DRUGS FOR THE THIRD WORLD

Nations that are thought of as belonging to the third world are in fact in varying stages of development, but they have in common a low per capita income, inadequate food supplies, relatively low standards of hygiene, education and communications, and a high incidence of disease, especially infections.

The problems are often compounded by gross maldistribution of medical services. Usually the overwhelming majority of doctors work in the towns, when over 80% of the people live in rural areas. The total health budget may be as little as U.S. \$1.00 per head per year and in some cases a high proportion of what money is available is spent on one or a few expensive institutions.

The world economic climate is likely to remain hostile for some years to come. Most of the less developed countries are facing increasing difficulty in paying for imported fuel and manufactured goods, with falling revenue from basic commodities, and it is unlikely that the amount, or more importantly the purchasing power, of foreign aid will substantially increase.

It therefore becomes extraordinarily difficult to allocate priorities between drugs and many other medical and social needs, as well as between and within therapeutic categories, especially since disturbance of the ecological balance might create even greater problems in the future. So often in the past foreign aid and local initiative have failed to reach the people whose need is greatest, but in the last few years there has been an important change in emphasis towards building health services from the periphery to the centre and there are already some exciting examples of what can be achieved (Newell, 1975).

The procurement and use of drugs must be seen in this context. In the hope of saving money, developing countries may be tempted to undertake local manufacture, and, indeed, some of the more advanced can provide up to 80% of their own requirements. Many others, however, do not yet have the basic skills and services of many kinds on which such an industry could be built. It is a sound generalisation that quality has to be paid for, and if drugs are bought cheaply or made locally, they may well have a smaller margin of quality assurance. In view of the potential risk on the one hand and the possible savings on the other, the control of quality is of the utmost importance.

One organisation which is now providing drugs of assured quality is ECHO (Equipment for

Charity Hospitals Overseas, 5 Robin Hood Lane, Sutton, Surrey). It was started about ten years ago to supply medical missionary societies with equipment as cheaply as possible, and soon widened its scope to include any charity or non-commercial organisation anywhere in the world regardless of creed or race. By a simple piece of market research in 1975 it found that, with minor variations, the main requirements of these countries could be met from a list of only about thirty generic drugs. By being able to place huge orders for these, it has obtained good quality products at remarkably low prices. It is of course easier both in purchasing and in ultimate utilisation to handle a small list of preparations, and the underlying philosophy is entirely consistent with the policy of decentralisation and the imperative need of these countries to make the best use of scarce resources for the greatest good.

However, without more research, there will be no further progress in finding new and better drugs for tropical diseases. The international pharmaceutical industry has grown up in the industrialised countries and is geared to their needs and their economies. Tropical diseases, despite their prevalence, tend to receive low research priority and, in fact, potentially promising compounds are known to be lying dormant because the likely financial return or possible risk of failure do not make the huge present day development costs seem justified. This type of research could be sponsored by governments or by agencies such as WHO, but subsequent licensing arrangements would have to be made sufficiently attractive to compete favourably with other opportunities open to the manufacturer. The implications are complex but deserve further study.

Meanwhile, in an attempt to break out of this deteriorating situation, WHO has proposed an extremely ambitious Expanded Research Programme based on a series of institutes in Africa with WHO Task Forces tackling the six major diseases that are said to affect one thousand million people worldwide (WHO, 1975). The emphasis would be more on prevention than on cure. Added advantages would be that local ethnic, environmental and nutritional conditions could be taken into account and the institutes could serve as foci for technical training. The administrative, technical and especially the financial problems in implementing this imaginative scheme are formidable, but there are resources around the world if

only they could be harnessed. Britain might no longer be able to make a large financial contribution, but there is still a substantial pool of expertise in tropical diseases.

The multinational pharmaceutical industry is often criticised for failing to meet the needs of these people. It is under no obligation to provide drugs at less than economic prices, but it does have a strong moral responsibility not to encourage sub-optimal prescribing or the wasteful spending of precious foreign exchange. Its critics should

remember the enormous potential benefit from the efficient utilisation of drugs that are now available so cheaply. Most of these were developed by the industry and but for the industry they would not exist.

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References

- NEWELL, K.W. (1975). *Health by the People*. Geneva: WHO.
WHO (1975). *Tropical Diseases Today—The Challenge and The Opportunity*. Geneva: WHO.