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Access to Medicines at the Point of Service Delivery

"If you get sick, you have to choose: you either go without treatment or you lose the farm."[i] A century ago, this was the reality in rural Canada. It may still be the unforgiving reality for many Filipinos today.

The Philippines government has taken a high level political commitment and provided strong policies to improve this situation. The Generics Act of 1998 and the Cheaper Medicines Act of 2008 provides the directions for the progressive realization towards greater access to essential medicines.

Access is defined as having medicines continuously available and affordable at public or private health facilities or medicine outlets that are within one hour's walk from homes of the population.[ii]

Any health system cannot function and will not achieve the desired health outcomes without medicines. The availability of affordable and effective drugs is, therefore, one of the most visible indicators of the quality of health services. [iii]

Major challenges account for the low access to quality assured essential medicines in the Philippines, but availability and high prices are the most compelling ones. Other factors include financing, selection mechanisms, rational use and efficiency in procurement and supply systems. In the Philippines context however, a critical issue that needs conscious discussion, is the process of disengagement brought about by the devolution of health services.

The purpose of decentralization was to empower and provide autonomy to local decision makers, so that they can dispense basic services at the point where people need them. But an unintended effect which has never been acknowledged and consciously dealt with is the process of disengagement which has become apparent in two levels. First disengagement from the national to local governments - where local governments have been presumed to be responsible for all the health needs of their constituents and second, at the level of the local government and the patient, where local health systems are pursuing the idea of less and less expenditure in health, and are shifting the burden to the people for their health needs.

Medicines Availability.

The WHO/HAI survey published in 2006 showed that the availability of essential medicines is only 11 and 15% in the public and private sector respectively.

Availability of medicines is affected by multiple and complex factors. In a decentralized system however, there are two compelling causes: 1) inadequate budgetary provision and entitlement for medicines to cover the poor and vulnerable and 2) inefficient procurement and supply systems.

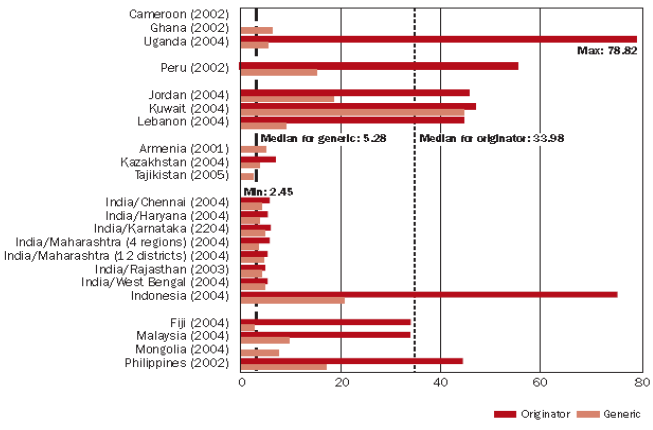
Local government units have become responsible for the provision of medicines in devolved public health facilities. The WHO Office of the Representative in the Philippines commissioned a case study in 2006 in 19 devolved health facilities under different LGU income groups, using a basket of 30 essential medicines. Results showed that the availability ranged from 0-33%. An ocular inspection in one district hospital showed none of the 30 essential medicines is available at all during the time of visit.

Inefficient procurement systems are also severely affecting the availability of essential medicines. Long procurement cycles which can be as long as 480[iv] days result to frequent stock outs of essential medicines in local health facilities.

Medicines Prices

The price of medicines in the Philippines is 3.4 to 184 times the international reference index. In an inter-country price comparison study, the Philippines is procuring an originator brand of Ciprofloxacin at 33.6 times the international reference price.[v] Figure 1.1 below shows that the Philippines has the second highest price for Atenolol among its Asian counterparts.

Fig. 1.1 Median price ratios, atenolol 50 mg tablets, purchased from private retail pharmacies



Source: Gelders S et al. *Price, availability and affordability: an international comparison of chronic disease medicines*. Cairo, World Health Organization, 2006.

Source: Primary health care, more than ever, WHO, 2008

Inefficient procurement systems are also driving the prices of medicines up in the public sector. An inter-country comparison study showed that the procurement price in the Philippines for generics is 2.94 times the international reference index.[vi] The wide differential in procurement prices, also leads to high prices at the point of service delivery. The difference of procurement prices across regions range from 1-1048%.[vii]

Disengagement

Disengagement, although a problem in the broader health systems context needs to be addressed and discussed here, for the primary reason that, the most direct and immediate effect are patients paying out-of pocket for health services, especially for medicines at the point of service delivery.

Disengagement is the withdrawal by the state in the active provision of health care. In the context of the Philippines, this was unconsciously brought about by the process of the devolution of health services.

To an extent, it has contributed to wider disparities in the type of health services that are given to the poor. As mentioned above, there are two levels of disengagement in the Philippines decentralized context:

1) National to local

Health outcomes have increasingly become dependent on the local political milieu, as decision making and autonomy in the disposition of resources has been devolved to the local government units.

The Local Government Code provides that the Department of Health shall exercise supervisory function over all the LGUs in terms of health services provision. Section 17, paragraph 4-f of which however provides, that the national government or the next higher level of local government unit may provide or augment the basic services and facilities assigned to a lower level of government unit when such services or facilities are not made available or, if made available, are inadequate to meet the requirements of its inhabitants.

In the late 1990's a local government equalization fund was established to support the needs of hospitals which were underfunded from LGU budgets. Provisions of such nature must be revisited and structures to implement the support envisaged by the Local Government Code must be laid down.

2) At the level of the LGU

Medicines provision at the local level, particularly for health facilities in the public sector, has been totally dependent on local health budgets. Budget for health and medicines in particular have to compete with other basic services such as social welfare, education and infrastructure.

As a way of dealing with these budgetary constraints, local government units tend to disengage in the provision of basic medicines, and look at medicines as goods that must be contributed by the patients in the provision of health care. Some local government units, have engaged into programs that support the development of "economic enterprise" – a policy which was adopted in the late 1990's to earn revenues from government operations. This is one adverse policy when applied to medicines and health services. Although the aim was to increase the operational budget in order to improve services, it did not necessarily benefit the patients. Today, many hospitals consider their pharmacies as profit centers, such that revenues must be earned to support over-all hospital operations.

There are lessons that can be learned from disengagement. China's deregulation of the health sector in the 1980's and the subsequent steep increases and reliance in out-of-pocket payment is a case in point and should serve as a lesson to the world. [viii]

Policy Interventions:

Policy interventions for service delivery must be beneficial to both the public and private sector. However, in the current state of inequity in health services provision it is imperative for the government to provide immediate solution and focus on reforms in the public sector, where majority of the poor and disadvantaged Filipinos seek health services. Policy interventions must be based on the following key points.

1. Every national medicines policy should be anchored on the basic premise that access to essential medicines is a human right. The UN Report on Medicines and Human Rights asserts that a state has the core obligation of immediate effect – not subject to progressive realization – to make available and accessible throughout its jurisdiction the essential medicines on its national list.[ix]

2. In so meeting this, medicines policies and programs should be anchored on the four components of the access framework, which are: a) rational selection, b) affordable prices, c) sustainable financing and d) reliable health and supply systems. Such policies need to be pursued in combination with each other.

3. In the current Philippines context, the most urgent intervention is ensuring that medicines are available at the point of service delivery, and ensuring that all patients, particularly the poor are provided essential medicines at the point of care.

4. There is a need to reverse or address the process of disengagement in the provision of health services and medicines, brought about by the structure of decentralization.

The high political commitment and the practical approaches the government has started to pursue have great potential in improving access at the point of service delivery. It is imperative however, that these programs should be delivered comprehensively and that efficient mechanisms to sustain them must be clearly spelled out in both policy and practice.

The following are the doable approaches that can improve access to medicines at the point of service delivery.

1. Ensuring Quality of Generic Medicines

At the outset, it is important to mention that quality of generic medicines is a precondition for all other measures to improve generic use. If consumers harbor doubts regarding the standards of generic drugs, they are often in a position to refuse them.[x]

The Bureau of Food and Drugs must ensure that medicines are of assured quality and efficacy. Ensuring quality of medicines however requires a continuum of measures that go along the supply chain, and requires the participation of key stake holders involved in the manufacturing, distribution, supply and management and use of medicines.

2. Ensuring Affordable Prices

a. The Botika ng Barangay and the P100 program.

The Botika ng Barangay and the P100 programmes are important interventions and have the potential for improving access to medicines. The following measures are important to ensure that both of these can contribute to better medicines access and health outcomes:

a.1. A reliable and efficient procurement supply system which can ensure the availment of cost-effective and quality assured medicines must be established (HPN Volume 1, Issue No. 6);

a.2. The Botika ng Barangay Program must be established as a tool for improving access and thus it must be linked to the primary and local health system. These should not be treated as standalone economic enterprise ventures at the barangay level.

a.3. Safeguards for rational use and leakages into the for-profit sector must be instituted. Monitoring and inventory management and control are important.

a.4. The packages for both the BnB and the P100 program should be determined based on the health needs of the community.

a.5. Financing mechanisms for LGU's must be developed to enable them to avail and sustain the P100 program. Linking these to the out-patient benefit (OPB) package of Philhealth with LGU's must be pursued.

a.6. Review the significance of including over the counter medicines in the packages.

b. Use of Generic medicines

Generics strategies are based on two main features: The widespread use of generic names and the availability of a selection of pharmaceutically equivalent products which can be readily identified as substitutes for each other and which are competitively priced. When implemented in both the public and private sectors, these strategies can result in lower pharmaceutical prices and expenditures. A generics strategy improves access to essential drugs and is also fully compatible with measures which promote the rational use of medicines.

Improving generic use needs interventions at both the supply and demand side. Supply side interventions however are beyond the scope of this paper. At the demand side and point of service delivery, sufficient policies and laws have been provided to influence prescribing and dispensing patterns, re-imbursement, and generic substitution. The critical step is to move towards implementation and monitoring.

Monitoring and feedback mechanisms should focus on the following:

1. Prescription audits, and monitoring of the "generic only" provision that is mandated in the public sector.

2. Compliance of retail outlets on the provision of information to patients on the availability and prices of generic alternatives.

3. Close monitoring of the use and compliance to the PNDF in government procurements.

4. Quality monitoring at the local level, using currently established approaches such as sampling of products as a part of the inspection process, and use of basic test (such as the use of Minilab/BFAD in a suitcase.)

The Philippines experience in depending on the imposition of penalties in the implementation of the Generics Act must be seriously reviewed. The lack of mechanisms for reporting, feedback and the stringent legal procedures showed that the penalty mechanism may not be important, but may not be the total and ultimate strategy to ensure implementation. Designing incentive systems and programs to influence behavior and acceptance of generic medicines is important complimentary mechanisms.

c. Price Information Systems

Effective decision making processes on the part of the health care provided and the patient can only be had when adequate information is available. Prices of medicines vary across regions and provinces.

The Essential Drug Price Monitoring System (EDPMS) which is now being piloted by the Department of Health can provide substantive

information on both procurement and retail prices. DOH must ensure that the result of such monitoring should e made accessible to both health providers and consumers.

3. Reducing out-of-pocket burden

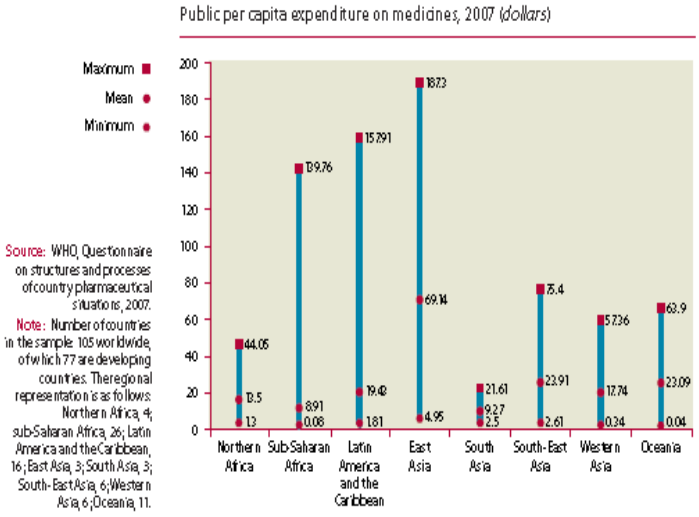
High out-of-pocket payments need to be addressed at the level of service delivery. For those not covered by health insurance, medicines payment often lead to financial catastrophe. WHO has proposed that health expenditure should be viewed as catastrophic whenever it is greater than or equal to 40% of a household's non-subsistence income, i.e. income available after basic needs have been met.[xi] When out-of-pocket expenditure is less than 15% of the total spending, few households face catastrophic payments.[xii]

4. Ensuring availability

a. Budgets

Public financing of drugs, at some level and in some form, is required to ensure optimal consumption of drugs which have a high degree of public benefit and to subsidize essential drugs for the poor.[xiii] Inadequate financing and underbudgeting can result in insufficient funds to meet the national needs. Figure 2 shows the per capita expenditure for medicines across countries.

Figure 2[xiv]



b. Defining essential packages

The variability on budgetary provisions and the level of availability of essential medicines may in part be secondary to the lack of technical guidelines on what Local Government Units must provide. Experiences prove that when LGUS are given the technical guidance to fulfill their mandate, they will adopt a positive approach into fulfilling such guidelines. Local legislative bodies for instance would immediately passé local measures to implement newly approved national laws.

Currently, there are no technical guidelines on minimum provision or essential packages for medicines that local government units must provide. Minimum provisions or "essential packages" must be defined at each level of health care so that local government units would be guided, or ideally, must be mandated to provide. The following principles[xv] of good practices may be adopted in developing the minimum provision or essential packages:

1. The exercise should not be limited to a set of defined priorities: it should look at demand as well as the full range of health needs;
2. Should specify what should be provided at the primary and secondary levels;
3. The implementation of the package should be costed so that political decision-makers are aware of what will not be included if health care remains underfunded;
4. There have to be institutionalized mechanisms for evidenced-based review of packages of benefits
5. People need to be informed about the benefits they can claim.

In the implementation of essential packages, feedback and monitoring mechanisms are important. What can work in the context of decentralization is the provision of budgetary incentives and disincentives, and link performance to the audit system. Currently, WHO is supporting the development of the Philippine Pharmaceutical Benchbook to ensure that minimum provisions and standards for access to medicines are met.

5. Efficient procurement and reliable supply systems

Medicines procurement should be carefully planned. Stock-outs must be addressed by shortening procurement cycles, and monitoring supplier performance. Procurement of medicines is done according to RA 9184. In as far as procurement of medicines is concerned; the law needs to be reviewed as to its applicability in meeting two critical objectives:

1) efficiency of procurement to ensure availability at all times and 2) assured quality of medicines procured.
With a disorganized demand sector and a truncated and numerous parallel supply systems, the intervention that is necessary and urgent is to secure the supply system for the public sector. Pooled procurement mechanism and the prequalification of suppliers at the central level are some practical strategies that need consideration (HPN Volume 1, Issue 6).

6. Rational Selection and Use

Rational use means therapeutically sound and cost-effective use of medicines by health professionals and consumers.[xvi] It is important that each individual receive the best possible treatment, but it is also vital

for society to maximize health benefits vis-a-vis expenditures. The costs to society of inappropriate drug use are significant and may well exceed overall pharmaceutical expenditures. Efforts to improve rational drug use must cover both public and private sectors and can include educational, managerial, and regulatory strategies.

a. Selection of Medicines

Selection of medicines must be evidenced-based and should take into account public health relevance, the best available clinical evidence of efficacy and safety as well as an assessment of comparative cost-effectiveness. The process needs to be transparent and should consider the perspectives of the patient, health professionals and national authorities.[xvii].

There is however one gap that needs to be addressed urgently, and that is the formulation of **National Treatment Guidelines (NTGs)**. NTGs are defined by WHO as systematically developed evidence-based statements which assist providers, patients and other stakeholders to make informed decisions. It can guide drug selection both at the national and local levels, and help provide rational procurement plans for health care providers.

One key direction that must be pursued to address this gap is for the Department of health to develop a protocol for the preparation of NTG's, and that a body should be established to review and approve treatment guidelines for national use.

b. Selection of medicines at the local level.

Selection of medicines at the local government units and at the facility levels should be based on the PNDF and on standard treatment guidelines. The preparation of the annual procurement plan (APP) or therapeutic plan should also take into consideration the needs and the morbidity profile of the community.

c. The Role of the Drug Therapeutic Committees.

All health facilities are required to establish a Drug Therapeutic Committee. Local government units must also be required to put up one at each level. It is however important that DTC's should be made functional such and should work along the following principles:

1. The terms of reference must be clear
2. Selection of members of the DTC must be transparent
3. Each member should be made to declare conflict of interests
4. The DTC must be separate and distinct from the Bids and Awards or procurement committees.

The DTC's must lead in evidenced-based selection of medicines at the local level, and ensure that local medicines procurement and use adhere to the PNDF and the National Treatment guidelines. They must also be trained to monitor drug utilization, prescribing and advocacy for rational use for both patients and practitioners.

d. Drug promotion

Overzealous and inappropriate pharmaceutical marketing practices can result in irrational drug use and subsequent health and cost-burdens.[xviii] An enforceable policy which establishes clear and effective limits on promotional activities is synergistic with a generics strategy and together they can achieve a reduction in irrational drug use while supporting competitive markets.

There must be a clear policy for control of drug promotions. At the national level, a law on controlling promotions and advertisement for medicines may be needed. At the local level, local ordinances to control promotions and visit of medical representatives to facilities under the LGU's jurisdiction may be passed and enforced.

7. Reversing disengagement

A strong case should be made in reversing the unintended effects of disengagement.

The first level of disengagement can be resolved through the following:

a. Defining minimum levels of provision or "essential packages" for local government units

b. Providing support, to local government units and health facilities that are chronically unfunded. The increase in the DOH budget should not be seen as a central and a mere policy budget- but a budget that should be dissipated in terms of actual health services that are provided to local government units and health facilities.

c. Use of monitoring tools, such as the Pharmaceutical Benchbook to ensure compliance to standards and good governance for medicines.

d. Linking budgetary incentives and disincentives and audit systems to LGU performance.

At the second level of disengagement the following are proposed:

1. Mandatory requirement for LGU's to provide adequate budget for medicines (what is adequate will need to be defined on the context of local needs);

2. Entitlements for the poor and vulnerable must be defined and provided, as much as possible at the point where patients seek medical care;

3. Mandatory requirement for hospitals to provide medicines for all admitted patients. Dispensing of prescription for charity patients, who are not covered by health insurance, is a lopsided policy, and is a mechanism of exclusion.

8. Transparency and Good Governance

Transparency, accountability and good governance are mechanisms that must be in place along the registration, selection, procurement, allocation and use of medicines. The high price differential of procurement prices across regions in the country is partly secondary to the lack of information and accountability checks. Two important initiatives that can be leveraged are the Good Governance for Medicines (GGM) program and the Medicines Transparency Alliance (MeTA) initiative.

Conclusion

The provision of essential medicines is key to service delivery. The government must ensure that such medicines are available at service contact points, and at prices that can be affordable to patients. While the achievement of these objectives may be arduous, there are practical approaches that can be pursued. The local government units should leverage on the empowerment and autonomy provided to them to pursue these practical approaches. At the same time, the national government, aside from providing national health policies, is expected to provide clear and workable operational structures for extending support, regulatory control, and monitoring performance of local government units.

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