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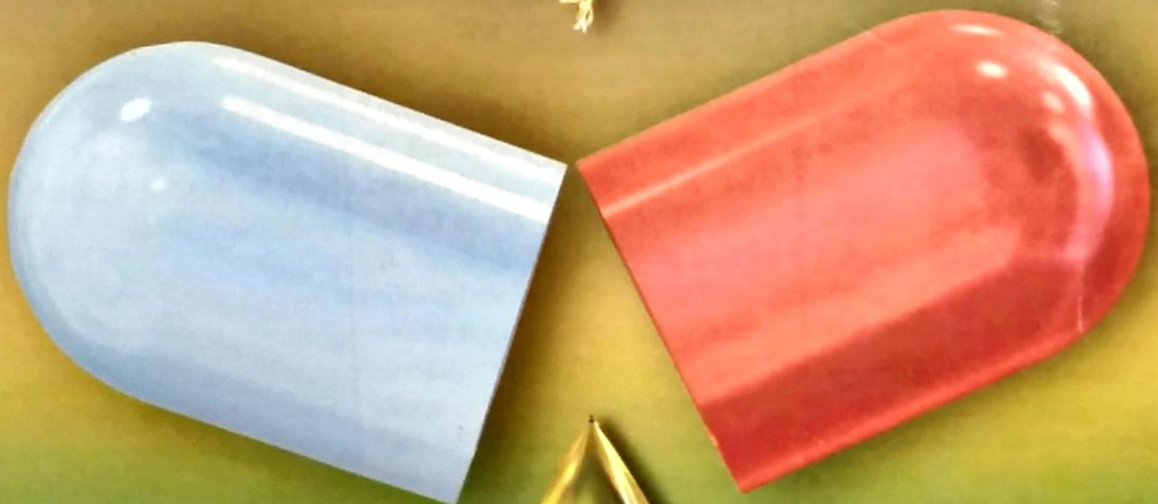

Towards Achieving Accessibility, Affordability, and Safety of Medicines

health action

HAFA

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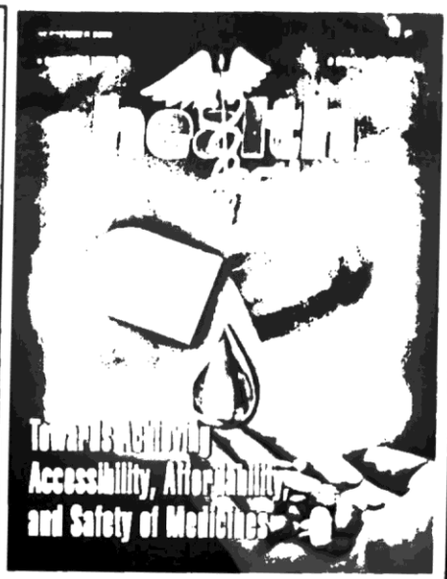

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Thought for the Month

"Healing may not be so much about getting better, as about letting go of everything that is not you; all of the expectations, all of the beliefs, and becoming who you are."

Rachel Naomi

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COVER STORY

Essential Medicines

Economic constraints in access in India

Dr. Purnabrata Gun & Sushanta Roy

Essential medicines are among the most cost-effective elements in modern health care and their potential health impact is remarkable.

This year alone, there will be over 40 million deaths in developing countries, one-third among children under age five. Ten million deaths will be due to acute respiratory infections, diarrheal diseases, tuberculosis, and malaria. Safe, inexpensive, essential drugs can be life-saving in all these disease conditions. Simple iron-folate preparations can reduce maternal and child mortality from anemia of pregnancy; treatment of sexually transmitted diseases reduces transmission of the AIDS virus; and treatment of hypertension reduces heart attacks and strokes.

A global concept

The concept of essential medicines is forward-looking. It incorporates the need to regularly update medicine selections to reflect new therapeutic options and changing therapeutic needs; the need to ensure drug quality; and the need for continued development of better medicines, medicines for emerging diseases, and medicines to meet changing resistance patterns.

Evolution of pharmaceuticals and the WHO model list of essential drugs

Earlier, different herbs and minerals were used to treat diseases. In 1897, aspirin was introduced as the first synthetic pharmaceutical. In the next 100 years, the world has seen the introduction of the first modern antibiotic (in 1941), the first commercially formulated antimalarial (in 1943), and the first antitubercular (in 1944). The 1950s saw the first clinical use of oral contraceptives, of drugs for diabetes and of drugs for mental illnesses. The development of drugs for other infectious diseases, cardiovascular diseases and for a wide range of other conditions quickly followed.

In the next few decades, there was a huge proliferation in the number of formulations, many of them being unnecessary, irrational or hazardous. There was a cry worldwide for rationalization of medicines. When WHO published the first Model List of Essential Drugs in 1977, it identified 208 individual medicines which together could provide safe, and effective treatment for the majority of communicable and non-communicable diseases.

Access, quality and rational use of medicines and essential medicines

The economic impact of pharmaceuticals is substantial, especially in developing countries. While spending on pharmaceuticals represents less than one-fifth of total public and private health spending in most developed countries, it represents 15 to 30% of health spending in transitional economies and 25 to 66% in developing countries. In most low-income countries, expenditure on pharmaceuticals is the largest public expenditure on health after costs for personnel and the largest household health expenditure. And the expense of serious family illness, including drugs, is a major cause of household impoverishment. Despite the potential health impact of essential drugs and despite substantial spending on drugs, lack of access to essential drugs,

irrational use of drugs, and poor drug quality remain serious global public health problems.

Situation in India

The World Medicines Report [2004] of the World Health Organization finds that India is the country with the largest number of people [649 million] without having access to essential medicines. Today, India is the 4th largest producer of medicines in the world and it exports medicines to over 200 countries, clearly deficiency in local production and availability are not major constraints.

Studies also indicate that poorer populations spend larger proportions of health care expenditure to buy medicines. A very large portion of this cost is borne by the people themselves. And the cost of the medicines is a major barrier to access to healthcare. The situation is compounded by the fact that the proportion of private expenditure of the total expenditure in health is one of the highest in the world— 84% as compared to public expenditure which is just 16%.

The National Sample Survey (NSS) clearly stated that the proportion of expenditure on medicine in the total expenditure on healthcare is higher among the poor. Thus universalization of access to essential medicines, in such a situation, would have to look at economic constraints that compromise access. It is estimated that the total expenditure on medicines in India is in excess of Rs. 30000 crores – or to put it in another way Rs. 1500/- for every family in the country. It is easy to comprehend that an expenditure of this magnitude would place a major burden on the finances of the poor family, especially in a situation where different estimates project that 20-35% of the Indian population live below poverty level.

Community Development Medicinal Unit, West Bengal

Community Development Medicinal Unit (CDMU), West Bengal, began its journey in 1984, as a unit of West Bengal Voluntary Health Association, out of human cry for medicines. Initiated as pooled procurement that guaranteed cost containment it distributes the same to various health mission organizations in West Bengal.

Presently, CDMU reaches to more than 200,0000 people through its network of 600 partner-members or member organizations [MOs] working in the field of healthcare.

Mechanism of cost-containment of medicines, supplied by CDMU

Escalating prices of essential medicines is a major public health concern. Despite this constraint, many NGOs are working in the field of healthcare with dedication and successfully implementing various national programmes on specific diseases within their limited resources.

In keeping with World Health Organization [WHO] guidelines and our National Essential Medicines List, CDMU operates by a list of essential medicines and medical supplies. This list includes items stocked regularly at Kolkata and Siliguri units and various reserve items – required by some of the MOs in special situations.

The following criteria are followed:

- Medicines are supplied in their generic names.
- The medicines are selected on the basis of the following criteria:
  - Assured quality
  - Affordable price [to the MOs]
  - Appropriate strengths and dosage forms
  - Adequate information-backing
  - Past performance of the supplier

During the final selection of the suppliers , the prices quoted and quality are carefully considered by CDMU.

How people benefit from medicines supplied by CDMU

The table shows some of the prices that CDMU offers and how people are benefited:

Name of the medicines	Pack size	Average Brand price [Rs]	Generic price [Rs]In CDMU	Benefit in Rs.
Tab Paracetamol 500 mg	10's	9.49	2.90	6.59
Tab Ciprofloxacin 500 mg	10's	89.60	12.00	77.60
Cap Amoxicillin 500 mg	10's	80.55	21.00	59.55
Tab Albendazole 400 mg	1's	15.52	1.85	13.67
Tab Amlodipine 50 mg	10's	33.56	3.36	30.20
Cap Omeprazole 20 mg	10's	47.33	4.95	42.38
ORS Sachet	21gm	12.00	3.00	9.00

Thus the medicines that are supplied by CDMU actually reach the poor through its network of MOs and the poor people can respond to their illnesses when they are sick.

Thus CDMU paves the way for universalization of access to essential medicines in the last 2 decades and will continue this effort in the coming days. ■

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