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ANALYSIS OF AFFORDABILITY AND ACCESSIBILITY OF QUALITY MEDICINE IN DEVELOPING COUNTRIES

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ABSTRACT

India lags behind in providing 'Quality Healthcare for all' has been a key challenge for the Government in recent times. Under the Constitution of India both the Central and States Governments have concurrent duties for drug control, safety, quality and efficacy. The main objective of health policy is to achieve an acceptable standard of good health and ensure availability of quality medicines at a reasonable cost to the society and to promote development of domestic pharmaceutical industry. On the contrary, existing public health infrastructure is far from satisfactory and availability of essential drugs is minimal and capacity of the facilities is grossly inadequate. In India where patients die because they cannot afford the drugs that could improve, extend, or save their lives. Price is not the only reason why people do not get the medicines they need, but it is a major barrier. The high cost of many life-saving drugs not only keeps patients from getting treatment, but also discourages health ministry from improving the quality of patient care through the use of newer and better medicines.

KEYWORDS: Availability, Accessibility, Affordability, Out-of-pocket, Expenditure, Healthcare, Quality, Cost, Medicine, Per-capita, Inadequate.

INTRODUCTION

India has made tremendous progress in the pharmaceutical sector and medical tourism but faces mindboggling shortfalls in healthcare delivery to its population. Poor access and mortality due to non-availability of medicines is among the highest in the world. Access to essential medicines remains limited and inequitable. In a move towards Universal Health

Coverage (UHC), the National Health Assurance Mission (NHAM) has been announced by the Central government for providing assurance to make 50 priority essential medicines available at all times at all levels to the citizens of India living below poverty line. This paper reviews, assesses and compares the strategies adopted by various Indian States for improving availability and access to medicines. The strengths and weaknesses of the two most challenging functions i.e., procurement and supply chain management are discussed in the paper. Centralized procurement of carefully selected priority essential medicines along with Supply Chain Management (SCM) by an outsourced agency appears promising under given constraints. Alternatively, SCM can be continued to be managed by states themselves but with adequate utilization of digital technology. Access to essential medicines as part of the right to the highest attainable standard of health ("the right to health") is not only a social right but is also well-founded in country's constitution and health policy. It is, therefore, the responsibility of the government to ensure that this initiative is taken forward. Limited resources should not hold back this very important social commitment. Providing medicines to all, being an essential component of health care, should be implemented immediately to reduce out- of- pocket expenses for medicines (Sharma Sangeeta et al,).

METHODOLOGY

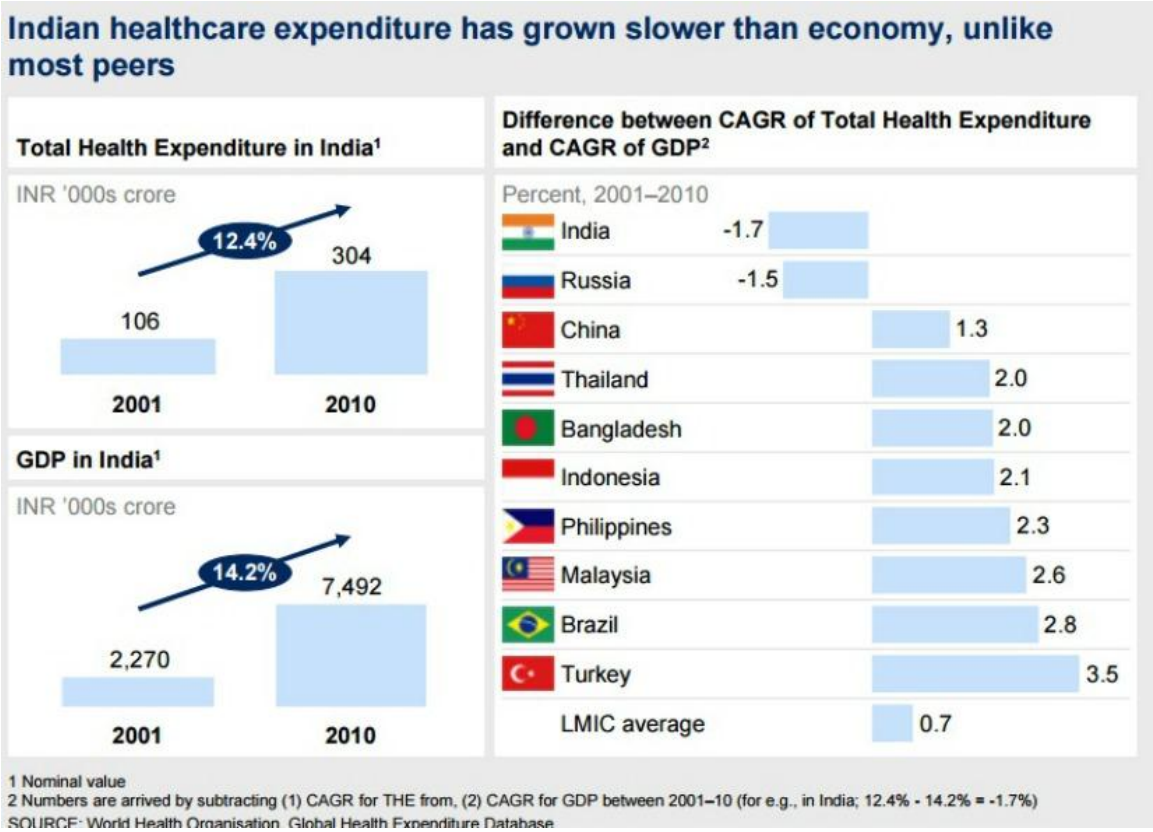
The method of study based on the collection of data from Published articles, Journals, WHO, World Bank, NHP India, NSSO reports 'Health in India', News paper (TOI) articles and others, RMSC, Pub Med, Google Scholar, Websites of relevant Organization etc. The study is based on the secondary data analysis. All the data are collect from the relevant sources. Compilations of data are done made in word sentences and in graphical form representing in a clear way, so as to understand the project. All the data describes related to the project topic which covers the affordability and accessibility of quality medicines in developing countries.

Expenditure on health sector in India Compare to neighboring countries

The target of increasing health expenditure to 2.5% of GDP by 2025, set by the National Health Policy 2017, is very low in comparison to what has been achieved by the neighboring countries, say experts. Discontent over the National Health Policy-2017 continues even though the prime minister has dubbed it a futuristic policy.

Ashok Aggarwal, an advocate and a civil rights activist told *First post*, " Increasing health expenditure only up to 2.5%, that too in a period as long as eight years is seen as a trifle variation from what it is now, considering what neighboring countries are spending on this

essential service." World Bank data shows that India is only ahead of Pakistan and Bangladesh in health expenditure and countries like China and Sri Lanka are way ahead of it in facilitating health care to the citizens. As per the report, India spends a meager 1.4% of its GDP, which is a few steps ahead of Pakistan and Bangladesh, the neighboring nations that spend 0.9% and 0.8% of their GDPs respectively on the health sector.



On the other hand, China and Sri Lanka spend 3.1% and 2% of their respective GDPs on health expenditures. Dismal health expenditure figure has caused massive pressure on the existing health infrastructure, says Aggarwal. "Most of the government hospitals fail to meet the growing patient demands. Many of these hospitals are overcrowded making treatment nearly impossible," he adds. He also says that since many of the hospitals lack required infrastructure, a patient is often referred from one to another for treatment as a result of which hospitals in Delhi get nearly 40% of its patients from other states.

"It not only increases the time required for treatment, but also the expenditure, as many government hospitals also charge money for many treatment and services," he laments. "I have met a person who was asked eight lakhs for kidney transplantation by AIIMS," he cites

an example. Low health budget, he says that also leads to low insurance coverage and high out-of-pocket expenditure.

As per a World Health Organization study, India features among the countries with high out-of-pocket expenditure where 89.2% of the expenses of medical treatment are borne by the patients.

"In our country high out-of-pocket expenditure in healthcare makes the condition of the patient and his or her family not better than that of a beggar," he says.

Even the National Health Policy admits that yearly 63 million people are pushed to poverty due to health care costs, thus causing further economic disparity. Not only the goal of increasing health expenditure is low, but also lacks adequate orientation says Dr. Jayalakshmi Sridhar to *First post*. "The National Health Policy 2017 speaks of increasing the health budget in a time-bound manner stepwise. But it does not mention in which year how much of it is going to be increased," she says.

To attain the target, she says that India needs better budgetary oversight, as to keep tab of how the money is spent and whether it is spent within stipulated time. "We often see cancellation of funds to the central pool due to lack of manpower to implement projects and projects not taking off. To plug this lacuna, the government needs to audit the health sector throughout the year and thus ensure that no fund goes back," she said.

The earlier health budget accepted during the previous NDA regime, in the year 2002, had set the goal of increasing health expenditure by 2%. But a study conducted by McKinsey and Company shows that during the period 2001 to 2010 India's investment in health rather declined in comparison the increase of GDP. During the above mentioned period, India's GDP grew by 14.2% and health expenditure by 12.4%. The difference between Compound Annual Growth Rate of the economy and health expenditure was -1.7%.

Out-of-pocket expenditure in Urban and Rural India

The WHO'S World Health Statistics 2012, released on Wednesday says almost 60% of total health expenditure in India was paid by the common man from his own pocket in 2009.

In comparison, Nepal's OOP health expenditure stands at 49%, Sri Lanka (44%), Indonesia (41%), Maldives (18%), Thailand (15%), and Bhutan (13%).

Myanmar has the worst OOP expenditure at 82%, followed by Bangladesh (65%) in the same region. Pakistan's OOP stands at 41% and China's OOP stand at 38%.

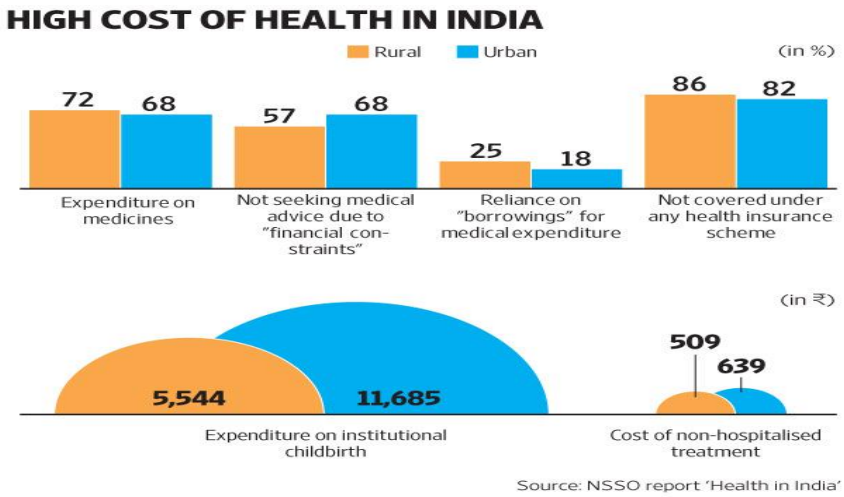
The WHO had earlier said that 3.2% Indian would fall below the poverty line because of high medical bills with about 70% of Indians spending their entire income on healthcare and purchasing drugs.

It says 39 million Indians are pushed to poverty because of ill health every year. Around 30% in rural India didn't go for any treatment for financial constraints in 2004. In urban areas, 20% of ailments were untreated for financial problems the same year, said a recent study in the Lancet.

Out of all health expenditure, 72% in rural and 68% in urban areas was for buying medicines for non-hospitalized treatment, according to the 'Health in India' report, which draws data from the 71st round of the National Sample Survey conducted from January to June 2014.

Data from the 60th round of NSSO, which was conducted in 2004, too had shown that 70% of out-of-pocket medical expenditure is on medicines.

The report shows the high cost of treatment ails India's health sector the most and patients avoid health services even when needed. As many as 68% of patients in urban India and 57% in rural areas attributed "financial constraints" as the main reason to take treatment without any medical advice.



"When cuts in budgets happen, then the cost of maintaining the infrastructure and salaries has to be maintained. It is consumables like medicines that get hit. Then, there is an issue of spiraling of prices of medicines in recent times. All this contribute to high share of medicines in overall medical expenditure," said Amit Sengupta, general secretary, Jan Swasthya Abhiyan, India chapter of People's Health Movement, a global network of health experts and activists.

Sengupta said the way out could be implementation of the central government's scheme of free medicines and diagnostics in public health facilities. The central government approved the scheme in 2011. Different states are at different stages of implementation, from merely approval by state cabinets to implementing it on the ground.

Last month, Jammu and Kashmir became the last state in India to announce free medicines and diagnostics. Tamil Nadu and Rajasthan are cited as the most successful examples of states which have implemented the scheme.

In case of their inability to pay from household income, many depend on borrowings to fund their treatment. The Health in India report shows, in rural India, 25% patients relied on "borrowings" for hospitalization and 68% on household income and savings. In urban India, 18% patients had to borrow while admitted in hospital and 75% relied on income or savings.

Financing on health in India

Macroeconomic situation

Population (million)	**2016**	**1324.2**
General financing		
GDP (trillion current US$)	**2016**	**2.264**
GDP per capita (current US$)	**2016**	**1709.4**
GDP annual growth (%)	**2016**	**7.1**
Total government revenue* as % of GDP	**2013**	**12.6**
Population living below poverty line at $1.90 a day (2011 PPP) (% of population)	**2011**	**21.23**
Health financing		
CHE as % of GDP	**2015**	**3.93**
CHE per capita (current US$)	**2015**	**63.94**
GGHE-D as % of GDP	**2015**	**0.92**
GGHE-D per capita (current US$)	**2015**	**14.91**
Out-of-pocket payment as % of CH	**2015**	**67.78**

CHE: current expenditure on health; GDP: gross domestic product; GGHE-D: domestic general government health expenditure * Total taxes and other revenues received by the national government (excluding grants)

Since 2000, how has health financing changed?

Overall spending on health.

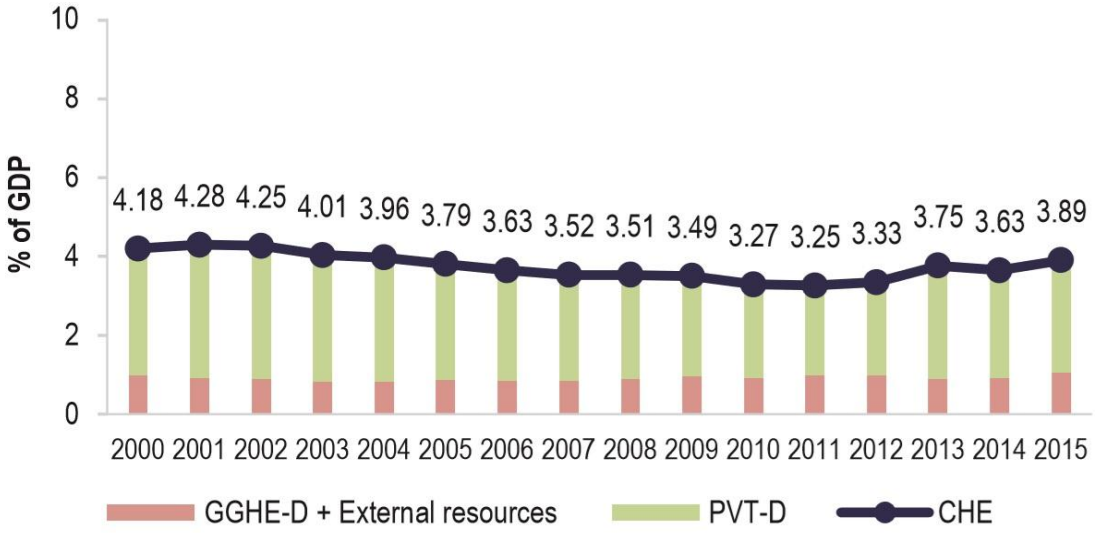


Fig. 1: Current expenditure on health as a % of GDP, 2000–2015.

CHE: current expenditure on health; GDP: gross domestic product; GGHE-D: domestic general government health expenditure; PVT-D: domestic private health expenditure * PVT-D refers to spending on health including voluntary health insurance schemes, enterprise financing schemes and household out-of-pocket payment.

Sources of health revenue

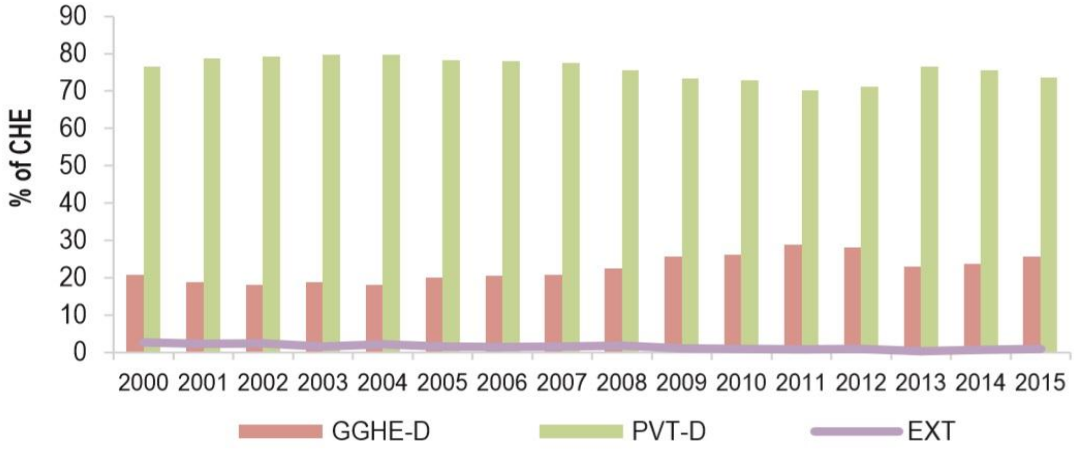


Fig. 2: Share of revenues for health as a % of current expenditure on health, 2000–2015.

Government spending on health

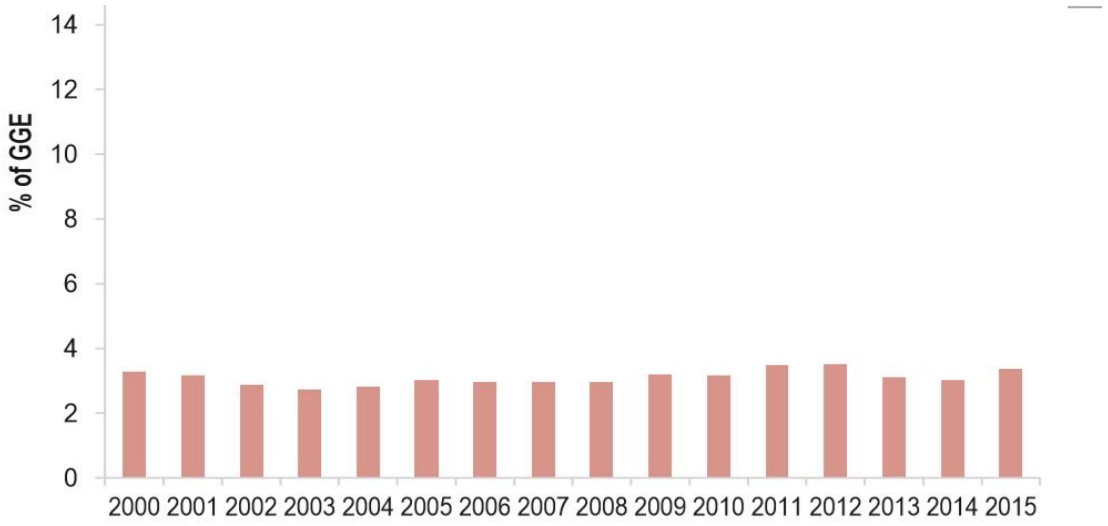


Fig. 3: Domestic general government expenditure on health (GGHE-D) as a % of general government expenditure (GGE), 2002–2015.

Spending per person on health ($),by source

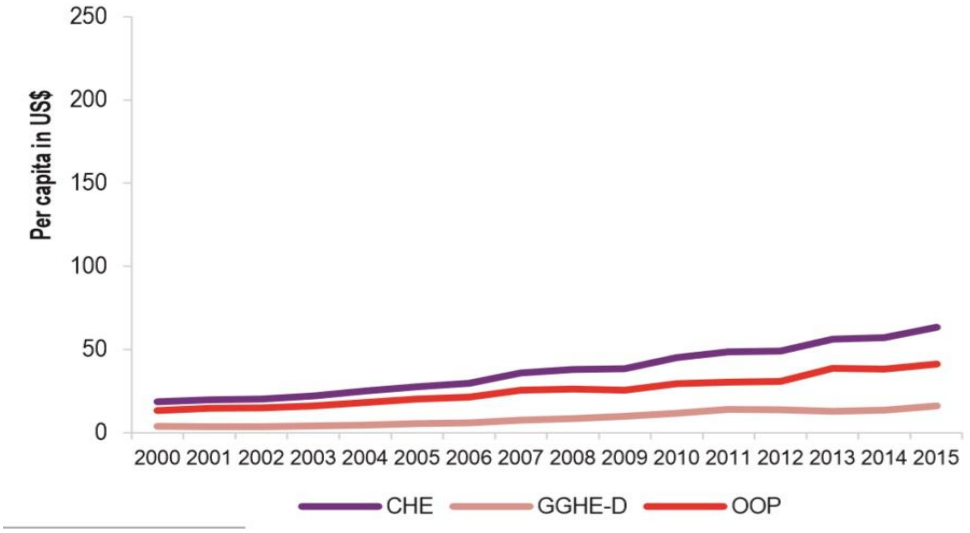


Fig. 4: Current expenditure on health (CHE), domestic general government health expenditure (GGHE-D), out-of-pocket (OOP) payment, per capita US$, 2000–2015.

Share of OOP expenditure (%)

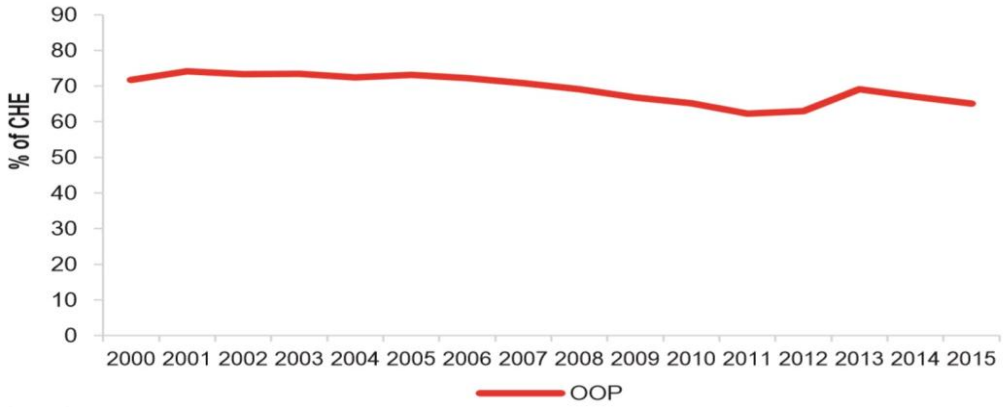


Fig. 5: OOP payment as a % of current expenditure on health (CHE), 2000–201.

Funding for health by donors

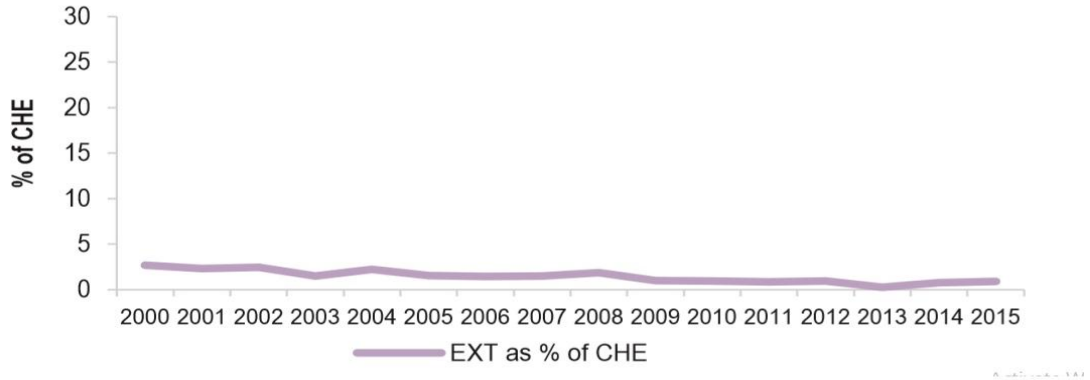


Fig. 6: External expenditure on health (EXT) as a % of current expenditure on health (CHE), 2000–2015.

Developing countries health expenditure on health

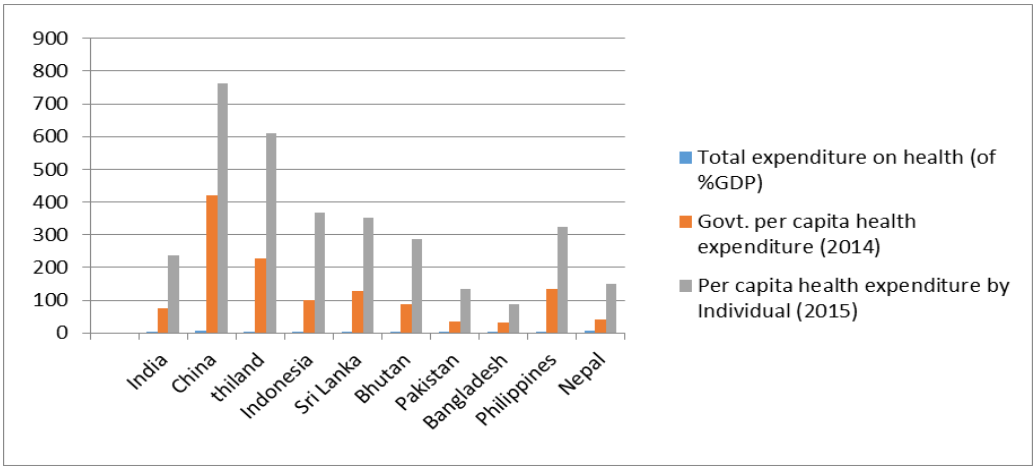


FIG1. Expenditure on health by Govt. (of total GDP, per capita expenditure by Govt., and individual per capita expenditure) in developing countries.

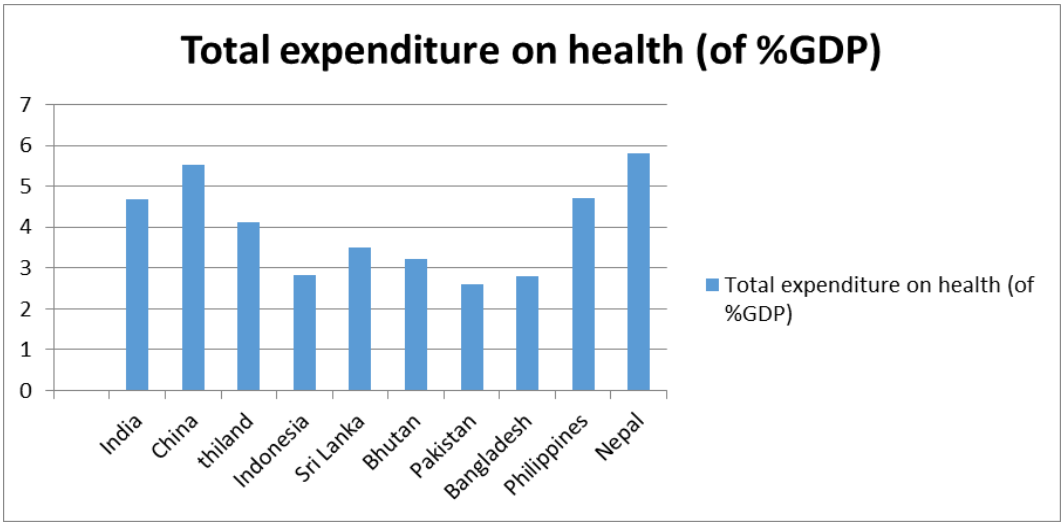


Fig2. Total expenditure on health (of %GDP) in developing countries.

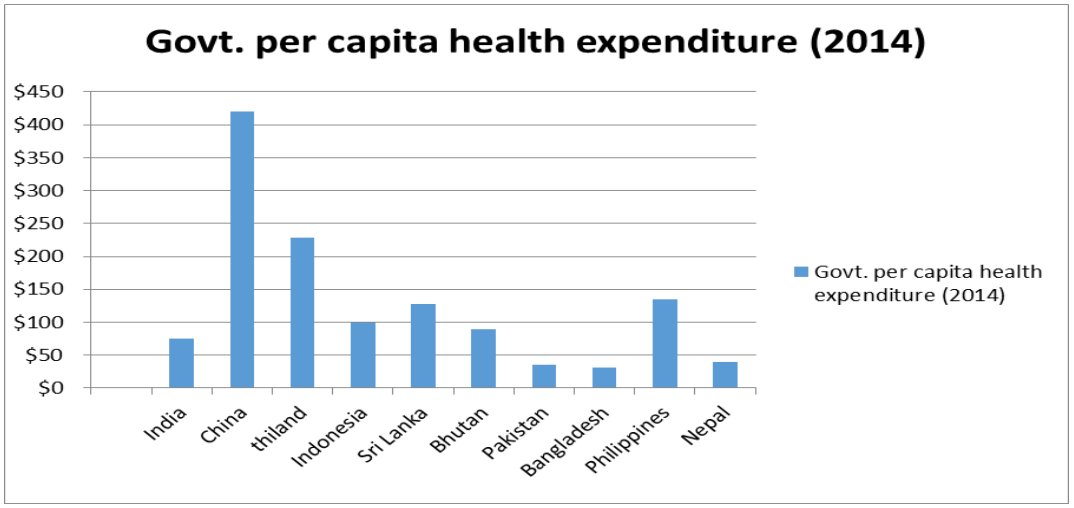


Fig3. Govt. per capita health expenditure (2014) in developing countries.

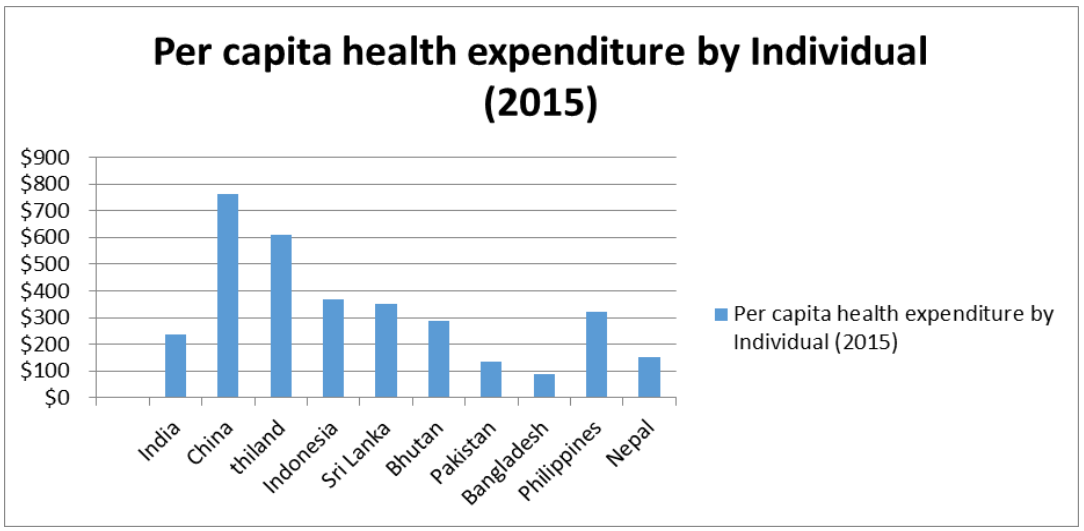


Fig4. Per capita health expenditure by Individual (2015) in developing countries.

CONCLUSION

Health is a basic human right and access to medicine is a basic tool to ensure health. This right and its tools are facing major issues in the world. In developing countries like India and others where majority of population are living below poverty line facing inadequate of access to quality medicine and unable to afford the quality of medicines. It has been seems that the people living below poverty line having low income less than $1.9-$2.5 per day, and the expenditure on health of each individuals are out-of-pocket (OOP).

Pharmaceutical companies play a substantial role in increasing the access to medicines in order to guarantee health.Till now and despite all shortages and difficulties, remarkable efforts have been made. Major pharmaceutical companies are helping billions of dollars by donating medicine to poor population or patients with neglected disease. WHO and human rights committee of United Nations also make several heads-up every year and seek new ways to improve the situation of access to medicine in co-operation with NGOs and governmental organizations. Also states have tried to create a better circumstance for increasing the availability and affordability of medicine. However, there is still a substantial need for improvements, as well as the notable potential for making changes.

More realistic accountability of different parties- including both states and big pharmaceutical companies- is the main necessity in this way. Without this accountability, there will be no real and long term change in the situation and every step would work as a temporary painkiller, but not as a cure.

Also it should be considered that this accountability cannot be realized automatically or through ethical advice, but needs serious legal acts in terms of defining crimes, binding state and non-state parties to increase their cooperation and to make a safe way for access to generic medicine in developing countries by restricting TRIPS and TRIPS-plus agreements. With all these efforts we can be hopeful that delayed goals for increasing health and decreasing inequity will be achieved.

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