STRATEGIES TO IMPROVE THE USE OF MEDICINES: WHAT MAKES THEM EFFECTIVE AND SUSTAINABLE?

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Inappropriate use of medicines is a prominent constraint in ensuring the accessability of the community to essential medicines. Worldwide more than 50% of all medicines are prescribed, dispensed, or sold inappropriately, while 50% of patients fail to take them correctly (WHO, 2002). Inappropriate use of medicines may occur in a form of unnecessary use of medicines, mainly antibiotics, indiscriminate use of injection, failure to prescribe correct medicines, etc. Improving the use of medicines in developing countries is not a simple task. The complexity of the medicine supply, imbalance between incentive and desinsentive, weaknesses in financing scheme, low salary, market failure, inadequate information to the patients, etc., may contribute to the problem.

Systematic approaches to promote rational use of medicines was started in 1989, when clinical pharmacologists/pharmacologists of ten countries from Asia and Africa regions involved in the establishment of the International Network for Rational Use of Drugs (INRUD). Each INRUD country member consist of clinical pharmacologist or pharmacologist, health manager, clinician, pharmacist, and behavioral scientist. The objective of the network is to develop well-proven strategies to improve medicine use through comprehensive transdisciplinary approaches.

Effective strategies have been identified and promoted. However, the improvements are not always maintained; as the medicine use often returns to the previous baseline after a period of time and makes the energy, time, and money spent on activities wasteful. As reported from the International Conference in Improving the Use of Medicine (ICIUM) in 1997, strategies to promote a better use of medicines should focus on specific disease problem, addressing the underlying motivations, interactive, problem-solving in small-group formats, along with feedbacks of performance to providers, monitoring and supervision, accompanied by peer group guidelines development. In other words, motivation to change prescribing behaviour should come from the heart, and supported by working environment conducive for improving prescribing practices.

One example of these strategies is reducing the unnecessary use of injections by applying Interactional Group Discussion (IGD) (Prawitasari, Suryawati, et al., 1996). When field-tested in public health facilities in Indonesia, IGD reduced the unnecessary injection use significantly, and this impact sustained for years. This study then triggered a successful national movement to reduce unnecessary injections. IGD is a form of behavioral intervention, wherein a variety of persons with different motives interact in a discussion of a target behavior, led by an expert facilitator. The success of IGD to reduce the use of injections might be due to the confrontation of during the discussions between patients and prescribers, reality testing regarding beliefs about patient demand, and consensus between both parties to reduce the injections. In brief, the study shows that better communication and thorough discussion between prescribers and the patients on a specific problem in

medicines use will change prescribing practices because both parties are convinced to do so.

In health facilities where there is imbalance incentive-disincentive system to support appropriate use of medicines, such as private clinics/hospitals, the situation might be more complex. Making a sustainable improvement in prescribing practices might be hardly possible without improving the work environment which is conducive to the positive attitude. In this situation, knowledge or understanding alone is not enough to lead to appropriate use of medicines. There should be managerial and regulatory decisions to support these changes. Personal interest for better incentive is quite common among prescribers, but this sensitive issue is unfortunately rarely spoken. A successful strategy named MTP (an abbreviation of Monitoring-Training-Planning) has therefore been developed and field-tested at hospital setting (Suryawati, 2004).

MTP strategy follows the quality improvement management cycles in hospitals, so that the activities are self- initiated, self-executed, and self-evaluated. This self-created activities allow sensitive issues be discussed and solved within the group of target. Each MTP cycle consists of three components of activities, i.e., description of the recent situation, problem identification and measuring the magnitude of the problem (M-Monitoring), reflection of previous experience in solving the problem and identifying strategies to solve the recent problem (T-Training), and setting the target of improvement, executing the strategy, and setting the next monitoring (P-Planning), etc. Based on the experience in implementing

MTP in Indonesia, Lao PDR and Cambodia, significant improvements are observed after three MTP cycles.

What the two examples tell us is that intensive interaction and thorough discussion, either between prescribers and patients or prescribers and health managers, will result in stronger basis for behavioral changes in improving prescribing practice. Inappropriate use of medicines is not a remote issue; sustainability of behavioral changes for better prescribing practice will not sustain longer without improving the work environment.

References

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