In the mid-1970s unacceptable differences in access to healthcare were recognised, both within and between countries, and resulted in the launch of the global Health for All movement at the 1977 World Health Assembly. In the same year, the first WHO Model List of Essential Drugs was published. The following year the need for universal access to healthcare was reinforced in the Declaration of Alma-Ata, which was endorsed by Member States at the 1979 World Health Assembly. However, 30 years later millions of people still lack access to essential medicines, a key component of which is the poor availability of medicines in the public sector in most countries.

Medicine price and availability surveys, using the WHO/HAI methodology, report percentage availability for individual medicines, and across a basket of medicines, in the public, private and other sectors within a country. Figure 1 shows the results for the countries where availability data were collected from public sector facilities. The overall median percentage availability of generic medicines is less than 60%. There are large variations from 10% or less, to over 90%.

People, especially the poor, rely on the public sector to provide medicines at no cost (or if they must pay, at low cost). When needed medicines are not available, people face the burden of much higher medicine prices in the private sector.

Low availability in the public sector can be due to a combination of factors, such as inadequate funding, lack of incentives for maintaining stocks, inability to forecast accurately, inefficient distribution systems, or leakage of medicines for private resale.

Government financing of medicines must meet people’s needs. In some countries medicine financing is woefully inadequate e.g. the government in Yemen spent only $0.34 per capita per year (2006 data) on medicines although the budget is expected to increase annually from 2010. While an appropriate budget and allocation of finances is vital, procurement efficiencies and supply chain management must also improve in many countries. Some governments buy high priced originator brands instead of lower priced generic equivalents. More patients could be treated at no extra cost if only the lowest priced quality-assured generics were purchased for off-patent medicines.

Procurement is often fragmented within a country, with numerous agencies buying medicines (e.g. Ministry of Health, military, academic institutions). Pooling procurement needs at the national level will likely be more efficient. >

1. Typically surveys include some non-EML medicines which, in some countries, would not be expected to be found in the public sector. Analysis using only survey medicines on the EML has not been possible due to lack of information. However, analysing only EML medicines is now possible in the workbook that accompanies the second edition of the manual.

The Philippines

Setting maximum retail prices

A year after passing the Cheaper Medicines Law and under pressure from the Senate to implement price controls, the Department of Health has recently proposed setting maximum retail prices (MRP) for originator brands of 22 medicines used to treat various conditions including hypertension, diabetes, asthma, cancer and infections. The recommendation is yet to be approved by the President.

The MRP will be set at about half the current price of the originator brand, despite the existence on the market of much lower priced generic equivalent products for many of the medicines. The impact of this initiative on the poorest sections of the population may be limited, however, as the new originator brand MRPs, and even lower priced generics, will still be unaffordable for many conditions.

As an illustration, Norvasc™ (amlodipine) 5 mg tablets will have a MRP of 22.50 Philippine Pesos per tablet ($0.47 USD), reduced from a reported price of P44.50. A recent survey conducted in the Philippines by the Health Action Information

Civil society voices concerns

To highlight the problem of poor availability of essential medicines in public sector facilities, HAI Africa and other civil society organisations in Malawi, Madagascar, Uganda, Zambia and Kenya launched a ‘Stop Stock-Outs’ campaign in February 2009. The campaign is calling on governments in the five countries to end stock-outs by:

- Providing financial and operational autonomy to the national medicines procurement and supply agency.
- Giving representation of civil society on the board of the national medicines procurement and supply agency.
- Ending corruption in the medicine supply chain to stop theft and diversion of essential medicines.
- Providing a dedicated budget line for essential medicines.
- Living up to commitments to spend 15% of national budgets on health care.
- Providing free essential medicines at all public health institutions.

For a week in late June 2009, dubbed ‘pill check week’, teams visited government health facilities in their countries to check the availability of 10 essential medicines. Using SMS (phone messaging) they quickly reported the data to a collation point for online mapping of stock-outs in each of the five countries.

From here, the results are automatically displayed on a map of the region (Figure 2). At the time of writing, 250 stock-outs of these essential medicines were reported. The results are being made available on the campaign website (www.stopstockouts.org) as they are collected and being used by civil society to urge governments to honour their commitments to provide essential medicines for all.
In 2007 SBDMA commenced a number of reforms to control prices. The first was to reintroduce government price-setting (which had been abandoned in 1992). The Board also acted to counter bonusing, as wholesalers commonly gave 20-50% free bonus stock to retailers. Legislation is now in place that limits the provision of free bonus stock to 10%. Medicine prices were reduced accordingly e.g. the wholesale price of a pack of 20 Ciplox 500mg tabs (ciprofloxacin) was reduced from 300 Yemeni Rials (YR) to 200 YR ($1 USD).

At a recent workshop to identify policies to improve medicine affordability and availability, held in Sanaa on 26-27 May 2009, the Director General of SBDMA Dr. Abdul Moneim Al-Hakami outlined a number of proposed reforms including:

- reducing the cumulative mark-up on imported medicines in the private sector from 55% to 43%. This would be achieved by reducing the wholesale mark-up (from 15% to 10%) currency exchange charge (5% to 3%) and storage and internal transport (10% to 5%). This will lower the prices of most products on the market as 90% are imported.
- abolishing taxes on essential medicines (5% customs duty, 5% general tax); discussions are underway with the Ministry of Finance.
- enforcing the ban on ‘middlemen’ buying medicines from wholesalers and selling to retailers. Although the practice is illegal, a medicine can pass through 1-3 middlemen in the supply chain which compounds the patient price.
- reducing the registration fee for generics and abolishing it altogether for cancer and other specialised medicines.
- recognising registration decisions taken by the regulatory authority in Saudi Arabia to speed up the registration process in Yemen; and requiring bioequivalence testing of appropriate generic products.
- increasing the medicines budget annually starting in 2010.

Workshop participants proposed a number of additional reforms including revising the 1998 National Medicines Policy, establishing an autonomous department on medicine prices (which would delink price-setting from product registration), building capacity on procurement and supply chain management, and pooling procurement nationally (government hospitals, police, army) and regionally with the Gulf Cooperation Committee.

Network showed that across 27 private retail pharmacies generic versions of amlodipine were available for as low as P8 per tablet (with a median price of P14 or $0.29 per tablet) – significantly cheaper than the proposed maximum retail price for Norvase™. Controlling the price of single-source medicines (i.e. products for which there are no generics on the market) is a positive step, but it is unlikely that medicines such as irbesartan and telmisartan (both on the MRP list) will be affordable for the majority of hypertensive patients, even at the MRP. These patented medicines will cost $0.50 per day ($182 per year) – a high price to pay when 34 million Filipinos are living on less than $2 a day. Interventions that shift demand to the use of cost-effective, evidence-based treatment options (such as thiazides in this case) are needed.

In all countries, a contextualised mix of policies is needed in order to improve access to medicines for those in greatest need. In the Philippines, this will include ensuring the quality of generics, improving the availability of low priced generics in the public and private sector, permitting and promoting generic substitution in the private sector, and promoting the use of low priced generics to the public.
The survey found that both the range and overall availability of medicines for palliative care was limited - with narcotic analgesics and psychotropic medicines for anxiety being widely unavailable. Basic palliative medicine needs were unaffordable to those on low incomes – with between 3 and 20 days of a low paid unskilled government worker’s salary required every month to pay for oral pain control, nausea and constipation (depending upon the choice of medicine and source of purchase). The survey also found that patient prices in the public sector were high, often higher than in private pharmacies, primarily as a result of high procurement prices. In private pharmacies, originator brands were being sold to patients at very high prices compared to their generic equivalent – up to 28 times more for diclofenac tabs. Generic versions of basic analgesics such as paracetamol and ibuprofen were being sold at very high prices in international terms.

United Arab Emirates

Acting to improve generic availability

A medicine price and availability survey in 2006, conducted by the Ministry of Health, showed that in the private pharmacies surveyed the availability of originator brands and generic equivalents was 100% and 74%, respectively. Prices of both products types were very high, and on average originator brands were three times the price of lowest priced generics. Many treatments were unaffordable to those on low wages when purchased from private pharmacies. Since the survey, the government has undertaken a number of reforms. A comprehensive revision of prices resulted in price reductions for many originator brands and generics. Margins have also been reduced for chronic disease medicines, resulting in a further 10% reduction in patient prices. To improve the availability of generics, the Ministry of Health has implemented a priority track for generic product applications where there are less than 6 generic equivalents on the market. In addition, pharmaceutical companies have been told that if they do not market registered products their registration may be cancelled.

A second and larger survey is planned to assess the impact of these reforms, and to investigate availability, prices and affordability for commonly used therapeutically equivalent medicines for various diseases.

Contact
Interested in learning more about medicine prices or conducting a survey? Then contact the pricing project’s coordinators:

Health Action International (HAI)
Global
Overtoom 60/III
1054 HK Amsterdam
The Netherlands
T (+31-20) 683 3684
W www.haiweb.org/medicineprices

Margaret Ewen
E marg@haiweb.org

Martin Auton
E martin@haiweb.org

Serena Fasso
E serena@haiweb.org

World Health Organization (WHO)
Avenue Appia 20
CH-1211 Geneva 27
Switzerland

Alexandra Cameron
T (+41-22) 791 3785
E cameron@who.int

Dele Olawale Abegunde
T (+41-22) 791 2826
E abegund@who.int

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