Editorial:

Essential Drugs

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The WHO recently finalized the list of "Essential medicines, 2015." [1,2] To we doctors at grass root level, such reports although prepared by top experts in multi-disciplinary teams after studying all aspects with due diligence and a lot of hard work, it is conventionally perceived as merely a list of minimum basic medicines only, applicable to the developed countries at large. This is far from truth. The global effort to list out the very "Essential medicines" in a consolidated form is applicable to all countries in all settings.

However, the individual governments of the member countries often shy away in implementing the WHO list as it is, pleading for country specific lists, taking several plea, mostly on economic and other commercial considerations, rather than strictly on regional variation in disease. The tremendous influence of the industry lobby is anyone to see. Of late,inclusion of few newer costly medicines by WHO has raised many eye brows.

The earlier concept of essential medicines have since lost their relevance as a list of just basic medicines. Should the list include medicines not yet authorized by stringent regulatory authorities or not easily available such as - newer anti-cancer drugs, antibiotics, monoclonal antibodies, anti-HCV drugs, anti-TB and anti-HIV drugs against multi-drug resistant strains. In all rationality, the list automatically should include any medicine mentioned in a WHO treatment guideline. But the member countries have their own understanding of the problem. It is nothing but bureaucratic hypocrisy, at least with our present attitude.

Every one admits the dismal budget allocation of meager 4% of our GDP for health in India as compared to almost 12% by Brazil, another smaller developing country. There, cost-effectiveness has been proved with supply to health-care system mostly from Government owned public sector industries, restricting the private sectors for a selected few like disposables and implant devices under strict vigilance and price control. Our smaller neighbours like Srilanka, Bangladesh and Nepal are far ahead of us on health indices. Surprisingly, our public sector industries are being closed one by one, showing increasing dependence on private sector industries and hospitals, contrary to recommendations. All of us, including ones in the government have shown concern, but no action is visible on ground except few knee jerk reactions here and there.

On the other hand, we have arbitrarily given a very free hand to the insurance companies, mostly operating in urban areas where they have their accredited hospitals. No one is really serious as to how to provide adequate health cover to the rural poor in villages who constitute more than 70% of our population. Establishing AIIMS model hospitals in few state capitals is not going to help. It is like carrying coal to New-Castle. The common man must get proper care and right medicine in right time, establishing more first referral units, in functional condition close to their home, may be at each Taluka HQ, looking at our population density.

Providing health care happens to be basically a state responsibility as per our constitution. However, it is regarded as a fundamental right under right to life guaranteed by the Constitution. Access to health care for the public has certainly improved, albeit marginally in last 70 years of independence. But one must see the difference in pace at which our other neighbours like China have progresses over all these years. We call ourselves an emerging superpower! What a misplaced priority!

Let's come back to the issue of "Essential medicine list" now. The new WHO list of 2015 for the first time is beyond those minimum number of medicines, considered bare minimum to manage most of the common diseases and emergencies.

The WHO recommends treating all individuals who are sero-positive, irrespective of their CD4 count. But our NACO in India insists that drug treatment to be started only when the CD4 count goes below the dismal 350, citing logistical and economic burden! An individual once seropositive is not going to be cured without the ART. S/he is certain to deteriorate to exhibit lower CD4 count sooner or later. Rather there will be more economic burden on the country, considering a cumulative impact! It is time that our wiser planners realise this sooner than later, shredding their utter complacency and 'Chalta hai' attitude.

In 2002 the WHO had included 12 ARV drugs against HIV/AIDS despite patent laws in place in western and African countries. It was aimed at to face the critical and helpless situation at that time. It took almost a decade to get serious attention of member countries to reach the unfortunate victims at grass root level through the public health system. Only generic drugs manufactured by Indian companies saved millions in Africa, further in Europe and all other western countries, from sure clutches of death and despair. The Indian gesture compelled Governments all over the world to modify their patent law in the interest of human lives. Now also, Hep-C affected people from countries like Australia, Canada, US and Europe are already bee lining to India as the drug is rationed in their own country, besides exorbitant cost to which even they are not able to afford [4, 5, 6].

In 2013, WHO list included Bevacizumab for the treatment of macular degeneration, on the basis of available evidence but in the absence of regulatory approval for that specific indication [7]. In 2005, child-friendly formulations of zinc sulfate tablets were added, though such dispersible dosage forms were not widely available [8]. The WHO list for children considerably improved in 2013 [11].

WHO current essential drug list (2015) [2] includes medicines for drug resistant tuberculosis, such as - Bedaquiline and Delamanid. India is considered a global burden of MDR TB. Should we not only contain it but also stamp it out altogether now; or allow the calamity to engulf us like HIV/AIDS did to Africa in the recent past? Is a global disgrace and human tragedy that Tuberculosis, a curable disease, is killing 1.5 million people in the world yet due priority is not assigned to contain it in war footing. Only India harbours 2.3 million cases with 3 lakh deaths every year; amounting to an economic cost of 1.3 lakh Crore and a loss of 17 crore work days annually. Urgent planning and allocation of funds is mandated taking into consideration such staggering loss, an emerging economic giant such as India cannot afford to ignore, said Sri K. N. Singh Deo, our M.P. and member of the Global Coalition against Tuberculosis Advisory Board spoke at Cape-Town in the Union World Conference on Lung health recently [10].

The national TB free campaign of our country is gaining momentum, albeit slowly but definitely; with an wishful thought and aim to stamp out this dreaded disease by 2035 [10]. The initial budgetary requirement is 1,500 crores and an additional 750 crores annually to contain the human tragedy. On the other hand, MDR and XDR TB are spreading in geometric proportions like a wild fire in the community. Besides provision of advanced diagnostic tools such as - GeneXpert machines at peripheral referral centres, newer effective drugs against resistant TB, drugs such as Bedaquiline, Linezolid, PA-824 and so on are required to be brought under the essential drug list, as suggested by WHO. A six months long course in India to cost approximately 2 lakhs per patient.Hence the duty of any welfare Government to comply, at least in public interest.

Of late, the incidence of cancer has increased in monstrous proportions world over, including India. If at all diagnosed early, the cost of surgery / chemotherapy / radiotherapy is just not affordable

by most. Further, none of the combination chemotherapies are sacrosanct even after the prolonged costly treatment and recurrence is so common than not. The cost of second line chemotherapy, particularly with newer molecules and biologicals is just exorbitant, being mostly manufactured and monopolised by multinationals. Even the doctors and health-care industry do not hesitate to fleece patients as middle men. Ultimately, most offered 'Palliative care' and 'Counselling' to accept fate accompli.

On the other hand several cancers are curable if diagnosed and treated early by appropriate drugs by trained personnel. Unfortunately, such drugs, in the name of patent laws and cost of R&D, production, are exorbitantly priced by the monopolising industry. Here, the WHO have now taken a very bold step by rightly including such newer biologicals used in cancer treatment like Imatinib, Rituximab and Trastuzumab (Monoclonal antibobies) under the "Essential list" [2,15]. We must wake up!

So also is the case of 'Directly acting Anti-retroviral Drugs' [1] for treatment of chronic Hepatitis-C infection [3,4,9,14]. There was no hope for cure with Interferon based combination regimen with Ribavirin, despite high cost, resistance and side effects. The DAA include Sofosbuvir, Simeprevir, Daclastavir, Ladipasvir and Ombitasvir. A 3 month course of Sofosbuvir combination drug would cost a whooping 95,000 US$ or 50,000 Euros (Nearly INR 70 lakhs) in the west where as the generic copy cat version in India would cost about 100th (1,000 US $ or INR 60,000) [9]. this has been vehemently objected to by the multi-national manufacturers. The patent for Sofosbuvir is valid upto 2024-30 [3]. According to WHO, we have in India about 12 million people suffering from chronic hepatitis-C infection, destined to die without treatment. There was no provision for screening donors' blood in blood banks before 1992. Their number is bound to increase in geometric proportions, particularly in rural areas. Can we afford to wait and allow these unfortunate population to perish without treatment just because they cannot afford or come forward to produce generic versions on war footing in public interest?

However, it takes a long time to take appropriate bureaucratic decision and the political will to go ahead. Fortunately for us, the apex committee of the Central Drugs Standard Control Organisation (CDSCO) have recently granted waiver for local trials for this crucial drugs falling under DAA [9, 13, 14]. The waiver for Sofosuvir and Ledipasvir co-formulation and Daclastasvir is expected to bring into market the long awaited cheaper generic versions when allowed manufacturing by multiple industries, opening up competition in the segment [17]. The Indian generic versions are expected to revolutionaries the Hep-C treatment regimen, not only in India but also globally as India had done in the past to confront artificial crisis created in case of HIV/AIDS by the multinationals with just a similar strategy.

The availability of low-price generic antiretroviral medicines in the early 2000s has since closed. Key generic producing countries have implemented the 1995 World Trade Organization (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), and now have to provide 20-year patent terms for pharmaceutical products [16]. Some recent bilateral and regional trade agreements even add further barriers to generic competition. These changes in trade regulations represent serious challenges to the access to life-saving medicines. By that time more resistant bugs must have arrived to pose new challenges if the present organisms are spared to grow and get half treated in half hearted manner. Under the constitutional provision of the 'Right to life', people need to be assured and urgent intervention warranted against such inhuman trade policy. The Government of India of course formulates its own essential drug list, simply identifying the minimum most drugs to be stocked in the Government hospital inventories in the periphery [12]. Moreover, it takes years each time

to formulate and finalise the same on various considerations, push and pull. The current concept of WHO essential drug list should be an eye opener for us to include a broad spectrum of medicines considered as life savers to many, irrespective of the cost [18], at least from the Government hospitals on confirmation of diagnosis. In fact the government must adopt the broad "WHO Essential Drug List" as a whole, bringing all the items under strict price control or as generics, open for manufacture by companies under WHO GMP, to encourage competition. The government may consider restricting certain costly drugs for use strictly for in-patients under care of experts in the respective field. Cost alone should not be the only factor to keep these really essential drugs out of 'Essential Drug List'.

When new effective medicines emerge to safely treat serious and widespread diseases, it is vital to ensure that everyone who needs them can avail their benefit, says the WHO.

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