UN MDG Gap Task Force Report

Ban Ki-moon calls report a ‘wake-up’ call

At the halfway point in the progress towards the Millennium Development Goals (MDGs), essential medicines are still more costly and less available than necessary, especially in developing countries. Data on medicine prices and availability is contained in a report released by the UN Secretary-General Ban Ki-moon on 4 September 2008.

Delivering on the Global Partnership for Achieving the Millennium Development Goals was prepared by the MDG Gap Task Force on global partnerships, created by the UN Secretary-General to track international commitments on aid, trade, debt and to follow progress on access to essential medicines and technology. MDG Target 8.E is dedicated to achieving access to affordable essential medicines in developing countries.

The report found that in the public sector, generic medicines are only available in 34.9% of facilities, and on average cost 250% more than the international reference price. In private sector pharmacies, availability was 63.2% but the cost was about 650% more than the international reference price. The data comes from medicine price and availability surveys undertaken using the methodology developed by WHO and HAI. The MDG Gap Task Force report acknowledges the contribution that the surveys have made, and cites policy recommendations based on the findings of over 50 surveys completed to date using the WHO/HAI survey tool (see box). Ban Ki-moon described the report as “a wake-up call”.

WHO and HAI believe it is not enough to produce effective medicines if people cannot access them where and when they need them. The power of health interventions, medicines and technologies are not yet matched by an equal power to deliver them effectively to those in greatest need. Go to the WHO website (www.who.int/medicines/mdg) or HAI website (www.haiweb.org/medicineprices) for more information or to access the report.

Accelerated progress requires explicit national and global targets in a number of areas.

At the national level:
- eliminate taxes and duties on essential medicines;
- update national policy on medicines;
- update the national list of essential medicines;
- adopt generic substitution policies for essential medicines;
- seek ways to reduce trade and distribution markups on prices of essential medicines;
- ensure adequate availability of essential medicines in public health care facilities;
- regularly monitor medicine prices and availability.

At the global level:
- encourage pharmaceutical companies to apply differential pricing practices to reduce prices of essential medicines in developing countries where generic equivalents are not available;
- enhance the promotion of the production of generic medicines and remove barriers to uptake;
- increase funding for research and development in areas of medicines relevant to developing countries, including children’s dosage forms and most neglected diseases.
Second edition of survey manual published

The second edition of *Measuring medicine prices, availability, affordability and price components* includes updated versions of the survey manual, workbook and CD-ROM of tools and background materials, all of which have been refined based on the lessons learnt in the 50+ surveys conducted to date. What’s new?

**Sampling**
Due to poor medicine availability, the number of survey areas has been increased from 4 to 6 to improve price data analyses.

**Medicines**
The core list of 30 medicines has been replaced by a global core list of 14 medicines used in all surveys, plus region-specific lists of 16 medicines to account for regional differences in usage. Up to 20 supplementary medicines are still selected at the country level for their local importance.

**Price components**
The methodology for collecting medicine price components has been improved and now enables comparisons across health systems and countries. Data are now analysed in 5 common stages of the supply chain from the manufacturer’s selling price to the dispensed price.

**International price comparisons**
Guidance is given on how to undertake valid international price comparisons using survey data from different years, taking into account the reference prices used, inflation/deflation and differences in purchasing power.

**Policy options**
Greater guidance is provided on policy options relevant in circumstances of high prices and/or low availability.

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Kenya

**Artemether/lumefantrine availability improves**

When the Kenyan Ministry of Health, HAI Africa and WHO started monitoring medicine prices and availability in April 2006, the availability of artemether/lumefantrine (AL) 20/120 mg tablets in the public sector was only 3% (where it is supplied free-of-charge), compared to 31% and 72% in the mission and private sectors respectively. This was of critical concern as AL is the recommended first line treatment for uncomplicated malaria, and prices in private retail pharmacies and mission facilities were beyond the reach of most Kenyans.

Since then, there has been a dramatic improvement in the availability of AL particularly in the public and mission sectors (see chart). The most recent data shows 81% and 69% availability in the public and mission sectors respectively (although public sector availability has fallen from 100% in Oct 2007).

Interestingly, in 2006 the Global Fund started providing financial support for the purchase of AL. It is now generally free-of-charge to patients in mission facilities, as well as in public sector facilities. This data demonstrates that the public sector can improve medicine availability when adequate financing is available. It also demonstrates the value of regular monitoring so the impact of interventions can be assessed.

However, problems remain. The availability of amodiaquine remains high in all sectors although it is no longer recommended as monotherapy. The availability of sulfadoxine/pyrimethamine is also high so it is probably being widely used despite national recommendations limiting use to presumptive treatment in pregnancy. Strategies to counter the inappropriate use of these medicines will need to be implemented.
Philippines

New law to reduce prices

Medicines in the Philippines are high priced compared to many other countries in the Asia-Pacific region. The Universally Accessible Cheaper and Quality Medicines Act of 2008, aimed at making medicines more affordable to Filipinos, was signed into law in June 2008.

Key regulatory tools in the new law include:
- provisions to increase the use of more affordable generics e.g. mandatory production of an unbranded generic equivalent product for each branded generic produced locally
- narrowing the definition of what medicines, or alterations to existing medicines, can be patented by disallowing evergreening
- permitting the government to issue compulsory licenses, and broadening the parallel importation provision

The new Act also permits the Department of Health to regulate medicine prices, including imposing maximum retail prices (although they have stated that price regulations will only be used as a last resort when competition is ineffective in reducing prices).

The Implementing Rules and Regulation (IRR) “operationalising” the new law are currently under development. These are important as the Philippines has past examples of well written legislation which lacked adequate implementation and enforcement.

Stakeholders have commented at public hearings that many of the provisions of the new act are ambiguous and hence open to interpretation, and do not ensure transparency and accountability of public officials and government agencies. Once the draft IRR becomes publicly available, these discussions will certainly increase. But beyond the writing of rules and regulations is the question of commitment; whether the Philippines government will evoke any of the provisions to bring prices down and improve access to medicines.
Regressive mark-ups & more

A 2004 medicine price and availability survey, undertaken by the Ministry of Public Health, found that medicine availability in public sector facilities was poor (where they are provided free to patients). With no other choice, patients paid high prices for both originator brands and generics in the private sector.

The government quickly acted on the findings. Procurement prices of approximately 2,200 imported medicines were compared against prices in Saudi Arabia and Jordan. Large differences led the government to reduce prices by 20-30% for 1100 medicines (a quarter of Lebanon’s registered medicines). At the same time, the government also increased the budget for purchasing cancer, HIV and other specialized medicines, expanding it from US$14 million to $55 million.

In 2005, the government implemented regressive margins for importers, wholesalers and pharmacies (i.e. as the medicine price increases, the mark-up decreases). This was expected to decrease patient prices for imported medicines by 3-15%.

By 2007 the Ministry had reviewed the price of all medicines registered between 2000 and 2006. Across 1037 medicines, prices were lowered by an average of 14%. Currently, the prices of 833 medicines registered between 1996 and 2000 are being reviewed. By March 2008, 116 had been reviewed resulting in price reductions for 67 medicines.

To improve transparency, in 2006 the Ministry commenced publishing patient prices and pharmacy margins on its website (www.public-health.gov.lb). The following year, the first edition of the Lebanon National Drug Index was published. The Index lists all registered products. Product information includes the active ingredient, dose form and strength, Anatomical Therapeutic Chemical (ATC) classification, MOH code and registration number, importer, manufacturer and country of origin, whether it is a generic or originator brand – as well as the patient price and whether the product is covered by the National Social Security Fund.

Survey results

In late 2006, the Food and Drug Administration, Ministry of Public Health and the Faculty of Pharmacy, Mahidol University measured the price and availability of 43 medicines in a total of 20 public sector medicine outlets and 21 private pharmacies in Bangkok and three other districts: Phitsanulok (North), Suratthani (South), and Nakornrachaseema (Northeast).

Overall, the availability of originator brands and generics in the public sector was 10% and 75% respectively. In the private sector the availability of both product types was 28.6% (patients largely buy prescription medicines in the public sector).

Government procurement prices of lowest priced generics, and public sector patient prices, were 1.46 and 2.55 times the international reference prices respectively. In the private sector, originator brands were nearly 4 times the price of the lowest priced generics. While lowest priced generics were reasonably priced (but poorly available) in the private sector, originator brands were high priced at about 12 times the reference prices.

In both sectors, standard treatments with lowest priced generics were generally affordable for the lowest paid unskilled government worker. However, some treatments with originator brands were unaffordable e.g. in the private sector 5 days wages are needed to purchase a month’s supply of Zantac™ (ranitidine) 150mg tabs to treat an ulcer.

Median percentage mark-ups charged by public sector outlets and private pharmacies were 22-31% for originator brands and 80-96% for generics. However, patient prices in private pharmacies were about 40% higher than in public outlets. An import duty of 10% is levied on many medicines. Recommendations included stimulating the use of lower priced generics.