

THE ROLE OF PHARMACEUTICALS IN PUBLIC HEALTH

ACCESS TO ESSENTIAL MEDICINES AS A KEY DETERMINANT TO UNIVERSAL HEALTH COVERAGE



September 15, 2016

9 a.m.–5:30 p.m.

#BUSPH40 #BUSPHSymposia



School of Public Health

FOUR DECADES FORWARD

CELEBRATING BU SPH'S 40TH ANNIVERSARY

Markets, Development Assistance, and Access to Medicines: Enabling and Informing Policy

Dean's Symposium
The Role of Pharmaceuticals in Public Health
Boston University School of Public Health
September 15, 2016

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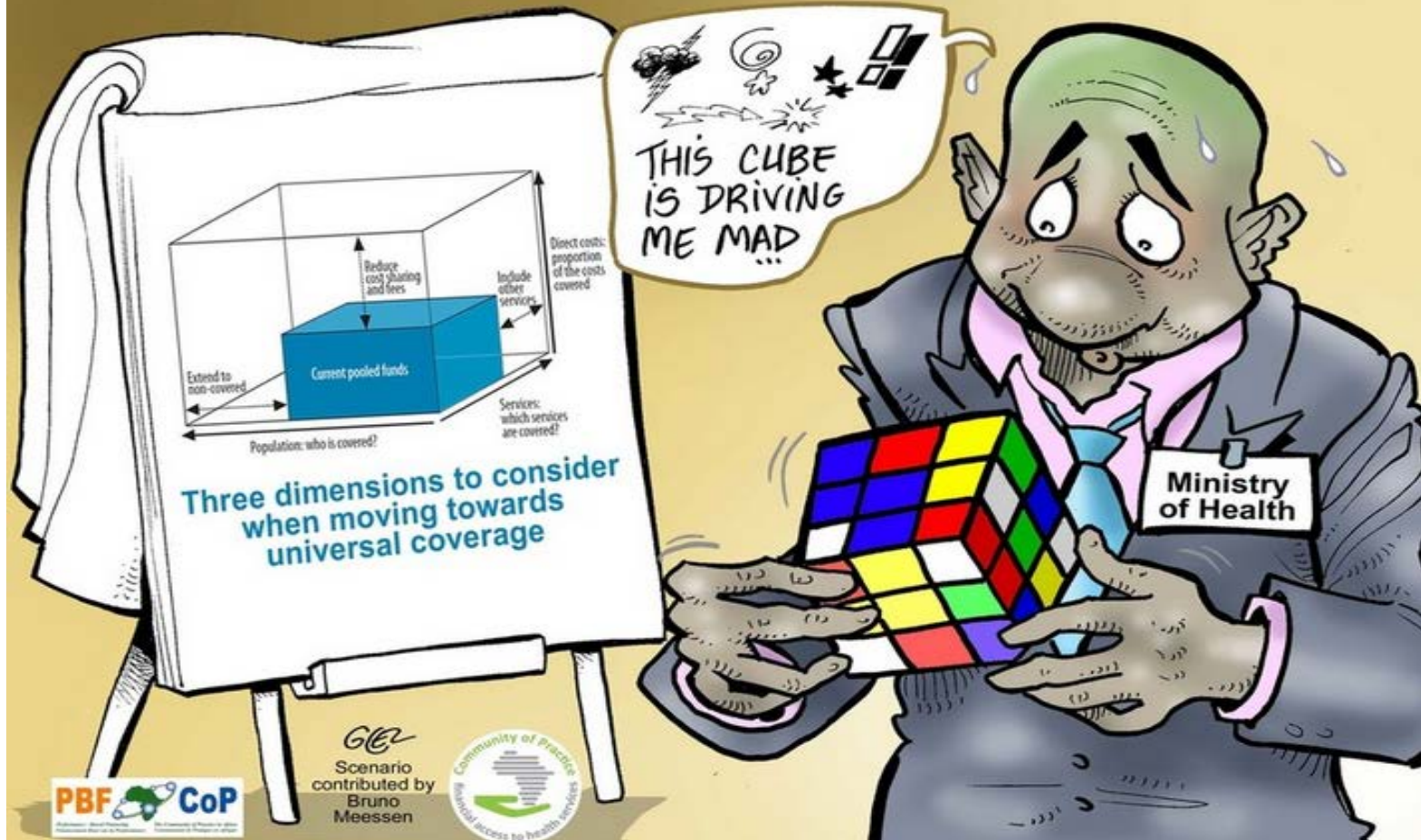
Overview

- Access to essential medicines in LICs and MICs is affected by market failures and government failures
- Illustrative case study of the Affordable Medicines Facility for malaria
- Political economy of decision making around findings from an independent evaluation
- Reflections on lessons learned
- Potential applications of the private-public approach to other pharmaceuticals and health technologies
- Implications for evidence-based decisions in global health and development assistance

Role of the State and the Market in Financing, Service Delivery and Regulation of Health Systems

Universal Health Coverage: Touchstone?

Moving towards Universal Health Coverage... more difficult than expected



Major Market Failures in the Health Sector

- Asymmetry of information between patients and doctors/nurses/midwives/pharmacists
- Adverse selection plagues health insurance
- Barriers to entry, as patent laws → near monopolies in the markets for medical technologies and pharmaceuticals

[Hsiao and Heller, 2017]

“The reason that the invisible hand often seemed invisible was that it wasn’t there...” Joseph Stiglitz <https://www.youtube.com/watch?v=9qjvwQrZmpk>

Ergo, Must Government Do Everything?

- Given market failure, many countries turn to the government to regulate, finance, and provide health services.
- But Government failure is widespread, too.
- So, what is the sensible mix of government and market functions across multiple dimensions of work in pursuit of public health goals?

Calibrating the Balance

When informing policy and practice on a large scale, we should always keep in mind:

- The goal in the context of social narratives
- The question, “compared to what?”
- When in doubt, insist on better equity

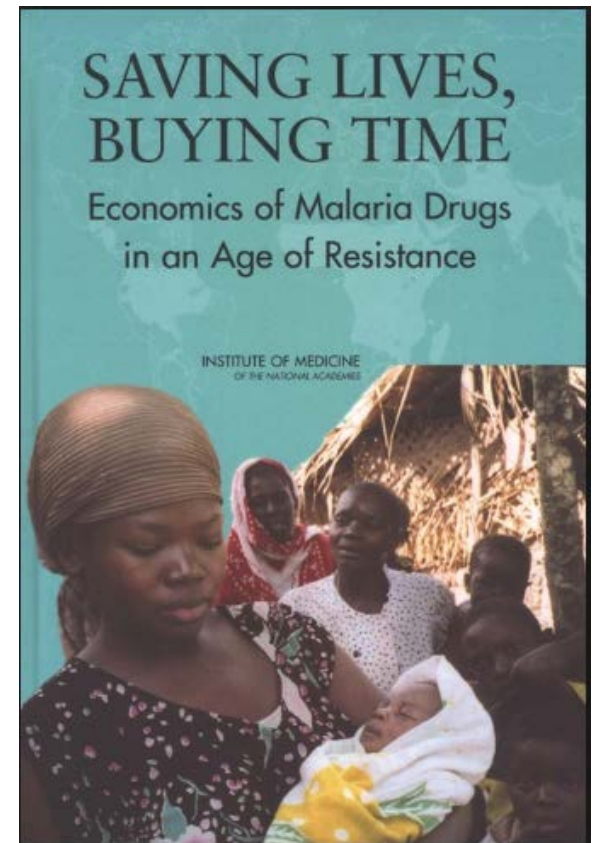
Ideological absolutism and romantic attachments to perfection are not virtues in the practice of public policy

Evidence in Global Health Policy: A Case Study

The Challenge: Finding a Scalable Business Model to Ensure Access to Effective, Affordable Antimalarials

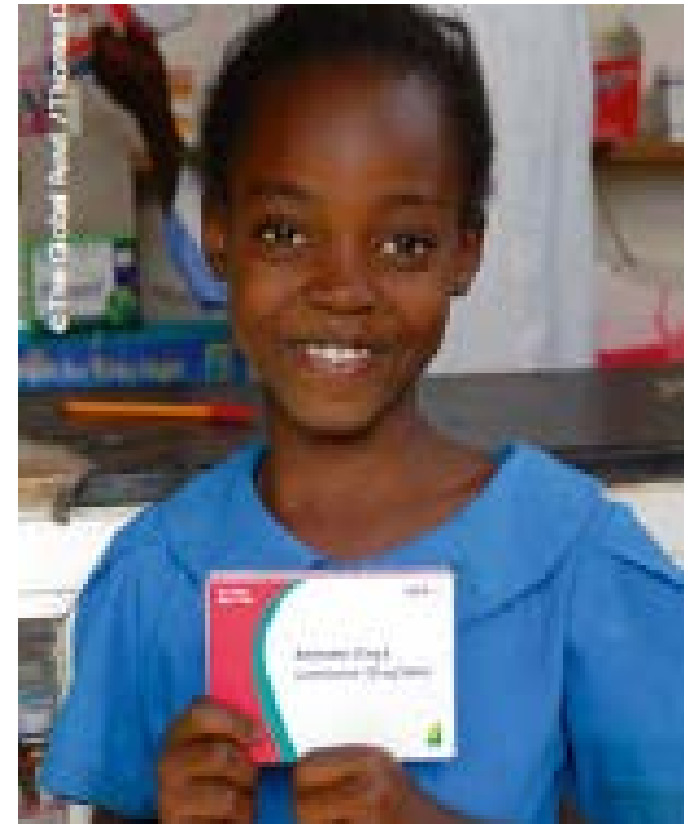
A Conceptual Breakthrough in 2004:

“a sustained global subsidy of [ACTs] in order to reduce malaria mortality (“saving lives”) and delay resistance (“buying time”)” until new categories of antimalarials could be developed.”



Purpose of the Affordable Medicines Facility-malaria (AMFm) Phase 1

- Reduce retail prices of ACTs
- Increase availability of ACTs
- “Crowd out” oral artemisinin monotherapies
- Increase use of ACTs



Risks and Risk Mitigation

- Affordability? Will middlemen capture the subsidy?
- Availability? Will it reach distant/remote locations?
- Product/ price arbitrage?
- Drug resistance?
- Patient safety?
- Buyer purchase behaviors

The Independent Evaluation

FINDINGS

“In all pilots except Niger and Madagascar, there were large increases in QAACT availability (25.8-51.9 percentage points), and market share (15.9-40.3 percentage points), driven mainly by changes in the private for-profit sector. Large falls in median price for QAACTs per adult equivalent dose were seen in the private for-profit sector in six pilots, ranging from US\$1.28 to \$4.82. The market share of oral artemisinin monotherapies decreased in Nigeria and Zanzibar, the two pilots where it was more than 5% at baseline.”

INTERPRETATION

“Subsidies combined with supporting interventions can be effective in rapidly improving availability, price, and market share of QAACTs, particularly in the private for-profit sector. Decisions about the future of AMFm should also consider the effect on use in vulnerable populations, access to malaria diagnostics, and cost-effectiveness.”

Was it successful?

- When judged by pre-established benchmarks (intended to de-politicize a judgement) and the independent evaluation, AMFm succeeded.
- The pre-established benchmarks provided a basis for answering the “compared to what?” question.
- As of November 2012, when the Global Fund decided on the future of the AMFm, there was no other published independent evaluation of similar rigor, on a large scale, of approaches to the improvement of access to malaria medicines.
- The AMFm was “the Fund’s only multicountry experiment, and the evaluation is the Fund’s only deliberate attempt at rigorous, albeit imperfect, evaluation.” [Bump, J. and others. 2012. The Lancet]

Potential applications to other challenges of access

Can similar approaches be used for other health technologies, including diagnostics and treatments for acute respiratory tract infections, diarrheal diseases, and potentially for selected chronic, non-communicable diseases, especially where

- price is a barrier to access, and
- public-sector dominated supply chains are dysfunctional?

Can components of the AMFm approach, specifically price negotiations and factory-gate subsidies, be useful for middle-income countries, regardless of development assistance for health?

“The Affordable Medicines Facility — Malaria: Killing It Slowly”

“In November, 2012, the Board of the Global Fund will vote to either continue AMFm in a modified form after December, 2013, or terminate the programme. There is a strong push from donors (though not from countries) to integrate AMFm into the regular Global Fund model, whereby countries would choose how much of their country budget envelopes, which are already committed to other priorities supporting the public sector, to reallocate to AMFm. We believe that this approach will create instability in artemisinin demand, lower the number of ACT manufacturers, increase ACT prices, and abandon the millions who depend on AMFm-subsidized ACTs. Most importantly, it will kill a programme that, when fully implemented, rapidly met its benchmarks despite the many constraints, expectations, and unrealistic timelines imposed on it. We must acknowledge that an efficient approach to subsidising antimalarial drugs has worked, making them available in the private sector where people go to buy them.”

*Kenneth J. Arrow, Patricia M Danzon, Hellen Gelband, Dean Jamison, *Ramanan Laxminarayan, Anne Mills, Germano Mwabu, Claire Panosian, Richard Peto, Nicholas J White. The Lancet. www.thelancet.com Vol 380 December 1, 2012*

How well does Global Public Health handle evidence?

Oscar Wilde: Life imitates Art far more than Art imitates Life

https://www.youtube.com/watch?v=UXoNE14U_zM

- “The [Global Fund] Board decides to modify the existing AMFm business line by integrating the lessons learned from the operations and resourcing of Phase 1 of the AMFm into Global Fund grant management and financial processes by...” <http://www.theglobalfund.org/Knowledge/Decisions/GF/B28/DP06/>
- "This raises an awful lot of worries. I'm concerned that its decision is more determined by politics and ideology than a focus on how to deal with kids and adults with fevers in poor countries." Barry Bloom, Harvard School of Public Health, 2012. <http://www.npr.org/sections/health-shots/2012/11/15/165231445/global-fund-moves-to-discontinue-project-subsidizing-malaria-drugs>
- “.... in what world does it make sense to abandon a simple program that saves lives?” Kenneth Arrow. Stanford University. 2012.
http://www.nytimes.com/2012/11/14/opinion/saving-a-malaria-program-that-saves-lives.html?_r=0

For Reflection

What do these reflections mean for global public health policy and practice?

- For teaching
- For research?
- For policy makers?
- For durable partnerships that disproportionately benefit the poor?
- For development assistance for health?

Thank You

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