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**FINANCIAL AND MARKETING SURVIVAL ISSUES
FOR TWO CARIBBEAN PUBLIC HEALTH ENTERPRISES:
AGAPCO in Haiti & ECDS in the Eastern Caribbean**

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Influencing International Policies and Strategies**

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**MARKETING AND FINANCIAL SURVIVAL ISSUES FOR TWO CARIBBEAN
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INTRODUCTION:

During the 1980s USAID has supported the establishment of two public enterprises in the Caribbean whose mandates were to improve the provision of pharmaceuticals in the region. Both were also designed to become financially self-sufficient.

The Agence d'Approvisionnement des Pharmacies Communautaires (AGAPCO) was established under the Rural Health Delivery Systems (RHDS) Project as a semi-autonomous agency of the Ministère de la Santé Publique et de la Population (MSPP) in Haiti in 1981. The Eastern Caribbean Drug Service (ECDS) was established under the Regional Pharmaceuticals Management (RPM) Project as an agency of the Organisation of Eastern Caribbean States (OECS) in 1986. In both cases, technical assistance (TA) was provided by Management Sciences for Health (MSH), a Boston-based non-profit.

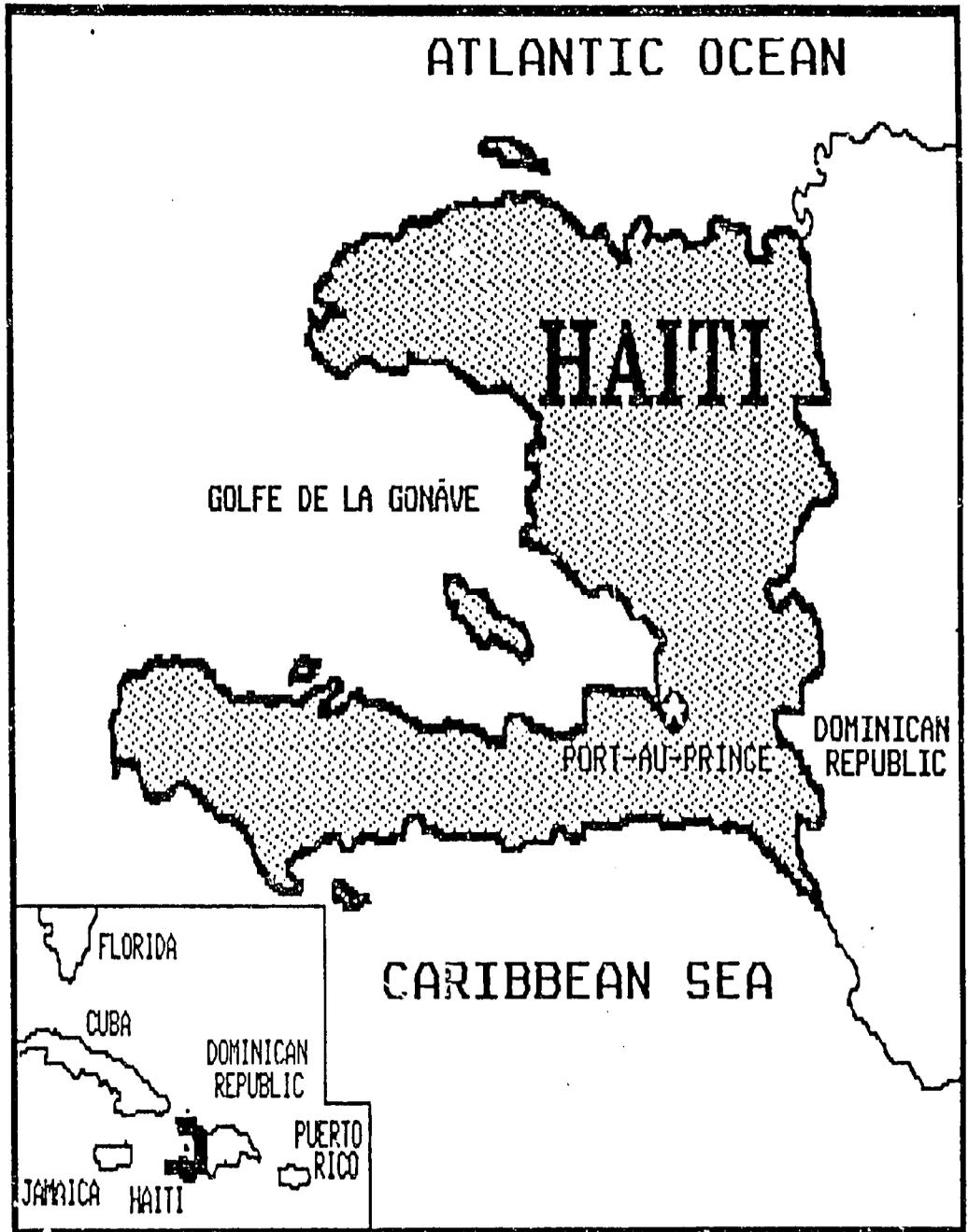
Although the RHDS and the RPM projects were both launched in the Caribbean, the social, economic, and political environments within which the two projects operated present sharp contrasts. Haiti has a population of over six million (6,000,000); per capita GNP is three hundred and fifty US dollars (\$350); and life expectancy is under fifty-five (55) years. The total population of the seven countries in the Eastern Caribbean (EC) served by the ECDS is less than ten percent (10%) of Haiti's; per capita GNP for the countries averages around twelve hundred US dollars (\$1200); and life expectancy is around seventy (70) years. While the institutional politics of implementing a project in the Eastern Caribbean that serves seven countries with separate governments present special issues, the very severe political problems encountered in implementing any project in Haiti are well known¹.

Author's note: This paper was prepared for the NCIH 1989 Annual Conference, Toward a Healthier World: Influencing International Policies and Strategies. While it comments on donor agency policies and strategies, it should be understood that any decisions taken by USAID officers were informed and supported by TA members involved in the implementation of the two projects.

From 1981 through to the present, I have spent approximately five years working with the two organizations described in this paper. In addition to my own experience and the documents listed under references, I have relied on the insights of my counterparts and other professionals in the Caribbean region, USAID officers, and other consultants. While my first hand experience with the two organizations has informed the observations made here, it may also, as is often the case, have clouded objectivity. Opinions expressed here are my own.

¹For a full description of one donor agency's experience in Haiti during the last decade, see E. Philip English, *Canadian Development Assistance to Haiti: An Independent Study*. The North-South Institute, Ottawa, 1984.

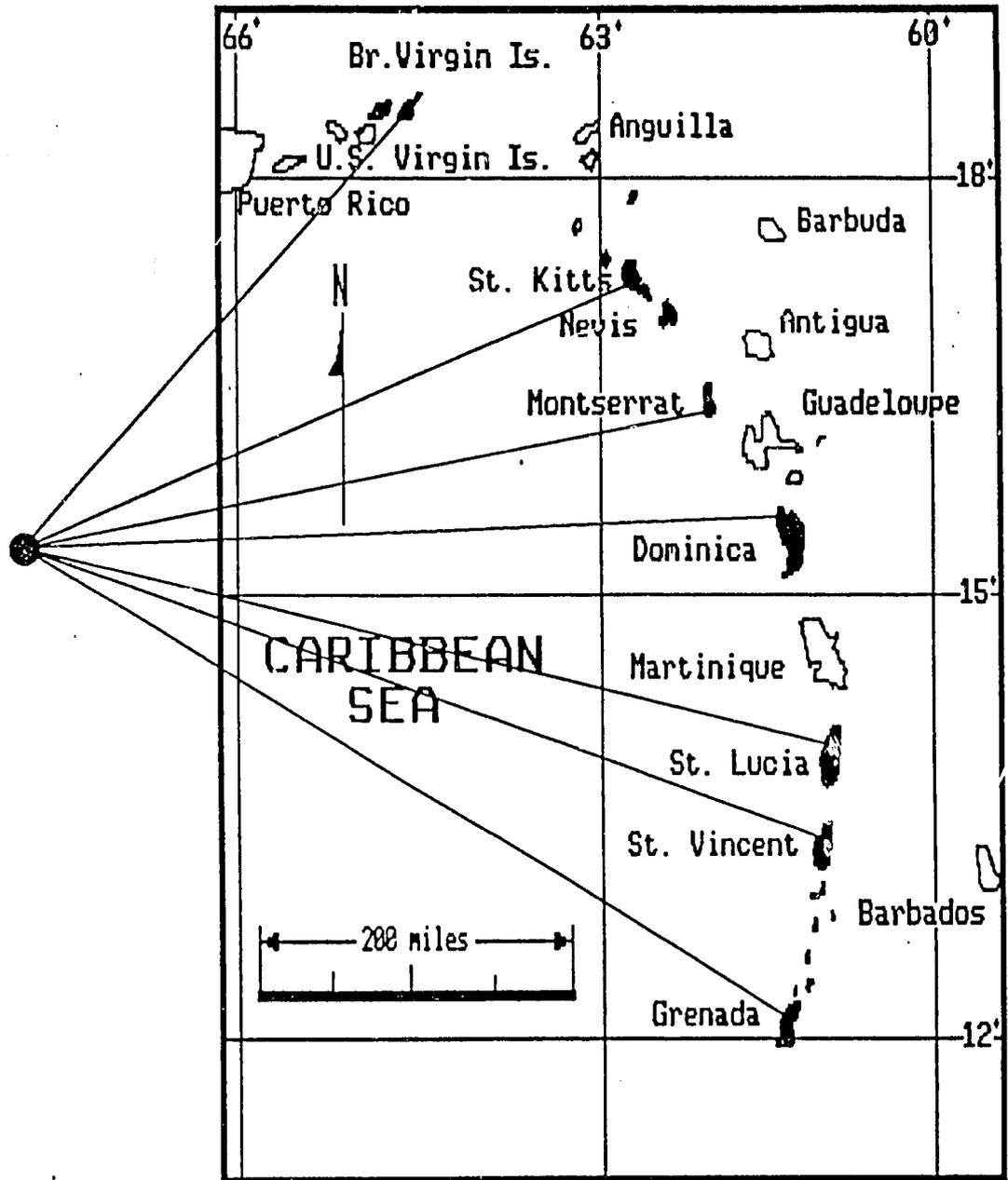
The Agence d'Approvisionnement des Pharmacies Communautaires (AGAPCO) was to serve the rural population of Haiti.



Similar Project Goals In Contrasting Caribbean Contexts.

This contrast between the contexts within which the projects operated, may make a comparison of the project models and their implementation even more useful. In one case political, economic, and organizational realities were largely put aside in a well intentioned effort toward "health for all," and the prospect for the public enterprise's survival are questionable. In the other, an attempt to harness political, economic, and organizational incentives have enhanced the possibility of creating a viable regional institution. Despite the more severe environmental constraints under which AGAPCO has operated, the model itself would be unlikely to enjoy significantly greater success in the Eastern Caribbean context.

The Eastern Caribbean Drug Service (ECDS) serves seven countries in the Eastern Caribbean.



Three strategic issues: organizational, marketing, & financing.

A number of strategic choices may have been instrumental in the likelihood of these institutions surviving: 1) the selection of the organizational site and organizational structures; 2) the design of the marketing mix; 3) and the mechanism for eventual financial self-sufficiency. Although other design and operational issues, such as levels of support to the projects, have played a role, it is these three key issues that will be explored in this paper.

DESIGN OF THE PROJECT MODELS & THEIR MARKETS:

How was the Organizational Site Selected?

In order to survive any public enterprise is normally expected to provide a public service and/or to generate public revenues; as part of the process of meeting these expectations, it needs to maintain its various constituencies - or markets.

How were the Project Models Designed?

In 1980, Haiti's MSPP and USAID launched the RHDS Project, a five year bilateral effort with an overall objective of creating a functioning "community based health care service system that would provide preventive health care services to about three million rural Haitians." AGAPCO evolved as an idea within the RHDS project once the project was in the implementation stage.

How was the Organization Structured?

How were Inter-organizational relationships established?

The RHDS project included budgetary allocations for pharmaceutical procurement, and an MSPP doctor suggested that if the drugs could be sold this would provide sustainability for the drug supply system beyond the life of the project. The law establishing AGAPCO as a semi-autonomous agency of the MSPP was signed by Jean Claude Duvalier in 1982.

What resources were provided?

The choice of an institutional base may have been a key element in the likelihood of AGAPCO's ultimate survival. Some have speculated that if AGAPCO had been established as an independent non-governmental organization (NGO or PVO) many problems could have been avoided. This question is certainly worth pondering, and its relevance pertains whether one considers the political situation pre or post "dechockage" - the grassroots revolution that ousted Duvalier. However, within the context of the bi-lateral agreement of the RHDS, there was no other option.

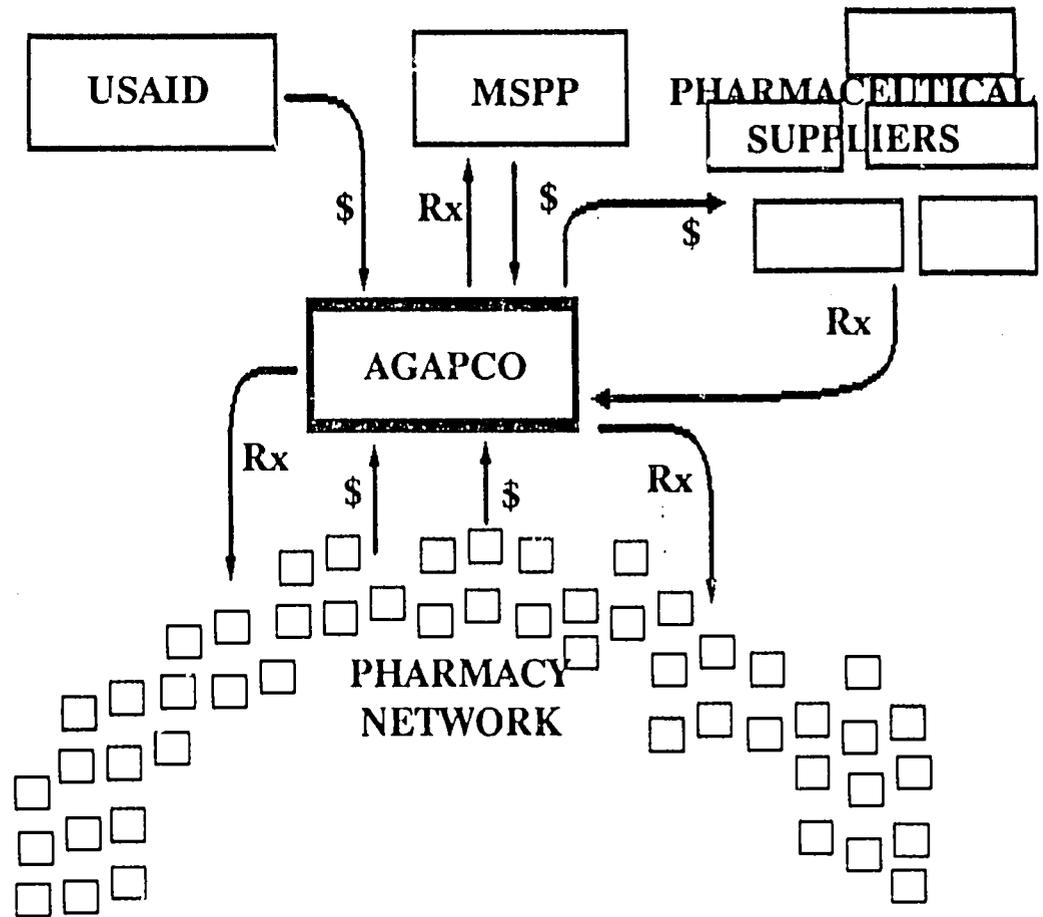
How were these resources organized?

AGAPCO's mandate was to create a network of "community pharmacies" managed by community councils and located primarily in the remote rural areas of Haiti. AGAPCO would procure drugs and supply this pharmacy network, NGOs, and the MSPP itself. These organizations would, in turn, pay AGAPCO for the drugs received including a margin intended to eventually support AGAPCO's operating costs. An additional suggested retail margin at the pharmacy level was designed to support the pharmacy network. During the initial years, as AGAPCO moved toward self-sufficiency, USAID would cover its operating costs and the purchase of drug inventories. However, other than an initial consignment of drugs, there was no mechanism to support the operating costs of the pharmacy network during the first years.

This meant that AGAPCO had both an administrative and financial reporting relationship with USAID, and, since USAID funds flowed through the MSPP, an administrative and financial reporting relationship with the MSPP. The average tenure in a key position in the MSPP was approximately nine months, and job security was an important element in the MSPP relationship.

At the same time, the community pharmacies were designed to be independent entities with no formal reporting relationship to AGAPCO,

Figure 1 - The AGAPCO System



although AGAPCO was responsible for establishing them, training the staff, and supplying them with drug stocks.

There was no Board of Directors, or specialized committees, to advise AGAPCO, assist in coordination, or promote the new agency. There was no mechanism to assure that it was the sole supplier to the MSPP or the pharmacy network. In fact, it may well have been seen as a competitor by wholesalers in the private sector. (At least two attempts were made to set up a Board with representatives from key donor agencies and the MSPP, but these were short lived.)

Figure 1 illustrates the institutional relationships and the flows of funds and drugs in the AGAPCO system.

The RPM Project was designed exclusively to improve drug supply in the Eastern Caribbean, and thus was clearly focussed on only this aspect of the Ministry of Health (MOH) systems, with a major objective of "improving the efficiency and effectiveness" of the drug supply systems. The project was to establish the ECDS; in fact most people in the region would refer to the project as the ECDS.

During the project design stage consultants hired by USAID considered six organizational alternatives as a site for the project². These organizations were scored on seven different criteria. Experience in health was not one of the criteria, which focussed primarily on organizational capability to manage a project of this nature. It is interesting to note that, although the seven categories were not considered additive, CARICOM received no "good" ratings, and OECS, in addition to being located in the EC, received one. The Eastern Caribbean Central Bank (ECCB), PAHO, the Barbados Drug Service (BDS), and the Caribbean Development Bank (CDB) each received from three to five "good" or "yes" ratings. The consultants felt the best option might be PAHO, but they also considered two other options: the ECCB, or a sharing of responsibilities between ECCB and the OECS Economic Secretariat in Angtigua.

Ultimately, the OECS Central Secretariat in St. Lucia was selected as the organizational site, with the ECCB performing the financial functions related to drug procurements. Although the reasons for this choice are not clearly documented, it seems evident that "demonstrated ability to coordinate policy with the Eastern Caribbean governments," for which only OECS and ECCB received "good" ratings, was considered a key to project success. In addition, selection of OECS and ECCB supported the development of institutions serving the subregion.

ECDS's primary service to the participating governments is a restricted international tendering and procurement system for the drugs needed by the MOHs. Under a sole source commitment, the participating countries agreed to buy ECDS contracted items only through the ECDS system, thus creating a buyers monopoly. (This idea was not part of the project design, but was strongly recommended by the project staff during implementation.) Governments also agreed to pay ECDS a fifteen percent administrative fee on the value of any drug orders processed through ECDS; this fee generated revenues to support ECDS operating costs. Like AGAPCO, ECDS's operating costs would be covered by the USAID grant to OECS during the initial years until the organization achieved self-sufficiency.

As a condition precedent to the grant agreement, governments were required to sign a letter of intent that stated the MOH's agreement to institute an appropriate cost recovery scheme (user fees) for their pharmaceutical supply system during the project. This action might have been loosely analogous to Haiti's retail charges through the pharmacy network; however, despite the letters of intent, cost recovery schemes were not established. (Although they had little or nothing to do with AGAPCO,

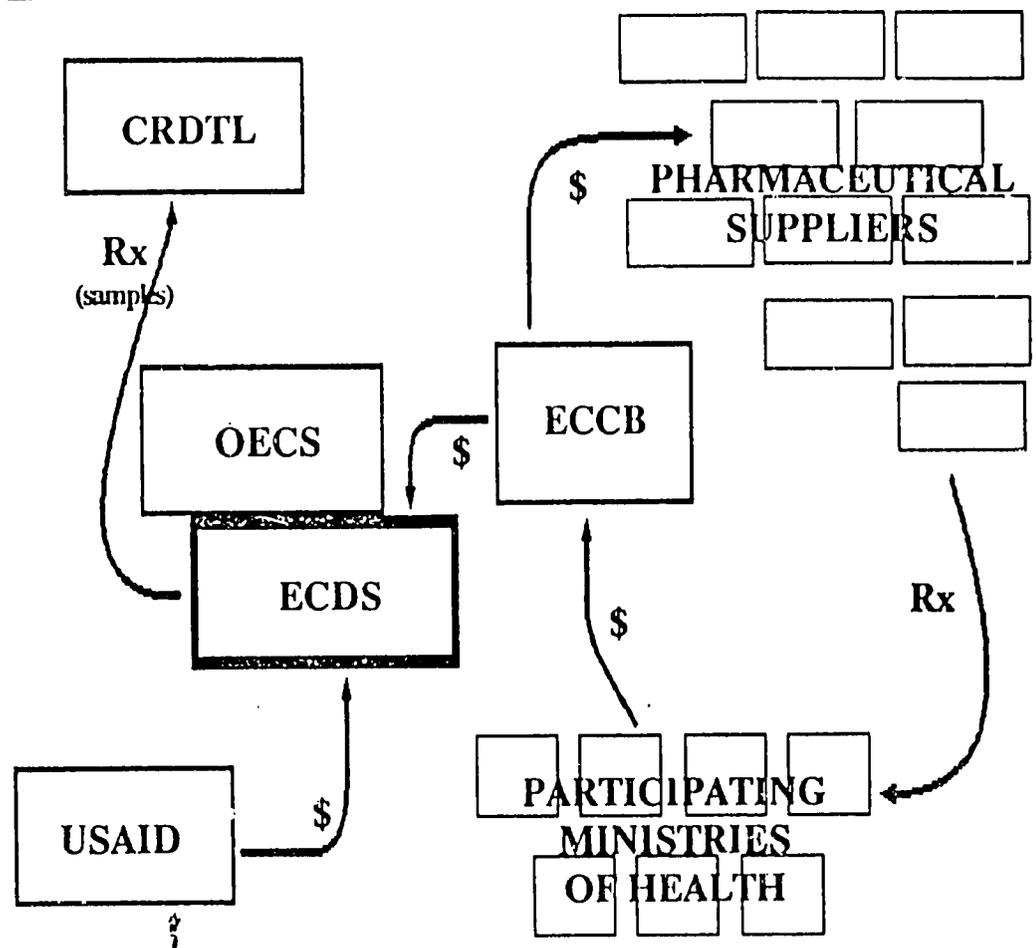
²Kempner, Daphne E. et al. *Health Sector Resources Management Project #538-0069, Pharmaceutical Component*. MSH, Boston, 1984.

there were also a number of conditions precedent in the RHDS Project that were not met.)

The ECCB acts as the financial agency that manages country drug accounts for the countries; each country provided advance funding for drugs by depositing an amount roughly equivalent to one-quarter or one-third of its annual drug budget. This ECBB service eliminates foreign exchange problems and charges associated with the commercial banking system. On instructions from ECDS, ECCB pays pharmaceutical suppliers on behalf of individual countries; it also pays the ECDS through the country accounts for the fifteen percent administrative fee. The ECCB notifies countries to reimburse the accounts in equivalent amounts. The ECCB also assists the ECDS by investing surplus funds in treasury bills issued by OECS governments.

Figure 2 illustrates the flow of drugs and funds between the organizations that participate in the ECDS scheme. The Caribbean Regional Drug Testing Laboratory (CRDTL) in Jamaica provides drug testing for ECDS products. This organization is funded by the CARICOM member governments through annual allocations.

Figure 2 - The ECDS System



The ECDS has an organizational structure that facilitates a high level of involvement from the participating countries. The ECDS Policy Board includes the Ministers of Health assisted by the Permanent Secretaries, the OECS Director General, and the ECCB Governor. Two subcommittees report to the Policy Board. The Formulary and Therapeutics (F&T) Subcommittee includes Chief Medical Officers or a senior doctor from each MOH. The F&T Subcommittee makes recommendations to the Policy Board on the drug items to be included in the Regional Formulary and, therefore, the list of items on which tenders may be invited. The Tenders Subcommittee includes the Supplies Officers from each MOH. The Tenders Subcommittee makes recommendations to the Policy Board on the award of drug items to selected suppliers. ECDS staff are members of these bodies but do not have voting rights; the Policy Board and the subcommittees meet at least annually and are chaired on the principal of alphabetical rotation by country.

In addition, the policy bodies for the OECS and the ECCB have identical membership. The Authority of the OECS comprises the Prime Ministers of member countries; while the Board of Authority for the ECCB comprises the Ministers of Finance. (All Prime Ministers are also Ministers of Finance.)

Under the RHDS Project, probably less than one dozen person years of TA were devoted to AGAPCO. While, at the end of its third year, the RPM Project had already used more than this. Under the RHDS Project funds were provided to purchase drugs. While, under the RPM Project, the countries themselves were to fund drug purchases. However, the RPM Project provided funding for vehicles, computers, copy machines, and typewriters for each country, plus minor refurbishing of facilities and significant training activities; ECDS has seven computers plus other essential equipment. AGAPCO had less resources for equipment, transport, and training, although the information systems, and staffing and distribution networks were significantly more demanding than those of the ECDS.

A Director General of AGAPCO was appointed, with technical assistance team members advising him or selected staff members, depending on their scopes of work. During the first three years of the project, the Director's General position turned over three times, but after this the same individual maintained the position for approximately five years. As is common practice, the TA team had advisory responsibility only, although, as is also common practice, they did carry out much of the implementation effort. The TA contract was a direct AID contract.

An Associate Director, who was in training under the TA Team Leader,

was appointed to the ECDS staff. Both positions reported directly to the Director General of OECS. The TA Team Leader had oversight responsibility for the ECDS during the first three years, after which the Associate Director was appointed as the Managing Director. The terms of the TA contract specifically called for the team to carry out implementation of the project in a number of areas, and, for the most part, counterpart relationships were clearly defined. The TA team was contracted directly by the OECS, according to AID host country contracting regulations under the grant agreement.

Although accurate accounting data that lends itself to comparison is not available, both AGAPCO and ECDS probably received similar resources through AID funding, including the costs of TA. However, if one discounts the value of drug purchases, AGAPCO received less resource support than the ECDS.

Significant design and feasibility work was done prior to the establishment of the RPM Project, while AGAPCO developed more organically within the context of the RHDS Project.

PRODUCT SELECTION & PROCUREMENT:

**How were
Product lines
Selected?**

Both AGAPCO and ECDS were designed as non-profit drug wholesalers, but their selection of product line and procurement mechanisms were very different.

**How were
Quantities
Estimated?**

Although AGAPCO was provided with funding for initial stocks of drugs, it also operated under additional constraints.

**How were
Products
Purchased?**

Since there was no good demand data on pharmaceuticals distributed through the MSPP system, they looked at need. Advisors combined disease prevalence rates with population data to develop a list of essential drugs in estimated annual quantities. Thus the product list and quantities were based on epidemiological need - not demand. Demand through private pharmacies or through a sampling of prescribing patterns was not assessed. While it is clearly the duty of health professionals to attempt to bring health need and demand for services into closer alignment, anyone who has worked with a family planning project knows that this is not accomplished simply by providing the essential commodities in the quantities that a population "needs" based on population growth rates. Pills would expire on the shelves while condoms collected dust balls; inventory would be wasted. (See Figure 3.)

From Whom?

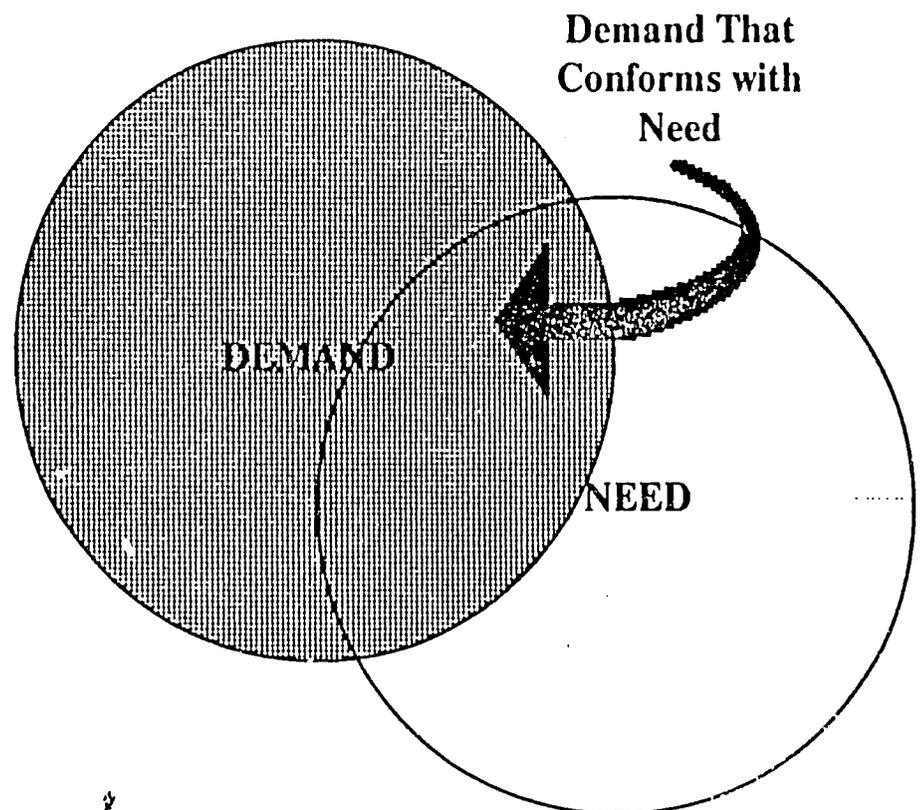
In planning whom to buy from, AGAPCO operated under two constraints: first the need to adhere to donor agency procurement regulations, and

second, when they had generated their own revenues, a shortage of foreign exchange. Although they have since been revised³, AID procurement regulations for pharmaceutical procurement were very complex. Given the combination of project urgency and the need to adhere to regulations that were difficult to understand, the first orders did not go through a public tendering process that resulted in the most competitive prices. With long lead times a similar order was placed through a similar process a year later, before AGAPCO had gained experience to better estimate demand. Later, when AGAPCO had generated its own revenues, procurements were made locally because of the lack of foreign currency, administrative ease, short leadtimes, and, possibly, other advantages of doing business locally.

At the end of fiscal year 1985, its second year of full operation, AGAPCO wrote off over three hundred and sixty thousand US dollars (\$360,000) worth of stock. The value of stocks sold during that year was two hundred and sixty thousand dollars (\$260,000). In fiscal 1986, AGAPCO wrote off an additional two hundred and seventy thousand dollars (\$270,000) of

³In 1988 guidelines for AID procurement of pharmaceuticals were revised and consolidated, see Aida A. Le Roy et al, *USAID Handbook and Field Operations Manual For Pharmaceutical Procurement in Latin America and the Caribbean*. Health Information Designs, Arlington, VA, 1988.

Figure 3 - Drug Need Versus Demand



stock. At this point in time AGAPCO is purchasing from UNIPAC, where Haitian gourdes are accepted as payment, and from a handful of local suppliers who may, in fact, be its competitors.

AGAPCO has carried a list of approximately eighty (80) generic name, essential drugs, although in 1988, a Canadian Pharmacy Consultant⁴ commented that drugs being sold did not conform to the published formulary list, and the formulary itself was clearly in need of revision. Brand names and products that were in conflict with Oral Rehydration Salts (ORS) promotion were included among the products being distributed, which might suggest that financial objectives were clouding public health objectives. This report also noted that AGAPCO had no access to quality assurance testing facilities in Haiti.

ECDS's initial selection of products, quantities, and suppliers was based on historic demand data from the Central Medical Stores (CMS) in the participating countries. Based on a subjective ABC Analysis⁵ by the Supplies Officer, data were collected for a twelve month period on prices paid and quantities purchased for the top one hundred (100) products in each CMS. The names of suppliers currently providing the CMSs and considered reputable were also collected. Although consultants involved with the project had some compunctions about not started the process by attempting to rationalize through a formulary process, workplan pressures called for the first contract to be initiated as soon as possible.

- In order to reduce potential resistance, only suppliers who were already operative in the subregion were invited to tender on the list, by generic names, of two hundred and twenty (220) products that evolved from the combined top 100 from the six countries that participated during the first cycle. Although the tendering process made some attempt to rationalize demand through standardization of pack sizes and strengths, and the use of generics over brand names, no efforts were made to change existing demand for specific products during the first cycle.

Based on the previous year's volume of demand and prices paid in each of the six countries, the first contracts resulted in a weighted average price reduction of forty-two percent (42%) for the fifty-nine (59) A-class items

⁴Bisaillon, S.M.A. *Rapport presente au Ministere de la Sante Publique et de la Population. Universite de Montreal, Canada, 1988.*

⁵An ABC Analysis is an inventory management technique whereby the quantity of each product, procured during a given period, is multiplied by the product's price to calculate each product's significance in terms of total costs. Products are then ranked in terms of total costs. As a rule of thumb, the top twenty percent of the products - the A Class items - normally account for approximately eighty percent of total inventory investment.

common to all six countries. This price reduction takes into account the payment of the administrative fee to ECDS. Those countries with the poorest payment histories with suppliers gained the largest price reductions, which seems to indicate that the guarantee of prompt payment through the ECCB had a significant impact on suppliers' tender offers. Although the buyer's monopoly, the competitive bid process, and the high proportion of generic names would claim a more significant influence. Figure 4 illustrates the price reductions for individual countries.

During the second year, ECDS held its first regional F&T Subcommittee meeting. A regional formulary, which attempted to rationalize the selection process, was established, and the first regional F&T Manual was published to coincide with the second contract cycle. Although the manual itself was excellent and the ECDS conforms to it through the tendering system, it is not clear how well the countries have adhered to the approved list. In fact, since MOHs can purchase non-ECDS drugs outside the ECDS system, it may have meant a loss of business for the public enterprise. (ECDS plans to collect data on non-ECDS drugs in the MOH systems during the next year.) During the second contract cycle, the market basket of A-class drugs experienced an additional price reduction of eighteen percent.

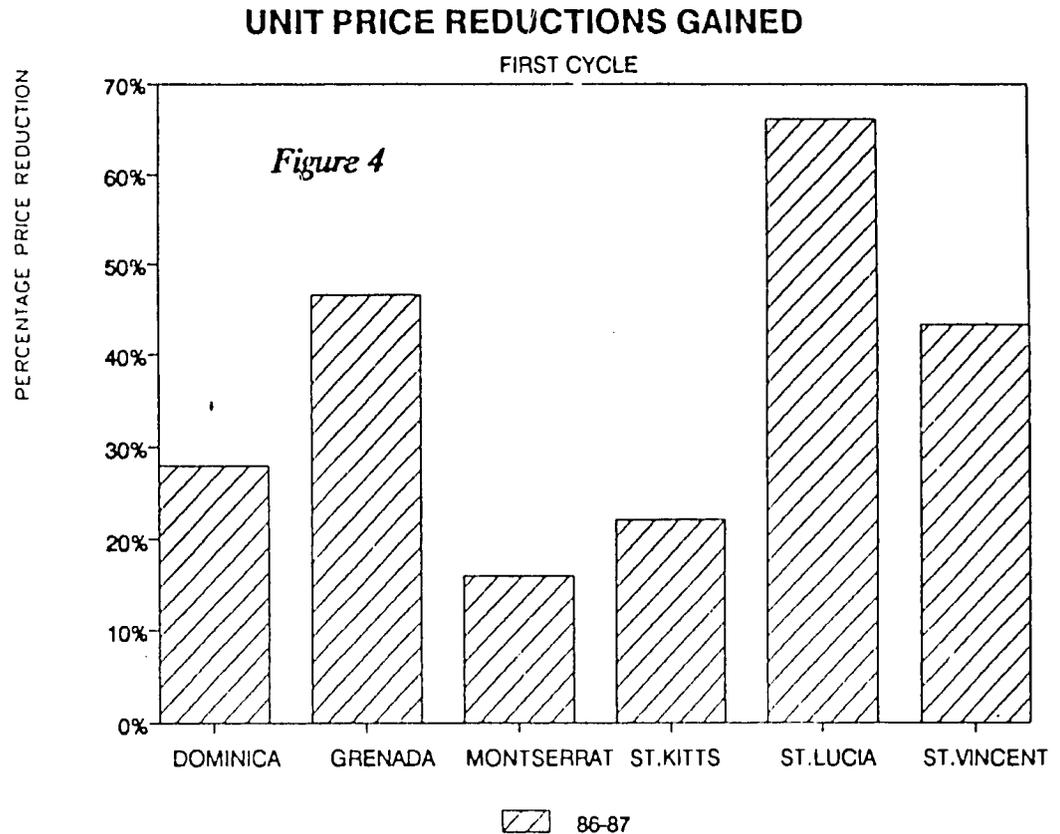
ECDS has been using suppliers in North America, Europe, and Barbados. Suppliers based in South Africa were excluded by the Policy Board, but there were no further restrictions other than approval by the Subcommittees and the Policy Board. During the first cycle, a supplier based in Europe provided drugs that had been manufactured in Communist Block countries. Although this created controversy and appeared on the agenda for the second Policy Board meeting, no firm policies were established. ECDS now suggests that drugs from these countries not be provided; the major concern was lack of information on the quality assurance of manufacturing processes in countries like Hungary and Yugoslavia.

During the adjudication process for the third contract cycle, ECDS moved more heavily toward Barbados-based suppliers. This was primarily as a result of the long leadtimes experienced with several key European suppliers. Prices have probably moved up somewhat, but the contracts take effect on July 1, 1989, and pricing shifts have not yet been calculated.

ECDS supplier contracts and the supplier selection process help to provide quality assurance and better supplier performance. The CRDTL in Jamaica also received approximately one-third of the samples it tested from ECDS during 1988; other CARICOM member countries are felt to be under utilizing the lab.

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Competitive procurement that results in low purchase costs is key to a program providing essential drugs at affordable prices.



PRICING & THE MECHANISM FOR SELF-SUFFICIENCY:

How were prices established?

Were ability and willingness to pay considered?

Were public health objectives considered?

Were competitive market prices considered?

Were there economic incentives for organizations and individuals?

Operating costs for AGAPCO and ECDS are somewhat comparable. In 1986, AGAPCO had operating costs of approximately two hundred and ninety-five thousand (\$295,000) US dollars. For the upcoming fiscal year (1989-90) ECDS has budgeted approximately two hundred and twenty-five thousand (\$225,000) US dollars. Wages are much lower in Haiti, but the staffing levels are higher, and AGAPCO does warehousing and repackaging while ECDS does not. The ECDS staff, who are graded into OECS personnel systems, enjoy relatively high salaries; the ECDS also funds airfares and per diems for approximately four major committee meetings each year. Annual publications, including a regional formulary, and support of limited training activities and a drug information system add additional costs.

There are two levels in AGAPCO's pricing mechanism, with multiple complications at both levels.

At the wholesale level, a twenty-eight percent (28%) mark-up was added to AGAPCO's purchase price for each product. This 28% margin was intended to cover AGAPCO's operating costs as the program grew and it moved toward self-sufficiency. A mark-up of this level should have been quite adequate to cover operating costs given a reasonable volume

How complex were mathematical calculations and accounting systems?

through the distribution system, as operating costs should be quite low compared to North America where the typical wholesaler's margin would be proportionally lower.

At which levels were the complex financial functions managed?

However, the mark-up was based entirely on cost recovery principals with no attention paid to competitive market prices. The discussion of product selection and procurement highlighted AGAPCO's less than competitive base purchase prices. With these higher base prices and the 28% mark-up, marketing studies in late 1986 indicated that AGAPCO wholesale prices were, on average, thirty-three percent (33%) higher than those of the private sector wholesalers, despite the intention of providing a limited list of essential drugs at low cost. The NGO market was not expanding, and the MSPP itself had purchased far less than was originally projected⁶. Naturally, the higher volume wholesale purchasers, such as NGOs, would be more price sensitive.

What were the cost recovery objectives?

Were they realistic?

However, despite the absence of formal commitments to do so, the pharmacy network continued to be supplied by AGAPCO, for the most part. Having been established by AGAPCO, the pharmacies retained organizational allegiance. At this level there was a second retail mark-up intended to cover the operating costs of the pharmacies. Although retail prices were referred to as "suggested," they were actually printed on those products that AGAPCO had repackaged and on a price list that AGAPCO supplied to the pharmacies. The retail margin was generally referred to as twenty-five percent (25%). Pricing mark-ups at the retail level are generally higher than the wholesale level in the private sector, and it stands to reason that, with economies of scale, the operating costs of a larger agency like AGAPCO should have been proportionally lower than those of the small pharmacies when compared to the value of the flow of drugs distributed. Also, while AGAPCO had USAID funding to cover shortfalls in revenues generated to cover operating costs, the pharmacies had no such additional support. There was no mechanism to cover the products that were ultimately destroyed because they were not selling. However, this lower retail margin did mean that AGAPCO products were often competitively priced at the retail level.

Although, the retail margin was generally referred to as 25%, pricing was much more complex at this level and the real gross margin was unknown. Public health agendas, although they had not been considered in the wholesale pricing, came into play in the retail pricing. Attempts were made to encourage the use of some products by reducing margins. ORS, for example, had a zero margin. Subsidies and surcharges in the pricing

⁶Huff, Maggie. *Financial Management and Planning in the Agence d'Approvisionnement des Pharmacies Communautaires*. MSH, Port-au-Prince, Haiti, December, 1985.

mechanism were intended to result in an average margin of 25%. However, a market survey of annual sales for twelve pharmacies indicated an average gross margin of twenty-one percent (21%)⁷. This study also suggested that drugs with the lowest mark-ups might be moving more quickly, and pharmacies were therefore experiencing stock-outs in the high volume items.

In addition to this complication, when AGAPCO understood that the profits were inadequate to cover costs at the pharmacy level, pharmacies were instructed to retain thirty percent (30%) of their revenues as "profit." However, pricing structures were not adjusted to accommodate this. With a real gross margin of 21%, it can easily be seen that, along with other contributing factors, this manipulation of cash flow would lead to decapitalization at the pharmacy level.

In addition to the complexity in the cost recovery and pricing mechanisms of the AGAPCO system, the ultimate financial support for the whole system depended on success at the retail level. The poorest population in the western hemisphere was expected to pay the full direct costs of drugs plus two mark-ups intended to support the operating costs of the supply system.

ECDS's pricing mechanism was far more straight forward. The mechanism designed for self-financing was the administrative service fee, charged to each of the participating governments at 15% of the value of the drugs ordered through the ECDS. In addition to providing funding for ECDS, this particular financing mechanisms offered two good control measures. First, the administrative fee makes pricing of the service to the governments more equitable because governments pay ECDS in proportion to the level of service they require. Second, because ECDS total operating costs cannot exceed total fees collected, they must be contained (at or below 15%) in proportion to the level of service (value of drug purchases) it is providing to the governments collectively.

The governments had committed themselves to the RPM Project primarily because of the potential economic gains in the health sector through reductions in unit costs, coupled with the perceived financial viability of ECDS. Therefore, the incentives for ECDS were to reduce unit drug costs appreciably while covering its own costs through the administrative fee.

Compared to the individuals who use the health care systems, the EC governments have relatively deep pockets, and, as volume purchasers, they readily appreciate the economic value of the lower unit prices obtained

⁷*Ibid.*

through the ECDS system. As discussed earlier, despite a condition precedent in the grant agreement, the governments did not create cost recovery systems through user fees. However, even if there had been the political will to do so, user fees could never have supported the total costs of the entire drug supply system in the Eastern Caribbean, as was the project design intention in the AGAPCO system.

PLACE - THE DISTRIBUTION NETWORKS:

Where were the distribution outlets?

There was some evidence that the people of Haiti were willing and able to pay for health services, but they had little trust in the country's government, and therefore the MSPP and AGAPCO. Although the original plan called for community pharmacies operated by community councils, in fact, as the project evolved several types of pharmacies were created: community pharmacies, NGO pharmacies, MSPP facility pharmacies, and pharmacies that were operated through a combination of community and institutional efforts. The majority of the pharmacies were in MSPP facilities.

How were they selected and established?

How much effort was involved?

Who managed the outlets?

The selection of an MSPP facility was often made because USAID or other donors had build facilities that were underutilized, and one of the contributing factors to underutilization was felt to be the lack of drug supply. Sites were also selected where there was no prescriber practicing regularly, although most drugs sold through the system required prescriptions. And sites were selected where there was a competing private or mission-run pharmacy nearby. With multiple competing agendas, there was rarely sufficient time to adequately assess the viability of a new location.

What were the utilization rates?

Did the public have confidence in the health facilities and their staff?

Although it has never been documented in a report, Haitian consultants have suggested that the establishment of a distribution system located primarily in MSPP facilities was a detriment to AGAPCO's ability to market the system. The population may have been less than confident in this network. Certainly, we did find evidence of the population's willingness to pay more for the same products in mission-run health facilities. This, however, is largely an issue for speculation; consumer preferences were never tested.

How complex was the distribution network?

How much control did AGAPCO and ECDS have over their distribution networks?

AGAPCO's distribution network was complex. It operated at three levels: 1) AGAPCO's central warehouse; 2) three regional warehouses, and, 3) two hundred pharmacies by the end of 1985. The entire network had been established by AGAPCO, although the physical buildings usually pre-existed the AGAPCO system. Although the pharmacies could be classified into three major categories as described above, there has been much greater variety in the management structures within each pharmacy,

including policies for handling of cash flows. AGAPCO was responsible for training its own staff and each of the "regisseurs" who operated the pharmacies, in addition to supplying the pharmacies with initial and replacement stocks, and, occasionally, refurbishing buildings.

The establishment of this network was a very ambitious effort, and it took much time and attention away from other areas. At the beginning of 1985, under pressure to increase sales volume, AGAPCO saw expansion of the network of outlets as the best avenue to achieving this goal. In late 1984 there were one hundred (100) pharmacies in the system; by late 1985 two hundred (200) pharmacies had been established. This meant that the thinly staffed agency was creating pharmacies at the rate of two per week.

In the meantime, already established pharmacies were becoming nonfunctional through lack of support and supervision, or the decapitalization that took place through stock expiry and the pricing/cash flow mechanisms. Despite the apparent doubling of the distribution network, sales revenues over the year-long period remained flat. By early 1989, AGAPCO's management estimated that approximately one hundred and twenty (120) of the pharmacies were still functional.

ECDS was not under pressure to create a distribution network. Drugs are shipped directly from the suppliers to the CMSs in each country. The CMSs, in turn, distribute directly to MOH facilities as they always have done. ECDS is responsible for monitoring and processing of paperwork between the CMSs, the suppliers, the ECCB, and itself. ECDS staff and the TA team have had a responsibility to assist the MOHs with the strengthening of their drug supply systems. Vehicles have been purchased; computerized inventory control and procurement planning systems have been installed in each CMS; and minor refurbishing of facilities has been completed.

As is typical, strengthening of the country supply systems has moved slowly. In fact the unanticipated longer lead times that often accompanied lowered prices may have contributed to stock-outs in some countries. Since ECDS has no formal authority over CMS management, behavior modification among the staff can be very difficult. ECDS is the servant of the participating CMSs, not the master. At the same time, ECDS has had a major advantage over AGAPCO in that it is working through an established distribution network and has had a sole source commitment from the network to procure only through ECDS for contracted items.

PROMOTION & PACKAGING:

Were the right drug products at the right prices in the right places?

As noted earlier, AGAPCO's published formulary, the list of products that should have been available for sale through the system, did not represent the product line that was really available. The program had been operative for four years before the formulary was published, and it has not been revised since. Distribution of the formulary manual has been haphazard, and AGAPCO has never had a forum to work more directly with prescribers in Haiti.

Were the programs ready for promotion?

During 1985, along with expansion of the distribution network, AGAPCO embarked on a promotional campaign. Posters, calendars, and over-the-counter price lists were printed. Metal signs with an AGAPCO logo were affixed to the pharmacies. Radio jingles, and even a TV spot, were developed. Messages focussed on essential drugs at low prices. Aside from questions about the appropriateness of the promotional techniques employed, this was no time for promotion.

What promotional techniques were used?

Were they appropriate?

When the product, price, and place factors in the marketing mix had not been adequately developed, public promotion of the system was only apt to result in increased negative word-of-mouth advertising. Patients hearing the marketing messages could only be disappointed when they discovered stock-outs or expired stock, high prices, and closed facilities.

Did they speak to the appropriate audiences?

Did they send the appropriate messages?

AGAPCO also repackaged, in course-of-therapy quantities, a number of its drugs. The repackaging unit operated inside the Port-au-Prince AGAPCO offices. The unit was very inefficient; there were very limited quality assurance measures; and management had little time to supervise the unit. Although the packaging was superior to brown paper wrappers often supplied in the private sector, a study indicated that it would have been more cost effective to contract out for the service⁸. However, jobs that have been created in a public organization are difficult to abolish. The unit also added to the managerial complexity of AGAPCO's business activities.

Were the messages valid?

The MOHs, who pay the 15% administrative fees to ECDS, directly reap the economic benefits of the project: reduced pharmaceutical prices through a public tendering system. These benefits are measurable and therefore can be promoted by the ECDS to the governments, its main constituents or clients.

In addition the Policy Board and its two subcommittees have provided

⁸Ibid.

ready-made promotional mechanisms for ECDS. Key policy makers (Ministers of Health, the OECS Director General, and the Governor of the ECCB), key MOH administrators (MOH Permanent Secretaries), key medical personnel (CMOs, and other senior doctors), and key pharmacists (supplies officers) are all an integral part of the system. ECDS is in regular contact with these individuals through telephone calls, correspondence (including the distribution of project quarterly reports), and regular meetings.

Training programs have offered an opportunity for contact with a larger number of health care professionals in the subregion. ECDS has also launched a newsletter, and is currently publishing a brochure. The total audience of constituents for ECDS is also much smaller and more coherent than that of AGAPCO.

The strength of the ECDS supplier contracts and the regular testing of products has also served to increase the confidence of prescribers in the participating countries. Although, as with AGAPCO, pharmaceutical suppliers who have lost profits through the system, will attempt to erode that confidence. This has been particularly true for the brand name companies who have lost business.

CONCLUSIONS:

The revenue generation and pricing mechanism for any self-financing public enterprise needs to consider the clients' ability and willingness to pay. These mechanisms and the level of donor funding must create incentives for both revenue generation and containment of operating costs. A public health enterprise must balance these financial survival elements alongside the public health goals it was designed to achieve. These two major elements must be taken into account as it designs its marketing mix and sets the plan and pace for implementation.

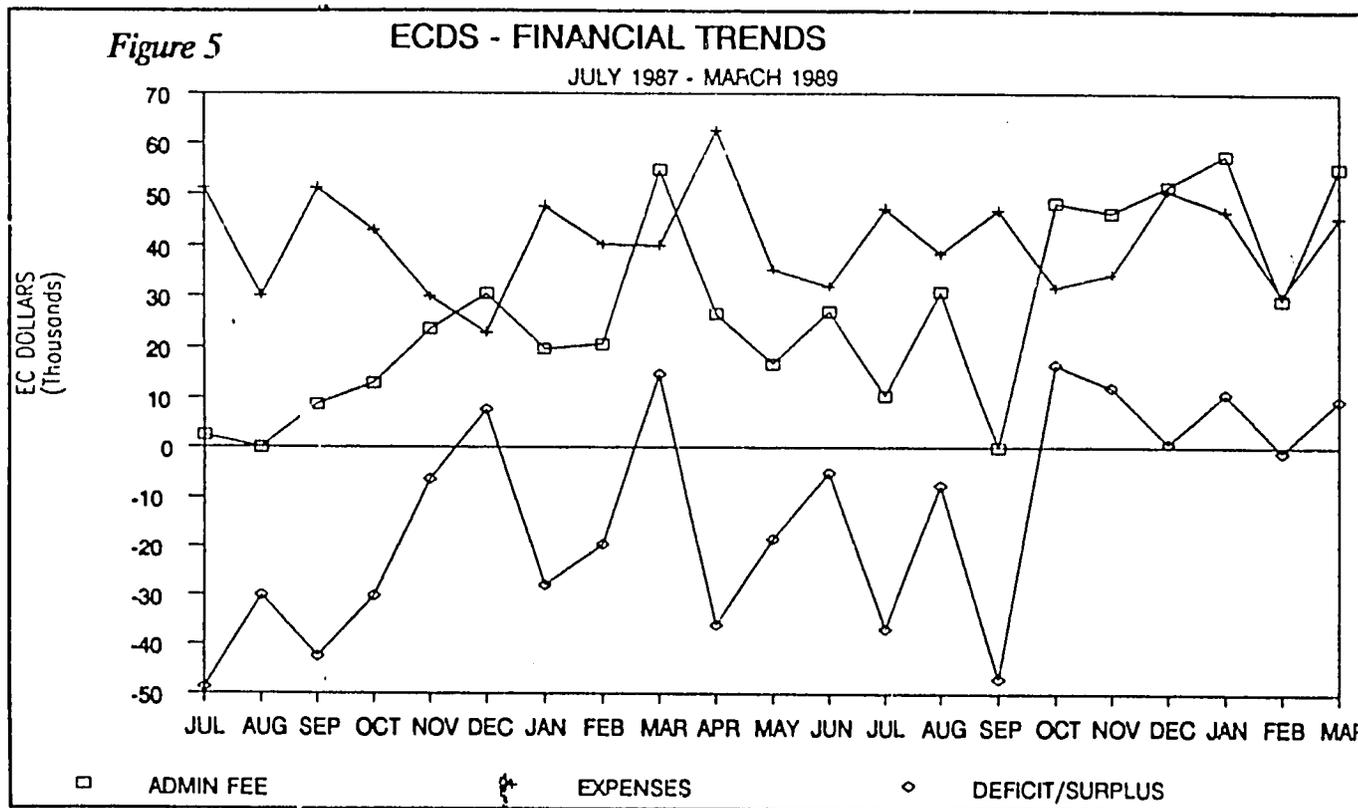
Although it is imprudent to draw firm conclusions about a development program that is only a few years into implementation, ECDS is currently considered a success story in the Eastern Caribbean. It seems to represent a cost-benefit model of functional cooperation for the participating countries. One additional country has joined the scheme, and several have expressed interest in joining.

Since health does not warrant significant donor investment in the Eastern Caribbean, the ECDS is unlikely to attract significant additional funding; however, administrative fee revenues covered sixty-five percent of costs during the first year of operations, far in excess of project paper (PP) expectations. During its second year of operation, monthly revenues

began to cover costs during most months. (See figure 5.) The ECDS is expected, based on conservative projections, to breakeven during 1990 when the grant funding will terminate. In the meantime the surplus built up through administrative revenues is being invested by the ECCB, and will probably augment administrative fees by an additional ten percent (10%) during 1990.

Despite this apparent success, the political realities of establishing a viable regional institution in the Caribbean should not be underestimated. The region is littered with current and historical examples of failed or floundering regional institutions and initiatives. The process of gaining independence for the micro, mini, and small countries of the Eastern Caribbean has probably contributed to further political fragmentation as a growing sense of national identity conflicts with simultaneous movements toward integration. This process has been exacerbated by geography -- the separation of the island states by the Caribbean sea and the high cost of communication and inter-island travel; and by history, as competing colonial powers have influenced their social and political development, spawning unique national identities.

The choice of OECS, assisted by ECCB, as the institutional base for ECDS has been critical to its success, as has the establishment of the various representative bodies from the participating countries. These aspects of the project design must have been considered very carefully. They have increased costs and complexity, but contributed powerfully to regional



commitment.

Aside from the limited ability of the people to purchase drugs, it was difficult for AGAPCO to develop a workable marketing mix and promote itself. With donor funding to support operating costs during the initial years, AGAPCO's focus was on increasing retail sales revenues rather than reducing operating costs, including the purchase cost of pharmaceuticals. During the implementation phase, its two major constituencies were USAID and the MOH, not the two hundred community pharmacies that it had established in the rural areas. This was the result of a combination of financial support and physical proximity.

In late 1985, after three years of operation, a financial analysis indicated that AGAPCO was moving further away from, rather than toward break-even⁹. (See Figure 6.) It had been doing a better job of absorbing donor funding than of increasing the volume of pharmaceuticals distributed through its network of community pharmacies. In early 1986 the grass roots revolution, "Dechokage," uprooted the Government of Haiti. Approximately two years later, the American Government withdrew financial support from the Haitian Government, including AGAPCO.

The establishment of AGAPCO was a complex and highly ambitious effort, particularly given the Haitian context. While many mistakes were made during implementation, AGAPCO was seen as a comparative success. Haitian staff members and TA team members referred to it fondly as the "royal crown jewel of the RHDS Project." Much was accomplished in a short time span.

USAID health development efforts have continued to support PVOs in Haiti, and, if AGAPCO had been established as an independent PVO it might currently have a brighter future. Its prospects for survival are considered "bleak."

However, the AGAPCO system is still operating a full eighteen months after the withdrawal of donor support. Cash reserves, built up during the period of donor support, have provided for the continuation, but, given the history of other projects in Haiti¹⁰, this is perhaps AGAPCO's most significant accomplishment. An analysis of key assets on the AGAPCO balance sheets for 1984, 1985, and 1986 indicates that inventory was being converted into cash, and advances to suppliers were increasing. (See

⁹*Ibid.*

¹⁰Philip English, *Canadian Development Assistance to Haiti: An Independent Study*. The North-South Institute, Ottawa, 1984.

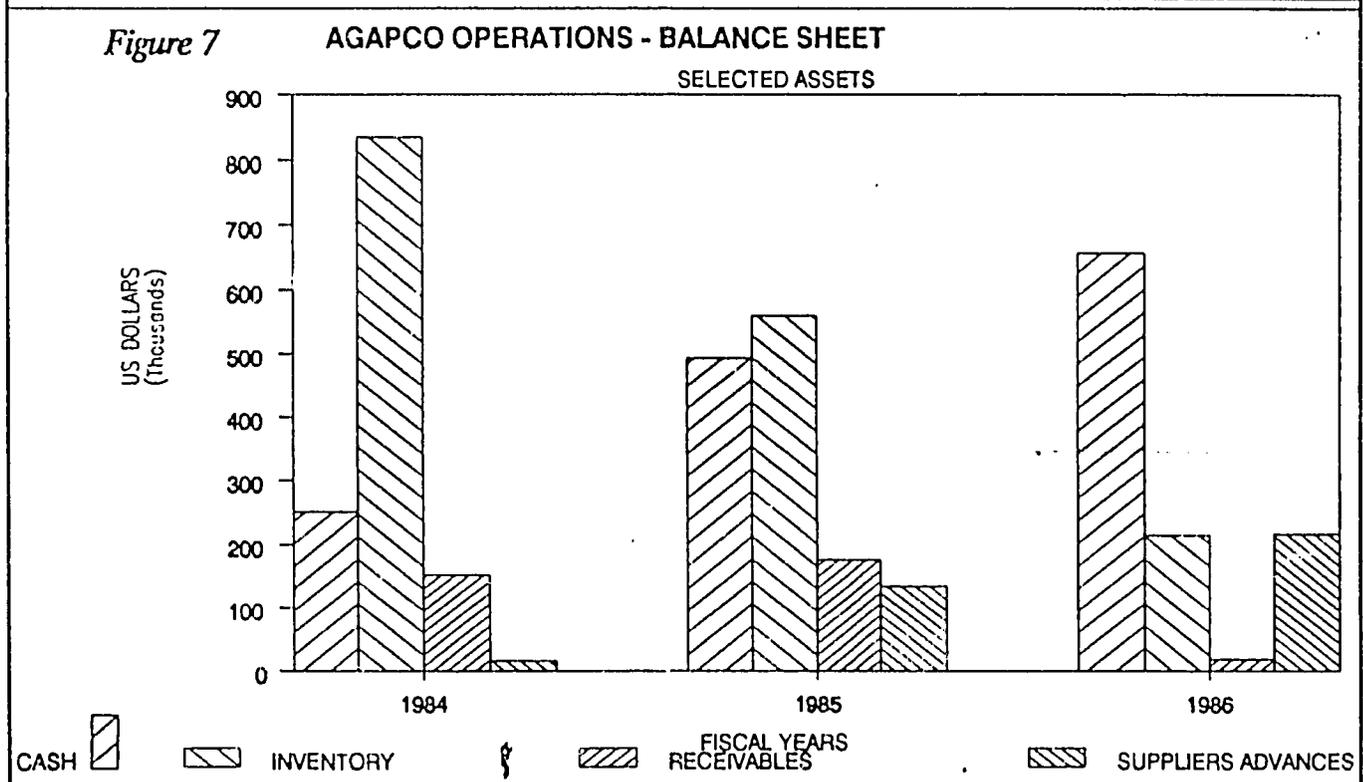
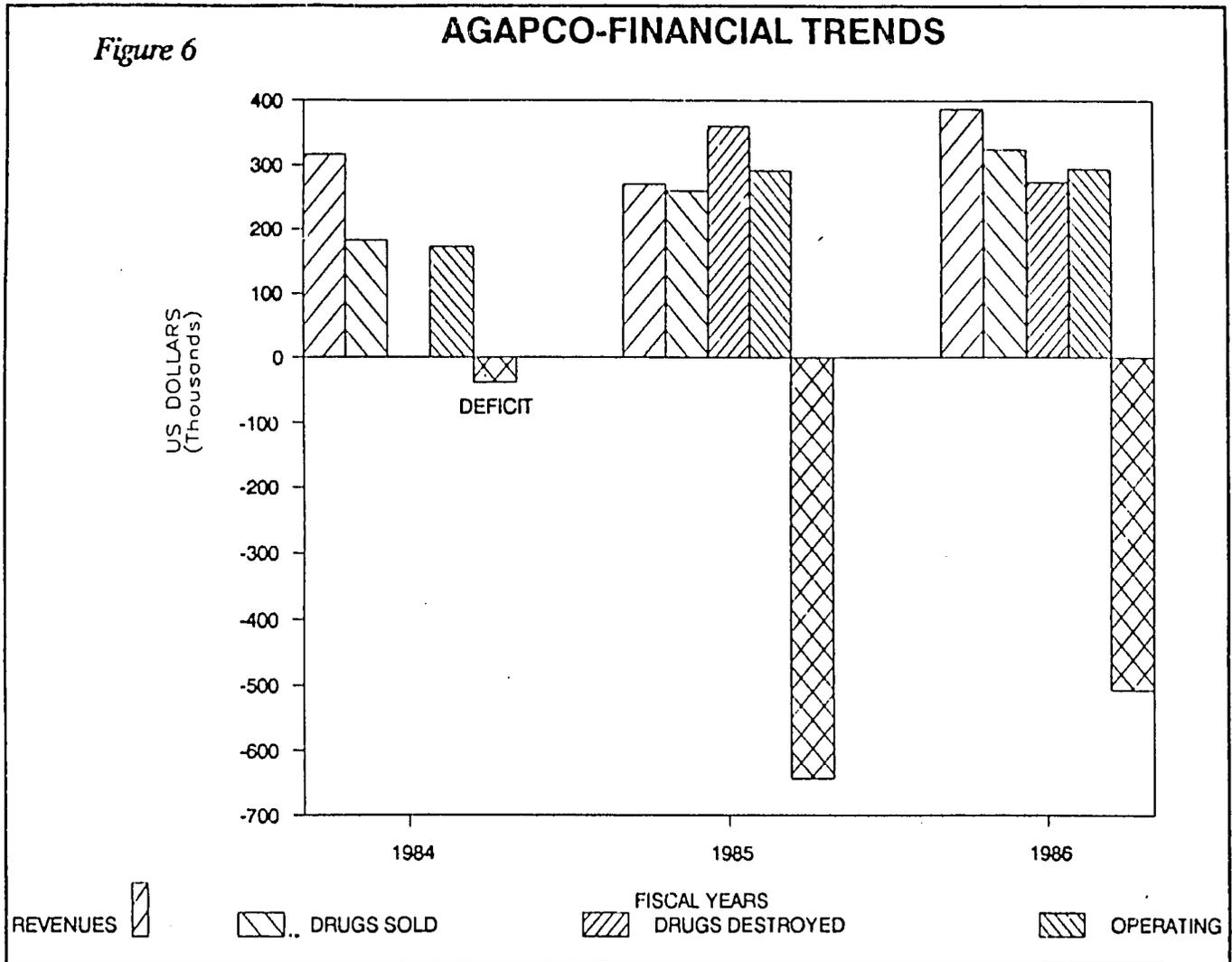


Figure 7.) However, without information on which items are currently available in stock and financial statements for the more recent years, it is not possible to draw useful conclusions relevant to the current period. AGAPCO's situation is both bleak and murky, as is the situation in Haiti. Judgements on both are often based on word-of-mouth information that is little more than part of a complex rumour mill where fact and fiction blur into indistinguishable shades of grey.

Despite this contextual greyness, AGAPCO's design and implementation does lend itself to analysis and comparison with other project models such as the ECDS:

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| <p>Politics has a role; management of the political environment is essential to gaining commitment.</p> | <p>Inter-institutional politics and institutional commitment are commonly the underlying factors that ultimately determine the success of a project. They cannot be ignored during the design and implementation phases.</p> |
| <p>Realistic goals support success.</p> | <p>Any project needs to be realistic about its ambitions, both the goals and the speed with which goals can be reached. Full cost recovery of all direct and indirect costs for a major drug sales program within a five year time span is probably unrealistic in most developing country contexts. Such an objective can create incentives that undermine both potentially conflicting public health goals and the project itself.</p> |
| <p>Epidemiology does not sell drugs.</p> | <p>A drug sales program needs to consider demand first; respond to the rational aspects of that demand; and progressively attempt to shift demand closer to need through appropriate social marketing techniques.</p> |
| <p>Other program costs build up from the base price paid for drugs. That price must be competitive.</p> | <p>Any program that intends to sell low price drugs must begin with a competitive procurement system that obtains the lowest possible prices for quality products. This is particularly true if the program intends to use fixed margins to mark-up drug prices in order to recover indirect program costs. Pricing layers are built up from the base price.</p> |
| <p>Cost recovery targets must be realistic; competitive market prices cannot be ignored.</p> | <p>While pricing levels should also consider real indirect costs at each level of the system, there is little utility in establishing one hundred percent cost recovery of all direct and indirect program costs if that goal is impossible to obtain. For example, AGAPCO could have set a goal of recovering only margins that would support operating costs for the pharmacies during early years. They are the roots that nurture the system, and if they die so will the system. Partial cost recovery is an advance over no cost recovery, and relieves some of the financial burdens on public health systems. If the ECDS's survival had depended on full cost recovery through MOH system user fees, its prospects for survival would be as bleak as AGAPCO's, despite the more affluent population in the EC subregion.</p> |
| <p>Nor can ability and willingness to pay.</p> | |

Elevated ambitions and rapid growth are high risk attributes.

Expansion of a program, especially a program intended to establish a network of distribution outlets, must move at a pace slow enough to allow for adequate planning of new outlets and simultaneous support of established outlets. No private sector business would attempt to expand at the rates AGAPCO was encouraged to achieve.

Identify key constituents as the target market.

Finally politicians and government administrators are usually the key support for a new public enterprise, as are donor agency officers when they are providing funding. Doctors, pharmacists, and other health professionals drive the demand for pharmaceutical supply; patients' influence is minimal compared to theirs. These are the key constituents for any public enterprise involved with drug supply.

Give them what they want; then, promote your ability to provide it.

These constituents want the right drug products, at the right price, in the right places. That is the promotional message that agencies like AGAPCO and ECDS should be able to deliver to their markets. The message is simple. Creating the reality is not.

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GLOSSARY

<i>AGAPCO</i>	<i>Agence d'Approvisionnement des Pharmacies Communautaires</i>
<i>BDS</i>	<i>Barbados Drug Service</i>
<i>CARICOM</i>	<i>Caribbean Community</i>
<i>CDB</i>	<i>Caribbean Development Bank</i>
<i>CIDA</i>	<i>Canadian International Development Agency</i>
<i>CMO</i>	<i>Chief Medical Officer</i>
<i>CMS</i>	<i>Central Medical Stores</i>
<i>CRDTL</i>	<i>Caribbean Regional Drug Testing Laboratory</i>
<i>EC</i>	<i>Eastern Caribbean</i>
<i>EC Dollar</i>	<i>Eastern Caribbean currency; 2.7 EC\$ - 1 US\$</i>
<i>ECCB</i>	<i>Eastern Caribbean Central Bank</i>
<i>ECDS</i>	<i>Eastern Caribbean Drug Service</i>
<i>F&T</i>	<i>Formulary and Therapeutics</i>
<i>GNP</i>	<i>Gross National Product</i>
<i>Gourde</i>	<i>Haitian currency; 5 gourdes = 1 US\$</i>
<i>MOH</i>	<i>Ministry of Health</i>
<i>MSH</i>	<i>Management Sciences for Health</i>
<i>MSPP</i>	<i>Ministere de la Sante Publique et de la Population</i>
<i>NGO</i>	<i>Non-governmental Organization</i>
<i>ORS</i>	<i>Oral Rehydration Salts</i>
<i>OECS</i>	<i>Organization of Eastern Caribbean States</i>
<i>PAHO</i>	<i>Pan American Health Organization</i>
<i>PP</i>	<i>Project Paper</i>
<i>PVO</i>	<i>Private Voluntary Organization</i>
<i>RHDS</i>	<i>Rural Health Delivery Systems Project</i>
<i>RPM</i>	<i>Regional Pharmaceuticals Management Project</i>
<i>TA</i>	<i>Technical Assistance</i>
<i>USAID</i>	<i>United States Agency for International Development</i>