

# **FINANCING DRUGS IN SOUTH-EAST ASIA**

## **Report of the first meeting of the WHO/SEARO Working Group on Drug Financing**

Korat, Thailand  
26-28 November 1996

Action Programme on Essential Drugs  
Geneva

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# Contents

<b>Executive summary</b> .....	<b>i</b>
Background .....	i
Drug financing issues.....	ii
Cost-sharing for drugs .....	iii
Monitoring for equity and quality.....	iii
Conclusions and recommendations.....	iv
Workshop evaluation .....	vi
<b>1. Introduction</b> .....	<b>1</b>
1.1 Opening session.....	1
1.2 Background.....	2
1.3 Objectives of the Working Group .....	2
<b>2. Country presentations on drug financing</b> .....	<b>5</b>
2.1 Indonesia (presented by Dra Andayaningsih) .....	5
2.2 Myanmar (presented by Dr Than Zaw).....	10
2.3 Nepal (presented by Dr Singh Karki) .....	15
2.4 Thailand (presented by Dr Porntep Siriwanarangsun) .....	22
2.5 Summary.....	29
<b>3. Korat provincial field visit</b> .....	<b>31</b>
3.1 Soongnern Community Hospital.....	31
3.2 Maa Kleur Kao Health Centre.....	34
3.3 Village drug funds (or drug cooperatives) .....	35
<b>4. Drug financing issues</b> .....	<b>38</b>
4.1 Drug financing alternatives (by Dr German Velasquez) .....	38
4.2 Cost-sharing for drugs (by Dr Petcharat Pongcharoensuk) .....	42
4.3 Monitoring for equity and quality (by Dr Jonathan Quick) .....	48
<b>5. Country priorities for drug financing</b> .....	<b>55</b>
5.1 Indonesia.....	55
5.2 Myanmar .....	55
5.3 Nepal.....	55
5.4 Thailand.....	56
<b>6. Priorities for work group action</b> .....	<b>57</b>
6.1 Group A.....	57
6.2 Group B .....	58
<b>7. Conclusions and recommendations</b> .....	<b>60</b>
7.1 Country priorities for action .....	60
7.2 Recommendations.....	62
<b>Annex A. Agenda</b> .....	<b>64</b>
<b>Annex B. List of participants</b> .....	<b>66</b>
<b>Annex C. List of documents</b> .....	<b>70</b>
<b>Annex D. Message from Regional Director, WHO South-East Asia Region</b> .....	<b>72</b>
<b>Annex E. Evaluation of the meeting. Priorities for the Working Group</b> .....	<b>76</b>
1. Evaluation of the meeting .....	76
2. Priorities for the next Working Group meeting .....	78

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## Abbreviations

AFTA	The Asian Free Trade Agreement
BNMT	British-Nepal Medical Trust
CCS	Community cost-sharing
CMSD	Central Medical Store Depot
CSMBS	Civil Servant Medical Benefit Scheme
DAP	Drug Action Programme, Action Programme on Essential Drugs
ED	Essential drugs
FDA	Food and Drug Administration
GDP	Gross domestic product
GMP	Good manufacturing practices
GPO	Government Pharmaceutical Organization
HC	Health centre
HDS	Hill Drug Scheme
HMG	His Majesty's Government (Nepal)
INGO	International nongovernmental organization
INO	Indonesia
km.	kilometres
MMR	Myanmar
MOH	Ministry of Health
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NED	Non-essential drugs
NEDL	National essential drugs list
NEP	Nepal
NGO	Nongovernmental organization
NLR	The Netherlands Leprosy Relief
OPD	Outpatients department
PHC	Primary health care
RHC	Rural health centre
Rp	Rupiahs
Rs	Rupees
SEAR	South-East Asia Region
SEARO	South-East Asia Regional Office
sq. km.	square kilometres
THA	Thailand
TRIPS	Trade-Related Intellectual Property Rights
UMN	United Missions to Nepal
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCS	Workman Compensation Scheme
WHO	World Health Organization

**Current exchange rate to one US\$ (November 1996)**

<b>Country</b>	<b>Amount in national currency</b>	
Indonesia	Rupiahs	2 330
Myanmar	Kyats	5.88
Nepal	Rupees	56.80
Thailand	Bahts	25.40

# Executive summary

## Background

A new initiative in drug financing within the context of health economics is proposed for the WHO essential drugs strategy. As part of this initiative, the WHO/SEARO Working Group on Drug Financing came into being. This Working Group will meet regularly in the next two to three years. Members will learn from each other about drug financing, both policy and implementation.

The objectives of the Working Group are:

- To promote the development and strengthening of effective drug financing systems.
- To facilitate and improve access to essential drugs at affordable prices for the entire population.

## Country presentations on drug financing

Country papers from Indonesia, Myanmar, Nepal and Thailand were presented at the meeting. They have been abridged to focus on country specific issues. Even though drugs play an important role in primary health care (PHC) in the four countries, most of the drug financing in these countries comes from non-government sources; i.e. private households (Indonesia and Thailand) or donors plus private households (Nepal and Myanmar).

Countries provided the following information on user charges and cost-sharing for drugs:

### **Indonesia**

User charges for medical services exist in hospitals, but drugs for PHC facilities are provided free of charge.

### **Myanmar**

Several cost-sharing programmes jointly funded by the Government and external donors have been implemented during the past several years, and some have proved to be working well in improving the availability of drugs in PHC facilities. However, the programmes' viability in the long-run is still questionable since not all donations will continue. Therefore, Government, as well as alternative sources of funding, need to be developed for long-term development and sustainability.

### ***Nepal***

Several experimental programmes on cost-sharing have been implemented and some are more successful than others. An insurance programme (the United Missions to Nepal (UMN) scheme) showed the best performance in improving drug availability and accessibility.

### ***Thailand***

Thailand has the most complicated mix of health insurance among the four countries. Drug financing is from a mixture of private and public sources provided through various forms of insurance. User charges are common practice in health service provision (including drugs). In addition, several public assistance programmes for the underprivileged and the needy are also provided by Government allocation.

### ***Korat Provincial field visit***

There were three field visits: to Soongnern Community Hospital, Maa Kleur Kao Health Centre and to village drug funds (or drug cooperatives).

## **Drug financing issues**

The main principles behind the economic strategy for drugs recommended by WHO are that:

1. the objective of various drug financing systems must be to improve and facilitate the access of the whole population to essential drugs;
2. the responsibility and will of the State to participate in paying the national drug bill are fundamental;
3. the money saved by the selection of drugs to circulate in the country and their rational use must be one of the main sources of additional income for the purchase of drugs;
4. the allocation of an adequate percentage of the State budget to health, and consequently to drugs, must be a priority; for many countries this will require an increase in public spending for health.

Possible drug financing options include public financing, health insurance, user charges, private or cooperative not-for-profit financing, donors and international loans. In some countries the option is a pluralistic approach in which different financing mechanisms are used to serve different groups of the population.

Nevertheless, it is the responsibility of governments to ensure that drug financing mechanisms are managed in such a way as to achieve universal access to essential drugs. Health financing mechanisms may be evaluated and compared in terms of equity, efficiency, sustainability, and feasibility.



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## **Cost-sharing for drugs**

The objectives usually cited for cost-sharing for drugs are to: (1) promote efficiency; (2) foster equity; (3) promote decentralization and sustainability; (4) foster private sector development; (5) promote consumer satisfaction, and (6) generate revenue.

The potential advantages of cost-sharing are:

- Revenues collected are added to government budget, not a substitute for government allocation
- Promotes referral system
- Encourages rational drug use by reducing unnecessary demands for health care and drugs
- Risk-sharing among the well-off who are able to pay and the poor
- Decentralization by local retention and control of money collected
- Promotes private sector development
- Consumer satisfaction with more availability of drugs and improvement of quality of care

Common problems and disadvantages are:

- Collection cost greater than revenues generated due to inefficient management
- Discourages the poor from primary care, if they are unable to pay for the services
- User charges will increase the burden on the poor rather than the well-off
- No improvement in service quality
- No improvement in drug availability
- Encourages over-prescribing, if more drugs lead to more revenues

## **Monitoring for equity and quality**

User fee programmes can have positive effects, such as increasing access to essential drugs and improving rational use of drugs. But user fee programmes can also have negative effects, such as reduced access to treatment and reduced public expenditure for health. When embarking on a new user fee programme or when making significant changes in an existing programme, it is essential that the effects of the programme be carefully monitored. The following questions should always be asked in monitoring the cost-sharing programme:

- Revenue generation -- Are cash and insurance revenues generated as expected from service volume?
- Revenue expenditure -- Is the expenditure spent according to guidelines, 75% for the facility and 25% for public health care expenditure?

- Quality impact -- Is quality of service improving?
- Equity effects -- Are people being excluded from essential health services because of fees? Or are households worse off because of fees?
- Budget impact -- Is fee revenue supplementing or substituting for central Treasury expenditures?

Experience from monitoring user fee programmes in Africa and Asia indicates that four types of monitoring methods should be used together: (1) field supervision, (2) routine reporting, (3) sentinel systems, and (4) special studies. Each type of monitoring provides different information and has different resource requirements.

### **Country priorities for drug financing**

Participants from each country identified the following main concerns and/or problems as their priorities:

- To increase the health budget as well as the drug budget.
- Inadequate financial support for drugs from Government. How to reduce irrational drug use (financial mechanisms to improve use and reduce cost)?
- Lack of coordinated effort among all nongovernmental organizations (NGOs), and the public sector.

## **Conclusions and recommendations**

### **Indonesia**

- The meeting facilitated an exchange of information, which it is hoped will continue.
- Future priorities include:
  - ⇒ Proposing additional budget for drugs to pay for activities, such as:
    - improving the coverage of hepatitis B vaccination for new-born babies;
    - improving the coverage of the TB programme;
    - increasing the local government budget for drugs;
    - encouraging and enlarging the programme for community participation.
  - ⇒ Requesting WHO to distribute guidelines for cost-sharing schemes (public-private mix) to countries participating in the next meeting. This meeting should:
    - discuss the development of national guidelines;
    - formulate an action plan;
    - include field visits.
  - ⇒ Requesting WHO or other agencies to provide assistance for a pilot cost-sharing project.

## **Myanmar**

- The meeting increased knowledge of drug financing concepts, as well as allowing an exchange of experiences with other countries.
- Future priorities include:
  - ⇒ Strengthening and extending cost-sharing activities.
  - ⇒ Improving financial management through training.
  - ⇒ Promoting the plan of action for drug financing, and the development of drug financing mechanisms, through presentations and discussions on models for financing systems. This will be done in consultation with local hospitals and drug stores.
  - ⇒ Helping to coordinate external assistance.
  - ⇒ Requesting WHO to provide technical tools for the review of the drug financing situation in each country.

## **Nepal**

- Concepts of drug financing have become clear as a result of the meeting.
- Future priorities include:
  - ⇒ Convincing higher authorities as well as users about the benefit of cost-sharing schemes.
  - ⇒ Reviewing the progress made between this meeting and the next.
  - ⇒ Promoting the exchange of experiences between Member Countries.
  - ⇒ Supporting the development and use of guidelines and monitoring systems for drug financing and providing updated information.

## **Thailand**

- The meeting facilitated technical cooperation among the four countries and encouraged participants to share experiences and ideas.
- Future priorities include:
  - ⇒ Strengthening essential drugs programmes in the public and private sectors.
  - ⇒ Holding a follow-up meeting.
  - ⇒ Requesting WHO to provide technical support in the areas of operational research, provision of documents, and short-term consultancies.

## **Workshop evaluation**

An evaluation of the different aspects of the workshop was made. Participants identified topics based on the prevailing needs of the countries. The topics which could be taken up at the next meeting of the Working Group are in order of priority: public financing, including drug financing indicators and ways to increase public drug budgets; policies and guidelines for cost-sharing; public-private roles in the pharmaceutical sector; and financing mechanisms to improve rational use of drugs.

The next meeting will be held in Yogyakarta, Indonesia in November 1997.





# 1. Introduction

## 1.1 Opening session

The meeting was opened by Dr Godfrey Walker of the WHO Representative's Office. Dr Walker thanked the Thai Food and Drug Administration for organizing the meeting. He then read a message from Dr Uton Muchtar Rafei, Regional Director of WHO/SEARO, which emphasized the changing scenarios in the national health systems in the Region and the role of both the public and private sectors in providing equitable health care services. Privatization has become an important issue and some countries are implementing such policy. This is a result of the observation that a centralized economic system does not necessarily provide equitable health services and public sector financing alone is not adequate for the attainment of the goal of Health For All.

Advocates of privatization argue that private health care and drug financing would lead to equitable, effective and efficient care by having the well-off pay for services while the underprivileged are subsidized by government allocation. Opponents, on the other hand, argue that privatization would lead to commercialization of services which could result in cost escalation without quality improvement. Therefore, a compromise between the two views needs to be identified to bring together the benefits of both, to ensure equity and quality of health care.

To ensure equity and availability of essential drugs, different drug financing strategies are available, such as redistribution of public resources, introduction of user fees and community cost-sharing schemes. Appropriate drug financing strategies should be considered for countries in South-East Asia where essential drugs are indispensable tools in the prevention, control and treatment of diseases. It is the primary role of ministries of health to be the architects of national drug policy, based on the essential drugs concept, within the context of overall health policy. To achieve this, government takes the initiative in strengthening policy and regulation, advocacy, provision and dissemination of information, price control, distribution of sufficient amounts of quality drugs, and related services.

Furthermore, the complementary roles of the public and private sectors need to be strengthened and harmonized through realistic policy instruments, such as incentives, regulation and other measures, for a successful symbiotic relationship. (The full text of the Regional Director's message is contained in Annex D).

Dr Chalermchai Chumuang, Deputy Secretary-General of the Thai Food and Drug Administration (FDA) also welcomed all participants to the meeting. He urged exchange of knowledge and experiences for better understanding and contributions to the development of drug financing policy and management in the Region.

Dr Jonathan Quick, Director of the Drug Action Programme, WHO/HQ, in his opening statement emphasized that drug financing is a universal problem. In many parts of the world, drugs are still not sufficiently available to all who need them. Dr Quick apprized that different drug financing schemes are available; government taxes, insurance, user fees, donations or even loans. However, WHO suggests that policy for drug financing should meet the following five criteria: equity according to need, access (availability and affordability), rational drug use, efficiency and sustainability. While WHO recommends that countries develop national drug policies, these do not improve health if drugs are not adequately financed.

## **1.2 Background**

A new initiative in drug financing within the context of health economics is proposed for the WHO essential drugs strategy and the WHO/SEARO Working Group on Drug Financing came into being. This Working Group will meet from time to time in the next few years and members will learn about drug financing, policy and implementation from each other, in order to achieve the five criteria mentioned above. This will ultimately stop millions of preventable deaths in the Region.

It is considered that one of the best ways to assist South-East Asia Region countries to improve accessibility to essential drugs is to review their existing primary health care (PHC) supply schemes and to provide other options for strengthening supply systems.

One of the effective ways could be financing schemes, such as community cost-sharing (CCS). Functional and effective scheme(s) which are in operation in the countries of the Region can be evaluated, improved and adapted where necessary. Implementation of CCS would involve intersectoral collaboration and coordination of the ministries of health, planning and finance, trade and industry and their relevant departments.

## **1.3 Objectives of the Working Group**

1. To promote the development and strengthening of effective financing schemes/systems so as to ensure availability at all times of essential drugs of assured quality for PHC.



2. To facilitate and improve access to essential drugs at affordable prices for the entire population.
3. To identify ways in which the public can contribute to the cost of essential drugs.
4. To improve financial management including cost analysis and cost-sharing mechanism(s) to help ensure regular supply of essential drugs.
5. To improve the rational selection and the application of appropriate drug purchasing system(s) so as to accrue a significant impact on the prices of drugs.
6. To explore ways and means of improving the supply of essential drugs so as to promote their availability.

Expected results include the following:

1. Clearer understanding of practical drug financing mechanisms for government health services and, in particular, for PHC.
2. Self-assessment of cost-sharing for drugs, including policy, management, access and equity effects, drug availability, and financial aspects.



## 2. Country presentations on drug financing

Country papers presented at the meeting were abridged focusing on country specific issues.

### 2.1 Indonesia (presented by Dra Andayaningsih)

#### **General information**

Indonesia has five main islands and 13,677 small islands, with an area of 5,193,250 sq. km., 39% of which is land and 61% sea territory. Indonesia is the fourth most populous country in the world, 193 million, with an annual growth rate of 1.34% (1990-93).

The average economic growth rate was 6.8% per annum, while the inflation rate was 8.7% per year during the 1980s. Per capita income has increased from US \$70 in 1967 to approximately US \$650 by 1993.

#### **Health status**

In 1993, mortality rates per 1 000 lives births were given as follows: 58 for infant mortality, 81 among the under fives and 4.25 for maternal mortality. Life expectancy at birth was 62.7 years. Severe protein energy malnutrition was 11.8%.

#### **Health care system**

Using the primary health care approach, the National Health System was adopted in 1982. The system, consisting of four levels (central, provincial, district/sub-district, village), includes the referral system to secondary and tertiary levels of services as well as community outreach programmes.

For primary public health care, there were 6 954 health centres, 19 977 sub-health centres, and 6 024 mobile health centres in 1993. The referral system consists of 1026 hospitals (with a total of 114 174 beds) in the districts and major cities. Decentralized administration is encouraged. Health services are provided by 14 072 physicians (1993), 4 635 dentists (1993), 114 712 nurse/midwives (1993), 6 245 pharmacists (1992), and 39 908 assistant pharmacists (1992).

## **The National Drug Policy**

The Indonesia National Drug Policy was established in 1983 with the objectives of ensuring availability of quality drugs, equitable distribution, efficacy, safety, as well as rational use of drugs.

## **Implementation of National Drug Policy**

### ***Drug evaluation***

Drug registration and evaluation include pre-marketing drug evaluation, re-evaluation of 13 000 marketed drugs and evaluation and supervision of clinical trials. Adverse drug reaction monitoring is also carried out based on voluntary reporting.

### ***Implementation of National Essential Drugs List (NEDL)***

The fifth edition of NEDL consists of 320 active substances with three different lists of essential drugs according to the level of health facilities: 320 for hospitals, 167 for community health centres and 32 for village drug depots.

### ***Drug supply management***

To ensure the timely supply of low-cost but high-quality essential drugs, the Ministry of Health (MOH) appointed Government owned companies as the main suppliers of essential drugs. The prices of essential drugs are controlled by the Government. In addition, use of generic drugs in the public health facilities is mandatory. The Government regulated the production of drugs by 51 manufacturers and also the distribution of generic drugs.

In order to improve drug supply management for PHC in the public sector, a District Pharmaceutical Warehouse (GFK) was developed in every district to carry out functions of drug supply, from planning based on the needs of health services, drug management, monitoring of drug accessibility and availability in health centres, to quality maintenance of the stocks. There are around 300 GFKs throughout Indonesia. Being an executing unit of the District Health Office (DHO), GFK assists the DHO in coordinating the supply of drugs originating from different budget sources, to ensure a timely and regular distribution to health care services in the districts according to actual need.

### ***Drug distribution and pharmacy services***

The distribution network is made up of private sector outlets as well as public sector units. In 1992, drug distribution was carried out by 293 GFKs, 1 173 wholesalers, and 3 520 pharmacies/dispensaries.

### ***Quality assurance***

Implementation of Good Manufacturing Practices (GMP) was started in 1971 and revised in 1988 on three basic elements of quality assurance: legal, regulatory and technical aspects.

The Indonesian Pharmacopoeia clearly describes the methodology for quality control testing, quality specification requirements and other quality regulation of finished products and raw materials.

***Rational use of drugs including control on drug labelling and promotion***

High priority is given to improving rational use of drugs. A Standard Treatment Guide for Health Centres and a National Drug Formulary for Over-the-Counter (OTC) Drugs have been developed. A National Drug Formulary for health professionals and materials for improving drug counselling are being developed.

Regulation requires that drug information on labels or promotional materials for drug advertising must conform with criteria of objectivity and completeness and should be unbiased. Drug products to be promoted must be registered and approved for marketing by the MOH.

A guideline on drug advertising was established in 1994, based on the WHO Ethical Criteria for Medicinal Drug Promotion and adapted to meet Indonesian needs. Advertisements on OTC drugs can only be made after obtaining approval from the MOH.

***Generic Drug Programme***

Drug coverage in Indonesia is similar to PHC coverage. To improve drug accessibility, the MOH promotes the use of generics. The Generic Drug Programme was launched in mid-1991. The quality and price of generic drugs are strictly controlled by the MOH and public health facilities are obliged to use them. Table 1 shows increasing use of generic drugs from year to year.

**Table 1. Increase in the use of generic drugs**

<b>Fiscal year</b>	<b>Expenditure (in billion Rupiah)</b>	<b>Percentage growth on previous year</b>
1992 - 1993	195.10	--
1993 - 1994	213.63	9.5
1994 - 1995	282.14	32.0
1995 - 1996	326.42	15.7

***Economic strategy for drugs: user charges***

Indonesia has a system of user charges for public health services in both hospitals and health centres. The MOH sets a very low uniform fee for health centre services across the country (Rp. 300 or about US \$0.12 per visit). This was designed to make the health centres affordable to the general population, so these services are heavily subsidized. For the hospitals, central Government hospitals follow fee schedule guidelines issued by the MOH. Even though

provincial and district hospitals are expected to conform with these guidelines, the responsibility for setting fees rests on the provincial or district government.

## **Health and drug expenditures**

### ***Health expenditure***

The Gross Domestic Product (GDP) of Indonesia is growing at about 6-7% per year but total health sector expenditure is currently increasing at more than 20% per year. During the early 1990s, private health expenditure increased by 27.6% per year while public expenditure increased only 2.1% annually from 1987-1990. Consequently, the proportion of total expenditure from the private sector increased from 68.8% in 1989 to 79.9% in 1993 and was projected to be 89.5% in 1996 (estimated at US \$4.7 billion).

The range of per capita health expenditure varies widely across the income distribution but is relatively constant in terms of percentage of annual income. There is also a marked variation between regions of the country and between urban and rural areas. Total health spending for both public and private sectors is only 2% of GDP, which is about half of that spent in other countries of comparable average income.

The Government health budget system is fragmented. There are various types of budget at the central, provincial, and district levels. Despite a large increase in Government spending on health care, Indonesia's health expenditure for both public and private sources are US \$12 per capita, much lower than other countries in the Region (World Development Report, 1993).

### ***Drug expenditure***

In 1994, the total cost of drugs for health services, including programmes in the public sector and health insurance, was 20% of US \$938 million. This was the figure for total drug consumption. Likewise, the growth of the pharmaceutical market from 1992-1996 was around 20% annually (Table 2). This is more or less at the same level as the growth of health expenditure.

**Table 2. Size in million US Dollars and growth of pharmaceutical market, 1992-1996**

<b>Sector</b>	<b>1992</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>	<b>1996</b>	<b>Average annual % growth</b>	<b>Total cumulative growth, 1992-1996</b>
Pharmacy	323.7	404.4	441.4	525.2	610.8	17.4	88.7
Drug store	196.3	241.9	266.9	339.6	413.0	20.6	110.4
Hospitals & Institutions	106.3	127.6	140.8	174.8	208.6	18.4	96.2
Total	626.3	773.9	849.1	1 039.8	1 232.4	18.6	96.7

Drug expenditure constituted about 40% of the country's health expenditure, including public and private sector spending. This was about US \$5 in 1990 and drug consumption is among the lowest in developing countries (Table 3).

**Table 3. Annual drug expenditure per capita in selected countries, 1990**

Country	Expenditure (US \$)	Country	Expenditure (US \$)
Brazil	16	Indonesia	5
Philippines	11	Kenya	4
Ghana	10	India	3
China	7	Bangladesh	2
Pakistan	7	Mozambique	2

Source: World Bank (1995)

### Drug financing

The total drug budget allocated for PHC services amounted to US \$86 million in 1994.

Moreover, the Government provides certain drugs required for some of the health programmes. They include the programme to handle highly prevalent contagious diseases, such as acute respiratory tract infection, diarrhoea and tuberculosis; the programme to handle chronic diseases or conditions, such as goitre and anaemia; the family planning programme; and immunization programme.

It is estimated that 84% of drug financing is derived from private funding and the rest (16%) is from the Government budget. However, drugs procured with the Government budget cover more than 70% of the population through public sector health care units (health centres and other PHC units), which are established across the entire country.

In general, Government control on drug prices is enforced only for the provision of drugs in the public sector and Generic Drug Programme. Essential drugs for the public sector are subsidized through various budgets, mainly the central Government budget, the "Presidential Health Budget" (Table 4).

**Table 4. Drug budget for the public sector (Billion Rupiahs)**

Source of Budget	1995 - 1996	%
INPRES (Presidential Health Budget)	151.34	73
Health programme	23.95	12
Health insurance	14.20	7
Provincial and district budget	13.80	7
Transmigration	2.65	1

The rationale for the high proportion of central Government budget used for drug procurement is to ensure more equitable access to drugs across the country.

Drugs for public sector PHC are mainly provided free to the community through Government subsidy. Subsidized essential drugs for PHC are distributed to 6 954 health centres and 19 977 auxiliary health centres throughout Indonesia to provide primary health services. The drugs provided for PHC and related referral services are based on the NEDL covering the needs forecast by the health centres at district level, using a dual planning approach, the consumption and the morbidity pattern, and integration of various budget sources.

Besides the free drugs provided through primary health services in the public sector, a Government health insurance has been developed, based on civil community participation, to provide drugs for civil servants and their families.

## 2.2 Myanmar (presented by Dr Than Zaw)

### General information

Myanmar is a country in South-East Asia, with an area of 676 577.5 sq. km. and 43.13 million population. The country's GDP was 61 949.81 million kyats (with a 6.8% growth rate) in 1994-1995 and Government budget was 44 099.8 million kyats.

### Health statistics

Infant mortality rate per 1 000 live births	47.4 (urban)	49.8 (rural)
Under-5 mortality rate per 1 000 live births	72.7 (urban)	No data
Maternal mortality rate per 1 000 live births	1.0 (urban)	1.8 (rural)
Life expectancy at birth (years)	58.6 (male)	62.6 (female)
Crude birth rate per 1 000	28.1 (urban)	30.0 (rural)
Crude death rate per 1 000	8.7 (urban)	9.9 (rural)
Protein energy malnutrition under 3 years old (%)	34.9	

### Health care delivery

At the peripheral level, the township health department is responsible for the implementation of health care services delivery. The township health department consists of a township hospital (16-25-50 beds), with a medical officer in charge and one or more assistant surgeons and/or health officer. There are a total of 320 township hospitals, 348 station health units, 1 455 rural health centres and 5 537 sub-rural health centres in the country. The number of health facilities and health personnel are shown in Table 5.

**Table 5. Number of health facilities and health personnel in 1994-1995**

Health facilities	1994-1995 (provisional)
Government hospitals	720



Total no. of hospital beds	28 202
No. of hospital beds (per 10,000)	642
No. of dispensaries	295
No. of primary and secondary health centres	88
No. of maternal & child health centres	358
No. of rural health centres	1 455
No. of school health teams	85
No. of traditional hospitals	3
No. of traditional medicine clinics	178
Health personnel	
Total no. of doctors	12 464
(a) Public	4 901
(b) Cooperative & private	7 563
Dental surgeons	810
(a) Public	403
(b) Cooperatives & private	407
Nurses	9 704
Health assistants	1 327
Lady health visitors	1 682
Midwives	8 724
Health supervisor 1	510
Health supervisor 2	1 250
Traditional medicine practitioners	508

### **Health care financing**

Health expenditure is 3.33% of GDP and 4.7% of total Government expenditure. Per capita expenditure on health was 47 kyats in 1994-1995. The Government health budget as well as the drug budget are shown in Table 6. The household expenditure survey conducted in Yangon from March 1978 to January 1979 found that 2.48% of household expenditure was used for medical care. The percentage increased to 2.58 in 1989.

**Table 6. Government health budget and drug budget for 1990-1995**

Fiscal year	Government health budget (million Kyats)			Drug budget (million Kyats)	
	Recurrent	Capital	Total	Total	% health budget
1990-1991	664.5	917.5	1 582.0	24.07	1.52
1991-1992	697.5	1 188.8	1 886.3	5.96	0.32
1992-1993	796.1	1 280.6	2 076.7	7.53	0.36
1993-1994	948.6	872.9	1 821.5	9.64	0.53
1994-1995	1 000.8	1 063.8	2 064.6	4.79	0.23

In Myanmar, the sources of financing for health services, including drug financing, can be classified as follows:

- Public sources
  - (a) MOH
  - (b) Other Government departments and enterprises
- Social Security System
- Cooperatives
- Private sources
  - (a) Private household
  - (b) Community contributions
- External sources
  - (a) Bilateral
  - (b) Multilateral

### **Current drug financing and future development**

The Government of Myanmar has provided free medical services to its citizens including free supply of drugs since independence in 1948. However, it seems that inequity in the distribution of resources, with high input into expensive modern technologies which serve the few, continues to grow, while simple low cost interventions to prevent diseases in the community are underfunded, including drugs (as shown in Table 6). In addition, due to increased population and limited allocation of funds for drugs within the total health budget, the extent of the problem of shortage of drugs in health facilities has increased gradually but very markedly in recent years.

#### ***Cost-sharing***

After 1988, with the change in the socioeconomic system and under the guidance of National Health Policy, the MOH has introduced a community cost-sharing mechanism for drug financing in some township hospitals, namely:

- User charges for selected essential drugs at hospitals
- User charges for essential drugs in project areas
  - (a) Community cost-sharing project in Taik-kyi township
  - (b) Myanmar Essential Drugs Programme
  - (c) Community health management and financing project

**(a) User charges for selected essential drugs at hospitals**

One of the major problems at hospitals in Myanmar is shortage of drugs. Patients have to buy drugs at high prices from the private market and drug peddlers, and the quality is not reliable. Therefore, a new system of drug distribution to hospitals was introduced in February 1993. At present, 254 community cost-sharing (CCS) drug shops have been established at the hospitals. Initially, 23 items of essential drugs were provided by the Department of Health's Central Medical Stores Depot (CMSD). In 1996, another 20 items of essential drugs were added to the initial list but antituberculosis and antileprosy drugs were not included. The drugs are sold at a marginal profit of 10%-15% on the CMSD's basic prices i.e. Government controlled prices. In addition to this, 43 items of essential drugs, other essential and complementary drugs are purchased from the market and sold at a reasonable price with a marginal profit. The capital for drugs is credited to CMSD and the profit is utilized for the maintenance of the shop including the provision of salary for a book-keeper. The remaining profit can be used for extension and development of CCS drug shops and the hospitals.

The hospitals where the CCS drug shops are operating have to provide morbidity data to the CMSD, so that essential drugs are provided according to the morbidity pattern. Through this community cost-sharing mechanism, partial cost recovery for drugs is maintained in these hospitals.

**(b) User charges for essential drugs in project areas**

- Community cost-sharing project in Taik-kyi township

The MOH has introduced a community cost-sharing scheme based on the Bamako Initiative, a pilot project in Taik-kyi township, with the cooperation of The United Nations Children's Fund (UNICEF) which provided essential drugs at the initial stage. The main objective is to recover a portion of the cost of health services delivery, so that additional resources for PHC are obtained and both community involvement in managing health services and resources will be enhanced.

The first phase was implemented at a rural health centre and a station hospital in 1992. By 1994, all the rural health centres in the township were implementing the community cost-sharing scheme and replenishment of drugs in these health facilities is underway with the funds recovered.

- Myanmar Essential Drugs Programme

Myanmar Essential Drugs Programme has been implementing its activities in phases, as a pilot project funded by the Finnish Government through WHO, in which nine townships in Bago Division were supplied with essential drugs in 1991 and 1992. At the commencement of the project activities in the townships, training sessions were conducted for the township's basic health personnel on the concepts of essential drugs, rational prescribing, standard

treatment schedules and calculation of drug requirements based on morbidity data, procurement and storage of drugs, etc.

Incorporating a cost recovery scheme into its initial activities in 1994, the Myanmar Essential Drugs Programme is now implementing its activities in 58 townships. Restocking of drugs is carried out with recovered funds from respective townships by the relevant township medical officers, who procure drugs locally in kyats. When the scheme becomes successfully operational, the Government will not need to provide funds for essential drugs in these townships.

- Community health management and financing project

Myanmar is one of the beneficiaries of the assistance provided by the Nippon Foundation in close collaboration with UNICEF. The assistance, in the form of essential drugs, is aimed at promoting PHC at minimum cost and preventing shortages of essential drugs. It was agreed that cost recovery mechanisms or revolving drug funds were to be established in the townships, which are to be provided with essential drugs down to the grass-roots level. Altogether, 41 townships were selected to implement the project in 1994. A health card system was introduced in the project area.

For the period covering November 1994 to June 1995, a total of 210 322 people have been provided with medical care in 41 townships. Among them, 15 085 (7.2%) utilized the health card system, while 193 676 people (92.1%) utilized the user charge mechanism. The total number exempted from health care charges (1 561 people) accounted for 0.7% of total attendance. The total funds recovered from the health card project was 0.6 million kyats and 5.5 million kyats from direct user charges.

### **Exemption mechanism**

In all the project townships, the supervisory committees for health have established criteria for exemptions. They are: families which are designated as indigent, homeless people, orphans, medical emergencies, members of all religious orders and prisoners.

After a certain period of implementing different forms of drug financing based on community cost-sharing, the cost recovery rate is found to be 20% for the Community Health Management and Financing Programme, but more in other programmes. Experiences in implementing the different forms of drug financing are noted and views are exchanged among the implementing personnel. At this early stage of drug financing based on community cost-sharing, drugs are provided either from the Government sector or from respective cooperating agencies, such as UNICEF, WHO and the Nippon Foundation. Up to now, there are no specific problems in the distribution and sale of drugs, with marginal profits and maintenance of funds recovered.

## **Problems in cost-sharing for drugs**

1. Comprehensive replenishment of drugs is not yet carried out in either form of drug financing mentioned above.
2. Local production of essential drugs cannot satisfy the requirements of the whole country. Many essential drugs have to be procured from private drug dealers, but good quality essential drugs are not available in adequate quantities at reasonable prices on the market.
3. Due to inadequate local production of essential drugs, the MOH is trying to find ways and means for increasing local production in coordination and cooperation with Myanma Pharmaceutical Factory.
4. As donors are phasing out their assistance, townships need a lead time for developing a viable system for replenishing drugs. The combination of cost recovery through different forms of drug financing, sale of CMSD drugs and donor support would enable townships to develop sustainable revolving funds for drugs by 1999. Continuous donor support will be very helpful until then.

### **2.3 Nepal** (presented by Dr Singh Karki)

#### **Location**

The Kingdom of Nepal with an area of 147 181 sq. km. is a land-locked country situated on the southern slopes of the Himalayan Mountains.

#### **Health status**

Total population is 20 million. Life expectancy at birth for both males and females has increased between 1985 and 1991 from 47.5 to 55.2 years for men and 45.0 to 52.6 years for women. The infant mortality rate is estimated to be 101 per 1 000 live births, about half of the infant deaths occur in the neonatal period and are partly attributed to low birth weights. 83.5% of children aged 6 months to 5 years have some degree of malnutrition with 8.6% suffering from severe malnutrition. Maternal mortality rate is estimated to be 85 per 100 000 live births, i.e. about 6 000 women die in childbirth each year.

#### **National health system**

The health system at the national level consists of the MOH, Department of Health Services with its various divisions and units. The preventive, curative, and promotive health services have been provided through 74 hospitals, 17 health centres, 79 primary health centres, 765 health posts and 2 588 sub-health posts, and 47 950 community level health workers.

## **Health policy strategy**

Even though Nepal has already benefited greatly by all seven of its development plans, the health status of the people has not improved well enough, as indicated in the health statistics above. To create a socioeconomic environment that will enable Nepalese citizens to lead healthy lives, in keeping with the saying 'Health is Life,' the Government is committed to providing preventive and curative health services to the people, with the rural population as top priority. Services are rapidly expanding to the grass-roots level. It is expected that each village development committee will have at least one health post by the end of the Eighth Plan period (1992-1997).

## **Public and private sectors in health care**

Nepal remains largely a rural society with 91% of the population living in rural areas. The Government remains the only source of health care in rural areas. Private-for-profit services have a limited role and nongovernmental organizations (NGOs) are limited to highly selective and focused projects. There are 55 nursing homes registered in Nepal; 32 are located in Kathmandu and Lalitpur, the remaining 23 are also in major cities i.e. Biratnagar, Dharan, Janakpur and Pokhara. The majority of the rural population has very limited access to such centres and cannot afford health care at full cost. On the other hand, it is estimated that there are 400 000 to 800 000 traditional healers, such as faith healers and Ayurvedic practitioners, who are examples of private sector participation in rural health care, even if the quality of such care remains unassessed. Moreover, growing numbers of private pharmacies (5 629) in the country indicate increasing private sector involvement in health care.

## **Health care financing and macroeconomic indicators**

Health care in Nepal is mainly financed by the public sector through the MOH. However, the total health expenditure includes NGO and private sector funding as well. NGO funding is channelled through the Social Welfare Council and private sector expenditure is paid out-of-pocket by individuals or households for drugs and other health services. Based on the household budget survey conducted by Nepal Rastra Bank in 1984-1985, it is estimated that the public sector contributed not more than 31% of the total health care expenditure.

The trend in the health budget's share of GDP from the fiscal year 1984-1985 to 1992-1993 was within 1.64% (1988-1989) and came down to 0.96% (1990-1991) at constant price. The share of health budget to national budget was 4.45% and 4.79% in the fiscal years 1991-1992 and 1992-1993 respectively. This share of health budget to national budget came down to 4.11% in 1993-1994 with a slightly increasing trend of 5.16% in 1994-1995, 4.91% in 1995-1996, and 6.01% in 1996-1997.

Nepal is one of the poorest countries in the world, with a per capita income of US\$160. The per capita health expenditure for the year 1984-1985 was Rs. 33 and increased to Rs. 72 in 1988-1989 and reduced to Rs. 61 in 1989-1990. The per capita expenditure for the year 1992-1993 was Rs. 85.

### **Cost-sharing**

Given the budgetary constraints, shortage of drugs in health institutions has always been a problem in serving the poor, underprivileged rural population. Studies have shown that the annual consignment of drugs supplied to the health institutions is not sufficient to meet the demand for more than three to five months. Moreover, on account of the resource constraints, re-ordering drugs is impossible until the next year.

With increasing demand for health services, the Government is able to provide far less than are needed. The drugs supplied to the health institutions of Nepal are less than 50% of the quantity requested. Health institutions are meant to serve the people but when there is short supply of drugs, they cannot be effective. As both the Government and the people have their own limitations in bearing the entire burden of drug costs, some cost-recovery schemes for health services and drugs are implemented.

### **Community involvement in cost-sharing**

There are a number of cost-sharing programmes with community involvement as summarized in Table 7.

#### ***Britain Nepal Medical Trust (BNMT) Cost-Sharing Drug Scheme.***

In 1980, the BNMT initiated the "Bhojpur Drug Scheme", a cost-sharing drug scheme with the objective of ensuring year round supply of essential drugs to the public, at affordable prices through all health institutions. The scheme was first introduced in Bhojpur District through a hospital and nine health posts and has now been extended to three districts; Taplejung, Panchthar and Khotang.

Under the scheme, all patients attending either a hospital or health post are required to pay a prescription fee of Rs 2 originally and now Rs 6 in hospitals and Rs 5 in health posts, for which they are entitled to a full course of treatment, including inpatient treatment in hospital, if needed. The scheme was first initiated in Bhojpur District based on the findings of a survey in 1978, which indicated that people would prefer some sort of fee for prescriptions rather than an insurance scheme. However, the Expanded Programme on Immunization (EPI), the Family Planning Programme (FPP), Kala Azar, CDD, ARI, vitamin A, the Action Programme for the Elimination of Leprosy (LEP), and the Malaria Control Programme (MAL) were excluded from the scheme and services are provided free of charge.

***BNMT Hill Drug Scheme (cost recovery drug scheme)***

Hill Drug Scheme (HDS) was initiated by BNMT in some of the mountainous districts of the Eastern Region and is now in its twenty-sixth year. The main objective is to increase the local availability of cheap but quality drugs in the hills. Retailers in HDS are local shopkeepers who sell food and dry goods in the village, and who must have studied to at least eighth grade at school. They contract with BNMT Drugs Project to buy selected drugs and to sell them at their shops at fixed prices that allow a 12.5% (originally 10%) profit. The drugs are divided into two types: the “P” list or prescription list, which should only be sold with a prescription from the Department of Drug Administration or HMG prescriber, and the “G” list or general list, which can be sold without a prescription.

BNMT buys drugs from Royal Drugs Limited from the market in Biratnagar, with the benefit of bulk buying. The drug are charged to the retailer at cost plus 10% to cover the cost of administration, transportation and loss due to damage and expiry. The retailer abides by certain regulations including posting the prices of all drug items, limiting their sales to drugs from the approved lists and selling the full course of drugs. Most of the HDS retailers had the retail drug shopkeeper training course offered by His Majesty's Government (HMG). There are altogether 28 shops in several hill districts in the Eastern Region.



**Table 7. A summary of drug schemes in Nepal, 1993**

### ***Revolving Community Drug Cooperative Supply Scheme (RCDCSS)***

In 1986, HMG and WHO jointly initiated this scheme to overcome the shortage of drugs at health post level and also to promote greater community involvement and participation in the management affairs of the health posts. The scheme is geared towards helping the community establish its own drug supply cooperative scheme by providing seed money as a small revolving fund for the community, so it becomes self-reliant in drug supply for its health posts.

The scheme involves the normal Government drugs budget worth Rs. 10 000 annually (now Rs. 50 000) per health post plus a WHO fund to procure additional quantities of essential drugs. An additional amount of Rs. 5 000 is initially provided to each health post for preparatory activities. In addition, Rs. 50 000 is deposited in favour of each health post.

In this scheme, Rs. 2 was levied on each patient as a registration fee (except for tuberculosis, leprosy and malaria cases). Normally, the money from the levy on patients plus the interest from the money deposited in the bank per year (now abandoned in the third phase of the scheme's expansion, after the Government increase in the drugs budget from Rs. 25 000 to Rs. 50 000) exceeds the amount needed to purchase supplementary drugs every year.

### ***Lalitpur Medical Insurance Scheme***

The scheme was initiated by the United Missions to Nepal (UMN) initially at six health posts (now five). The health committees are responsible for the management and set the premium, which ranges from Rs. 30 to 125 per year depending on the different health post. The members of insured households are entitled to free services for a specified number of visits during the year. Non-member households receive a free consultation service at health posts, but receive a prescription instead of free drugs. Only drugs and vaccines provided in the health post and mobile maternal and child health (MCH) clinics are free of cost to all, regardless of insurance.

### ***Terhathum Cooperative Drug Scheme***

According to the scheme, Rs. 13 000 is initially provided to each health post to procure additional required quantities of essential drugs from The Netherlands Leprosy Relief (NLR) funds, in addition to the normal Government annual drug budget. A fixed bank deposit of Rs. 40 000 is made in favour of each health post from NLR. In addition, a sum of Rs. 5 000 is provided as an initial fund to each health post for preparatory and administrative costs.

### ***Surkhet Drug Scheme***

This scheme is based on the HMG/WHO model. The only difference in the two models is in the fixed bank deposit. In the HMG/WHO model, Rs. 50 000 is deposited in a bank account, while in this model, only Rs. 20 000 is deposited. Drugs for treating tuberculosis, leprosy and MCH care are provided free of cost.

**Dolakha Drug Scheme**

Dolakha Drug Scheme was initiated by Integrated Hill Development Project (IHDP) in 1981. A grant from IHDP was provided, which was decreased by 10% each year over a period of five years with a corresponding increase in the local resources. The prescription charge is Rs. 1 to 2, which is fixed by the local health post committee.

**Assessment of cost-sharing programmes**

A study team has recently examined the three significant cost-sharing programmes in Nepal: the UMN, BNMT and HMO/WHO cost-sharing programmes. The comparative performance of the three programmes is shown in Table 8.

**Table 8. Comparative performance of three drug programmes**

<b>Indicators</b>	<b>BNMT cost-sharing</b>	<b>UMN Lalitpur insurance</b>	<b>HMG/WHO community</b>
Availability of drugs (MOH = 60%)	72.4	84.0	57.2
Subsidy increase (Rs)	17 978	10 577	0
HP drug stock increase (%)	76.3	65.3	6.9
HP utilization increase (%)	53.5	198.5	No data
Consultations per year	3 059	6 000	No data
Average drug cost per patient (Rs)	26	12	No data
Relative unit purchase costs (%)	101.9	78.2	144.3
% drug costs recovered	18.7	56.5	27.1
Village committee's authority	Limited	Extensive	Extensive
Administrative overheads	High	High	Nil
Replication feasibility	Limited	Limited	High

Source: Rational pharmaceutical management project, Kathmandu, Nepal  
Management Sciences for Health/United States Agency for International Development (MSH/USAID)

**UMN**

In 1994 and 1995, approximately 40.8% and 38.2% respectively, of the households in the Lalitpur target area purchased insurance. In 1995, approximately 17 000 people were covered by the scheme. The scheme provides 27 tracer drugs for the health posts and achieves 84% drug availability with the lowest subsidy. The total value of drugs received per health post was Rs. 68 830.91 in the financial year 1991-1992. When the lower unit costs UMN pays for its drugs are taken into account, the volume of drugs distributed at Lalitpur scheme health posts is 60% greater than an average health post in Nepal.

## **BNMT**

In 1993, the Hill Drug Scheme supplied Rs. 513 594.36 worth of drugs to 35 retail shops. Well over half of these drugs were delivered to two shops, while 10 shops received no drugs at all. The remainder received an average of just over Rs. 9 100 per year. The money collected is deposited in a BNMT account to purchase replacement stock.

## **HMG/WHO**

The first 12 participating health posts received Rs. 50 000 endowment, the 13% interest from which could be used for the purchase of essential drugs. Later, the scheme eliminated the endowment and provided a Rs. 25 000 grant instead. Up to 20% of the money could be used for administrative costs while the remainder is intended for the purchase of essential drugs. The income reported by facilities is Rs 14 904 on average, of which Rs. 5 058 is spent on drugs. Most of the remainder is deposited in bank accounts. The balance in these accounts now averages nearly Rs. 70 000 and has been increasing at an average of Rs. 8 000 per year. The replacement stock can be purchased from any convenient wholesale or retail outlet, which generally do not carry the full range of needed drugs.

The result of the cost-sharing programme at community level has been found to be encouraging and has demonstrated reasonable success. The most positive result of the scheme has been the willingness of poor people to pay for such a scheme irrespective of their financial hardship. As their income increases, people come forward to contribute more for such a scheme.

## **Conclusion**

The cost-sharing initiatives operating in Nepal can be classified into three main types of health financing methods. The first is the full cost recovery scheme (Hill Drug Scheme). The second is the cost-sharing programme initiated by HMG/WHO, a revolving cooperative drug scheme and the third is a pre-payment scheme in the form of compulsory insurance. Although the schemes are not problem free, they provide opportunities for improving drug supply with active participation from the community.

## **2.4 Thailand** (presented by Dr Porntep Siriwanarangsun)

### **Drug system overview**

#### ***Size of market***

In recent years, the portion of Thailand's drug expenditure which actually passes through the pharmacy shops, doctors' practices, health centres, etc. has doubled, from 1/3 to 2/3. This highlights the importance of educating

pharmacists and doctors on proper drug selection, which is of paramount importance in creating an essential drugs list. Exact figures for pharmaceutical products on the market are difficult to determine, and estimates vary, but it is certain that at least 22 000 different drug products, from only about 2 000 generic drugs, are sold in Thailand.

### ***National Drug Policy***

The National Drug Policy was first developed in 1981 by a National Drug Policy Committee appointed by the Cabinet. It aimed at accomplishing availability, accessibility and rational use of good quality essential drugs. The policy was revised and the second version was approved in 1993. It helped guide the total development of the national drug system. Major developments are: an improvement of drug quality and infrastructure to assure quality control; the establishment of an essential drugs list; increase in the capacity and standards of the Thai drug industry; the strengthening of rational use of drugs; and the use of traditional and herbal medicines at the PHC level.

### ***Registration and patent issues***

A huge drawback in the drug system is that the provisions of Thailand's copyright law do not extend to drugs, so that, by changing the shape and colour, multiple brand names can be produced from a single generic drug. Drug management problems and inappropriate drug use result from too many drugs being registered, as companies promote their products, rather than promote rationality. On the other hand, many believe that such pharmaceutical diversity creates competition in both price and quality. For example, prices for piroxicam range from 0.25 baht to 7 bahts, with the cheapest tablet differing from the most expensive one only in the absorption and peak blood level times. Still, a surplus of drugs does exist in the Thai market. Despite this, however, there are 40 'orphan' drugs which have definite therapeutic value, but there are no producers or importers because of poor market potential. Plans have been formulated to import eight of these drugs with partial Government subsidy and to manufacture two others.

Two other factors may contribute to there being too many drug products in Thailand: fast registration time and low registration fees. The procedure for registering new drugs is much less sophisticated in Thailand than elsewhere (8-10 months, as opposed to 33 and 30 months in the US and Japan respectively). Some people feel that quick registration should be promoted, as this will reduce importation and production costs, thereby reducing the capital investment costs and, thus, the consumer price. Others, however, are concerned that overly rapid registration could pose a threat to health, as this will lead to insufficient testing of drug products. Thailand charges a registration fee of US \$100 compared to US \$100 000 for the US. The Ministry of Finance collects the fees and does not reroute them back into the system to improve the registration process.

The Food and Drug Administration (FDA) has attempted to cancel the registration of drugs which have not been manufactured for at least two years, which would reduce the number of registered drugs to 16 000. Unfortunately, the FDA's efforts have been circumvented by the practice of some drug companies to produce just enough of some drugs once every two years to keep them registered.

### ***Essential Drugs List***

Thailand's Essential Drugs List has been revised five times. Actual promotion of essential drugs occurred infrequently because of the FDA's inefficient organizational structure; and enforcement was resisted, because of infrequent updating. The 80:20 ratio of the essential: non-essential drug budget was not considered by many to be uniformly suitable for all levels of health facilities.

### ***Rational use of drugs***

Drugs are used very irrationally in Thailand. This irrational use of drugs, an increasingly critical issue, may be traced to several causes. They are: unethical drug promotion, too many drug products on the market, the prevailing culture of prescribing, inefficient regulatory and monitoring systems, and lack of training for health personnel.

### ***Drug industry***

Thailand's drug industry includes 173 pharmaceutical factories and 496 importers. Thailand itself produces just 25 varieties of raw materials. Local preparations constitute 65% of total drug expenditure, and most of these contain imported raw materials. Quality control for local drugs is very important, the FDA, which gives top priority to monitoring pharmaceutical factories, has been inspecting the medicines available and certifying factories with the label 'GMP' (Good Manufacturing Practices). Just 8% of drugs manufactured in Thailand fail to meet the desired quality. However, only 7% of the GMP factories' drugs were found to be substandard, whereas 25% of non-GMP factories were judged to be so (all pharmaceutical factories are expected to be GMP-certified by 1996). However, criteria for fake drugs are based only on the drugs' active ingredient and not on their solubility, bioavailability or therapeutic efficacy.

New drug research and development in Thailand is difficult, due largely to the significant financial investment required to pay for highly-trained personnel. Thailand's pharmaceutical industry produces mainly for the domestic market, but drug exports are rising. The Asian Free Trade Agreement (AFTA) will conceivably expand Thailand's drug market from its current potential 60 million to a possible 300 million customers. Stiff competition is expected from other regional countries, and small companies could suffer.

## **Drug financing**

Estimates of total drug expenditure in Thailand vary anywhere from 25 billion to 80 billion bahts annually. Drugs accounted for 35% of all health expenditure in Thailand in 1993 (Suwit et al., 1995), compared with 8.25% and 20.7% in the US and Germany, respectively. As there is no data collection on what the Thai population spends on drugs, the total amount of drug expenditure can only be a rough estimate.

This paper will show the channels through which people can get medical services (including drugs) when they are sick. The sources of funds are as follows: paid by people's tax; paid by people's own pocket; paid by both people's tax and people's pocket; paid by the participation of health care insurance of both public and private sectors; and village drug funds.

### ***Paid by people's tax (public taxation)***

There are two schemes for providing Government budget. One is known as the Public Assistance Scheme and the other is the Civil Servant Medical Benefit Scheme (CSMBS). These schemes are for the underprivileged, low-income group, school children, the elderly, and Government officials and public enterprise employees, through Government health care facilities. They include regional hospitals, provincial general hospitals, community hospitals and health centres. Details of the two schemes are given below.

The Public Assistance Scheme covers 27% of the population. It is financed through Government tax revenue for the low income households, the elderly and primary school children for free care at public outlets. In 1995 public source funding was 4 305 million bahts (Supachutikul, 1996).

Medical fringe benefits for generally low paid Government officials, such as the CSMBS, are financed by general tax revenue and offer generous coverage, which includes parents, spouse and up to three children under 18 years old. Population coverage of the scheme is approximately 10% in 1996. In 1995, public funding was 9 954 million bahts (Supachutikul, 1996).

### ***Paid by people's own pocket (personal out-of-pocket expenditure)***

People use services from general drug stores, private clinics, polyclinics and both public and private sector health care facilities. There are no data available on drug purchasing.

### ***Paid by both people's tax and people's pocket***

In this case, people have to pay a certain amount of money for drugs and medical treatment according to some predetermined guidelines. For example, a Government official who goes for health services at a private hospital can be reimbursed part of the total payment. The official has to pay the remaining amount of the expenditure himself according to Government rules and regulations. Another example is that if the Government official uses some

unusual medical service, such as plastic surgery, the money paid for this kind of service cannot be reimbursed. No data are available on this kind of payment.

***Financing public and private sectors by the health care insurance system***

There are various health insurance systems, such as the Health Card Project, Social Insurance Scheme, Labour Welfare Scheme, Private Health Insurance Scheme, etc. The money spent on medical care can be reimbursed from a central agency where funds are available as detailed below.

The Social Security Scheme (SSS) is financed on a tripartite basis with Government, employee and employer contributing a total of 4.5% (1.5% each). The insurance covers formal workers in establishments of more than 10 employees for non-work related sickness, maternity, invalidity and death compensation. In 1993, the public contribution was 3 803.74 million bahts and the private contribution was 5 553.52 million bahts (Supachutikul, 1996).

The Workman Compensation Scheme (WCS) is financed solely through employer contributions, for work related sickness, disability and death compensation. In 1993, private contribution was 921 million bahts (Supachutikul, 1996).

Private insurance schemes cover higher income people.

MOPH voluntary health insurance, Health Card Project (HCP) covers the borderline poor and more well off in rural areas. In 1994, private contribution was 807.4 million bahts and public contribution was 400 million bahts (Supachutikul, 1996).

***Village drug fund (or drug cooperatives)***

A village drug fund is set up with the main objectives of providing essential drugs for the relief of sickness and training local people to learn about teamwork and administration in drug funds. It was estimated that 74% of all villages in Thailand have set up a drug fund (Tavitong et al., 1993). However, there is a high rate of drug funds dissolving due to poor utilization and management. Half of the funds have an income of less than 200 bahts per month which is not economical to operate. There were 37 016 drug funds in Thailand in June, 1996.

Initially, there were 63 358 drug funds for the whole country. Thus, a total of  $700 \times 63\,358 = 44\,350\,600$  bahts were initially invested in the Fifth and Sixth Health Development Plans. The Laemthong Sahakarn group, a private company, also provided 20 million bahts to 20 706 drug funds from 1983 to 1993, resulting in a total amount of 19 648 900 bahts.

A study in 1992 showed that 40.5% of drug funds had working capital of 300 to 2,500 bahts, 36.7% had more than 2,500 bahts and 22.8% had no working capital. The number of people visiting drug funds was as follows: 40.5% had



10-25 visitors per month, 23.4% had 26-50 visitors per month and 18.4% had fewer than 10 per month.

A study by Pornthip Supradit in 1995, found that people buy drugs from drug funds and grocery stores. The most important sources of information which influence drug buying decision-making are neighbours and senior-relatives. The second most important sources are radio and television. The best selling drugs in grocery stores are anti-pyretic and analgesic drugs, and it was found that grocery stores sell those drugs which are demanded by villagers.

A village drug fund is established with funds from villagers and with support from central and provincial organizations, to help people buy standard quality drugs at cheap prices. This fund is managed by a village committee. Benefits from the fund can be used for development of the village. Figure 1 shows the channels for drug procurement and distribution for village drug funds. It highlights the involvement of central organizations, such as the office of PHC and GPO, the provincial level health offices and the village drug fund, in improving accessibility of drugs to the consumer.

## **Pharmaceutical market value and drug distribution**

### ***Value of drug distribution in the wholesale market in 1992***

The IMS Data, Thailand, conducted a survey from hospitals and drug stores and estimated the value of drugs on the wholesale market in 1992 at 18 006 million bahts.

The combined estimated value of allopathic medicines from the production reports submitted to the FDA by local producers and drugs imported from abroad into the country at wholesale prices was 16 878.367 million bahts. This value was not considered to be accurate and might be underestimated up to 48% according to an official random survey carried out during 1987-1992. Therefore, the value, after adjusting for 48% error, would be 35 163.3 million bahts.

***Wholesale value report at factories owned by the Government*** (including the GPO, Military Pharmaceutical Factory, Thai Red Cross Society, and Government hospitals, for which reporting is not legally required). It is estimated that the total value of drugs from the four sources was 1 904 million bahts.

***Wholesale value of addictive and psychotherapeutic drugs was 33 million bahts.***

The estimated drug value (wholesale), based on the limited data above, ranged between 18 650 to 36 935 million bahts. From this amount must be subtracted the value of drugs produced for export and sales abroad, the total value of which was 700 million bahts. Therefore, the wholesale value of drugs distributed in the Thai market in 1992 ranged from 17 950 to 36 235 million bahts.

## **Pharmaceutical market value of drug consumption by population**

This had been computed in various ways as follows:

Computed from the wholesale value of drugs distributed in the market multiplied by the percentage mark up (usually 30-70%) retailers add to wholesale prices, gives an estimate of 23 335 to 61 599 million bahts.

The National Economic and Social Development Board (NESDB) using household survey data and adopting the UNSNA (United Nations System of National Account) method for calculating drug expenditure estimated the pharmaceutical market value of drug consumption to be approximately 80 000 million bahts.

In 1990, Dr Viroj Tangchareonsathian, using household survey data and MOPH budget data, estimated the value at 53 894 million bahts.

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## 2.5 Summary

Even though drugs play an important role in PHC in the four countries, a majority of the drug financing in these countries came from non-Government sources; i.e. private households (Indonesia and Thailand) or donors plus private households (Nepal and Myanmar).

Country information on user charges and cost-sharing for drugs:

**Indonesia.** User charges for medical services exist in hospitals but drugs in PHC are provided free of charge in primary care facilities.

**Myanmar.** Several cost-sharing programmes jointly funded by the Government and external donors have been implemented during the past several years and some proved to be working well in improving the availability of drugs in PHC facilities. However, the programmes' viability in the long-run is still questionable since all the donations will not continue. Therefore, Government

as well as other alternative sources of funding need to be developed for long-term development and sustainability.

**Nepal.** The situation is very much like that in Myanmar. Several experimental programmes on cost-sharing have been implemented and some are more successful than others. An insurance programme (the UMN scheme) showed the best performance in improving drug availability and accessibility.

**Thailand.** Thailand has the most complicated mixtures of health insurance among the four countries. Drug financing in Thailand is from a mixture of private and public sources, provided through various forms of insurance. User charges are common practice in health service provision (including drugs). In addition, several public assistance programmes for the underprivileged and the needy are also provided by Government allocation.

### **3. Korat provincial field visit**

There were three field visits, but, due to time constraints, each participant could only see two places. All participants went to Soongnern Community Hospital and had a choice of visiting either a health centre or a village drug fund.

Soongnern district is 36 km. from the provincial capital and 222 km from Bangkok. It covers a total area of 768.5 sq. km., 11 sub-districts, 103 villages and 15 029 households with a total population of 69 870 (35 381 females and 34 489 males) in 1995.

#### **3.1 Soongnern Community Hospital**

Soongnern Hospital is a 60-bed community institution, under the MOPH. There are also 12 health centres, 1 malaria centre, 3 private clinics and 8 drug stores in the district. In 1996, there are a total of 148 staff in the hospital: 4 doctors, 2 dentists, 2 pharmacists, 2 experts, 28 professional nurses, 17 technical nurses, 4 dentist assistants, 2 pharmacist assistants, 5 community health workers, 5 laboratory technicians, 9 administrative officers, 20 nurse assistants and 48 employees.

The five most common illnesses in 1995 were diseases of the digestive system, respiratory system, musculo-skeletal system, endocrine system and nutritional problems. The top five causes of death were senility, circulatory system failure, vehicle accidents, cancer and respiratory system failure.

### **Duties and responsibilities of the hospital**

1. To provide curative, preventive, promotive and rehabilitative health services. The community hospital has official responsibility for providing supervision and technical support to all health centre personnel as well as 1 385 village health volunteers in the villages. It also serves as the referral centre at the secondary level.
2. To set up a support system for PHC activities, such as training and supervision of village health volunteers, drug cooperatives, deep well drilling projects, water container construction, latrine construction and herbal medicine projects.
3. To provide training to all health personnel: medical, nursing, pharmacy, dental, public health and administrative students.
4. To undertake research activities, such as Thai traditional medicine research.

### **Health care financing at Soongnern Hospital**

In 1995, Soongnern Hospital spent approximately 17 to 18 million bahts (excluding salaries) on provision of health care services (including drugs) to the community. The majority of the money came from user charges, with only 5 million bahts from the Government budget. Different sources of health finance can be seen at Soongnern Hospital.

### **Sources of funds**

1. National budget allocation for public assistance programmes (the poor, elderly, primary school children, children under 12 years) is through the Provincial Health Office which then allocates the budget to the hospital.
2. User fees from medical benefit provided to Government employees and their families are reimbursed directly from the Ministry of Finance on a fee-for-service basis.
3. Social security benefit is a pre-payment budget on a per capita basis.
4. Health card benefit is also a pre-payment programme with 50% contribution from the household and 50% from Government allocation.

5. The third-party motor accidents programme is reimbursed from a private insurance company.
6. Out-of-pocket payment.

Detailed information on sources of health finance at the hospital:

Tax allocation for public assistance programmes	
plus user charges for Government employees	44%
Out-of-pocket expenses	40%
Social security scheme	8%
Health card project	4%
Third-party motor accidents	3%
Others	1%
Total	100%

These expenditures are used to cover patients in the following programmes:

Poor people	22.5%
Elderly	10.6%
Primary school students	10.5%
Children under 12 years old	9.4%
Village health volunteers	8.0%
Health card patients	6.2%
Social Security patients	4.4%
Civil servants and family	3.4%
Out-of-pocket	20.4%
Others	4.5%

## **Public Health Pharmacy Section**

This work unit at Soongnern Hospital is responsible for all drug supply management and other duties in the district. Six major areas of responsibility are:

### ***1. Drug management***

The main objective of this duty is to ensure rational essential drug use in the community, which can be achieved through proper selection, procurement, distribution and use of essential drugs.

#### *Selection*

The Pharmacy and Therapeutic Committee (PTC) set up the hospital drug list called the "Common Drug List" which consists of 324 EDs and 89 NEDs. A separate list of 100 essential drugs exists for health centres.

#### *Procurement*

Approximately 100 ED items are purchased through the G.P.O. while the rest are from private companies. A group purchasing method was set up so that more bargaining power can be obtained to negotiate prices as well as drug quality. By regulation, the Government drug budget has to be spent at the ED:NED ratio of 4:1.

#### *Distribution*

Soongnern Hospital is responsible for supplying drugs to all services within the hospital. It is also responsible for the supply of all drugs to the units outside the hospital, such as health centres and drug cooperatives.

#### *Drug use*

Promotion of generic prescribing and dispensing are encouraged within the hospital. The hospital has also set up a 'Community Drug Store' where consumers can buy drugs for common diseases directly without consulting the physician first. This Community Drug Store also provides drug supplies to all 141 village drug funds (or drug cooperatives) within the district.

#### **2. Pharmaceutical services**

Services provided to outpatients, inpatients, mobile clinics, and other units.

#### **3. Production services**

Antiseptics, normal saline solution for dressings and some drugs, such as antacids, are locally produced.

#### **4. Community pharmacy**

The objectives are to support PHC by setting up drug cooperatives in villages, and to promote herbal medicine use.

#### **5. Pharmacy training**

Pharmacists are responsible for training of pharmacy students and hospital staff as well as consumer education. They also serve as guest lecturers at colleges and universities.

#### **6. Administration**

Pharmacists are also in charge of all management aspects in the section.

### **3.2 Maa Kleur Kao Health Centre**

This health centre is staffed by one midwife, one registered nurse and one technical nurse with responsibilities covering eight villages or 600 households. The health personnel also provide support and supervision to 162 village health volunteers in the community.

Basic PHC services, such as vaccination, family planning, health education, etc. are the responsibility of each health centre. Some curative treatment of minor illnesses can also be done at the health centre. At the moment, there are an average of 30 patients per day.



Fees for the services can also be charged to patients who are able to pay for drugs and some diagnostic tests. Soongnern Hospital is responsible for monitoring of the services as well as charges made to the patients.

The drug list used in health centres is determined by the District Pharmacy and Therapeutic Committee. There are approximately 100 items of essential drugs available at the health centres, including some injections and common antibiotics, such as penicillin and amoxycillin. Soongnern Hospital is the only source of drug supply to all health centres in the district.

### **3.3 Village drug funds (or drug cooperatives)**

A drug cooperative is a type of village drug fund, set up to solve inappropriate drug use in the community, with the principle of people participation by voluntarily sharing their money as shareholders. The field visit described here was to the drug fund at the Baan None Kah village.

The village drug cooperative was started in 1986 with initial one-time capital of 1 000 bahts from the Government and from selling shares to voluntary members. Each member has to buy share(s) at 10 bahts per share with a maximum limit of 10 shares per person. At the moment, the drug cooperative has 48 members and about 90 shares altogether.

Drugs supply is purchased at the Community Drug Store at Soongnern Hospital with a 25% discount from the purchasing price that the hospital paid. There are two types of drugs available, 20-30 items of household drugs and seven items of herbal medicine.

The revenue generated is approximately 900 to 1 000 bahts per month (there is no exemption). Basically, drugs are sold at a fixed price as labelled on the package. The profits are divided into three parts: 40% as dividend for shareholders, 40-50% for the sellers responsible for all the business management and another 10 to 20% put in a bank account. The community committee is responsible for the profit sharing decisions.

For accountability, an information system is developed which includes the financial aspects and drug use information. For drug use data, the name of drug sold, diagnosis of the symptoms and price charged are recorded. The record will be monitored by the community pharmacists or the assistants. The financial aspects should be reported by the volunteers to the members at least once a year.

It can be concluded that this drug cooperative at Soongnern District is one of the successful examples of community self-reliance as the first contact for PHC with strong community participation. Sustainability of the programme depends

on the effectiveness of the management system, which includes capable, highly motivated and dedicated volunteers as well as adequate supervision by health personnel at district level.



## 4. Drug financing issues

### 4.1 Drug financing alternatives (by Dr German Velasquez)

Questions related to health economics have become more and more crucial in the formulation and implementation of national drug policies. Such policies have moved from the purely technical and pharmacological to the economic and social spheres. Each component of a national drug policy - including selection, supply, quality assurance, storage and distribution, and rational use - has economic effects.

Macroeconomic changes, have an important impact in the health field, and particularly on the financing of drugs. Furthermore, the new economic policies in the drug sector may have direct consequences, as yet not clear, on access, quality and rational use of drugs. The economic dimensions of national drug policies are therefore a question of concern, not only for ministries of health, but also for all other government departments.

The relationship between the public and the private sectors is an important consideration. Markets usually allocate resources efficiently, if competitive conditions prevail. But the pharmaceutical market, if left alone, may fail and monopolistic conditions may arise.

Government action is therefore needed:

- to establish a regulatory framework that ensures efficacy, safety and quality of drugs;
- to create the incentives required to guarantee competition for the benefit of consumers and the efficiency of the economy at large;
- to negotiate with suppliers when monopolistic conditions prevail;
- to provide access to essential drugs to the whole population, and particularly to finance the needs of the poor.

Markets do not necessarily achieve equity. The public sector has a responsibility to improve the distribution of health care and drugs among social groups. Taking into account the particular socioeconomic circumstances, every government should allocate a certain amount of resources to satisfy the essential drugs needs of the poor and other target groups.

Economic strategies for drugs should be adapted to the particular needs of each country. Countries are diverse with respect to population, income levels, health expenditure and other relevant factors. National spending may vary from 2 to 400 US\$ per person per year.

Countries that are small, do not have the necessary infrastructure, or experience extreme economic hardship may find it difficult to achieve a sufficiently competitive pharmaceutical market. In such instances, public supply through competitive procurement and distribution through public health networks may be necessary. International cooperation, aid and technical assistance may be required.

### **Organization of markets to foster competition**

With adequate institutions, information and incentives, national pharmaceutical markets can be organized to promote price competition.

### **Rules to organize the pharmaceutical market**

First the basic rules have to be established. Some of the basic rules to organize pharmaceutical markets are peculiar to the sector: drug evaluation and licensing, drug selection, quality assurance, public purchasing regulations and laws on patents and trade marks, for example.

The Uruguay Round of trade negotiations under the General Agreement on Tariffs and Trade concluded in 1994 with an important agreement on trade-related intellectual property rights (TRIPS). It establishes the obligation for all signatory countries to recognize patents on pharmaceuticals under stringent conditions, which entails a significant change in the basic rules of the markets of a number of countries. Industries in such countries, which used to produce pharmaceuticals patented in developed countries without the permission of the patent holder, will no longer be allowed to do so once the agreement is implemented. However, the agreement provides for a transitional period of 10 years and some possibilities, such as compulsory licenses, to balance the exclusive rights conferred by patents and consequent higher prices, with public health needs.

### **Information**

More and better information is also needed to foster competition. Private and public institutions should disseminate information on the technical characteristics, prices and cost-effectiveness of medicines to physicians, pharmacists and patients.

### **Incentives**

Incentives are devised to encourage consumers, health workers and the industry to take appropriate actions that are both economically and

therapeutically beneficial. Monitoring is essential to ensure that incentives produce the intended effects. The following examples illustrate some possibilities:

Public demand for lower priced drugs can be increased by publishing information on drug prices.

Altering levels of cost-sharing can achieve a number of outcomes depending on the particular context of programmes or subsidy schemes. It may, for example, increase user awareness of cost, reduce wastage and increase the use of essential drugs compared to less useful drugs.

Methods of payment of health care providers can affect the way drugs are prescribed, dispensed, selected and used. Incentives to encourage cost-effective prescribing and a high quality of care by doctors can be designed by altering the method by which they are paid.

### **Drug financing options**

The main principles of the economic strategy for drugs recommended by WHO are:

1. the objective of various drug financing systems must be to improve and facilitate the access of the whole population to essential drugs;
2. the responsibility and will of the State to participate in paying the national drug bill are fundamental;
3. the money saved by the selection of drugs to circulate in the country and their rational use must be one of the main sources of additional income for the purchase of drugs;
4. the allocation of an adequate percentage of the State budget to health, and consequently to drugs, must be a priority; for many countries this will require an increase in public spending for health.

Possible options of drug financing include public financing, health insurance, user charges, non-State collective non-profit-making financing, donors and international loans. In some countries the option is a pluralistic approach in which different financing mechanisms are used to serve different groups of the population.

Nevertheless, it is the responsibility of governments to ensure that drug financing mechanisms are managed in such a way as to achieve universal access to essential drugs. Health financing mechanisms may be evaluated and compared in terms of equity, efficiency, sustainability, and feasibility .

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## **Public financing**

Stable government financing through the State budget for essential drugs may be facilitated by convincing decision-makers of the importance of health for national social and economic development. As part of the regular State budget, the following are some of the options for State drug financing:

- Taxes and levies allocated to drugs

Taxes on lotteries, alcohol and tobacco consumption can yield considerable financial resources. The allocation of such income to drugs or health in general makes the idea much more acceptable to the population. To make this allocation obvious and secure, the sums concerned should pass through a fund with separate accounts.

- Local and regional authorities

Local and regional authorities can help to finance people's access to essential drugs. The funds available may be small, but since they are managed in a decentralized way they may be easier to negotiate than those from the central authorities.

- Health insurance

Insurance schemes collect premiums from individuals or their employers to pay for health expenditures incurred by the members. A major advantage of insurance schemes is that health care costs are shared by healthy and ill people alike. The experience of many countries has shown that compulsory social insurance is a necessary step to a more equitable health care system.

## **User charges**

User charges should be seen as a complement to government financing, not a substitute. User charges for drugs at the present moment in several New Independent States, due to the very low income of the majority of the population, could drastically reduce the access to drugs of certain groups, particularly in the rural areas. Privatization of pharmacies, for example, often means that drugs have to be financed by the population, this decision, without prior analysis of the patient's ability to pay, can exclude part to the population from basic health care.

## **Non-State collective non-profit-making financing**

Solidarity within various population groups could play an important role in financing the health services. Financing by cooperatives, State or private companies (such as railways or mines) and the community should be considered as complementary to State financing of the health services.

Collective financing does not leave the financial burden on the shoulders of the patient during illness, but distributes it among other economic actors.

### **Donors**

For some countries, economic necessity may require dependency on an external funded drug programme for a relatively long period of time. With donor drug financing, governments need to ensure that realistic transition is made to an ongoing mechanism funded through a line item in the ministry of health budget or appropriate other institutional funding mechanisms. Careful evaluation of external drug financing is needed.

### **International loans**

Loans may contribute to long-term development of human and physical infrastructure for the health sector. However loans should not be used for financing the recurrent cost of drug supplies.

## **4.2 Cost-sharing for drugs** (by Dr Petcharat Pongcharoensuk)

### **Introduction**

Cost-sharing is a drug financing programme that is sustainable with contributions from both the public sector as well as the private sector (through user fees), to achieve the goal of better efficiency and equity in drug supply.

Facing the shortages of drug supplies for PHC in many developing countries, it was recommended by the World Bank in 1987 that some mechanisms of user charges should be implemented in the community, and the money recovered should be used for the replenishment of drug supplies in that community. It is believed that user charges for publicly-provided health services can lead to more efficiency than health services provided free of charge, since people will think twice when they have to be responsible for part of the cost for services, including drugs. This can lead to reduction of unnecessary utilization of services as well as a more efficient provision of health services.

### **Objectives of cost-sharing**

Several aspects of cost-sharing in health care are being tested in financing programmes in African countries (Shaw and Griffin, 1995). The objectives of such programmes are to:

1. Promote efficiency. User charges can move the patients from health facilities in big cities to the lower level in the referral system, if the charges are set properly among different levels of health facilities. This will make the referral system function more efficiently by re-channelling the patients to an



appropriate level of care; those who need basic health care go to the lower level facilities (health centres, primary health centres) and those who need more sophisticated care go to the higher level of health facilities, i.e. hospitals.

2. Foster equity. By charging people who are able to pay and willing to pay, more money will be made available for the poor who are in need of the health services but may be unable to pay for them.
3. Promote decentralization and sustainability. User charges provide ways and means for decentralization of health policy to the community level. This gives the community the opportunity to learn how to manage and control health services in their own communities. User charges collected in the primary care facilities should be retained and used for the community health activities, including replenishment of drug supply in the facilities, which will enhance sustainability of the health programme.
4. Foster private sector development. Appropriate user charges should provide opportunity for the private sector to be more competitive in providing services and hence, would result in more efficiency in services' provision. Also, public-private cooperation in drug management can be enhanced since a major source of drug supply is in the private sector.
5. Promote consumer satisfaction. The ultimate result of user charges should be increased consumer satisfaction, which can include benefits for patients, such as availability of drugs, cleanliness of the facility, a better relationship between patient and provider of care, etc.
6. Generate revenues. This can be a means to generate more revenues for the facilities, so that more resources will be available to keep the programme sustainable in the long-run.

### **Pros and cons of cost-sharing**

Cost-sharing in health care has both its advantages and disadvantages. All the positive aspects should be encouraged and strengthened, while the negative aspects need remedial action.

#### **Pros:**

1. Revenues collected are added to government budget, not a substitute for government allocation
2. Promotes referral system
3. Encourages rational drug use by reducing unnecessary demands for health care and drugs
4. Risk-sharing among the well-off who are able to pay and the poor

5. Decentralization by local retention and control of money collected
6. Promotes private sector development
7. Consumer satisfaction, with more availability of drugs and improvement of quality of care

**Cons:**

1. Collection cost greater than revenues generated due to inefficient management
2. Discourages the poor from primary care, if they are unable to pay for the services
3. User charges will increase the burden on the poor rather than the well-off
4. No improvement in service quality
5. No improvement in drug availability
6. Encourages over-prescribing, if more drugs lead to more revenues

**Planning and implementation of cost-sharing programmes**

Before starting a cost-sharing programme, several important factors should be taken into consideration during the planning, as well as during the implementation process (Quick J.D. et al., 1996).

***Situation analysis and feasibility assessment of both external and internal environment***

The political environment and economic situation of a country are the two major external factors which need to be assessed to make sure that the programme will have political support from the government, as well as financial support from both the government and the community. In addition, it is necessary to establish the managerial capability of the implementation agency.

***Financial planning***

Financial planning should address the following questions: what are the cost recovery objectives, since cost recovery may cover partial drug costs, full drug costs, or full drug costs plus administrative costs? How much initial capital is needed? where will the money come from - government, community or donors? and how will the revenues be efficiently collected and managed? For countries with little local drug manufacturing capability, does foreign exchange affect drug supply management? Is there local banking facility in the

community for the money collected, and what are the operating costs of the programme?

### ***Organizational structure***

The organizational structure of the programme should be conducive to implementation at the community level. People in the community should be able to manage and have control of the programme to ensure success in the long-run. Drug supply systems should be managed efficiently; to reduce waste and ensure low cost, high-quality drugs are continuously available locally. Staffing requirements other than health personnel, such as people with management skills, accounting person, finance person are needed for the administrative work. Also, community participation is an essential requirement for the success of the programme.

### ***Implementation***

Programme implementation can be done either from the higher level facilities first and lower level facilities later (top-down) or first in the lower level facilities and higher level facilities later on (bottom-up). And this will be done in phases, with a pilot testing programme to determine if any advantages and disadvantages become apparent during the testing phase. Advantages of bottom-up and top-down programme implementation are:

- | Top-down  | Bottom-up   |
|---|---|
| <ul style="list-style-type: none"> <li>• more equity for people in greatest need to seek care</li> <li>• reinforcement of referral system</li> <li>• greater revenues potential</li> <li>• better administrative capacity</li> <li>• easier to monitor the impact of the programme</li> </ul> | <ul style="list-style-type: none"> <li>• serve local demand for essential drugs</li> <li>• provide more alternative health services</li> <li>• support preventive services in-community</li> <li>• greater community involvement</li> </ul> |

### ***Pricing and exemption***

#### a) Pricing strategies.

Before setting the fee, a survey should be conducted to determine the community's willingness to pay, as well as other opinions on the new programme. There are several pricing strategies for the drug programme:

- \* course of therapy fee, fixed fee for diagnosis and treatment
- \* prescription fee, fixed fee per prescription regardless of the items of drugs dispensed
- \* fee per item, fixed fee per item of drug
- \* multi-level item fee (VEN), different fee for different type of drugs, for example no fee for vital drug (V), lower fee for essential drugs (E), and higher fee for non-essential drugs (N)
- \* variable item fee, cost of drug plus a fixed percentage mark-up

b) Equity of access.

User charges should not have negative consequences by preventing poor people from getting the care they need.

c) Exemption policy and administration.

People who are unable to pay should be exempted. They are: poor people, children, elderly people, the disabled, people with some health conditions, such as pregnancy, tuberculosis, AIDS, etc.

Administering exemption is also an important issue, in order to make sure that the target group is really exempted. Policy and guidelines need to be developed for exemption.

***Drug management and financial management***

a) Drug supply management. Waste and inefficiency in drug supply management (selection, procurement, quality assurance, distribution, inventory control, information management and rational drug use) need to be minimized to ensure a reliable supply of drugs at all times.

b) Financial management. Proper financial management of drug supply and services should be developed. A simple accounting system provides a means for information management as well as accountability of the programme. In addition, money collected should be retained at the community level with community controls, so that some type of business-like management can be developed and practised.

***Public communication***

a) Implementation of the programme requires support from health staff, patients and the community. Good training and good communication among people involved should be developed at the commencement of the programme.

b) All health staff should be trained in relevant areas (drug management, accounting, finance) to ensure the dissemination of knowledge and practice, and to improve motivation.

c) Communication to the public is important to gain acceptance of the programme and participation in it. A public opinion survey and a public relations campaign with appropriate messages for the target audience should serve as a good starting point for programme implementation.

***Monitoring system***

Monitoring and evaluation of the programme on a regular basis are essential to determine the success of the programme. Particular attention should be paid to the adverse consequences, such as reduction in utilization of the programme (the number of people attending the programme after the implementation as

compared to before the implementation), revenue collection administration, exemption administration.

Another important concern is to avoid decapitalization, which can occur for several reasons:

- Increased procurement cost of drugs
- Under-estimation of capital cost
- Rapid programme expansion
- Loss of drugs due to damage, theft, date expiration
- High operating costs
- Too low price charged
- Too many exemptions
- Funds tied up in the banking system and reimbursement
- Delayed payments from reimbursement
- Foreign exchange limitations.

### **Conclusions**

Cost-sharing for drugs can serve as an alternative method of drug financing at the community level. If properly planned and managed, the programme can lead to an increase in the availability and accessibility of essential drugs for primary health care. However, careful considerations to prevent all possible negative consequences of cost-sharing such as disincentives for the poor to join the programme, inefficiency in revenue collection, are needed, inappropriate exemption policy and decapitalization of the programme, inefficiency in revenue collection.

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### **4.3 Monitoring for equity and quality (by Dr Jonathan Quick)**

User fee programmes can have positive effects, such as increasing access to essential drugs and improving rational use of drugs. But user fee programmes can also have negative effects, such as reduced access to treatment and reduced public expenditure for health.

When embarking on a new user fee programme or when making significant changes in an existing programme, it is *essential* that the effects of the programme be carefully monitored. The following questions should always be asked in monitoring the cost-sharing programme:

#### **User fee monitoring questions**

1. Equity effects -- Are people being excluded from essential health services because of fees? Are households better off or worse off?
2. Quality impact -- Is quality of service improving?
3. Revenue generation -- Are cash and insurance revenues generated as expected from service volume?
4. Revenue expenditure -- Are funds collected being spent as expected to improve quality of services?
5. Budget impact -- Is fee revenue supplementing or substituting for central Treasury expenditures?

#### **User fee monitoring methods**

Experience from monitoring user fee programmes in Africa and Asia indicates that four types of monitoring methods should be used together: (1) field supervision, (2) routine reporting, (3) sentinel systems, and (4) special studies. Each type of monitoring provides different information and has different resource requirements.

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### **1. Field supervision**

Regular supervision at each level of the health system is necessary to effectively implement new management systems associated with user fees. It is also necessary to assess the impact of new fees. Field supervision often follows structured checklists, based on the key monitoring questions. Supervision is most cost-effective when it is targeted to districts and health facilities which are having problems (management by exception).

Supervisors should be trained how to assess collection records, dispensing records, and records of exemptions. This approach reinforces recording and report systems. It also identifies particular problems (equitable use of exemptions, for example) which may require special study. Finally, supervision provides a “reality check” on the accuracy of routine reporting data.

### **2. Routine reporting**

Most countries have some form of Health Information System (HIS) which typically includes information on numbers of outpatient visits per month to hospitals, health centres and dispensaries. Most HIS systems also include information on inpatient admissions, occupied bed days and so forth.

For drug fees and other outpatient user fees, the most cost-effective monitoring tool is to simply plot monthly attendance, beginning several months before a fee is introduced. Figure 3 shows the graphs for two hospitals in the Region. It is clear from the graph that the first hospital experienced a mild decrease in utilization, while the second hospital experienced a severe and persistent decrease. The graph for the Township Hospital should cause policy-makers to assess the way in which user fees were implemented. Prices may be too high, the public may misunderstand the system, or exemptions may not be well-implemented for those truly unable to pay.

**Figure 3. Monthly outpatient attendance at two hospitals in Myanmar,  
1993-1995**



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In addition to health information, a user fee programme requires a Financial Information System (FIS). The FIS must be linked to a basic and transparent recording system for collections, banking, and payments. Monthly or quarterly financial reports should indicate monthly banking, monthly payments from user fee revenue, expenditure plans, cash collections, value of services provided (including waivers and exemptions), insurance and revenue (claims and payments, if applicable).

Good financial management, including a basic FIS, is vital to the sustainability of a user fee programme. Many revolving drug funds soon cease to revolve because they have not adequately monitored financial performance. The FIS should allow health providers at each level in the system to assess whether, for example, the total cash collected is sufficient to replace the drugs dispensed (see Figure 4).

**Figure 4. The financing cycle for user fee programmes**

**3. Sentinel system**

Routine reporting systems should be limited to the *minimum* amount of information which can be feasibly collected from all health facilities and districts. However, during the early years of a new programme, additional

detailed information is often needed to assess the impact of the programme. Such information is best collected through a “sentinel system” or system of “indicator districts”.

For a sentinel system, a small number of districts (at least six) and a sample of facilities within the districts are selected for more intensive data collection. The impact of user fee programmes can best be assessed by collecting the same data with the *same* survey instruments and *same* sampling methods before and after major fee changes. Surveys should be kept very short and focused on a small number of key issues which are directly related to the major monitoring questions.

In one user fee programme, sentinel district data collection included a set of four surveys conducted before and after major fee changes:

- Rapid household survey -- two-page survey of households with illness within two weeks, which included illness type and severity; source of care, costs of care, satisfaction; and patient and household characteristics.
- Patient profile -- one-page - completed by clinicians, which included patient characteristics; diagnosis, prescription details, and diagnostic tests.
- Outpatient survey -- two-page survey which included patients' socioeconomic characteristics; perceptions of quality; and knowledge of waivers and exemptions.
- Inpatient survey -- three-page survey similar in content to the outpatient survey.

Together these surveys gave a very practical picture of which groups had been affected by user fees, how they had been affected, the impact of the fees on perceived quality, knowledge of waivers, and other key issues.

#### **4. *Special studies: short, ad hoc studies***

- National Hospital Insurance Fund (NHIF)
  - actual vs. expected claims
  - reimbursement vs. claims
  - payment delays
- Outpatient exemptions
  - number and value for pharmacy and laboratories
  - breakdown by reason
- Inpatient collection performance
  - actual vs. expected claims
  - reasons for under-collection
- Primary health care expenditure
  - status of PHC plans and expenditure
  - reasons for not having active plans

#### **Quality of care assessment**

When assessing quality of care in a user fee programme, it should be kept in mind that patients and providers of care have different perspectives on quality

of care, as shown in Table 9, below. When patients are receiving “free” care, they may be less demanding regarding quality. However, when there are user charges, patients expect that quality of care should meet their needs.

**Table 9. Perspectives on quality of care**

<b>Providers' perspective</b>		<b>Patients' perspective</b>
Staff -- types, qualification, numbers Equipment -- types, working order Facilities -- casualty, OPD, theatre Supplies -- drugs, dressings Organization/structure -- How staff and facilities used	Inputs  ↓	“Good” doctors? “Good” nurses and support staff? New building? Clean waiting areas? Clean toilets? White coats? (clean?)
Patients seen by correct provider? History adequate? Physical examination adequate for condition? Investigation appropriate? Treatment appropriate?	Process  ↓	Waiting time Courtesy “Act like a doctor” Concern, compassion
Immediate observable endpoints: Live baby delivered Surgical procedure completed Illness resolved Disability reduced Mortality decreased	Outputs	Drugs available? Pain relieved? Wound looks good? Symptoms better?

### **Policy issues of user fees**

If user fees in government health facilities are to improve coverage and quality, then they should supplement, rather than substitute for existing financing from general revenues. In other words, user fees should be “additive” to other revenue sources. This can be assessed in three different ways:

1. Consideration of user fee revenue in budgeting process: Is user fee revenue reflected as income in official budget documents?
2. Government allocations to MOH: Are allocations to the MOH reduced or growing more slowly as a result of user fee revenue?
3. Allocations within the MOH to revenue-generating facilities: Within the Ministry, is there redistribution of central allocations from revenue-generating activities to non-revenue-generating activities?

### **Summary -- indicators for monitoring user fee programme**

In summary, to ensure that user fees achieve their intended objectives of increasing equity and quality, it is necessary to monitor their impact. A systematic low-cost monitoring plan should be developed and implemented in advance of major new fees. It is useful to think in terms of “indicators” or summary measures of impact. These may include the following:

#### Equity indicators:

- utilization rates (increasing or decreasing?)
- exemption rates (are the poor and other target groups protected?)
- care-seeking patterns;
- household expenditure;
- treasury allocation.

#### Quality indicators:

- quality inputs, drugs, etc.;
- patient perceptions.

#### Financial indicators:

- collections, actual vs. expected;
- revenue by source;
- revenue vs. expenditure;
- expenditure by type.

## 5. Country priorities for drug financing

Participants from each country have identified the following concerns and/or problems as their priorities:

### 5.1 Indonesia

1. Increase the health budget as well as the drug budget.
2. Improve proper health budget allocation based on cost-effective programmes.
3. Increase efficiency of implementation of the programme.
4. Improve equity of the health services to the poor and improve Government subsidies.

### 5.2 Myanmar

1. Inadequate financial support for drugs from Government.
2. Weak financial management at health facilities practising cost-sharing:
  - no adequate drugs
  - low quality of care
3. Sustainability/replenishment of drug supply - initial supply at low price (Government, UNICEF, and the Nippon Foundation):
  - procurement for replenishment
  - very limited foreign exchange

### 5.3 Nepal

1. Lack of coordinated effort among all NGOs, INGOs and public sector activities in drug financing.
2. Lack of proper guidelines and policies for the cost-sharing scheme.
3. Problem of purchasing quality drugs at the lowest prices.

## **5.4 Thailand**

1. How to reduce irrational drug use (financial mechanisms to improve use and reduce cost).
2. How to establish good data systems for drug financing in district hospitals and health centres.
3. How to introduce good drug financing systems in the private sector.
4. How to control drug prices and the number of drugs registered (the number of NED in the public and private sectors).

## 6. Priorities for work group action

After each country had discussed its priorities, participants were paired into two groups; Group A (Thai-Indonesia) and Group B (Nepal-Myanmar) and they discussed tasks for work group action on priorities listed earlier. Abbreviations in parentheses indicate which countries chose particular issues as a priority.

### TASKS

For each of the priority issues indicate:

1. What might be done at the country-level to address the issue?
2. What information-sharing or other actions involving the four countries and WHO would help to address the issue?
3. What should be done at the next Working Group meeting in terms of field visits, presentations, discussions, or other actions?

Summary of the two work groups:

### 6.1 Group A

**Issue 1:** How to increase the public health budget as well as the drug budget (THA, INO, MMR).

**Strategy:**

A situation analysis of the current health problems and priorities should be the basis for requesting an increase in the budget for health and drugs.

**Issue 2:** How to introduce financial mechanisms to improve rational drug use (THA).

**Strategies:**

1. Each country should calculate the drug budget needed, based on morbidity data and health priority setting.
2. Each country should formulate a system of efficient drug supply management, including selection, planning, purchasing, storage, distribution, monitoring and evaluation.
3. The budget for drugs should also include budget for the overall management of the drug sector.

**Issue 3:** How to improve equity and ensure that government subsidies reach target populations, including low income groups (INO).

**Strategies:**

1. Each government should allocate special funds for free health services to the poor.
2. The community must be involved in the management of the cost-sharing programme.
3. Each country should develop an effective mechanism to ensure that government subsidies reach the poor, by strengthening planning, implementation and monitoring and evaluation.

## 6.2 Group B

**Issue 1:** How to formulate policy and guidance for cost-sharing schemes (INO, MMR, NEP, THA).

**Strategies:**

- a) WHO should provide advice on policy as well as law and/or regulations for cost-sharing scheme(s) to countries that decide to implement this type of programme.
- b) Country situation studies should be made to formulate suitable policy and guidance for cost-sharing schemes.

**Issue 2:** How to control drug prices on the open market (THA).

**Strategies:**

- a) Government should formulate appropriate drug pricing policy to ensure access to essential drugs.
- b) Price lists should be displayed in medical shops as should information for the general public about the price of the drugs promoted.
- c) The use of generic drugs should be promoted.
- d) Some countries may consider providing incentives for local drug manufacturers to reduce the prices of essential drugs.

**Issue 3:** How to re-supply health services and get quality drugs at the lowest possible prices (MMR, NEP).

**Strategies:**

- a) There should be a good management information system.
- b) There should be good inventory control and transportation systems.
- c) Producers and suppliers should have to be prequalified.
- d) There should be competitive group bidding and bargaining among prequalified suppliers.





## 7. Conclusions and recommendations

### 7.1 Country priorities for action

Each country's final assignment was to consider its own health and drug financing situation and priority needs, and the role of the Working Group. They were asked the following questions:

1. What have been the most important insights and experiences from this meeting?
2. What actions can be taken to improve the drug financing situation in your country?
3. How can the next meeting of the Working Group best serve your needs? What field visits, presentations, or discussions would be most helpful?
4. Could you see the Working Group providing any other assistance?
5. Is there any additional information or assistance which WHO can provide to help improve the drug financing situation?

The responses were:

#### **Indonesia**

- The meeting facilitated an exchange of information, which it is hoped will continue.
- Future priorities include:
  - ⇒ Proposing additional budget for drugs to pay for activities, such as:
    - improving the coverage of hepatitis B vaccination for new-born babies;
    - improving the coverage of the TB programme;
    - increasing the local government budget for drugs;
    - encouraging and enlarging the programme for community participation.
  - ⇒ Requesting WHO to distribute guidelines for cost-sharing schemes (public-private mix) to countries participating in the next meeting. This meeting should:
    - discuss the development of national guidelines;
    - formulate an action plan;
    - include field visits.

⇒ Requesting WHO or other agencies to provide assistance for a pilot cost-sharing project.

### **Myanmar**

- The meeting increased knowledge of drug financing concepts, as well as allowing an exchange of experiences with other countries.
- Future priorities include:
  - ⇒ Strengthening and extending cost-sharing activities.
  - ⇒ Improving financial management through training.
  - ⇒ Promoting the plan of action for drug financing, and the development of drug financing mechanisms, through presentations and discussions on models for financing systems. This will be done in consultation with local hospitals and drug stores.
  - ⇒ Helping to coordinate external assistance.
  - ⇒ Requesting WHO to provide technical tools for the review of the drug financing situation in each country.

### **Nepal**

- Concepts of drug financing have become clear as a result of the meeting.
- Future priorities include:
  - ⇒ Convincing higher authorities as well as users about the benefit of cost-sharing schemes.
  - ⇒ Reviewing the progress made between this meeting and the next.
  - ⇒ Promoting the exchange of experiences between Member Countries.
  - ⇒ Supporting the development and use of guidelines and monitoring systems for drug financing and providing updated information.

### **Thailand**

- The meeting facilitated technical cooperation among the four countries and encouraged participants to share experiences and ideas.
- Future priorities include:
  - ⇒ Strengthening essential drugs programmes in the public and private sectors.
  - ⇒ Holding a follow-up meeting.
  - ⇒ Requesting WHO to provide technical support in the areas of operational research, provision of documents, and short-term consultancies.

### **Workshop evaluation**

An evaluation of the different aspects of the workshop was made. The participants identified topics based on the prevailing needs of the countries. The topics, in order of priority, which could be taken up at the next meeting of the Working Group are: public financing, including drug financing indicators and ways to increase public drug budgets; policies and guidelines for cost-sharing; public-private roles in the pharmaceutical sector; and financing mechanisms to improve rational use of drugs.

Regarding the format of the meeting, the group felt that there should be more field visits, more time for group discussions and about the same number of presentations (See Annex E for further details).

## **7.2 Recommendations**

The Working Group members agreed on the following recommendations:

1. Member Countries should strengthen national and local drug financing schemes to ensure equity and access (availability and affordability) to essential drugs.
2. The Ministry of Health, in collaboration with the Ministry of Finance (Treasury, other relevant ministries), has the obligation to ensure adequate financing for essential drugs to meet the basic needs of the population.
3. If cost-sharing is introduced, revenues should be used to supplement government allocations for health and drug financing, and not as a substitute for government financing of health and essential drugs.
4. Financial and other economic mechanisms to promote rational use of drugs should be identified.
5. The Ministry of Health should explore ways to achieve optimal public and private financing of health and drugs, in order to achieve equity of access and quality of care.
6. If cost-sharing is introduced, policy and guidelines should be formulated by the Ministry of Health to define the objectives, responsibilities, and method of operation for the cost-sharing scheme.
7. Appropriate pricing policies should be formulated by the government to ensure that prices of drugs, especially essential drugs, are affordable for the majority of the population.

**Next Meeting:** Yogyakarta, Indonesia in November 1997.



## Annex A. Agenda

### **26 November 1996**

08.00 - 9.00: Registration  
09.00 - 10.00: Opening session

Welcome by the Deputy Secretary-General, FDA, Ministry of Public Health  
Message from the Regional Director, WHO Regional Office for South-East Asia  
Statement by Dr Jonathan Quick, Director, DAP/WHO/HQ

Introduction of participants

Nomination of Chairperson, Co-chairperson & Rapporteur

Background and objectives of the meeting ( Dr Kin Shein, WHO/SEARO)

Administrative announcements:

(Ms. Suboonya Hutangkabodee, Director Technical Division, FDA)

10.00 - 10.30 Group photograph, followed by coffee/tea break

10.30 - 12.00: Drug financing situation: 3 country presentations  
(15 minutes/country)

- Country participants:

- \* Thailand
- \* Nepal
- \* Myanmar
- \* Objectives of field visit: Dr Jonathan Quick

12.00 - 13.00: Lunch

13.00: Depart hotel for field visit

13.30 - 17.00: Field visit to: Soongnern Hospital  
Health centre  
Village drug fund  
Debriefing at hospital

### **27 November 1996, Wednesday**

8.30 - 9.30: Review of major observations from first day

9.30 - 10.00: Country presentation - Indonesia

10.00 - 10.30: Coffee/tea break

10.30 -11.30: Drug financing strategies: Dr German Velasquez  
(Presentation and discussions)

11.30 - 12.30: Cost-sharing for drugs: Dr Petcharat Pongcharoensuk  
(Presentation and discussions)

12.30 - 13.30: Lunch

- 13.30 - 15.30: Country priorities for workgroup action:  
Dr Jonathan Quick, Dr German Velasquez
- (Discussions and presentations, four groups)
- 15.30 - 16.00: Coffee/tea break
- 16.00 - 17.00: Monitoring for equity and quality: Dr Jonathan Quick  
(Presentation and discussions)

**28 November 1996**

- 8.30 - 10.00: Priorities for Working Group action  
(Discussions, two work groups)
- 10.00 - 10.30: Coffee/tea break
- 10.30 - 12.30: Report from work group and discussions
- 12.30 - 13.30: Lunch
- 13.30 - 14.30: Country priorities for action (four work groups)  
Health and drug financing indicators (four work groups)
- 14.30 - 15.00: Presentation of country priorities for action
- 15.00 - 15.15: Presentation of health and drug financing indicators:  
Dr Jonathan Quick
- 15.15 - 15.30: Evaluations and recommendations
- 15.30 - 16.00: Next meeting, timing, venue and closing of meeting.

## Annex B. List of participants

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## Annex C. List of documents

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## **Annex D. Message from Regional Director, WHO South-East Asia Region**

Read by Dr Godfrey Walker representing WR, Thailand.

Distinguished participants, Dear Colleagues, Ladies and Gentlemen,

I have the honour to present greetings from Dr Uton Muchtar Rafei, Regional Director of the South-East Asia Regional Office of the World Health Organization, to the Ministry of Public Health, Thailand and the distinguished participants. The Regional Director would have liked to be in our midst today, as the subject of our deliberations is of importance to WHO. However, this could not be possible due to his unavoidable commitments. Under the circumstances, I have the honour to read his message on this occasion.

I quote: " I take this opportunity to welcome the initiative taken by the Drug Action Programme of WHO Headquarters, Geneva which enables us to convene this meeting of the WHO Working Group on Financing of Essential Drugs. I also welcome and extend my greetings to all of you. I am happy that such an important activity is taking place in our Region.

I wish to thank the Ministry of Public Health, the Royal Thai Government, for hosting this important meeting and the Technical Division of the Food and Drug Administration for making excellent arrangements.

The changing scenarios in development of national health systems necessitate a critical look at the respective roles of the public and private sectors in providing health care services. Based on the overall status of national health care needs and the capabilities of the public and private sectors in filling those needs, an appropriate public-private mix for the provision of essential drugs should now be put in place. This is a dynamic process which will depend on the overall socioeconomic development status of a country and will require continuous monitoring and evaluation of services rendered and the impact they have on the health of the people.

Privatization of health care is becoming a topical subject of discussion. Recent health plans put into operation in some countries of the South-East Asia Region have given importance to the role of the private sector in the delivery of health care. This is in the light of the observation that a centralized economic system does not necessarily result in providing equitable health services, thus further

demonstrating the fact that public sector financing alone is not an ideal solution for the attainment of Health for All goal.

It is contended by the advocates of the private sector that the solution for establishing equity in health care lies in its privatization, including its related components such as drug supply and laboratory services. The idea that private health care and drug financing would lead to effective and efficient health care delivery for those who are able to pay for it is strongly highlighted. These, it is hoped, would pave the way for appropriate reallocation of Government resources for the underprivileged and underserved groups of people.

On the other hand, it is argued by the public sector advocates that privatization would lead to commercialization of services which would result in cost escalation due to undesirable prescriptions, unethical practices in dispensing of drugs, superfluous investigations and even unnecessary surgical procedures. Charging of commission for referral services without actually improving the quality of health care has also been cited. Collectively, these could be seen to have a negative impact on equity in health. A meeting point of these views needs to be identified, bringing together their useful aspects to ensure quality of health care.

In any drug financing scheme, it is important to ensure equity in availability of essential drugs. This can be promoted by redistribution of adequate resources from the public sector, or introduction of, or increase in user-fees within the context of revolving drug funds, community drug schemes and other similar mechanisms. Community cost-sharing of drugs can have provision for subsidizing quality drugs for the poor and needy. Donor financing and development loans can improve accessibility of essential drugs and vaccines to the target groups in both rural and urban communities.

In the South-East Asia Region, quality essential drugs and vaccines are indispensable tools in the prevention, control and treatment of diseases. It is important to ensure that they are readily available in sufficient quantities at the primary health care level as well as at other levels of health care at all times. In order to achieve this goal, it would be important to consider a drug financing strategy which is suitable and appropriate for each country. But, before instituting such a measure, optimum utilization of available financial resources must be ensured through judicious selection and quantification, proper procurement, efficient distribution and rational use of drugs.

In countries where the supply of essential drugs is adequate, the drug management cycle, which may consist of selection, procurement, distribution and use, must be maintained with parameters which lend support to its adequacy and sustainability. Similarly, priority should be given to improve the drug management cycle through regular monitoring, evaluation and remedial measures in countries where the supply of essential drugs is not adequate.

In undertaking any of the above measures, governments have a critical role to play in areas such as: policy making and regulation, advocacy, provision and dissemination of information, price control, distribution of sufficient amounts of quality drugs and related services.

The primary role of the Ministries of Health, depending upon the national set-up, will continue to be the architect of the national drug policy within the context of the overall health policy. It would be important to critically look at the state of development in the availability and accessibility of quality essential drugs against the needs of the consumers. The requirement of the public will have to be given priority over that of the interest groups. Furthermore, the complementary roles of the public and private sectors need to be strengthened and harmonized through realistic policy instruments such as incentives, regulation and other measures for a successful symbiotic relationship of the two sectors.

It is important that financing schemes now operating in some of the Member Countries should be evaluated so as to identify successful approaches to financing of essential drugs in the health care system and to facilitate their adaptation and application.

I am confident that this expert Working Group will measure up to the task at hand. I wish you every success in your deliberations and a fruitful meeting. I also wish you a pleasant stay in Nakhorn Ratchasima." Unquote.

I shall, of course, apprise the Regional Director of your deliberations and the outcome of the meeting. Before concluding, I would like to thank the Ministry of Public Health for giving me this opportunity to bring the Regional Director's message to this august gathering.

Thank you.





## Annex E. Evaluation of the meeting. Priorities for the Working Group

### 1. Evaluation of the meeting

1. Evaluation forms were filled out by all 10 participants plus 4 observers from the Thai Ministry of Public Health. Each topic covered at the meeting was evaluated on its **usefulness** (scores are: 4 = very useful, 3 = useful, 2 = not too useful, and 1 = useless), and **time spent** (scores are: 3 = too little time, 2 = about right, and 1 = too much time). The mean scores and standard deviation are shown below.

For the hotel, the satisfaction scores are:

5 = excellent, 4 = very good, 3 = good, 2 = fair, and 1 = poor.

Topic	Usefulness		Time spent	
	n	mean $\pm$ s.d.	n	mean $\pm$ s.d.
<b>Tuesday</b>				
Country presentations (Thailand, Nepal, Myanmar)	14	3.21 $\pm$ 0.43	14	2.14 $\pm$ .0.53
Field visit to hospital	14	3.57 $\pm$ 0.51	14	2.21 $\pm$ .0.43
Field visit to health centre	11	3.55 $\pm$ 0.52	11	2.18 $\pm$ .0.40
Field visit to village drug fund	10	3.50 $\pm$ 0.53	10	2.20 $\pm$ .0.42
<b>Wednesday</b>				
Discussion of field visit	13	3.23 $\pm$ 0.73	13	2.00 $\pm$ .0.58
Country presentation (Indonesia)	14	3.14 $\pm$ 0.36	14	2.21 $\pm$ .0.43
Drug financing strategies (Dr Velasquez)	14	3.50 $\pm$ 0.52	14	2.21 $\pm$ .0.43
Cost-sharing for drugs (Dr Petcharat)	14	3.57 $\pm$ 0.51	14	2.07 $\pm$ .0.27
Priorities for drug financing (priorities for each country)	14	3.21 $\pm$ 0.58	14	2.21 $\pm$ .0.58
Monitoring for equity and quality (Dr Quick)	14	3.64 $\pm$ 0.50	14	2.14 $\pm$ .0.53
<b>Thursday</b>				
Priorities for drug financing (Group work)	14	3.43 $\pm$ 0.51	14	2.36 $\pm$ .0.50
Priorities for country action (Country group)	14	3.43 $\pm$ 0.51	14	2.36 $\pm$ .0.63
National health and drug financing indicators	14	3.50 $\pm$ 0.65	14	2.43 $\pm$ .0.65
Hotel	Satisfaction			
Accommodation	14	3.93 $\pm$ 0.73		
Food	14	3.79 $\pm$ 1.05		
Meeting room	14	3.50 $\pm$ 0.85		

2. Comments and suggestions on content and format of meeting:

- All right.
- Very good.
- Fine in format, but the agenda is too tight.
- 3-days meeting, 1 day field visit (2).
- 4-days workshops.
- Content and format very useful.
- For the next meeting, it would be better to invite an expert on public health with international experience.
- Too many subjects to be discussed, need more time.
- Content and format are appropriate to the subject of the meeting.
- Detailed information on the contents of the meeting should be given earlier.

3. Comments and suggestions on accommodation:

- Dinner should also have been provided in the hotel, eating places are not near by.
- Special food should be provided for Muslims.

4. Comments and suggestions on travel and other administrative arrangements:

- Not so bad.
- Financial difficulty. No money is provided to cover the hotel and other expenses here.
- The meeting should be held where there are good connections between international and domestic flights.
- WHO could provide a normal ticket for each participant to avoid difficulties.
- The ticket should be normal fare.
- Good.

## 2. Priorities for the next Working Group meeting

Participants indicated the following priorities:

Topic	n	Rating for priorities			
		4 = very high	3 = high	2 = low	1 = very low
<b>1. Public financing</b>					
1.1 Health and drug financing indicators	10	7	3	0	0
1.2 Experiences in increasing government health and drug budgets	10	5	3	2	0
<b>2. Cost-sharing for health and drugs</b>					
2.1 Policies and guidelines	9	5	4	0	0
2.2 Report of experiences/lessons from cost-sharing systems	7	3	4	0	0
<b>3. Insurance for health and drugs</b>					
3.1 Alternative insurance systems	8	2	6	0	0
3.2 Mechanisms for providing drugs through insurance	6	3	2	1	0
<b>4. The use of international loans in the pharmaceutical sector</b>	6	3	2	1	0
<b>5. Drug pricing policies and mechanisms</b>					
5.1 Control of drug manufacturers' prices	8	5	0	3	0
5.2 Distribution mark-ups (wholesale and retail margins)	8	2	3	3	0
5.3 Use of generic drugs to promote competition	8	3	4	1	0
5.4 Cost containment in the drug sector	8	3	5	0	0
<b>6. Financing mechanisms to improve:</b>					
6.1 Drug selection	9	3	5	1	0
6.2 Drug supply	7	3	1	3	0
6.3 Drug quality assurance	8	2	6	0	0
6.4 Drug distribution	6	3	3	0	0
6.5 Rational use of drugs	7	4	3	0	0
<b>7. Health reform and global change</b>					
7.1 Drugs and health sector reform	7	4	3	0	0
7.2 Impact of globalization WTO/TRIPS on drugs	8	3	4	1	0
7.3 Public-private roles in pharmaceutical sector	8	6	2	0	0

## Questions

1. For field visits, should there be:
  - ⇒ more visits/different types of facilities (5)\*
  - ⇒ same number of visits (4)
  - ⇒ no field visit (0)
  
2. For prepared presentations on specific topics, should there be:
  - ⇒ more presentations (2)
  - ⇒ same presentations (6)
  - ⇒ fewer presentations (0)
  
3. For group discussions, should there be:
  - ⇒ more time (5)
  - ⇒ same amount of time (3)
  - ⇒ less time (0)
  
4. Other comments:
  - ⇒ More time for presentation and discussion, and for discussion on the field visits.
  - ⇒ Participants should know what to prepare, etc. at least one month beforehand.
  - ⇒ Health economics experts should be invited to the next meeting and presentation.

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(\*) Number in brackets indicates the number of responses

