lishment, the EBM was highlighted. In 2004, the EBM subcommittee was established under the CMDA.

*Chinese Medical Association.* Since 2002, the Chinese Medical Association recognized the value of EBM.

**EBM in universities.** Many other Chinese universities have developed their university-based center for EBM, including Beijing University, Fudan University, Lan Zhou University, Guang Xi University of Medical Sciences, and Zhe Jiang University. Several universities have developed courses for EBM postgraduate and undergraduate courses.

**Conclusions**
The birth and development of EBM in China was a result of practical needs, governmental support, and international efforts. The further development of EBM will be full of challenge and opportunity. But we are confident to promote further the development in China. The EBM in China is part of the world efforts, and the world involvement in EBM cannot be without the Chinese role.

**References**

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**Drug Control and Formulary Management in Malaysia**

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**Introduction**
From the year 2000, the national drug expenditure has seen an increase from RM346 million ($91 million) to RM915 million ($241 million) in 2005. From the year 2004 to 2005, an increase of 13.3% was recorded [1]. Factors that may contribute to this increase include increase in drug prices, a growing and aging population, higher expectation of the public regarding equality in accessing therapy, long-term drug treatment and polypharmacy, improvements in diagnosis and treatment of diseases, and technological advancement that produces newer expensive drugs [2,3].

**Drug Registration and Regulation in Malaysia**
A statutory body known as the Drug Control Authority (DCA) is responsible to ensure that medicines marketed in Malaysia are safe, efficacious, and of quality. This is done through a systematic registration, licensing, and surveillance scheme which is part of a mandatatory product registration process. The National Pharmaceutical Control Bureau is an organization under the Pharmacy Division. It is responsible for the Quality Assurance program and performs the operational function of the DCA. This include activities such as product evaluation, product assessment (laboratory testing), Good Manufacturing Practice inspections, processing of product certificate and licences, postmarketing surveillance, and monitoring of Adverse Drug Reaction.

**Malaysian Ministry of Health (MOH) Drug Formulary**
In Malaysia, drugs that are made available for use in the public health-care system are controlled through the MOH Drug Formulary. The MOH Drug List was first introduced in 1983 and contains a list of drugs that have been approved for use in the MOH hospitals and institutions. The use of nonformulary drugs requires prior authorization and approval by the Director-General of Health. The use of this formulary does not include the private hospitals and teaching hospitals. By the end of 2005, there were 1322 preparations listed in the formulary. Drugs in the formulary are classified.
according to the World Health Organization (WHO) Anatomical Therapeutic Chemical classification and a Malaysian Drug Code is assigned to each particular drug in the formulary for identification purposes. The drugs are listed according to their generic name and also has the category of prescriber-authorized indicated. The category of prescriber authorization are consultant/specialists for specific indications only (A*), consultant/specialists (A), consultant/specialists/family physician specialists (A/KK), medical officers (B), paramedical staff (C), and paramedical staff doing midwifery (C+). Depending on the therapeutic classes (there are 14 therapeutic classes), there may be 10–30 different drugs available for each class. For example, there are more than 26 nonsteroidal antiinflammatory drugs (constituting 13 active ingredients) and more than 60 antihypertensive agents (constituting 34 active ingredients) available presently. The MOH Drug Formulary has varying degrees of prescriber restriction to control and optimize drug use.

To review and update the Drug Formulary periodically, the MOH has a Health Drug List Review Panel consisting of senior consultants and pharmacists from the MOH. The drug review will be made based on factors such as clinical advantage, best and current treatment options, current and previous usage, prescribing pattern, approved dosage and indication, and cost of treatment. This panel also meets two to three times in a year to consider proposal for new drugs, and for deletion, alteration, addition of the drug/dosage form/formulation/indication/category of prescriber for the MOH Drug Formulary.

**Challenges and Strategies for Improvement**

Findings of a recent WHO/Health Action International (HAI) report, “A Survey of Medicine Prices Availability, Affordability and Price Components in Malaysia” [4] showed that drug prices in Malaysia are generally higher for both generics and innovator drugs when compared with the international reference price. The report also noted that there was low affordability for all categories of drugs studied for both innovator brands and generics. These were for common ailments such as hypertension, asthma, and diabetes. As Malaysia practices free market for drug prices (i.e., does not control the price of drugs), a market failure situation is expected to occur because of the asymmetrical nature of the information available coupled with the monopoly and patent protection of the pharmaceutical industries. It is important that the MOH implement policies that can avoid this situation while at the same time improving efficiency of the public health-care services. A full pharmaco-economic evaluation and continuously measuring outcome for selection of new drugs are some of the strategies suggested. Other strategies include generic substitution policy and using standard treatment guidelines in clinical and policy decision-making to ensure that the most cost-effective and evidence-based alternatives are chosen.

In 2004, the National Medicine Use Survey was undertaken by the MOH as a maiden landmark project to obtain baseline data on the national drug utilization pattern. The survey found that among the top five drugs by therapeutic group utilization are drugs for diabetes, beta-blockers, agents acting on the rennin-angiotensin system, drugs for chronic obstructive airway disease, and systemic antihistamines [5]. Drug utilization patterns give early warning signs of inappropriate drug use and are part of a continuous quality improvement program.

**Conclusion**

A mandatory registration process has been implemented since 1984 to ensure that medicines are safe, efficacious, and of quality. In Malaysia, the public health facilities support 80% of the country’s patient population and the drugs made available for use in the public health care are controlled through the MOH Drug Formulary. Faced with an increasing drug expenditure and limited resources, strategies involving drug policy and formulary management must be considered by the Malaysian MOH to ensure efficient resource allocation.

**References**