grass-roots levels shall sell drugs with zero mark up."
- Essential medicines will be insured, "with the reimbursing levels much higher than that of non-essential medicines."
- Patients are allowed to purchase drugs in retail pharmacies with prescription.

**(3) Strengthening grass-roots health services**

- Construction of around 2000 county-level hospitals (including TCM hospitals) within three years
- 3700 urban community health centers and 11,000 community health stations will be newly built or renovated in three years
- Train 360,000 health care professionals for township health centers, 180,000 for urban community health institutions and 1.17 million for village clinics in three years
- "The service charges of grass-roots health care institutions shall be set according to the costs after deduction of government subsidy. As long as drugs are sold at zero price margin, the revenue from drug sales will no longer be compensation sources for funding grass-roots health care institutions, and drug discount shall not be accepted."

**(5) Government hospital reform pilots**

- Local governments encouraged to experiment
- Remove reliance on drug dispensing revenues
- "The separation of health care services and drug sales should be promoted, gradually reducing the drug price margin, and defining the acceptable level of any drug procurement discount. The revenue reduction and losses incurred from the reform shall be resolved through introducing prescription fees, readjusting the charging criteria for some technical services, increasing government investment, and etc. The prescription fees shall be integrated into the reimbursement scope of the basic medical insurance.
- "Special needs [VIP] services limited to no more than 10% of services provided"
- "Non-public investors are encouraged to sponsor non-profit hospitals. Non-public hospitals are entitled to the same treatment with their public-owned counterparts…"

**Why it matters for us**

- Global pharmaceutical supply chains, safety and quality
  - E.g. Heparin – see Santoro and Liu chapter
- Pharmaceutical industry development globally, supply of innovative drugs, international initiatives on health (MDGs and beyond)…

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**DRUG DEVELOPMENT AND ACCESS: PACIFIC ISSUES**

John H. Barton
Professor Emeritus
Stanford Law School

Colleague and friend: May he rest in peace
MIDDLE-INCOME MARKETS
e.g. ASIA

- The area of growing market share that will ultimately have to be a source of innovation return.
- Yet, much poverty.
- Therefore, the IP battleground (e.g. current Thai debates).
- A market division would be ideal, but pattern unclear - and hypercomplicated by health-care provider reliance on drug sales.

A PLAUSIBLE GLOBAL DEAL

- Commitments by high-income nation health care systems to buy products at cost-effectiveness based prices.
- Commitments by the same nations and by global funds to pay for products unique to developing nations at prices that create research incentive.
- Generic-priced market for poorest nations.
- Special arrangements for middle income nations like China.
- Possibly implement as a sector-specific WTO code.

UNAVOIDABLE ISSUES

- Move toward cost-effectiveness-based pricing in developed world
- GFATM etc. & research donor policies to support technology development
- Generic prices for low-income nations
- Patents losing relevance
- Roles for middle income (e.g. Asian) nations:
  - Market division
  - Research & production (China and India)

PRIORITY REVIEW VOUCHERS TO ENCOURAGE INNOVATION FOR NEGLECTED DISEASES

Henry G. Grabowski
David B. Ridley
Jeffrey L. Moe
Duke University

Some Important Features of Priority Review Vouchers

- Vouchers can be transferred or banked
- Companies must pay a supplemental user fee to utilize a priority voucher
- Companies must give FDA 365 days notice before using the voucher

U.S. Sales Profile with Voucher