Reforms in relation to access to essential medicines and technologies in South Africa

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16 December 2014
Apartheid-era health policies

- South Africa - substantially shaped by its colonial and apartheid past that divided society by race and class
- Health fragmented along racially divided lines
- Bantustans systematically underfunded
Effects on the availability of medicines

- 14 different departments of health involved in selection of medicines
- Irrational selection reflecting the bias of individual prescribers
- Illogical, duplicative and inefficient procurement lists
- Health financing and availability of medicines inequitable and divided along racial lines

The manifestations of inefficiencies
Post-apartheid health reforms

- Creation of a unitary health system
  - National Department of Health; 9 provincial Departments of Health; National Health Council; municipal health services delivered by local authorities

- Public sector inadequately funded
  - 2011 per capita expenditure ZAR 2,667 (390 USD)

- Private sector expensive
  - 2011 per capita expenditure ZAR 11,048 (1,600 USD) (mostly for members of “medical schemes”)
Key inefficiencies in medicines supply

- Fragmentation - selection of medicines by 14 departments of health
- Racially-defined financing - inequity
- Loss of access to distribution facilities as a result of new provincial boundaries, and
- Lack of influence over the rational use of medicines by health professionals and patients.
- Procurement lists that were over-priced & bloated with non-essential drugs (2,600 items in 1994)
Reforming the provision of medicines

- National Drug Policy (1996) - to ensure the availability and accessibility of essential drugs to all citizens.
  - Essential Drugs Programme (EDP) – to address selection of essential medicines and rational and safe use.
- National Essential Drugs List Committee for PHC level
  - Multi-professional membership
  - Standard treatment guidelines as the starting point for the development of an essential medicines list
Essential drug lists and treatment guides

- A three-tier system involving national, provincial and local government;
- Based on Essential Medicines List and Standard Treatment Guidelines

PHC (4 editions)  Paediatric (3 editions)  Adult (3 editions)
Evolution of the reforms

1996 - 1999
Introduction of evidence based medicine
- Introduction of therapeutic class – increased competition.
- Multi source pharmaceutical products or generics
- Prices published in formularies and “code lists”

2000 onwards
- Peer review mechanism
- Review format standardised
- EBM approach strengthened
- Greater use of pharmacoeconomics
- Improved alignment between the tender and the EDL
Evidence-based selection meant to improve procurement processes and result in efficient use of limited resources that would lead to rational use of medicines.

Pooling procurement as per EML at a national level was expected to result in lower prices by leveraging volume and increasing competition.
Implementation challenges

- Provinces had autonomy over finances (Constitution)
  - threatened to reverse the efficiency gains expected from the nationally-determined essential medicines lists.

- Provincial Pharmacy and Therapeutics Committees continued to make selections
  - sometimes different medicines of the same pharmacological class without evidence-based reasons.

- PTCs meant to be established in all provinces but vary in capacity and performance.
  - Some stable and effective but others have had to be revived.
Implementation challenges

• Poor quantification of demand
  o Central pharmaceutical data warehouse planned but never implemented.

• Out-sourcing of provincial depots to private operators
  o Use of proprietary procurement and supply management software; problems of cross-systems interoperability

• Ownership and monitored dissemination of EDLs
  o EDL Committees were dissolved once the books were published; guidelines produced by national vertical programmes increasingly deviated from the selection made by the EDL committee in 2003
Effects of the reforms

- % of encounters in which an injection was prescribed
- % of encounters in which an antibiotic was prescribed
- % of items prescribed generically
- % of prescribed medicines from the EML
- % availability of medicines from EML
- % availability of key medicines
- % availability of STG/EML

Results of the reforms
Effects of the reforms

- No published evidence whether standard treatment guidelines and essential medicines lists improved the efficiency of procurement of medicines
- Recently, changes to the procurement system reducing the involvement of the National Treasury
- Use of indicative prices, resulting in lower prices for the procurement of antiretroviral drugs - Same approach applied in other recent tenders
- More centralised and NDOH-controlled process for the procurement and the distribution of third-line antiretroviral medicines for HIV infection.

Results of the reforms
Effects on the private sector

Of specific relevance to the private sector:

• if managed health care entails the use of a formulary or restricted list of drugs, must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability;
Effects on the cost of medicines

- 1996 National Drug Policy made provisions for reducing costs (use of generics, rational use, etc.)
- 1997 Medicines and Related Substances Amendment Act created Pricing Committee (advisory to Minister of Health
  - single exit price for all prescription medicines;
  - regulated maximum dispensing fees;
  - a ban of off-invoice bonuses, rebates and other marketing incentives; ban of the supply of free samples of medicines;
  - (voluntary) guidelines for the submission of pharmaco-economic evaluations of new medicines

Results of the reforms
Impact of private sector cost reforms

Impact of pricing policies according to annual reports of the Council for Medical Schemes.

- Expenditures on fees for health professionals remained relatively constant.
- Expenditures on medicines declined after 2001 with a more accentuated decline after 2003.
- Coincided with increased prescriptions of generic medicines
- Rate of increase in expenditures for medicines in the private sector is far less than the rate of increase in the costs of private hospitals and medical specialists
What remains to be done?

• Persistent problems with data quality of the National Health Information System

• Persistent information gaps between province and national levels in relation to the overall supply, management and use of medicines and technologies.

• Problems in quantification of needs by provinces - affects national tenders and planning cycles of suppliers.

• Variable financial management by provinces - some provinces unable to pay suppliers on time
Lessons learned

• Socio-political and economic context
• Regular monitoring and updating
• M&E included and supported in the implementation
• Sustainable financing
• Transparency in selection, procurement and regulation
• Essential medicines lists based on evidence and constantly updated