APPROACHES TO PROMOTE AVAILABILITY OF ESSENTIAL DRUGS FOR PRIMARY HEALTH CARE IN THE SOUTH-EAST ASIA REGION

Report of an Intercountry Consultative Meeting
New Delhi, 21-25 April 1997

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ACRONYMS

ADB  Asian Development Bank
CMSD  Central Medical Stores Depot
CMSSD  Central Medical Stores Sub-Depot
DD  Diarrhoeal Diseases
EC  European Commission
GMP  Good Manufacturing Practices
GNP  Gross National Product
JICA  Japan International Cooperation Agency
MoH  Ministry of Health
MoPH  Ministry of Public Health
MSD  Medical Supplies Department
NED  National Essential Drugs
NEDL  National Essential Drugs List
NDP  National Drug Policy
OTC  Over the Counter
PHC  Primary Health Care
SEAR  South-East Asia Region
SEARO  South-East Asia Regional Office
SPC  State Pharmaceuticals Corporation
TCDC  Technical Cooperation among Developing Countries
TRIPs  Trade Related Aspects of Intellectual Property Rights
UNFPA  United Nations Fund for Population Activities
UNICEF  United Nations Children's Fund
USAID  United States Agency for International Development
WHO  World Health Organization
WTO  World Trade Organization
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1. INTRODUCTION

An Intercountry Consultative Meeting on Approaches to Promote Availability of Essential Drugs in Primary Health Care was held in South-East Asia Regional Office (SEARO) of the World Health Organization (WHO), New Delhi, from 21-25 April 1997 with the following objective:

Objective

To support the development and strengthening of approaches which ensure availability of essential drugs of assured quality, safety and efficacy for primary health care in SEAR Member Countries.

Specific objectives

(1) To analyse essential drug programmes in SEAR countries with a focus on ensuring access to essential drugs in primary health care;

(2) To prepare national and regional guidelines and outline of plans to improve drug supply at primary health care level, and

(3) To prepare national and regional guidelines for drug financing through mechanisms such as cost-sharing in the national health programmes.

The meeting was inaugurated by Dr Uton Muchtar Rafei, Regional Director (RD), WHO/SEAR. In his inaugural speech, the RD said that a major realization of the last decade was that the public sector alone may not be able to achieve equitable health service coverage. Several countries have therefore resorted to health care reforms to achieve efficiency, equity and effectiveness. Since drugs play a crucial role in health programmes, reappraisal of this sector in the light of new economic strategies has become necessary. In 1996, WHO/SEARO constituted a working group on drug financing, and identified country-specific priority issues to ensure equity and access to essential drugs and recommended development and strengthening of alternative drug-financing schemes. He emphasized the need to evaluate drug policies, their implementation with respect to accessibility, both geographical and economic, of essential drugs, and relevance to country priorities as countries enter the 21st century. Equity, economic efficiency and
sustainability, are important issues which should be addressed at this meeting and the
meeting should recommend innovative strategies to improve drug financing and access of
all people to essential drugs at prices they can afford. He urged the participants to
formulate practical guidelines and recommendations towards achieving this goal.

Dr Jonathan D. Quick, Director, Action Programme on Essential Drugs,
WHO/Geneva, in his opening remarks appreciated the initiative of the Regional Director
and the Regional Committee for focusing this year's intercountry essential drugs meeting
on the availability of drugs for primary health care. He said that many deaths which occur
due to infectious and other diseases could be prevented through adequate treatment.
According to WHO estimates, at least one-quarter of the Region's 1.5 billion people lack
regular access to essential drugs. This meeting, therefore focuses on the two closely-related
elements which ensure access to essential drugs, namely drug-financing strategies aimed at
affordability of drugs (economic access) and supply strategies aimed at availability of
drugs (geographic availability). Dr Quick reminded the group that access to health care,
including essential drugs, is a basic human right which has been endorsed by all the 191
WHO Member States. To help people achieve this right, WHO has reaffirmed the goal of
Health for All with three main future directions:

- Establishment of the HFA value system;
- Universal acceptance of health as central to development, and
- Development of sustainable health system.

He further elaborated that ensuring access to health care including essential drugs is
not an easy task. There may be several challenges such as changing the therapeutic
needs/public-private roles, globalization, new international trade arrangements, quality
assurance and health reforms. All these may have to be taken into account in future health
improvements. Countries are therefore rethinking the role of governments.

WHO has been involved in a number of activities related to the evolving public and
private roles in the health and pharmaceuticals sectors. The growing involvement of the
private sector in health may change the role of governments but it cannot reduce their
responsibility to ensure accessibility of health services of acceptable quality. The
establishment of World Trade Organization (WTO) and agreements on Trade-Related
Aspects of Intellectual Property Rights (TRIPs) impose new challenges. WHO's interest in
TRIPs is to ensure good quality essential drugs, and their availability, particularly in the
least developed countries. DAP is working in WHO regions and Member States to review
the implications of the new international trade agreements.
The challenge for the countries, therefore, is to find practical approaches to better implement the existing regulations and guidelines. The new essential drugs strategy of WHO provides greater emphasis on country-level implementation.

Dr Quick briefly mentioned the work of WHO action programme in the last two decades. The programme has developed particularly in areas of national drug policy, quality assurance of essential drugs and their rational use and human resource development. DAP has provided direct technical support to over 80 countries. WHO is now facing new challenges and uncertainties and therefore WHO has adopted a new essential drugs strategy. The new strategy makes a commitment to essential drugs concept as representing the best of modern, evidence-based, cost-effective health care. The concept is flexible in that it is implemented from local PHC services to large health insurance programmes. It is also forward-looking. Matched by changes in programme structure, planning and budgeting, the new strategy should lead to increased effectiveness and impact.

Dr Sanjiv Kumar, United Nations International Children Education Fund (UNICEF), in his presentation mentioned that, since 1946, UNICEF is engaged in supplying drugs and vaccines. UNICEF is now actively involved in the WHO (DAP) Essential Drugs Programme and also with Global Programmes for Vaccines Immunization (GPV). Experience has shown that the use of essential drugs is not only successfully and epidemiologically correct but also economically more affordable. In order to support primary health care programmes, UNICEF has established a special Working Capital Fund which allows eligible countries to pay for essential drugs on delivery rather than in advance as is normally required for procurement services by UNICEF.

2. BRIEF OVERVIEW OF WHO COLLABORATION IN PROMOTING ACCESS TO ESSENTIAL DRUGS OF GOOD QUALITY, SAFETY AND EFFICACY IN THE SOUTH-EAST ASIA REGION

Dr Kin Shein, Regional Adviser, Essential Drugs and Vaccines, WHO/SEARO, gave an overview of WHO collaboration in promoting access to essential drugs of good quality, safety and efficacy in the SEAR countries. He informed that national drug programmes of the SEAR countries have been developing along with the various components of the drug policy, including drug registration and regulatory control; national essential drugs list; public sector procurement; storage and distribution; drug quality control, and rational use of drugs. However, components such as drug quality assurance in its totality, drug information and economic strategies for drugs which are advocated in the report of the
WHO Expert Committee on national drug policies, published in June 1995, have not been included in some of the national drug policies.

He emphasized that access to essential drugs is a priority issue in SEAR. An important consideration in developing national drug policies is to improve the availability of essential drugs for primary health care. The concept of availability has a connotation of accessibility which, in the context of primary health care, translates into availability of essential drugs in the remote health facilities. It also implies that drugs that are needed should also be affordable if an individual is required to pay for them. One of the important realizations of the last decade has been that the public sector alone in most of the developing countries in the Region is unable to provide health care coverage to the entire population.

WHO assistance was focused on four technical areas between 1990 to 1995. These areas were: (1) development and strengthening of national drug policies and management; (2) drug quality assurance with emphasis on laboratory quality control of drugs; (3) supply and logistics with the thrust of activities being on drug selection, quantification, procurement, storage, inventory control and distribution, and (4) rational use of drugs with focus on the development of standard treatment guidelines, diagnostic flow-charts and national formularies. As a result of active collaboration between WHO and all Member Countries of the Region, national drug policies or health policy including pharmaceutical policy (in the case of DPR Korea) have been developing progressively.

One of the important approaches in assisting SEAR countries in improving the accessibility to essential drugs is to review the existing schemes on drug supply in primary health care and improve their effectiveness. Other options can also be explored, where applicable, for strengthening the supply system. An effective option could relate to financing schemes such as community cost-sharing. Functional and effective financing schemes which are in operation in the countries of the Region could be reviewed in order to serve as examples in formulating national strategies for improving economic access to essential drugs. The recommendations of the meeting of the WHO/SEARO Working Group on Drug Financing which was held in Nakom Ratchasima, Thailand, in November 1996 are relevant to developing or strengthening cost-sharing mechanisms in the provision of drugs and health services.
3. STRATEGIES TO PROMOTE THE AVAILABILITY OF ESSENTIAL DRUGS FOR PRIMARY HEALTH CARE IN SEAR MEMBER COUNTRIES

Dr Gaitonde reviewed the present drug scenario in countries of the Region and highlighted the achievements in the last two decades. He mentioned that there are some very positive developments in the countries such as formulation of national drug policy, acceptance of essential drug concepts, and establishment of national list of essential drugs, and human resource development particularly in regulatory control. However, on the negative side, objectives of NDP have not yet been realized in a number of countries, resource allocations for health and drugs has gone down in real terms because of worsening socio economic conditions, and there is as yet lack of equity. Several countries have resorted to health sector reforms ending up in "liberalization" which has shown positive gains in terms of improved availability or accessibility of essential drugs for PHC in some countries. He then proceeded to highlight some of the problems and constraints in drug management, and suggested strategies to promote the availability of essential drugs, such as better drug management, rational use of drugs, standard treatment guidelines, effective quality assurance at PHC level, and a plan of human resource development in different areas of drug programme. Several models of procurement, such as centralized versus decentralized; autonomous; semi-private, and prime vendors etc. were discussed, underlining advantages and disadvantages of each of the models.

Affordability is directly dependent upon the economic situation of a country. Most governments cannot continue to provide free health care as before. Several strategies to improve affordability were suggested such as price regulation, price information, use of generics, user fees for service, different types of insurance mechanisms and donor financing. He emphasized that rational prescribing is an important prerequisite for improving affordability, and eliminates unnecessary and useless expenditure on drugs.

He suggested the use of flexible approaches, depending upon country situations for improving drug supply in peripheral health facilities.

4. MONITORING THE AVAILABILITY AND AFFORDABILITY OF ESSENTIAL DRUGS

Ms Karin Timmermans gave a brief account of indicators developed by the Action Programme on Essential Drugs of WHO for monitoring National Drug Policies (NDPs) towards measuring the effectiveness of the strategies developed as well as the activities
implemented for achieving the NDP objectives. They have been selected on the basis of a logical approach comprising the following steps:

- What are the key issues in the pharmaceutical sector? (diagnosis of problems)
- What are the main objectives of NDPs?
- What are the main strategies/activities which should be developed in order to meet those objectives?
- How are these strategies/activities to be monitored?
- How is the impact of these strategies/activities to be monitored?

The outcome (OT) indicators are used for monitoring the impact and address the four objectives of virtually all NDPs, namely making essential drugs available and affordable; ensuring that they are of good quality, and that they are used rationally. The outcome indicators, therefore, evaluate how far these objectives have been met.

The structural and process indicators monitor the strategies/activities employed for reaching the objectives. The structural (ST) indicators reflect the extent to which an infrastructure, or any other key structure, has been established, while the process (PR) indicators measure the degree to which activities are being implemented and/or the changes in performance over time.

The structural (ST) and process (PR) indicators have been designed to monitor seven key components that have been identified as important for the achievement of NDP objectives. In order to understand what is working well and what is not, why objectives have been met or not, it is important to see for each component whether the structures are in place and whether the performance is satisfactory (or to look at its ST and PR indicators).

Finally, the background (BG) indicators provide information on the context in which the NDP is being implemented.

Ms Timmermans gave some illustrations of countries/states which have used some of the indicators in monitoring their national drug policies.

5. **DRUG SUPPLY STRATEGIES**

Dr Jonathan D. Quick, Director, Action Programme on Essential Drugs, in his presentation on drug supply strategies discussed the alternative drug supply system for public health services. He mentioned that countries may have central medical stores as a conventional
supply system for procurement and distribution but there are other alternative systems such as autonomous supply agency, directly delivery system, dual contract systems (primary distributor or prime vendor) and fully private, which should be considered with their advantages and disadvantages. He gave examples of countries using one or a mix of these systems, bringing out merits and demerits with particular reference to supply at the primary health care level. He illustrated a model in which there was effective collaboration of public sector, non-profit sector and the community towards improving drug supply.

He then went on to elaborate on the alternative strategies of health reforms with particular reference to drug supply. One of the strategies used by some of the countries is decentralization which may involve delegation, devolution and privatization. Decentralization in certain situations has resulted in problems such as lack of financial resources at local level, lack of staff capacity, inadequate accountability, increased cost and sometimes suspect or decreased quality assurance. In privatization, "third sector" (nongovernmental organizations, professional organizations and other non-commercial entities) are involved. While privatization may improve the efficiency and effectiveness of a system, several problems may arise with such alternative drug supply systems such as quality, of both drugs and services, and financing.

In conclusion, Dr Quick asked the countries to compare all these alternative systems with the type of system that being followed by them and the possible impact of drug supply reforms on availability and affordability. There is a need, he said, for evaluating this impact, particularly, with reference to efficiency, equity of access and quality.

6. DRUG FINANCING ALTERNATIVES

Dr German Velasquez, in his presentation, outlined drug financing options, compared these in terms of feasibility (financial sustainability, administrative requirements, and public/political acceptability) and outcome (equity, efficiency, and rational use). He emphasized that whatever the modality for financing of drugs, it is the responsibility of governments to ensure that drug financing mechanisms are managed in such a way as to achieve equity of access to essential drugs.

Public financing of drugs occurs through national and local government budgets using general revenues or revenues earmarked for health. Public financing can also be managed through compulsory programmes, such as social security and national social insurance schemes, or compulsory taxes for income redistribution.
In virtually every country, central and local governments play some role in financing of health services and drugs. Paradoxically, in low-income and middle-income countries (which often have the greatest inequities in income distribution), public spending on health is typically one-quarter to one-half of high-income countries when measured as a percentage of gross domestic product (GDP).

The level of public commitment for financing health care and drugs should be a matter of explicit public policy, based on an analysis of health care needs and financing options. Some form of public spending will nearly always be needed to ensure access to drugs of the poorest in society; to ensure provision of drugs for tuberculosis, sexually transmitted diseases, and other communicable diseases, and to ensure care for target groups such as mothers and children.

Another alternative is health insurance provided through social insurance, social security, private insurance, and informal community health insurance. The experience of many countries has shown that compulsory social insurance can be a critical step to a more equitable health care system. A major advantage of insurance schemes is that health care costs are shared by the healthy and the ill, the poor or not so poor. Solidarity within various population groups can play an important role in financing drug and health services. Financing by cooperatives, state or private companies and the community can contribute to improving the overall health care and drug financing situations.

User charges are being implemented by governments and local communities in countries at all levels of development, both to supplement general government revenues or insurance premiums, and to help control utilization. Though such programmes often start at the community level, reasons favouring a top-down approach, starting with major national and local hospitals, include equity, reinforcement of the referral system, revenue potential, administrative capacity, and impact evaluation. User fees should supplement government allocations for pharmaceuticals, but should not replace them. Future efforts need to ensure that the lessons from existing research and actual experience are applied to the design, implementation and monitoring of user-fee programmes so as to ensure that access to drugs does improve and that rational use does not suffer. A top-down approach, starting with major national and local hospitals, may have advantages in terms of equity, reinforcement of the referral system, revenue potential, administrative capacity, and impact evaluation.

Several countries are using donor financing mechanism which includes bilateral and multilateral grants. For some countries, economic necessity may require dependency on an
externally funded drug supply for a relatively long period of time. Although this is not the best or ideal situation, it can benefit the poorest population.

Development loans through the World Bank and regional development banks have contributed to long-term development of the human and physical infrastructure for the health sector in a number of developed countries. However, loans should generally not be used for financing the recurrent costs of drugs, but only for capitalizing a new drug supply or financing system or in case of extreme, or temporary emergency situations when external aid is insufficient.

In any case, attention should be paid to ensuring that international loans, frequently accompanied by the imposition of conditions, do not distort national drug policies defined by governments.

7. REPORT OF THE FIRST MEETING OF THE WHO/SEARO WORKING GROUP ON DRUG FINANCING

Dr Kin Shein presented a report on the meeting of WHO/SEARO Working Group on Drug Financing which was held in Nakorn Ratchasima, Thailand, from 26-28 November 1996. The objectives of the meeting were to: (1) facilitate affordability of essential drugs; (2) assist cost-sharing of drugs, if introduced; (3) promote development and strengthening of effective financing schemes; (4) improve financial management; (5) improve the drug purchasing system in order to accrue significant impact on prices of drugs, and (6) explore ways and means of improving the supply of drugs.

The agenda of the meeting consisted of country presentations, a field visit and plenary presentations on drug financing issues and drug financing alternatives, cost-sharing of drugs and monitoring for equity and quality.

A field visit was made to a community hospital, a health centre and a village drug fund in a province of Nakhorn Ratchasima. The financing schemes, health and drug services provided and the administration of the health facilities were studied.

The report of the meeting highlighted the following issues:

Country priorities for action: These are to increase the health and drug budget, increase efficiency of budget utilization, development of guidelines for cost-sharing
schemes, purchase of quality drugs at low prices, and sustainability and replenishment of the drug supply system.

Priorities for the Working Group: These are on public financing, insurance for health and drugs, health reforms and global change - public and private roles in the pharmaceutical sector.

The Working Group sets the following issues as priorities for action. They are relevant to public financing - a study of experiences in increasing government budget on health and drugs, policies and guidelines for cost-sharing in health and drug sectors, drug pricing policies and mechanisms. It made the following recommendations: strengthen national and local drug financing schemes so as to ensure equity and access to essential drugs; the Ministry of Health to ensure adequate financing of essential drugs, if cost-sharing is introduced; revenues should supplement government allocation and not be a substitute for it; identify financial mechanism to promote rational drug use; the Ministry of Health to explore optimal public and private financing of health care and drugs, if cost-sharing is introduced; the Ministry of Health to define objectives; operation for cost-sharing scheme, and governments to ensure that prices of essential drugs are affordable for the majority of the population.

8. COUNTRY ACTIVITIES

Bangladesh

The Bangladesh National Drug Policy (BNDP) was introduced in 1982 and its main objective is to provide safe, efficacious and quality drugs to the entire population and encourage local production. The NDP identified a National List of 150 essential drugs, out of which 33 drugs were selected for use at the primary health care level. The BNDP had a very positive impact on the drug situation in the country and resulted in increased availability of essential drugs.

The country has established facilities, both in public and private sectors, for the production of medicines; the share of production of essential drugs is about 76%. The per capita consumption of drugs is US$ 2.2 (1995).

Drugs are supplied to consumers through both public and private channels of distribution. The public sector supply is through the Central Medical Store which procures drugs by a tender system. However, not more than 20% of the population receives essential
drugs through the public health care system. The total annual public drug expenditure is TK 660 million. In addition, about 10% of the drug budget comes from international aid. There are some voluntary organizations supporting primary health care and their share of the drug bill is approximately 3%. There are no other funding mechanisms for drug supply in primary health care except for some national programmes such as malaria control, DD, and TB, etc. Almost 80% of drug supplies for these programmes come from international donors.

The major constraints to drug supply in PHC are inadequate funding and lack of trained human resources in drug management.

**Bhutan**

The Essential Drugs Programme was initiated in the country in 1985 in collaboration with WHO. The National Drug Policy has been adopted and implemented. A national list of essential drugs has been prepared and only essential drugs are procured and used in all the health facilities in the country. The supply and management of essential drugs has been streamlined through the supply unit in the Directorate of Health Services and the Modern Store Organization. Primary health care covers the entire population and supplies the essential drugs for free. The government funds cover 80% of the drug supply while the remaining are provided by international donors, in particular, UNICEF, Government of India and DANIDA. There are no other funding schemes.

The quality of drugs is ensured by judicious selection of supplies, the use of WHO Certification Scheme for pharmaceutical products moving in international commerce, and occasional drug sample testing in WHO collaborating centres for quality control of drugs.

The total public expenditure on drugs is 29.73 million NU (1US$ = 35.15 NU) and the per capita expenditure on drugs works out to US$ 1.40.

The entire drug financing is through the MoH, and there are no other funding schemes operating in Bhutan.

**India**

In the Indian federal system, administration of health care is the responsibility of the States. However, with limited funds available, states offer free health care to their employees and to the economically weaker sections of the society. The finances for health care are sourced
through government budget (central, state and local) and private out-of-pocket expenses. Organized labour is covered by a compulsory insurance scheme. Voluntary insurance is available through two public sector insurance corporations, which have not yet made any significant contribution in health care. The Central Government has organized national programmes on the control of several endemic diseases of high morbidity and mortality. Some of these programmes offer 100% facilities for diagnosis and treatment, while for others there is sharing of expenses with state governments.

In 1995-1996, the total drug consumption in the country was about Rs 77000 million. Out of this, the total retail sale in the private market was Rs 62200 million and the remaining Rs 14800 million was due to institutional sale. The institutional sale mainly includes government spending, NGO and donor spending on health.

The drug distribution system is mostly under private control. However, centralized distribution for government facilities is in operation both at the central and state levels through their respective medical store depots. The procedure for purchase of essential drugs is as per standard government protocols or as per international bid document criteria, where quotations are invited from the registered vendors. WHO-GMP, past performance and batch-testing, etc. constitute important benchmarks for the bid documents. ABC analysis is being introduced for inventory control along with inflow-outflow analysis by bin-card or by computer system. No real shortages of supply of essential drugs have been reported excepting those due to restriction of finances. In future, it will be possible to introduce the system of indicator drugs to monitor the performance of each MS depot. The institutions prefer to buy drugs with generic names because of their price advantage due to absence of excise duty (15%). The Drug Price Control Order (DPCO) requires the manufacturer of any drug formulation (both price-controlled or decontrolled) to intimate the revised price within 15 days of effecting any change. A margin of 16% on the retail price is permitted to the retailers under DPCO for price-controlled drugs.

According to the World Bank estimates, the national per capita health expenditure was US$ 4 for the public sector and US$ 14 for the private sector in 1993. The total health care expenditure in 1993 was 6% of the gross national product (GNP), out of which the Government expenditure amounted to 1.3%. The sector-wise spending in terms of percentage is: Central Government 6.1; state and local governments 15.6; corporate and third party 3.3; NGOs 15, and private sector 60%. For health expenditure, the drug component is not separately estimated. In the public sector, a maximum of 15% of the budget has been reported to be spent on drugs and pharmaceuticals.
In 1996, the National Essential Drug List was introduced in consultation with states and various agencies. The Employees State Insurance Scheme (ESIS) covers 35.9 million beneficiaries (3.4% of the all-India population). The Central Government Health Scheme (CGHS) provides comprehensive medical care facilities to four million beneficiaries. International assistance in the supply of drugs has been gradually reduced as India is considered self-sufficient in the manufacture of drugs.

The Central Government has empowered itself under the Drugs and Cosmetic Act to weed out formulations considered irrational. This is a continuous exercise. It has so far weeded out 56 categories of formulations, most of which are fixed-dose combinations of drugs. This is a step forward towards rational therapeutics. The government is considering establishing a National Drug Information Centre for disseminating information to prescribers and to consumers at large.

**Indonesia**

Indonesia is the fourth most populous country in the world, with an annual population growth rate of 1.34% (1993). The average economic growth rate was 6.8% per annum, while the inflation rate was 8.7% per year during the 1980's. The capita income has increased from US$ 70 in 1967 to approximately US$ 1000 by 1996.

Using the primary health care approach, the National Health System was adopted in 1982. The system consists of four levels (central, provincial, district/sub-district, village) and includes the referral system to secondary and tertiary levels of services as well as community out-reach programmes. There were 6954 primary health centres, 19 977 sub-health centres, and 6024 mobile health units in 1993. Decentralized administration is encouraged.

The Indonesian National Drug Policy was established in 1983 with the objectives of ensuring the availability and accessibility of safe, efficacious and quality drugs as well as their rational use.

In order to ensure timely supply of low-cost but high-quality essential drugs, the Ministry of Health (MoH) appointed four government-owned companies as the main suppliers of essential drugs. The prices of essential drugs are controlled by the government. In addition, the use of generic drugs in public health facilities is mandatory. The government regulates the production of drugs by 51 manufacturers and also the distribution of generic drugs.
In order to improve the drug supply management for PHC in the public sector, a District Pharmaceutical Warehouse (GFK) was developed in every district to carry out the functions of drug supply, including 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), the GFK assists the DHO in coordinating the supply of drugs originating from different budget sources, so as to ensure timely and regular distribution to health care services in the districts according to actual need.

In order 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 facilities are obliged to use them. The use of generic drugs is increasing from year to year.

The per capita drug expenditure in 1996 was around US$ 5.

The total drug budget allocated for PHC in 1997 amounted to US$ 170 million. It is estimated that 84% of drug financing is derived from private funding and 16% from government budget. However, drugs procured with government budget cover around 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's control on drug prices is enforced only for the provision of drugs in the public sector and for the Generic Drug Programme. The essential drugs for the public sector are subsidized through various budgets, mainly the Central Government budget - the "Presidential Health Budget". The rationale for the high proportion of Central Government budget being used for drug procurement is to ensure more equitable access to drugs across the country.

Indonesia has a system of user charges for public health services in both hospitals and health centres. A very low, uniform fee for health centre services is implemented throughout the country. The Central Government hospitals follow the fee schedule guidelines issued by the MoH. The provincial and district hospitals are expected to conform with these guidelines. 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.
Quality assurance is ensured by regular routine inspection for the GMP implementation and programmed sampling of marketed drugs for analysis by Government Quality Control Laboratories established in 27 provinces and by the National Quality Control Laboratory in Jakarta as the top referral laboratory.

High priority is given to improve the 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. 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. A guideline on drug advertising was established in 1994, based on the WHO criteria for Medicinal Drug Promotion and adapted to meet Indonesian needs. Advertisements on OTC drugs can only be made after obtaining the MoH’s approval from the MOH.

Maldives

Health is a basic right and the government has implemented several programmes to promote the health status of the people.

The government, in collaboration with WHO, established essential drugs programme to ensure availability, quality, safety, affordability and rational use of essential drugs. The country imports both essential and non-essential drugs mostly through the State Trading Organization and private importers (95%). Five per cent of essential drugs and vaccines are supplied by UNICEF. The Department of Public Health distributes drugs to all public health institutions. Private pharmacies are also allowed to import drugs either directly or through STO. Quality is ensured by the use of WHO Certification Scheme and imported only through registered manufacturers and by physical checks at the port of entry. The price control mechanism operated by MoH and Ministry of Commerce ensures to some extent that drugs are sold at reasonable prices. Private pharmacies mainly supply drugs in the private sector.

The total public health budget is 25 370 827 MRF (local currency) while the donors contribute 3.5 million MRF for the health sector. The total public expenditure on drugs is US$ 66 000 and international donors provide US$ 185 000 for supply of drugs.

All drugs are provided free at the PHC level and there are no schemes for alternative financing for drugs.
Myanmar

The Essential Drugs Programme activities starting from 1989 were followed to cover the entire country by community cost-sharing system based on a revolving fund and user-charges strategy with the future extension plan of five years ending in 2001. Community cost-sharing in the hospitals was started in 1990 by providing accommodation (private room for inpatient's), diagnostic facilities and drugs through the user-charge system. Concerning drug control, the adoption of the National Drug Policy in February 1992 followed by the establishment of the National Drugs Law facilitated the establishment of the Drug Authority for licensing of drug sellers and framing rules and regulation for ensuring the quality of drugs.

The problems encountered at present are shortage of trained persons in the areas of pharmacy, health economist and health financing management, etc. Funding is inadequate and so is the infrastructure for local manufacture of drugs.

The medical supply system of the Department of Health is based on a central storage and distribution system at the Central Medical Stores Depot (CMSD) which procures, stores and distributes all drugs and equipment from both local and foreign sources for all hospitals, health centres and other health facilities under the Ministry of Health throughout the country, directly or through sub-depots at Mandalay and Taunggyi (sub-depots) and eleven transit camps.

The Myanmar Pharmaceutical Factory (MPF) is the major supplier of drugs to the CMSD. While the major portion of the demand is met by the MPF, some drugs are procured through direct import, if foreign currency is available. Tenders are issued abroad following the system of direct tenders or limited tenders and open tenders depending on the quantity and type of medical supplies to be purchased. A fairly large amount of drugs and chemicals are supplied by external aid organizations, such as UNICEF, WHO and NGOs, almost all of which are meant for the rural health services and specific disease control programmes. The UNICEF supplies are obtained against the demand forwarded by Project Managers who estimate annual requirements on the basis of the needs of new projects as well as of the ongoing programmes.

All the medical supplies received from all sources are stored in different warehouses dealing with drugs, sundries, and UNICEF supplies, till they are despatched to the consuming units.
There are 16 warehouses with an average size of 100 feet x 40 feet. Two are assigned to receiving section, one to packing despatch section and two for storage of UNICEF supplies. The medical supplies are stored category-wise in the remaining warehouses.

The bincard system is in use, thus enabling the authorities to have a better control of stocks and to know the location of each item.

Computerization of the inventory system has just started and is still in its initial stage; its upgrading will start soon in the near future.

The present procedure for all health institutions (with the exception of 16-bed and station hospitals, rural, urban and school health centres) is to request medical supplies from CMSD or Central Medical Stores Sub-depot (CMSSD) by indent system annually within their budgetary allocation based on their own perception of needs and preference. Apart from these indents they can also submit emergency indents whenever there is a disaster or an epidemic outbreak.

The medical supplies to the 16-bed Station Hospitals, rural, urban and school health centres are issued once a year according to the standard lists.

At present, the major portion of medical supplies is despatched to the end-users by using five-ton CMSD trucks, nine in number, obtained with ADB loan. For some remote areas, medical supplies are distributed by air. For remote areas without easy access, such as Kengtung and Tachileik townships of Shan State and Papun township of Karen State, the drugs are distributed by chartered plane. For coastal townships, the medical supplies are despatched by schooner.

**Nepal**

The total expenditure on health is 6% of the total national budget. The Department of Drug Administration was constituted in 1979 for effective implementation of the Drug Act and to ensure quality assurance.

Government's drug policy is to maintain, safeguard and promote the health of the people by making the country self-reliant in drug production and ensuring the availability of safe, effective and standard quality drugs at affordable prices, in quantities sufficient to cover the needs of people in all parts of the country. The main objectives of NDP arc:
- Selection of essential drugs for different levels of health care - central, regional and primary;
- Ensuring quality through regulatory control;
- Manpower development;
- Research and development, and
- Encouraging self-reliance by promoting local production of essential drugs.

There is a large factory in the public sector producing essential drugs, and about twenty other factories in the private sector.

Health expenditure is about 1% of the national DGP. The per capita expenditure on drugs is about US$ 1.0 and the total annual budget for supply of drugs in the public sector is US$ 20 million. Seventy two per cent of the health budget is spent on primary health care, 16.8% on hospitals and 12.4% on others.

There is a policy of decentralization and 32 out of 75 districts are allowed direct procurement of essential drugs for public health facilities in their respective districts.

The financing mechanisms for drug supply for primary health care are: government budget (80%); about 20% donations (WHO, UNICEF, Nippon Foundation, USAID, JICA, UNFPA and EC) totalling about 416.2 million Nepalese Rupees (1994-1995); user fees (introduced in some districts), and drug cooperatives. The health management committees in each health facility are responsible for managing user fees. Managing the country's logistics is difficult because of the mountainous terrain. The storage and distribution systems consist of a central warehouse, transit warehouses, regional warehouses (five in number) and district warehouses. Drugs are not available at PHC at all times due to delays in procurement. The situation has, however, improved recently.

Sri Lanka

The state drug expenditure for a population of 18 million is Rs 1.2 billion. Sixty per cent of the total health budget is spent on community health. About 80% of the drugs are imported. The list of essential drugs was first published in 1985 and was revised in 1988. This list has been revised again in 1997 and will be published soon.

The legislature responsible for drug regulation is the Cosmetics Devices and Drugs Act of 1980. The Drugs Evaluation Sub-committee advises the Ministry of Health on registration of drugs. The State Pharmaceuticals Corporation (SPC) is responsible for procuring drugs for the State. Drugs are procured by the SPC through worldwide or
restricted tenders, twice a year, based on estimates sent by the Medical Supplies Division (MSD). Drugs in the essential drugs list and other drugs requested by the hospitals are also distributed by the MSD. However, shortages occur from time to time. These are mainly due to inaccurate estimates submitted to the MSD. All drugs are given free of charge to patients in the state hospitals. If a drug is not available at a particular hospital, the patient may be requested to buy the drug from the private sector depending on his economic status.

The SPC is also the largest importer of drugs for the private sector and these drugs are sold at their retail pharmacies (osusals) and at private retail pharmacies selling SPC drugs which are called "franchise" osusals. Drugs are also imported by private importers and sold at private retail pharmacies. The drug prices in the private sector are regulated by the Fair Trading Commission. However, drugs imported by private importers sold at different pharmacies may have variable prices. It is important to stress that the SPC is responsible for the stabilization of drug prices. The State Pharmaceuticals Manufacturing Corporation (SPMC) manufactures about 40 essential drugs. The transnationals and other private manufacturers manufacture mainly OTC drugs but there are a few local companies that have ventured to manufacture essential drugs.

The National Quality Assurance Laboratory is responsible for quality assurance before drug registration and post-marketing surveillance of random samples from state hospitals and private pharmacies.

The biggest constraint to the implementation of the essential drugs programme is the shortage of pharmacists. The training of pharmacists is also at a low level and very inadequate. At present, only a diploma course in pharmacy is conducted by the Faculty of Medicine, Colombo, to improve pharmacy education. Presently, a proposal to commence the B.Pharm. course in two universities is under consideration.

Drug information to prescribers and consumers is inadequate. The Sri Lanka Prescriber, an independent drug bulletin for prescribers, published by the Ministry of Health and the Faculty of Medicine, Colombo, was started in 1993 and is published on a quarterly basis. The Sri Lanka Medical Association has appointed a sub-committee to promote the rational use of drugs and it has commenced a programme of improving consumer education through the print and the electronic media. Rational drug use will be introduced into the schools' curricula. A Sri Lankan Hospital formulary was published in 1994. Prescriber guidelines are lacking. However, the preparation of National Antibiotic Guidelines has commenced. National Health Policy and National Drug Policy documents were published in 1997.
Thailand

The national drug policy has been implemented since 1981, both conceptually and in practice. Its first revision occurred in 1993 and focused on: adequate supply of safe and good quality drugs to the population; reduction of drug wastage by using the essential drugs strategy; strengthening of the drug quality assurance scheme; developing the production of raw materials, and promotion of traditional medicines in primary health care. The first National Essential Drugs List (NEDL) was formulated in 1982 and implemented by all public health care systems with a medium price list in order to regulate drug supply economically. A manual of Essential Drugs Utilization was also established in order to promote and strengthen the utilization of the essential drugs. In addition, the essential drugs list for primary health care was developed for drugs and the manual of drug utilization management for drug cooperatives and practising health volunteers was revised in 1986 and in 1993. Drug procurement criteria using NEDL are also established for public hospitals outside the Ministry of Public Health. In the hospitals under the Ministry of Public Health, 80% of the budget for drug procurement has to be used for purchasing essential drugs. In addition, under the 1990 Social Security Act, medical and health services of both private and public sectors are indirectly obliged to use the NEDL as their minimum standard drug list. It can be said that the application of NEDL has helped achieve the rational use of drugs as well as to strengthen the drug supply system of the country.

For supplying drugs to the government health service at the community level, apart from community hospitals and health centres, the MoPH has also established village drug cooperatives towards improving the accessibility of essential drugs in villages. However, the study and report of the Primary Health Care Committee concluded in 1993 that 37% of these drug cooperatives which have been established in over 60,000 villages since 1977 were still operational and had expanded their roles and activities.

In Thailand, drug financing has been included partially in the national health and drug policy. Although an analysis of health service needs has been undertaken, there is yet no specific system for comprehensive estimation of drug financing needs. Only a little statistical data has been collected on drug financing under the National Drug Financing Information System. And, some data are available in the reports of a few research studies.
9. **GROUP WORK**

The participants were divided into two groups to discuss and report on the following tasks. Group I focused on supply and Group II on financing:

1. Discuss the actual situation in countries with regard to strategies for the supply of essential drugs for primary health care, and present an overview.

2. List options with their advantages/disadvantages (experienced as well as expected).

3. Make guidelines: process/content (try to cover all the options).

4. Based on these guidelines:
   - draft an outline of the action plan for country level, and
   - indicate the assistance expected from WHO.

5. Develop recommendations:
   - for governments/countries, and
   - for the regional level: WHO/SEARO.

Both groups had to discuss tasks 1-5 in their group work taking into account country situation and country perceptions on the availability and affordability of essential drugs at the primary health care level, comparing systems operating in each of the countries and present their reports at the end of the group work.

Both groups, after thorough discussions, prepared and presented their reports in the plenary session during which they interacted with each other.

9.1 **Report of Group I**

Group I discussed the drug supply system presently operating in countries, its advantages and disadvantages and also compared the same with alternative systems or mechanisms for the supply of essential drugs for primary health care. On the basis of discussions, they prepared guidelines for countries to promote the availability of essential drugs at the primary health care level. The following tables summarize the comparison of the public supply system (Table 1) and information on the individual components of the supply system in each of the countries (Table 2).
### Table 1. Availability of Essential Drugs for PHC: Comparison of Supply Systems, Production, Procurement, Storage and Distribution in Countries of SEAR

<table>
<thead>
<tr>
<th>Country</th>
<th>Production (PHC EDs)</th>
<th>Procurement</th>
<th>Storage</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bhutan</td>
<td>-</td>
<td>160</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>India</td>
<td>100</td>
<td>-</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Indonesia</td>
<td>100</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Maldives</td>
<td>0</td>
<td>100</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Myanmar</td>
<td>30</td>
<td>70</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Nepal</td>
<td>35</td>
<td>65</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>20</td>
<td>80</td>
<td>Y</td>
<td>-</td>
</tr>
<tr>
<td>Thailand</td>
<td>100</td>
<td>-</td>
<td>Y</td>
<td>-</td>
</tr>
</tbody>
</table>

A: Average; Ad: Adequate; C: Central; DC: Decentralized; E: Enough; N: Not; G: Good; L: Limited; Mech: Mechanism; Mgmt: Management systems (design and functioning); Pers: Personnel (type, number, training of staff); Pri: Private; Pub: Public; Facil: Facilities; P: Peripheral.
### Table 2. Information on Public Sector Drug Supply* in South-East Asia Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Supply System Organization (Main public sector system)</th>
<th>Procurement method (main method for most drugs)</th>
<th>Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Decentralized to district CMS</td>
<td>Open tender (by districts) Restricted tender</td>
<td>- Public</td>
</tr>
<tr>
<td>Bhutan</td>
<td>CMS</td>
<td></td>
<td>Private Public</td>
</tr>
<tr>
<td>India:</td>
<td>National CMS</td>
<td>Open tender</td>
<td></td>
</tr>
<tr>
<td>- State</td>
<td>Mixed: CMS Direct delivery</td>
<td>Open tender</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>Primary distributor Direct delivery</td>
<td>Mixed: A, B drugs**: negotiation with state producer C drugs**: provincial tender</td>
<td>Private Public</td>
</tr>
<tr>
<td>Maldives</td>
<td>CMS</td>
<td>Open tender</td>
<td>Public Public</td>
</tr>
<tr>
<td>Myanmar</td>
<td>CMS</td>
<td>Open tender</td>
<td>Public (CMS) Private Mostly private also public</td>
</tr>
<tr>
<td>Nepal</td>
<td>Mixed: CMS (mostly) Direct delivery</td>
<td>Negotiation (state producer, RDL) Open tender</td>
<td>Public (CMS) Private contract Mostly private</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>CMS</td>
<td>Open tender</td>
<td>Public P-L Public</td>
</tr>
<tr>
<td>Thailand</td>
<td>Mixed: Provincial CMS Direct delivery (hospital pooled bargaining)</td>
<td>Negotiation (state producer, GPO) Restricted tender (GMP producers only)</td>
<td>Public (CMS) Private Public</td>
</tr>
</tbody>
</table>

* Comparison does not include special supply systems which may exist for vertical programmes such as TB.

** ABC drugs refer to ABC analyses in inventory management.

CMS Central Medical Store
GPO Government Pharmaceutical Organization
RDL Royal Drug Laboratory
The following are the guidelines for promoting the availability of essential drugs:

9.2 Guidelines for promoting availability of essential drugs

(1) Production

(a) Local Manufacture:

- Good Manufacturing Practices should be promoted;

- Local manufacture of essential drugs including raw materials should be encouraged by providing incentives (equipment, loans, tax benefit, financial incentives to employees, bonuses etc.);

- In order to encourage and promote the use of essential drugs in public health services, a better market share has to be ensured and import may have to be reduced. Technical capabilities in national manufacturing of essential drugs should be strengthened;

- In order to ensure acceptability of essential drugs, mechanisms to improve and ensure quality should be established;

- Technical cooperation among countries involved in large-scale production should be promoted;

- Activities relating to improvement of drug formulations should be assisted;

- Pool production of essential drugs by countries who possess capability and capacity should be encouraged, and

- Efficient and effective drug management should be ensured in order to provide:

  - drug quality assurance;
  - improved pharmaceutical supply system;
  - security;
  - introduction of new technology i.e. computerization, and
  - human resource development.
(b) Importation
   
   - The National Drug Regulatory Authority should be further developed and strengthened, in particular the registration system with special reference to essential drugs.
   
   - Tax incentives/benefits should be provided for the import of essential drugs.

(2) Procurement

   - The planning should be good in order to avoid unnecessary delays.
   
   - WHO Certification Scheme to ensure quality of product to be imported should be rigorously implemented.
   
   - There should be regular quality checks.
   
   - Lead time for tendering should be reduced to the minimum.
   
   - Information on availability and prices of essential drugs should be made widely known.
   
   - Pharmaceutical specifications and contract terms for procurement purpose should be established.
   
   - Quantification should be flexible so as to facilitate procurement.
   
   - A performance monitoring system for suppliers, including physical inspection for quantities and qualities of all deliveries and selective quality control testing should be established.
   
   - Pre-qualification for tendering should be established, where feasible.
   
   - Documentation system to record payments for procured drugs should be established.

   - There should be proper training on procurement process.

(3) Storage

   - Adequate storage space and storage facilities such as shelves, cold chain and dehumidifier, etc. at the periphery level should be established.
There should be adequate security for narcotic drugs and general security for storage establishment.

- Standard guidelines for Good Storage Practices should be established.
- Training of personnel in store management and inventory control should be undertaken on regular basis.
- Proper recording and monitoring are prerequisites for proper storage.

(4) Distribution

- Transportation system should be improved and there should be flexibility in channels of distribution.
- A system of "right drug on right time" and "first expiry first out" should be established and implemented.
- Drug utilization studies should be undertaken.
- Proper drug management and information systems should be established.

9.3 Report of Group II

Group II discussed different mechanisms of ensuring the availability of essential drugs for PHC; situation in SEAR countries with regard to financial strategies for providing essential drugs for primary health care, and various country options along with their advantages/disadvantages.

The group discussed in depth the mechanisms for financing primary health care in each country. By and large, the public sector financing plays a very dominant role in all countries. Some countries, however, are using alternative mechanisms for financing to a limited extent, viz. user fees, drug cooperatives, revolving funds and drug insurance schemes.

Bangladesh

In Bangladesh, the government provides finance to the extent of 80% for supply of drugs at PHC levels, while the NGOs contribute to the extent of 20%. However, the funding is not adequate to meet the needs throughout the year. Approximately 35% of the population
seeks facilities of the public sector. The remaining population either avails of the facilities offered by the private sector or may not have any access to health facilities at all.

**Bhutan**

In Bhutan, the entire population is covered by public health facilities. Almost 80% financing is borne by the government and 20% comes from international donations.

**India**

India is a vast country with an extensive network of comprehensive PHC system. Financing at PHC level comes from the following sources:

1. The Central Government contributes 50-100% towards the purchase of drugs for diseases covered under national programmes, such as malaria, filariasis, tuberculosis and leprosy, etc.

2. State governments and local self-governments provide finances for procurement of drugs for other primary health care activities. Drugs are provided free. The public sector caters to about 40% of the population and remaining 60% is served by the private sector.

3. The Employees State Insurance Scheme (ESIS) covers 40 million factory workers who form about 3.3% of the total population of the country.

4. The Central Government Health Scheme (CGHS) provides comprehensive medical care free to central government employees and their families. It has so far covered 4 million people i.e. 0.5% of the population.

5. The NGOs operate in some areas, where they contribute 5-8% towards drug financing.

6. International assistance for drugs is less than 3%.

India spends about 6% of GNP on health care, out of which 1.3% is by public sector and 4.7% by private. At least 15% of the health budget is spent on drugs and pharmaceuticals. Out of 6% GDP, 1.2% is spent on drugs. The budget spent for essential drugs at PHC would be 0.6% of GDP.
Indonesia

In Indonesia, 70% of the financing for drugs comes from the Central Government (Ministry of Health).

Health insurance contributes 24.3% of the financing while the local government (provincial, district) contributes 5%; 0.7% is provided by other central government ministries.

Primary health care from public facilities is availed by 80% of the rural population while 20% avail it from the private sector. In urban areas, it is just the reverse: the distribution would be 60% rural and 40% urban. It is interesting to note that Indonesia spends almost 40% of its health budget on drugs.

Myanmar

Township hospitals and rural health centres constitute the primary health care system. Total financing of drugs is done by the Ministry of Health. Insurance coverage is less than 0.4%. The government has started user charges so as to recover the entire cost of drugs in 60 out of 320 townships. In another 51 townships, a donor agency is contributing to an extent of 10% of the user charges.

The public sector covers 100% of the population.

Maldives

It is a country of many islands with 32 PHCs and four hospitals. Financing for essential drugs is 67% by the Ministry of Health and 33% by donor agencies (mainly WHO and UNICEF) for specific programmes. The population coverage is 74%. No other financial scheme is operating in the country.

Nepal

Drug financing for primary health care is by the Ministry of Health. However, in six districts, a cost-sharing scheme has been started which contributes 20% of the drug cost i.e. the government recovers 20% of the drug cost.

The total population coverage does not exceed 20%. Special national health programme financing comes from donor agencies to the extent of 70%. In certain areas, NGOs are also operating. However, their contribution for drug financing does not exceed 2%.
Thailand

The Ministry of Health meets 70% of the drug financing for primary health care while 10% is contributed by insurance. The remaining 20% cost of drug supply is met by village drug cooperatives. The village drug cooperatives have received initial funding from internal donors. The system of user charges has been introduced but it does not contribute to more than 10% of the funding for drugs.

The following table (Table 3) gives the comparative analysis of mechanisms used for drug financing in the SEAR countries.

**Table 3. Financial inputs for drug supply at PHC level**

<table>
<thead>
<tr>
<th>Country</th>
<th>Public Finances</th>
<th>User Charge</th>
<th>Insurance</th>
<th>Donors</th>
<th>Coops</th>
<th>Loans</th>
<th>NGO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Central</td>
<td>State</td>
<td>Local</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>80%*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>&lt;1%</td>
<td>&lt;15%</td>
<td>-</td>
</tr>
<tr>
<td>Bhutan</td>
<td>80%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20%</td>
<td>-</td>
</tr>
<tr>
<td>India</td>
<td>For Nat. Prog. (50-100%)</td>
<td>80-85%</td>
<td>+5%</td>
<td>-</td>
<td>3%</td>
<td>&lt;2%</td>
<td>-</td>
</tr>
<tr>
<td>Indonesia</td>
<td>70%</td>
<td>-</td>
<td>5%</td>
<td>-</td>
<td>25%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Maldives</td>
<td>70%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30%</td>
<td>-</td>
</tr>
<tr>
<td>Myanmar</td>
<td>90%</td>
<td>-</td>
<td>-</td>
<td>Introduced in 123 PHC Townships</td>
<td>-</td>
<td>10%</td>
<td>-</td>
</tr>
<tr>
<td>Nepal</td>
<td>70-80%</td>
<td>-</td>
<td>-</td>
<td>Community Drug Sys. As introduced for cost sharing</td>
<td>&lt;0.4%</td>
<td>20%</td>
<td>-</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>&lt;1%</td>
<td>-</td>
</tr>
<tr>
<td>Thailand</td>
<td>70%</td>
<td>-</td>
<td>-</td>
<td>20% (in Coop.)</td>
<td>10%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Indicates percentage of drug budget at primary health care level.
The countries suggested options along with the advantages/disadvantages:

**Bangladesh**

The present public financing of procurement of drugs for primary health care makes drugs available to only 20% of population. Public financing may be enhanced in a phased manner. There is room for consideration of user's charge and introducing insurance scheme to make the system viable.

**Bhutan**

The present system includes advantages of implementing equity, safety and solidarity. The existing system continues to support and expand the Knowledge, Attitude, Behaviour Practices (KABP) in modern health care and helps 100% health service coverage. It allows procurement of essential drugs by generic names only and thus maintains the uniform prescribing trends of physicians and paramedics.

However, sustainability is the only major problem. It is suggested that while the present system may be maintained, other financial alternatives may be studied and evaluated for self-reliance in drugs supply.

**India**

In spite of structural health care and diagnostic facilities, drugs are not available to a good percentage of people due to financial constraints.

A scheme like Employees State Insurance Scheme (ESIS) with total insurance coverage at the optimum cost may be introduced in a phased manner to cover all districts in a period of five years. The disadvantage of the new scheme is that it involves a huge infrastructure and its management.

**Indonesia**

The advantages of the present system are:

1. Accessibility is high, and
2. The cross-subsidy among regions creates more efficient use of the budget.
The disadvantages are:

1. People who can afford to pay are also covered by the government although it is really meant for the needy and the poor;
2. Needs intensive supervision to ensure quality, and
3. Lacks local government participation.

**Maldives**

The present system allows accessibility of essential drugs of good quality to the poor and helps promote rational use of drugs.

**Myanmar**

At present, the financing is inadequate. The sudden change from the public financing system to cost-recovery system has resulted in underutilization of the public health facility during the initial phase. Sustainability of donor funding is very crucial at this juncture.

The revolving fund system born out of the seed-money provided by the government or donor is successful as it is not required to send back the revenue to the central agency and the decision for replenishing the drug supply rests on local persons.

**Nepal**

The present system allows people to obtain essential drugs free of cost. However, its disadvantages include: lack of sustainability; burden of bearing the increased cost of drugs due to inflation, and the system not being self-reliant.

**Sri Lanka**

Drug financing for primary health care is met by the Ministry of Health. Sixty per cent of the health budget is spent on community health. About 8-10% of the health budget is invested in pharmaceuticals.
Thailand

The present system allows for accessibility of essential drugs of good quality to the poor and helps promote rational use of drugs, but getting drugs free in some cases may lead to overutilization of curative health. Although the strategy of having drug cooperatives in villages is suitable for making available essential drugs to the community, it may not be economical to operate.

9.4 Guidelines for ensuring affordability of essential drugs at Primary Health Care level

The following are the guidelines for ensure affordability of essential drugs at primary health care level:

(1) Allocation of budget at the primary health care (PHC) level for essential drugs should be reviewed from time to time, taking into account morbidity data and treatment episodes.

(2) Budget and drug utilization should be assessed at regular intervals in order to promote optimum use of available resources;

(3) The essential drug list should be revised from time to time so as to reflect the changing drug needs and it should be implemented as a policy commitment;

(4) Rational drug use has to be promoted, both in public and private sectors;

(5) Whatever funding mechanisms are used for financing the health care system, the accessibility to essential drugs at PHC level has to be ensured;

(6) Appropriate and authentic drug information should be available on a regular basis at all health facilities;

(7) Drug prices should be reviewed constantly and measures to optimally utilize the resources should be taken with special emphasis on the following:

(a) Incentives for production of generic drugs and generic prescribing at all public health facilities;

(b) Bulk procurement;

(c) Tariff relief for essential drugs;

(d) Providing information on comparative prices to prescribers, patients and public, and

(e) Regulation of profit margins for supply of essential drugs in public sector;
(8) Countries should evaluate drug financing strategies for optimum coverage, taking into account country situation. The following alternative strategies may be considered:

(a) Public financing
(b) Insurance schemes
(c) Cost-sharing
(d) Revolving funds
(e) Drug cooperatives
(f) Donor contributions (WHO Guidelines for Drug Donations should be taken into account), and

(9) The entire drug supply system including financing at the PHC level should be monitored once a year, using appropriate indicators. The WHO model indicators may be adapted to country situations.

9.5 Plans of Action

The two groups also developed outlines of country and regional plans to ensure availability and affordability of essential drugs at primary health care level. These are as follows:

9.5.1 Availability - Group I presented the following:

General Action Plan at Country Level

(1) Evaluation of the existing National Supply Strategy.
(2) Human resource development - fellowships in GMP, procurement and study tours, etc.
(3) Promotion of rational use of drugs.
(4) Promotion of bioequivalent generic products.
(5) Price regulation.
(6) Drug utilization studies.
(7) Quality assurance/control.
(8) Improvement in stores and their management.
(9) Improvement in transportation.
(10) Consideration of alternative strategies to improve drug supply, distribution and transportation.
### Table 4. Strategies to Promote Accessibility of Essential Drugs – A Regional Plan

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>(1) Action Programme on Drug Supply Management for PHC</td>
<td></td>
<td>All Member Countries</td>
<td>In-country training for the trainers</td>
</tr>
<tr>
<td>(a) Evaluation of management system</td>
<td></td>
<td>Training for trainers</td>
<td></td>
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<tr>
<td>(b) Introduction of new technologies in stores management</td>
<td></td>
<td>All countries for software Fellowships</td>
<td>Fellowships</td>
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<tr>
<td>(c) Supply</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(d) Human resource development</td>
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</tr>
<tr>
<td>(2) Develop TCAC</td>
<td></td>
<td>Package study tour</td>
<td>Package study tour</td>
</tr>
<tr>
<td>(a) Study tour</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>(b) Linkages with ASEAN</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>(c) Workplan for TCAC: Bi-regional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Consultative Meeting on Drug Supply and Management</td>
<td></td>
<td>Towards the end of 1999</td>
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</tr>
</tbody>
</table>

**Assistance expected from WHO to improve accessibility at PHC level**

1. **Technical Assistance**
   - (a) Training in pharmacy and stores management
   - (b) Evaluation methodology
2. **Drug information**
3. **Drug utilization studies**
4. **Improvement in transportation system**
5. **TCAC in the field of quality assurance**
6. **Applications of new models of supply system**
7. **Supplies and equipment for stores management**
9.5.2. Affordability - Group II presented the following:

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>National Workshop</td>
<td></td>
<td>Study tour on GDP and local training in GDP</td>
<td>Establish DIC Centre</td>
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<tr>
<td>Bhutan</td>
<td>Workshop</td>
<td></td>
<td></td>
<td>Studies and RUD training</td>
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<tr>
<td>India</td>
<td>Regional workshops</td>
<td></td>
<td>Pharmacy training, study of stores management at PHC plus group meeting</td>
<td>Preparation of IEC materials &amp; group activities</td>
</tr>
<tr>
<td>Indonesia</td>
<td>STC, Intercountry Meeting</td>
<td>STC for evaluation, group activities for training of trainers, workshop for NGOs</td>
<td>Fellowship, Pharmacist</td>
<td>Group training, evaluation by STC, fellowships in clinical Pharmacy and DIC in hospitals</td>
</tr>
<tr>
<td>Maldives</td>
<td>Study tour</td>
<td></td>
<td>Fellowship in quality assurance</td>
<td>Publication of bulletin, workshop for training at PHC</td>
</tr>
<tr>
<td>Myanmar</td>
<td>STC, Workshop</td>
<td>Review by National Consultant</td>
<td>Hospital Pharmacy curriculum; workshop</td>
<td>Fellowships</td>
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<tr>
<td>Nepal</td>
<td>Study tour</td>
<td>National Committee on study and evaluation National Consultant</td>
<td>Training of pharmacists (group training)</td>
<td>Bulletin on rational drug use, training in drug utilization and audit</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Study tour</td>
<td></td>
<td>Consultation in pharmacy education</td>
<td>DIC: Fellowship, information leaflets</td>
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<tr>
<td>Thailand</td>
<td>Study tour</td>
<td>Training</td>
<td>Fellowship - Pharmacoeconomics</td>
<td>Training in R&amp;D</td>
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DIC: Drug Information Centre  
DP: Good Dispensing Practices  
IEC: Information, Education and Communication
### Table 6. Outline of Regional Plan to improve Affordability

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<tr>
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<tbody>
<tr>
<td>(1) Pricing Policies:</td>
<td>STC/TA - 4 Wks</td>
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<tr>
<td>A study on pricing policies in the countries of the Region</td>
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<tr>
<td>(2) Rational Use:</td>
<td>IC Meeting</td>
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<tr>
<td>IC meeting on RUD with NGO participation to prepare an Action Plan</td>
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<tr>
<td>for rational use.</td>
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<tr>
<td>(3) Consultation on alternative strategies of financing drug supply</td>
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<td>Consultative</td>
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<tr>
<td>– follow up and review</td>
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<td>Meeting</td>
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<tr>
<td>(4) Preparation, testing, adoption and dissemination of audiovisual</td>
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<tr>
<td>materials on:</td>
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<tr>
<td>(a) Drug supply at PHC level</td>
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<tr>
<td>(b) Good Dispensing Practices (GDP)</td>
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<td>(c) Community education on essential drugs</td>
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<tr>
<td>(d) Rational use of essential drugs in training of medical, dental and</td>
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<tr>
<td>other health personnel including RUD in teaching curricula.</td>
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<tr>
<td>(5) A study on the implications of new WTO/TRIPs agreement on availability</td>
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<td>Consultant 2 weeks</td>
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<tr>
<td>and cost of pharmaceuticals and biologicals.</td>
<td></td>
<td>followed by consultation meeting for 1 week</td>
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<tr>
<td>(6) Research and Development</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(a) Multicentre study on selfmedication</td>
<td>1998</td>
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</tr>
<tr>
<td>(b) Drug utilization studies at PHC in some countries</td>
<td>1998-1999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Promotion of traditional medicine at PHC: use, quality control and</td>
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<td>1999-2000</td>
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<tr>
<td>research</td>
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<tr>
<td>(7) TCDC</td>
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<tr>
<td>Follow-up of the bi-regional meeting on TCAC: in availability and</td>
<td></td>
<td></td>
<td>2000-2001</td>
</tr>
<tr>
<td>affordability of essential drugs</td>
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</table>
10. RECOMMENDATIONS

10.1 Availability of Essential Drugs for Primary Health Care

Recommendations for countries

(1) Countries should continue strengthening their national essential drug supply schemes in order to ensure the availability of essential drugs;

(2) Countries should conduct regular updating of NEDL for PHC;

(3) Countries with production facilities should encourage production of essential drugs and all Member Countries should encourage utilization of generic products;

(4) Countries should encourage private sectors to get involved in the production and utilization of essential drugs;

(5) Countries should enhance the training of personnel involved in drug management;

(6) Operational research should be conducted on the various aspects of NED supply system as well as on R&D of pharmaceutical formulations in accordance with national priorities in order to improve the system;

(7) Countries should develop and strengthen the drug information for consumers, pharmacists and prescribers, and

(8) Countries should develop and strengthen the essential drug transport system so as to make essential drugs available at the PHC level.

Recommendations for WHO

(1) WHO should organize regional package study tours for training in drug supply and management;

(2) WHO should assist countries in the transfer of technology for production of raw materials;
(3) WHO should provide consultants to assist countries in improving the availability of essential drugs;

(4) TCAC should be promoted in the area of drug supply, and

(5) WHO should assist countries to find alternative approaches for drug in order to improve drug availability at PHC level.

10.2 Affordability

Recommendations for countries

(1) Member Countries should strengthen their plans as well as the technical justification in order to ensure adequate budget for drugs at all levels with particular attention to the PHC level. The budget should be based on the data on quantification, coverage and economic and financial analyses;

(2) Countries should organize training programmes on drug financing and financial management for managers responsible for drug supply;

(3) Any mechanism of drug financing should ensure access to essential drugs to the whole population;

(4) If cost-sharing is introduced, it should be used to supplement government budget and not as a substitute; and guidelines should be formulated to define its objectives and methods. Also, the impact on equity and on the access and availability of drugs should be carefully monitored, and

(5) The countries should explore financial and other economic mechanisms in order to promote the rational use of drugs in public and private sectors.

Recommendation for WHO

WHO should provide technical assistance to countries identifying appropriate drug financing systems.
### Annex 1

**FINANCING FOR HEALTH AND DRUG SUPPLY - COUNTRY SITUATION**

<table>
<thead>
<tr>
<th></th>
<th>BAN</th>
<th>BHU</th>
<th>IND</th>
<th>INO</th>
<th>MAV</th>
<th>MMR</th>
<th>NEP</th>
<th>SRL</th>
<th>THA</th>
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<tr>
<td>Health expenditure per capita (US$)</td>
<td>3.31</td>
<td>10</td>
<td>14</td>
<td>12</td>
<td>54</td>
<td>12.11</td>
<td>-</td>
<td>-</td>
<td>107</td>
</tr>
<tr>
<td>Drug expenditure per capita (US$)</td>
<td>0.14</td>
<td>1.50</td>
<td>3</td>
<td>5</td>
<td>20</td>
<td>0.2</td>
<td>1.0</td>
<td>-</td>
<td>18.0</td>
</tr>
<tr>
<td>Health expenditure as % of GDP</td>
<td>1.43</td>
<td>5.3</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>0.45%</td>
<td>1.26%</td>
<td>1.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Drug expenditure as % of GDP</td>
<td>0.06</td>
<td>0.7</td>
<td>1.2</td>
<td>-</td>
<td>-</td>
<td>0.006%</td>
<td>-</td>
<td>-</td>
<td>0.6</td>
</tr>
<tr>
<td>Drug expenditure as % of health expenditure</td>
<td>3.95</td>
<td>5.8</td>
<td>19.5</td>
<td>42</td>
<td>-</td>
<td>1.43%</td>
<td>-</td>
<td>-</td>
<td>16.8</td>
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</tbody>
</table>
Annex 2

OPENING ADDRESS BY DR UTON MUCHTAR RAFEI,
REGIONAL DIRECTOR, WHO, SOUTH-EAST ASIA REGION

I have great pleasure in welcoming you all to this intercountry meeting on Approaches to Promote Availability of Essential Drugs for Primary Health Care. As you are aware, Member Countries of WHO are strengthening primary health care in the context of the goal of Health for All. One of the eight elements of primary health care, as identified at Alma-Ata is the provision of essential drugs.

In this context, a major realization of the last decade has been that the public sector alone cannot achieve equitable health services coverage. Limitations on the part of the public sector to adequately finance health care have resulted in the restructuring of health policies and strategies in some Member Countries of our Region. These include decentralization of health care and its managerial infrastructures, introduction of cost-sharing schemes, and allowing the development of the private sector for providing and financing health care.

In each and every instance of health care reform, pharmaceuticals in general, and essential drugs and vaccines in particular, have a vital role to play. This is because a host of re-emerging diseases, such as plague, drug-resistant tuberculosis, and malaria and dengue haemorrhagic fever, among others, continue to proliferate in our Region. This is despite vigorous efforts in the prevention, control and treatment undertaken by the public health services.

Ladies and gentlemen, the public sector has traditionally been providing health care services for which effective funds-generating mechanisms are usually not well established. This, in turn, affects the availability and distribution of resources in spite of efforts made by national health departments and international organizations to promote equity. Hence, in the area of essential drugs, economic strategies have become an important component which merit serious consideration and inclusion in national drug policies.

The World Health Organization has been collaborating with Member Countries in the South-East Asia Region in the development, strengthening and revamping, where necessary, of national drug policies. These activities have been based on the essential drugs concept and the Revised Drug Strategy of WHO which was adopted by the World Health Assembly.
As a result of active collaboration between Member Countries and WHO, the implementation of national drug policies has progressed in various aspects. This includes the selection and supply of essential drugs, drug quality assurance, rational use of drugs, drug regulatory control, human resources development and technical cooperation among countries.

In this regard, the first meeting of the WHO/SEARO Working Group on Drug Financing was held in Nikorn Ratchasima, Thailand, in November 1996. The meeting identified country-specific priority issues and recommended among others, strengthening of national and local drug financing schemes in order to ensure equity and access to essential drugs.

It is important to measure the progress of national drug policies in terms of their achievements, particularly with respect to the accessibility of essential drugs, both in physical and financial terms. It is also important to plan for meeting the future health care needs of Member Countries and evaluate the relevance of national drug policies against these needs within the countries’ priorities as we enter the 21st century. In this regard, WHO has published and distributed a manual on indicators for measuring the progress of national drug policies.

Several countries in the Region are moving towards an alternative mechanism to effectively deal with drug shortages by allowing the development of an appropriate public-private mix in the pharmaceutical sector. The public and private sectors constituting this mix should complement, rather than compete with, each other. The developmental trend, therefore, is envisaged as an increase in the role of the private sector which would also include the involvement of private-for-profit as well as private-not-for-profit mechanisms. It is important that governments harmonize these mechanisms in order to achieve equity in the provision of essential drugs to satisfy health services’ needs to the maximum extent possible.

Ladies and gentlemen, access to essential drugs is a priority issue in our Region. The supply of essential drugs varies from mostly public to mostly private funding, with varying proportions of the two systems working in combinations. In order to effectively promote equity in access to drugs, it is most appropriate to evaluate and improve our existing strategies for the supply and distribution of essential drugs as they form integral parts of an equitable health care system.
The key issues which are still relevant in order to promote universal access to essential drugs continue to be equity, efficiency, economic sustainability and alternative financing.

In this regard, equity in accessibility to essential drugs has been a major and long-standing goal of WHO. It is an important goal since every citizen has the basic right to health care and, thus, to needed drugs. The goal becomes even more important in situations involving a high percentage of people living below the poverty line. Inequity becomes more prominent when the drug supply coverage by the public sector is insufficient compared to the total requirement.

One of the ways of promoting equity is for the public sector to look after those who are unable to pay for themselves. The private sector, on the other hand, can meet the needs of those who are able to pay.

Economic efficiency through obtaining essential drugs with the lowest possible cost is another goal that we must pursue relentlessly. The Ministries of Health, despite their attempts to increase the allocation for the drug budget often, in fact, have decreased the budget in real terms. Hence, there is a great need for making the best use of available resources in the procurement of drugs.

Economic sustainability in the context of drug management is also a critical issue. This has led, in some instances, to privatization which is an attempt at improving the availability of essential drugs. In this context, it is important that governments set forth national drug policy directions to enable tangible benefits to accrue from the public as well as private pharmaceutical sectors.

The alternative financing mechanisms, such as the user-charge system, social health insurance and health card schemes have proved to be feasible in providing health care as well as drugs. Hence, the process of privatization as a means to satisfy the increasing demands and offset the rising costs in the health sector should complement the efforts of the public sector to bring about equity. In a situation where the market forces may diminish the quality of the health and pharmaceutical services provided, the good quality of drugs and health services need to be ensured, both in the rural as well as urban communities.

Finally, ladies and gentlemen, I wish to bring to your attention the issue of sustainable access to essential drugs within the context of the overall health services. This inevitably raises the question of financial sustainability since funds within the public health facilities are generally inadequate for procuring the required drugs. Among the various
strategies aimed at supplementing the national budget, cost-sharing has been shown to be crucial if its implementation is monitored and regulated effectively. It is necessary in this case that all practical mechanisms that would promote and ensure universal access to essential drugs are put into operation.

I would therefore urge you to examine the various issues related to improving the access to essential drugs, and to recommend innovative ways of improving the existing drug financing schemes. In undertaking this task, let us re-dedicate ourselves to attaining the goal of universal access of all people to necessary medicines at prices which they can afford.

Priority must be accorded to drugs which meet the real health needs of the majority of population. There must be equitable distribution of health services and essential drugs between cities and rural communities. Quality assurance mechanisms for drugs must be further developed and strengthened to ensure their quality, efficacy and safety.

The rational use of drugs should be vigorously promoted as everyone, at one time or another, would need medicines for their health. In order to achieve and sustain these goals, innovative approaches need to be identified for promoting and sustaining the progress achieved in these areas.

I wish you every success in your efforts at promoting the availability of essential drugs. I am sure you will strive not only to facilitate the improvement of access to essential drugs but also to formulate practical guidelines and recommendations towards achieving this goal. This, in turn, would improve and strengthen health services at all levels of health care.

In conclusion, I wish all of you a very fruitful meeting and a pleasant stay in New Delhi.

Thank you.
Annex 3

PROGRAMME

Day 1: Monday 21 April 1997

<table>
<thead>
<tr>
<th>Time</th>
<th>Programme</th>
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<tbody>
<tr>
<td>0815 - 0900 hours</td>
<td>Registration</td>
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<tr>
<td>0900 - 1000 hours</td>
<td>Inaugural Programme - attached</td>
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<tr>
<td>1030 - 1230 hours</td>
<td>A Brief Overview of WHO Collaboration to Promote Access to Essential Drugs of Good Quality, Safety and Efficacy in SEAR - Dr Kin Shein, SEARO</td>
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<tr>
<td></td>
<td>Strategies to promote availability of Essential Drugs for Primary Health Care in South-East Asia Region Countries - Dr B.B. Gaitonde, STC/SEARO</td>
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<td></td>
<td>Monitoring of availability and affordability of Essential Drugs</td>
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<td></td>
<td>- Ms Karin Timmermans, STP/SEARO</td>
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<td>Country Papers:</td>
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<tr>
<td></td>
<td>Bangladesh: Report on Present Situation of Essential Drugs in Bangladesh</td>
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<td>Bhutan: Background Paper on Approaches to Promote Availability of Essential Drugs for Primary Health Care</td>
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<tr>
<td>1400 - 1500 hours</td>
<td>Country Papers (contd.):</td>
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<tr>
<td></td>
<td>India: Approaches to Promote Availability of Essential Drugs for Primary Health Care</td>
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<tr>
<td></td>
<td>Indonesia: Implementation of Essential Drug concept and drug financing strategies</td>
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<td></td>
<td>Maldives: Approaches to Promote the Availability of Essential Drugs for Primary Health Care</td>
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<tr>
<td>1530 - 1630 hours</td>
<td>Myanmar: Country Paper</td>
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<td>Nepal: Country Paper</td>
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<td>Sri Lanka: Aspects of Sri Lankan Drug Policy</td>
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<td></td>
<td>Thailand: A country report</td>
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Day 2: Tuesday 22 April 1997

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>0830 - 1030 hours</td>
<td>Drug supply strategies - Dr Jonathan Quick, DAP/HQ</td>
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<tr>
<td></td>
<td>Drug financing strategies - Dr German Velasquez, DAP/HQ</td>
</tr>
</tbody>
</table>
1100 - 1230 hours : Report of WHO/SEARO Working Group on Drug Financing, Dr Kin Shein
                      : Formation of Groups: Guidelines for Group work
                      : - Ms Karin Timmermans
                      : - Introduction to Group Work (Group I) - National
drug supply strategies - Dr Jonathan Quick
                      : - Introduction to Group Work (Group II) - National drug
financing strategies - Dr German Velasquez
                      : - Group Discussions on Tasks I and II

1400 - 1500 hours : Group Meetings - continue group work

1530 - 1630 hours : Group meeting continues - Group Work on Tasks I and II

Day 3: Wednesday 23 April 1997

0830 - 1030 hours : Plenary Session - Group reports on Tasks I and II

1100 - 1230 hours : Group Meeting - Discussion on Task 3, preparation and
presentation of report on Task 3

1400 - 1500 hours : Group Meeting - continue - group work on Task 4

1530 - 1630 hours : Group Meeting - continue group work

Day 4: Thursday 24 April 1997

0830 - 1030 hours : Group Meeting - Preparation of reports on task 4

1100 - 1230 hours : Group meeting: Discussion and preparation of reports on Task 5

1400 - 1500 hours : Plenary discussions: Presentation of reports on Task 4 and 5

1530 - 1630 hours : Preparation of recommendations of the meeting.

Day 5: Friday 25 April 1997

0830 - 1030 hours : Plenary Session
                    : Presentation of Report and Recommendations.

1100 - 1200 hours : Adoption of the Report and Recommendations
Annex 4

LIST OF PARTICIPANTS

Bangladesh
Dr Abdul Maleque
Chief, Drug Testing Laboratory
Institute of Public Health
Mohakhali,
Dhaka

Dr Md. Abul Kalam Zakaria
Pharmacologist
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Institute of Public Health
Mohakhali
Dhaka

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Pharmaceutical Officer
Ministry of Health
Male, Republic of Maldives

Mr Ahmed Wajeeh
Supervisor, Drug Supplies & Equipments Project
Department of Public Health
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Pheckon Township
Shan State

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Department of Health Services,
Ministry of Health
Kathmandu

Indonesia
Dra Andajyaningisih
Director for Drug Control
Directorate General of Drug and Food Control
Jakarta

Dr I.G.P. Wiadnyana
Director for Health Centre Development
Ministry of Health
Jakarta

Bhutan
Dr Nor Tshering Lepcha
District Medical Officer
Punakha Hospital
Punakha, Bhutan

Mr Dorji Thinlay
Pharmacist
Essential Drugs Programme
Thimphu

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Annex 5

LIST OF BACKGROUND DOCUMENTS

HQ Documents

1. Indicators for monitoring national drug policies, A practical manual

   Chapter 1 – Towards Sustainable Supply and Rational use of Drugs
   Chapter 6 – Drug Supply Strategies
   Chapter 13 – Managing Procurement
   Chapter 40 – Drug Financing Strategies

3. Drugs and Money, The problem of cost containment (Sixth Edition)

4. Essential Drugs in the New Socioeconomic Context of Latin America and the Caribbean Principles and Strategies

5. Health Economics – A guide to selected WHO literature
   Health Economics – A Bibliography of WHO literature

6. Alternative Drug Pricing Policies in the Americas – Health Economics and Drugs DAP Series No.1

7. The public and private circuits for the distribution of drugs in the Chilean health system – Health Economics and Drugs, DAP Series No.2


9. The Revenue generating potential of user fees in Kenyan Government Health facilities

11. Doing Business in Primary Health Care: Selling Essential Drugs in Haiti, June 1985

12. Spending money sensibly: the case of essential drugs

13. Health 2000, Paying for health services in Developing countries: a call for realism


15. Drug Pricing Systems in Europe – An overview

16. Community Financing Experiences for Local Health Services in Africa

17. Economics of essential drugs schemes: The perspectives of the developing countries Section H


19. The Economics of Pharmaceutical Policy in Ghana

20. Economy in drug prescribing in Mozambique

21. Drug supply in rural Nepal


23. Ten questions to ask about revolving drug funds

24. The multinational drug companies in Zaire: Their adverse effect on cost and availability of essential drugs

25. Polices for financing the health sector (Health Policy and Planning)

26. Charging for drugs in Africa: UNICEF’s ‘Bamako Initiative’ (Health Policy and Planning)
27. Community financing of drugs in Sub-Saharan Africa

28. Setting the price of health:
Implementing national health objectives through drug pricing policy

SEARO Documents

29. Outline for the preparation of the country paper – Part II
   (a) Indicators for Monitoring (pages 17–28)
   (b) Calculating the value of a basket of drugs (pages 52–56)
   (c) Additional information on basket of drugs and basket of food

30. Current Concerns – SHS Paper No.8

31. Lessons from Cost-Recovery in Health

32. Health Economics – Drugs and Health Sector Reform

33. WHO Essential Drugs Strategy – Objective Strategy
Objectives, priorities for action, approaches (Action Programme on Essential Drugs).

34. Theme Paper for Discussion – Health Reform and Drugs Financing: Overview of experiences, options and priorities for action (Action Programme on Essential Drugs)