SOME ASPECTS OF PHARMACEUTICALS IN SRI LANKA

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Economic Review : Drugs are an important part of the health care system. Do governments have policies regarding drugs (pharmaceuticals)?

Dr. K. Weerasuriya : Superficially the situation appears very straightforward. Drugs are needed to cure illness, and those who prescribe them know what they require. Therefore these requirements need to be fulfilled as economically as possible.

However such simple statements hide the enormous complexity of the pharmaceutical policy. Drugs are needed according to health needs. However the pharmaceutical industry itself has also to be considered. In some countries this industry is a big employer of highly skilled personnel as well as manual labour and brings in much needed foreign currency through exports.

In the United Kingdom the pharmaceutical industry is very strong. It is a net foreign exchange earner, employing highly skilled personnel in research, production and marketing. The industry also supports research in the universities with the hope of commercially exploiting any discoveries. However this has resulted in the production number of drugs for the same indication with very little to choose between them. This inevitably led to using sophisticated selling methods to grab a share of the market and thus to increasing costs. For example there are twenty drugs in the benzodiazepine group of drugs. The most well known member of this group is diazepam; most would recognise in by its trade name, Valium. The National Health Service (NHS) of the United Kingdom has therefore decided to limit the number of benzodiazepines available on its prescriptions. However all the rest are available on private prescriptions and are exported too. These are equal in quality, efficacy and safety to what is available in the NHS; they have just been simply considered unnecessary and too expensive. Ironically such constraints on market forces were applied in the free market Thatcher era. In keeping with it's free market policy, the government has no objection to these drugs being exported.

The pharmaceutical industry in India represents a very different situation. The government in the 1950s decided that a strong pharmaceutical industry is necessary and gave every encouragement via the industrial sector. At present India has a very advanced pharmaceutical industry which is interested in producing high value drugs with a high profit margin. However the health needs of the country require a limited amount of drugs which can be manufactured and sold cheaply. The pharmaceutical industry is not particularly interested in these types of products; no industry being run on a profit motive would be. There is therfore, a constant struggle by the government, to encourge the production of necessary drugs through tax incentives and other financial measures. The Indian pharmaceutical industry, despite having the capacity, is not serving the health needs of the country. However economically, it is a net foreign exchange earner and has been a power house in the industrial sector.

E. R : What is the Sri Lankan situation with regard to pharmaceuticals when compared to other third world countries?

Dr. K. W : On the whole Sri Lanka compares very favourably with most third world countries with regard to pharmaceutical policy and supply of drugs. This is possibly due to the government involvement in the health care of the population thus placing the need of getting good quality drugs at reasonable prices above the priorities of the pharmaceutical industry. Neither the needs of the pharmaceutical industry nor its employment potential figure in the equation of obtaining drugs. It was more important economically, for the government to get health care at reasonable prices rather than stimulate investment and employment in the pharmaceutical sector.

In the late 1970s the World Health Organisation (WHO) developed the Essential Drug Concept; a limited number of drugs based on health needs of the country to serve the vast majority of the population. The drugs in this Essential Drug List (EDL) were mainly tried and tested ones which were available at reasonable prices. Professor Lionel from the Colombo faculty was a secretary of the Expert Committee that developed the initial list. Sri Lanka developed its own list in 1985 based on the WHO prototype and it was updated in 1988. Practically, for the non specialist doctor, it comes down to about 150 drugs when the anti cancer and other similar drugs are excluded.

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An EDL is important as it allows the government to prioritise the drugs

needed. Otherwise there might be confusion as to the types and the quantities of drug imports and sometimes illogical and inevitably wasteful choices would be made. The EDL also limits the scope for corruption. In one African country, rifampicin, a rarely used antibiotic, was imported by the government in vast quantities because the importers were politically influential.

E. R : Is there some plan or list of what drugs should be supplied to the different grades of hospitals (Peripheral Hospitals, District Hospitals, Provincial Hospitals etc) of the government health service?

Dr. K. W : The government hospitals have been divided into four levels, based on facilities available, for the purpose of durg supply. These are Central Dispensaries, Peripheral Units, District Hospitals and Base Hospitals. Most of the drugs available in a big general hospital are available in base hospitals too. Many patients are ignorant about this; there is a lot of unnecessary travel to obtain drugs from a larger hospital when they are available in the local hospital. For example in a recent study by medical students, a patient from Tangalle was attending a clinic in the General Hospital, Colombo for drugs that were available in Tangalle Hospital. He was spending about Rs. 250.00 for this; if he bought it from a pharmacy instead of going to the hospital it would have cost him less than Rs. 10.00.

E. R : You have mentioned about the pharmaceutical industry and its influence on the pharmaceutical policy of the country. However is it not another manufacturing industry facing the constraints of all manufacturing industries in producing and selling?

Dr. K. W : It is another manufacturing industry; in fact most of the pharmaceutical industry has a good reputation for quality control which other manufacturing industries could be proud of.

However when it comes to selling their products they are in a very special situation. Market forces do not operate when the patient (consumer) buys the product (drug). The patient will in most instances will be unable to buy the cheaper of equivalent products. The prescription written by the doctor specifies what is bought; since the doctor does not pay for the drug, cost may not be a primary factor in his decision. Even if the doctor would like to prescribe a cheap drug he may hesitate as the patient may not be satisfied. The patient may think that cheap drugs are ineffective.

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Health is a very emotive issue and irrational decisions are as common as rational decisions. Therefore patients themselves might prefer the more expensive drugs thinking if it is expensive it must be good. The answer is educating the public but, the simplicity of the solution is matched by the complexity of implementation.

E. R : Does this mean that the price of drugs might not reflect the cost of production? What about price competition in the pharmaceutical industry?

Dr. K. W : In any market the seller tries to sell the maximum the market will bear. In pharmaceuticals this is done to the extreme. For example anti cancer drugs as a group are one of the most (if not the most) expensive group of drugs. This is because cancer patients will literally pay anything (after borrowing and pawning every thing) to buy the drugs.

It is also important to understand the concept of brand and generic names to comprehend why there can be enormous variation in the price of the same drug manufactured by different companies. A drug is given an official name which is internationally accepted and therefore recognisable by the doctors the world over. This is known as the generic name; an example is diazepam. Distinctive names are given by manufacturers to the diazepam they produce; these names are known as brand names. For example in Sri Lanka, diazepam is available under the brand names of Valium, Ciplium, Atensine. It is also available as a generic, as plain diazepam. Inevitably the branded drugs are more expensive than generics. If a manufacturer could persuade the doctor to prescribe as Valium rather than diazepam the pharmacist is obliged to dispense that rather than the cheaper diazepam. It is obviously in the interest of the manufacturer to do so by advertising, visits by medical representatives, free samples and other more dubious means.

Why would doctors prescribe the more expensive drugs when the cheaper generics are available? Many reasons are given by the doctors with enthusiastic support from the brand manufacturers. Only a few have any merit. One that needs to be considered is that the extra profits are used for research to discover new drugs. However the research is for drugs for conditions prevalent in developed countries which would be commercially exploitable. For example pain killers are commonly prescribed and there are over twenty available and many more in the pipeline. A few in developing countries may benefit from these new pain killers. However malaria which is a developing countries problem has only one new drug and that too was developed in China. So the extra profits in branded drugs generated in developing countries are not used for benefit of the patients in those countries.

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As for price competition in the Pharmaceutical trade, an example from Sri Lanka will suffice. The government as a

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response to the exorbitant profit making has promulgated a price control order on imported pharmaceuticals and the retail price is set at 165% of the CIF value. Only a very few of the importers have set retail prices below this to try and capture a greater share of the market. The vast majority of the importers are quite happy to sell at 165% and maintain their niche in the market. Can one, for example, imagine tyre importers agreeing to such a margin and harmoniously coexisting without cut throat price competition to increase sales? In fact the whole pharmaceutical trade appears to be like a docile government corporation, with almost a monopoly control of the market, happily producing a constant return on its capital and sheltering under the benevolent price control order. Perhaps some might use the word "Cartel" to describe this situation.

There is little quality control of drugs after the registration for import. There have been problems in quality and this situation will continue to be; however the extent of the problem has been exaggerated by the some sections of the industry for their own benefit. Those firms that import drugs from outside Asia promote the idea that drugs manufactured in Asia are suspect. However drugs manufactured in Asia have a substantial market share since they are cheap and effective. The very same firms that promote the tale of inferior Asian drugs, also import Asian drugs through another branch of theirs.

E. R : What are the requirement for the registration of drugs for import.

Dr. K. W : Any drug that can be shown to be effective and safe can be registered. It does not matter that equally effective and cheaper drugs are available. There is no "need" clause i.e. Is the drug needed? It is quite possible to bring a drug and create a need for it by good selling techniques. Such a need clause exists in Norway and as a result that country has the least number of registered drugs in Europe. The population of Norway are among the healthiest in Europe. Therefore the thinking that the bigger the number of drugs the better the health is not correct. The department of Health in Sri Lanka is considering some kind of "need" clause; its implementation would be a significant step forward in the evolution of our pharmaceutical policy.

What the people get will be what the people ask for. The drugs, their availability and cost will depend to a large extent on the pharmaceutical policy of the government.

Therefore supplying the drugs that are needed by the population at the best price available and keeping a low, but reasonable, margin of profit does not figure very high in the pharmaceutical trade's priorities. This priority would not be high in other industries either, but what makes the pharmaceutical industry different is their pretension and masquerade of "serving the health of the people". I must add this attitude is not unique to Sri Lanka and is inherent in the pharmaceutical trade itself.

E. R : What about the implementation of pharmaceutical regulations in Sri Lanka?

Dr. K. W : This leaves much to be desired. Though this is not a defence of our situation, this is a common problem in most third world countries. It is mostly a question of priorities – where do you put the limited amount of resources that is available? Into enforcing good environmental hygiene? Into safe foods? The enforcement of these regulations come about as a part of the general development of the country and should not be examined in isolation.

In conclusion I would like to stress that health and health care is, in a sense, a political decision. To quote Karl Virchow, a name familiar to medical students and considered by some to be the father of Pathology, "Medicine is a social science, and politics nothing but medicine on a grand scale". What the people get will be what the people ask for. The drugs, their availability and cost will depend to a large extent on the pharmaceutical policy of the government. Especially in a small developing country like Sri Lanka that will depend on whether the government places more emphasis on the health needs of the people, than on the needs of the pharmaceutical industry. So far despite an ebb and flow of the pharmaceutical industry. So far despite an ebb and flow of other narrow interests the emphasis has been on the health needs■