Development of a standard manual to investigate access to chronic disease medicines, supplies and care

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Abstract

This paper reviews two surveys that investigated access to diabetes medicines, supplies and care and discusses the development of standard methods from the surveys. Surveys based on a rapid assessment protocol were conducted in Vietnam and the Philippines. The surveys showed some similarities and differences. They suggested future application of methods to policy-oriented research for other chronic diseases and in other middle- and low-income countries.

keywords access, chronic diseases, essential medicines, health services research

1. Introduction

Chronic non-communicable diseases (hereafter chronic diseases) have human and economic impact through impaired quality of life, premature death and other adverse effects. It is estimated that chronic diseases account for 60 percent of all deaths or 35 millions deaths in the world in 2005. They are now rapidly spreading in middle- and low-income countries and 80 percent of deaths caused by chronic diseases occur there.\(^{1}\)

The rise of chronic diseases in middle- and low-income countries involves more serious issues than the epidemiological transition in industrialized high-income countries in the past. The current change in middle- and low-income countries is being compressed into a shorter time frame than was experienced in high-income countries before. The burden of chronic, non-communicable diseases is increased where the burden of acute communicable diseases still exists. As historical experience shows that rapidly spreading diseases are likely to have a disproportionate effect on the developing world, the impact of the current increase of chronic diseases in such countries, especially on poor and disadvantaged populations, is cause for concern. The World Health Organization (WHO) warns that it may contribute to widening health gaps between and within countries.

In poor countries, less attention to these diseases has been paid by policy makers, aid donors and academics than to acute, communicable diseases. For example, few studies have examined patients’ access to essential medicines for chronic diseases, although it is important that affordable medicines and care are available to control the diseases. There is a need to address the potential impact of the rising trends of chronic diseases, which may overburden both the health system and household and thus impact on development.

Diabetes is one of the most important chronic diseases and Asia will be the region in the world to see the largest increase in prevalence of diabetes. Vietnam and the Philippines are part of it. The International Diabetes Federation estimates that the prevalence of diabetes in adults in the 20-79 age groups for Vietnam is 2.5% and in the Philippine 6.5% and will be
3.5% and 8.1% in 2025 respectively. Both have similar size populations (around 86 million). The countries followed policies of decentralization in 1990’s, and are in the process of trying to achieve universal coverage with health insurance. According to World Bank’s classification, Vietnam is categorized in the low-income group and the Philippines in the low-middle income group.

This study aims 1) to review two surveys in Vietnam and the Philippines that investigated access to chronic disease medicines, supplies and care, and 2) to discuss future development of standard methods based on experiences in the two countries.

2. Rapid Assessment Protocol for Insulin Access (RAPIA)^2 and a modified version

Prognosis of insulin-dependent patient is poor due to difficult access to insulin; however, merely increasing insulin supply cannot solve the root of the problems. Recognizing these facts, the Rapid Assessment Protocol for Insulin Access (RAPIA) was developed by the International Insulin Foundation (IIF). The framework of the RAPIA studies the path of insulin to the point that it reaches or the point that it fails to treat the patient effectively. Although it initially focused on insulin and patients with insulin-dependent diabetes, it now also includes oral diabetes medicines and patients with noninsulin-dependent diabetes. The RAPIA aims to identify possible barriers to access by gathering information at different levels of the health system through multiple data sources. Fifteen questionnaires have been developed for different target groups from the relevant ministries at the central level to health professionals and patients in the community. Respondents are purposively sampled including the private and public sectors.

A similar survey on diabetes care was planned in the Philippines modifying the RAPIA methods. Questions were adapted to make them suitable for the highly decentralized health system. Reflecting the country’s complex health situations, more health professionals and patients in the community were interviewed than in the original RAPIA, simplifying each questionnaire. The Philippine survey was also intended to test future possibilities for wider application of the methods to other chronic diseases and in other countries so that many researchers can utilize them in their own situations.

3. Vietnam and Philippine surveys^3, 4

Each survey was independently conducted to identify the barriers to diabetes medicines, supplies and care in each country in 2008. In Vietnam, 190 interviews were conducted in four sites, including the two biggest cities, and in the Philippines, 359 respondents in five sites, including the capital city, were interviewed. The Vietnam survey was conducted as the first RAPIA implementation in Asia by the RAPIA developer (DB). The Philippine survey was planned by another investigator (MH). Selected findings from each survey and common recommendations are as follows:

**Vietnam:**

**Procurement and supply** The Ministry of Health prepares guidance prices for different medicines. These are used by each facility to prepare their individual tenders. Beside few exceptions, insulin and oral diabetes medicines were readily available in both the public and private sector.

**Accessibility and affordability** Public insurance covers both inpatient and outpatient services. Some people in preferred to pay out-of-pocket as they felt they received better
services. Government guidance prices for medicines are higher than those available on the international market.

**Policy environment** A program to control non-communicable diseases for the period of 2002 to 2010 was approved in 2002. Based on this, a preliminary National Plan for Diabetes was prepared. Due to decentralization, the impact of policy decisions at the central level on actual practice is hard to quantify.

**Standard treatment** No national guidelines were observed. Some hospitals have developed their own guidelines based on guidelines from other countries.

**Diabetes group** Diabetes clubs exist at different facilities and in different provinces. Their aim is to provide support and education to people with diabetes. Clubs are dependent on healthcare workers at facilities to manage their activities.

**Adherence** The high cost of treatment and medicines and a lack of adequate information were seen as two main problems with regards to patient adherence.

**Philippines:**

**Procurement and supply** Public facilities procure medicines through the public bidding at each local government unit based on the annual procurement plan. It was suggested that a bidding price be influenced by the amount of procurement and geographical convenience for bidders. Availability of medicines at public pharmacies was low, which made patients to use the private sector where the price of medicines is higher than in the public sector.

**Accessibility and affordability** Public insurance does not enable patients to obtain care for chronic conditions in outpatient services. Many people believed that contribution was not worth the benefits. It was suggested that health insurance schemes, in particular, “Individually Paying Program”, were inconvenient to use. A series of policy efforts in the Philippines to lower medicines prices is not functioning well.

**Policy environment** Reduction of mortality and morbidity from lifestyle-related diseases, including diabetes, is listed as one of the goals of the National Objectives for Health 2005-2010. Because of decentralization, dedication to implement the program varied among local government units.

**Standard treatment** Treatment and management of diabetes was dependent on the physician. Specialist doctors individually referred to available guidelines, usually, American or European one. Standard management guidelines for general practitioners were not observed, but it was reported that they would be published soon.

**Diabetes group** Diabetes-related activities varied among surveyed provinces. In two of the five areas visited, it was reported by the health offices that no diabetes patient support club existed. Establishing and continuing a club seemed to rely on the availability and leadership of physicians in the area.

**Adherence** Intermittent medication due to financial constraints was frequently suggested. Household financial issues were much more highlighted than any other factors.

**Common recommendations from both surveys:**

Specific findings and recommendations were presented in each country. Common issues suggested a need to define role of each level of the decentralized health system in the struggle against the increase of chronic diseases. It is also necessary to utilize public health insurance for the continuing care of diabetes in order to achieve better patient adherence. This may reduce burdens both of patients and society. Patient adherence to diabetes care should be promoted in both countries. To support this, a stable and effective procurement system,
pricing mechanism for affordable medicines and standard treatment guidelines are required simultaneously.

4. Development of standard methods

Many middle- and low-income countries have not yet established effective strategies to tackle the rapid increase of chronic diseases. Research, like that in Vietnam and in the Philippines, is required to describe the present situation of single or multiple chronic disease(s) as well as to identify possible barriers to access to medicines, supplies and care for the target disease(s) in a country. Methods used in Vietnam and the Philippines are suited to such objectives because of characteristics of the rapid assessment protocols like pragmatism, speed, use of multiple data sources and cost-effectiveness. It is important to get a picture of the health system for different stakeholders involved in the target disease(s) in a given country to make recommendations for action. The process is expected to raise awareness of the disease and to increase the availability of the data required for this survey.

Standardizing methods will be useful for countries for several reasons. Firstly, such countries usually cannot afford to devote much time or resources to conducting research. Applicable standardized methods will save time and resources in developing survey methods. Secondly, as controlling a disease often needs regional strategies beyond national level, standardized methods will be helpful for cross-country comparison to contribute to broader regional policy issues.

However, some issues might cause concern. As the methods used are based on a rapid assessment protocol that originates from an anthropological idea, some may think it unsuitable for standardization. Furthermore, since purposive sampling is applied, some may think that it lacks scientific rigor, in particular to deal with quantitative data. Standardized methods will need to be tested in more countries so that above-mentioned issues can be solved.

5. Conclusion

Health systems in many middle- and low-income countries need to develop strategies for managing chronic disease. Experiences in Vietnam and the Philippines have shown a way forward.

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References
