Routledge Handbook in Global Public Health

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Introduction

Access to essential medicines has led to dramatic health impacts, saving lives and improving health. Each year an estimated 10 million men, women, and children – nearly all in low- and middle-income countries (LMIC) – die from conditions for which safe, effective, affordable prevention or treatment exists through medicines, vaccines, and improved health habits. Medicines also have a huge financial impact on individuals, families, communities, and governments.

This chapter briefly describes the rapid emergence of modern pharmaceuticals in the last century. It reviews the two ‘eras’ in access to medicines: the development of the essential medicines concept from the mid-1970s, and the access to medicines campaign from the late 1990s. It then uses the lens of access to AIDS medicines to illustrate core essential medicines concepts and the success of the access to medicines campaign. The concluding section looks at some of the opportunities and challenges for essential medicines in the twenty-first century.

The century of the modern pharmaceutical

Cave paintings discovered in Lascaux, France, tell us that humankind has used herbal and other traditional medicines since at least 12000 BC. Yet by 1900, there were no mass-produced, widely available medicines or vaccines. It was only in 1928 that Alexander Fleming discovered penicillin, and not until the mid-1940s that the world saw the first clinical use of modern pharmaceuticals when antibiotics, anti-malarials, tuberculosis medicines, smallpox vaccine, tetanus toxoid, and other vaccines were used for large military populations during the Second World War. The 1950s, 1960s, and 1970s saw an explosion of development and marketing of antibiotics, mental health medicines, oral contraceptives, cardiovascular medicines, and many other medicines and vaccines. By the year 2000, over 7,000 unique pharmaceutical compounds had been discovered, and tens of thousands of different individual products were on the market in countries around the globe. In less than 100 years, the lives of literally billions of people had been transformed by the widespread availability of medicines and vaccines, contributing to
greater productivity, increased well-being, and the near doubling of average life expectancy in high-income countries.

**Two eras in access to essential medicines**

The twentieth century truly was the century of the modern pharmaceutical. By the mid-1970s, the world had developed vaccines and medicines for prevention or treatment for the majority of known major killers. Yet an estimated 2 billion people – half the world’s population at that time – lacked regular access to essential medicines (WHO 2004a). Mostly living in Africa, Asia, and Latin America, these people might as well have been living in the year 1900 – or the year 12,000 BC.

This ‘fatal gap’ between those with access to medicines in the world’s richest countries and those without access led in the mid-1970s to the first era in access to medicines, which focused on the World Health Organization’s (WHO) ‘essential drugs concept’. Then, in the late 1990s, the stark gap in access to AIDS medicines and to new medicines for tropical diseases led to an ‘access to medicines campaign’, driven initially by advocacy organisations. These two eras have defined the access to medicine landscape over the last 30 years.

**Rise of the essential medicines concept**

Building on successful experiences in countries as diverse as Norway, Sri Lanka, Bangladesh, and Papua New Guinea, the WHO in 1975 formally adopted the concepts of ‘essential medicines’ and ‘national drug policies’ aimed at ensuring the availability, safety, and rational use of medicines. Two years later, WHO produced the first ‘model list of essential drugs’, which contained 224 medicines and vaccines. The list has been updated nearly every two years by a WHO committee on essential medicines, consisting of relevant experts from around the globe. In 2001, WHO fundamentally revised the entire process for selecting essential medicines to make it more evidence-based, transparent, responsive, and timely (WHO 2001). According to WHO:

> essential medicines are those that satisfy the priority health care needs of the population. Essential medicines are selected with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.

(WHO 2009a)

A national drug policy is a commitment to a goal and a guide for action. It expresses and prioritises the medium- to long-term goals set by the government for the pharmaceutical sector, and identifies the main strategies for attaining them. It provides a framework within which the activities of the pharmaceutical sector can be coordinated. It covers both the public and the private sectors, and involves all the main actors in the pharmaceutical field.

(WHO 2001)

Within 25 years of the first model list, nearly 160 countries had developed national or local essential medicines lists; over 130 countries had developed independent treatment guidelines and/or formulary manuals; over 100 countries had national medicines policies to guide public and private action in the field; and numerous countries had established programmes to assure
medicines’ quality, implement generic competition, provide public price information, and incorporate essential medicines into their training. Most heartening for public health was the fact that over 25 years of community, national, and international action by public, private, and civil society actors had expanded the number of people estimated to have regular access to essential medicines from 2.1 billion in 1977 to over 4 billion in 2003 – roughly increasing from one-half to two-thirds of the world’s population (Quick 2003a).

Access to medicines campaign

During the late 1990s, three new challenges in access to medicines began to command the world’s attention: (1) the ‘fatal gap’ in access to AIDS treatments in resource-poor countries, (2) the dearth of research and development for malaria and other tropical diseases, and (3) the potential impact of new international patent and other intellectual property requirements on access to medicines.

In many ways, each of these three challenges had its own driving forces and public health implications. Yet across individual issues, the era of the ‘access to medicines campaign’ has been characterised by new dynamics of engagement by political leaders, public health leaders, advocacy groups, international organisations, superstars, the general public, and communities of affected people. Of the three challenges, measureable progress has been greatest in reducing the gap in access to AIDS medicines. In many respects, this reflects the combined effect of applying both the ‘classic’ essential medicines concept and this ‘modern’ campaign dynamic. Lessons from this approach are described in the following section.

Access through the lens of AIDS medicines

The dramatic increase in AIDS treatment medicines between 2002 and 2007 represents the largest access to medicines scale-up in public health history. In just five years, the estimated number of HIV-positive people on antiretroviral (ARV) medicines in Africa increased 40-fold, from roughly 50,000 to over 2 million. For all LMIC combined, the total number on treatment reached nearly 3 million people – 30 per cent of the estimated number of people needing treatment (WHO et al. 2008). As recently as 2001, however, ARV prices remained unaffordable, the quality of generic ARVs was unproven, views varied widely on treatment regimens and monitoring requirements, funding for large-scale ARV treatment programmes was non-existent, and few supply systems were up to handling the projected volume of ARVs.

In its framework for access to essential medicines, WHO defines four critical factors, each of which must be in place to ensure access: rational selection and use, affordable prices, sustainable financing, and reliable supply and quality assurance systems (Quick 2003b; WHO 2004a). The role of each of these factors is well-illustrated by the scale-up in access to AIDS medicines.

Selection and rational use

The WHO list of essential medicines has no direct authority over the production, procurement, distribution, or use of medicines in any major health system in the world. Similarly, WHO treatment guidelines have no inherent authority over diagnosis, treatment, clinical monitoring, or patient care. As expert guidance, however, such tools provide essential information and send important signals to public health officials, donors, the generic and brand-name pharmaceutical industry, low-cost essential medicines suppliers such as the United Nations Children’s Fund (UNICEF) and the International Development Association (IDA), and many others. As a
result, the addition of 12 ARVs to the WHO model list and the publication of WHO guidelines for scaling up antiretroviral treatment (ART) in resource-limited settings – both in 2002 – represented significant steps forward in scaling up AIDS treatment.

The guidelines for scaling up ART provided health officials, clinicians, and others with much needed and heartily welcomed advice on when and how to start ART; recommended first-line and second-line treatments; ART in pregnancy, adolescents, children, and infants; adherence to treatment; and monitoring of ART (WHO 2002). A key principle underlying these guidelines was that the inability of an AIDS treatment programme to provide optimal laboratory monitoring did not justify withholding treatment, as long as the basic recommended or absolute minimum testing could be provided. The addition of selected ARVs to the WHO model list included the most comprehensive publicly available analysis of ART effectiveness and safety to date, authoritative formulary information on ARV use, quality assurance standards for ARVs, and additional reference information. For the treatment advocates, such information may have seemed like academic footnotes to a foregone conclusion. But for Ministry of Health officials, donors, international agencies, and many in the public health community, such definitive guidance from the world’s leading health authority helped to convince the undecided and counter the sceptics (of which there were still many).

Scaling up ART has contributed to a range of efforts to promote rational use. Programmes to strengthen adherence counselling skills in Kenya and Ethiopia have improved communication skills to the benefit of all patients (MSH 2009a). In Namibia and other countries, AIDS treatment has increased attention on pharmacovigilance (monitoring drug effectiveness and safety) to inform patient and provider decisions, improve treatment results, and minimise adverse effects (MSH 2009b; Sagwa et al. 2009).

**Affordable prices**

The prices of medicines matters a lot, especially for low-income countries and poor households. Getting to the best achievable price for pharmaceuticals requires a combination of strategies. Patients in low-income countries pay as much as 25 times the international reference price for the lowest-costing essential medicines (Cameron et al. 2009). Whereas in high-income countries the cost of supply chain, dispensing, and taxes rarely adds more than 20 per cent to a manufacturer’s price, in developing countries such intermediary costs can double, triple, or in some cases even quintuple the final cost to the patient.

Affordability strategies, therefore, must target the full range of factors that determine the final cost of a medicine. Effective strategies include use of price information; competition among qualified suppliers; bulk procurement; generic substitution; differential pricing for newer essential medicines; elimination of duties, tariffs and taxes on essential medicines; more efficient distribution and dispensing systems; local production of quality essential medicines where feasible and financially competitive; and appropriate use of compatible safeguards such as compulsory licensing and price negotiation (see Figure 41.1).

In the case of ART, a stunning and unprecedented 98 per cent price reduction (from over US $10,000 to less than $200 per person per year) was achieved over just six years through a combination of negotiation and competition. In 1997, the UNAIDS Drug Access Initiative negotiated the price to between $7,000 to $8,000; by 1999, competition within Brazil’s AIDS programme lowered the price to $5,000; in May 2000, five pharmaceutical companies offered UN agencies prices of less than $2,000; in 2001, the Indian manufacturer, Cipla, offered competitive pricing of $360 ($1 per patient per day); and finally, in 2003, the Clinton Foundation announced that it had negotiated with manufacturers a price of less than $140
Rational selection and use of essential medicines

- Develop national treatment guidelines based on the best available evidence concerning efficacy, safety, quality, and cost-effectiveness
- Develop a national list of essential medicines based on national treatment guidelines
- Use a national list of essential medicines for procurement, reimbursement, training, donations and supervision

Affordable prices

- Use available and impartial price information
- Allow price competition in the local market
- Promote bulk procurement
- Implement generics policies
- Negotiate equitable pricing for newer essential medicines for priority diseases
- Undertake price negotiation for newly registered essential medicines
- Eliminate duties, tariffs, and taxes on essential medicines
- Reduce mark-ups through more efficient distribution and dispensing systems
- Encourage local production of essential medicines of assured quality when appropriate and feasible
- Include WTO/TRIPS compatible safeguards into national legislation and apply

Sustainable financing

- Increase public funding for health, including for essential medicines
- Reduce out-of-pocket spending, especially by the poor
- Expand health insurance through national, local, and employer schemes
- Target external funding – grants, loans, donations – at specific diseases with high public health impact
- Explore other financing mechanisms, such as debt-relief and solidarity funds.

Reliable supply systems

- Integrate medicines in health sector development
- Create efficient public-private-NGO mix approaches in supply delivery
- Assure quality of medicines through regulatory control
- Explore various purchasing schemes: procurement cooperatives
- Include traditional medicines in the health care provision

Figure 41.1 WHO Framework for Equitable Access to Essential Medicines

per person per year for one of the most commonly used triple combinations (Kapstein and Busby 2009).

Sustainable financing

With the feasibility of treatment demonstrated through thousands of patients in over half a dozen developing countries, expert support available for treatment protocols, and falling ARV prices, the question of funding became predominant. Following an intensive two-year effort by AIDS activists, politicians, governments north and south, multilateral organisations such as the UN and WHO, outspoken academics, and high-profile rock stars, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) opened its doors in January 2002. Within three months, the GFATM had approved initial grants to 36 countries. The GFATM has since
approved grants for over $15.5 billion – almost 60 per cent allocated to HIV response, and nearly 50 per cent allocated for medicines and commodities (GFATM 2009).

The launch of the Global Fund was followed by the five-year US President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, the US President's Malaria Initiative (PMI) in 2004, the French-initiated UNITAID in 2006, and re-authorisation of PEPFAR in 2008. Together, this explosion of ‘mega-funds' has resulted in the commitment of over $80 billion to global health, the largest share to HIV and AIDS, and a sizable share of this to AIDS treatment.

**Reliable supply and quality assurance systems**

Responding to the AIDS epidemic has provided developing country pharmaceutical supply and quality assurance systems with huge challenges. At the same time, there are a growing number of examples of the positive effects of AIDS funding on pharmaceutical systems. In Rwanda, the stakeholder Coordinated Procurement and Distribution System helped to standardise ART and commodity selection across all external donors; simplify pharmaceutical management; enable CAMERWA, the national procurement agency, to access pooled donor basket funding; and optimise use of donor resources. In a growing number of countries, new pharmaceutical supply and dispensing information systems help reduce stock-outs, quantify ART use, calculate inventory requirements, report patient care statistics, and reduce staff needs through automated labelling. In Namibia and South Africa, task-shifting for ART has led to increased production of pharmacy assistants (Embrey et al. 2009; Walkowiak and Keene 2009).

The desire to address HIV scale-up challenges helped bring together the 14 member countries of the East, Central and Southern Africa Health Community (ECSA HC) to create the Regional Pharmaceutical Forum to provide technical leadership, enable national policy environments, share best practices, and exchange price and supplier information. Supply of HIV-related pharmaceuticals and commodities has increasingly been integrated into the essential medicines supply system, thereby strengthening existing systems (Oomman et al. 2008).

Increasingly, large-scale public health programmes are looking at options for integrated systems that use an appropriate mix of public, private, and non-governmental capacity. Alternatives to the classic central medicines stores include autonomous supply agencies, direct delivery, and the primary distributor model (MSH 1997). Innovative public–private arrangements such as these have been tested in several African countries, including Zambia, parts of South Africa, Tanzania, Kenya, and Uganda (Quick et al. 2005). The success of such efforts depends on reliable private sector partners, capable public oversight, and accountable governance.

Faith-based organisations provide a large share of health care services, especially in rural Africa, and have played a vital role in the AIDS response. A WHO study of 15 faith-based medicines supply organisations in ten countries found that these organisations served 25 to 60 per cent of the population. Though performance varied, these organisations were generally performing well, had transparent procurement procedures, competitive prices, and highly motivated staff; maintained strong relationships with their customers, Ministries of Health, and founding church bodies; and operated like small business entities, with boards or committees to oversee their work (Banda et al. 2006).

In the face of rapidly falling pharmaceutical prices and uncertainty about the quality of generic ARVs and other AIDS medicines, in 2001 WHO, with other UN partners, set up the Prequalification Programme for Medicines (PQP). The programme has since been expanded to cover malaria, tuberculosis, and reproductive health. Initially focused on products ready for patient use (‘finished dosage forms’), the programme has been broadened to manufacturing sites.
for active pharmaceutical ingredients, research organisations involved in bioequivalence and other testing, prequalification of pharmaceutical quality control laboratories (QCLs), advocacy for medicines quality, and capacity-building drug regulatory authorities (WHO 2009b).

The WHO PQP and US Food and Drug Administration (USFDA) Fast Track Approval Process have facilitated generic procurement, with literally billions of dollars being spent by PEPFAR, the GFATM, and others. The USAID-funded Supply Chain Management System (SCMS), for example, during its first three years of operation, saved an estimated $364 million (compared to the purchase of equivalent branded products) by purchasing 90 per cent of its ARVs as generic products (SCMS 2009).

Global access opportunities and challenges in the twenty-first century

Since the first widespread use of essential medicines and vaccines barely 70 years ago, tremendous progress has been achieved in creating access to these life-saving products. The effectiveness of the essential medicines public health concepts for access, quality, and rational use of medicines have been proven by the test of time. Yet millions of people still lack regular access, needed new medicines are slow in coming, and vast amounts of resources are wasted through mismanagement. The following section addresses a few of the many global access opportunities and challenges which face us in the twenty-first century.

Access to essential medicines as human right

The International Covenant of Economic, Social and Cultural Rights (ICESCR) forms the reference text in international treaties regarding the right to health. The ICESCR explicitly recognises that not all rights can be realised immediately. Thus, the right to health is a ‘progressive right’. The right to health includes a right to health care and a right to healthy conditions, but not the right to be healthy, as such, since this reflects individuals’ genetic make-up, socio-economic conditions, and the resources of the state (WHO 2009c). As a result of WHO’s joint effort with the United Nations Committee on Economic, Social and Cultural Rights, in 2000, access to essential medicines was explicitly incorporated into the right to health (Seuba 2006).

The power of rights-based social mobilisation in securing access to medicines is vividly illustrated by the 1996 victory by AIDS activists in the legal battle for universal access to ARV treatment in Brazil. This groundbreaking action provided the critical catalyst for Brazil to build its successful national AIDS treatment programme and become the inspiration for scaling up AIDS treatment throughout the world. The growing international recognition of health as a human right, and the now explicit recognition of access to essential medicines as part of that right, is becoming an increasingly potent tool in expanding access to medicines. This is especially true in pursuing the rights of the vulnerable and underserved in areas such as child, reproductive, and maternal health. One caveat, however, is that misapplication of this right can, and has, led to legal action forcing health care programmes to provide access to medicines which are unproven or of marginal value.

Essential medicines for priority needs

Keeping the essential medicines relevant and dynamic is both a challenge and an opportunity for the twenty-first century. Two recent examples illustrate how the essential medicines approach continues to catalyse action by the international health community to address priority
health needs. The first addresses access to medicines for children, and the second to medicines for reproductive health.

Most of the 9 million annual deaths of children under five years are preventable with adequate access to essential medicines and vaccines for children. The WHO and other international partner agencies have launched several initiatives to address the global need for safe, effective, and accessible medicines for children through the ‘Better Medicines for Children’ and ‘Make Medicines Children Size’ campaigns. Some of the issues surrounding access to medicines for children include the absence of children’s medicines on essential medicines lists, inadequate development and production of children’s medicines, availability and regulation of dosage forms for children, and unclear ethical guidelines for clinical trials in children (WHO 2009d). Progress is currently being made with funding research and development, and forming ethical guidelines for drug trials in children.

Reproductive health covers a range of conditions that include healthy sexual development, reproductive and fertility regulation, prevention of STIs and HIV/AIDS, and safe motherhood. Reproductive health problems account for up to 18 per cent of the global burden of disease and 32 per cent of the total burden of disease for women of reproductive age (AGI and UNFPA 2004). A 2006 review of national health policies and essential medicines lists found that inclusion of reproductive health medicines to be absent or inadequate in the majority of cases (PATH et al. 2006). Without question, the addition of needed reproductive health medicines to essential medicines, and action to ensure access, quality, and appropriate use is essential for the reproductive and overall health of women and their families.

Global access to new medicines

The stunning gap in research and development of drugs for neglected diseases such as malaria, sleeping sickness, and other tropical diseases was incisively documented by Médecins sans Frontières/Doctors without Borders (Trouiller et al. 1999), which launched the Drugs for Neglected Diseases Initiative that same year with the funds from winning the Nobel Peace Prize.

Since 1999, there has been series of promising new initiatives aimed at developing new medicines, vaccines, and other technologies for global health, including the Bill & Melinda Gates Foundation Grand Challenges in Global Health initiative, the Medicines for Malaria Venture, the Global Alliance for TB Drug Development, the International AIDS Vaccine Initiative, and the Malaria Vaccine Initiative. In addition to these initiatives for tropical and other neglected diseases of developing countries, it must be borne in mind that developing and developed countries alike face significant ‘pharmaceutical gaps’ in areas of chronic disease, children’s medicines, reproductive health, and other areas of public health importance for which pharmaceutical treatments either do not exist or are inadequate (Kaplan 2004).

Long delays in the adoption of community-based treatment of childhood pneumonia and in expanding access to artemisinin-based combination therapies (ACTs) attest to the challenge of ensuring rapid, widespread global access to new medicines. Initiatives involved in developing these products must from the outset work together with the full range of public health, pharmaceutical, regulatory, financial, and other expertise to ensure rapid widespread adoption.

Drug financing through health insurance

Community financing broadly describes a wide variety of health financing arrangements, some of which include community cost-sharing, community prepayment, micro-insurance, community health funds, rural health insurance, revolving drug funds, and community involvement in
user-fee management (Ekman 2004). In low-income countries, community health insurance (CHI) has been introduced in different forms to pool risks and reduce the economic burden of out-of-pocket spending on health. Out-of-pocket payments account for 85 per cent of private health care expenditures, and over 50 per cent of total health care expenditures in these countries (Vialle-Valentin et al. 2008). Medicines were also found to constitute the largest reported component of out-of-pocket payments for health care ranging from 11.1 per cent of health expenditures in Chad to 68.8 per cent in Nepal.

Drug benefits are thus an integral part of community health insurance. There is a paucity of detailed information on the extent to which medicines are covered in CHI in low-income countries. A 2008 study identified CHI plans in only one-third (19 out of 54) low-income countries (Vialle-Valentin et al. 2008). Several medicine coverage forms include medicine co-payment, in-patient and outpatient medicine benefits, and essential medicines and generic policies. Some of the challenges of medicines coverage in CHI include weak drug supply systems, low enrolment and ‘access’ among the poor, insufficient political support, low voluntary enrolment and diversity of communities, and lack of infrastructure and technical capacity. If scaled up adequately to include medicines coverage, CHI can improve access to and use of essential medicines in low-income countries.

Quality assurance in a global market

Pharmaceutical quality cannot be ‘tested into a product’ – it must be built in by its manufacturer through the formulation, production, and packaging processes. Effective medicines regulation by an established government authority provides the needed oversight to ensure that quality is created by manufacturers, and preserved at each step in the supply chain from producer to patient (WHO 2003). The effects of counterfeit and substandard medicines are seen around the world, from the consumption of harmful ingredients in fake medicines, to the promotion of drug-resistant microbial strains of diseases, drug resistance in individuals and populations, intellectual property theft, loss of productivity, loss of confidence in health-delivery systems, and death. Estimates of the prevalence of counterfeit medicines range from less than 1 per cent of market value in most industrialised countries, to 50 per cent in parts of Africa, Asia, and Latin America (WHO 2009e; Newton et al. 2006).

Factors encouraging counterfeiting of medicines include lack of regulation and enforcement in many developing countries, greed, relative high costs of genuine medicines, and light penalties for producers and traffickers (Newton et al. 2006). Several interlinked strategies are required to effectively combat the problem of counterfeit medicines. Greater intergovernmental collaboration, stricter penalties at points of source, and increased diplomatic pressure are needed to minimise the production, trading, and selling of fake medicines around the globe.

Good governance for medicines

The World Bank has described corruption as the ‘greatest obstacle to economic and social development’, and Transparency International (TI) has estimated that 10 to 25 per cent of global public health procurement spending is stolen or otherwise misused. Corruption in the pharmaceutical sector can occur through bribery of procurement official; theft in the distribution chain; falsification of data on quality, efficacy, or safety; or any of a number of other ways (Vian 2002).

Though spoken of quietly for decades, corruption and other failures in good governance for medicines has only received systematic visible attention by the international community.
since the early 2000s. TI, the leading global civil society organisation committed to fighting corruption, has taken as one of its global priorities corruption in the health sector, including in health services, the pharmaceutical industry, and in the procurement of medicines and equipment (TI 2009). The WHO Good Governance for Medicines (GGM) programme, started in 2004, works with governments and other stakeholders to reduce corruption in the pharmaceutical sector (WHO 2009f). Lastly, a comprehensive initiative of the UK Department for International Development (DFID), the Medicines Transparency Alliance (MeTA), brings together governments, pharmaceutical companies, civil societies, and other stakeholders aimed at promoting access to essential medicines in developing countries (MeTA 2009). The effects of a more transparent and accountable pharmaceutical system has seen the reduction in pricing of medicines in several countries including Tanzania, Jordan, and Zambia (MeTA 2009).

Anti-microbial resistance

The world has been experiencing a steady increase in microbial resistance to traditional first-line medicines for malaria, tuberculosis, HIV, and other diseases. Anti-microbial resistance (AMR) has severe consequences, some of which include treatment failure, prolonged illnesses, avoidable death, and the higher cost and often toxicity of second- and third-line medicines. It is estimated that more than half of all medicines are prescribed, dispensed, or sold inappropriately. Achieving rational use of medicines is dependent on the whole health system, health practitioners, and consumers (WHO 2009g). Active local coalitions can do a great deal to contain AMR (MSH 2008).

Conclusion

It is sobering to note that modern medicines and vaccines have been available to the world for barely 70 years, and that for the first half of this period, access to these magic bullets was quite limited in most LMIC. Yet over the last 30 years, tremendous progress has been achieved in access to essential medicines, and the last ten years has seen stunning progress in access to AIDS medicines.

Amid this progress, serious challenges remain. The dearth of research and development for malaria and other tropical diseases, unreliable supply systems in many places, the high prevalence of counterfeit and substandard medicines in several parts of the world, slow uptake of new medicines, unaffordable medicine pricing, and AMR are but a few of the challenges which remain unresolved.

At the same time, there are promising efforts and some notable progress in areas such as development of needed new medicines for children, neglected diseases and other unmet needs; expanded financing of essential medicines through health insurance; and innovative efforts to improve governance for medicines. Ultimately, the success of twenty-first century medicines programmes will be determined by the accessibility of medicines to the populations and regions where they are needed most.

References

Global Access to Essential Medicines


