

Access to affordable essential medicines

Target

8e In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Indicator

8.13 Proportion of population with access to affordable, essential drugs on a sustainable basis

There are few international commitments in relation to the provision of medicines other than those for the three high-profile diseases, HIV/AIDS, tuberculosis and malaria. These are addressed under MDG 6 and their progress is monitored annually in *The Millennium Development Goals Report*.¹ Existing commitments regarding medicines often lack quantitative targets and, unlike the other commitments addressed in this report, usually do not refer to either the aggregate global or the country-level supply. This makes it difficult to both measure a “delivery gap” with regard to global commitments and assess the distribution of benefits across countries (the “coverage gap”).

Access to medicines depends on four key factors: first, it depends on ensuring that patients receive appropriate medicines in the correct dosages and within the required time frames; second, Governments and individuals must be able to afford the medicines essential to maintaining health; third, funds to pay for treatments must continue to be available when needed; and, fourth, access to medicines needs to be supported by health and supply systems that ensure their availability when required.

Since health goals primarily relate to individuals, international commitments usually take the form of improving people’s access to either preventive measures (for example, vaccines, insecticide-treated bednets or potable water) or curative medicines and treatments (such as antiretroviral therapies for HIV/AIDS and directly observed treatment, short course (DOTS) for tuberculosis). Like food, however, access to medicines is not only a question of total supply being adequate to meet total demand; it is also a matter of supply being available where and when required and a matter of individuals, particularly the poor, being able

¹ See *The Millennium Development Goals Report 2009* (United Nations publication, Sales No. E.09.I.12).

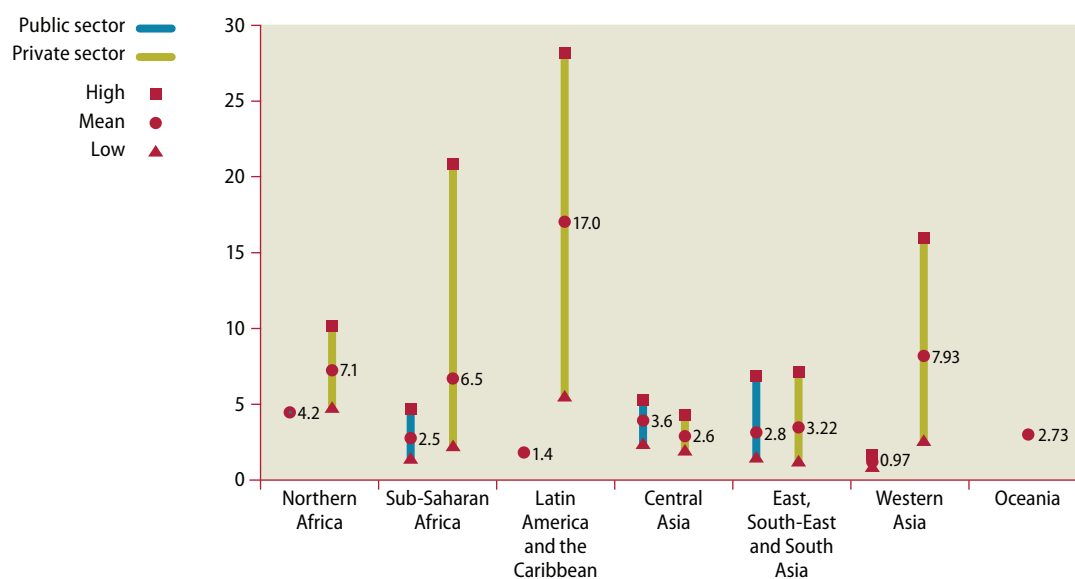
The price of medicines
in developing countries
remains high

to meet their needs. The latter requires that medicines be affordable to the poor either through government channels or in private sector markets. This is essentially a “needs gap”, rather than a “delivery gap” or a “coverage gap”, although it contains elements of both.

The *MDG Gap Task Force Report 2008*² found that large gaps exist in the availability of medicines in both the public and private sectors and that prices vary widely across countries and are generally much higher than international reference prices. These two factors combine to render essential medicines inaccessible to many of the world’s poor. The global economic crisis has plunged tens of millions more people into poverty, adding commensurately to those who do not have access to medicines. Even before the crisis, the availability of selected essential medicines in developing countries was low (38.1 per cent in the public sector and 63.3 per cent in the private sector) and this, together with high prices, had been already limiting access. Median prices were, on average, 2.5 times higher than international reference prices in the public sector and 6.1 times higher in the private sector (see figure 21). China, India, the Islamic Republic of Iran and

Figure 21

Ratio of consumer prices to international reference prices for selected generic medicines in public and private health facilities during the period 2001-2006



Source: World Health Organization, using WHO/HAI standard methodology and data from surveys of medicine prices and availability (see <http://www.haiweb.org/medicineprices/>).

Note: The number of countries included in the sample were distributed as follows:

	Public sector	Private sector		Public sector	Private sector
Northern Africa	1	3	East, South-East and South Asia	6	9
Sub-Saharan Africa	9	11	Western Asia	2	7
Latin America and the Caribbean	1	2	Oceania	0	1
Central Asia	2	4			

² *MDG Gap Task Force Report 2008: Delivering on the Global Partnership for Achieving the Millennium Development Goals* (United Nations publication, Sales No. E.08.I.17).

Uzbekistan were the only countries surveyed that had succeeded in achieving private sector patient prices for generic medicines that were less than twice the international reference price.

High prices of medicines are caused in part by high add-on costs in the supply chain, such as wholesale and retail margins and duties and taxes, all of which can increase final prices in both the public and private sectors. In the limited number of developing countries for which data are available, private sector wholesale markups range from 2 to 380 per cent and retail markups from 10 to 552 per cent.³ In countries where value added tax is applied to medicines, the charge varies from 4 to 15 per cent. In addition to supply chain costs, manufacturers' publicity and marketing costs for promoting the use of medicines are often a significant component of the final price.⁴

Measuring the gap in access to medicines

The major causes of disease

Of every ten deaths worldwide, six are due to non-communicable conditions, three to infectious, reproductive or nutritional conditions and one to injuries (see figures 22a).⁵ Non-communicable diseases are the leading cause of death in low- and middle-income countries, which account for approximately 80 per cent of such deaths (see figure 22b).⁶ Chronic non-communicable diseases not only have a financial impact on individuals and families but also undermine national macroeconomic development. For example, estimated losses in national income from heart disease, stroke and diabetes in 2005 were \$18 billion in China, \$11 billion in the Russian Federation, \$9 billion in India and \$3 billion in Brazil. These losses accumulate over time. Between 2005 and 2015, it is estimated that China will have lost \$558 billion (or about 1.5 per cent of gross domestic product (GDP) per annum) in forgone national income owing to heart disease, stroke and diabetes alone.⁷ Despite the substantial and growing burden of these diseases in developing countries, improving access to medicines to treat them has received little international attention.

Access to medicines for children is another area of concern. It is estimated that up to 10.5 million children die each year, many of them from conditions that can be treated with existing essential medicines. However, many essential medicines do not exist in appropriate dosage forms for children. Even where paediatric

Non-communicable diseases are the leading cause of death in developing countries

³ Alexandra Cameron and others, "Medicine prices, availability, and affordability in 36 developing and middle-income countries: a secondary analysis", *The Lancet*, vol. 373, No. 9659 (17 January 2009), pp. 240-249.

⁴ World Health Organization, *Report of the Commission on Intellectual Property Rights, Innovation and Public Health: Public Health, Innovation and Intellectual Property Rights* (Geneva, 2006).

⁵ World Health Organization, *The Global Burden of Disease: 2004 Update* (Geneva, 2008).

⁶ Derek Yach and others, "Chronic diseases and risks", *International Public Health: Diseases, Programs, Systems, and Policies*, 2nd edition, Michael H. Merson, Robert E. Black and Anne J. Mills, eds. (Sudbury, Massachusetts, Jones and Bartlett Publishers, 2006), p. 293.

⁷ World Health Organization, *Preventing Chronic Diseases: A Vital Investment* (Geneva, 2005).

Figure 22a
Distribution of deaths worldwide, by sex, 2004 (percentage)

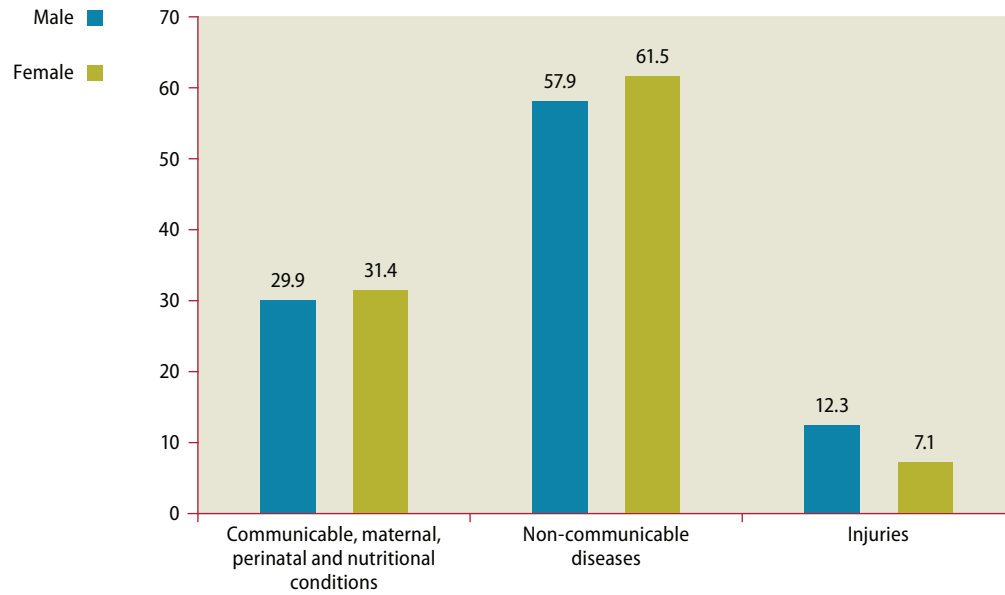
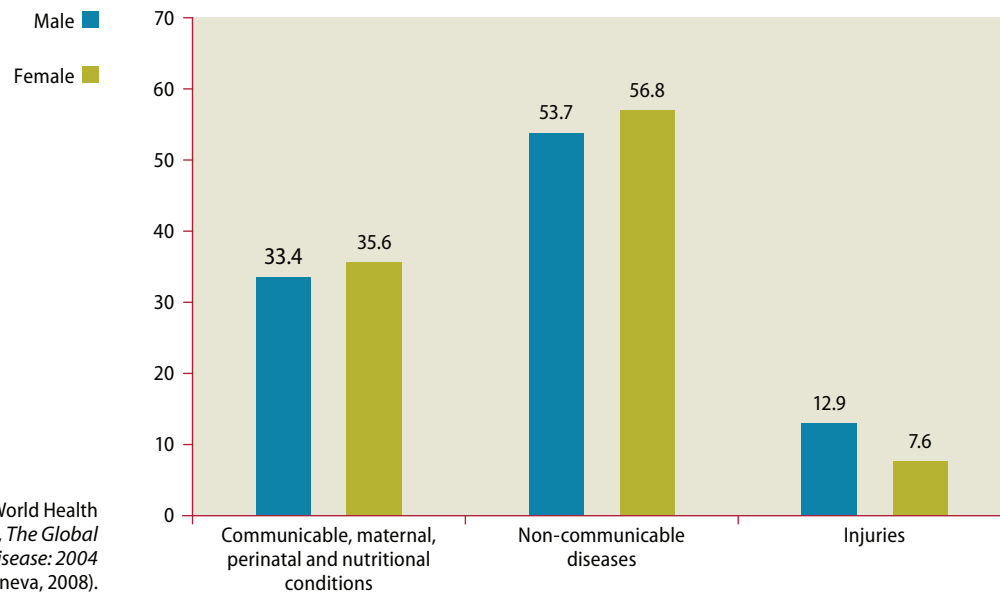


Figure 22b
Distribution of deaths in low- and middle-income countries, by sex, 2004 (percentage)



Source: World Health Organization, *The Global Burden of Disease: 2004 Update* (Geneva, 2008).

dosage forms exist, their use can be problematic. For example, although oral liquid forms are available for some medicines for HIV/AIDS, they cost two to three times more than the same dose for the same product in pill form for adults.⁸

Other factors that inhibit the supply or use of paediatric medicines include their higher weight due to syrup content (resulting in increased shipping costs), lack of clean water for dissolving powders into liquids and the difficulty of administering liquid formulations in accurate amounts to children of different ages. Furthermore, liquid formulations are generally less stable than solid dosage forms and often require special storage conditions.

Affordability of essential medicines for non-communicable diseases

In order to judge affordability, it is necessary to establish a benchmark that relates the cost of medicines to income. One day's wages might be considered an affordable monthly cost for medicines that are required on a continuous basis for the remainder of a patient's life. For income, a readily and widely available benchmark for the country's poor is the earnings of the lowest-paid government worker. However, many people in low- and middle-income countries earn less than the lowest-paid government worker. Possible alternative benchmarks are the income levels used as benchmarks for international poverty, namely, \$1.25 (formerly \$1) per day (extreme poverty) and \$2 per day. Regardless of the benchmark used, medicine affordability does not take other treatment costs, such as diagnostics, into account and thus will underestimate the true cost of health care.

Diabetes mellitus affects over 220 million people worldwide⁹ and its prevalence is rising throughout the world, especially in low- and middle-income countries.¹⁰ For many in these countries, the cost of basic oral diabetes treatment alone is unaffordable when using the yardstick of one day's wages. The lowest-priced generic combination treatment regimen for diabetes costs over two days' wages in the majority of countries, reaching as much as eight days' wages in Ghana (see figure 23). Costs are even higher in the case of brand products. Moreover, diabetes sufferers also often have concomitant conditions, such as hypertension, which can increase the cost of treatment and further reduce its affordability.

Diabetes treatment costs over two days' worth of wages in most countries

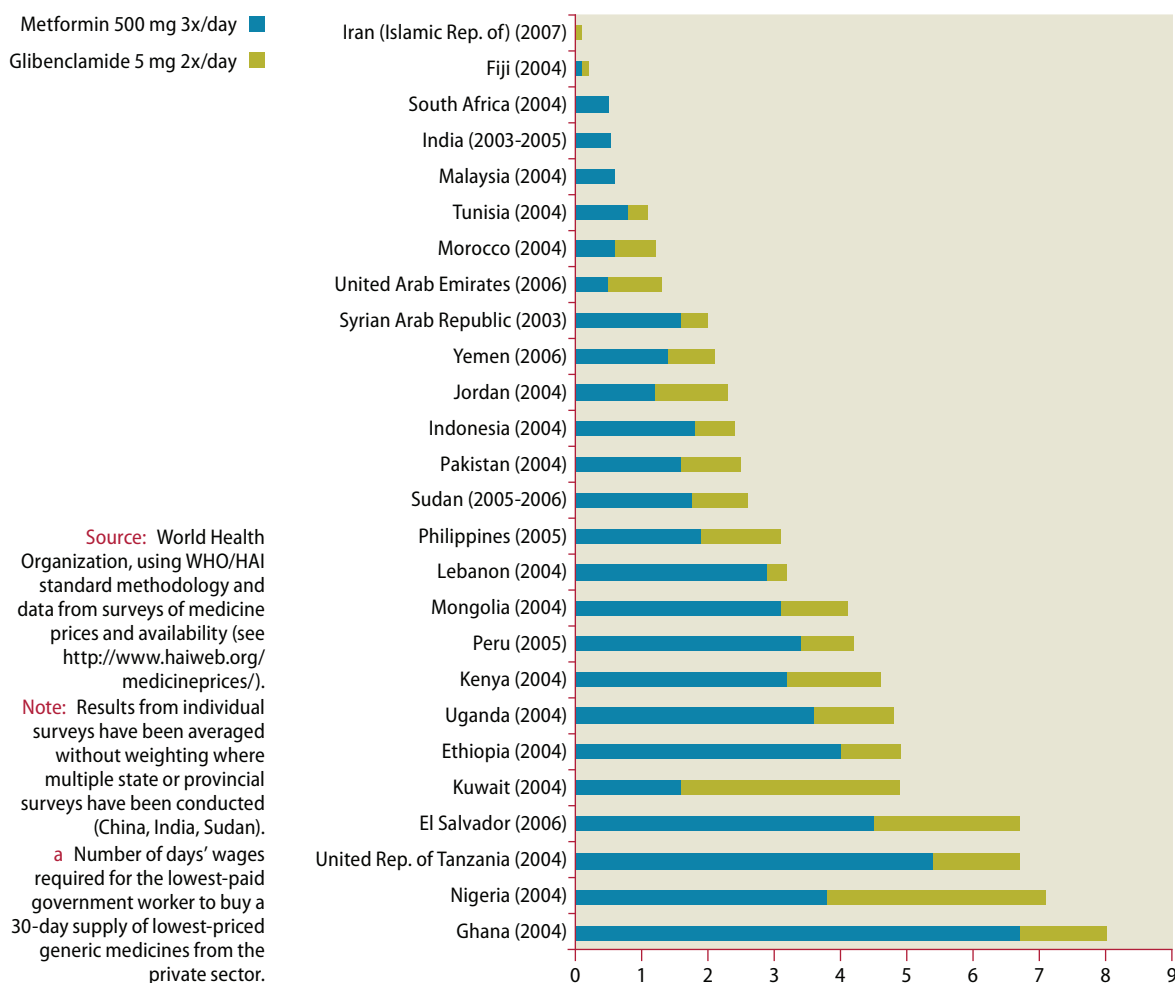
A similar situation prevails with respect to asthma. Even when the lowest-priced generic equivalents are used, asthma treatment is unaffordable in almost all countries (see figure 24), and becomes even less affordable when originator brand medicines are prescribed and dispensed. In Kenya, the lowest-paid government worker would need nearly 10 days' wages to purchase these brand medicines, while the cost in Brazil, Kuwait, Peru, Sri Lanka and Uzbekistan would be over 5 days' wages. Overall, the use of originator brand inhalers may have an

⁸ Management Sciences for Health, International Drug Price Indicator Guide estimates, available at <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=Dmp&language=English>.

⁹ World Health Organization, *The Global Burden of Disease*, op. cit.

¹⁰ It is estimated that 7.3 per cent of the world's adult population (20-79 years of age) will suffer from diabetes by 2025 (International Diabetes Federation, *Diabetes Atlas*, 3rd edition (Brussels, 2006)).

Figure 23
Affordability of treatment for diabetes (days' worth of wages^a)



adverse effect on the affordability of treatment for many of the 235 million people worldwide who suffer from asthma.¹¹

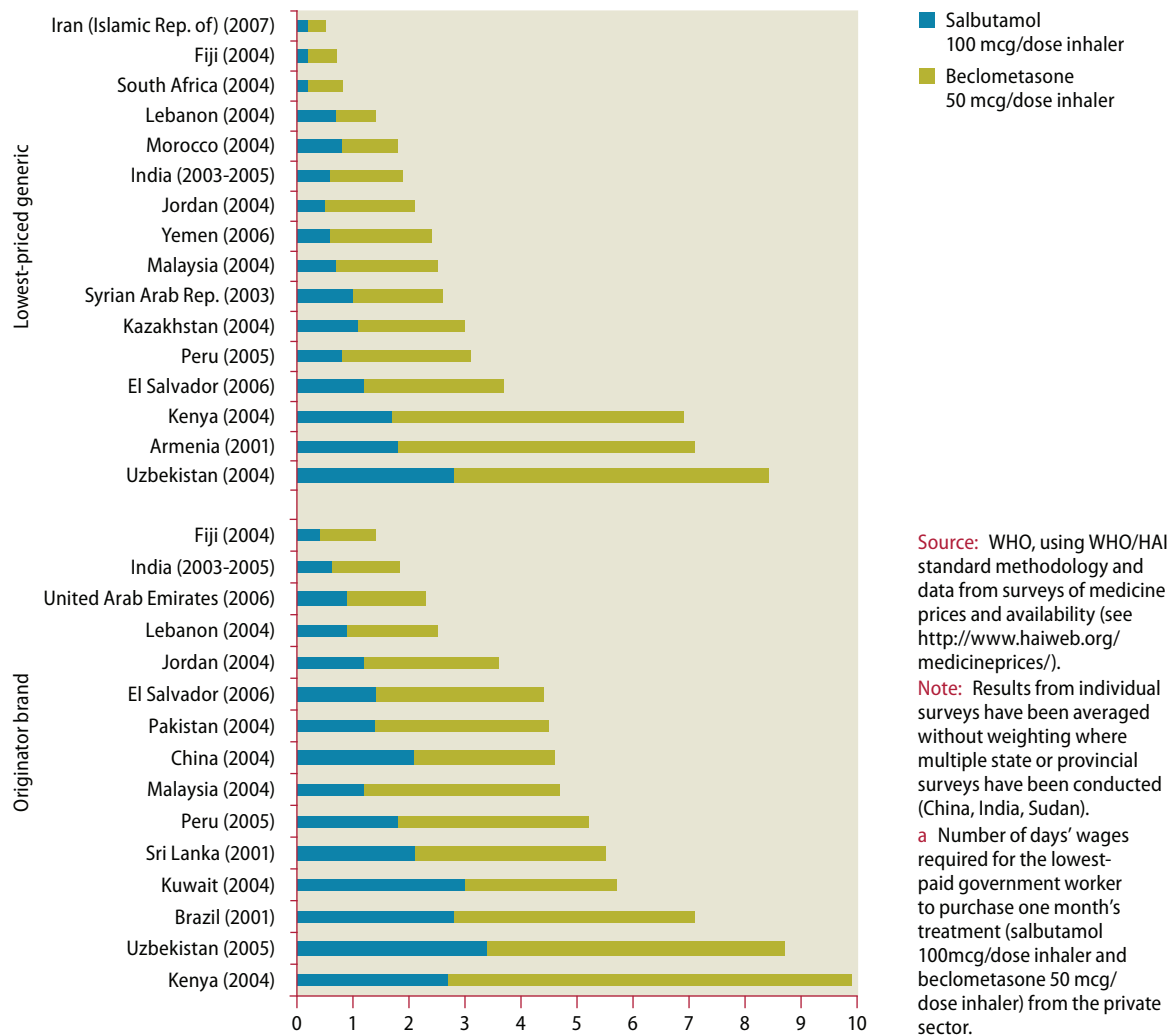
Cardiovascular diseases are the leading cause of death in developing countries

Cardiovascular diseases are the leading cause of death worldwide and account for 28 per cent of deaths in low- and middle-income countries.¹² For the lowest-paid government worker, the costs of hypertension treatment using a common Angiotensin-Converting Enzyme-inhibitor (captopril 25 mg cap/tab, 50 mg per day) exceed two days' wages in the majority of countries and may therefore be deemed unaffordable (see figure 25). Moreover, in all of the sample countries except Kyrgyzstan, Tajikistan and Uzbekistan, the lowest-paid government worker earns more than the \$1 per day benchmark for extreme poverty, meaning the treatment is even more unaffordable for the poorest in the population. In Peru, for example, treatment with captopril is relatively affordable for the lowest-paid government worker (0.8 days' wages), but the majority of the population in Peru earns less than this norm. For them, treatment is far less affordable:

¹¹ World Health Organization, *The Global Burden of Disease*, op. cit.

¹² Ibid.

Figure 24
Affordability of treatment for asthma (days' worth of wages^a)



Source: WHO, using WHO/HAI standard methodology and data from surveys of medicine prices and availability (see <http://www.haiweb.org/medicineprices/>).
 Note: Results from individual surveys have been averaged without weighting where multiple state or provincial surveys have been conducted (China, India, Sudan).
 a Number of days' wages required for the lowest-paid government worker to purchase one month's treatment (salbutamol 100mcg/dose inhaler and beclometasone 50 mcg/dose inhaler) from the private sector.

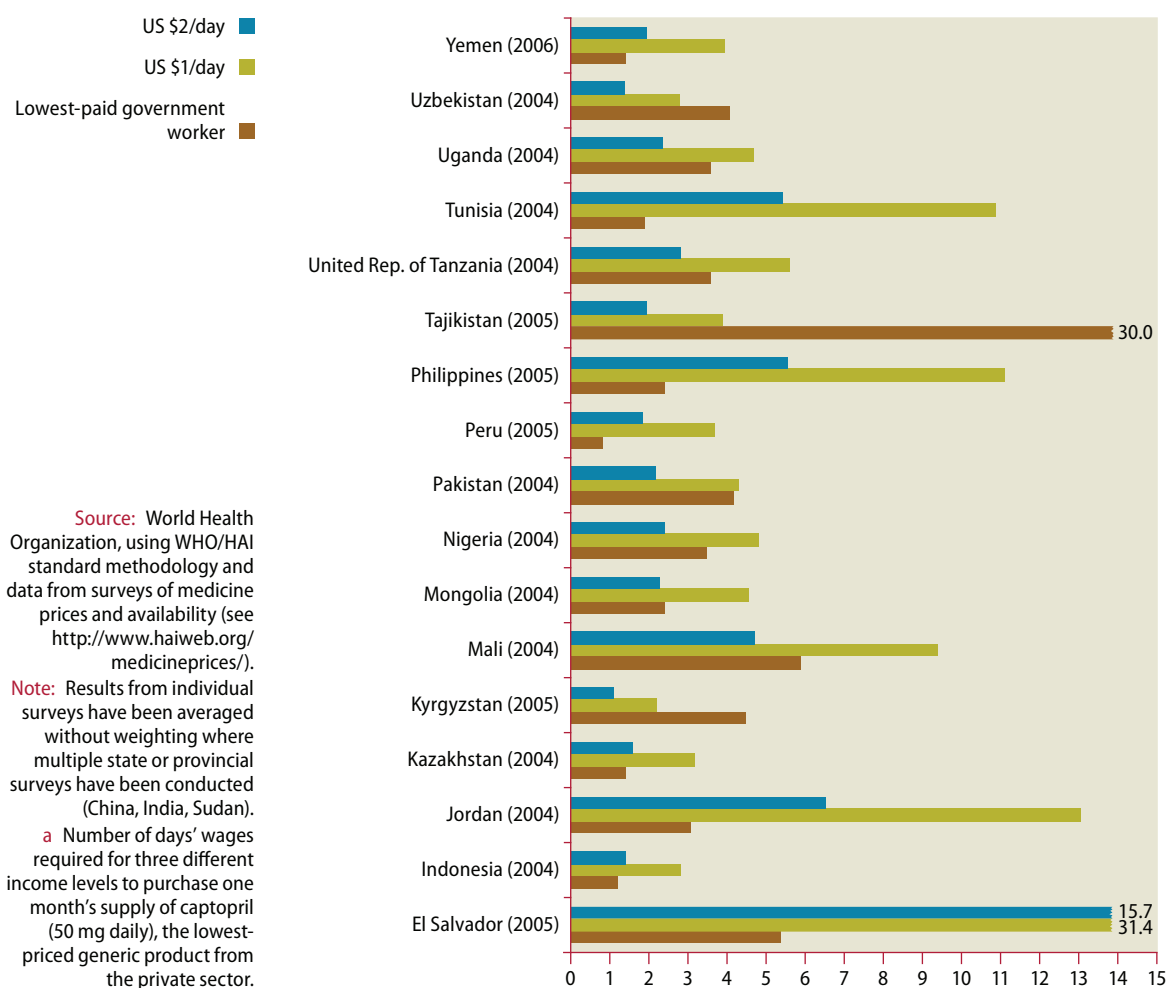
it requires 3.7 days' wages for those earning \$1 per day, and 1.8 days' wages for those earning \$2 per day.

The cost of treatment for chronic diseases is particularly unaffordable because of their ongoing nature and the frequent need for combination therapy. No matter how low prices are in the private sector, the poorest sections of the population will usually not be able to afford them. Even for those who are less poor, ongoing payments for medicines and catastrophic medicine costs can plunge families into poverty.¹³ Priority should therefore be given to strategies that help improve the affordability of essential medicines for chronic diseases for the poorest population groups and communities, including making such medicines available through the public sector at little or no cost. This, in turn, will contribute to increased access to treatment and care for the poorest and the most vulnerable.

The chronic nature of some diseases makes them more unaffordable

13 Ke Xu and others, "Household catastrophic health expenditure: a multicountry analysis", *The Lancet*, vol. 362, No. 9378 (12 July 2003), pp. 111-117.

Figure 25
Affordability of treatment for hypertension (days' worth of wages^a)



Other factors affecting the affordability of medicines

National expenditures on pharmaceuticals

Total expenditures on pharmaceuticals are closely related to a country's GDP and to its total health expenditures. Expenditures on pharmaceuticals range from 1.35 to 1.5 per cent of GDP, with the share of GDP spent on pharmaceuticals being lower for higher-income countries than for lower-income countries. The proportion of total health expenditure spent on pharmaceuticals is also lower in rich countries than in poorer countries (see table 9).

There is also a difference between the sources of financing for medicines in developed and developing countries. In developed countries, the public sector accounts for almost 60 per cent of total pharmaceutical expenditures, with government health insurance or social security systems paying for most medicines. In developing countries, governments pay for less than one third of all expenditure on medicines. In these countries, most payments for pharmaceuticals are private, out-of-pocket expenditures. Among developing countries, the proportion of pri-

Table 9
**Cost of medicines in relation to GDP and health expenditures,
 by income group, 2006**

Income group	Population (millions)	Number of WHO members	Sample size	Share of GDP (percentage)		Share of total health expenditure (percentage)	
				Mean (percentage)	Median (percentage)	Mean (percentage)	Median (percentage)
High	983	48	43	1.40	1.40	18.6	17.9
Upper-middle	782	42	35	1.35	1.20	21.5	19.8
Lower-middle	3 106	54	33	1.48	1.20	25.3	22.7
Low	578	49	19	1.50	1.50	28.9	26.0
Total	5 449	193	130	1.40	1.30	22.6	20.2

Source: World Health Organization, National Health Accounts.

vate expenditures is inversely related to income: in low-income countries, private payments account for a higher proportion of expenditures on medicines than in higher-income countries, albeit only slightly.

Health insurance coverage

Comprehensive public health insurance which covers the cost of medicines is the most equitable system for making treatment widely available. Unfortunately, only a small proportion of people in developing countries are covered; in low-income countries, only 2.8 per cent of the population have health insurance and they tend to be mostly in the upper income brackets. In all but the high-income countries, less than half of the population are covered; the proportion of people with insurance covering medicines is even smaller.

Health insurance coverage is extremely low in developing countries

Impact of the global economic crisis on access to medicines

Through a number of channels, the global economic crisis has served to increase the proportion of people in the developing world without access to affordable medicines. On the demand side, the number of poor has increased, and the newly poor will be added to those who can no longer afford to buy medicines. At the same time, the crisis may increase demands on public health services because rising unemployment and lower incomes make people less able to maintain their health and expose them to greater health risks, thereby increasing the incidence and prevalence of disease.

On the supply side, discretionary public sector spending is under pressure around the world, particularly so in developing countries that are unable to borrow sufficiently to cover their fiscal deficits. If the budgets of health ministries are cut, salaries may be maintained while expenditure on medicines and transport are cut disproportionately. If exchange rates depreciate, medical imports, such as raw materials for the production of medicines or finished products for countries without manufacturing capacity, are likely to become more expensive. The global

credit crunch may also mean that importers will not be able to obtain credit to purchase medical products.¹⁴

Countries with a well-developed, well-stocked public sector system of essential medicines and countries with a well-established health insurance system that provides selected essential generic medicines will be better able to cope and adjust to these developments. The situation will be more difficult for countries with a poorly funded or inefficient public sector procurement and distribution system; for countries where the poor have to pay for medicines out-of-pocket; and for countries with a branded, rather than generic, supply system in the private sector.

In order to measure the impact of the global economic crisis on health systems, the World Health Organization (WHO), in cooperation with IMS Health, has put in place a programme to track the consumption of medicines.¹⁵ In most countries, there has been an increase in the average price of medicines.¹⁶ In some countries, this was associated with an increase in total expenditure on pharmaceuticals in the last quarter of 2008 and the first quarter of 2009; however, in most countries, except for a few in Eastern Europe, the consumption of pharmaceuticals does not appear to have been adversely affected.

As of the end of the first quarter of 2009, there did not appear to be either a major change in the overall volume of medicines used or a decline in the use of medicines against chronic diseases, as had been the case during the Asian crisis of 1998. There was no change from branded to unbranded formulations of these medicines. Overall, therefore, there is no firm evidence that the economic crisis has had a negative impact on access to medicines or that the moderate price increases have reduced the consumption of medicines.

However, the magnitude and duration of the crisis remain uncertain, and previous economic crises demonstrate that their impact is rarely consistent across countries. Past crises also suggest that the impact on medicines lags behind a fall in GDP. It may therefore be too early to observe the effects of the current crisis on pharmaceutical consumption. Should the situation deteriorate, Governments have a range of policy instruments at their disposal to alleviate the situation.

Some medicines, such as those funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) or the Global Alliance for Vaccines and Immunizations (GAVI), including antiretroviral (ARV) medicines and Artemisinin-based Combination Therapies (ACTs), are likely to remain available regardless of the crisis. However, even where these programmes are paying for medicines, the economic crisis may still adversely affect prevention programmes. For other medicines, particularly chronic disease medicines, the situation is likely to deteriorate. The increasing incidence of chronic diseases has already raised demand for such treatments as insulin, cardiovascular medicines and asthma inhalants. Families that have to pay for chronic disease medicines on an ongo-

The impact of the global economic crisis is still unclear, but countries must strengthen health insurance systems

¹⁴ See the section on debt sustainability for a discussion of the impact of the economic crisis on trade credit.

¹⁵ No IMS Health data are available for sub-Saharan African countries, with the exception of South Africa.

¹⁶ IMS Health, "Indicators for tracking the effect of the economic crisis on pharmaceutical consumption, expenditures and unit prices", report prepared for the World Health Organization, 20 May 2009 (available at <http://www.who.int/entity/medicines/areas/policy/imsreport/en/index.html>).

ing, out-of-pocket basis are likely to become progressively impoverished, and the economic downturn is likely to exacerbate this effect.

On the positive side, experiences in Indonesia and Thailand suggest that economic crises can provide an opportunity to make needed but difficult policy changes. For example, during the crisis of the late 1990s, the Indonesian Ministry of Health took several measures to maintain access to medicines, including:

- Establishing a monitoring system to ensure the availability of key essential medicines in public health facilities and of generic products in the market.
- Maintaining a national buffer stock of essential medicines.
- Providing subsidies for the purchase of raw materials for pharmaceutical companies producing generic products.
- Taking actions to ensure the efficient use of donations.

As a result, the availability of key medicines remained high during both the acute crisis and the recovery phase, and the use of essential medicines in public health facilities remained high throughout the crisis.¹⁷ However, in both the public and private sectors, patients paid about 25-50 per cent more per prescription following the crisis.

The need to meet the costs of a global pandemic

In addition to improving access to treatments for longstanding, persistent and well-recognized diseases, developing countries, like developed countries, face the challenge of random outbreaks of new infectious diseases and potential pandemics, such as severe acute respiratory syndrome (SARS) in 2003 and the recent H1N1 flu. As demonstrated by HIV/AIDS, failure to stop or slow the spread of such diseases in a timely fashion can have devastating consequences in terms of mortality, morbidity and health status—as well as for health costs and economic development, over the longer term.

Responses may vary from preventive actions, to vaccines (if one is available or can be developed), to treatment of the disease itself. In all these areas, developing countries face greater difficulties than developed countries because of their relative lack of resources, mainly, but not limited to, those of a financial nature. Rapid dissemination of information about such diseases and the actions necessary to control them are hampered by poor communications and lower levels of education. Few developing countries have the capacity to develop new vaccines and, as with all other medicines, face difficulties in making them available on the scale required at an acceptable cost. This is also true for treatment.

As demonstrated by the recent outbreak of the H1N1 flu, while there is always room for improvement, the developed countries have been able to develop a response to the current global pandemic. This case of H1N1, however, may also provide evidence of whether the response is equally effective in developing countries, in particular whether it is possible to make the forthcoming vaccine

Of major concern is whether developing countries can respond effectively to the threats of the H1N1 flu

¹⁷ Sri Suryawati and others, “Impact of the economic crisis on availability, price and use of medicines in Indonesia, 1997-2002” (World Health Organization, Geneva, 2003).

available at an affordable price to all those in developing countries that are considered to be at risk. There is some evidence of the private sector's facilitating access to flu medicine.

Financing the gap to meet MDG target 8e

The creation of the High Level Taskforce on International Innovative Financing for Health Systems prompted efforts to estimate the cost of strengthening health systems, scaling up service provision and reaching the health-related MDGs in low-income countries.¹⁸ This exercise included the costing of the essential medicines required to treat a selection of mostly chronic conditions in 49 countries with a gross national income (GNI) per capita of \$935 or less in 2007, most of which were in sub-Saharan Africa.

The resulting estimates indicate that, in order to achieve the health-related MDGs in these countries, the funding for treatments for conditions other than those covered by MDGs 4, 5 and 6 would have to be increased by about \$630 million in 2009, increasing, as coverage and the population at risk rose, to \$3 billion in 2015. The incremental costs per year would increase from \$150 million in 2009 to \$1.17 billion in 2015. The annual per capita cost of these essential medicines is estimated to range from slightly less than \$0.50 in 2009 to almost \$2 in 2015.

It should be affordable to meet these gaps in access to essential medicines, as it would add less than \$1 per capita to a country's annual pharmaceutical expenditure. Mobilizing such amounts should be achievable with appropriate financing mechanisms, since the total per capita cost and the incremental per capita cost required each year to provide the treatment needed to meet MDG target 8e are only small fractions of a country's annual per capita health expenditure.

Role of pharmaceutical companies in increasing access to affordable drugs

UNITAID, an international pharmaceutical financing body, is consulting with pharmaceutical companies and other stakeholders to establish innovative mechanisms for improving access to medicines. Established in 2006 as a way of securing sustainable financing of medicines for HIV/AIDS, tuberculosis and malaria, UNITAID seeks to have a lasting impact on markets, essentially by reducing prices and increasing production. UNITAID also plans to play a role in ensuring the development of paediatric formulations for HIV/AIDS drugs or fixed-dose combinations where they do not exist.

The implementation of the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) of the World Trade Organization (WTO) is leading to the patenting of new medicines in countries that traditionally have been important producers of generic essential medicines. As a result, generic versions of new medicines will become available only after the 20-year patent has expired,

Patenting is making
essential medicines
more expensive

¹⁸ See <http://www.internationalhealthpartnership.net/index.html>.

unless action is taken to the contrary. Patented medicines are, in general, more expensive. For example, treating a patient for one year with the most affordable, improved first-line regimen for HIV/AIDS, as recommended by WHO, costs between \$613 and \$1,033 using originator products compared with \$87 for the generic medicine.¹⁹ Patents may also stand in the way of the development of fixed-dose combinations or formulations for paediatric use because the patents on the different components are held by different companies.²⁰

One means of addressing the difficulties created by patents is the creation of patent pools. While patent pools exist in other sectors, they have yet to be applied in the pharmaceutical sector. Medicine patent holders have previously opposed measures that facilitate market entry of generics,²¹ but interest in making patent pools operational is growing. For example, on 13 February 2009, Glaxo Smith Kline (GSK) announced that it would put into a patent pool any chemicals or processes over which it has intellectual property rights that are relevant to finding medicines for neglected diseases listed in the United States Food and Drug Administration's voucher scheme,²² thereby allowing them to be explored by other researchers. This may be particularly useful in countries where patent research exemptions do not exist.

In July 2008, the UNITAID Executive Board decided to establish an international HIV/AIDS Medicines Patent Pool to deal with both access and innovation issues. In the patent pool, different patent holders, such as companies, universities and research institutes, would voluntarily make their patents available to others on a non-exclusive basis. In exchange for payment of a royalty to the pool to remunerate the patent holders, generic manufacturers can obtain a licence to access patents in the pool in order to produce HIV/AIDS medicines, make further improvements to them and produce and sell them in developing countries at low cost. The pool will therefore act as a licensing agency that manages licences, negotiations and the receipt of royalties without necessitating any fundamental changes to the existing medicines' patent system. This voluntary scheme provides an opportunity to improve access to affordable medicines, but its success will depend on the willingness of both patent holders (to put their patents into the pool) and generic manufacturers (to pay royalties, use the patents and adapt the medicines). It will therefore serve as an important measure of the willingness of the pharmaceutical companies to achieve the target of providing access to affordable essential medicines in developing countries.

The creation of patent pools may help alleviate the situation

¹⁹ Médecins Sans Frontières, "Untangling the web of antiretroviral price reductions", 11th edition, July 2008.

²⁰ At its 2009 meeting, the Expert Committee on the Selection and Use of Medicines of the World Health Organization endorsed a list of missing fixed-dose combination medicines for HIV/AIDS as potential candidates for a patent pool (see http://www.who.int/selection_medicines/committees/expert/17/WEBuneditedTRS_2009.pdf).

²¹ Ellen F. M. 't Hoen, *The Global Politics of Pharmaceutical Monopoly Power: Drug Patents, Access, Innovation and the Application of the WTO Doha Declaration on TRIPS and Public Health* (Netherlands, AMB Publishers, 2009).

²² The scheme allows the sponsor of a newly approved drug which prevents or treats an eligible tropical or neglected disease to receive a priority review voucher which can then be applied to another product. Priority review reduces the time it takes the Food and Drug Administration to assess a product submitted for approval. Alternatively, the owner of the voucher can sell it on the open market.

Strengthening the global partnership to provide access to affordable essential medicines

There are large gaps in the availability of medicines in both the public and private sectors in developing countries, as well as wide variations vis-à-vis the international reference prices for medicines. Both factors make many essential medicines inaccessible, especially to the poor. This is not only a substantial obstacle to accelerating progress in the achievement of MDG 8 but also a barrier to the achievement of MDGs 4, 5 and 6.

Actions required at the national and international levels to improve the accessibility and affordability of essential medicines include the following:

- Governments should provide additional protection to low-income families to cope with the rising costs of medicines as a consequence of the global economic crisis.
- In addition to national efforts, further international actions should be taken to improve the availability and affordability of essential medicines, such as the establishment of international patent pools.
- Countries with manufacturing capacity should facilitate both the exporting of generic medicines to countries in need, in line with flexibilities contained in the TRIPS Agreement, and, where possible, the exchange of technology transfer between developed and developing countries for the production of essential medicines. Governments of low- and middle-income countries should reform national intellectual property legislation to enable TRIPS flexibilities and facilitate access to medicines for all.
- The public sector, in collaboration with the private sector, should strive to make essential medicines available at affordable prices and step up efforts to improve health insurance coverage.
- Governments, in collaboration with the private sector, should give greater priority to treating chronic diseases and improving the accessibility of medicines to treat them.