

Equity Issues in MeTA Country Reports – Overview

Issue	Ghana	Jordan	Peru	Philippines	Uganda
<p>Identification of barriers in poor and disadvantaged people’s access to medicines</p>	<p>Most facilities have charged formal or informal fees for services and/or commodities. This has been a major barrier to accessing care, including medicines</p>	<p>15-30% of population are below poverty line. What are implications for their access to medicines? Are there specific issues regarding Palestinian refugees’ access to health care & medicines?</p>	<p>Access to essential medicines by the poorest segments of the population is jeopardised by a combination of barriers on: price, physical access (especially in rural areas), availability (as essential drugs may not be available) and quality (both “market” incentives and weak regulatory mechanisms allow low quality medicines access to the market).’</p>	<p>High income and health inequalities. 40% of population live on <\$2/day. Barriers to access related to poverty (30-40% of people cannot afford essential medicines). Also region/ conflict (Mindanao). Lack of availability of small number of drugs that should be free in public sector outlets.</p>	<p>Medicines are expensive in private sector (retail pharmacies, drug shops and dispensing doctors) and unavailable in public sector (where they should be free)</p>
<p>Analysis of disadvantaged people’s patterns of medicines access and use</p> <p>(No systematic analysis for any of countries)</p>	<p>N/A</p>	<p>N/A</p>	<p>About 70% drugs purchased without prescription (across quintiles). Role of <i>jaladores</i> (brokers) obtaining medicine for patients at lowest prices but may involve compromise on quality.</p>	<p>47% health spending out of pocket. Any breakdown by quintiles? Low compliance with treatment regimes for chronic conditions due to high cost of drugs. In 6 months in 2006 44% Filipinos bought generic drugs in a 6-month period in 2006,</p>	<p>1/7 compliance with ARV regimens – due to poverty?? Quality of generics is generally mistrusted, implying that people unnecessarily spend scarce resources on more expensive branded drugs which they</p>

				while 17% bought branded and generic drugs implying that focus on essential drugs may meet health needs of majority. 95% of medicine supplied by private outlets and hospitals. Middle & low income people purchase drugs from drug sellers (mainly), public hospitals and socially franchised outlets.	perceive to be of higher quality.
Existing policy to enhance access to medicines	<p>Principles of equity and people-centredness are central to health sector Programme of Work 2007-11</p> <p>National Health Insurance Scheme – up to 70% of the population is exempt from contributions – e.g. all children under 15 years of age are exempt. A stated 95% of health conditions are</p>	Health insurance – 68% insured, 32% not insured. (55% through NHI, 18% through refugees' insurance and 7% private insurance).	<p>Medicines supplied through public health network incur 25% mark-up.</p> <p>Free medicines (a) drugs for specific diseases treated in the public sector (TB, malaria, AIDS, leprosy and others) and (b) vulnerable population groups (pregnant mothers and children). Aim to increase to universal coverage but funding unlikely in the near future.</p>	PhilHealth insurance programme covers 50 - 85% population for basic care. Working on expanding outpatients benefits' coverage (likely to pilot a chronic disease area of high public health importance, such as prevention of cerebrovascular and cardiovascular disease, which would cover anti-hypertensive medicines), including the package of medicines to be included in the reimbursement	Free essential drugs in public sector clinics; free primary health care treatment.

	<p>covered by the NHIS, which reimburses providers in all three sectors according to set tariffs. There is no co-payment by patients, for services or prescriptions. Broader GNDP-led efforts to strengthen cross-government collaboration on medicine policy issues, and work on patient and provider education on rational drug use and other medicine issues (e.g. use of ACTs)</p>			<p>scheme and accreditation of health facilities who would be eligible for reimbursement through their programme Voluntary agreements of 20% drug price reduction to older people in public outlets, which should not charge more than 35% mark-up to anyone.</p>	
<p>Proposed activities likely to benefit poor/disadvantaged</p>	<p>Proactive dissemination of existing data (on quality, availability and pricing Improved quality testing particularly sample testing in rural areas,</p>	<p>Ethical medicines promotion Dissemination of information to prescribers and patients on the quality of generics Improved rational use of medicines with a focus</p>	<p>Research on poor people's access to medicines using the General Household Survey (GHS) Otherwise too early to specify</p>	<p>Revision of PhilHealth reimbursement mechanisms for medicines, development of affordable outpatient benefit package pilot (with support of the WHO Collaborating Center at Harvard</p>	<p>Disseminate price and quality info via media (print, radio, SMS) Research into dispensing doctors' high prices and unavailability of public sector drugs.</p>

	<p>incorporating sentinel sites where people actually purchase / consume medicines</p> <p>Suggested focus on malaria medicines and possibly reproductive health commodities would bring strong equity focus, as both are crucial to reducing high child and maternal mortality, where poorest are disproportionately affected.</p> <p>Ensuring that strengthened capacity on accountability leads to greater public understanding – recommend translating data and analysis emerging through MeTA into clear messages, in a range of local languages.</p> <p>Strengthening</p>	<p>on physician prescribing behaviour and standard treatment guidelines (how far is this likely to reach disadvantaged people? How far do they access medicines via doctors/ with prescriptions?)</p>		<p>School of Medicine and Boston University)</p> <p>Address patient empowerment: better information on benefits package, prices, quality seals, quality-assured alternative sources of supply.</p> <p>Identify action plans for existing strategies and new strategies where there are gaps for reducing patient prices of essential medicines (e.g. implementation of Generic Medicines Act; review of hospital policies for drug pricing to patients which rely on substantial medicines mark-ups to cross-subsidize other services, and barriers to competition for hospital medicines)</p> <p>Develop alternative strategies for supplying affordable, quality essential medicines at the community level, especially in poor and</p>	
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	reporting and debate of medicines issues on community radio will be key.			rural areas. Provide support for safety and quality at the community level (adoption of acceptable minimum safety and quality standards for community dispensing at the BnB level; program of action against unregistered sellers) Ethical medicines promotion. Develop easily usable and transparent reporting system for physicians and patients to submit complaint on quality of medicines	
Activities that could be designed to enhanced impact on poor/ disadvantaged	Activities outlined should already have positive impact on poor and disadvantaged.	See above	Too early to specify	Update HAI pricing survey focusing on particular therapeutic areas (Possibility to select these with a view to burden of disease on poorest?) Dissemination of results (on ‘quality seals’) to physicians and patients to counter false perceptions on the	Further detail of plans needed to comment.

				quality of generics and help promote rational prescribing –extend impact by also targeting drug sellers?	
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Other comments:

- 1) No reports discuss issues of social exclusion and access to medicines systematically eg gender- or age-related barriers to health care and medicines. This may reflect MeTA’s ‘upstream’ focus. However, this broader equity analysis is an important part of the background analysis that is needed in each country. Otherwise MeTA may end up inadvertently worsening the position of certain social groups.
- 2) No reports discuss how increased accountability and transparency could specifically benefit poor and disadvantaged people, though it may be inferred from some of the analysis and proposals. Also there is no discussion of possible perverse effects eg capture by middle classes and unintended outcomes. This analysis is needed.
- 3) Some thought needs to be given to how poor and disadvantaged people’s concerns will be represented in MeTA country coordinating groups and wider stakeholder fora.