Rationing in developing countries

SIR,—Rationing in health care is increasingly being discussed in developed countries.^{1,2} In state health services in developing countries it has existed for decades under a different name—namely, shortages. Attempts at rationing, especially in developing countries, however, are like the person pulling drowning children out from the stream without being able to do anything about the person upstream throwing them in. The cost of drugs is a large component of the health care budget in developing countries, accounting for up to 40% of the total³; the annual trading deficit in pharmaceuticals of these countries was estimated to be \$4 billion 10 years ago.⁴ In developed countries drugs account for about 10% of the health care budget.⁴

To select just one example from pharmaceuticals, the net price of a Zantac tablet (150 mg) manufactured and sold in the United Kingdom is about 50p⁵; this same tablet is sold in Sri Lanka for 30p and, as in the United Kingdom, is the only brand of ranitidine available. The difference in cost could be due to the manufacturers' desire to provide drugs at reasonable cost or the market conditions in Sri Lanka not permitting a higher price, or both. In India the same manufacturer produces ranitidine with a slightly different brand name, Zinetac, presumably with the same standard of good manufacturing practice that it maintains worldwide. The net price of this ranitidine (Zinetac), however, is about 5p; other brands of ranitidine are available in India. Because of company policy the cheaper ranitidine is not imported into Sri Lanka; the company does, however, import other products from its Asian subsidiaries. The patent laws do not allow third parties to import the Indian ranitidine into Sri Lanka. To put the costs in perspective, a labourer earns the equivalent of about £1 a day in this part of the subcontinent.

This type of control resulting in much higher prices for pharmaceuticals is the rule rather than the exception. Multinational pharmaceutical companies with headquarters outside Asia register and export the more expensive products to Sri Lanka (database of pharmaceuticals registered in

Sri Lanka, department of pharmacology, Faculty of Medicine, Colombo, Sri Lanka). The subsidiaries of these companies in India produce and sell the same product at a fraction of the price for use in that country only. As with ranitidine, the patent laws of the developed countries (accepted also by Sri Lanka) prevent the cheaper product being imported.

Richard Smith made a convincing plea for the discussion on rationing of health care in developed countries to be brought out into the sunlight.⁶ In developing countries such matters are still in darkness, an ideal environment in which may thrive the avaricious streak of an industry claiming to help to alleviate disease.

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2 Moss AH, Seigler M. Should alcoholics compete equally for liver transplantation? *JAMA* 1991;265:1295-8.
3 World Health Organisation. The selection of essential drugs: report of a WHO expert committee. *WHO Tech Rep Ser* 1977;No 615.
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6 Smith R. Rationing: the search for sunlight. *BMJ* 1991;303:1561-2.

*We sent this letter to Glaxo, whose reply is given below.

SIR,—Glaxo agrees that there is reason for concern about the financing of health care in the developing world. Throughout the developing world many people do not have sufficient access to health care. The pharmaceutical industry should not, however, be portrayed as a villain in this. Glaxo and other companies have a considerable commitment to improving health care in the developing world.

It is not appropriate to consider pharmaceutical companies' contribution to health care—and to label the industry avaricious—on the basis that they price their medicines similarly in developing

and developed countries. Glaxo establishes prices with the goal of providing good value to patients, health care providers, and society while also generating revenue to fund future innovation. On this basis Glaxo believes that its prices are fair and that having a separate pricing structure for developing countries is inappropriate. (India is mentioned as a low priced market. Most countries, including Sri Lanka, realise that adequate patent protection is essential to maintain a viable pharmaceutical industry. India apparently does not share that view. On 29 April the United States imposed sanctions on India for its refusal to provide patent protection for foreign pharmaceuticals.)

Krisantha Weerasuriya and Colvin Goonaratne state that pharmaceuticals are a large component of the health care budget in developing countries. But focusing on the proportion of the budget spent on pharmaceuticals misses the point that pharmaceuticals are often cost effective in relation to other alternatives.

Glaxo's efforts to improve and expand access to health care in the developing world take several forms. For example, Glaxo has funded a chair in molecular parasitology at Cambridge University. At the local level Glaxo's companies organise and support efforts to improve distribution systems for medicines and to advance general health education. Local initiatives in Sri Lanka include medical education programmes, a public education programme on asthma, and contributions to hospitals and to regional medical camps for the country's poor. By its presence Glaxo also contributes to economic growth. In Sri Lanka it has about 230 employees. It manufactures medicines in many countries, such as Bangladesh, where it employs 800 people. The economic impact of the industry may best be illustrated by Mexico, where the pharmaceutical industry employs over 45 000 people.¹

The pharmaceutical companies, by working with officials in the developing countries and through continued commitment to economic development there, help to improve the quality of and access to health care.

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1 Mexican 1990 Pharma market. *Scrip* 1992;No 1684:20.

mathematical models of viral transmission, suggest that measles can persist despite coverage of over 90% with a single dose and that additional vaccination will be required to achieve elimination. To be successful, however, this must reach those not already vaccinated and at an early age. Offering measles, mumps, and rubella vaccine to secondary school children will not achieve this. Firstly, uptake of rubella vaccine in 10-14 year old girls is lower than that of measles, mumps, and rubella vaccine in 2 year olds. Secondly, similar social factors will probably determine compliance at each dose, and the net benefit of the second dose will probably largely be seroconversion in the few children in whom the initial vaccination failed. Thirdly, to delay revaccination for 10 years would be beneficial only if immunity induced by vaccination waned, but this does not seem to be an appreciable problem.

Alternative strategies for keeping the susceptible pool below the minimum necessary to maintain

Measles, mumps, and rubella vaccination

SIR,—Recent authors have reported the continued occurrence of measles in older children in Fife and Somerset and argued that, to ensure elimination of disease, measles, mumps, and rubella vaccine should now be given to secondary school children in addition to 1-2 year olds.^{1,3} The occurrence of measles in older, unvaccinated children in areas with previously poor uptake of single antigen measles vaccine is to be expected in the short term, and extending the original measles, mumps, and rubella catch up programme for younger children to older age groups may be indicated as an interim measure in such areas. Nationally there is no indication that cases in older subjects have a major role in maintaining transmission (table). The increase in the proportion of cases in older age groups since the introduction of measles vaccine

in 1968 is the expected consequence of a mass immunisation programme targeted at young children.⁴

Although vaccinating secondary school children may provide some interim local benefit, advocating this as a national strategy for elimination is in our view misguided. Observations from other countries, supported by calculations based on

Measles notification rates 1967-91, England and Wales

Age (years)	Rate/100 000			% Of total		
	1967	1987	1991	1967	1987	1991
<1	2237.4	574.4	381.0	4.0	9.2	27.5
1-4	7763.4	666.3	153.2	56.7	41.0	43.3
5-9	4450.5	511.7	49.4	36.4	38.1	16.6
10-14	248.8	87.3	19.5	1.8	6.4	6.1
15-24	44.5	17.7	5.1	0.7	3.4	4.0
≥25	4.9	2.5	0.7	0.3	2.0	2.4

Breakdown by age available for January-June only.