



Pharmacy system performance and integration: two essential conditions for the success of free healthcare measures in Côte d'Ivoire

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The free healthcare measures decreed in 2011 and 2012 in Côte d'Ivoire further weakened a drug supply chain that had been precarious for several years. Rapid depletions of stocks of medical inputs and of financial resources paralyzed the healthcare system. The free healthcare measures need to be revisited and properly funded, and their implementation must be improved to meet the population's health needs. The drug supply chain is also in need of its own reform.

INTRODUCTION

In April 2011, after the post-electoral crisis, the government of Côte d'Ivoire decreed health services to be free of charge in public health centres (HC) for the entire population and for all services, examinations, and drugs [1]. This "generalized free healthcare" measure was presented as the first step in a more comprehensive reform leading to universal medical coverage as part of the President of the Republic's "Vivre Ensemble" (Living Together) program. This free healthcare immediately increased the use of healthcare services and brought the population's healthcare needs into the spotlight. However, as the healthcare system had not been prepared, it encountered difficulties, and in March 2012 the Ministry of Health and AIDS Control (MSLS) and the Ministry of the Economy and of Finance were obliged to move instead to "targeted free healthcare" [2]. The problems persisted, especially the problem of drug shortages. In this policy brief, we analyze the effects of these two free healthcare measures on the drug supply chain [3].

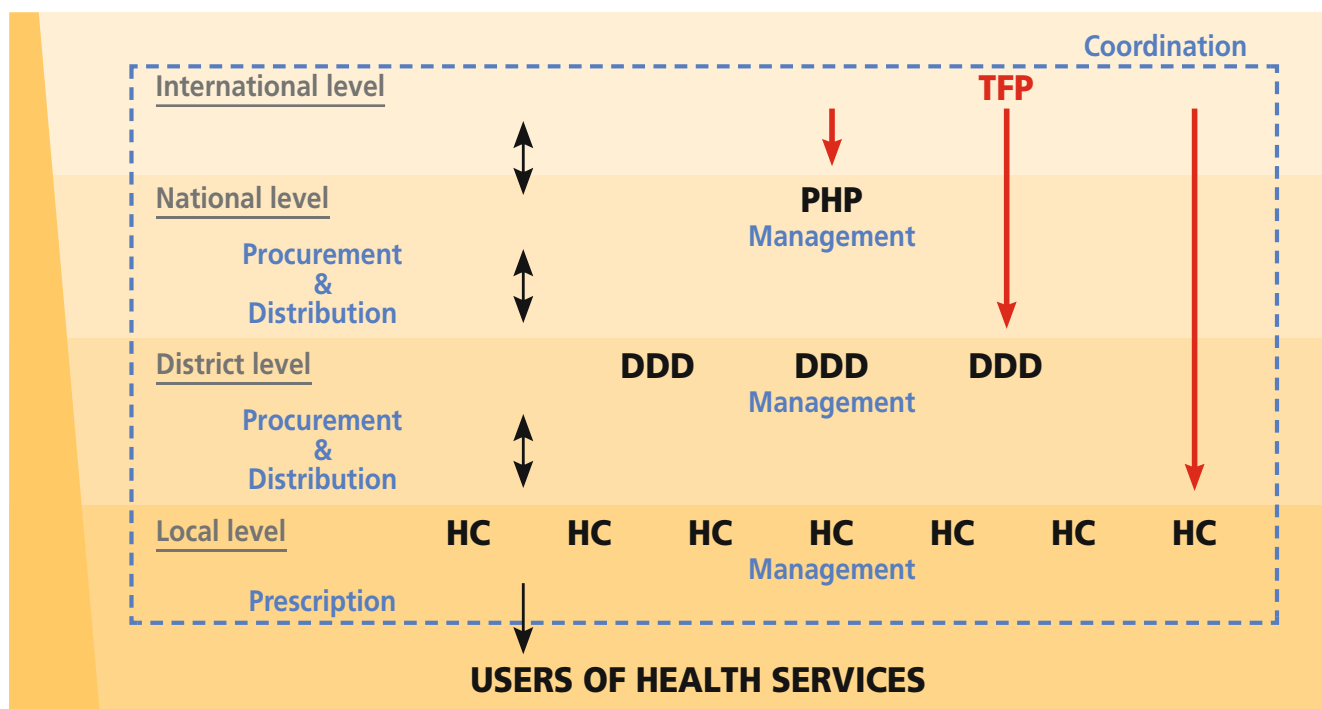
METHOD

This was a multiple case study focused on free integrated healthcare for childhood illnesses, malaria, and childbirth services. Two cases were analyzed: generalized free healthcare and targeted free healthcare. The approach was qualitative, using documentary review, semi-structured interviews (n=33) and observations in two district distribution depots (DDD) for medical inputs and six HCs. Data were collected between May 23 and June 6, 2012, at the central level and in two health districts, one supported by a non-governmental organization (NGO) and the other not, thereby allowing comparisons to be made. The six HCs were selected in consultation with the district management teams and the managers of the NGO involved according to criteria related to geographic access and performance. The analysis described in this policy brief addressed the channels for pharmaceutical inputs: purchasing, distribution, management, use of pharmaceutical inputs, and coordination.

RESULTS

The figure illustrates the channels for pharmaceutical inputs from the international to local levels. The main functions studied for each level, and between levels, are indicated in blue. The black double arrows represent the normal channel for pharmaceutical inputs between levels. The public healthcare pharmacy (PHP) is the national procurement centre. It supplies the DDDs, which then supply the HCs. However, certain technical and financial partners (TFP) bypass all or part of the PHP (red arrows).

Figure. Simplified channels for pharmaceutical inputs in Côte d'Ivoire



When healthcare is free, the drug supply chain suffers from inadequacies directly linked to the user fee exemption measures as well as from the exacerbation of its own weaknesses.

Inadequacies related to exemption measures that are detrimental to the supply chain

Planning. Both free healthcare measures (2011 and 2012) suffered from a lack of planning. Medical emergencies covered by the targeted free healthcare were not clearly defined. This was the case for complications, length of hospital stays, laboratory tests, etc. No list was drawn up of drugs associated with the various pathologies exempted from payment. Also, targeted free healthcare was interpreted differently in each HC: exemptions for medical acts only, exemptions only for some acts or inputs, such as delivery kits or ACT, etc. There were major differences in the implementation of free healthcare for children under the age of five years. Most often, only treatment for the most common pathologies was really free for patients.

Funding. The generalized free healthcare measure was only very partially funded. The presidential emergency program provided 3 billion francs CFA (F CFA) for the PHP. The MSLS released 7 billion F CFA (of the 30 billion announced in the emergency fund) and the Agence française de développement (AFD), 5.3 billion F CFA, both amounts destined for national public institutions (NPI) [4]. This combined 12.3 billion F CFA, in fact, only covered the debts that had been accumulated by the NPIs before free healthcare. Added to these funds were inputs provided by certain TFPs (UNFPA, the Global Fund, WHO, UNICEF, NGOs, etc.), which were not attributed a monetary value. The targeted free healthcare measure was estimated to require 90 billion F CFA per year but had not yet been budgeted. At the time of our study, no funding had yet been released by the State, including funds promised as part of the two free healthcare measures to cover contract workers' salaries, incentive premiums, operating costs, etc., in public and private HCs. The European Community Humanitarian Office (ECHO) provided a significant contribution through UNICEF and four NGOs.

Reimbursement system for HCs. The reimbursement system constitutes a major weakness in the implementation of free healthcare, as is the case in other countries of the subregion [5]. The team in charge of this policy in the financial affairs department of the MSLS has been reduced and the tools for managing targeted free healthcare had still not been validated at the time of our data collection, even though they had been implemented since March 2012.

Separation of drug stocks. The PHP asks districts to separate the management of pharmacy products "normally" paid by patients from those prescribed free of charge, and to make up for any shortages by moving drugs between stocks as needed. This is a surprising recommendation that, in practice, is implemented unevenly from one district to another.



Financial situation of HCs. According to the local managers, because the State has not adequately fulfilled its third-party payer role, the HCs have used up their financial reserves and are now unable to replenish their drug stocks, pay the contract workers required for their functioning, pay staff premiums, or deal with needed maintenance and repairs.

Exacerbation of weaknesses in the drug supply chain with free healthcare

PHP¹. In July 2010, well before the free healthcare measures studied here, the PHP's situation was already precarious. It had only 2.5 billion F CFA of stock to cover needs estimated at 25 billion F CFA, and calls for tender were too far apart in time to warrant any hope of stock replenishment [6]. By the end of 2011, following the introduction of generalized free healthcare the previous April, the PHP provided services only to vertical programs and with emergency international aid [3]. For targeted free healthcare measures, pharmaceutical input needs were estimated at 22 billion F CFA for emergencies, 5 billion for children, and 4 billion for pregnant women. The presidential emergency program provided only 3 billion. Thus, the PHP has urgent needs in terms of financial liquidity and the procurement of pharmaceutical products [7]. The rate of satisfaction in the districts regarding orders from the PHP dropped from 30% before free healthcare to 10% after (but 25% in districts receiving NGO support).

Coordination. The management of pharmaceutical products procurement at the national level is also complicated by the fact that there is no consultative structure within which drug-related issues can be specifically addressed [8], despite the involvement of numerous national programs and international TFP's (UNFPA, the Global Fund, WHO, UNICEF, NGOs, etc.). For this reason, many of those actors bypass the PHP, purchasing and distributing pharmaceutical inputs themselves.

Quantification of needs. While there is distribution data available from the PHP and DDDs, there is no data on HCs' consumption of these products. The HCs do not maintain any reserve stock. Some TFPs also provide drug supplies to HCs in ways that are often unpredictable and sometimes without taking into account their actual needs. Under these conditions, it is impossible to quantify needs. In any case, there was no anticipation of any increase in needs when the free healthcare measures were put in place.

Distribution. There are weaknesses in the means of distribution all along the supply chain: lack of vehicles, maintenance problems, insufficient financial resources to cover transport, etc.

Management of stocks. The requirement that "free" drug stocks be managed separately is a common principle for the management of pharmaceutical inputs, as in most vertical programs. Aside from the latter, we counted up to six different stock management systems in a single HC, including those for normal cost-recovery stocks, for drugs designated "free" by the MSLS, for drugs received from an NGO, for drugs used by nurses and those used by midwives, etc. Drug expiry rates are high. This situation cannot be improved, as training and supervision for drug management are too infrequent.

Use of medical inputs. Training and supervision are also inadequate when it comes to the rational use of medical inputs, especially since national diagnosis and treatment protocols are not disseminated.

CONCLUSION

The free healthcare measures studied in this policy brief have further weakened a drug supply chain that had already been precarious for several years. Rapid depletions of stocks of medical inputs and of financial resources have paralyzed the system at both the central and peripheral levels. When drugs are not available in public HCs, users are obliged to buy them from private pharmacies, on the street, etc.; this encourages patients to consult elsewhere (private sector, traditional practitioners, etc.). As a result, costs are often higher (drugs, transportation, etc.) and people's confidence in the public healthcare system is greatly eroded. NGO support helps to mitigate the situation for some HCs but still does not bring it to an acceptable level.

The free healthcare measures decreed in Côte d'Ivoire need to be revisited and properly funded, and their implementation must be improved to meet the population's health needs, which were revealed - as if that were necessary - when free healthcare was introduced. While the drug supply chain must be taken into account when reforming the free healthcare policy, it also warrants its own reform.

(1) As this policy brief was being drafted, the PHP was undergoing extensive reform: change in status (becoming a non-profit organization), creation of a board of directors, election of a board chairman, etc.



KEY RECOMMENDATIONS

- ➔ Strengthen the PHP : modify its status, improve procedures, make available sufficient operating funds to meet the needs, integrate parallel channels, improve procurement and distribution logistics, etc.
- ➔ Organize a comprehensive and computerized management of pharmaceutical inputs.
- ➔ Set up a consultative structure to address issues related to pharmaceutical inputs and promote the dissemination of technical information and documents.
- ➔ Reinforce competencies and supervision regarding the management and use of medical inputs.
- ➔ Clarify (with clear definitions of intervention kits, lists of associated pharmaceutical inputs, etc.), reorganize, and fund (based on cost studies) the user fee exemption measures.
- ➔ Improve the implementation of these user fee exemption measures, particularly the reimbursement system (third-party payer function).

This note and other documents on the financial accessibility of healthcare services in West Africa are available on the websites: <http://equitesante.org/helpburkina>, <http://www.help-ev.de/en/projects/burkinafaso/> (NGO Help), <http://www.medecinsdumonde.org/Nos-Combats/Priorites-d-action/Promotion-de-la-sante-sexuelle-et-reproductive-SSR> (Médecins du monde-France) and <http://www.oxfamfrance.org/-Sante-> (OXFAM-France).

The authors wish to thank Professor M. Samba, Director of Forecasting, Planning and Strategy at the MSLS, Côte d'Ivoire, and Professor A. D. Yapi, Executive Director of the Côte d'Ivoire PHP, for their collaboration in the conduct of this study.

References

- [1] Circulaire 001/MSLS/CAB/DGS, April 16, 2011.
- [2] Ministerial decree No. 0047 MSLS/MEF/CAB, March 21, 2012.
- [3] Belaid L., Baudry M., Queuille L., Ridde V. Rapport d'étude sur les intrants pharmaceutiques dans le contexte des mesures de gratuité en Côte d'Ivoire. CRCHUM/HELP/MDM/OXFAM/ECHO, 2012.
- [4] <http://www.presidence.ci/presentation-detail/13/le-programme-presidentiel-d-urgence-sociale>
- [5] Olivier de Sardan J.-P., Ridde V. Les contradictions des politiques publiques. Un bilan des mesures d'exemption de paiement des soins au Burkina Faso, au Mali et au Niger. *Afrique contemporaine*. 2012;243(3):13-32.
- [6] Pidault P., Blanchot M., Barbereau S., Kone Bamba D., N'Guessan Koffi T. Etude situationnelle de la Direction de la pharmacie et du médicament (DPM), du Laboratoire national de santé publique (LNSP) et de la Pharmacie de santé publique (PSP) de Côte d'Ivoire pour un renforcement de la régulation pharmaceutique et l'amélioration de la disponibilité des Médicaments essentiels génériques (MEG) dans les FS. Programme FED pour la Côte d'Ivoire. July 2010.
- [7] Atelier Santé Côte d'Ivoire 2012 "Partenariat pour la transition en Côte d'Ivoire", ECHO/EuropeAid 2012.
- [8] Noirhomme M. Appui à l'atelier sur la stratégie d'exemption pour les parturientes et les enfants de moins de 5 ans. Agence Européenne pour le développement et la santé 2012; Abidjan, January 10-11, 2012.