Introduction to Health Systems of BRICS Countries

Brazil

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The Brazilian health system is a mixed system, formed by a large public health system, the SUS (Unified Health System), the health supplemental companies, and out-of-pocket payments. The public system, by definition, is a system of universal coverage, and so every Brazilian citizen can use the system at no additional cost. Even with this guaranteed right to health, included by the country constitution, 25 percent of the population (about 49 million people) have health insurance, but still they are entitled to use the public system.

The federal budget to health in Brazil in 2014 is R$106 billion, and beyond this federal investment, states and municipalities also allocate part of its tax collection to the public health system.

The most recent change in the health system was in April 2011, with the enactment of Law 12.401, which amended the Act No. 8080 in 19th of September 1990, to define therapeutic care provision and health technology incorporation within the Unified Health System - SUS.

This law established that health technologies available in SUS will be those evaluated for its efficacy, safety, effectiveness and cost-effectiveness for the different phases of the disease. This law also established a major change, the creation of the National Health Technology Incorporation commission (CONITEC), a multidisciplinary committee that has both a technical area as a decision-making body, and that the incorporation, exclusion or modification by SUS of new products, medicines or procedures, as well as the modification or creation of treatment guidelines, are functions of the Ministry of Health, which will be advised by CONITEC.

The CONITEC reports on new technology assessments evaluate: the scientific evidence on the accuracy, safety, efficacy, effectiveness of the technology in health (medicine, procedure or product); comparative economic evaluation of costs and benefits, in comparison with technologies already present in SUS, and analysis along with the budgetary impact that new technology would result in the system, and the structural impacts on the system (facilities, professional training, logistics, distribution, etc.) are also taken into consideration.

The evaluation process of CONITEC has a period of 180 days to have a position issued officially, and this period may be extended for another 90 days when necessary and authorized by the Ministry of Health, using appropriate justification. After publication, the position goes through a public consultation and a public hearing, if necessary, before the final decision on the case.

Despite CONITEC being a committee focused on the public health system, the supplementary health system has used the results of assessments to base their decisions on incorporation and reimbursement as well.

Thus, HTA has become an important tool for the health system in Brazil, being used in deciding incorporation of health technologies for safer and real positive effects on patients’ health technologies, thereby justifying investment in them, being available in the public health system and supplementary health in Brazil.

Reference:

Brazil. Law 12.401, 28th April 2011. Amends Law No. 8080 19th September 1990, to provide for the therapeutic care and the incorporation of technology in health within the Unified Health System - SUS. Official Gazette, Executive, Brasília, DF

Russia

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Russia has been undergoing constant health care reforms in the last 10 years. Significant government funds have been pumped into the health care system through drug reimbursement programs, National Priority Project Health, Regional
Health Care Facilities Modernization Project and Pharma 2020 strategy. The government health care spending increased sixfold over the last decade, but its share in GDP remains critically low amounting to only 3.3%. Life expectancy is one of the lowest in developed and developing world reaching only 70 years.

Russian health care expenditure is poorly allocated and administered with up to 40% of its total volume being used ineffectively. Ministry of Health continues efforts aimed at increasing the effectiveness of health care spending and applying evidence-based medicine and health economics approaches in decision-making. However Russia is the only developed country which does not have an official HTA body. The need for HTA is understood at the highest governmental level, and it is expected that an HTA body will be established in the country by the end of 2014.

The coverage of population is nominally universal, free and guaranteed as a constitutional right. The responsibility for enforcing this right is shared between the central, regional and local authorities. The scope of free medical care is determined by the state medical benefit package providing comprehensive coverage of basic benefits which is undermined by the persisting scarcity of resources and informal payments. Outpatient prescription drugs are not covered by the aforementioned benefit package and must be purchased out-of-pocket by the majority of the population except for a limited number of “vulnerable” groups. 70% of out-patient drugs are covered out-of-pocket.

Russia utilizes a hybrid social insurance and budgetary health system model which lacks efficiency. Health financing is a relatively even mix of financing from compulsory sources (general taxation and payroll contributions for Obligatory Medical Insurance) and out-of-pocket payments. Currently 60% of health care spending comes from the budgets of all levels while 40% - from the Obligatory Medical Insurance Fund (OMI). It is planned that by 2015 more than half of health care spending will be channeled through OMI covering both current and long-term capital investment demands of the healthcare establishments. Transition to a predominantly one channel OMI funding system over the next several years is considered as a tool to reduce duplication and increase efficiency. However such important players of the OMI system as insurance companies still do not create adequate pressures for efficiency. Russia has not yet determined which of the two health care models – Bismark or Beveridge - it is going to strive for in the next few years.

Regulatory requirements for orphan drugs were simplified, the list of priority orphan diseases was established and criteria for funding orphan drugs are being developed.

Ministry of Health continues working on developing a roadmap to a sound drug reimbursement and pricing system to be introduced in 2015-2016. It also plans to develop a list of interchangeable drugs to increase access of generics and move from direct government price regulation to reference pricing and price negotiations with the industry.

India

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The WHO Country Office for India’s areas of work is enshrined in its new Country Cooperation Strategy (CCS) 2012-2017. In order to improve access to quality-assured essential medicines at affordable cost, the CCS has strongly focused on Strengthening the pharmaceutical sector including drug regulatory capacity of regulatory bodies in line with the emphasis on “trade and health” (TRIPS), continued advocacy for reducing prices, improvements in procurement and supply chain management of essential medicines including reducing “stock-outs” in public health facilities, ensuring quality especially for quality essential products for managing NCDs, TB, HIV/AIDS, malaria and neglected tropical diseases (NTDs), among others. It has also recommended for scaling up of rational drug use initiatives and sector inspections (e.g. distribution, prescription, and delivery over the counter) in order to protect customers and contain antimicrobial resistance.

The WHO CCS – India (2012-2017) has been jointly developed by the Ministry of Health and Family Welfare (MoH&FW) of the Government of India (GoI) and the WHO Country Office for India (WCO). Its key aim is to contribute to improving health and equity in India. It distinguishes and addresses both the challenges to unleashing India’s potential globally and the challenges to solving long-standing health and health service delivery problems internally. (Source: WHO India)

As a part of these initiatives some states in India have revised their drug policy and have also established Jan Ausadhi stores (for selling low cost quality assured generic medicines), state-funded medical corporations (other states are in the run) for strengthening procurement & supply chain management of essential medicines & commodities as a mandate of government for free distribution of medicines including but not limited to promoting rational use of medicines through updating EDL, STG & its use, addressing the training needs of medical fraternity including the paramedical staff,
strengthening drug regulatory system for strengthening quality assurance of medicines which is aimed at reducing out of pocket expenditure, thereby improving availability and access to essential medicines.

**China**

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The big organizational and structural change in 2013 was the merging between the Ministry of Health and the National Population and Family Planning Commission. Now the National Health and Family Planning Commission (NHFPC) is being formally established, which is working on the rational use of medicines, selection of essential medicine list (EML) and drug procurement and bidding in national and provincial levels.

China’s health system is very fragmented. For instance, the Pricing Bureau of National Development and Reform Commission (NDRC) is in charge of drug pricing, the formulation of drug reimbursement list (DRL) and payment system design is led by the Ministry of Human Resources and Social Security (MOHRSS). The drug registration and approval is managed by China Food and Drug Administration (CFDA), finally, the drug distribution and retail is administered by Ministry of Commerce (MOC).

The share of national total health expenditure in GDP was 5.4% in 2013. It is the first time that the national health expense exceeded 5% GNP, which is the standard of NHA in developing countries advocated by the World Health Organization in 1970s. The proportion of pharmaceutical expenditure was 42.2% (2.28% GDP); the pharmaceutical expenditure per capita in China in 2013 was equal to $138.82 USD. Although China is an emerging market, the pharmaceutical expenditure per capita is still at a very low level.

The tendency of cost- plus based drug pricing systems will be gradually shifted to the value-based pricing, and through price bidding, bulk purchasing and price negotiation. Health technology assessment and pharmacoeconomics have been recognized by the authorities of health, pricing and payer sectors. The economic outcomes (one of ECHO indicators) of a drug is becoming one of the important criteria in the selection of DRL (innovative and established products). The latest version of the national essential medicine list was issued in 2012, which includes 520 items (317 chemical drugs and bio-products, and 203 traditional medicines). All essential medicines are belonging to Class A in the drug reimbursement list without co-payment by insured.

The community health centers in urban and rural areas will utilize essential medicines with zero- markup (margin), however, the volume and the value of essential medicines used in secondary and tertiary hospital are still under the discussion, supposedly, it will be 40%-50% and 25%-30%, respectively. The market access will be expected to grow since the generic products can be widely used in China along with the merging of three medical insurance schemes (urban basic employee basic medical insurance, urban resident basic medical insurance and rural cooperative medical system). In the future, the urban and rural resident basic medical insurance schemes will be merged together under one roof; the benefit package will also be unified soon.

The recent health system reform is emphasized on the reforms of city and county public hospital and medical insurance payment systems. The rationalization of medical service and pharmaceutical price setting and the control of drug prices remain the future policy direction.

**South Africa**

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The health care market is a 2-tiered system, with distinct private (insured) and public (government) sectors, consuming 8.5% of GDP on health, i.e. R 272 billion. The population of 50.59 million may be categorized into 3 groups consuming health care services: 51% unemployed, 32% employed but uninsured, 17% employed with insurance, using public, public and private, and private services respectively.

Current government budget on health represents 4% of GDP, typically serving 83% of the population, with private sector contributions, covering 17%, representing 4.5% of GDP.

National Department of Health (NDoH) policy dictates that priority is given to primary care and the quadruple burden of disease. Historical consequences of underfunding in the public sector have resulted in deterioration of standards, infrastructure, equipment and skills. Government is driving a turnaround strategy to ultimately provide universal health
care, through the implementation of a national health insurance (NHI), beginning with infrastructure recapitalization and improvement, skills development and accreditation.

The private funding industry comprises just over 95 schemes, with over 330 plans, depending on health need and affordability. Each scheme may or may not sub contract administration and/or managed health care (MHC) services, which provide clinical risk-based health technology assessments (HTA) of all health interventions, drugs, medical devices and equipment that define benefit design. This includes reviewing clinical evidence, cost-effectiveness and budget impact to that scheme and mechanisms to monitor use, evaluate clinical necessity, efficacy, and appropriateness, efficiency of services, procedures and settings.

Reimbursement is predominantly on a fee-for-service, evolving towards alternative reimbursement models i.e. DRGs. Schemes pay independent medical practitioners in private practice, and private hospitals directly and separately. The private hospital industry is dominated by 3 major listed hospital groups, who make up 90% share of hospital beds.

Health care professionals, organized into special interest groups typically by specialty, may also have a commercial arm which looks after business interests (tariff negotiation) for each group.

South African market access for drugs is regulated by the Medicines Control Council (MCC), whose scope also extends to combination device/drug devices. Currently no regulations exist for medical devices, only electro medical equipment. A new regulatory South African Health Products Regulatory Authority (SAHPRA) entity is being established but timelines for this are unknown.

Reimbursement for any product in the private sector is subject to the allocation of a NAPPI Code (NAtional Pharmaceutical Pricing Index) to that product, but is not a guarantee for reimbursement. Each new product, once registered where relevant, then passes through various mechanisms for approval with private funders, and may include HTA and price benchmarking.

The public sector purchases based on a tender system, or buyout, depending on departmental need and approval by budget holders.

HTA and pharmacoeconomics are recognized by the NDoH as key features for managing market access of affordable and sustainable health technologies. Guidelines for Pharmacoeconomic Submissions came into effect on 1 April 2013 but shall be on a voluntary basis until the Director General of Health declares otherwise. There is however no clear threshold or guidance on an appeals process.

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