

COMMONWEALTH PHARMACEUTICAL ASSOCIATION

CPA is “a decided plus” in the Commonwealth family of nations, says deputy secretary general

The eighth Commonwealth Pharmaceutical Association conference took place from 14 to 17 August in Ocho Rios, Jamaica. Over 400 delegates from more than 40 countries attended the conference, which was hosted by the Pharmaceutical Society of Jamaica. Graeme Smith reports

Delivering the keynote address to the conference during the opening session, Winston Cox, Commonwealth deputy secretary general, said he was pleased that the Commonwealth Pharmaceutical Association works closely with the Commonwealth Secretariat and its health section to improve the health of the people of the Commonwealth.

“As someone who has worked in a ministry of health and whose present areas of responsibility include the core social areas of health, gender and education, I am aware of the important and valuable contribution pharmacists make to the delivery of health care in all countries, but especially the members states of the Commonwealth. There, many factors tend to work against our best efforts to provide and maintain conditions necessary for the delivery of accessible quality health care,” he said.

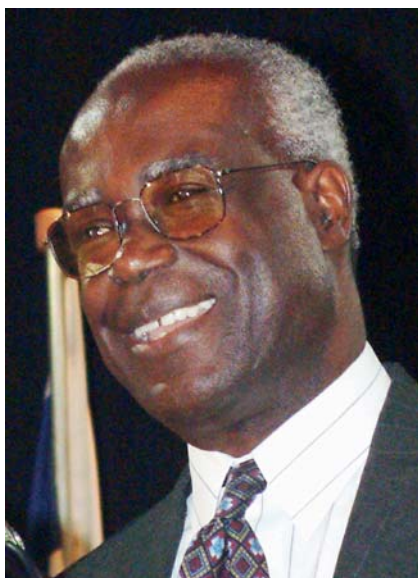
He told assembled pharmacists that the Commonwealth Secretariat has a special focus on human capacity development because it is critical to every aspect of a country’s growth and ability to benefit from globalisation. The CPA, he said, has been mindful of the need to offer its members opportunities to keep abreast of new ideas and research findings and also of possible new roles for pharmacists as the health sector tries to address effectively and efficiently the several care needs presented by old and new diseases.

“The secretariat acknowledges and commends the CPA and its regional and national members for commitment to the continuing development of the pharmacy profession and to improving services. It is a decided plus in our family of nations,” he said.

HIGHLY RESPECTED AND TRUSTED

Of special value is pharmacists’ ability to translate the elements of national care policies and guidelines into deliverables for its clients, said Mr Cox.

“We all know that throughout the world pharmacists are among the most highly respected and trusted of all professions and, in many cases, may be the first and perhaps the only source of health care to communities.”



Winston Cox: throughout the world pharmacists are among the most highly respected and trusted of all professions

He said that pharmacists’ ability to influence the attitudes and behaviours of patients is being more and more acknowledged. The pharmaceutical care role takes cognisance of pharmacists’ special knowledge and ascribes to the pharmacist an important place in therapeutics where not only the pathological condition is considered but also other factors that are critical to securing the best outcome.

“Pharmacists are well placed to influence care outcomes through advice and counselling on adherence to therapy,” said Mr Cox, acknowledging that this was not new and had long been at the heart of pharmacists’ interactions with patients and clients. “I therefore encourage you to continue your excellent work in assisting national pharmaceutical societies in their advocacy to governments for greater recognition of the pharmacist’s role in the improvement and delivery of health care,” he said.

Turning to HIV/AIDS, the subject of a special session at the conference, Mr Cox said that every country has to take specific account of the impact of the disease on its current activities and its plans for the future. The pandemic has reversed development

trends in many countries, he said. As health care professionals working at the front line, pharmacists see the ramifications of HIV/AIDS as it affects the lives of HIV-positive individuals and their families. “As development professionals, my colleagues and I in the secretariat see the costs and the slippage in development that results from the loss of skilled middle level professionals in education, in health, in public administration and in the private sector,” he said.

IMPORTANT CHALLENGES

The degree of complexity involved in caring for persons infected with HIV or who already have AIDS has evolved dramatically over the past few years. What was previously a progressive disease is now becoming a treatable chronic condition in many persons. However, the significant changes in management, including combination anti-retroviral therapy and testing, that prompted this transformation have resulted in important challenges for pharmacists, clinicians, public health specialists, social workers, nutritionists, policy makers and patients alike, said Mr Cox. He acknowledged that pharmacists’ role in prevention, treatment and care of people living with HIV/AIDS is difficult because all the advances are not yet available in many countries.

He told the conference that the Commonwealth Secretariat engages in a series of activities at regional and national level to assist member states to achieve the specific United Nations goal of halting and reversing the spread of HIV/AIDS by 2015. “Our niche areas include advocacy and policy dialogue, the promotion of the multi-sectoral approach to HIV/AIDS and the mitigation of the impact of HIV/AIDS on the human resource capacity of members countries,” he said.

He was aware that guidelines from the CPA on HIV/AIDS are to be published later in 2003 and he hoped that the conference would make recommendations on a reasonable approach to pharmacy practice and agree an acceptable standard of management.

Wishing the conference every success, he said he is looking forward to strengthening the partnership between the CPA and the Commonwealth Secretariat.

Think globally, act locally

Welcoming participants to the conference during the opening session, Grace Allen Young, vice-president of the Commonwealth Pharmaceutical Association and permanent secretary in Jamaica's ministry of health, said that emerging themes in health care create priorities for the health care system in general and professions in particular.

Recent examples of this are the impact of the new disease SARS on the economies of the areas where it arose and the spread of HIV/AIDS in sub-Saharan Africa and the Caribbean. These force us to focus on the changing health landscape, she said.

Patient outcomes are relevant to the quality of life enjoyed by individuals, their contribution to the social fabric of our nations and the impact of their absence or reduced presence from the workforce on economic activity and development.

Pharmacists, especially community pharmacists, are the first port of call in minor self-limiting illnesses. Pharmaceutical interventions must therefore be outward-looking rather than inward-looking.

If medicines continue to pass over the counter without the professional counselling or interaction of a pharmacist, pharmacy will continue to be viewed by some as



Grace Allen Young: open minds, new paradigms and global perspectives

glorified shopkeeping, she warned. If there continues to be reflex opposition to health policy rather than observing the opportunities it presents, the profession will be diagnosed as suffering from myopia. If the pharmacy degree becomes a status symbol rather than a means of making a difference

in practice, patients will be denied improved outcomes.

Mrs Allen Young reminded the conference of the CPA slogan: "Think globally, act locally." This translated into open minds, new paradigms, global perspectives and one integrated team with different players for improved patient outcomes.

She said that once in a while the opportunity presented itself for individuals and professions to make a life-altering intervention that will leave an indelible mark on history. The conference was just such an opportunity. It met so that pharmacists could interact to improve scientific knowledge in order to be able to make a signal change in the quality of life of patients.

The president of the association, John Bell, of Australia, also extended a welcome to participants. He said that the Commonwealth Pharmaceutical Association has never been more relevant. The world is an international village and the appearance of new diseases such as SARS has demonstrated the need for co-operation among nations in order to defeat them.

He told participants that a theme of the conference was "Partners in development". This is how the CPA operates: it works in partnership with national associations; it plans and facilitates, he said.

Trust is a highly vulnerable and volatile social asset

Pharmacists are often proud to say that they are a highly trusted group of health professionals in their communities and there is evidence to support this, but it must be remembered that trust is a highly vulnerable and volatile social asset. Mutual trust is easily destroyed, sometimes irreversibly.

So said Murtada Sesay, technical officer, Unicef supply division, Denmark, and a past president of the Commonwealth Pharmaceutical Association, when he delivered the B. V. Patel memorial lecture during the opening session of the conference.

Probably, one of the reasons why trust is so vulnerable is because we take it for granted. One only needs to follow and analyse current economic, social and political debates and commentary via international broadcast and other media to come to the conclusion that all is not well with the level of trust between and within countries and peoples.

"We hear of national and international treaties being signed today and revoked tomorrow," said Mr Sesay. This is a major problem for human development efforts. Mutual trust remains frail, fragile and vulnerable, he said.

"It is absolutely critical that mutual trust is not lost, because then all will be lost. The world cannot afford this," Mr Sesay declared. If a prerequisite for the achievement of the goals of the international health and human development effort is that coun-



Murtada Sesay: promoting health for all is valuable, honourable and noble

tries and peoples must work together, in trust, then a minimum threshold level of trust is required between governments and their peoples, between health personnel and their communities, between and within families and between religious groups, he added.

Earlier in his presentation, Mr Sesay asked how pharmacists and health professionals individually and collectively are con-

tributing to promoting health and human development in their communities.

He said that there is evidence that, over the past three decades, the health situation in every country has changed considerably. There have been major modifications in the patterns of disease, in demographic profiles, in exposure to major risks and in the socio-economic environment. There have also been trends towards more integrated models of care and greater pluralism in the financing and organisation of health systems. Governments continue to rethink their roles and responsibilities in relation to population health and the organisation and delivery of health care, thereby changing the context for framing and implementing health policy.

Mr Sesay told the conference that the 2003 World Development Report had stated that during the past 30 years, the world's population increased by two billion people, mostly in developing countries, and that substantial gains in human welfare accompanied that growth. Infant mortality rates in low and middle income countries was cut in half from 11 to 6 per cent of live births, and illiteracy among adults fell from 47 to 25 per cent and among women from 57 to 32 per cent. Real per capita income rose from \$989 in 1980 to \$1,354 in 2000.

The report also stated that more of the world's people enjoy freedoms and greater opportunities to participate in democratic processes than did three decades ago. In the

past 10 years, access to sanitation in low to medium income countries rose from 44 to 52 per cent.

The report warned, however, that some of the trends associated with past development strategies are not sustainable, Mr Sesay said. There are still 1.2 billion people living on less than \$1 a day, despite the success in reducing this number by at least 200 million in the past two decades. The average income in the richest 20 countries is 37 times that in the poorest 20, a ratio that is said to have doubled in the past 40 years, mainly because of a lack of growth in poor countries.

In the 1990s, 46 countries were involved in conflicts, mainly civil. "These conflicts have high costs, destroying past development gains and leaving a legacy of damaged

assets and corrosive mistrust that impedes future progress," said Mr Sesay.

More than one billion people in low to medium income countries still lack access to safe water, and two billion people lack adequate sanitation, subjecting them to disease and premature death.

But pharmacists and other health professionals can only effectively contribute to community health to the extent that the environment created by national political and socioeconomic development permits, Mr Sesay said. This is true for both developed and developing countries. "But, by the same token, being the highly educated and costly-to-train health professionals that we are, we cannot take the restrictive path and assume we do not have a role to play in the broader national development process.

Limiting our scope only to what we are professionally trained or employed to do is unnecessarily wasteful."

We can, he told assembled pharmacists, use the trust communities have in us to influence human development events in our countries. However, he acknowledged that things are not always as simple and linear as good intentions might lead us to believe. He said he was fully aware of the battle for day-to-day basic survival that professionals face, especially in developing countries.

"We must break this vicious circle of poor health and poverty sometime, somewhere, and the only way," Mr Sesay concluded, "is to make sacrifices and persevere because the mission of promoting health for all can only be described as valuable, honourable and noble."

Issues of access and equity: how to ensure that patients get the medicines they need

Access to essential medicines is a human right as well as an important feature of any health care service, said Paul Spivey, a British pharmacist who provides consultancy services to countries in Africa, Asia, the Middle East and Eastern Europe.

Speaking at a conference session on "Access and equity of pharmaceuticals", Mr Spivey said that an estimated two billion people still lack access to essential medicines and of these most are in rural and remote areas in low-income countries. Governments in low-income countries struggle with limited human and financial resources to provide health care, and one area that is weak is that of pharmacy services and medicine supply. The few pharmaceutical staff in post are often overwhelmed and under-trained, and unable to initiate and implement change to improve the situation. The options for change vary from minor changes to radical system reform; none will succeed without the implementation of good practice by individual people and the interest and support of the pharmaceutical profession, he said.

Mr Spivey told the conference that, when travelling to remote areas of countries in Africa and Asia, he often reflected on the fact that although we cannot achieve the regular availability of essential medicines, the Coca Cola Company can always manage to ensure that Coke is available. The Coca Cola website says that in Africa "its beverages are marketed and distributed by bottling partners in over 160 plants serving 830 million consumers in 54 out of 56 countries and territories". If only we could match its achievements, he said, adding that access to Coca Cola is not a human right but access to health and to essential medicines is.

The World Health Organization, said Mr Spivey, has declared that the number of people with access to essential medicines has almost doubled in the past 25 years, but there is a constant figure of 1.7 to two million people who remain without regular access to essential medicines. Most of these



Paul Spivey: better systems focused on true need are required

live in rural and remote areas in low-income or middle-income countries.

In addition, there is the ongoing debate on patents and intellectual property rights and the relationship of these to human rights and public health, with particular reference to those health problems that are predominantly in the developing world for which new treatments are urgently needed or existing treatments are unaffordable. This debate again focuses on the same old problem for pharmacy: finding the right balance between professional or ethical responsibility and commercial necessity, Mr Spivey said.

Access to medicines is certainly not equitable. There are huge contrasts between rich and poor countries, and within countries there are contrasts between access for rich and poor people, and for urban populations and rural populations. These contrasts arise in developing countries partly because medicines are highly political enti-

ties and their distribution is influenced by political and professional interests and pressures.

Partly the inequities are a result of the nature and extent of government funding of health care. Recent WHO findings are that:

- Average per capita spending on pharmaceuticals is 100 times more in high-income than low-income countries — about \$400 compared with about \$4. At opposite ends of the spectrum, there is a 1,000-fold difference between what the highest spending and lowest spending countries spend on pharmaceuticals
- Private sources of finance for pharmaceuticals have become more important in all countries since 1995, with attendant risks to public health objectives
- Governments' share in pharmaceutical spending has fallen faster than their share in total health spending
- Although external assistance has boosted pharmaceutical spending in a small number of countries, most countries with high HIV/AIDS mortality are still spending less than \$5 per capita on medicines

Partly the inequity is a geographical one: in urban areas sometimes there is an excess of access to medicines through the private sector — too great a variety, too easily available (often through illegal vendors) in an unregulated environment, and of variable quality and price. This overabundance provides a safety net for the occasions when public services cannot provide. In rural areas there is often limited access to few medicines, caused by erratic supply lines, poor management and dependency on an inadequately resourced and poorly staffed public sector. In addition there is no professionally provided private sector and therefore no safety net.

These are issues and problems that ought to concern us as pharmacists, not because it is ruining our business but

because of the professional and ethical concerns for the welfare of people and public health. Pharmacists should be working as individuals, as professional groups and maybe as international organisations to find solutions, even though there are many factors out of their control.

CONSTRAINTS

Mr Spivey went on to describe the constraints affecting equitable access to essential medicines.

First there are financial constraints. All countries, regardless of economic status, are facing the financial pressures of providing a universally accessible health service in the light of increasing costs and pressures to provide more sophisticated services. Where a government still bears the major burden of cost it is implementing measures to control the costs and share the financial responsibility with the consumer. This is no new experience for those who live in rural and remote areas, particularly in low-income countries. For the past 40 years, as health care systems moved to become institutionally based in the 1960s and 1970s, using increasingly sophisticated and expensive technology (including synthetic and mass produced medicines), the problems of access emerged as financial resources were no longer adequate.

Second is the concentration of resources on secondary and tertiary care. Although medicines constitute a large proportion (between 25 and 40 per cent) of the total recurring health expenditure, most of the expenditure is used to fund supplies for inpatients in tertiary and secondary care institutions serving a relatively small proportion of the population, mainly in urban areas. As a consequence, resources have not been available for funding the supply of services to the majority of the population, particularly those living in rural areas, and they do not have access to basic essential care and medicines.

Then there are flawed systems of supply in government or public services. Current systems for the supply and distribution of medicines continue to demonstrate some of the problems that stimulated the "essential drugs" concept. There is still poor correlation between supply and need, both in range and quantity. It is not uncommon to find large overstocks of some unnecessary items and desperate shortages of essential and regularly used items for common ailments.

There are no rational methods in place for estimating needs, neither in range nor quantity, leading to shortage and waste. The supply is often related either to the whims and fancies of the clinic health worker, the actual availability in the warehouse or the desire of the warehouse to offload donated or near-to-expiry stock from its shelves, none of which necessarily coincide with the actual need. Systems are weak in management and accountability resulting in untraceable losses. There is no monitoring of performance, either of the system or of the personnel.

A fourth constraint is that untrained

personnel operate the systems. Staff at both ends of the supply chain (the warehouse and the clinic) are not adequately trained or motivated to manage ordering and storage of supplies.

There are also problems for the private sector. Rural communities rarely provide a sufficient market to justify a commercial venture. In urban areas, when public services fail to provide, the private sector is a back-up. In rural areas there is no private sector, no back-up, and therefore there are severe problems of equity and access to essential medicines. Some of the gaps are filled by entrepreneurs selling medicines of questionable origin and high prices, and with no knowledge about their proper use. Such medicines are sold like any other commodity.

One way of improving things would be to strengthen the public system, Mr Spivey said, in order to supply the relevant items in sufficient quantity and on a consistent basis. Potential solutions are based on correlation of supply with need, management of supply and on effective systems operated by trained staff.

Primary care supplies, in terms of both range and quantities must be related to the disease pattern and to the numbers of patients, and in primary health care this should mean taking care of the top five or 10

health problems which account for the majority of the patient load. The principle of evidence-based selection based on disease patterns and treatment method criteria must be applied to establish the range of items. The quantity of each product then relates to the patient load, and this can often be brought to a monthly average requirement.

Training the personnel involved would also give rise to improvements. Staff must be trained or trained staff used. One of the problems faced is that pharmacy and pharmacy technician training establishments in general, like medical schools, train professionals for work in an institutional environment rather than in primary health care. As a result it is not surprising that provincial or regional pharmacists are mainly focused on supplies for secondary care rather than primary care. It is time to make a shift of emphasis, he said.

In conclusion, Mr Spivey said that equitable access remains a problem for all but particularly for people in rural areas. However, the situation could be improved with better systems focused on true needs. Solutions may lie outside the exclusive public systems, and may involve local communities. He suggested that pharmacists, though few, should pay more attention to primary care supply.

Room for improvement

Marthe Everard, technical officer in the Essential drugs and medicines policy department at the World Health Organization in Geneva, had some suggestions as to how access to essential drugs could be improved. During the access and equity session, she told the conference that access is based on rational selection and use of medicines, affordable prices, sustainable financing and reliable health and supply systems. All of these are inter-related and all are necessary for equitable access.

Rational selection involves defining what is most needed. Actions required are



Marthe Everard: staggering health inequities still exist

the development of evidence-based treatment guidelines and then using those guidelines to define the essential medicines required. These guidelines need to be regularly updated and used for supply and reimbursement procedures. Treatment guidelines can also help define what level of training and supervision is required, said Ms Everard. All of this has a bearing on prevention of disease, and the care of the patient and standard treatment guidelines, when effectively implemented, can save lives.

Turning to affordability of medicines, Ms Everard said that advocacy, corporate responsiveness and competition can lower prices. In the case of HIV/AIDS treatment, this had resulted in reducing the prices of triple treatment by as much as 95 per cent in three years.

On sustainable funding, she said that increased funding could contain the costs of ill health, pointing out that, in more than 38 countries, public drug expenditure is less than \$2 per person per year, which is inadequate by most estimates. She said there needs to be increased funding for cost-effective medicines, insurance plans, external funding for the poorest populations and better use of out-of-pocket spending. By this she meant that when poor people have saved enough to buy medicines, there is a need to make sure that the most effective treatments are sold.

Finally, there needs to be reliable health and supply systems to ensure quality and availability of medicines. Achieving this might involve integrating supply manage-

ment with health system development, developing an efficient mix of public and private funding, assuring drug quality throughout the distribution channel, and promoting the rational use of medicines.

There is a need to start small, Ms Everard said. She referred to a successful project in India where an essential drugs programme had been started in the state of Delhi. That programme is now being used by 13 Indian states and reaches 580 million people, almost the population of sub-Saharan Africa.

So there is hope, she concluded, although staggering inequities still exist.

IN ZIMBABWE

Localised access and equity problems were described by Sakhile Dubé-Mwedzi, a pharmacist from the Medicines Control Authority of Zimbabwe.

She described a situation where systems were in place to ensure that people had access to health services and medicines through a hierarchy of local, district, provincial and central hospitals, and a procurement system that involved purchasing drugs at a national level and distributing them through Natpharm, the national pharmaceutical company of Zimbabwe, by road.

The system is effective, she said, but is beset by problems and limitations. There is, for instance, less than optimum drug availability and a critical shortage of profession-



Sakhile Dubé-Mwedzi: system in Zimbabwe beset by problems and limitations

als to manage it. Most have gone abroad, she said, attracted by the salaries and working conditions of companies in the United Kingdom and other developed countries. She did not blame these pharmacists for leaving Zimbabwe; it was a matter of their own personal choice, but it has left the country in some difficulty.

There are fuel problems in the country that compromise the distribution of drugs and, even when drugs are available, their affordability is a major issue. People have the choice often of buying food or buying medicines.

However, despite the critical situation in her country, Ms Dubé-Mwedzi said that all is not lost. Private retail pharmacies are beginning to appear in remote areas, although there is a question as to how long they will remain in business owing to the severe economic situation. Drug donations are helping availability and guidelines have been drawn up concerning how such donations are dealt with.

New partnerships are also being formed, for example, with medical insurance companies, and she hoped this will help to alleviate the situation.

INTERNATIONAL DISPENSING

Of course, access and equity issues do not only affect poor people in developing countries.

Jeff Poston, executive director of the Canadian Pharmacists Association, described an international prescription service whereby senior citizens in the United States can obtain the medicines they need from Canada at lower prices than they could buy them for in their own country.

The service is provided from certain Canadian community pharmacies via internet or fax. American prescriptions are countersigned by a Canadian physician and the medicines sent to the US citizen. Four factors have driven this, said Mr Poston: the fact that there is a lack of insurance coverage for senior citizens in the US, there are government-imposed price controls on medicines in Canada where none exists in the US, favourable currency exchange rates and the availability of generics in Canada. It makes less expensive medicines available to US senior citizens who are often on fixed incomes.

The system was also profitable for Canadian pharmacists, of whom 40 to 60 were involved in the service.



Jeff Poston: professional relationships with patients are crucial

However, some issues arise, said Mr Poston. The ideal standard of patient care is face-to-face contact and clearly this is impossible in this situation. Canadian pharmacists' expertise is effectively being exported while there is a shortage of pharmacists in Canada. There is a possibility that Canada's system of price controls may be eroded and the local supply chain disrupted. More serious is the fact that research and development investment in Canada might be cut back. After all, why should a pharmaceutical company invest in a country that is selling its medicines to possibly its most lucrative customer (the US) at lower prices? All of this might result in delays in new drug introduction in Canada.

The system is illegal in the US, but the legislation is not being enforced by the US Food and Drug Administration or Customs, said Mr Poston. Customs permit US citizens to import 90 days' worth of medicines.

Other issues include the threat of counterfeit or substandard medicines being used, therapeutic inequivalency, and the fact that Canadian pharmacists are effectively "practising" in the US, where they may not be licensed to do so.

The critical issue for pharmacists is that it demonstrates that professional relationships with patients are crucial. If, through what is effectively "telepharmacy", a non-local pharmacy can develop good relationships with patients who are far away, patients may begin to support that pharmacy rather than a local one, Mr Poston warned.

Presentation of Albert Howells awards

Two Albert Howells awards were presented during the conference to pharmacists who have made an "outstanding contribution to pharmacy at the Commonwealth level".

The recipients were Mr Murtada Sesay, technical officer (pharmaceuticals) at Unicef and immediate past president of the Commonwealth Pharmaceutical Association, and Sir Kailash Ramdane, a pharmaceuti-

cals manufacturer in Mauritius. After working for Unicef in his native Sierra Leone, Mr Sesay joined the World Health Organization in Geneva in the essential drugs and medicines programme with responsibility for the "Roll back malaria" project. In 2000, he returned to Unicef in the Bangladesh office and in 2002 was transferred to the Unicef supply division in Denmark, where he is currently based.

Sir Kailash, after qualifying as a pharmacist in 1954, became a community pharmacist in Mauritius. In 1970 he moved into manufacturing, and his company, Mauritius Pharmaceutical Manufacturing, is among the leading companies in the region and has collaborative agreements with major international manufacturers.

The Albert Howells award is named after the founder of the CPA.