RESEARCH

SENEGAL: Willingness and ability to pay for drugs

COMMUNITY financing has been the focus of a lively debate during the last few years. In the face of the inability of governments to guarantee the availability of free medicines – unfortunately 'free' medicines all too often means no medicines – a number of schemes have been developed in the public sector under which the community is required to pay for drugs and/or for other health services.

The reasoning behind most of these initiatives is that individuals already spend quite a large amount of their income on drugs, bought mainly by brand name at high cost in the private sector. It is argued that if the availability of essential drugs under generic name at low cost can be ensured in the health facilities, people would be willing to pay for these at a price which would eventually permit the financing of other costs of the health services.

For such schemes to succeed, willingness and ability to pay must be determined; a number of articles have pointed out the drop in utilization of health services when introducing user charges.[1,2] Others, on the contrary, state that when an improvement in quality of care coincides with the introduction of fees, utilization rates have increased.[3,4]

Research recently undertaken in Senegal by Environment and Development in the Third World (ENDA), with the support of the Action Programme on Essential Drugs, brings new information on the debate.[5] Senegal, one of Africa's poorest countries, faces major problems with respect to the availability, accessibility and use of drugs. The public sector is unable to meet the pharmaceutical needs of the population. The private sector is flourishing but is unequally distributed and financially inaccessible to many. The Ministry of Health is trying to rationalize the public system and the Pharmacie nationale d'Approvisionnement is being reorganized. Cost recovery systems have been proposed for adoption in the public sector but are still under discussion. With this background, a major objective of the study was to determine if families and individuals could mobilize resources for the acquisition of drugs, and what was the origin of these resources.

The study covered three regions representative of the social, economic and political diversity of the country: Diombel, Kaolack and Tambacounda. Surveys were made of 500 households, and a sample of 94 women patients and 93 prescribers at health centres; in addition the demand for drugs bought with and without a prescription was analysed in 14 pharmacies and 7 drug outlets.

The study found that although drugs are in very short supply in the health facilities, 57% of the households in case of illness still seek advice in the first instance from a health care establishment; nevertheless over a third said that they first resort to self-medication. Contrary to the commonly accepted idea, people do not routinely bypass health posts and centres in favour of hospitals: the majority first consult these local resources. This high degree of consultation shows the great significance that must be attached to the quality of services at this level.

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In many countries drugs are seen as a priority and households spend precious resources to procure those which have been prescribed.

Willingness to pay...

However most patients (90%) do not obtain drugs from such centres but only a prescription. This was confirmed by the fact that in the pharmacies and drug outlets surveyed, over 87% of the prescriptions analysed come from the public sector. In 84% of these cases, people purchased the drugs prescribed within the three days following the health centre consultation and 66% of the households bought the total of what was prescribed, at an average cost per prescription of US$9. This amount, which is similar to that found in other West African countries (see article on Benin), is quite high compared to the purchasing power of the majority of the population; however these results seem to indicate willingness and ability to pay.

Ability to pay...

Further results tend to contradict these first conclusions, which hide in reality the difficulties households face in obtaining the financial resources needed to pay for the drugs prescribed.

First, some patients do not go to the pharmacy for days; which means that in the absence of drugs in the health facilities, they probably go without. Although the consultation fee in the health facilities is low – less than US$0.35 in most cases for a child, and between US$0.35-0.70 in most cases for an adult – 20.4% of the women interviewed said that they would not be able to spend more even if a regular supply of drugs were ensured; 35% were willing to pay between US$0.70-1.75; 27% between US$1.75-3.50, and only 23% more than US$3.50.

Second, of the patients who go to the pharmacy or drug outlet, a number (36%) did not buy all the prescribed drugs – some decided not to buy the most expensive drugs (26%) without consideration of medical need, and others sought advice before selecting which drugs to buy from the prescriber (21%) or from the pharmacist (10%).

Third, among the households surveyed, while the majority (72%) stated that they generally succeeded in purchasing the drugs, less than one in four said that they could afford to do so from their income alone. The difficulty in paying for the prescribed drugs occurs to various degrees in all the socio-economic categories surveyed. Less than half the households of civil servants and retired people, although in a relatively privileged economic position, said that household income was generally sufficient to purchase the prescribed drugs.

Turning to the community...

When income is insufficient, the most widespread response of the families (45% of the cases) is to look immediately for help in obtaining the money needed. This attitude is not confined to a few social categories it occurs in different proportions in all the socio-occupational categories interviewed. Parents are asked first (62% of cases) followed by neighbours (13%) and friends (8%). 65% of the households covered by the survey said that they had already been asked for help in paying for prescribed drugs. The ability to afford the prescribed drugs therefore depends in many cases on households' capacity to tap other resources than their own.

While most households tend to seek financial aid, 16.5% of them said that they did not try to obtain such aid and instead waited before buying the prescribed drugs or bought only some of them; nearly 12.4% adopted specific solutions (purchase with vouchers or asking the prescribers for assistance) or alternative solutions (resort to medicinal plants). 11% were forced into financial commitments (credit from the vendor or borrowing), 13% said that in this case they reduced daily expenditures or sold something they owned. In a situation where financial resources are scarce, therefore, purchasing prescribed drugs may compete with other basic needs and even impair the productive resources of the households.

Among the people who were able to tap other people's resources, solidarity networks seem to play a remarkable role in the search for money to pay for prescribed drugs. The capacity of households to meet the cost of prescribed drugs is proportionately greater (this varies according to regions) in households whose head belongs to a religious, social, political or trade union organization.

Thus, in the survey as a whole almost 85% of households headed by a member of a social organization succeeded in paying for the prescribed drugs, against 68.2% of the households not in that position. 79.1% of households whose head belonged to a religious organization and 76.3% of those in which she/he was a member of a political or trade union organization said that they could generally manage to pay for prescriptions, as against 67.1% and 68.5% respectively of those not in that position.

Other results support this analysis: households with a relative exercising political or administrative responsibilities were able in 82.3% and 85.4% respectively of cases to pay for the drugs prescribed; only 67.8% of those who did not have relatives in such positions could do the same.

Household membership of family or social solidarity networks undoubtedly makes it possible in the short term to resolve the problem of affording drugs in a large number of families with inadequate financial resources. However, in the medium and long term, in the absence of measures to promote better availability of drugs in health care establishments, this type of solidarity will merely accompany or even contribute to an increase in the present inequalities in access to drugs.

Conclusions

Willingness to pay for drugs: drugs are seen as a priority and households spend precious resources to procure those which have been prescribed. Unfortunately such drugs are not always essential. 80% of the prescribers did not know the concept of essential drugs and for 77% of them medical representatives were their principal source of information. It is clear that there is an urgent need to inform not only the prescribers but also the public, and to rationalize drug consumption.

Ability to pay: this is probably much less than hoped by many health policy makers. Any cost recovery scheme should be planned very cautiously so that it does not exclude a portion of the population. Most important, rationalization at all levels in the public sector should be the first step before asking the poor to pay.

Community solidarity: this certainly exists, and we need to determine how to draw on this in ways which reduce rather than enhance inequality and promote real forms of social solidarity.

References

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