Using strategic price negotiations to contain costs and expand access to medicines in China

Lei Si, L, L, L L L L, 1,2 L L L L L L, 3 Mingsheng Chen, 4,5,6 Stephen Jan 1,2

As China moves toward achievement of universal health coverage, it is critical that measures are in place to contain expenditures on medicines. Between 2001 and 2016, such expenditure rose by 664%.1 Historically, perverse provider incentives in which doctors were remunerated through commissions on markups on sales of medicines, as well as a fragmented system of regulation, have been major contributors to these cost pressures.2,3 While recent reforms have moved in some way to rectify these problems,4 estimates from 2016 indicate expenditure on medicines represents 36.3% of overall healthcare expenditure.1

Against this background, on 28 November 2019, China’s National Healthcare Security Administration (NHSA) and the Ministry of Human Resources and Social Security released: Notice on Including Year 2019 Negotiated Medicines in ‘National Basic Medical Insurance, Work-related Injury Insurance and Childbirth Insurance Medicine List (Category B)’. Lying within this seemingly anonymous report is a landmark shift in health policy in China. A key feature was a process of centralised strategic price negotiation with pharmaceutical companies underpinned by evidence from health technology assessment (HTA).

The process involved negotiations over 3 days between representatives of pharmaceutical companies and the NHSA. For each medicine, the company had two shots at bidding for a price. The medicine was rejected if both of these bids were 15% higher than the audited price provided by the NHSA. The audited price was based on independent analyses from two expert HTA panels drawn from a pool of pharmacoэкономists and health insurance auditors. A total of 150 medicines were included in the price negotiations, including 119 new medicines and 31 previously listed medicines. The outcome was that 70 new medicines (31%) were listed and 27 existing medicines (87%) were retained following these price negotiations. On average, the price of new medicines was reduced by 60.7% and that of existing medicines subject to review reduced by 26.4%.3 For Category B medicines (ie, newer-generation medicines that are either patented or have recently expired patients), the patient copayment is generally set at around 50% of the listed price, although it varies among jurisdictions. After these price reductions, it is expected that such copayments will fall to below 20% of the prelisting price of the medicines. As a result of the price

Summary box

- A key feature of the amendment to the list was a process of centralised strategic price negotiation with pharmaceutical companies underpinned by health technology assessment (HTA) evidence. In addition, medicines for cancers, rare diseases, chronic diseases and children’s diseases were prioritised in the price negotiations.
- In China, there is a nascent HTA network housed in 48 academic centres across the country and routinely called on to conduct such studies and deliver workshops and seminars. Although it draws on much guidance from HTA institutions in high-income countries (eg, UK and Australia), it differs in its independence from government and its decentralised nature.
- It is vital for China to continue to build capacity in the field of HTA and institutionalise it into health sector decision making to expand access to healthcare at reasonable cost and thereby achieve universal health coverage.
negotiations, the price of these five selected medicines is
will fall considerably.

Figure 1 illustrates the price comparison of five selected
medicines with revealed price in China, Australia and the
UK. For example, the price of dapagliflozin (10 mg) per
tablet is 4.36 RMB Yuan (approx. US$0.62), which is
cheaper than the prices in Australia ($A2.01 or approx.
US$1.36; price ratio: 2.19) and the UK (£1.31 or approx.
US$1.69; price ratio: 2.73). For the selected medicines,
the prices will in the UK and Australia will be between
135% and 620% of what is paid in China.

Another feature of this round of amendments is that
medicines for cancers, rare diseases, chronic diseases and
children’s diseases were prioritised in the price negoti-
ations. For example, sintilimab, which is a fully human
IgG4 monoclonal antibody that binds to programmed
cell death receptor-1 is now publicly available to Chinese
patients for the first time. Further, to tackle the burden of
hepatitis C, three new medicines have been added to the
list.

This new framework for the negotiation of pharmaceu-
tical prices represents an example of a country using its
strong purchasing power to achieve lower prices in phar-
macueticals. A key element in this process is that it is not
simply about driving prices to the lowest possible level,
but that the negotiations are underpinned by an evidence
base of the comparative value (or cost-effectiveness) of
each medicine. This underlying value of each medicine,
typically measured in terms of health gains, gives the
purchaser (government) an idea of the price it needs to
obtain in order to achieve value for money.

Such economic evidence comes from the third-party
independent evaluations in the guise of HTA. In China,
there is a nascent HTA network housed in 48 academic
centres across the country and routinely called on to
conduct such studies and deliver workshops and sem-
nars. Although it draws on much guidance from HTA
institutions such as the National Institute for Health
and Care Excellence in the UK and the Pharmaceutical
Benefits Advisory Committee in Australia, it differs in its
independence from government and its decentralised
nature.

The recent edition of the National Basic Medical Insur-
ance, Work-related Injury Insurance and Childbirth Insurance
Medicine List represents a landmark shift in medicines
policy in China. This initiative will promote resources
being allocated on the basis of value for money and lead
to improvements in access to medicines for Chinese
patients. In this first round of this reform, we observe
reductions to price levels that are substantially lower than
Australia and the UK.

This process of negotiation is underpinned by evidence
generated through a formal HTA process. Building
capacity in the field of HTA and institutionalising it into
health sector decision making is critical for enabling
countries such as China to expand access to healthcare
at reasonable cost and thereby achieve universal health
coverage.

Contributors All authors conceived, wrote and edited the commentary.

Funding This research is funded by the National Natural Science Foundation
of China (Grant number: 71503137, 71874086) and the China Medical Board
(Grant number: 19-346). LS is funded by a National Health and Medical Research
Council Early Career Fellowship (Grant number GNT1139826). However, the views
expressed do not necessarily reflect the policies of the grant funding body.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement No data are available.

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ORCID iD
Lei Si http://orcid.org/0000-0002-3044-170X

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