



Access to drugs and vaccines II

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Twenty-five years of essential medicines: progress and agenda for regulators

Dr Jonathan Quick, WHO

The first model list of essential drugs, produced by WHO in 1977, has been considered a public health revolution. Right now, 160 countries have their own model list of essential drugs, most of which have been updated within the past five years. On average, there are about 400 drugs per list in low-income countries, about 600 in middle-income countries and about 1200 in high-income countries. Well over 100 countries have developed clinical guidelines that bring the essential drugs list to clinicians and link it with supply systems. Over 100 countries have developed national drug policies.

Generally, WHO updates its model essential drugs list every 2 years. In 2000-2001, WHO undertook an extensive review of the approach, and revised the definition of essential medicines. Essential medicines are defined as those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price that the individual and the community can afford. The essential drug concept is intended to be flexible and adaptable to different situations. Hence defining which drugs are essential in a given context remains a national responsibility.

WHO has established a library on essential medicines, which brings together information from various partners. WHO has worked closely with the Cochrane Collaboration to obtain comparative data, cost data, statistics and information on adverse drug reactions. Moreover, in collaboration with the British National Formulary, WHO has developed a model formulary.

Drug regulators have a vital role to play in improving the accessibility of drugs. Consideration should be given to rational selection of essential drugs, affordable prices, sustainable financing and reliable systems.

- Rational selection — information on comparative efficacy, safety and cost-effectiveness should be considered.
- Affordable prices — high levels of generic drug use should be promoted. This requires a combination of factors such as supportive legislation and regulation, reliable quality assurance capacity, professional and public acceptance, and economic incentives.

In conclusion, much has been achieved by WHO in the past 25 years. The essential medicines concept remains a strong public health tool. Drug regulators have a vital role to play in improving drug accessibility, particularly in promoting the rational selection of essential drugs at affordable prices.

Essential drugs list: South African experience Ms Malebona Precious Matsoso, South Africa

South Africa did not have a national drug policy prior to 1994. Following the introduction of the new democratic process, a drug policy was developed and used as a basis for the national health policy. South Africa has now integrated a number of services that were fragmented, has embarked on a special drug programme with the assistance of WHO, and has amended legislation in order to improve drug accessibility.

Before 1994, the procurement list for the public sector had about 2600 items, and involved a lot of duplication. Therefore, an essential drugs programme is being developed to:

- ensure the availability and accessibility of essential medicines to all citizens;

- guarantee the safety, efficacy and quality of all medicines;
- encourage good prescribing and dispensing practices; and
- promote the rational use of medicines by health professionals and patients.

The working principles underlying the essential drugs list are to:

- identify the most common health problems, their severity and prevalence;
- develop treatment guidelines, based on best available clinical evidence, clinical experience and best practice models;
- ensure quality, efficacy and safety of medicines;
- promote the use of generic names;
- ensure applicability by amending legislative provisions;
- promote the use of single pharmaceutical agents; and
- carry out regular updates.

We have encountered some difficulties in the consultation process, especially from specialists in cardiology and psychiatry. However, we have had good cooperation with the nursing profession, medical practitioners, and also family medicine practitioners. In addition, we have held several workshops with a number of stakeholders to promote the concept. Draft guidelines and essential drugs list were disseminated to 250 institutions for comment and eventually specific inputs from 57 specialists and consultants were received.

The development of the essential drugs programme has reduced the number of items on the procurement list from 2600 to about 1000. This significant reduction applies just to the public sector. The private sector has developed its own formularies. The medical practice groups, managed care organizations and private health insurers have embarked on formulary development.

There have been a number of impact studies in South Africa. Baseline studies were conducted in nine provinces using 13 indicators adapted from WHO. The results showed that 84.6% of key medicines were available in most of the clinics. However, this still needs to be improved, and similar studies should be done at hospital level.

Access to antiretroviral drugs remains a major challenge in South Africa. There is an urgent need for the standardization of clinical

guidelines, development of decision-trees on safety, and fast-track training of clinicians. Also, an infrastructure for monitoring resistance should be set up and massive resources should be redirected.

In conclusion, there are several interventions that could further improve the selection and quality of drugs. First, for the selection of drugs, the essential drugs list should be regularly updated, and provincial therapeutics committees should be established or strengthened. Updated and locally relevant information on efficacy and safety of antiretroviral drugs should be disseminated. For the quality of drugs, results of quality control tests should be used as the basis of prequalification of suppliers in adjudicating tenders. Law enforcement, particularly within the developing country context, should be strengthened in order to combat counterfeit drugs.

The role of government and essential drugs — Indonesian experience

Dr Lucky S. Slamet, Indonesia

During the past 20 years, the Indonesian government has applied national strategies to the drugs sector to ensure the availability and accessibility of drugs. A national drug policy was established in 1983 and has been used since as a guideline for pharmaceutical development. This policy is now being updated to take account of recent developments. The concept of national essential drugs was adopted in 1980, with the aim of ensuring the cost-effective use of drugs. The list is revised every 3-4 years.

A third strategy is a generic drug policy, which aims to ensure accessibility of essential drugs, especially for the lowest-income population. All public sector health facilities are obliged to procure essential drugs in the form of generic products.

A fourth strategy was the establishment of a quality assurance system for premarket and postmarket control. All drug manufacturers and distributors are required to obtain a licence and comply with GMP, and all drugs must be registered prior to marketing. Drug inspection and quality control laboratories have been established throughout the country.

A fifth strategy was the development of a programme on rational use of drugs, which seeks to ensure proper prescribing, dispensing and use of drugs.

An early warning system has been developed to monitor the trends in the percentage of districts with drug stocks below the minimum level. The availability of key essential drugs in public health centres is considered satisfactory, at between 81% and 94%. Generic products are also well represented in pharmacies, ranging from 90% to 94%.

In terms of the percentage of essential drugs prescribed, health centres showed the best prescribing practices while the private sector used fewer essential drugs. This might reflect the pattern of prescription of private physicians.

The generic drug policy has had an indirect impact on the pharmaceutical market, where the market share of generics reached 12.8% in 2001. The policy has to be supported by a sustainable supply of products of assured quality and a good distribution mechanism.

To promote the rational use of drugs, easy access to objective information on drug efficacy, safety and quality has been provided for health professionals, as well as the community. The information includes treatment guidelines, a formulary, bulletins and journals. A hotline for consumer complaints about drugs and food has been set up so that consumers can request information directly.

In conclusion, the implementation of the essential drugs concept and the generic drug policy, through integrated drug planning at the district level, pooling procurement, direct distribution to districts, and intensive monitoring of availability and quality, have been the key factors in maintaining access to drugs for the public in Indonesia. However, more efforts are needed to maintain the availability and accessibility of affordable drugs.

Thailand's experience in access to medicines Dr Yuppadee Jarroongrit, Thailand

Thailand improves the accessibility of medicines by ensuring the availability of medicines at an affordable price. However, there are still some accessibility problems in Thailand, particularly in relation to orphan drugs and “high-price” medicines, such as those for AIDS and related diseases.

Thailand has developed strategies and approaches to support the importation of orphan drugs, such as providing fast-track registration. Thailand is also coordinating the updating of the list of orphan drugs, as well as dealing with tax issues. Public hospitals and the health sector are also allowed to import certain orphan drugs without a licence or registration. Research and development of drugs for neglected diseases is promoted. However, these efforts are still at an early stage, and a lot of work needs to be done on funds, infrastructure, resources and other related issues.

For the high-price medicines, especially for AIDS and related diseases, we have developed strategies and approaches on two levels. The first level is prevention. Antiretroviral medicines are provided to new mothers and their babies 2 hours after delivery to prevent vertical transmission of HIV infection. The second level is treatment. Negotiations have been held with pharmaceutical companies for a lower drug price and broader provisions have been implemented to obtain generic ARV medicines as soon as possible. In addition, research and development of these drugs has been promoted and supported. The major achievement is the local manufacture of a three-drug combination containing stavudine, lamivudine and nevirapine, which offers the advantages of good patient compliance, assured treatment quality, affordable price and high accessibility. Fast-track registration has been provided for this drug.

In addition to the national essential drug list, other strategies and approaches include negotiation with companies to lower the price of medicines, parallel import measures, Bolar Provision measures, research and development, priority-setting and fast-track registration, though these are still at an early stage. Moreover, further work such as simplification of the drug registration process is required.

In view of the above, we have some suggestions for the future. Regional cooperation on regulatory issues, to meet country-specific public health needs, should be encouraged. There is a need to promote research and development, public sector drug development and also public-private partnerships. Parallel imports and Bolar Provision measures should be empowered with full support from WHO.

Current vaccine shortages in the United States of America

Mr Mark A. Elengold, United States of America

The number of licensed vaccine manufacturers in the USA fell from 26 in 1967 to 17 in 1980, and down to 12 in 2002. There are currently shortages of a number of vaccines, including DT, TT, MMR, varicella, pneumococcal polysaccharide conjugates and influenza.

The three major causes for the current vaccine shortages in the USA are the limited production capacity, vaccine use and the economic situation.

The production capacity of vaccines is limited by the following factors:

- aging and inflexible plants;
- differences in regulatory requirements in different countries;
- scientific challenges, e.g. use of different adventitious agents and additives in different countries; and
- costly GMP requirements.

Vaccine use changes as a result of changes in recommendations, and in response to changes in public acceptance. Such changes can make it difficult for manufacturers to plan their manufacturing.

The difficult economic situation is related to:

- the uncertainty of the market;
- the complexity of the product; and
- the low price generally paid for preventative measures.

The USA currently faces a number of challenges including:

- ensuring the supply of vaccines;
- developing new vaccines;
- combination vaccines; and
- supplying vaccines at an affordable price to developing countries.

In order to increase vaccine availability, the USA should:

- improve early and frequent communication among the relevant parties;
- develop research that facilitates product development, improvement and safety;

- allow fast track and accelerated approval;
- increase the price of vaccines;
- limit liability by, e.g. offering indemnities to manufacturers; and
- seeking a balance between the risks and benefits of vaccines.

Expanding access to essential medicines and vaccines: lessons learnt in Brazil

Dr Jorge Bermudez, Brazil

In order to expand access to drugs, Brazil has taken the following actions since formulation of the Patent Law in 1996:

- establishment of the National Drug Policy in 1998;
- review of the national essential drugs list in 1999;
- development of a basic pharmacy programme from 1997 to 1999;
- decentralization of basic pharmaceutical care in 1999;
- establishment of the new health surveillance system and regulatory agency in 1999;
- enactment of the Generics Act in 1999;
- establishment of a parametric formula for readjustment of prices of drugs in 2000; and
- exemption from federal and state taxes for drugs for continuous use in 2001.

The Brazilian HIV/AIDS programme is a broad-based programme with a comprehensive infrastructure for patient care which includes hospitals, specialized care services, day hospitals and home care. The Government is responsible for the procurement of 13 drugs used to treat HIV/AIDS. A computerized system has been developed for the control of drug logistics for the care of AIDS patients.

The prices of antiretroviral drugs have been reduced by 78% through domestic production, and by 70% through negotiation based on differential prices. The prices of imported antiretroviral drugs have also been reduced by 25%. As a result, it is estimated that 234 000 AIDS-related hospital admissions were avoided between 1997 and 2000. AIDS-related mortality has been reduced by approximately 50% and the incidence of the major opportunistic conditions

associated with severe immunodeficiency in patients with HIV/AIDS decreased by 60-80%. In the future, we plan to make cooperation agreements with other countries.

The market for generic drugs is expanding and more companies are interested in manufacturing generic drugs in Brazil.

The Brazilian national immunization programme was created in 1973. The overall coverage increased from 40% in 1978 to 94.7% in 1999. 75% of the vaccines are locally manufactured (there is a development programme sponsored by the Ministry of Health) or supplied under international cooperation and technological agreements.

Our experience leads to several recommendations for expanding access to drugs:

- give importance to formulating, implementing and monitoring health sector policies;
- use regulation as a framework for political commitment of governments;
- potentiate alliances with developing countries;
- adopt a public health approach to trade issues;
- hold discussions with ICH and emerging countries on standards for manufacture of raw materials; and
- reaffirm government commitment and undertake necessary actions to ensure equitable access.

Recommendations

1. Countries should implement programmes aimed at assuring the availability, accessibility, quality and rational use of essential medicines.
2. The Model List of Essential Medicines is a central element of national drug policies. WHO should continue to maintain the Model List and support countries in adapting it to their needs and national context. Selection of essential medicines should be based on safety, quality and efficacy in addition to accessibility.
3. Access to medicines is improved by competition brought about by generic products. Countries should take measures to foster the development of a competitive generic market.
4. Countries and WHO should further develop initiatives aimed at expanding the implementation of the concept of essential medicines to encompass both the public and private sectors.
5. Countries and WHO should intensify efforts aimed at improving access to vital medicines, particularly those used for HIV/AIDS-related care and treatment.
6. Problems of vaccine availability are becoming more frequent. Countries and WHO should intensify their efforts to prevent supply shortages.
7. Countries and WHO should continue to study the impact of international trade agreements on access to medicines and initiatives aimed at promoting essential medicines and rational use.
8. Progress should be reported back to the ICDRA