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ACCESS TO MEDICINES AN ISSUE OF SOCIAL JUSTICE

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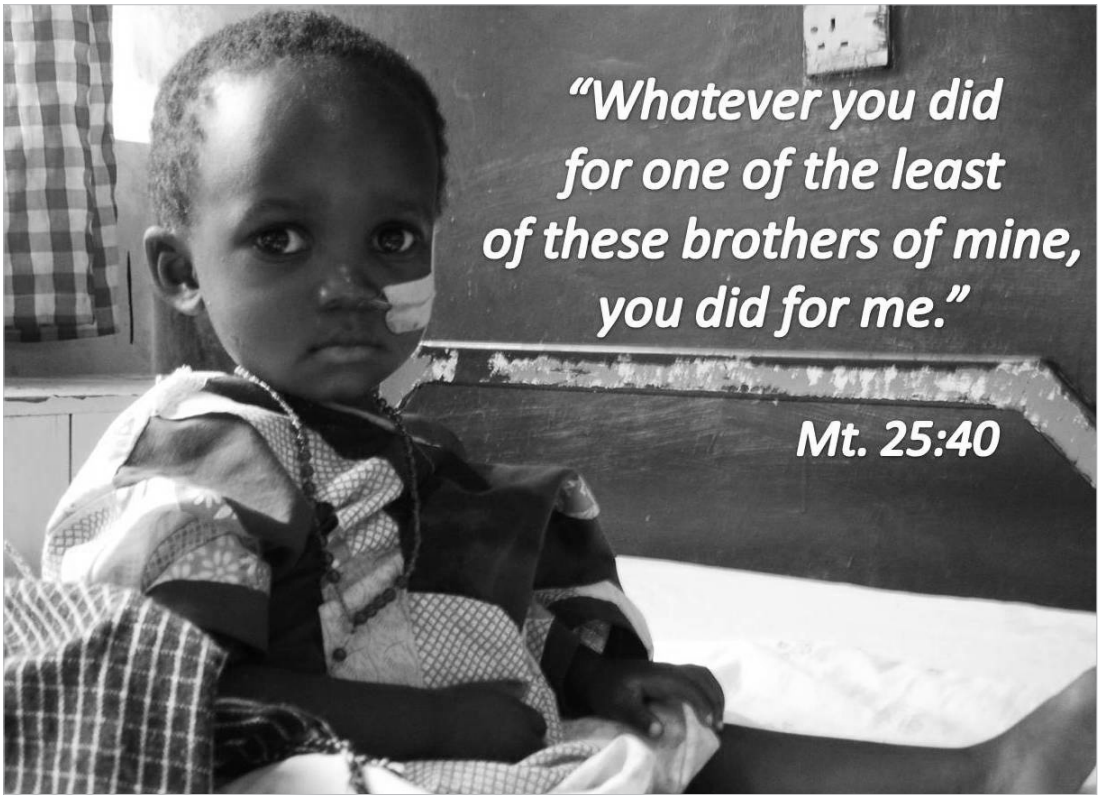

Photo Credit: Church of Uganda Kisiizi Hospital

ACCESS TO MEDICINES: OUR RIGHT, OUR RESPONSIBILITY

EPN believes access to medicines is a basic human right and every effort should be made to ensure that all actors in the health sector take up the challenge of ensuring that medicines are available, accessible and affordable to all, including the poor and marginalised. This sentence is taken from the EPN strategy (2010-2015). Access to medicines is still number one of the four strategic priority areas of EPN.

The human right to health is also still a top priority in the United Nations Agenda during the last year. On 12th December 2012, the UN General Assembly adopted the goal of Universal Health Coverage (UHC). All countries should ensure access to health care without causing financial suffering. The contribution by Wemos (p4) deeply reflects on principles of social justice. What can be done to overcome the huge inequality of income globally but also within countries? Micah 6:8 (New American Standard Bible) says: '*He has told you, O man, what is good; and what does the Lord require of you but to do justice, and to love kindness, and to walk humbly with your God?'* As Christians we could recall more verses which guide us to live for social justice and to follow Jesus' example. Yet, we have not managed to establish better systems to cover the health care for the poor. And poverty is the key which hinders the access to health care. Self-protective politics preserve the inequality and hinder access.

After diving into the philosophical aspects and the model of the Health Impact Fund, Crystal Yim, who joined EPN last year, illustrates the Australian approach to strive for Universal Health Coverage (p8). The Australian model takes the income and disadvantages some parts of the populations face into account and thus charges them differently. This measure improves the affordability and thus the access also to medicines.

Kala azar, black fever, is still a burden in Kenya, as in other countries. Thanks to the MSF Access Campaign as they constantly call out for inequality in health care. Their contribution (p13) in this issue illustrates that access to existing medicines is only part of the solution. Research activities do not focus on neglected disease. This is another area political decision makers have to install regulations to allocate financial resources.

Immunisation has saved many lives. In a Public Private Partnership, African governments and donors managed to keep up the vaccination rates and to ensure access to vaccines (p16). Still many questions have to be answered on how this model can be improved and continued in the future.

There are countless insurance systems and models out there. One could follow the poor introduction of "Obamacare" in the US. Is there any success? Yes: Kisiizi Hospital Community Health Insurance (p20). It is a model which works without any donor money. Exciting to read.

In the same way, action medeor builds ways - literally - to reach the unreached (p23).

The best welfare we might expect finally from God. Jeremiah 29:11 (English Standard Version) '*For I know the plans I have for you, declares the Lord, plans for welfare and not for evil, to give you a future and a hope.'* Till this day will come, it is us to look out for solutions for social justice, as our Bible study will inspire you to do (p25). There is no court on earth which will punish the injustice, inequality, the lack of funding for health care for the poor. The broad spectrum of this Contact Magazine gives nutrition for fruitful insights and to bear the consequences.

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There is no court on earth which will punish the injustice, inequality, the lack of funding for health care for the poor.

ACCESS TO MEDICINES AND PRINCIPLES OF SOCIAL JUSTICE

World Poverty and Human rights

In 2005, 44 percent of the world population was living on less than 2USD a day (A more generous international poverty line as defined by the World Bank). This 44 percent has access to only 1.3 percent of the global product, and would just need an additional 1 percent of the global product to escape poverty. On the contrary, high-income countries with 995 million citizens have about 81% of the global product. Severe poverty is an ongoing harm that the affluent citizens mainly in high-income countries inflict upon the poor. The global poor have a much stronger moral claim to that 1 percent of the global product to meet their basic needs, than the affluent have to take 81 rather than 80 percent. This is in essence the moral imperative that Thomas Pogge presents[1]. The work of Pogge builds forward on the *Theory of Justice* as defined by John Rawls in two main principles: The first principle of *Liberty*; each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others. The second principle of *Equality*; social and economic inequalities are to be arranged so that (a) they are to be of the greatest benefit to the least-advantaged members of society, and (b) offices and positions must be open to everyone under conditions of fair equality of opportunity.[2]

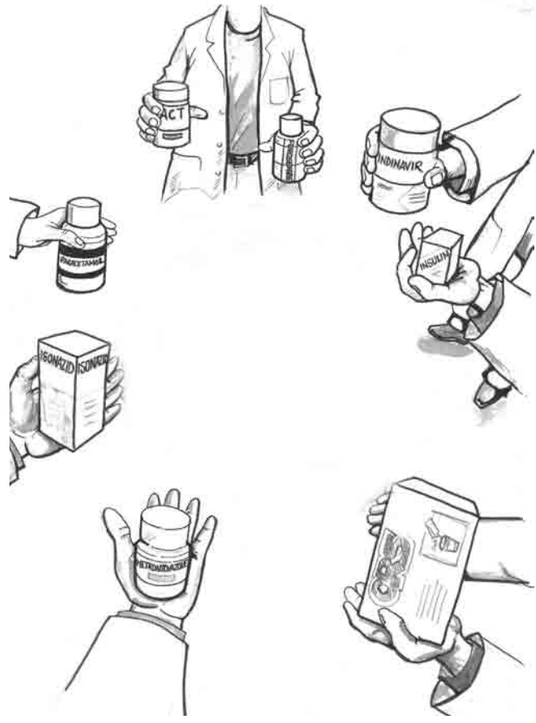
Most of today's morbidity and mortality are poverty related.

In relation to these principles, there are three notions of harm that Pogge identifies. First, there are lasting effects of historical crimes (E.g. slavery, colonial exploitation, discrimination) that are still imposed on the global poor and that maintain inequalities. Secondly, the global poor are deprived from a fair share of basic goods and needs. Even if for historical and natural reasons inequalities would be justified, then still one cannot not realistically conceive the current suffering and early deaths on the scale we are witnessing today. The global poor are worse off than they would have been in a *natural state of order*. And lastly our present global institutions (E.g. World Trade Organisation, International Monetary Fund, UN-institutions) reproduce radical inequality. The wealthy are preserving great economic advantages by imposing a global economic order that is unjust in view of the massive and avoidable deprivations it foreseeably reproduces. "We are harming the global poor if and insofar as we collaborate in imposing an *unjust* global institutional order upon them, for instance via an inegalitarian intellectual property regime".[1] In Human Rights theory this is seen as a violence of a *negative right*, which is the principle of inaction or *Do no harm*. While in current global health practice there is much focus on *positive rights*, such as the provision of basic health services, provision of essential medicines and Universal Health Coverage, there is a relative neglect of the Do no harm principle, which is too often being violated via institutional regimes at the global, national or local level.

Hans Hogerzeil, Professor in Global Health at the University of Groningen (The Netherlands), has echoed some of the above thinking in his inaugural lecture in 2013, with the title "Whom do we choose to ignore? Choices in global Health". From a human rights perspective, he analyses that also in a country like the Netherlands not only at the global level, such a violation of negative duties can take place. As an example he outlines the decision of the government to remove the free supply of oral contraceptives to young women between 21 and 25 years from the basic health insurance package. This affects more or less 250,000 women. Would this removal not constitute a violation of the right to health? Going back on an earlier achievement is a violation of the International Covenant of Economic, Social and Cultural Rights of 1966, which is signed and ratified by the Netherlands. At the same time the government chose to cover treatment costs for patients with certain rare diseases, such as Pompe's disease, a rare muscles disease. The additional benefits of a treatment, expressed in "quality-adjusted life years gained (QALY's) can be calculated, and this benefit can then be compared with the additional cost of the treatment. For Pompe's disease, the cost per successful treatment could be as high as several millions Euro per QALY gained. The hard fact is that with the same money, the Dutch government could probably have helped many more individual patients with other diseases. For example, with one-fifth of this money, modern contraception could have been given to 250,000 women.[3]

The Health Impact Fund

Shortfall in the realisation of the right to health is highly correlated with poverty. Most of today's morbidity and mortality are poverty related. Mover-over, rich states also insist that their intellectual property rights - ever-expanding in scope and duration - must be vigorously enforced in the poor countries. Millions would be saved from diseases and death if generic producers could freely manufacture and market life-saving drugs in the poor countries. Pogge questions "whether affluent countries may promote the enforcement of temporary monopolies that foreseeably make advanced medicines inaccessible to a majority of humankind". Defenders of the current property regime, known under the abbreviation TRIPS, argue that there must be an economic incentive for Pharmaceutical Research & Development. Rather than modifying the current TRIPS agreement of the World Trade Organisation, Pogge has suggested an alternative mechanism, which is called the *Health Impact Fund* (HIF)[4]. In essence the HIF would be financed mainly by governments, and is a pay-for-performance mechanism that would offer innovators the option - no obligation - to register a medicine. By registering its product with the HIF, the innovator would make it available during 10 years on the market, wherever it is needed, at no more than the lowest feasible cost of production and distribution. In exchange, the pharmaceutical innovator would receive, during those 10 years, reward payments based on its product health impact (to be measured in QALY's). In essence, the HIF would enable national governments to take a pooled, public share in the private medicine market, so as to ensure that the poorer part of the population is guaranteed financial access to essential drugs. The incentive for innovators to be involved with the HIF would be to have a guaranteed longer, annual period, pay-out, as long as it is evident that the product has considerable health impacts.



The HIF mechanism has received severe criticism, amongst others by the organisation *Knowledge Ecology International* as it doesn't address the Social Determinants of Health as key drivers for poverty or disease; that registrants to the HIF would retain their intellectual property rights and hence their monopoly; and that the Public-Private Partnership model of the HIF would entail considerable management and project costs. Thomas Pogge has responded to these critiques[5] but until today, the Health Impact Fund hasn't yet been operationalised. *Incentives for Global Health*, a non-profit organization devoted to advancing market-based solutions to global health challenges, promotes the HIF and is in the phase to develop a pilot project.[6]

Rights, Redistribution and Regulation for global health equity

The proposal for the HIF provides reflection about research and recommendations for improved global health equity as conducted by Ronald Labonté and Ted Schrecker.[7] Their first advice for global health actors: Do no Harm! Secondly, if global health is to be advanced in an equitable way, the following "3 R's" need to be considered; Systemic resource *Redistribu-*

tion between countries and within regions and countries as to meet human needs; Effective supranational *Regulation* to ensure that there is a social purpose in the global economy; Enforceable social *Rights* that enable citizens and residents to seek legal redress. The interesting part about The Health Impact Fund mechanism is that it addresses the right to health and redistribution of essential medicines according to health impact. It has a serious omission, however: the HIF does not promote or alter supranational regulation that would guarantee compliance to equitable intellectual property regimes. Neither it obliges innovators via regulations to participate in the fund; it only provides them the option to do so. As a result, innovators would only join this fund if it provides them an attractive market. Also, the donors (mainly affluent governments) would only pool funds in this global mechanism if it leads to measurable results that are attractive to present to their citizens and taxpayers. In general, poverty related chronic diseases are not attractive. It is likely that the fund will attract mainly products that show rapid effects such as new, non-resistant, malaria or TB medications, rather than medicines for chronic physical (e.g. diabetes or asthma) or mental health conditions.

In conclusion, the HIF mechanism is a promising platform to improve health related rights and redistribution mechanisms for medicine R& D. However, if the HIF, its actors or its alliances do leave aside the global institutional economic and trade arrangements that maintain global inequalities and poverty, its moral claim will be weakened. The supranational regulation required to address inequalities in access to medicines is the Achilles' heel of the HIF. It requires the architects of the HIF to consider joining alliances that advocate for alternative TRIPS agreements and/or other property related regional or bilateral free trade agreements, so that intellectual property becomes more fairly and equitably available for the global poor. It can also support the growing interest for a global medical R&D convention, to be developed and negotiated by the World Health Organization and its member states. This convention, that would finance and coordinate R&D for diseases that affect the poorest populations, has been derailed and taken off the negotiation table at the World Health Assembly in 2013.[8] Undoubtedly, attention will return and it will receive further thoughts in the coming years.

Remco van de Pas and Annelies den Boer are Global health advocates at Wemos foundation, the Netherlands

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Unethical clinical trials, an example of civil society practice in global health

Wemos, a health advocacy organisation from the Netherlands, has since several years been working on the ethical aspects of clinical trials, and how health and human rights of trial participants can be protected, especially in less affluent countries.[9]

Pharmaceutical companies do not always act in compliance with the rules for testing medicines and take advantage of vulnerable people. Usually, test subjects are poor, illiterate and hardly have access to health services.

Wemos lobbies for
- Adherence to the rules that protect vulnerable people against unethical clinical trials.
- Fair medicines at the European market.

Before new drugs are marketed, they are tested on human beings to determine their efficacy and safety. Pharmaceutical companies are increasingly testing new medicines on people in Eastern Europe, Asia and Latin America, because of the low costs and because test subjects are easier to find in these areas. For test subjects from vulnerable groups it is often the only way to get treatment or earn some money. Sadly, participants hardly receive any information and have no idea about the risks they run.

International regulations are rather straightforward. Pharmaceutical companies, however, do not adhere to the agreements, while governments insufficiently monitor the rules. Moreover, Western countries contribute to continuation of the situation, as they allow unethically tested medicines to enter their markets.

Wemos contests unethical clinical trials by:
- advocating for closer supervision at the European level, to prevent unethically tested medicines to be marketed in Europe;
- closely monitoring the activities of pharmaceutical companies and publishing research reports;
- collaborating with international civil society organizations;
- attracting the attention of the media.

Medical needs clause

Many of the clinical trials performed globally are not meant for the development of new drugs, but are intended merely to protect the market share of companies. By adding minor variations to their blockbuster drugs, they are trying to get a 'new' product on the market by the time the patent of the old drug has expired, thereby preserving their revenue stream. Such clinical trials which have little or no benefits for patients are ethically questionable, according to Wemos.

This problem is key to what professors Light and Lexchin call the 'hidden business model', as a result of which only one in ten newly approved medicines substantially benefits patients. According to experts cited in this report, drug regulators such as the EMA and FDA play an important role in sustaining this model as they do not require new drugs to be significantly better than drugs that are already on the market; neither do they evaluate whether there is a public health need for such a drug. Instead they treat drugs as if they were common commodities.
- Together with the European Public Health Alliance Wemos investigates the feasibility of a medical needs clause in European legislation.
- Wemos advocates for the medical needs clause.

The example of the medical needs clause mimics somehow the proposal of the Health Impact Fund to use health impact as an indicator for a medicine to be allowed on the market. The difference between the two is that within the EU, regulation exists that protects its citizens and their health. In many less affluent countries similar regulation and protection does not yet exist. Pharmaceutical companies use these 'loopholes' as a way to cheaply develop new medicines. It also indicates that while regulation is important, it requires close monitoring on its implementation and the strong interests that try to weaken it.

UNIVERSAL HEALTH COVERAGE AND ACCESS TO MEDICINES – AN AUSTRALIAN PHARMACIST'S PERSPECTIVE

In December 2012, stemming from 'the right to health' initiative, the United Nations General Assembly adopted a resolution prioritizing the goal of Universal Health Coverage (UHC) on the global health agenda. The resolution urged countries to develop their own health systems to ensure all people obtain the health services they need without suffering financially to afford them. Universal Health Coverage is firmly based on the WHO constitution of 1948, declaring health a fundamental human right, health for all and equity paramount.[1,2] On 15th August 2013, Dr Chan, Director-General of WHO, described UHC as 'a powerful social equalizer and ultimate expression of fairness.'[3]

One of the core principles of the right to health initiative is the right to essential medicines. Medicines should be available to all health care facilities and accessible to every patient.[4] According to the WHO, the concept of essential medicines with its focus on equity, solidarity and social justice is in line with the principles of human rights.[5,1] EPN also believes that access to medicines is a basic human right and every effort should be made to ensure that medicines are accessible and affordable to all. Therefore, it is paramount that EPN and faith-based health organizations assist governments in developing countries to achieve the right to health by providing patients access to safe and efficacious medicines as a marker of social justice.[6]

Since 1981, EPN has been working on the issue of supply, distribution and use of medicines; back then in the form of an advisory service, now as global network. The programme is now called the Access to and Rational Use of Medicines Programme and is an essential component to ensure EPN members are able to complement government's efforts in order to achieve the Millennium Development Goal 8: Target 8E: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries, *Proportion of population with access to affordable essential drugs on a sustainable basis.*

Towards universal health coverage

Every year, 100 million people are pushed into poverty because they have to pay for health services directly. A way to prevent increased poverty and to increase universal coverage is to use taxation or insurance as a means of pooling funds through compulsory contributions. People then draw upon these funds in case of illness, regardless of how much they have contributed.[7]

By spreading the costs across the whole population, each person would pay less in times of sickness and those in need of serious treatment would be spared from enormously high costs, thus illness would no longer regularly bring financial ruin.[8] Ghana increased value-added taxes by about 3 percent in 2003 and pooled the revenue to fund the country's UHC, while Nigeria used revenue freed up by debt relief to fund pilot universal coverage programmes for expecting mothers and children.[9]

Globally, 20-40% of resources spent on health are wasted. A common inefficiency found by WHO includes the inappropriate use or overuse of medicines amongst others such as de-motivation of health care workers and duplication of services.[7] EPN and its network are perfectly positioned to provide united support and local research for their developing countries to achieve universal health coverage.

The *EPIC* road to UHC

The Lancet (http://www.thelancet.com/themed-universal-health-coverage) series on UHC indicates that implementers may like to investigate several points which deserve deeper appreciation. The acronym EPIC is used to describe the points.

E. Economics. Good health is not only a consequence of economic development, but also a driver of it. Healthier people can do more by contributing to greater productivity, entrepreneurialism, improved educational performance and reduced poverty. Good health systems not only exchange these benefits by improving health but also yield additional economic benefits. An example would be improved financial protection for families against large medical bills thus reducing their risk of financial debt, making assets and savings more secure, enabling them to save more, resulting in increased economic activity which can stimulate improved economical development.[8] According to the African Development Bank Group, a majority of African countries will be in a position to ensure at least minimal health coverage for their populations, if not full coverage, by 2060.[15]

P. Policies and politics. The importance of good policies and good management of political challenges is compellingly evident from the huge differences in health achievements between countries with similar per head incomes. An example would be Thailand which introduced UHC in 2002. The country has seen exceptional improvements in mortality for children under 5 years old. The Thai Government has extensively invested in health infrastructure, successful integration of primary health vertical programmes, developed robust training institutions paired with policies mandating rural service by health workers and has reformed health financing to ensure equitable access to care and improved health to the Thai people at fairly low costs.[8]

I. Institutions. Economics, policies and politics enable change, but institutions deliver the services. Private and public institutions both have critical roles. Good health system performance requires an optimum mix of functions between them. Stewardship and fair financing are essential public responsibilities whereas delivery of services is best served through a pluralistic mix that includes the private sector and civil society. Institution building requires long term investment that is difficult to secure in the short term world of politics. Strong leadership is essential, with the strategic vision, technical knowledge, political skills and ethical orientation necessary to manoeuvre through the complex process of policy design and implementation.[8]

C. Costs. Economics, policy, politics and institutions can do a lot, but if costs of improved health aren't met in a sustainable and equitable manner, the concept of UHC is lost. Countries which have planned how to cover health-care costs reasonably well, by collecting revenue fairly and deploying it efficiently, have been shown to thrive, whilst those that have not implemented sustainable financial policies have struggled.[8] In Rwanda, taxes are set at 2.40€ per person per year. But, according to WHO experts, a minimum amount of 44€ per capita will be required to ensure treatment during the main epidemics as well as prevention against non-communicable diseases. Therefore, Rwanda may need to consider raising taxes or identify other ways to increase revenue to cover preventative health programs.[15]

The cost of inaction is also important. People without coverage impose hidden costs on their country. Inadequately treated health problems result in decreased productivity, higher future costs and disrupted families and communities; thus leading to under-investment in the next generation, thereby imposing even greater future costs. Inadequate prevention results in higher treatment costs. A life saved and given the chance to be more fruitful not only imposes less cost on society but also brings more benefit to it. Furthermore, a good health system promotes human rights and enables every individual to realise their potential. This outcome is the ultimate measure of success of UHC.

Therefore, the acronym EPIC can be used by implementers of UHC as a simple tool to focus on areas required to develop and implement successful UHC reforms for their country. Introduction of reforms that promote UHC is not only the right thing to do ethically; it is also the wise thing to do in order to achieve economic prosperity.[8]

Taking time to get things right at the beginning of implementation can have large positive impacts in the future, while rushing into implementation without solid research and policy formulation, may result in high costs and unanticipated problems.

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Learning from the Australian UHC system

Medicare is Australia's universal health insurance scheme which was introduced by the Australian Government in 1975. Its objectives are to make health care affordable for all Australians, to give all Australians access to health care services with priority according to clinical need and to provide a high quality of care.[10] As a means of providing Australians with universal access to medicines, the Government started *The Pharmaceutical Benefits Scheme* (PBS) under the National Medicines Policy. The PBS was introduced in Australia in 1948 as a limited scheme with free medicines for pensioners and a list of 139 lifesaving and disease preventing medicines free of charge for others in the community. The PBS is funded through taxes and a Medicare levy paid by Australian taxpayers.[11]

The scheme provides Australians with timely, reliable and affordable access to necessary medicines. Under the PBS, the government subsidises the cost of medicine for most medical conditions. For medicines to be listed on the PBS, the medicine first has to be cost effective as well as efficacious.[12] Today, over 1000 medicines are listed on the PBS scheme with new medicines added on a monthly basis after appropriate approval.

Currently, a general patient pays a maximum of 31USD for a PBS listed medicine. A patient with a concession card (senior citizen, pensioner, carer, disability support pensioner or on youth allowance, etc.) will pay just over 5USD. If a PBS listed medicine is 60USD, a general patient will only pay 31USD with the scheme subsidising 29USD. If the patient has a concession card, he or she will only pay 5USD, with the scheme subsidising 55USD.

Even though this scheme is funded through the Government, most of the listed medicines are dispensed by private community pharmacies and used by patients at home.[11] When a community pharmacy dispenses medicines from the PBS list, the Government pays a dispensing fee to the community pharmacy.

The PBS aims to meet medication and related service needs to optimally balance health outcomes and economic objectives, however, this is an ever increasing challenge.[11] Expenditure on health is growing every year in Australia and the PBS is constantly struggling to manage the rising costs of advancing medicines and increasing health demands of Australians.[12]

Other causes of high expenditure on the PBS include; increasing number of aged people with chronic conditions, increasing availability of new and effective – but high cost drug treatments, the growth of preventative medicine, national campaigns to improve detection and treatment of previously inadequately treated conditions, increasing community awareness of and expectations of assessing new, effective and often expensive drug treatments, irrational prescribing and pharmaceutical manufacturer's promotion.[13] Therefore, it can be predicted that the struggles of the Australian system are also likely to occur in developing countries' own universal health care systems.

To help maintain the viability and sustainability of the PBS, cost control strategies have been initiated which include: increasing patient co-payments every calendar year in line with inflation, introducing brand price premiums to patients – thus preferring generic dispensing, limiting drug manufacturers' influence on prescribers with the aim to increase rational prescribing and rational use of medicines.[13] As it can be predicted that the struggles of the Australian system are also likely to occur in developing countries' own universal health coverage systems, some of these cost saving strategies, initiated in Australia, may help developing countries to implement sustainable universal health coverage systems. There must be a constant balancing between universal access to medicines and the rising costs of making these medicines accessible to all.

UHC can be achieved in many ways and countries are encouraged to develop their own paths to achieve a programme that reflects its own culture, previous health care systems and economic situations. The Joint Learning Network For Universal Health Coverage countries including Ghana, Mali, Nigeria, Kenya, Vietnam, Thailand, India, Indonesia, the Philippines and Malaysia seeks to share knowledge and experiences regarding UHC formulation.[14] Countries in the process of developing their own UHC are encouraged to adapt the shared knowledge to their relevant cultural and financial situations and incorporate it into their plan

EPN's contribution to improved health coverage

Currently, EPN is trying to increase the access to and rational use of medicines in East Africa through a Pooled Procurement project between BUFMAR in Rwanda, MEMS in Tanzania, MEDS in Kenya and JMS in Uganda. By facilitating the pooling of procurement between these faith-based drug supply organisations, EPN hopes to achieve greater access to safe, reliable medicines to their faith-based dispensaries in all four countries. A technical working group has being gathered from all four organisations to start the implementation of this project.

In Cameroon, churches and church organisations started a discussion on pooled procurement last year. The synergies of a pooled procurement process could reduce the costs for the medicines and thus increase the access to it. It should also improve the safety and reliability of supply to faith-based dispensaries.

In other 'Access' programmes, EPN are currently conducting two children's medicines projects in Tanzania and Cameroon. The projects involve surveys which are investigating the availability of children's medicines, availability of staff and resources available in 50 dispensaries of each country.

Therefore, EPN's programme of Access to and Rational use of Medicines is an essential component to ensure our members are able to complement government's efforts in order to achieve the Millennium Development Goal 8 – Access to affordable essential drugs and to achieve the ultimate goal of successful implementation of universal health cover in developing countries.[16]

for UHC.[8] As a result; the shared knowledge and experiences from the Australian UHC example above, can give implementers of UHC in developing countries ideas in which they can adapt the information and develop their own tailored UHC framework.

UHC is an opportunity for developing countries to better the health care and decrease financial burden on their people, however, it is not a guarantee for progress. It is imperative to have a good foundation for UHC supported by evidence-based research into the current health care and economic funding aspects of the country. Taking time to get things right at the beginning of implementation can have large positive impacts in the future, while rushing into implementation without solid research and policy formulation, may result in high costs and unanticipated problems.[8]

Crystal Yim recently joined the Ecumenical Pharmaceutical Network (EPN) secretariat in Nairobi, Kenya in 2013. She worked as a volunteer Pharmaceutical Program Officer for 5 months through the Australian Youth Ambassadors for Development Program, an Ausaid initiative. She was assigned to the Access to and Rational Use of Medicines projects.

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SOCIAL JUSTICE AND MEDICAL INNOVATION: WHY THE SYSTEM NEEDS REFORMING

Visceral leishmaniasis – or kala azar, meaning 'black fever' in Hindi, as it's commonly known – affects around 4,000 people in Kenya each year. With cases found especially among the sparsely-vegetated areas of the Rift Valley, near the border with Uganda, kala azar afflicts primarily the young men and boys who tend to their livestock. But it affects everyone; women, children, old and young.[1]

This neglected tropical disease (NTD) is caused by a parasite carried by an infected sand fly, which infects the body once a person is bitten. The parasite then attacks the internal organs, and the disease is ultimately fatal unless proper and timely treatment is received.

Kala azar is curable, but the treatment methods currently used are long, painful and expensive, both in terms of cost to the patient and to society. Current treatment is 17 days of daily painful injections, requiring the patient to be treated in hospital, often far away from home, and unable to work and provide an income for their family.[2] This situation however – an ill-adapted, painful, expensive treatment for a NTD – is not unusual.

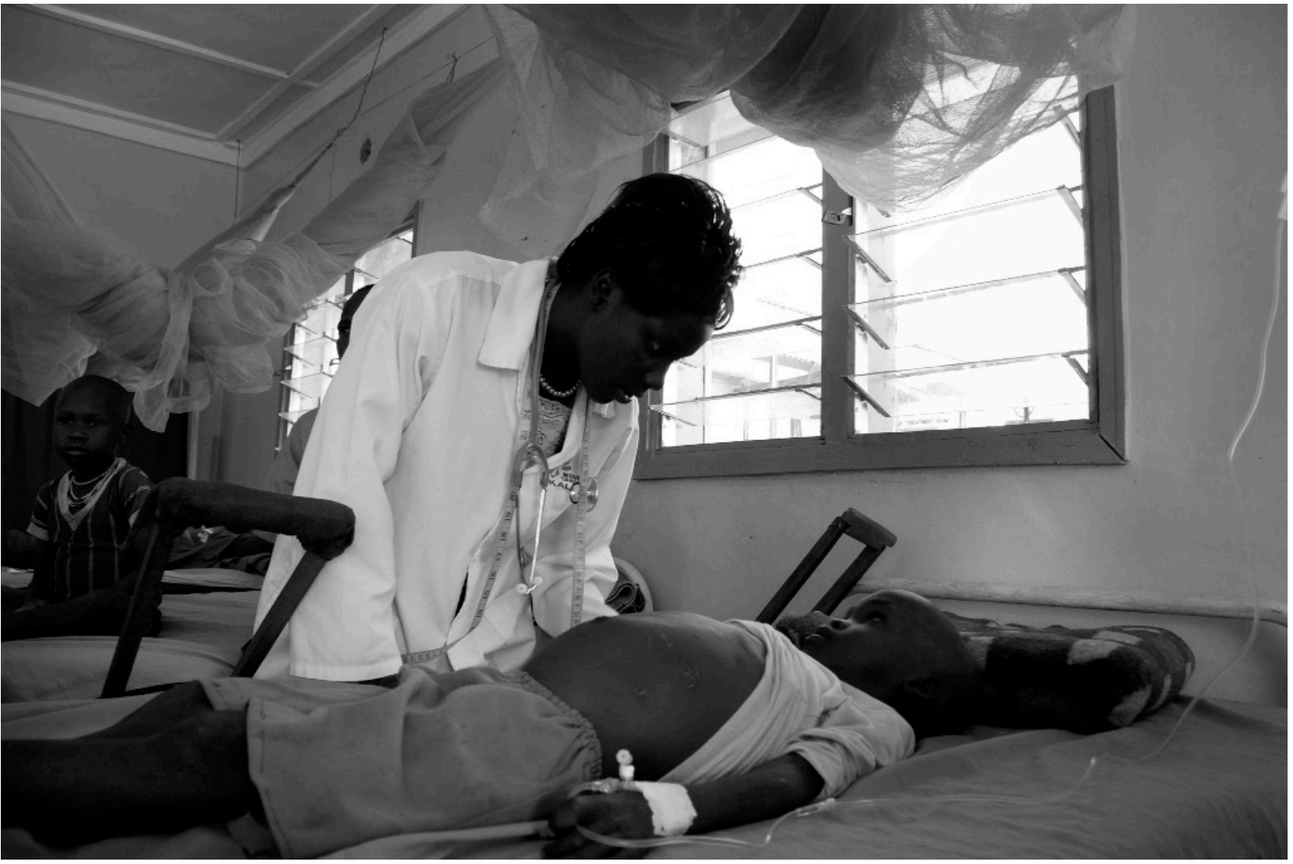
In fact, because of the way research and development (R&D) into new diagnostics and treatments are funded, diseases that affect primarily poor and neglected populations are more commonly overlooked in efforts to develop better, more effective tools and drugs. All people must be able to access affordable healthcare as a basic human right. But commercial imperatives, and not medical needs, are what drives medical innovation and determines for which diseases drugs and diagnostics get developed. The needs of the poor remain neglected.

According to a recent survey on R&D funding, only 13% of research into NTDs comes from the private sector, the bulk of the effort coming from governmental or philanthropic sources.[3] A separate study co-authored by Médecins Sans Frontières (Doctors Without Borders) this year showed that of the 336 totally new drugs approved between 2000 and 2011, only four, or 1%, targeted neglected diseases, even though these afflictions account for over 11% of the global disease burden.[4]

In the current R&D model, the cost of research is paid for by charging high prices for drugs – this link between cost and price is the heart of the matter. And so medical innovation focuses on diseases that affect rich countries, where people can most afford to pay. The diseases of the poor – kala azar, sleeping sickness, tuberculosis, plus many more – miss out as the people which these diseases affect the most cannot pay high prices. Where is the social justice in this?

It's this same chase for the dollar that – as well as neglecting the needs of the poor – also has pharmaceutical companies charging the

MSF Nurse Moses Rutale prepares an injection at the MSF Swiss kala azar clinic Kacheliba, northwestern Kenya. *© Susan Sandars*



MSF Clinical Officer Loice Mukenyang examines six year old Yeko Lolem at the MSF Swiss kala azar clinic in Kacheliba, northwestern Kenya. This is the second time that Yeko has been admitted to the clinic suffering from kala azar. As he has relapsed he must now be treated with a second line drug, Ambisom, which means he must have a two hour infusion everyday for seven days. The scars on Yeko's stomach are from traditional healing. *© Susan Sandars*

high prices for drugs, so much so that new drugs are now increasingly unaffordable for people even in wealthy countries. Witness a new treatment to cure hepatitis C which the manufacturer intends to launch at a staggering 1000USD per pill.[5]

Developing countries are hard hit by high prices too. In Kenya, a country where the per capita income per year is 865USD[6], the price of just one HIV drug, darunavir, costs at best 730USD per person per year[7]. Innovation for new drugs remains meaningless if no-one can afford them.

R&D must be rewarded somehow, but there needs to be another way to allow researchers to recoup their costs without passing on this burden to the patient. There need to be other ways to incentivise developers to come up with new drugs that are ultimately affordably priced. To do this will require us to break the link between cost and price; in the jargon, this is known as 'delinking' the cost of R&D from the high prices that are charged once the drug hits the market.

This idea is making slow progress in the power circles. At the World Health Organization, discussions on the need for a better R&D system have been ongoing for a decade, with Kenya among the leading countries which highlighted the need for change. In 2012, an expert working group recommended that talks be started on an international treaty for R&D, where countries would allocate 0.1% of GDP to funding R&D needs and prioritising the funding and development of diseases that affect developing countries.[8] Since then, little has happened, as countries and the WHO once again shy away from reform in favour of the status quo.

Greater social justice on access to medicines and medical innovation – with affordable, adapted treatments that address neglected needs in kala azar, tuberculosis or HIV – is possible, but it will only be achievable if governments have the courage to grapple with the reforms that are needed.

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STRENGTHENING FAITH-BASED HEALTH PROVIDER SYSTEMS FOR IMPROVED ACCESS TO ROUTINE IMMUNIZATION?

Immunization has often been viewed as the leading star of public health intervention – the 'magic bullet' providing a seemingly simple solution to some of our worst diseases. The WHO notes that the two public health interventions that have had the greatest impact on the world's child health are clean water and vaccines[1].

Immunization sits at the heart of maternal and child health activities as well as primary health care (PHC). Immunization is seen as a core component of achieving the Millennium Development Goals and millions of dollars have been spent on immunization campaigns. However, alongside every success, have come equally frustrating failures. In high-income countries, within some communities there is general resistance to the idea of immunization, and in development contexts, recurring failures in the elimination of poliomyelitis despite massive campaigns and spending have demonstrated the challenges of implementation, and the need to understand reasons for resistance, and improved strategies for reaching 'missed populations' or 'closed communities'. One of the greatest challenges is that the places where the burden of disease is the highest also tend to have the most fragile health systems - making delivery of vaccines a greater challenge in the places where they are most needed. This has resulted in a massive shift of attention towards health systems strengthening (HSS) for immunization intervention. For example, one of the GAVI Alliance's main strategies for immunization is HSS – noting that "by the end of 2010, GAVI had committed 568 million USD to health system strengthening support."

However, specific strategies and successes in strengthening health systems for immunization are elusive. A WHO working group, the 'Strategic Advisory Group of Experts on Immunization' were tasked with asking whether new vaccines had a positive or negative impact on the health systems of the countries in which they were introduced, and they found that "while reductions in disease burden and improvements in disease and adverse events surveillance, training, cold chain and logistics capacity and injection safety were commonly documented as beneficial impacts, opportunities for strengthening the broader health system were consistently missed during [new vaccine introduction (NVI)]. Weaknesses in planning for human and financial resource needs were highlighted as a concern...future NVI should explicitly plan to optimize and document the impact of NVI on broader health systems"[2].

One of the key issues is the strengthening of routine immunization (RI) systems. The ARISE (Africa Routine Immunization System Essentials) project observes that while RI has been called the 'backbone' of immunization programmes, in concrete terms its importance is not yet realized. "When it comes to provision of support for RI, however, particularly for the recurrent costs essential to programme operations, a gap remains between the rhetoric and the reality. Initiatives to eradicate polio and eliminate measles have built support for RI, to a limited extent, into their budgets and into the activities of their technical field staff as time permits. But the vast majority of their resources cover costs directly associated with controlling those diseases...The GAVI Alliance, with its focus on the introduction of new and underutilized vaccines (NUVI), has a strategic objective of strengthening health systems and immunization service delivery. However, less than 15% of GAVI's budget is for non-commodity support, including support to the country programmes responsible for ensuring that children and other target groups actually receive the newly-introduced vaccines. A similar situation is apparent in the plans of technical agencies; for example, less than 5% of the budget for the 2012 immunization plan of action for the Regional Office for Africa of the World Health Organization is devoted to routine immunization system strengthening - and that line item is not fully funded. This situation has been observed each year, for over a decade"[3]. This highlights the tensions between immunization intervention, and the systems strengthening necessary to support immunization intervention (whether through campaign or RI).

If immunization is one of the leading stars of public health, then 'religion' is one of its frustrating complexities. There has been a resurgence of interest in religion and public health over the last few years – and broad-scale attempts have been made at a number of levels to bring faith-based institutions 'back to the table' and to 'map' them more effectively. Under the uncomfortable realization that the world is as furiously religious as ever, religion has slowly come back onto the agenda. Regarding immunization, systematic and scoping review shows a surprising abundance of literature on religion as a determinant of immunization uptake or refusal. There is also a rapidly emerging body of information on vaccine-related intervention through religious leaders and local faith communities (seen especially in UNICEF materials).

We have been reminded that there are historical links between religion and vaccination since its earliest records – for example, the introduction of the variolation technique (an early form of vaccination no longer in use) has been credited to an 11th century Buddhist nun in China. What the more recent literature shows is the incredible complexity of overlapping perceptions or determinants such as religion, culture, economics and politics that simultaneously influence vaccine refusal or acceptance. Nothing demonstrates this complexity as well as the massively publicized rejection of polio immunization that exploded in Northern Nigeria in 2003, vocalized by local Muslim clerics, but driven by interweaving social, political, economic and religious concerns. The rejection of the polio vaccine spread like wild-fire through the country and beyond – resulting in renewed outbreaks of polio in many countries in the region which had previously been declared polio-free, and resultantly led to high-level political blame-and-shaming. This event has in turn caused the international community to look more intensely at religion as an important determinant of vaccine success or failure, and religious leaders as key 'influencers' in immunization interventions[4].

So review shows increased attention on 'religion' as an individual determinant of vaccine acceptance/refusal, and on religious leaders as key influencers in immunization intervention – with the role of religious leaders in the Nigerian polio boycott dominating the literature. However, Clements et al[5] argue that one of the main determinants of the Nigerian oral polio vaccine boycott was a weakened health system. They note that the national health system has suffered in the last three decades, the PHC system has been in decline, especially in the northern regions and there is one consistent pattern "where routine vaccination rates are poor, poliovirus infection rates are high". There are multiple examples from Asia and Africa where the underlying reason for resistance to vaccination has been reported as being based on communities' rejection of massive campaigns with international priorities in the face of their prioritization of access to basic health care. For example, in relation to Nigeria, Cheng[6] point out that "...would-be poliomyelitis eradicators face a non-compliant population whose resentment is ever-hardened by failure of the country's health system to meet their most basic needs". However, while there are multiple points of discussion on religious leaders' involvement in Nigeria – there is nothing on the role of faith-based health providers (FBHPs) as key systems components for RI – in Nigeria or elsewhere.

In fact, there is virtually no literature which describes RI provided by or through FBHPs, or the effects of health systems strengthening

One of the greatest challenges is that the places where the burden of disease is the highest also tend to have the most fragile health systems.

(HSS) interventions on FBHPs in relation to immunization. All that can be safely said is that we can assume that 'many' faith-based health providers are providing RI.

Part of the reason that we do not see FBHPs in this literature is because the RI provided by FBHPs is often amalgamated into national immunization figures (or as part of the Expanded Program on Immunization - EPI). For example, in Malawi, the Christian Health Association of Malawi (CHAM) has a formal agreement with the Malawian government, which includes an essential health package and participation in national disease control programme (e.g. TB and ARV distribution) as well as the EPI. As part of this agreement, the government of Malawi has placed Child Health Monitors into CHAM member facilities (who are government employed staff), who conduct vaccinations and a range of other public health and community outreach activities inside and around CHAM member hospitals and clinics.[7]

In fact, it is often assumed that national governments have the main responsibility for vaccine provision. Perhaps some FBHPs no longer see immunization as their priority area. A study conducted in Uganda hints at this, when a participant from the Uganda Catholic Medical Bureau talked about the nature of PPP (public private partnership) in Uganda, saying: "... the issues raised by the MoH for discussion tended not to be about the main concern for private-not-for-profits (PNFP), namely, human resources...Instead, they focused on logistical or technical problems like reforming the accounting or health information system, or how to increase the vaccination coverage, issues on which PNFPs might not feel they had a particular contribution to make".[8]

A report by the International Finance Corporation (IFC) and the World Bank in 2011 notes that PPP around immunization is one of the few areas of collaboration between African governments and private providers that is working well. They highlight the strategy where private health providers are receiving vaccines from government for distribution as part of a national immunization strategy, noting this is "one relatively uncontroversial avenue for engaging the private sector... providing financial or technical assistance for activities that have large public health benefits." They also note that RI data is one of the strongest flows of information from the private sector to local governments.

However, we would argue that while FBHPs might be increasingly involved in national routine immunization services, they are not often being considered in relation to the health systems strengthening that so many are noting is the key underlying component of successful immunization intervention.

We highlight some key questions and issues which relate to HSS, all of which require more attention (see the full review for more detail on each of these issues):

Does the introduction of new vaccines affect FBHP systems positively or negatively? What do different immunization campaigns and strategies do to the routine services and systems of FBHPs?

Do FBHPs provide a different access to basic services and primary health care? If, for example, FBHPs are providing services in areas where there are no other, or to communities which are otherwise missed, or providing a different financial access to basic health services which include immunization, then their provision of RI becomes even more critical.

Do FBHPs provide innovative solutions to improve access to RI in remote areas or to missed communities? For example, do FBHPs motivate their staff to work in remote areas differently? Do FBHPs have different challenges in getting vaccines out to rural areas, keeping them cold, and providing them to patients? Do FBHPs have different innovative strategies for reaching remote rural communities? (e.g. in a Salvation Army study in Indonesia, the officers were storing vaccines in the fridge of the church officer's home to support the cold chain[9]). What is the particular contribution of FBHPs to access to RI in remote areas or missed populations?

Do FBHPs have different access in terms of 'acceptability'? It is often stated in the literature that patients perceive a higher quality of service in FBHPs (although studies show mixed results, especially in relation to the availability of vaccines in FBHP facilities). Do quality perceptions impact on patient's willingness to access RI? Do FBHPs provide a more culturally acceptable service that draws more patients? Do the staff in FBHP facilities demonstrate a different or greater cultural or religious sensitivity to patients who are conflicted about vaccine uptake?

Do FBHPs provide a particular RI system in fragile or conflict contexts? While we know that FBHPs and FBOs are often a stabilizing force in fragile context (the best example of this is the DRC), there is still not sufficient acknowledgement of this role in the provision of RI in these contexts.

Do FBHPs have a different trusting relationship with patients and communities that strengthens RI? 'Trust' has become a key issue in both immunization intervention and health systems research. For example, patients choose to take up vaccines based on whether they trust the information provided to them by the provider. This is a key area in which more research is needed on the specific relationship of FBHPs – on whether FBHPs have different trusting relationship with the communities they serve for better RI services (for example, are the government immunization employees based in CHAM facilities more trusted because of where they are based?)

These questions highlight a broad area needing more focused attention from providers, funders and researchers. We would argue that routine immunization is not simply an additional service that FBHPs instrumentally conduct for the national government. Instead, looking at it from a systems perspective – we can argue that we need to understand how immunization campaigns and RI services impact on the broader FBHP services and what impact FBHPs are having on the broader national health system. For example, even if the medicine is the same, FBHPs might be providing routine immunization differently – in a different way, to a different extent, or to a different population who would not otherwise access immunization services for whatever reason. All of which require more attention.

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KISIIZI HOSPITAL COMMUNITY HEALTH INSURANCE – DELIVERING MEDICINES & QUALITY HEALTH CARE TO DESPERATELY POOR RURAL COMMUNITIES

In her "Message from the Director- General" in the World Health Report 2013, Research for universal health coverage[1], Dr Margaret Chan of the World Health Organization (WHO) reminds us of the target "to deliver affordable quality health services and better health for everyone." This is part of the goal of universal health coverage, a current key priority of WHO.

The challenge is to translate these noble principles into practice, especially in remote resource-poor populations. A number of models have been proposed including the use of health insurance.

Oxfam in its publication[2] in October 2013 "Universal Health Coverage: Why health insurance schemes are leaving the poor behind" criticizes some national schemes because they are "prioritizing people who are formally employed and excluding the most poor and marginalized who cannot afford to pay premiums, especially women."

In response to this paper by Oxfam, Professor Valery Ridde[3], University of Montreal/ CRCHUM, commented: "To move towards universal health coverage without thinking about access to healthcare for the poorest would be nonsense, at the very least at the level of ethics and equity."

KISIIZI HOSPITAL
HEALTH INSURANCE SCHEME
Affordable Access to Quality Health Care

A different model

Church of Uganda (COU) Kisiizi Hospital was established in 1958 and has as its motto "Life in all its fullness" taken from John 10:10.

As part of this goal to bring life in all its fullness to all members of our population, a community health insurance scheme was launched in 1996, the first of its kind in Uganda, with support from DFID and the Uganda Ministry of Health. Its motivation is to bring good health care, including access to quality medicines, to very poor communities.

The new insurance scheme built on the existing Engozi[4], community burial groups, a logical progression that has worked really well. The scheme was run by Kisiizi Hospital from 1996 to 2002 with support from Ministry of Health Uganda and Department for International Development UK [DFID]. Then in 2002, the scheme was operated by Microcare, a commercial organisation providing a range of insurance products, with Kisiizi Hospital acting as the service provider. In 2009, Microcare stopped its operations in Uganda and the scheme was taken over again by COU Kisiizi Hospital who have run it ever since without any external donor support.

One principle of the scheme is spreading risk and hence members are encouraged to join in groups by discounted premiums. In 2013, the premiums range between 10,000 and 15,000/- UGX (approximately 4.0 – 6.0USD) per annum. Members joining the scheme are photographed to facilitate accurate identification should they present for treatment. The scheme covers accident and emergency and acute out - patient services, in - patient services and surgery, and medicines prescribed according to agreed protocols. The scheme also covers maternity and dental care.

Exclusions include routine medical check- ups for employment, complications from deliberate self harm or from treatments against medical advice. Patients with chronic conditions such as diabetes, hypertension, asthma, etc. are covered for in-patient care if they have properly attended their specialist clinics, but the scheme does not cover out-patient chronic medication. This exclusion is in order to keep the annual premiums as low as possible to ensure that the very poor have access to life-saving emergency treatment. However, recognising the severe financial challenge of chronic illness, COU Kisiizi Hospital operates a "Good Samaritan Fund" which will subsidise the care of some of these patients. In addition, certain vulnerable groups including patients with mental illness, neonates and patients with disability receive subsidised care from the hospital in line with its Christian ethos.

Members of the scheme make a co-payment equivalent to 0.4USD for out-patient visits or 2.0USD for admission but then have no further charges for their hospital stay, investigations and treatments including medication and surgery. Women admitted in labour pay 8USD flat fee and do not have to pay any extra if complications arise, for example the need for caesarean section or for extra medications e.g. antibiotics, blood transfusion, intravenous fluids, etc.

Quality

COU Kisiizi Hospital obtains its pharmaceuticals from Joint Medical Store (JMS) in Kampala and is therefore confident in avoiding counterfeit drugs. Audits are performed of prescribing practice against the hospital Prescribing Standards Document to ensure appropriate therapy is used and to avoid unnecessary polypharmacy.

Progress

The scheme has proved very popular with increasing membership annually, so we now have the remarkable figure of 35,000 members in 4 districts up to 50 km from COU Kisiizi Hospital.

The scheme is a member of the Uganda Community Based Health Financing Association (UCBHFA) (www.ucbhfa.org) and is the largest in Uganda.

There are currently 173 groups, each with a chairperson, who are enthusiastic about the scheme as they recognise that they would otherwise never obtain health care of such quality at such low cost.

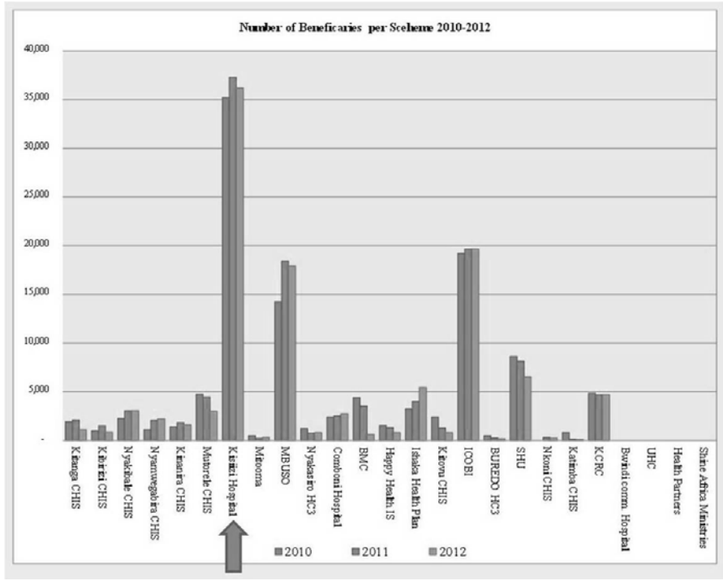
Viability

The enthusiasm of the groups and rising membership numbers year on year are encouraging. In the financial year to 30th June 2013, the scheme broke even. Our income was around 176,431USD, treatment costs 161,610USD and administration costs 10,022USD giving a balance of 4,798USD. Recognising that we serve a very poor population and that there is no external support for the scheme from donor agencies, this is a significant achievement.

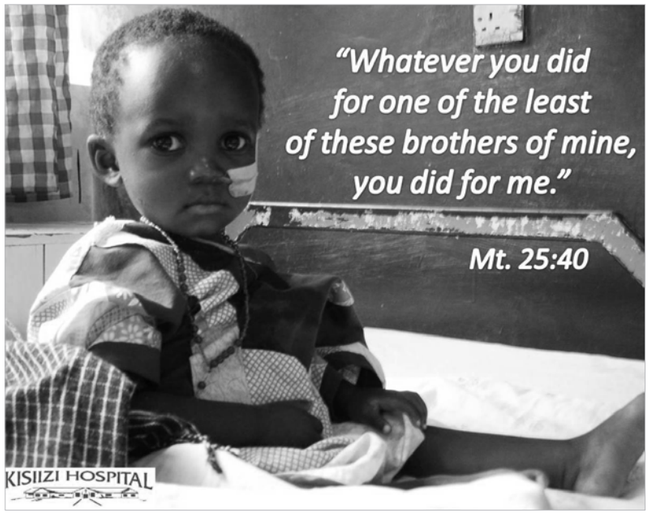
Health promotion

The scheme is further developing its health promotion activities to try and help its members avoid disease and to present promptly with symptoms to avoid delays in diagnosis and

Many patients, who otherwise would have experienced social injustice through inability to afford reliable medicines and health care, have benefitted from the scheme.



UCBHFA Membership 2010 – 2012, COU Kisiizi Hospital being the largest in Uganda.



treatment. Recently, we have made local language videos and intend to utilise these widely through the scheme and our church networks and schools to facilitate health promotion. Messages made for example include the need to keep medicines away from young children, the importance of completing courses of antibiotics and the value of bringing previous medical notes to consultations.

Training sessions for group leaders of the insurance scheme have been run successfully and we are currently researching the benefit of these interventions. It is well recognised that education, particularly of women in a community, facilitates health and social justice in that local population. We believe that the creative use of modern technology in making local language videos to facilitate health promotion offers the opportunity of making a dramatic impact on large numbers of our population and helping achieve our goal that all members of our community know the life in all its fullness Jesus came to bring.

Is this model transferrable?

COU Kisiizi Hospital has existing links with WHO. It is the only hospital in Uganda in the first wave of their African Partnership for Patient Safety (APPS) scheme and recently received first prize in the "Implementation Academy" section of the second International Conference on Prevention and Infection Control (ICPIC) in Geneva.

An example of outcomes from APPS is the on-site manufacture of alcohol-based handrub for clinical hand hygiene.

COU Kisiizi hospital is also involved in the new WHO "Surgical Unit-Based Safety Programme". WHO have expressed great interest in the community health insurance scheme and have asked Kisiizi to be one of 5 worldwide centres looking at how to achieve universal health coverage in practice.

The success of the scheme is undergirded by its Christian motivation to serve the poor rather than to generate profit.

Many patients, who otherwise would have experienced social injustice through inability to afford reliable medicines and health care, have benefitted from the scheme and this is the reason for its increasing expansion and success.

Dr. Ian Spillman FRCPCH is Medical Superintendent at the Church of Uganda Kisiizi Hospital.

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ACTION MEDEOR EXTENDS ITS SERVICES TO THE RURAL PERIPHERY IN SOUTHERN TANZANIA

Like in other low income countries, health services in rural Tanzania are often a challenge and even essential quality medicines are difficult to get. In 2004, action medeor Tanzania started its operation in the harbour city of Dar es Salaam on the shores of the Indian Ocean. Currently, the area counts more than 4 million inhabitants. action medeor managed to establish a complementary medicine supply system and close a huge gap that existed in this sector.

From the action medeor branch in Dar, medicines and medical equipment are distributed all over the country reaching even very remote areas, including the south, where communities live who are disadvantaged in several aspects (for example missing proper infrastructure like quality health services, logistics, clean water and electricity supply); but the distribution from Dar es Salaam remains a problem. "For example, Masasi, in Southern Tanzania, is only 600 km away from Dar, but during the rainy season the road which at some part does not have tarmac is difficult to pass and it may take days for one trip," comments Fritz Steinhausen, pharmacist and country director in Dar es Salaam.

How logistics affect access to medicines

Whether in Dar es Salaam or in Masasi, in general, medeor is often confronted with logistical problems. Consignments have to be transported over distances of more than a thousand km on roads sometimes without tarmac and under tropical climate conditions. Cool items are carefully packed in cool boxes, but if a bus or a lorry has a breakdown on its way and uses three or four days or more instead of one, that means trouble. But action medeor is continuously working on this and striving for improvement.

Nobody in this world should suffer or die from diseases which may be treated or prevented by the right medication. The ultimate goal and vision of action medeor remains in place: All people in need should have access to essential medicines and medical treatment. We are still very far from this goal. According to UN sources, more than six million children under five are still dying every year and four out of five of those are born in Asia and sub-Saharan Africa. With the availability of simple essential medicines and e.g. mosquito nets and an improved mother and child care during and after birth, millions of children could survive.

Local sustainable assistance is essential and therefore action medeor supports the establishment of health infrastructure in affected areas with the cooperation and assistance of local partners to provide essential medicines and create awareness and take preventive steps in the communities concerned. For this reason, action medeor initiated a second branch in Tanzania – which also serves as a pilot project – to facilitate accessibility and affordability to essential medicines in remote areas in the south, and in northern Mozambique.

Permanent staff together with Fritz Steinhausen, outside the Masasi branch. Photo Credit: Rüdiger Fessel.

Responding to the need

In June this year, the team of action medeor Tanzania opened its second medicines and medical equipment supplies unit, in southern Tanzania. From this new outlet, hospitals, health

The Masasi store. Photo Credit: Rüdiger Fessel.

The store in Masasi is a step further to improve health services in Tanzania.

centres, dispensaries and a large number of sparsely equipped smaller health facilities in this area may be served faster and better. "Our store in Dar es Salaam has proved to be successful in contributing to an improved health supply system and in recent times we were encouraged again and again by our local partners to open a branch in the south" says Fritz Steinhausen.

The catholic bishop of the Diocese of Tunduru-Masasi Castor Paul Msemwa who is very much concerned about the deficits in the health services in his area offered action medeor space on the premises of the diocese in Masasi to establish the new medicine store, for which we are very grateful. A German company 'Jungheinrich', which specializes in stores establishment and logistics and is a cooperation partner of action medeor, kindly funded the equipment for the store in Masasi.

The store in Masasi is a step further to improve health services in Tanzania and the news about the new medeor unit spread very fast. "Already in the first three months – besides our old established customers – over 60 of the small simply equipped facilities in the area came to us to obtain their supplies, who had before often travelled to the faraway Dar es Salaam for this purpose" explains Gerald Masuki, pharmacist and general manager in Dar es Salaam. action medeor finances the establishment and the running of its medicine stores through the sale of medicines at cost price or donations. "However, the new branch in Masasi is also a challenge. The orders of these new small health facilities have often only very few items so that the expenses involved are not covered by the income. But this is exactly the point where we, action medeor as medical aid organization, are challenged" notes Gerald Masuki.

Fritz Steinhausen is pharmacist and country director of action medeor Tanzania.

ACCESS TO QUALITY MEDICINES

For anyone with a chronic or serious illness, being able to have a particular medicine can mean life. Yet today, millions of people cannot access the medicines they need. This is a challenge for all human beings, especially those of us who are Christians. In his determination to fight slavery, Charles Lavigerie, the founder of the Missionaries of Africa (men and women) said: "I am a man, and nothing human is foreign to me. I am a man, and injustice towards others revolts my heart. I am a man, and oppression offends my nature." Yes, humanity and solidarity are the ultimate vocation of all human beings and what touches other human beings touches me especially deeply as a follower of Jesus!

Jesus proclaimed "I have come that they may have life, and have it to the full" (John. 10, 10). Even if in the Gospel the Greek word for life, 'zoë', implies the quality and fullness of God's life that God shares with us, it is clear that Jesus also wants us to enjoy the fullness of physical life, 'bios'. Throughout his life and at his death, he showed this deep desire for us. His last words in Mark's Gospel (16, 17-18) are "And these signs will accompany those who believe: .... they will place their hands on sick people, and they will get well". His miracles often involved healing and restoring the healed person to full physical and spiritual wellbeing, including the blind, the deaf, the mentally sick and lepers excluded from society. He wanted them to enjoy a life of dignity.

In Luke 10, 30-37 we meet the traveller stripped and beaten by robbers. Jesus presents the attitude of the compassionate Samaritan as the model for all who want to live the commandment: "Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind'; and, 'Love your neighbour as yourself'." (Luke. 10, 27). The Samaritan sees and draws close to the one in need. He makes himself vulnerable to the point of becoming impure; he gets dirty, binds up the wounds of the man and shares with him his wine and oil - as medicine. Then he sets the man on his own mount, brings him to an inn and pays the innkeeper to look after him. Because the Samaritan takes responsibility and intervenes, the situation of the victim is transformed: from being half-dead, he is now on the way to recovery and regaining his dignity.

This is the attitude we Christians are called to adopt regarding access to quality medicines for everyone. We are to progress from compassion to active solidarity so that all may live in dignity. This will mean taking risks, becoming vulnerable and sharing what we have.

In John (10,10) Jesus draws the contrast between himself, the Good Shepherd and the thieves. The good shepherd protects the life of his sheep and keeps the thieves away. He leads his sheep to green pastures to ensure they have good food and good health. By contrast, false shepherds and thieves come to take life away by stealing and killing the sheep. Jesus wants his followers to be like him, a good, life-giving shepherd for his people.

Let's apply the parable of the good shepherd and the thieves to the current question of access to medicines of quality. Today, many people and organizations are striving to make quality medicines more easily available for all. But there are also many "false shepherds" who hinder or prevent this. Currently the "thieves" are often "structures of sin" that in various forms violate the right to health and access to quality medicines. The false shepherds are numerous and powerful: drug companies press governments to strengthen intellectual property rights (IPRs) including patents; countries and international institutions impose IPRs through trade and investment agreements; privatization and interference weaken national health systems; countries lack regulation or their national health laws do not protect the fundamental right to access to quality medicines.

Yet the right to health is a fundamental human right, necessary for a life of dignity, and the right to good quality medicines is inherent in it. All countries have signed the Universal Declaration of Human Rights, so are responsible for protecting the right to access quality medicines for all their citizens by developing suitable policies and implementation programmes. Yet in so many places, this is not being done and many are needlessly suffering and dying. The main obstacles to overcome are: high prices, the lack of appropriate medicines in the right dose, policies that prevent the availability of good, cheap generic medicines and the lack of appropriate supply systems.

The accomplishment of this right is a challenge to the whole of humanity. As members of the human family, we are inter-dependent and co-responsible for all human life and the Earth that sustains us. We are all in the same "boat" and what happens to others affects us, too.

Begoña Iñarra is the Executive Secretary of Africa Europe Faith and Justice Network (AEFJN).

(Holy Bible New International Version)

Universal Health Coverage Study Series
This study series by the World Bank offers knowledge and operational tools to help countries tackle challenges in ways that are fiscally sustainable and that enhance equity and efficiency. Studies from 22 countries and Massachusetts analyze the “nuts and bolts” of programmes that have expanded coverage from the bottom up - programmes that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol, studies, and technical papers contribute to discussions about universal health coverage, provide implementers with an expanded toolbox, and inform the universal health coverage movement as it continues to expand worldwide.
http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series

The impact of universal coverage schemes in the developing world: a review of the existing evidence
This report by the World Bank systematically reviewed evidence regarding the impact of universal coverage schemes and combined it with structured assessment of the robustness of such evidence. Findings from the report indicate that UHC interventions in low and middle income countries improved access to health care. It also indicates that UHC often has a positive effect on financial protection and sometimes has a positive impact on health status.
http://documents.worldbank.org/curated/en/2013/01/17291221/impact-universal-coverage-schemes-developing-world-review-existing-evidence

Universal Health Coverage - Why health insurance schemes are leaving the poor behind
This new report by Oxfam contains key recommendations for governments.
http://www.oxfam.org/en/policy/universal-health-coverage

Questions and answers on Universal Health Coverage... and some more comments and open questions
This paper by Medicus Mundi International (MMI) discusses key elements of the concept of UHC, as promoted by the WHO.
http://www.medicusmundi.org/en/contributions/news/2013/mmi-uhc-discussion-paper/uhc-mmi-discussion-paper-august-2013.pdf

Towards Universal Health Coverage
This website, funded by the Rockefeller Foundation, provides an information platform which collates information regarding UHC reforms from hundreds of sources. The website aims to inform people of health coverage efforts in countries around the world, explore key issues and policy debates related to universal health coverage, exchange of ideas and provide links to additional resources. This is a comprehensive resource for those looking to initiate and research UHC policies.
http://uhcforward.org/

World health report: Research for universal health coverage
This report by the WHO focuses on the importance of research in advancing progress towards universal health coverage. In addition, it identifies the benefits of increased investment in health research by low- and middle-income countries using case studies from around the world, and proposes ways to further strengthen this type of research.
http://www.who.int/whr/2013/report/en/

Human resources for universal health coverage
The WHO Bulletin Volume 91, Number 11, November 2013, is a special issue dedicated to the theme of HR for UHC.
http://www.who.int/bulletin/volumes/91/11/en/index.html

Contact deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical innovative and courageous approaches to the promotion of health and healing.

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