Guest Editorial

Access to medicines: Complex entities and behaviors seem unavoidable

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In most markets, a bargain or deal is arrived at when the seller agrees to part with his goods for an amount of money offered by the buyer. This describes the market for houses, foods, appliances, clothing, electronics and nearly everything else. Pharmaceuticals do not fit into that category. For one thing, the buyer (or patient) did not select the product, but instead, used a purchasing agent – the prescribing physician. Next, the buyer does not know the price of alternative options and does not have information about relative effectiveness. This makes the market for medicines somewhat unique.

If that were not stress provoking enough, the buyer is likely to learn that the medication is not a cure, but rather is means to control symptoms and that the patient is expected to take the drug daily for the rest of his/her life. And if that were not enough of a shock, the cost to the patient is likely to be a significant portion of the family income in developing countries. The physician neglected to mention that the new, reluctant purchase might cause gastritis, sexual dysfunction, a rash, fevers, headaches, or hundreds of other adverse events. This is a rather unfortunate but realistic view of a prescription drug purchase.

What can we expect to result from this situation? It is logical that the patient will seek a cheaper source of the product, driving him to the bazaar where there is a great possibility that a counterfeit or substandard product will be offered or even worse yet, a totally different product that may be expired, spoiled or present in the market in excess quantity.

However, the side effects are another story. If they are severe enough, the patient will determine that a total lack of compliance eliminates both the financial and adverse event problems.

Another scenario is one where the patient at a clinic receives a written prescription after waiting five hours to see the physician and then is told that another four hours wait is required to obtain the medication, if it is in stock.

Neither scenario is an encouraging one. In fact, if one wanted to design a system to discourage pharmaceutical therapy, either or both of these scenarios would be ideal strategies, and yet this is exactly the scene faced by millions of patients everyday.

If the patient waits for the medication, and it is in stock, we have to hope that it is not counterfeit, substandard, adulterated, expired or ineffective because of abusive storage conditions.

In many countries, physicians are scarce and patients seek care from local healers, village elders, religious leaders, and shamens. If these sources of care prove to be unhelpful multiple times, the ill will deal with medical problems with home remedies and treatments used in that tribe for many generations.

A possible solution for some of this is for us to adopt a new paradigm in seeing that patients get the best drugs possible. We need to join forces with government ministries, professional societies, pharmaceutical manufacturers and representatives from the distribution sector to see that several “As” are achieved.

The patient gets the appropriate medication only when there is a concordance of several endeavors. To achieve success, we need to have:

- Availability
- Affordability
- Access

The drug has to be available at the dispensing site; not out of stock, back ordered or expired. The drug has to be affordable by the intended patient. Access and availability are meaningless if the patient does not have the financial resources to enable attaining possession of the product. And there must be access. The patient who can’t cross the river to the clinic site, or who doesn’t have the strength to travel five hours will not try to get there, even if the drug is in stock and he can afford it.

So our mission in patient care as health professionals requires us to use a bigger picture of our variety of obligations to incorporate concern about access, affordability and availability.

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