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*Zugang zu Medikamenten*

***Economical solidity a precondition for equity***

# Manageable Bamako Initiative schemes

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*Based on experience with implementing revolving drug funds at district level in subsaharan Africa focus is put on the manageability of such schemes. The community itself should have ownership over drugs, materials and money. People's representatives must be able to manage the scheme in a safe and sustainable way. A well functioning community financing scheme has many positive effects besides health. It contributes to education, independency, self-assertiveness, commitment, motivation, and it diminishes poverty.*

In the move after the Alma Ata Declaration (1978) Village Pharmacies where created. Well before the Bamako Initiative was declared (1987), community financed essential drug schemes at village and communal level were realised. Later operational research on health systems' financing in East- and West-Africa contributed to a broader understanding.

Community involvement was often the critical issue. It usually was low, because of lack of communication, information and education. Keeping knowledge and power within the administration is easier than getting exposed to the critics of populations. A common feature of governmental services is the lack of true commitment for people's health. Low staff moral and ethics are a consequence of inadequate salaries and the lack of choice of civil servants to go and work where they wish to.

After Primary Health Care, The Bamako Initiative (BI) is an other attempt to give tools for health improvement into the hands of people. This paper looks at the issues which contribute to make Bamako Initiative schemes managerially and economically sound.

## Bamako Initiative (BI)

The 1987 conference of Ministers of Health under the auspices of WHO and UNICEF was a turning point for official health policy. Experience with revolving drug funds and community financing schemes are older. Mainly the private not for profit sector often charged for drugs

and services. If quality of care is high, clients are more willing to pay. But not all are able to pay. This has been a major concern for the international researchers. Studies on equity abound. An important source for inequity is giving exemptions to those who do not really need them.

Before it can be equitable, a BI-scheme has first to function. This aspect has been neglected. In order to function a system owned by the community has to be manageable by lay persons. Depending on the level of education and experience with management of money and stocks, the scheme has to be devised very simply.

If sustainability of the system is achieved a majority of the population will profit. People have now easy and regular access to drugs and services at the dispensary next door. A BI-scheme, even if no exemptions are allowed, can bring about marked equity-improvement.

Attention of the international research community is focused on the very poor. This is unfortunate for many reasons. Western concepts of poverty, i.e. having little money, are often not sufficient. Poverty in Africa has to do as well with social and or cultural isolation, with lack of education, with marginalisation, with absence of power. Communities have traditions in dealing with the deprived as this problem is not new. Solutions for the destitute should come from inside, rather than being imposed by external advisers.

Here the term BI is used to describe a variety of schemes having a few common features: Decentralisation of management at least to district level; payment by the users of drugs and/or services; ownership and management of stocks and money by the community; provision of a limited choice of essential drugs under generic names; efforts towards rational prescribing and use of drugs; revenue invested for health at the point of collection. The actual implementation of BI-schemes varies widely. Denomination also vary: Cost sharing, revolving drug fund, community-financing etc.

It is important to recall the reasons why the BI was declared in 1987. For years governmental health services were degrading, drugs and items became less available, corruption and self-service by the demoralised staff was common, personnel was plethoric but often not present at the working place, salaries became inadequate and irregular. Governmental health systems were characterised by centralisation of decision making. Staff movement, allocation of supplies, control and sanctions were teleguided by usually ineffective and partially corrupt central bureaucracies.

From this situation a big majority of the population was badly suffering. Drug shelves in state dispensaries were empty for month. Only the rich could afford to go and by drugs in the private pharmacy or to drive to town to a private practice or a charging hospital.

The at that time "République populaire du Bénin", was one of the first who could not stop the spontaneous introduction of small self-financing schemes even within the governmental sector. The state had nothing better to offer because support by communist countries was drying out.

Bilateral cooperation was given freedom to implement financing systems often inspired by the positive experiences from mission-hospitals. A diversity of community financing schemes were implemented. These were presented as successful examples to the Bamako meeting in 1987.

A crucial issue is whether peripheral health structures are allowed to keep their income decentrally and to use it according to their own decisions. Only where this is the case, there is real decentralisation and the possibility to become proactive for improvements of services and health.

# Manageability of a revolving drug fund

Whether a revolving drug fund at dispensary level is easily manageable by the owners themselves depends on several interlinked factors.

**Simplicity - price per item:** The simpler the better. An economic management system understood by (nearly) everybody is the one omnipresent on markets and shops. Each item has its price. The customer gives money and receives the goods. A community financing scheme is best understood where each item of drug or each service has its fixed price and is paid for at the moment of use. Control is easy, as the accounting system becomes straight forward.

**Transparent system:** Price per item of drugs is the only BI-system allowing full managerial control. As soon as a combination of services (e.g. consultation + laboratory exam + drugs) have a package price, it becomes difficult to control whether full value for money has been provided. If the treatment of malaria is defined as Chloroquine and Aspirin tablets, the drug-dispenser can "forget" to hand out the Aspirins. Prepayment systems, price for full treatments (independently on how long and what drugs they need) might be more equitable, but are difficult to control, mainly in an environment where moral is low.

**Realistic prices:** Prices must be realistic in order to allow for replenishment of stocks. Full cost recovery makes the revolving drug fund independent from foreign aid. In addition expiries have to be compensated and a surplus created which can be reinvested into the health system. Prices to patients should be the same at all levels of a district health system.

**Provision of what is needed:** Decentralisation means allowing the dispensary to buy what they need. The requisition system of drug provision allows autonomy and minimisation of expiries. The national essential drug list gives the guidelines. Implementation is the responsibility of the district. Centrally provided standard drug kits inhibit in the long run autonomy and lead to substantial wastage.

**Straightforward accounting system:** Let us take as an example the sale and provision of Chloroquine tablets. One tablet costs 10 MU (Monetary Units). An adult patient needs a full treatment, i.e. 15 tablets. With his prescription he goes to the dispensing window, gives 150 MU and receives 15 tablets of Chloroquine. At the end of the day the dispenser has sold 200 tablets and has cashed 2000 MU. The dispenser has always 2 tins of Chloroquine. As soon as

one tin is empty, he asks for a full one with the in charge of the main drug stock. The dispenser gives 10'000 MU and receives a tin with 1000 tablets of Chloroquine. Once every few months the "in charge" replenishes the main drug store. He goes and buys drugs at the Medical Stores at a higher level of the health pyramid or even in the private not-for profit sector. Whenever drugs are changing hands, the equivalent amount of money is given in return. In order to function, the system must first be filled with drugs. These are the initial stocks on all levels. Foreign donors often do provide them.

**Truth, Banking:** In the periphery such a system functions with hardly any written records. All is tangible: drugs, material and money. A proverb says "paper accepts everything". Records do not necessarily reflect reality. Depending on the infrastructures of the region, at some level cash-money has to be banked. In cities it could be done daily. In the periphery travelling to the bank should be done at least monthly. The receipts and records from the bank provide the best available truth on the income and the treasury situation. If no safe bank is available, keeping money has to be carefully organised and deeply rooted in the community. In any case it is advised not to accumulate money but to spend it by investing it into the health system and into health in general (co-financing water-supply and sanitation for example). In Dar es Salaam the committee decided that all income money should be banked without any exception. Whenever money is to be spent a cheque has to be signed jointly by a community representative and the in charge of the dispensary.

**No exemptions:** First a BI-scheme must be economically and managerially sound and sustainable. Health workers themselves often ask for exemptions, then their families and why not civil servants from other departments (education, agriculture etc.). After external aid stops, such schemes often collapse. Exempting the very poor would be laudable but is difficult to achieve. The BI-scheme adviser is on the safe side if giving priority to the economically soundness and sustainability, providing thus a solid base for limited locally devised and controlled exemption schemes.

**Immediate clarity:** Book keeping, both on drugs and money, must be thus that at any moment the stock and financial situation can be defined. The dispenser will probably count the cashed money daily and compare it with a record of the sold drugs. The in charge of the main drug stock will perform similar calculations maybe weekly. The dispensary as a whole will balance money against drugs monthly or trimestrially. Losses or errors are detected rapidly and corrective measures can be taken.

**Autonomy, full control over all steps:** Financial management procedures must be feasible by the implementers themselves (staff and community representatives) whenever they want or need to. They should not have to wait for a big inventory exercise conducted by controllers from outside. Regular supervision should accompany the process and can give hints for possible improvements. People themselves should have full power over the control mechanisms they put into place. They should be advised to have the revolving drug system audited regularly.

**Adaptation to the local circumstances:** The drug and money management system must be adapted to the local level of understanding, of technology, of safety, of moral. It can be fine tuned and further developed by people themselves. Studying carefully other similar projects already functioning in the area (from NGO or mission-hospitals, on the market, in shops, with cooperatives etc.) helps to find adapted solutions. Experts from industrialised countries tend to take managerial skills for granted, which are not part of the local culture or education. In Bénin, on dispensary level, records where kept manually using exercise-books, as those where available even in remote areas. Different exercise-books where used for income and expenses, for cash money and banked money. It had proven ineffective to combine too many transactions into one record.

**Flexibility for improvement:** A manageable system can not be static. As soon as difficulties appear, problem solving should take place. The classical reporting to the higher level of the hierarchy and waiting for the solution from above, should be replaced by a mechanism of reporting to the committee and asking a competent person for advice. Improvements and adaptations will constantly be necessary: Amounts of drugs ordered and bought, cashing and banking procedures, the use of surplus money, disposal of expired drugs etc.

**Inherent motivation, incentives:** A management system is operated by human beings. They must see advantages in the new system. If not they will quickly find possibilities to bypass the system. The improvement of quality of care is a strong non-material stimulus. Drugs and medical material are now regularly available, health staff can normally perform their jobs, patients are more satisfied. But the strict control of drugs and money can deteriorate the economic situation of staff and privileged customers. Where no exemptions are allowed, everybody has to pay whether member of staff or of parliament. This entails potentially important losses of money and power. A BI-scheme supported by the actors, must comprise material motivation. Giving free drugs and services to staff is a dangerous option, as it contradicts principles of clarity and transparency. It is also against the principle of equity, as a privileged group of the population (well educated civil servants receiving a salary) would get services free of charge. The approach used in the pilot-study in Tanzania was paying monetary incentives to the staff from the surplus generated by the revolving drug scheme. More incentives were paid out if the performance of the dispensary team was better. But how will community representatives be motivated? Should they also receive money for the work they invest for the population? The decision lies with the owners of the system, i.e. the population itself. They could decide on an encouragement for the committee members during the annual general assembly.

# Recommendations to policy makers

Ministries, Governments and foreign donors should concentrate on policy making rather than implementing health services. Critical policy decisions for BI are:

**Drugs and medical material:** Define and periodically revise Essential drug lists for the different levels. Allow import of drugs under generic name. Secure quality control.

**Funds:** Allow fees be raised and used within each public health care structure. Define and periodically revise guidelines for price-ranges (maximum / minimum). Give general rules on management of funds and drugs. Evaluate application and relevance of governmental rules and regulations.

**Choice of system:** Allow a diversity of systems. It secures the best possible adaptation to the national diversities. As each community financing scheme is owned and managed by the people themselves, the role of the state should be limited to support and supervision. To prevent each community re-inventing the wheel, schemes that have proven successful in the region, can be proposed. Complex systems (prepayment, insurance) work only where a large set of conditions is fulfilled. Such conditions are: trust in the health services, cohesive population, a certain level of prosperity, high moral.

**Staff:** Allow BI-schemes to hire staff (drug-dispenser, nursing-aids, unemployed graduates); give guidelines and organise opportunities for further training.

# Recommendations to the district level

Stick to the role of the health district, i.e. to support the periphery. Responsibility for the scheme should be as peripheral as possible. Availability of drugs and medical materials at affordable prices is one of the most visible, therefore rapidly and strongly perceived quality of care improvement. BI-schemes should first concentrate on achieving this in a sustainable manner.

# Recommendations to the community representatives

Become courageous and independent, find your own solutions. Report as well successful solutions to the higher level of hierarchy, and not problems only. The capital of a BI-scheme are the drugs and medical materials. This capital must be sustained. Exemptions, waste, expiries, theft, corruption are all eroding your capital. After enough money has been put aside to renew stocks, the remaining surplus money should be spent. Missing material could be bought, instruments or buildings repaired, a cleaner employed, water supply and sanitation improved etc. Motivated staff is paramount. Part of the surplus can be invested as incentives. But never pay incentives to yourself. Let the peoples general assembly decide.

Separate and share powers and duties. Three independent bodies are proposed: the medical staff is responsible for quality of care; the community representatives are in charge of money and stocks; these tasks could partially be outsourced to professionals in logistics and accounting; a social committee is concerned with equity issues; the committee assembles representatives from all segments of the population: churches, NGOs, foundations, cooperatives. The three bodies have to communicate and collaborate.

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