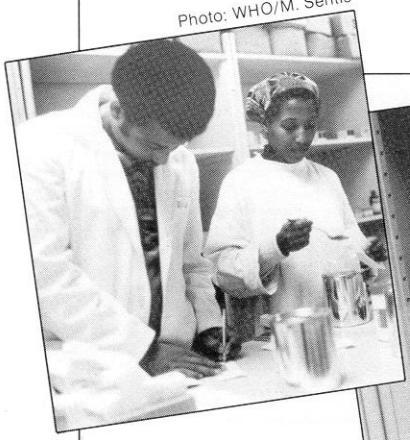


Photo: WHO/M. Sentis

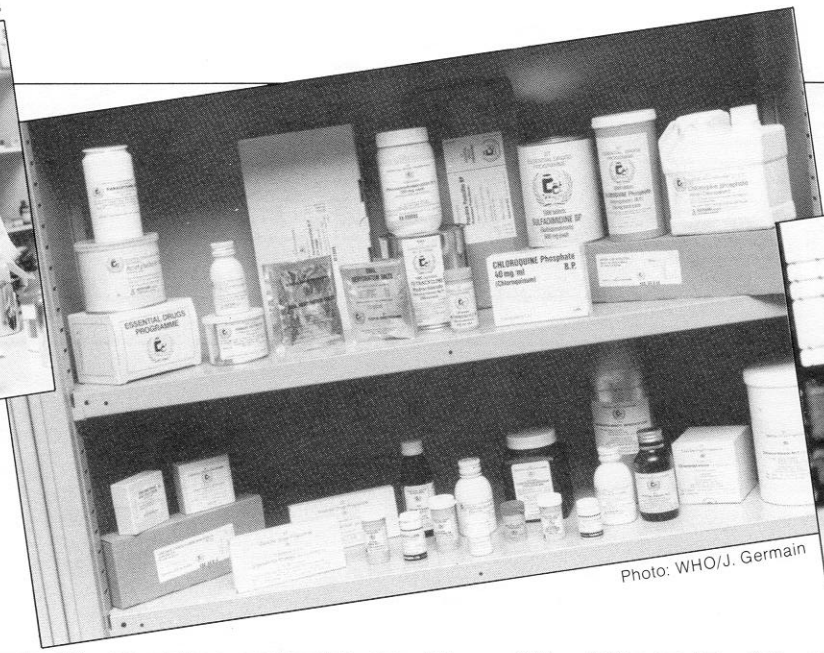


Photo: WHO/J. Germain

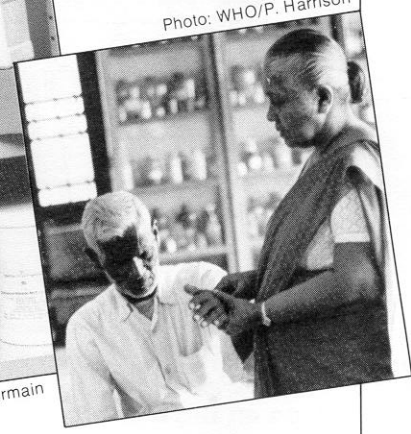


Photo: WHO/P. Harrison

Essential drugs to satisfy the health care needs of the majority of people

ESSENTIAL DRUGS

YOJANA SHARMA

Although three-quarters of the world's population live in the developing countries, Third World people represent just 15 percent of the world pharmaceutical market. Yet their drug needs far outstrip what they can actually obtain, not only because of the size of the Third World population, but also because of the disease patterns.

Diarrhoeal, parasitic, and infectious diseases, controlled in the developed world by improved living conditions, water and sanitation facilities, and better health services, are still rife in the Third World. Here diarrhoea is the single largest cause of death in children under five, accounting for some 4-6 million deaths a year. An estimated 210-220 million people suffer from malaria, a debilitating disease that saps strength and reduces productivity. Airborne diseases such as tuberculosis and diptheria are still important causes of death.

The real tragedy is that the vast majority of Third World ailments are treatable and curable with common, cheap, and easily available drugs. Yet these countries will continue to go without the medicines they need because it is purchasing power rather than real health needs that determine who gets the drugs.

Only 12 percent of drug production takes place in the developing countries and not a single developing country can claim to be self-sufficient. They have little choice but to buy the bulk of their drugs from the Western-controlled multinational drug companies, which control 90 percent of the production and trade in pharmaceuticals.

Such dependence also means these countries are vulnerable to overpricing. Purely arbitrary pricing policies of the multinational drug companies grossly inflate the medicine bill for the countries that can least afford it and deny drugs to those who need them most.

But what is even more worrying is the well-documented evidence that multinational drug companies supply and promote ineffective, inappropriate, and, even downright dangerous, preparations in developing countries, which have few effective controls.

Volunteer health worker in Nepal explains uses of essential drugs

Photo: WHO/UNDP T. Farkas

Multivitamins, cough syrups, appetite stimulants and potency drugs are just some of the nonessential drugs that are promoted and consumed at the expense of basic lifesaving drugs. In some developing countries, up to 25 percent of drugs consumed come under these categories. In Nepal, where serious respiratory disease and protein malnutrition are widespread, one-third of the drugs marketed are multivitamin tonics. And in Thailand it was found that consumption of the anti-malarial chloroquine was only 7 percent of the estimated need.

More frightening are the examples of fraudulent and misleading advertising which sometimes can be dangerous. Holland's biggest pharmaceutical manufacturer, Organon International, was brought to task by a Dutch industrial tribunal after a consumerist pressure group found it was promoting anabolic steroids for malnutrition and loss of appetite in countries like Peru, India, Bangladesh, Indonesia, and Kenya. These hormonal preparations can in fact stunt children's growth.

Consumer groups are convinced that these and many other examples they have picked up are just the tip of a huge iceberg, and have been calling for a World Health Organization (WHO) code of conduct to control the activities of the pharmaceutical companies. In 1982 when such a code seemed imminent, it was effectively forestalled at the World Health Assembly in Geneva. The drug manufacturing industry, under the auspices of the Inter-

national Federation of Pharmaceutical Manufacturers Associations (IFPMA), announced its own code of marketing which states, among other things, that manufacturers shall not make claims that cannot be supported scientifically, and that products must have "full regard for the needs of public health." At that time WHO officials felt that industry's own code should be given a chance before WHO drew up a code of conduct of its own.

At the May 1984 World Health Assembly, just two years later, many Third World delegates felt the gaping loopholes in the industry code were already too apparent. Foremost among the reasons for the ineffectiveness of the code, as far as delegates could see, was inadequate monitoring — a problem that sparked off a row at the WHO executive board meeting in January when the United States delegate, backed up by the IFPMA, objected to WHO monitoring the code. WHO officials had been notifying the IFPMA of breaches of the code sighted while on their travels. A U.S. state department official said it was not for WHO to monitor the code of a private organization.

But, as consumer groups vociferously pointed out, there is no way of finding out if action has really been taken by companies brought to order by the industry's code. Systematic monitoring is what is needed as self-policing just does not work. Proof of this is that, apart from WHO, only consumer groups have been submitting complaints to the IFPMA.

With developing countries sceptical of industry's stated intention to prevent wild claims being made about drugs, this year's World Health Assembly agreed to a meeting to be held this year to discuss information on the proper use of drugs and on drug marketing practices. Few delegates doubted that the meeting is the first step towards drafting a WHO code of conduct on the marketing of pharmaceuticals in the Third World.

In the meantime the needs of the Third World are pressing. They cannot wait for industry to prove its sincerity. It is impossible for them to try to counteract the market power of a hundred profit-seeking private enterprises, so they must organize their own buying force if they are to get anything like a fair deal.

The first step is an essential drugs list. A list of 250 essential drugs was drawn up by WHO in 1978. Since then about 80 developing countries have developed their own essential drugs list based on their own needs and disease patterns and following closely the WHO model list. With some 50 000 branded drugs on the market, this enables developing countries with scarce resources to concentrate on those drugs that they really need and keep the pharmaceutical bill low by shopping around for a limited list of medicines.

This is important in a market where pricing seems to follow few rules. The Algerian Committee Against Tuberculosis did a survey in 1976 and found that isoniazid from a Swiss company cost nine times more than the same drug bought from a French concern. Similarly streptomycin was four-and-a-half times more expensive in France than in Mexico. Even within the same company there seems to be little pricing logic. In 1980 Mozambique's central drug buying agency, Medimoc, studied the market for the drug furosemide. One company offered it for US$150 for a thousand tablets in one location and purveyed it elsewhere for US $36 per thousand. Doing the rounds of other companies, Medimoc eventually procured furosemide at US $8 per thousand tablets.

But this kind of shopping around, which is the basis of a country's bargaining power, depends on a thorough knowledge of the pharmaceutical market that many smaller developing countries lack. WHO therefore promotes pool procurement of essential drugs by several countries within a region. The Gulf states, for instance, have been pooling resources since 1978 and regularly save 25 percent of their total pharmaceutical bill in this way.

But for most countries pooled procurement is still a long way off. Even the hospital sector, the military, social security systems and other government departments still buy their medicines independently of each other, and these countries miss out on the opportunity to get lower prices.

UNICEF has been successful in getting low prices for bulk orders. In 1983 a system of international tender for about 40 essential drugs for Tanzania was tried out as a test case. Tanzania called for bids for a 3-year supply of drugs; financing was assured by Danish development aid. Competition was fierce among the 120 companies that participated in the bidding. WHO described the prices obtained as the lowest ever seen for essential drugs.

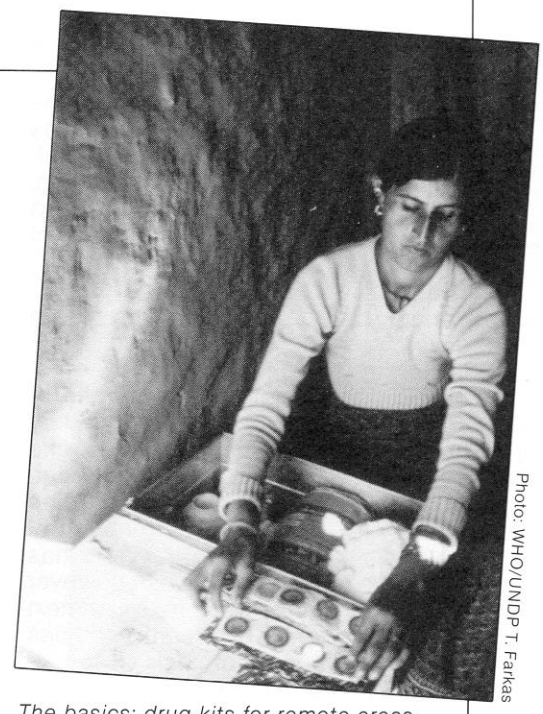


Photo: WHO/UNDP T. Farkas

The basics: drug kits for remote areas

But even these successes are limited, as there are few countries that can find the foreign exchange that the UNICEF scheme requires in advance. Some least-developed African countries only have enough foreign exchange reserves to meet all their import needs for only two months ahead. Buying drugs for a 3-year period, even if it means considerable savings, is out of the question.

This does not daunt either UNICEF or WHO. The possibility of accepting partial payment in local currency is being explored. And a US$5 million joint UNICEF/WHO trust fund has been proposed to help bulk procurement of essential drugs. If approved, the scheme could nudge more countries into starting essential drugs programs as these will be able to draw on the fund first.

Ironically, apart from UNICEF and WHO, poor countries have a third option when they want help with essential drugs, particularly distribution, storage, and training of personnel in the drug chain. At the 1982 World Health Assembly, the IFPMA agreed not only to supply a range of essential drugs under "favourable conditions" to underdeveloped countries, but also to help African countries with distribution. The move was seen as an attempt to improve industry's tarnished image.

But a WHO paper reports that no country has so far been able to receive drugs under "favourable conditions" according to the IFPMA offer. WHO estimates that at most the drug industry has contributed

about US$1 million worth for WHO's anti-malarial program and for a few bilateral schemes with African countries that are only marginally connected with WHO's essential drugs program, if at all.

The pharmaceutical industry is quick to point to its assistance to Gambia as an example of how it is helping developing countries with drug distribution. But one WHO official has described the program as the "biggest case of overkill seen in an African country." The sum of US$160 000 has been donated by 13 U.S. companies to develop distribution channels for drugs in Gambia, which has a population of only 650 000. The largest amounts, of some $17 000 each, were donated by huge billion-dollar multinationals like Eli Lilly, Johnson and Johnson, Pfizer, Schering Plough, Searle, Smith, Kline and Syntex. As Dr Ernst Lauridsen of WHO's essential drugs program has remarked, these initiatives, however welcome, must be seen in the context of the sums spent by drug companies on the promotion of their drugs — usually 10-20 percent of turnover.

Another pilot project, with the Swiss pharmaceutical industry, intended to improve distribution of drugs in the central African state of Burundi is being carried out in collaboration with WHO. Hoffman la Roche, Ciba-Geiby, and Sandoz have put up $30 000 between them to improve access of the 4.5 million population to drugs. But the Burundi project too has been attacked as simply a public relations exercise.

However, the Burundi health ministry officials do not accept the criticism, and seem genuinely appreciative of the initiative. Paul Mpitabakana, a health ministry official, expressed the real predicament of poor countries in his comment on accepting the industry offer: "We cannot do things by ourselves," he said. "We need help. And if someone comes to us offering that help, well, of course we take it; it is better than nothing." □

Yojana Sharma is a Brussels-based journalist specializing in Third World affairs.

Local resources for low-cost drugs

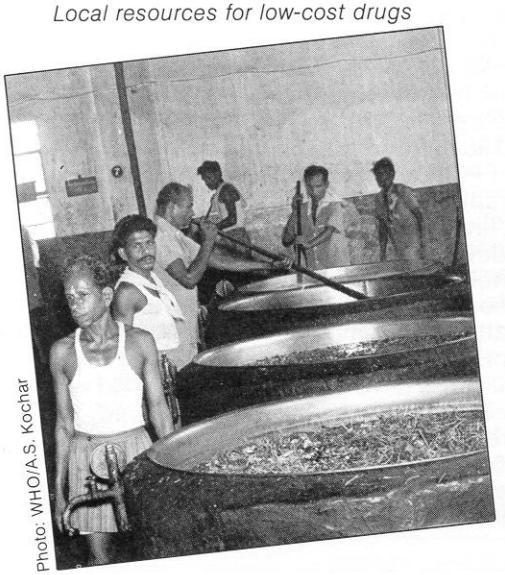
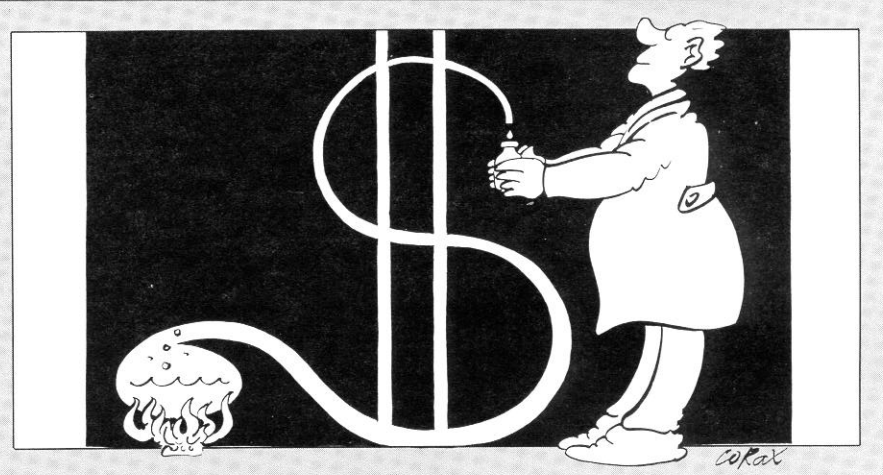


Photo: WHO/A.S. Kochar



CANADA

BY ANY OTHER NAME . . .

Third World countries are not alone in finding themselves embroiled in a debate about the higher costs of brand name drugs over their "essential" or generic counterparts. The Pharmaceutical Manufacturers' Association of Canada (PMAC) is pressuring the Canadian government to reverse a 1969 change to the Patent Act that permits companies operating in Canada to import the ingredients to make generic copies of brand name drugs by paying the patent holder, or investing company, a four percent royalty.

In submissions to a federal commission investigating the issue, PMAC claimed that the practice of compulsory licensing, as it is called, does not allow the 66 multinational companies PMAC represents to have a sufficiently long period of exclusive access to the market for new drugs they produce. The generic firms are being allowed to manufacture under license within four or five years of the brand name drug's entrance onto the market: the pharmaceutical multinationals claim that this is not sufficient time to recover the investment in research needed to develop the drug.

Consumer groups such as the National Anti-Poverty Coalition claim that the 15 year-old amendment to the Patent Act has saved Canadians — particularly poor ones — millions of dollars a year. They say that consumers save CA$130 million a year directly and that an additional CA$140 million is saved by taxpayers in lower costs for provincial plans that provide prescription drugs to the poor.

The Canadian Drug Manufacturers' Association (CDMA), which represents a dozen Canadian-owned companies that make generic drugs, wants the federal inquiry to recommend a continuation of the present licensing practices. As a compromise, to encourage research and development of new drugs in Canada, the association would accept the granting of a 5-year patent for pharmaceutical products invented, patented, and manufactured completely in Canada.

CDMA claims that competition between generic and brand name drugs keeps prices down and that the pharmaceutical companies make enough profit to recoup their investments. Prior to the 1969 legislation, Canadians were paying amongst the highest prices in the world for drugs. The success of the changes in licensing in lowering prices of drugs for Canadians has prompted other countries to approach CDMA and to inquire about following Canada's lead in this area.

The multinational companies' claim that compulsory licensing has reduced their profits and ability to develop new drugs is not supported by the facts, Lawson Hunter, director of investigation at the bureau of competition policy in Consumer and Corporate Affairs, told the inquiry. Mr Hunter said that virtually all research of new drugs is done in the home country of the parent company and the overall cost of research represents only 3.8 percent of the international sales of the pharmaceutical industry.

"The fact that compulsory licensing was done away with would not be likely to increase the pharmaceutical companies' commitment to research and development in Canada," he said.

Mr Lawson pointed out that the drug companies' profits in Canada have improved, or, at worst, remained unchanged since 1969. He felt that the companies were lobbying against compulsory licensing in Canada because if other countries that now have full patent protection adopted similar patent policies this would cut into the companies' international profits.