

National Technical Forum on
Need of Free Medicines and
Diagnostics to All

02nd - 03rd March 2016

Institute for Studies in
Industrial Development (ISID)

New Delhi, India



ISID



March, 2016

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A. Backdrop

Access to essential and life saving medicines free of cost to all patients is an urgent necessity in India given that a large section of people are denied medical care because of their financial inability to procure medicines from the market. The provision of free medicines is also necessary for promotion of rational prescribing and adherence to standard treatment procedures.

It was the state of Tamilnadu that introduced a scheme in 1995 to provide all commonly prescribed medicines to all patients seeking care in all government facilities free of cost. Sixteen years later in the year 2011, Rajasthan became the second state that launched a similar but more expanded scheme of free medicines and diagnostics. This initiative of the state of Rajasthan otherwise considered a not so well performing state has received considerable attention, both within the country and internationally.

Around the time Rajasthan rolled out the scheme, the working group on drugs constituted by the Planning Commission in May 2011 to input into the 12th five year plan (2012-2017) recommended for a national program of free medicines and diagnostics. This recommendation was echoed by the High Level Expert Group (HLEG) on Universal Health Coverage (UHC) constituted by the Planning Commission of India as well. Recognizing the importance and exigency of the issue, the then Prime Minister of India in his Independence Day speech on 15th August 2012 announced that a national scheme for free medicines and diagnostics would be launched soon. But, it could not be implemented for lack of preparedness in the states. However, once again the Finance Minister of India in his budget speech of 2014-15 made an announcement regarding a scheme of free medicines and diagnostics but did not make any earmarked allocation for it. Therefore, till date, there is no national scheme to provide medicines and diagnostics free to patients. However, stimulated by the successful initiative of Rajasthan, some state governments began to actively work towards launching new schemes and some began to redesign their existing schemes. There remains, however, considerable asymmetry and ambiguity in the manner of implementation of free-medicines and diagnostic schemes in the handful of states that have launched it in some forms.

The implementation of a scheme guaranteeing provision of free medicines and diagnostics requires a properly designed plan. This includes adoption of inventory of medicines to be provided free to patients called the Essential Drugs List (EDL), transparent and appropriate system of procurement of medicines with rigorous quality check, robust supply chain management to ensure last mile availability and finally distribution to patients with proper counselling. Patients education is very important because of the prevailing belief among the lay public that medicines supplied free in government facilities are sub-standard and not effective.

There are very few states who have declared a scheme of free medicines to all. Other states do provide medicines free to patients but since patients do not have any knowledge about the kind of medicines and where from to get them, the discretion of distribution is with providers. A cursory analysis shows that there are wide variations in the systems adopted by different states to supply free medicines and diagnostics to patients. Such differences are seen in the number of medicines in the state EDL, type of hospitals covered and the agencies created for procurement, supply, system adopted for last mile availability and finally distribution to patients. For example, Rajasthan has about 591 medicines in its list, while Tamilnadu has around 306 and Madhya Pradesh (MP) about 300 or so. Hospitals attached



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to medical colleges are included in Tamilnadu and Rajasthan for free distribution but excluded in MP, Odisha and Bihar. Procurement agencies in Tamilnadu, Rajasthan, Kerala, Bihar, MP and Odisha are autonomous corporations, while it is a logistics society in Karnataka, a programme management unit in Uttarakhand and a central procurement agency in Delhi. Systems adopted for quality check are also different in various states. Rajasthan, Tamilnadu, MP and few states have designated drug distribution centres in every health facility. In most states patients are not aware of their entitlements, about avenues to receive or demand for free medicines and diagnostics.

Although, there is no national scheme, it is pertinent to note that the central government is incentivising state governments through the National Health Mission to launch schemes of free medicines and diagnostics. It has also published guidelines for states to adopt and follow. However, a majority of the states are yet to respond.

Looking beyond free provision in government facilities, it needs to be kept in mind that about 60% of patients requiring hospitalisation and 80% of outpatients receive care from private medical facilities*. Cost of treatment is vastly different between public and private hospitals. While mean per hospitalisation cost borne out of pocket in public hospital is Rs. 6,120.00, it increases to Rs. 25,850/- in private hospitals, out of which about 65% is on medicines. But, currently there is no programme or scheme to meet the need of medicines of patients seeking care in private medical facilities except the Jan Aushadhi programme of the Department of Pharmaceuticals of the Govt. of India. Under the Jan Aushadhi scheme, shops have been established to sell generic (international non-proprietary name) medicines at cheaper rates than are sold in market. However, the scheme does not meet the objective because Jan Aushadhi shops are very few in number and largely unused as doctors do not prescribe medicines in generic names. It is therefore time to consider the possibility of bringing the private health sector into the ambit of free medicines and diagnostics schemes if out of pocket spending has to decrease.

To further evolve and concretise the perspective of free medicines and diagnostics to all patients, a technical forum was organised on 2nd and 3rd March 2016 by Prayas, Institute for Studies in Industrial Development (ISID) and Jan Swasthya Abhiyan(JSA) at ISID in New Delhi.

The objectives of the forum were to:

- Bring together policy planners of central and state governments, researchers, health activists, clinicians, representatives of pharmaceutical companies and medical associations to deliberate on proportions, rationale and operational systems for free medicines and diagnostics to all.
- Review and analyse the current status of schemes of free provision of medicines and diagnostics across different states of India
- Examine the linkages, through case studies, between free medicines and diagnostics and rational prescribing and adherence to standard treatment guidelines
- Discuss the role of private health sector in ensuring free medicines and diagnostics to all.
- Formulate an evidence based action plan to promote free medicines and diagnostics to all citizens of India

(*Key Indicators of Social Consumption in India Health; NSS 71st Round Jan-June 2014)

B. Session Details

Day 1

Inaugural Session

Ms. Chhaya Pachauli, Prayas



Ms. Chhaya Pachauli welcomed participants on behalf of the organizing team and then provided a brief overview of the second edition of the technical forum on universal access to free medicines and diagnostics to all. She mentioned that there is no reiteration required that the issue is very important and participation of senior and experienced representatives of the Govt. of India, state governments, research institutes, academia, media, civil society organizations, health campaigns and movements would guide into formulation of new pathways for universal access to medical care. She then invited the guests of the inaugural session to take over.

Prof. M.R. Murthy, Director, ISID

Prof. M. R Murthy expressed his gratitude towards all the participants for taking time out to join for deliberating on the subject of access to free medicines and diagnostics. He discussed about how access to free medicines was a very vital issue which needed wide attention. He also extended his thanks to Prayas and JSA for holding the in ISID forum which could bring the crucial issue to the forefront. He said that it was a great chance and platform to find the bottlenecks and hurdles on the way of access to free medicines scheme, since participants from various backgrounds were present under one roof for the two days



forum. He hoped that the forum would prove to be an excellent platform for the civil societies and the government to bond together and work hand in hand by making free medicines available to everyone and making Universal Coverage to Health a success.

Dr. Narendra Gupta, Prayas

Dr. Narendra Gupta welcomed the participants and extended his thanks to everyone who were present in the forum representing different fields, departments and states. He started his address by elaborating objectives of the forum. He mentioned about the first national forum which was held on 21- 22 January 2015 and how this forum was in follow-up to the same. He gave brief background of the access to free medicines campaign and informed that after Tamil Nadu and Rajasthan many more states had shown very keen interest in the scheme and had launched similar models in their respective states. Dr. Narendra Gupta said that it was quite shocking to know through the World Medicines Situation Report of World Health Organisation (WHO) which was released in 2012 that about 65% citizens of India did not have access to essential medicines despite the fact that India was the third largest producer of medicines. He added that medicines and diagnostics constituted a major portion of out of pocket expenditure (OoPE) which was 70% of the OoPE. He stated that the main reason for this was pharma companies which priced the medicines according to their choices and made desired profit. He talked about India's public health system and said that it was developed in a well planned manner based on various parameters, one of the main being population. However, there was a huge private system which grew in an unplanned manner just based on the profit motive and market based demand he pointed out.



Dr. Gupta then went ahead explaining the irony that despite having a well planned public health system how it was only one third of the population which accessed health care from public health system while the remaining two third of the population was dependent on the unplanned private health system set up with the motive of making profit. He compared the two systems and elaborated that according to a recent study the expenditure of the individual when admitted in a public health care system was around Rs 6000 whereas the same individual spent somewhere around Rs 24000 when admitted to a private health unit. He thus explained the present scenario and said that it was high time to take crucial steps to reduce OoPE in treatment in the country. He informed that as an initiative to reduce out of pocket expenditure on health care, government of India was soon to inaugurate 3000 new Jan Aushadhi Stores. He mentioned very clearly that alone public health system would not be able to provide an environment for free medicines and diagnostics, and it could be possible only with the help of private health system and trust hospitals shaking hands together with the government. Dr. Narendra Gupta concluded his address with the hope that the forum at the end of two days would be able to come up with new recommendations which could make universal access to free medicines and diagnostics a reality all over the country.

Dr. Amit Sengupta, JSA

Dr. Amit Sengupta provided a brief background to the forum by talking about the importance of the subject which the forum was going to discuss and as to why the issue needed so much of attention in the prevailing situation. He talked about universal access to free medicines and diagnostics by putting up an important fact that it was quite illogical to put so much stress on the issue of making the government provide free medicines to everyone, as this should have been a very obvious facility from the side of the government. He said that often when he discussed about the issue with his colleagues in international platforms, many times they were unable to understand the need for this pressure as they felt that it should not be an issue to convince the government for, as providing free medicines and other health related facilities to the public without cost was something which had been seen as obligatory for the governments all over the world. He added that it was more unfortunate on the part of India to fight for achieving an atmosphere of availability of free medicines because India had a well developed pharmaceuticals manufacturing sector which stood as third largest in the world in terms of the volume. He reflected his disappointment and said that despite having one of the most developed manufacturing sectors in pharmaceuticals the situation were not in a good shape because the country had one of the worst public health care systems in the world. He said that India despite having ability and resources, technologies and transport system to manufacture medicines has been unable to provide medicines to its own people when required. He pointed out that the same nation had been manufacturing and exporting medicines to enormous number of countries but failed to fulfill the requirement of its own population.



He further highlighted prevailing scenario and said that the domestic demand of medicines had not increased but manufacturing of medicines to meet the demand to export had increased over time. 70% of the money spent by an individual to meet the health expenses was out of pocket in India and then out of this 70% was spent on medicines alone he pointed out. He emphasized on the fact that the target of the pharmaceutical manufacturing industries was not to manufacture medicines for the domestic market but to fulfill the demand for medicines to be exported to other countries. Dr. Amit Sengupta expressed his disappointment and said that the saddest part was that India had become a trading hub in the place of a manufacturing hub; it was becoming more and more dependent on exports, reason being a poor public system which sat on the top and failed to deliver proper policies to monitor its own schemes. He said that the country has a health system which had been unwilling, unable and incapable to set the parameter of what

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was rational and what was to be prescribed. He added that after analyzing all the facts related to the condition of health, it was clear that the health issue needed much more attention and amendments in order to make it better. He informed that the country records for the most number of medicines in the market which should not have been in the flow ever. He pointed out that 90% of the combination drugs in the market are those combinations which should not have been allowed at all. He concluded his address by stating that while there were many more issues related to health which needed attention but one of the primary issues which should be given priority was to provide and build an atmosphere where essential medicines are accessible to all.

Keynote Address

Mr. Sudhansh Pant, Joint Secretary (Policy), Department of Pharmaceuticals, Ministry of Fertilisers and Chemicals, Govt. of India.

Mr. Sudhansh Pant began his address by recalling his days when the free medicines scheme was passed in Rajasthan in the year 2011. He happened to be a part of it though not directly he informed. He said that the Rajasthan government took the free medicines campaign very seriously and picked the best officials to make the scheme a success which was appreciated not just by the state but also by the Government of India. Many other states further replicated the model where he emphasized on the fact that political will of the state played a vital role in the launch of such a scheme in any state. Despite being a welfare scheme, the model cannot function properly if the



government lacked interest in the same he pointed out. In the context of free medicines scheme, he said that it was not just the launching of the scheme but the monitoring part that further leads to the success of the model. Mr. Sudhansh Pant highlighted the problem related to the funds and budget allotted for the free medicines scheme by the governments. He said that often the funds were not enough to meet the needs of the population of the state which ultimately becomes a huge hindrance in the execution of the scheme. Throwing light on the importance of free medicines scheme, he said that there was a need to understand that the country heavily depended on public health facilities and still people were ending up spending a huge amount out of pocket on medicines and diagnostics.

Talking about the Jan Aushadhi initiative, he pointed out the fact that even though it was a great effort by the government, yet the number of these stores was still not enough to meet the needs of the whole population of the country. Mr. Sudhansh Pant gave a rough figure and explained that there were around 250 Jan Aushadhi outlets which

was like a drop in the ocean. However, he informed that the government of India had made a recent announcement of scaling up the stores to 3000. He explained that how in order to execute these many numbers of outlets successfully it would be required to have proper implementation, better procurement system, smoother flow of medicines, ware housing, etc. He added that the older stores were not doing well because availability of medicines at the stores was poor and this gap needed to be rectified. He also explained how the profit earned by the retail stores while selling a generic medicine was much less than the profit the same stores earned while selling a branded medicine. It was one of the main reasons why the availability of generic medicines was always shorter in comparison to the branded medicines despite its production he elaborated. He appreciated the big announcement by the government to open 3000 new Jan Aushadhi Stores and hoped that it would be a great success in the future which would further promote opening of many more outlets nationwide.

Mr. Sudhansh Pant further talked about the role of the doctors in access to medicines. He focused on the point that until and unless doctors started prescribing generic medicines all the initiatives by the government to promote generic medicines shall not be fruitful. A pharmacist never had the power to substitute the branded medicines with the generic medicines consisting of the same composition; hence it must be made strict for the doctors to prescribe only generic medicines he emphasized. He stressed on the need of a nationwide movement for this to create pressure on the doctors to prescribe by generic names. He said that even though the central and the state government had tried their level best to make generic prescribing mandatory by various orders, pressure and even punishment, the result of all those steps were temporary and they lasted only for a short time. He said that if a permanent solution was to be brought about there was a need for a wider movement together by the civil society and the government, only then generic prescriptions would be ensured by the doctors. He recommended an environment where the civil societies and the government could work hand in hand in order to shape a much healthier India.

Mr. Sudhansh Pant then shifted his address to the issue of trade margins. He informed about the recent revolutionary recommendations by a committee which was set up to look after the pricing of medicines which also included some members from the civil society. Talking about the recommendations he informed that very soon non- scheduled drugs which until then were not under direct price control mechanism and had no limits of profit margin would be brought under restriction and hence the profit margin would be decided based on the value of the medicine. Until then the freedom to decide the maximum retail price (MRP) of the medicine was with the manufacturer, but if the above mentioned recommendations would be implemented it would lead to revolutionary changes in the price of medicines he said. He hoped for a fast and successful implementation of these recommendations. He also talked about the pricing of the patented medicines and informed that even though the sale of patented medicines in the country was just around 2% - 3%, yet it was one of the major issues. A committee formed some time back was about to come up with a report on the pricing of patented medicine which would be very helpful he said.

Mr. Pant further went ahead to discuss the ethical marketing code of medicines. He said a statutory code was documented which was being reformed by the government and would be soon brought under practice. He told that Medical Council of India (MCI) code and the new statutory code were both to be taken care of, as, if both contradict each other the new statutory code would remain of no value. He later concluded his address by saying that all the above-mentioned efforts were taken under consideration in order to establish an environment which succeeds in providing free medicines and diagnostics along with universal health care.

Session 1 : Free medicines and diagnostics to all - Current status in different states of India

Objective : Provide an overview of the access to medicines provision/schemes in different states

Prof. Dinesh Abrol, ISID



Prof. Dinesh Abrol chaired the first panel discussion where an overview of the access to medicines schemes in different states was discussed. Various states made it to the forum and shared experiences of their respective states. He welcomed the panelists and invited them to talk in detail about the schemes in different states.

Panelists

Dr. Pawan Kumar, Govt. of Delhi

Dr. Pawan Kumar talked about the various initiatives taken by the new government in Delhi to make health care services available and accessible to all. The very first thing which he talked about was the new concept launched in the state called 'Mohalla Clinics'. He said that Mohalla Clinic was the first level in Delhi government's three-tiered public health care structure. These clinics were introduced for primary health care services like basic consultation and medicines he informed. The second tier consisted of polyclinics offering specialist care and a wide spectrum of diagnostic services including X- ray and ultrasound. He said there was a strong will of the government to link the entire three tier in the state for



providing better health facilities. He also talked about the strong political will to launch free medicines scheme in Delhi which had started since 1st February 2016. Essential Drug List (EDL) had been prepared with long list of medicines for different facilities he updated. Central Procurement Agency (CPA) was also established for efficient procurement and supply of medicines he added. He informed that earlier despite having an EDL and assurance to provide free medicines in the state, patients were seen buying medicines from outside the system. After studying the problem it was observed that the main reason for the patients to buy medicines from outside the system was due to prescription of branded medicines by the doctors instead of generic medicines. He said that various efforts were made by the government to rectify the issue through two way communication with doctors and all other stake holders responsible for these irrational prescribing. He further talked about the application (Android mobile app) developed by Delhi government to make people aware about different free essential drugs and other health facilities related information. He informed that patients could file complaint or upload the pictures against the prescription written by doctors in branded names. He stated that CPA was soon to be converted into Delhi Health Corporation which would ensure that all the essential drug were supplied free of cost to every patient visiting public health facilities.

Dr. Pawan Kumar shifted his presentation to free diagnostics in Delhi. He informed that prior to 1st February some kind of user charges were taken from the patients for diagnostic services but from 1st February 2016 onwards all the charges had been waived off so that the services were affordable for every individual. He said that various private partners were already being approached to establish a public private partnership (PPP) model to provide better health facilities. Dr. Pawan Kumar moved towards the closure of his presentation and emphasized on the need for a system like Mohalla Clinic. He said that, in order to get treatment people had to travel and reach hospitals covering long distances adding up to OoPE. Mohalla Clinics would help in resolving this problem since every area or mohalla would have its own clinic for treatment, thus cutting down the expenditure and inconvenience people had to face to reach hospitals far away from them. He compared the rush at the government hospitals with the rush at the railway stations and said that they were almost the same and that an initiative like mohalla clinic would help to reduce the rush in the government hospitals. He emphasized that there was a great need to strengthen primary health facilities.

Dr. Rajesh Bharadia, Govt. of Rajasthan

Dr. Rajesh Bharadia gave insights in to the successful functioning of free medicines scheme in Rajasthan. He started his presentation by discussing various aspects related to the framework of the scheme. He informed that Rajasthan had a separate body looking after the free medicines scheme. He discussed in depth the procurement system in the state which consisted of Rajasthan Medical Services Corporation (RMSC), the agency responsible for centralized drug procurement. He informed that at district level there were district drug warehouses (DDWs) in order to meet drug demands from the districts and to store drugs scientifically. There was direct supply





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of medicines by suppliers to DDWs through RMSC and finally free distribution of medicines to patients was done from Drug Distribution Centres (DDCs) at the hospitals he informed. Providing more details on drug procurement, supply and distribution, Dr. Rajesh Bharadia explained that first of all an annual demand from the facilities was requested online to assess and process requirement for drugs for the whole state. Once the demand was generated, it was sent to district Chief Medical and Health Officers (CMHOs) which was then sent to Directorate of Medical and Health Services (DMHS) in Jaipur for compilation. DMHS Jaipur was responsible for sharing the compiled list with RMSC which then tendered the demand on quarterly or half yearly basis he explained. He stated that once the demand was met, the medicines were supplied to DDW after strict quality checking and from there to the health facilities as per their demand. The supply from DDWs was also released in the case of emergency apart from routine releases. Finally, medicines were issued to the patients as per the prescriptions from the DDCs he informed.

Dr. Bharadia moved ahead with his presentation and shared a few facts about the beneficiaries of the scheme. He said that the scheme was meant for everyone who came to be treated at the government hospitals of Rajasthan. This included the OPD patients, IPD patients, patients of thalassemia and hemophilia, all government officers, employees and pensioners. He pointed out that all the BPL, old age pensioners, widow, handicapped, etc continued to get the benefits of Mukhya Mantri Jeevan Raksha Kosh (MMJRK) even after the initiation of the scheme. He further talked about the DDW and told that there was one DDW established in each district and it supplied medicines to all the health facilities corresponding to its area. There was a strict quarantine and quality check mechanism followed at the DDW and a passbook system which allowed them to keep proper records of medicines supplied to the patients.

Dr. Bharadia then highlighted the key features of the Drug Distribution Center (DDC) and informed that the DDCs had been established based on OPD and IPD load of each institution. More the patient load, more are the number of DDCs at the health facility he said. A total of 15169 DDCs had been established across the state he informed. Each DDC was created with a budget of Rs 2.25 Lakhs. The DDCs have been equipped with all the infrastructure like the refrigerator, stationary, computer with printer etc he said. He then quickly mentioned some of the unique features of the scheme in Rajasthan. He discussed its policy entitlement system that made it universal in nature. He mentioned about the strict orders to the doctors by the government for prescription of only generic medicines. A strict system of prescription audit prevailed in the state which regulated the use of only generic medicines he pointed out. He informed that a unique system of sensitization and orientation of prescribers had been established in the state. He also listed out some other unique features of the scheme such as the constitution of DTCs (Drug and Therapeutic Committee), effective complain and feedback system, SMS based daily monitoring, slow moving and excess supply drug management, inventory management through e- Aushadhi application etc.

Moving towards the end of his presentation Mr. Bharadia talked about the various challenges the state had to face in implementing the scheme. Some of them being, the huge population of the state which led to longer waiting time for patients due to tremendous increase in OPDs and IPDs, the cold chain maintenance was a huge challenge in the state because of the temperature that even reached 51 degree Celsius in summers, high patient load in the tertiary care centers and shortage of doctors and pharmacists. Issue related to drug expiry, stock outs and breakage, deterioration etc were some other problems which Dr. Bharadia discussed. He concluded his presentation by listing some major achievements of Mukhya Mantri Nishulk Dawa Yojana (MNDY). He informed that above 90% of the urban area and 97%

of rural area benefitted from the free availability of quality medicines. About 60% and 20 % increase in the numbers of OPD and IPD patients respectively was recorded in the state after the launch of the scheme he stated.

Dr. Durbha Rohini Kumar, Govt. of Bihar

Dr. Durbha Rohini Kumar represented Bihar government and gave a presentation on the current status of Bihar with respect to the implementation of free medicines and diagnostic services. He started his presentation by mentioning a few issues which had made it difficult for the state to launch free medicines scheme. He pointed out two major issues, firstly, the huge population of the state and secondly, the wide gap between the number of blocks in each district which ranged from 5 to 26. Dr. Durbha Rohini Kumar however said that despite those issues there was serious commitment of the Government of Bihar to provide free health care services to all through public healthcare facilities. He mentioned some of the past initiatives by the government where resolutions were passed to provide free healthcare facility in the state. Some of them are listed below:



- Vide Resolution 383 (12) dated 9/7/2009 for free provisions for radiology and pathology services.
- Vide Resolution 770 (9) dated 8/7/2006 for provision of free medicine services.
- Vide Resolution 409 (12) dated 9/5/2011 government of Bihar had notified the list of free medicines.

Dr. Durbha Rohini Kumar then discussed the challenges which the state was facing while preparing for free medicines scheme. He said that selection of medicines for EDL was one of the toughest challenges. Streaming procurement process was another challenge for the state as it was difficult whether to choose a decentralized or centralized system. The state also faced problems with the selection of vendors which are very few in the state. Dr. Kumar also mentioned that the state had old designed warehouses and thus storage of medicine became another matter of concern. Quality control, distribution to the last mile and making cost effective generic drugs available in non public health sector were some of the other challenges faced by the state which he talked about. Dr. Kumar also discussed the initiatives taken by the government of Bihar so far. He talked about an Essential Medicines List (EML) that was formulated for two levels - the first was for medical colleges and the other for district hospitals up to PHCs. The government had also established BMSICL (Bihar Medical Services and Infrastructure Corporation Limited) which is in the lines of RMSC and Tamil Nadu Medical Services Corporation (TNMSC), thus there was a centralized procurement system in Bihar. He also talked about the e- procurement system where the whole system was to be made online through collaboration with Bihar Electronic. The government released a fund of Rs 168 lakhs for the launch of e-Aushadhi in the state after seeing it as a big success in the state of Rajasthan he informed. Three regional drug warehouses and various new district drug warehouses had been established by the government he mentioned. He also

informed about the initiative by the government in opening various new generic drug shops and the new five National Accreditation Board for Testing and Calibration Laboratories (NABL) accredited labs for quality check.

Dr. Kumar then moved ahead with his presentation and discussed the state policy for diagnostic services. He said that the Government of Bihar had adopted for PPP mode at government hospitals for delivering diagnostic services. Dr. Kumar also discussed about various problems and challenges which the state of Bihar was facing in delivering diagnostic services. He said that outsourcing as well as in house resourcing both had its own challenges. Talking about the challenges in outsourcing, he said that the first challenge was to attract sufficient number of agencies to deliver the services since there were very few in the state which made it difficult for the government to make it cost effective. Financial viability for agencies was another problem. Dr. Kumar said that monitoring of not just the mechanism but also the payment was a huge hurdle. Talking about the problems in in-sourcing Dr. Kumar discussed about the lack of human resource (HR), skill and infrastructure.

Dr. Kumar then talked about various initiatives by the Government of Bihar to strengthen health care services. He listed initiatives such as government planning to train MBBS doctors for Ultra Sonography (USG) services and training of lab technicians (LTs) for providing basic pathological services. He also informed about the supply of auto analyzers to health facilities. 149 First Referral Units (FRUs) were supplied with 2-auto analyzers, 496 PHCs with one semi auto analyzer, 443 with X-ray machines and 182 public healthcare facilities were equipped for ultrasound. He also mentioned about the proposal for nine ultra modern diagnostics centers and six medical colleges. He concluded his presentation with the hope that very soon Bihar would come up with a successful free medicines and diagnostics scheme.

Dr. B.K. Swain, Govt. of Odisha

Dr. B K Swain informed about the free medicine scheme in Odisha. Giving a brief background, he started by discussing some key features of the scheme and said that Odisha State Medical Corporation (OSMC) had been established to facilitate implementation of the scheme. It was a public limited company that was incorporated under the companies act 1956 by the Government of Odisha. It was notified on 26/06/2013 and was incorporated on 8/11/2013. The initial authorized capital allotted for it was 10 Crores, which was paid wholly by the government of Odisha itself he informed. He highlighted that improving access to essential medicines in the state was the most important objective of the scheme. Other objectives were reduction of financial burden due to cost of treatment, reduction in morbidity and mortality rate, improving overall health status of public, and to provide free of cost along with quality cure for all diseases for patient coming to government health facilities.



Dr. B K Swain moved ahead with his presentation and talked about the key functions of the corporation. Timely procurement of quality medicines, surgical items and equipments centrally adhering to a fair, transparent, competitive tendering process was one of the most important functions highlighted by him. One of the other functions which Dr. Swain discussed included managing central drug warehouse to ensure smooth flow of supply to health facilities through a centralized online Inventory Management System. He also talked about how the function of the corporation was also to monitor functioning of Drug Distribution Counters set up across health facilities and track prescription practices and disease patterns. Dr. Swain then talked about various functional divisions within the corporation which included the HR and administration, finance, procurement, quality assurance, logistics and supply chain, information and technology (IT) cell and equipment maintenance.

Dr. Swain then drew attention towards the chronology of events to the launch of free medicine distribution scheme in the state of Odisha. He informed about the sensitization workshop for manufacturers and suppliers which was organized on 5th January 2015 followed by first e- tender floated on 12 January 2015 which was also the first e- tender under the Health and Family Welfare Department. The OSMCL building in the state was inaugurated by honorable Chief Minister of the state on 28th April 2015. The free medicines scheme was named as NIRAMAYA and was launched by the Chief Minister on 25th April 2015. Dr. Swain further informed about the various key features of the scheme and discussed the overall progress of the scheme. He added that all the districts, Medical College Hospitals (MCH) and major health institutes had a drug warehouse of 5000 sq feet each. There were 37 such warehouses in the state. All Sub District Hospitals (SDH) and Community Health Centres (CHCs) had warehouses of 1000 - 3000 sq feet each. There had been installation of heavy duty racking in order to strengthen the drug warehouses.

He further gave details about the essential drug list which was prepared based on the category of institutions. The medicines to be provided free under the scheme included 570 items as in the state EDL and 122 non-EDL items (anti cancer and other drugs). There were 297 items in the drug list of primary healthcare institutions, 487 in the list of secondary healthcare institutions and 570 in the list of tertiary health care institutions. Moving ahead with his presentation Dr. Swain discussed about quality assurance mechanisms and said that the drugs received from the suppliers were kept in quarantine, which were further sent to eleven empanelled NABL labs after random selection from each batch. The drugs were finally released for consumption based on the test reports. Informing about the logistics management he said that the OSMC had 50 GPS enabled branded vehicles for different districts in order to deliver drugs up to the PHC level and to prevent stock outs and damage of drugs. He also informed that there were 50 vehicles with 107 material handlers in order to cover 377 CHCs once in every month. Dr. B.K. Swain also mentioned about the e- Aushadhi software which was being run in the state through a dedicated IT cell.

Dr. B K swain presented some data about number of patients who had benefited from the scheme from May 2015 to January 2016. The numbers were 4,414,186 patients in DHH, medical college and tertiary hospitals, and 908,861 in SDHs, thus making it a total of 5,323,047 patients. Towards the end of the presentation he listed a few plans which were in the pipeline, such as having fully computerized CHCs, functioning of DDCs at PHCs and assured free diagnostic services at various level of institutions.

Dr. Dileep Kumar, Govt. of Kerala

Dr. Dileep Kumar explained the structure and functioning of the free medicine scheme in Kerala through his presentation. He informed about the system and said that the state had a corporation Kerala Medical Services Corporation Limited (KMSCL) which was fully government owned company established in 2007, registered under companies act 1956 functioning with effect from 1st April 2008. It came under the Department of Health and Family Welfare, Government of Kerala. Moving towards the objectives of the scheme, Dr. Dileep Kumar said that the system was meant to provide an environment for uninterrupted supply of medicines in sufficient quantity to public health facilities utilizing modern supply chain tools. Further adding up to the information about the scheme he said that the scheme was a state sponsored scheme with an allocation of rupees 320 Crore budget per year. There were 585 items in the state EDL covering all the items in the NLEM with 428 drugs including 69 anti cancer drugs and 157 consumables. There were 1400 health facilities ranging from medical colleges to PHCs which were covered under the scheme.



Dr. Dileep Kumar then discussed the drug procurement and distribution system. He stated that the drug purchasing power of the state was over rupees 300 Crores through grant in aid from Government of Kerala. He said that procurement was only through e- tender process. There had been strict regulations regarding three year market standing, Good Manufacturing Practices (GMP) and turn over criteria for ensuring good quality products in the time frame. Dr. Dileep further talked about the quality control mechanism and said that a great amount of emphasis was being laid on assuring quality of drugs. Over 10000 samples were handed over every year to be checked on a random basis. Over Rs 2 Crores were spent on quality assurance by the state in order to minimize the procurement risk from illegal entities and spurious labels. A suit of eight NABL - accredited empanelled labs had been setup in the state Dr. Dileep informed. All the batches were supported by test or analysis reports furnished by independent NABL. He informed that till then 40 products and one company was blacklisted due to poor quality. Dr. Dileep said that blacklisting was strictly followed by the state in order to ensure strict quality control. He then discussed about FEFO (First- Expiry- First- Out), a system for inventory management that prioritizes the handling and moving of data sensitive inventory. Regardless of the date of the entry acquisition, inventory with the earliest expiration date was handled first. KMSCL only accepted the drugs having a shelf life of 80% he informed. He also talked about the IT enabled inventory management system, which helped in supply chain management, elimination of stock getting obsolete, transferring of slow moving and non-moving items and for enabling centralized monitoring of inventory in

all institutions. Dr. Dileep mentioned about some more initiatives by the KMSCL in order to provide smooth functioning of the scheme that included vendor management system and grievance redressal mechanism.

Dr. Dileep also mentioned some of the challenges that Kerala was facing with the scheme. Difficulties in the implementation of generic prescription practice among doctors, absence of standard treatment guidelines in line with the EDL, lack of strict regulatory mechanism to prevent irrational combination drugs in the market, and high pricing of life saving drugs were some of the challenges that he talked about. Dr. Dileep then provided brief information about various other schemes launched by the government of Kerala for increasing access to health care. He mentioned about the free diagnostics services that were free to all children under the age of 18 for 30 health conditions under Rashtriya Bal Suraksha Karyakram (RBSK). All the health issues for patients under the age of 18 were taken care of by “Arogyakiranam”, a state sponsored scheme. Apart from that under “Thalolam” scheme, Cancer Suraksha and Rashtriya Swasthya Bima Yojana (RSBY) also children were eligible for free diagnostics and treatment. All BPL and SC - ST patients were also entitled free diagnostics in all health facilities. He also informed about the Karunya Benevolent scheme where the revenue earned out of lottery was being used for free treatment and diagnosis of cancer and cardiac illness. Sampoorana Arogyakeralam was an umbrella under which the entire schemes converged in order to provide free diagnostics and treatment he informed.

Session 2 : Positioning access to free medicines and diagnostics as a priority national agenda

Objective : To set the context within which free and universal access to essential medicines and diagnostics should be prioritized and provisioned by the central govt.

Dr. Chirstiane Fischer, MEZIS

Dr. Christiane Fischer chaired the session and initiated the discussion by talking about how access to free medicines was no longer a problem only in the poor countries but a problem worldwide. She gave example as to how the cost of treatment for various diseases in Germany too was excessively high due to the cost of medicines, thus leading to out of pocket expenditure. She added that many times the medicines prescribed by the doctors in Germany when analyzed under the medical guidelines by the medical associates were found to fall in the guidelines that were irrational. She emphasized on the fact that the pharmaceutical industry convinced the doctors to replace the old effective low costing drugs by the new expensive drugs. In most cases, these increased the cost of treatment by a huge amount leading to profit for the doctor and the pharmaceutical industries. She



highlighted the fact that the problem was not just the increased cost for the patient but also the additional risks due to limited experience with new drugs, since the side effects of these newly launched drugs were not very well known in the long run.

Dr. Christiane Fischer then talked about MEZIS, which was started in 2007 with the aim to fight against the influence of the pharma industries on the doctors. MEZIS derived a “no free lunch” campaign that promoted not accepting any bribe by a doctor from the medicine company in order to change their prescription trend. She said that ‘no free lunch’ did not mean no to socializing as the name suggests, but was a campaign to say no to any gifts, trips, bribe, lunch or any other greed extended by the pharma companies to the doctors to prescribe their medicines in place of the old effective low costing medicines. She urged everyone in the forum to get attached to the ‘no free lunch’ campaign by filling up a form and to make the campaign a success in India too. She then carried the session ahead and invited the panelists to make their presentations.

Panelists

Mr. Oussama Tawil, Country Director, UNAIDS

Mr. Oussama Tawil started his session by regarding access to medicine as a very critical issue. He focused on the joint UN program on HIV and emphasized on the great attention India had been paying towards not just controlling AIDS but regarding all the health parameters. He added that all the civil societies from a very long time had been active partners for providing universal health care nationally. He also referred to the global landmark which India had made in the context of access to free medicine and diagnostics. He said that there had been numerous global initiatives over the years to provide better access to health facilities that had increased the number of people accessing treatment. Mr. Oussama Tawil however said that despite much initiative



both nationally and globally, India failed to reach the status in terms of health where it should have reached and that there was still a long way to go. Various challenges with regard to accessibility of medicines and other health issues needed to be resolved he stressed. India was the second largest country in terms of people who registered for treatment numbering close to 900 thousand, but that did not necessarily resolve the problem with regard to coverage of quality health he said. He then discussed Millennium Development Goals (MDGs) with regard to India. He said several of the MDGs were directly related to health. He talked about new Sustainable Development Goals (SDGs) which had various goals set to achieve between 2015- 2030. He emphasized on the goal which focused on complete eradication of AIDS as a public health threat by 2030. He said that in order to achieve the target there was a need to

increase the amount of investment on health instead of decreasing it. Access to universal health care to everyone was an important target yet to be achieved he pointed out. He referred to various efforts which had been made by different UN organizations through enormous number of initiatives with the aim to improve the level of health condition in India. Various strategies were under the planning mode and would soon be launched in the future he said. Though the parameters of health had shown great improvement in many ways, he said that there were still many issues that needed to be tackled in a serious manner. Many challenges like the supply, procurement, distribution were partially resolved but were not yet completely resolute. He ended his session with the hope that soon the challenges would be worked on and overcome.

Ms. Leena Menghaney, Medecins Sans Frontieres (MSF)

Ms. Leena Menghaney started her presentation by informing everyone about her close working with HIV positive people. She cleared the fact that the patient, that is, the people suffering from various diseases and medical issues were one of the most intensive part of health movement. The movement could not hold any meaning without the consumers of drugs and medicines being the part of various health movements she emphasized. She further discussed a case study which explained how cumbersome and tough it was for a drug to “become” generic drug in India. Ms. Leena Menghaney laid out various aspects about the enormous barriers one had to go through in order to make a generic medicine. Describing the barriers, she started



by talking about overcoming patent barriers in the first place. Then she discussed issues related to complying with GMP and schedule M. If the above-mentioned two steps were fulfilled the producer further needed to buy or make raw material to make medicines and conduct bio-equivalence studies related to it. She added that the generic medicine producer required conducting local clinical trials in order to obtain approval from Central Drugs Standard Control Organisation (CDSCO). Next, there were inspections of the manufacturing site by Drug Regulatory Authorities (DRAs) and producers like IDA, MSF, and UNICEF etc. Explaining more about the procedure, she described how the steps were further more difficult in the later stages. She said that the medicines when launched in Indian market had to face litigation from multinational companies. She mentioned a few more hurdles on the way for a generic manufacturer including the IP barriers in importing countries which included the patents, data exclusivity and patent linkage. She said that if generic producers managed to overcome all the above-mentioned barriers somehow they may still get sued at the last moment on a copyright issue. She thus explained the whole journey and the pain one had to go through in order to manufacture a generic drug in India.

She also mentioned another issue where she said that there was a requirement for local trail-phase-III in the country before the new drug was registered. Requesting waiver was important as originators were not interested and generics

found this requirement expensive to meet she said. Later she shared a case study about the registration of SOF and DAC in 2015 in India. Describing various reasons as to why the CDSCO needed to register an NS5a inhibitor, she gave the following reasons:-

- a) **Safer** : SOF cannot be used alone for treatment and has to be combined with RBV and/or PEG-INF/RBV.
- b) **Increased efficacy** : NS5a and NS5b inhibitor combinations can cure HCV in the majority of treatment- naive patients.
- c) **Pan-genotypic** : NS5a and NS5b inhibitor combinations, specifically ones using DCV, can be efficaciously used to treat all genotypes of HCV in India including the harder to treat genotypes.

She informed about raising awareness and how media very well presented the issue including the news in Times of India, with the headline saying “Hepatitis C Drugs Face Multiple Hurdles”. Indian DRA responded by asking BMS and Gilead to file their registration dossiers. She informed about the mass movement where the Indian civil society demanded DCV local trial waiver. She added and suggested requirement for the new local clinical trial, which would remove unnecessary delay in the path of introduction of new medicines that could have massive impact on the treatment of hepatitis C infection and many other diseases. Ms. Leena then talked about the results of the fight they fought together through various stockholders. She informed that Sofosbuvir and Daclatasvir were registered in January and November 2015 respectively and treatment with SOF+DAC started. It costs approximately 600 USD for three-months regimen she informed.

Ms. Leena emphasized on the crucial role played by the patients in the movement they fought. Despite having very little knowledge about the legal aspects related to medicines, they played a very vital role to accelerate a free flow for it she said. Ms. Leena ended her presentation by saying that the battle to ensure free universal access to medicines could not be possible until and unless the medicine procurement agencies were on their side.

Mr. Gopa Kumar, Third World Network (TWN)

Mr. Gopa Kumar started his session by complimenting the presentation of the earlier speakers and thanked them for sharing various facts related to access to medicines. He took the session further discussing the global challenges access to free medicine had been facing. He said that the biggest question which prevailed was how to insure universal access to medicines free and/or at affordable cost ? Moreover, he added that the question was not just about the medicines but also about the entire medical product that included diagnostic medicines, vaccines and all other devices required for treatment. He emphasized on the fact





that a competition was very necessary in order to meet the demand for medicines. He added that alone demand was not enough to solve the problem because a lot of times the producers had collective bargaining power which did not solve the purpose as they then saw only their profit motive. In order to deal with the situation he suggested a market friendly system and to develop a self sufficient system through public sector itself. He also talked about how WHO soon was about to announce some important initiatives in order to fight the global shortage of generic medicines.

Mr. Gopa Kumar moved ahead with his presentation and said that access to medicines was no more a problem just for developing countries, indeed the problem was also being faced by nations like Greece and UK. He informed about the mass movement of people in Spain where 50,000 people gathered in Madrid in order to demand access to free medicines. Mr. Gopa Kumar then talked about the role of international laws and policies in access to medicines. He connected them to right to health and right to science and explained how the access to medicines was actually more about rights related to both. He was sorry to say that despite it being an important right, a huge number of essential and expensive drugs were not in the list of procurement. Mr. Gopa Kumar then talked about three ingredients of SDG3. He explained about the three main features in detail and said the first and most important aspect of SDG3 was to ensure good health and well-being. Then he talked about the nine targets it promises which would be fulfilled or met by 2030. The targets covered many communicable and non-communicable diseases, cancer hypertension etc. SDG3 also laid down four means of implementation unlike the previous MDGs. The measure of implementation included addressing researches and using the flexibility of Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement.

Mr. Gopa Kumar further talked about the policy incoherency as an important issue which he felt needed to be given more attention. He said that one could easily get away by abolishing human rights but if the same person violates trade law, very serious measures are taken. He talked about this gap and said how human rights many times were not given the right importance in comparison to the trade law.

He further discussed the challenges in ensuring access to medicines. He discussed three main challenges namely the technological challenge, regulatory challenge and the Intellectual Property Rights (IPR) challenge. Firstly, in context of technological challenge he said that it was a big gap which comes on the way and hinders procurement of medicines. He said that there was a need to increase public investment which could further lead to smooth production of medicines. He also urged for assessment of technology that was very important in order to reach the demand of the consumers. Elaborating the next challenge Mr. Gopa Kumar said that regulation was another important problem that made the procurement difficult. He said it was very important to clarify who and how of the regulations. He also focused on evidence, which should be given importance but was quite neglected lot of times. Discussing the third challenge Mr. Gopa Kumar emphasized on the IPR and various patents and trademark and how the flexibility was misused. He said that various laws, policies and institutional bottlenecks were also other challenges to be tackled.

Mr. Gopa Kumar concluded his session by urging for assurance for access to medicines by bringing up coherence in the international law and policymaking. He emphasized on the need for reform in existing international IP and Trade regime. He emphasized on the need to implement new research and development (R&D) framework.

Dr. Gopal Dabade, All India Drug Action Network (AIDAN)

Dr. Gopal Dabade dedicated his presentation to Sangolli Rayanna who exercised Guerrilla warfare tactics and fiercely fought the British East India company much before the rebellion of 1857. He talked about his bravery and said how despite being illiterate the brave man fought against the wrong, although British hanged him to death on 26th January 1831 at Nandagat village.

Dr. Gopal Dabade then went ahead sharing what was happening in Karnataka around access to medicines. He informed that the Karnataka Drugs Logistics and Warehousing Society (KDLWS) was established during the year 2003 with the main objective of establishing an efficient, cost effective and decentralized drug logistics and warehousing system in the state, however no where the state had committed itself to “FREE MEDICINES”. He then discussed how things were all out of order and far away from the commitments. Elaborating the same Dr. Gopal Dabade informed that a high-level official committee was formed to study drug procurement system in the state. When Sharan Prakasher Patil, Minister for Medical Education disclosed the outcome of the study to the press, things didn't come out very positive about the existing drug procurement policy. He very heavy heartedly said that there were complaints over non-distribution of medicines to patients despite their availability in hospitals and doctor wrote prescriptions that forced patients to purchase medicines from pharmacies. He also highlighted various fake promises by the Karnataka Government to make free medicines available to all and how no implementations were made on behalf of the promises.



To give a much clearer picture as to what was the condition of Karnataka Dr. Gopal highlighted the findings of two reports in detail. The first report which he discussed was that of Dr. Kathleen A Halloway, Regional Advisor, Essential and Other Medicines, WHO Regional office for South East Asia in collaboration with Dr. Madhur Gupta of WHO India. The WHO study report showed the evidence of stock outs from both facilities and warehouses. He talked about various findings of the study and further discussed how the report recommended that the man power shortage rectification was indeed urgent. The report also recommended that drug schedules were to be enforced more strictly and a unit was to be established to monitor drug promotion activities. The WHO report talked about lack of staff in general, lack of regular staff dedicated specifically to KDLWS, and reliance on contract staff. Dr. Gopal Dabade informed that the report clearly stated that no standard formula was used for estimating medicines need and stock-out periods were not taken into account at all. The lack of systematic method of drug procurement was one of the major findings of the WHO reports. He mentioned that some facilities did not even know when their supplies would come. Both warehouses and facilities complained that they were not always sent what they asked for. Mr. Gopal shared some more findings and discussed how the reports come out with the conclusion that many doctors appeared to have regarded the EML as a basic set of drugs that could be afforded by the state, rather than a set of essential drugs

that could cover majority of health care conditions. Most of the injections prescribed were diclofenac injections, which consumed the second highest amount (4%) of the drug budget. Citing some other examples of inappropriate prescribing from the WHO report Dr. Gopal Dabade mentioned prescription of ranitidine or omeprazole to counter diclofenac, Metronidazole for acute diarrhoea, use of newer generation antibiotics such as cefadroxil and cefixime rather than the older antibiotic for upper respiratory tract infection cases.

Dr. Gopal Dabade in his second part of the presentation discussed report of a study conducted by Public Health Foundation of India (PHFI) on access to medicines in Karnataka. According to the report the tender of drugs was floated in 2013-14, and the agency received only 20.2% of total drug tenders floated. No transport of medicines from district warehouses to respective public facilities was arranged. 50% of facilities had drugs stored on the floor. 19 of the 53 PHCs surveyed (35.84%) had no pharmacists. In Bijapur district 16 of the 23 PHCs (69%) recorded stock-out of Anti-Rabies vaccine. There were no drugs to treat diabetes, cases of overuse of diclofenac were also reported. The report highlighted that 82.95% health facilities did not get all the medicines indented and 43.67% got other than indented drugs. Dr. Gopal Dabade also mentioned about the CAG report (2007-12) which highlighted poor planning of drug procurement and how procuring drugs from suppliers did not meet the technical specificities. He concluded his presentation by mentioning about the various roles the civil society was playing in order to fix the situation in Karnataka. He talked about the meeting they had with state health minister of Karnataka and various political party leaders from congress, JD and BJP to highlight gaps in access to medicines and how all of them had different reactions to the issue.

Session 3 : Differential pricing of medicines, drug price control, Jan Aushadhi Scheme and access to medicines

Objective : To discuss the dynamics of drug pricing in India and its influence on access to medicines

Prof. J.K.Das, Director, National Institute of Health and Family Welfare (NIHFW)



Prof. J. K. Das who was chairing the session thanked the organizers for holding the forum on a crucial issue related to health and hoped that the panel would further highlight critical points related to dynamics of drug pricing in the country. He then invited the panelists to make their presentations.

Panelists

Mr. Amitava Guha, JSA

Mr. Amitava Guha drew the attention of the forum to promotional agenda of the pharmaceutical companies. He started his presentation by briefly talking about the price control mechanism in the past which was based on cost of production of medicines. He mentioned that 3.4 crore people were pushed below poverty line due to expenses for medicines in 2011-12. He then talked about the impact of price control and said that by 2013 only 348 drugs were brought under price control which was only about 17% of the drug market. He further said that NDA government in 2002 decided to wipe out price control on medicines in steps which was challenged in the court and later the case reached the



Supreme Court. Mr. Amitava Guha also mentioned about the market based pricing and talked about how pharmaceutical pricing policy in 2013 was shifted from cost based pricing to market based pricing. Drug Price Control Order (DPCO) accordingly declared 'Drug Prices Control Order, 2013 applicable to all formulations under NLEM, 2011. Ceiling Price was fixed based on "prices of brands of a formulation having 1% or more averaged and added retail margin of 16% will be the MRP".

Further talking about the coverage of DPCO Mr. Guha said that by 2013 only 17% of the total market came under price control which now has reduced to about 15% due to introduction of many new medicines. Sales volume wise impact of DPCO was negligible at just 1.8% he informed. He further mentioned how mostly used medicines were excluded from the list of price control. No combination for NELM+NELM or NELM + Non-NELM was included. Retail sales of combination medicines occupied 42% of the total market which shows increased sales of irrational and fixed dose combination he said.

Mr. Amitava Guha then discussed the promotional agenda with respect to medicine and questioned the need for

promotion. He said that promotion was just to create an artificial demand which has resulted in hike in the sale of irrational medicines. Largest amount of irrational medicines are sold in India he pointed out. He further added that free samples raised health care costs by promoting the use of expensive products. In the US, prescription costs grew 5-fold from 1990 to 2006. A substantial fraction of the increase was attributed to a growing reliance on expensive, brand-name medications. He moved ahead and talked about the physician and industry relationship, how various gifts in various forms were given to doctors in order to prescribe their medicines. He talked about three 'C's of promotion: first, was to "Convince" doctors by using tall claims with cooked up evidences, the second 'C' was to "Confuse" doctors with the help of tailored data, sponsored trials and funded papers, and the third and the final 'C' was to "Corrupt" the doctors which included direct paying, gifts ranging from pen to car, pleasure trips to anywhere etc.

Mr. Amitava Guha concluded his presentation by discussing the code of ethics where he talked about the MCI's notification of 10 December 2009 which stated that "A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity". He said that the government later came with a draft 'code of marketing practice for Indian pharmaceutical industry' in June 2011 which was kept voluntary for the industry to implement. The Central Board of Direct Taxes issued a notice to the pharmaceutical companies informing the promotion expenses would no longer be kept out of taxes. He said that all this implied that the expenses made by the pharmaceutical companies on promotion would be booked under profits by the companies and hence would be rendered taxable.

Prof. Dinesh Abrol, ISID

Prof. Dinesh Abrol focused his presentation on explaining the detail layout of DPCO 2013 right along with the issues, concerns and the various gaps in it. He started his presentation by pointing out the fact that the implementation of the scheme of free medicines and diagnostics required attention to nature of price control and its problems because the challenges faced by the issue came basically from the budgetary constraints, unregulated prescription of medicines, growing control of foreign and control by the companies. He said that thus the price control played a vital role if free medicines and diagnostics really wanted to become a success not just in papers but in implementation. Talking about the various issues and concerns related to DPCO 2013,





ISID



Prof. Dinesh Abrol said that price and availability of drugs were determined by market structure. Large scale firms as suppliers were able to charge higher prices on account of market power through collusion, market segmentation and product differentiation, promotion and with physician support. DPCO 2013 utilized the formula of market determined pricing to undertake price regulation and covered the NLEM based products whose coverage was limited to 16% of the market and 84% happened to be outside the scope of price control. Prof. Dinesh Abrol further talked about the public procurement and production control and discussed how many essential medicines remained outside the coverage of DPCO 2013. He explained how on analysis of the impact of the DPCO 2013 on the prices of market sales leaders and those who have a share of 1% in the market indicated that the price impact outcome of DPCO 2013 was marginal for the drugs being consumed and prescribed in the country. He further added that the differences in prices of medicines sold to the government and through the private retail were huge and various interests and lobbies were going to influence the implementation process. He said that there was a strong need for DPCO 2013 to review and replace the mechanism based on cost plus price control.

Prof. Dinesh Abrol then shifted his presentation to the industrial policy and explained how industrial policy was impacting free medicines and diagnostics schemes. He said that the import dependence on medicines and diagnostics was a growing challenge, monopolies were growing in the sector, market leaders had been successfully enrolling physicians. The gaps in the industrial policy had led to the moving of Central Government Health Scheme (CGHS) and other schemes to the PPP mode. Further in order to explain the close relation between the industrial policy and healthcare system Prof. Dinesh Abrol said that the clinical diagnostics had been monopolized by big business because it was not regulated well, at the same time irrationality in prescription was another evidence in order to justify how wrong industrial policy became a hurdle on the way of free medicines and diagnostics schemes. He discussed the innovation of essential medicines and its price control and explained that market led price control would always encourage innovation which would be nothing more than product differentiation. Substantive innovation activity in respect of essential medicines needed targeted output based incentives he emphasized. He said that patented medicines needed to be procured and distributed by the government through Jan Aushadhi while taking effective steps to implement compulsory licensing and suo-motto steps for patent busting and opposition with the aim of ensuring local production, introduction of completion and price reduction.

Prof. Dinesh Abrol concluded his presentation by putting up suggestion in order to fill the gaps to the above mentioned problems. He stated that intervention of CSOs in respect of awareness cum audit for monitoring and social control of the implementation of free medicines and diagnostics was very crucial. He stressed on the fact that right to healthcare needed to be made a statutory obligation and the role of the state be legally subjected to social control. Attention should be given to the introduction of cost- plus price control mechanism in the case of essential drugs he highlighted. He also mentioned that the industrial policy needed to be linked by the states to the development of the local industry for “medicines security”. Talking about intellectual property he said that there was a need for it to be understood by both patents and brand names. He also said that documentation, transparency and accountability were without doubt the key factors in order to make free medicines scheme successful.

Mr. Anand Grover, Lawyers Collective

Mr. Anand Grover started his session by making the fact clear that dealing with price control of drugs by only linking it to the universal health coverage is like dealing with the problem partially. He said there was a need to deal with the problem of universal access to drugs in a much broader perspective. He said that the DPCO amendments were tough and informed everyone that there were fewer chances of these amendments to be launched in the favour of universal health coverage. There was a need of bulk procurement and replication of the Rajasthan and Tamil Nadu model of free medicines schemes he emphasized.



Mr. Grover further discussed some of the decisions taken by the multinational companies which had worsened the scenario.

He said that prior to 2005 they had tiered pricing which allowed different rates in different countries based on how developed a particular country was. The things were changed to universal pricing after 2005 he informed. He emphasized on the fact that the real motive behind this was to disinvest so that the patent rights could be brought under practice and further weaken the manufacturing ability of a country. In other words these rights cut down the investment and established power of the country making them more dependent on them for procurement of drugs. Once the country lost its manufacturing establishment the same establishment was needed to be settled outside the country giving these MNCs a more dominating position. In a situation like this DPCO remains of no use he pointed out.

He then talked about another important problem which was related to funds. He said that while currently India was getting funds from global corners, however from 2017 a lot of global fund would not be available for many ongoing programs and then the situation would arise how to fund those programs which were being funded internationally. He said that 30% of the poor were in India and thus it becomes really important to get some fund globally to deal with the problems.

Mr. Anand Grover moved ahead and talked about patent rights and compulsory licensing. He said that these were big threats and should not be allowed. India got the largest member of epidemics like T.B, hepatitis etc and yet there were no medicines available in sufficient amount. Hence there was a strong need to suppress the patenting of medicines by the MNCs. Even if the compulsory licensing was regulated, the MNCs had their own ways and strategies to come on the way for universal access to free medicine and thus in a situation like this the voluntary licensing makes

its way he pointed out. However, even in the case of voluntary licensing the battle gets difficult as it remains totally in the hands of MNCs and thus after all the analysis the only remedy which could be seen for a better tomorrow was opposing the patent completely he stated.

Towards the end of his presentation, Mr. Grover came up with some recommendations and advised for a healthy competition with a bulk purchasing power. He also advised for encouragement from government's side for compulsory licensing at least for the drug related to epidemics like T.B, Hepatitis-c and HIV. He pointed out need for more united efforts. He said that few years back there was unity among civil society and it fought together for same goals, however the civil society had divided today. The NGOs, civil society, patient groups all fight with different agendas and hence there is a need to unite with the goal and fight together. He ended his address by suggesting a need for re-educating the parliamentarians on the decisions they make for a better universal health access.

Dr. Mira Shiva, All Indian Drug Action Network (AIDAN)

Dr. Mira Shiva started her presentation by drawing attention to the fact that how nobody ever thought on the lines as

in how the drug policies were made in the country. She said that it was not the health ministry but the chemical ministry which played the lead role in the framing of drug policies in the country. Dr. Mira Shiva highlighted the fact as in how the market was flooded with combination drugs but failed to supply single dose even for tuberculosis when required. The availability of combination drugs had been less of an issue despite the reality that many times these drugs came along with serious side effects, while at the same time single ingredient was always difficult to be brought in to the market and circulated. Dr. Mira Shiva further discussed about 'essential medicines' and



said that people talked only about essential medicines whenever there was any discussion regarding health, which in other words mean that the remaining of the drugs were not essential. There was a need to shift the focus from only 'essential drugs' to rational prescribing she emphasized. She said that if an essential drug was circulated in the market and was used irrationally then the price paid for it was not just in the value for money but also in the form of the adverse effects it left on patient's health both long term and short term. She suggested that the loss an individual had



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to bear when not provided health facilities should not just be counted on the basis of out of pocket expenditure he made but also taking into account the various adverse effects it brought to the individual's health condition.

Dr. Mira Shiva further talked about different drug policies and declarations from past. She made the fact very clear that the issues related to free medicines and universal health coverage cannot be dealt without focusing on the drug and health policies. She reminded everyone in the forum about 1978 Alma-Ata declaration and said how the charter was very important even today to refer for a better primary health policy framing. She mentioned about Hathi committee report which was an inspiration for Bangladesh and formed its base for framing its drug policy. She informed about 2002 and 2006 drug policies in India which could never see the light of the day because of various defects and problems in them. She mentioned about National Pharmaceutical Pricing Policy (NPPP) which came in 2012, and informed that many people thought that it was a drug price control policy, which actually was not a policy to control the pricing of drugs. She referred about a PIL filed in 2002 by all India Drug Action Network, Medico-friend circle, Lowcost and Jan Swasthya Abhiyan against the order where the list of medicines to be brought under price control in 2002 were reduced to 30%. She said that once it would have happened there could have been no way to bring those medicines back to price control. She expressed her disappointment and said that the case was still in Supreme Court and there was a decision yet to be made. She added that issue today was that there were many diseases in the country both communicable and non-communicable and out of these non communicable diseases there were very few diseases which needed lifelong medication like diabetes. She said that there was a huge burden on the patients due to the price of medicines. Thus issue of price control and access to medicines without doubt was absolutely the most important she stressed. She informed about the strong opposition for the shift from cost based pricing to market based pricing, where the average of top three branded medicines were taken in order to fix the price of drug. She also added that there had been a lot of discussions regarding para-19 and if it was valid to have it or not.

Dr. Mira Shiva moved ahead with her presentation and raised a valid question on who was there to monitor the violation of all the issues related to pricing and access to medicines? She said that there was a need for strong acts which could ensure that no irrational and over priced medicines were being circulated through any means. Talking in the context of regulating the procedure and also the prescribing trend, she added that something like Clinical Establishments Act should be brought into action more seriously. All other efforts would remain of no use until and unless doctors were sensitized and convinced to prescribe only generic medicines she stated. She however said that every time when a medicine is low in cost it doesn't mean that it is rational or generic. She emphasized that any low cost medicine if found irrational needed to be removed from circulation. She suggested that bulk purchasing was one effective way to bring down the price. She focused again on the fact that the target should not just be the circulation of less costly and quality medicines. Towards the end of her session Dr. Mira Shiva said that there was a need for a body like National Drug Authority which could deal with the part of awareness creation and promotion of rational drugs not just among public but also among doctors. NPPP alone could not help to reach the targeted goal of free medicines and diagnostics to everyone she said.

Day 2

Session 4 : Role of private health care sector and pharmaceuticals in ensuring universal access to essential and life saving medicines

Objective : Exploring provision of free medicines in private health care sector and role of pharmaceutical

Dr. S.S. Agarwal, President, Indian Medical Association (IMA)



Dr. S. S. Agarwal chaired the panel which focused on the role of private health care sector and pharmaceutical in ensuring universal access to essential and life saving medicines. To begin the discussion he informed that he himself did forty years of private practice during which he understood the important role private sector played in order to provide treatment to the public. He added that it was a crucial topic to be discussed because despite huge public healthcare system in the country almost 60-70% of the population, both inpatient and outpatient, depended on the private health care providers for their treatment. Hence the role of private healthcare institution became very important if universal access to health was actually to be made cashless he said. He then invited the panelist to discuss further the role the private sector could play with regard to universal access to essential and life saving medicines.

Panelists

Dr. Rakesh Biswas, Professor and HoD Dept. of Medicines, LN Medical College Hospital, Bhopal

Dr. Rakesh Biswas started his presentation by thanking every one for giving him a platform to discuss a potential area that could develop into a useful activity for a large number of beneficiaries. His presentation focused on the 'integration of medical education and practice'. He said that in order to integrate the private and public workflow towards universal healthcare, most of the integration had to depend on trained human resource. His presentation focused on how to develop better delivery of universal healthcare through training of the available human resources that currently operated in a complex mash of inter linkages between multiple private and public stake holders, which however didn't appear to be transparent and accountable. He divided his presentation into three parts highlighting the "Good" "Bad" and the "Ugly" parts related to



the private sector in health care. Talking on the same Dr. Rakesh Biswas informed about the good part and discussed about the huge growth of private medical colleges in the country. He said that it might not sound a very good news to a lot of people, however he further explained the role of medical education and learning in universal healthcare. He said that the best thing about medical education was that there was a possibility of healthcare benefiting from quality improvement that could only emerge from continued medical education and learning in a much broader way. He stated that private medical colleges and their collaboration towards universal healthcare had various roles. He mentioned about the important role of a private medical college student and faculty, together forming a global-learning-ecosystem leading to a much better local care and clinical audit. He then talked about the various medical units in the medical- college- care. He said that healthcare percolates right from the tertiary set-ups to the most primary care set-ups both in urban as well as rural locations. After putting up his point Dr. Biswas shifted his presentation to an interactive section with the participants of the forum and asked for their personal views on universal health care and also about whom they felt were the prime beneficiaries of medical education.

Moving ahead with his presentation he informed about the eight dimensions of patient-centered care which included patient's preferences, emotional support, physical comfort, access to care, family and friends, information and education, continuity and transition and information and education. He said that all these dimensions were very well

related to the technology. However, he also pointed out that it was because of the the “bad part” that essential elements to fulfill these dimensions were not available despite the availability of infrastructure. He listed some “bad parts” related to the issue like how the current medical education was based on rote memorization of arcane facts, no emphasis laid on developing skills to solve real patient problems and also the lack of integration between education and practice. He said that ‘malpractices’ in health care delivery was one of the “ugliest” problems. He also said that a huge number of the cases related to ‘malpractices’ had been observed in public domain which had been recklessly discharged by unscrupulous and corrupt practitioners who had colluded with the government and who were 100% confident that no one was going to read or make-sense of their corrupt dealings. He said that lack of transparency and accountability along with the lack of clinical audit and patient centeredness were some other “ugly” parts of the story which needed solutions.

Concluding his presentation Dr. Biswas talked about some solutions and mentioned about an ecosystem for open accountable-patient-centered-healthcare as an important initiative for it. Patient-information-communication-managers can play a great role in creating information and awareness both among patients and doctors he highlighted.

Dr. Shailender Hooda, ISID

Dr. shailender Hooda in his session came up with many facts related to the growth of the private health care sector in India. He started by talking about the role the private sector was playing in order to provide health facilities in both rural and urban areas. Dr. Hooda talked about the present private health enterprises and said that 10.4 million private health enterprises were providing a wide range of health care services consisting of hospitals, medical, clinics, dental, diagnostics, Homoeopathic, Ayurvedic and nursing services in the country. He also said that the growth of private health care sector had been heterogeneous in India. Various range of providers like formal and informal, for profit and not-for-profit, national and multinational for-profit corporation, and small, medium and large corporation entities had opened up. Of the total 10.4 million health enterprises, the share of Own Account Enterprises (OAE), which functioned without hiring workers on regular basis was recorded around 71.3% in 2010-11 which amounted to 7.38 million in numbers. Dr. Hooda further informed that small enterprises especially ran by an





individual practitioner predominated the health care delivery market. Those practitioners were referred as traditional faith healers or jhola chhap doctors who generally provided outpatient care services. On an average 64% of the health enterprises, OAEs and establishments taken together were run by an individual practitioner he stated.

Dr. Shailendra Hooda further discussed the public health care facilities and government spending on health. He said that over a period of time the government spending on health sector had not increased even to provide the basic health services to the population. The spending level had been noticed to be lower than the required level of resources to meet even minimum level of basic health facilities in the country he highlighted. He added that, the current health spending level was noticed to be very low, 1.2% of GDP, which was significantly lower than the global average of 5% of GDP. Even after lot of ambitious commitments under NRHM in 2005 and High Level Expert Group (HLEG) meeting in 2011 to raise the public spending to 2-3% of GDP, government spending in health could not be increased. Low public spending in health confirms the low state investment in health sector which leads to inadequacy of services and provides leverage to private sector to exploit the health care market he said.

Dr. Hooda moved towards another important aspect of current health service approach where the traditional way of tax based health financing for the comprehensive provisioning of health care services to the financial protection was replaced by health insurance. He said that the employer based health insurance schemes like CGHS and Employees' State Insurance Corporation (ESIC) slowly opened gates for health insurance sector for private enterprises. The insurance sector further opened up for foreign players through FDI in health insurance. The FDI cap in health insurance increased from 26% to 49% in 2014. According to Dr. Hooda these insurance schemes were responsible for making people poorer in case of any hospitalization. According to his observation, insurance gave low-level income people also the paying capacity of high priced health care facilities leading to inaccessibility of public health care services. In order to increase the paying capacity, the private sector persuaded the central and the state governments to cover the poor and informal community under the government funded health insurance schemes. He gave the examples of Karnataka, Andhra Pradesh and Tamil Nadu, where pro poor health insurance schemes called RSBY was introduced in order to provide financial protection to poor community for availing health care from both public and private health care providers. He concluded that, health insurance schemes indirectly promoted private health care providers.

Dr. Hooda emphasized on the need for a strong regulation for private practitioners. He added that evidences show that about 66% of the health care enterprises were not registered under any act and only 43% were registered under Medical Practitioners Act (MPE). He also threw light on the fact that the status of private practitioners at the state level showed that out of 29 states about 16 states did not have any legislation that made it mandatory for the private establishments to have a license to function. He pointed out that despite the fact that the major part of India's population resided in the rural areas, the growth of private health care sectors was in urban areas. Citing data he said that establishment of private health care units were recorded as only about 18% in the rural areas and the rest 82% establishments in the urban areas in 2010-11. He said that this fact clearly reflected the lack of formally organized health facilities in rural areas and how smaller or individual practitioners dominated the health system. District level

information on private health enterprises showed that out of 568 districts only 29% (166 in number) districts were covered with large private allopathic facilities. The remaining 71% districts had only small providers. He added that out of this 70%, majority of them were informal providers whose educational status was very low and involved unethical practices. He also talked about states like Himachal Pradesh, Tamil Nadu, Andhra Pradesh and Kerala where 50%, 60%, 70% and 86% districts respectively were covered by large private allopathic facilities. He shared the information that the value of index turned out to be very high, 21.11%, in one district and as low as .0000184% in another district of India. This figure indicated that there exists high inequality in public provisioning of health facilities across districts in the country.

Dr. Hooda said that the growth of private sector had largely been urban centric in economically prosperous areas and in high health insurance penetration states. Private sectors had failed in mending the deficiency gaps in health services provisioned across states, districts and rural urban region. He also said that allopathic providers were on the high rise as compared to the AYUSH providers. Over the period, private sector overtook the health care provision and delivery market, but the services they provided were not cost effective he pointed out. He added that their only motive had been profit and promotion of branded medicines, which had resulted in high health care costs and high out of pocket payment burden in the country. He ended by urging for more investments by government towards health care and regulation of private health care providers.

Dr. Narendra Gupta, Prayas

Dr. Narendra Gupta started by discussing the fact that it was not just the doctors alone but a lot of other related factors and agents which affected universal access to free medicines. He talked about the irony where despite having a very well planned public health system which grew in a systematic way, yet people largely depended on private health system which grew in an unplanned manner just based on market and profit. He informed that around 40% of the population in the country sought treatment from the doctors who were not qualified enough to cure patients. He further raised an important question as in how all the health related institutions could collaborate so that access to free medicines and diagnostics becomes a reality all over the country. He talked about a strong need for public, private, trust hospitals and other health related institutions to come together, join hands in hands and make universal access to free medicine and diagnostics a success.



Dr. Narendra Gupta moved ahead and discussed the objective of universal access to free medicine and diagnostic schemes, where he cleared the fact that the motive of the scheme was not just to reduce out of pocket expenditure but to also promote more rational prescribing and standard treatment. He said that one of the biggest hurdles on the way of adoption of standard treatment guidelines was the link between the doctors and the medical representatives (MR). He added that the MRs convince the doctors that their medicines are much better than others without providing any evidence to prove that and a doctor gets convinced and starts prescribing the same medicines without bothering about its impact on patients both medically and financially. Thus the breaking of the linkage between a doctor and a medical representative was a crucial area which needed attention he emphasized.

Dr. Gupta further in his session talked about some of the issues which he felt were very alarming. He informed about the profit the pharma industries made which was even more than the total budget the central government allocated for health for a year. He then talked about how governments had been shaking hands with the private hospitals in ordered to provide private health insurance. Dr. Gupta felt that insurance was in no way a solution to deal with the problem, that too in collaboration with the private sector hospitals. He said that it could lead to a lot of irrationalities and was an expensive model too to work on. He discussed the current situation of the private health care system and said that they were already over- crowded and that adding up pressure for insurance in the same hospitals will further worsen the situation. He informed that two third of the IPD patients were already seeking health care from private medical system, and three fourth of the OPD patients were going to private institutions. He said that in a situation like this, loading the private sector with more burden would only deteriorate the quality of care. He said that shifting burden to the private sector was therefore not going to make the situation favorable in any sense.

Dr. Gupta next emphasized on pharma industry and its trend in manufacturing medicines. He highlighted the fact that the pharma industry was divided into two sections, the first bigger section selling and manufacturing branded medicines which was the area which fetched them the maximum profits, and second the generic medicine industry. He added that production of generic medicines was not given the same importance as production of branded medicines as the margin of the profit there was nothing as compared to that of branded medicines. He informed that out of 95 thousand Crores worth of medicines produced only 5 thousand Crores was the part covered by the production of generic medicines. Generic medicines were thus seen as more of a threat to the so called “business” for the pharma industries he stated.

Dr. Gupta concluded his presentation with a strong recommendation for the government to enhance the market of generic medicines. He argued that there was a need for a more comprehensive approach from the side of the government with respect to the analysis of health situation. He also added that too much emphasis on insurance with the motive to provide quality health needed to be reviewed. He said that instead there was a need to grow and increase the infrastructure which could handle the increasing load. There was also a need to engage with the private sector so that results are more fruitful and instant he felt.

Session 5: Ensuring free drugs and diagnostics within the paradigm of health insurance and PPPs

Objective : Examining scope for ensuring access to free drugs and diagnostics through insurance schemes and PPP models

Dr. Sanjiv Kumar, Executive Director, National Health Systems Resource Center (NHSRC)



Dr. Sanjiv Kumar chaired the session and began the discussion by stating how over the years in different countries he had witnessed the transformation of a socialistic health providing model to a model where private sector was engaged in order to provide universal health. He said that since even India was moving towards the same model it was important to analyze the problem various countries faced while and after the transformation from a socialistic model to a market based model. There was a need to look at the health issue more comprehensively he emphasized. He also added that it was sad to see that health was tackled only on the basis of problems relating to out of pocket expenditure whereas the same needed to be seen in the context of cost related to it. He said that the motive should be to come up with measures to keep the population healthy. He stated that while there had been an increasing focus on providing free medicines and diagnostics to people coming to health facilities for treatment, what was really required was a shift in focus to create an environment where less number of unhealthy people would require treatment. Only by this approach the purpose of universal access to health could be justified he emphasised. He concluded by saying that health was much more than insurance and insurance was not the solution in the prevailing scenario. He further invited the panelists to provide a clearer picture on the scope of PPPs and insurance schemes for ensuring access to free drugs and diagnostics.

Panelists

Dr. Ravi Duggal, Anusandhan Trust

Dr. Ravi Duggal in his presentation discussed various aspects and challenges related to health insurance and PPP. He started his session by giving an idea about two types of insurance models in the health sector. He talked about the first kind of insurance which was essentially insurance bought individually through a public or private insurance company. The second type of insurance he talked about was the social insurance cover by the government by deducting some amount that was further returned in the form of insurance like the ESIS and CGHS. He differentiated the two and said that the private insurance came with a cover limit and provided the services within that limit, on the other hand, social insurance did not come with any limit and it assured one a lifelong service with only one limitation that the amount of services provided indeed was limited. He elaborated that what was happening with social insurance in India was quite a matter of concern. He explained that how most of the public insurance schemes had huge budget but the fact was that a very small amount was actually spent on insurance and the remaining was channelized to private sectors through various ways. He gave example of CGHS which had a budget of huge amount of somewhere around Rs. 2000 Crores, out of which a very small amount was used for public and a big proportion went to the private sector. He also pointed out the fact that there was a very large gap on the spending by the government sector wise. Railways, defense, post, telegraph, and some departments enjoyed much larger budget on health and hence better health facilities compared to the remaining population where the allocation of finance was less comparatively.



Dr. Ravi Duggal further talked about the changing trend in the insurance pattern in India's population. He informed that the private insurance in the country covered a population of 50 crores out of which more than half of the money was paid by the government because of the integration of governmental scheme with private insurance. He said that private insurance covered a huge percentage of population and reached its peak in the year 2011-12. However, many states pulled out private partnership in insurance from government based health schemes and a drop was noticed in the private insurance coverage few years back. However, the private companies again through different steps came back into the market and many states again made the same mistake of falling for private insurance model he informed. Overall somewhere around 74% of the money of private insurance sector was sponsored by Indian government he stated. He mentioned that 59% of the population did not fall under either of the insurance policies. Insurance policy was one of the best ways to make government pay for all the investment by the private health care providers in the name of cover he said.

Dr. Ravi Duggal further shifted his discussion towards the central government's decision in the recent budget to dismantle one of the most important and effective health insurance program for the organized sector working classes, the ESIS. He added that the government was more focused on extending health benefits through targeted and restricted schemes using the route of private health insurance but all these efforts failed to have the intended impact and ended up benefiting the private hospitals and the insurance companies. He said that serious efforts were needed to be made to correct the defects in the design of insurance system in India so that the government's money was not misused and was utilized for the purpose it was meant for.

Dr. Ravi Duggal in the later part of his presentation talked about Public Private Partnership (PPP) model and different aspects and issues associated with it. He said that though the form and pattern of PPPs had changed over time and more structured PPP models were being replaced by the older models, yet the PPP models had been used by the private sector to milk the state. He added that there had been no regulations and no monitoring done to ensure that the beneficiaries of the subsidies fulfill their promises of offering subsidized services to poor and the needy patients. He said that he was not very sure about the success of the PPP model as not many PPP models in the health care sector were successful so far. He talked about examples from the past and many ongoing PPP models like the one in Gujarat and Uttarakhand. He said that there had been many examples where the PPP model had failed and no action had been taken by the government. He cited example of Apollo hospital in Delhi where despite a high court order, following an enquiry committee's investigation report pointing out discrepancies no action was taken by Delhi government against the hospital. Citing another example he said that the pulse polio campaign in Mumbai where private doctors were empanelled to provide vaccines were found to be charging a fee to deliver the vaccine to patients despite the fact that the Bombay Municipal Corporation (BMC) was already paying remuneration. He discussed about the PPP models abroad and said that models of PPP in Canada and Europe were much more effective but to launch the same in India would be an expensive matter. There was a need to divide the work clearly and strictly he emphasized. He ended his presentation by saying that there was a need for a regulatory body which could make private sector accountable and also punish the same in case the promises were not fulfilled. Both public and private health sectors should be governed by the same rules he stressed.

Dr. Madhur Gupta, World Health Organisation (WHO)

Dr. Madhur Gupta talked about the findings and outcomes of the baseline evaluation study of free medicines scheme in the state of Rajasthan which was undertaken by WHO along with PHFI and Prayas. The study was conducted two years ago and it took around nine months to complete the study because there were around 150 facilities which were visited. Before getting in to the details of the findings and outcomes of the study Dr. Madhur said that access to medicines was still elusive to a large segment of India's population despite it being referred to as "pharmacy of the global south". She



said that despite contributing 80% of the medicines to WHO and other international areas, India fails to provide and fulfill the requirement of medicines for its own population, which is a paradox, and hence this issue was much more important. She talked about the key barriers to access to medicines and highlighted some of them. The gross inadequacy of the government to spend on health care was one of the major barriers she pointed out. She felt that the spending needs to be well channelized and requires more monitoring. She added that inefficient procurement and distribution mechanism also needed many amendments. She also talked about unaffordable market prices along with irrational prescription and use of branded medicines as other key barriers to access to medicines.

Dr. Madhur Gupta moved ahead with her presentation and gave details related to Rajasthan's free medicines scheme. She informed that the scheme was introduced by the government of Rajasthan in October 2011. Free medicines scheme was developed in compliance with the state government's commitment to provide essential medicines free of cost to all the patients visiting public healthcare facilities in Rajasthan. The scheme began with 240 medicines initially and at present provided more than 600 medicines. She further talked about some other key features of the scheme and said that the scheme made significant increase in government expenditure on medicines. Rajasthan Medical Services Corporation (RMSC) was established to procure essential medicines and coordinate supply chain systems. The procurement was based on a two-bid system which involved technical and financial tenders. She also informed about the setting up of "e- aushadhi" platform to facilitate smooth functioning of entire value chain from procurement to distribution and dispensing of medicines.

Dr. Madhur Gupta further discussed the goal and objectives of the study conducted. She said that the main goal was to analyze the patterns of financing, solution, procurement and distribution, pricing, prescribing and dispensing of essential medicines. Talking about the objectives, she highlighted some of the major reasons to conduct the study as to examine budgetary allocation for medicines, financial risk protection related to medicines and examining procurement and distribution system. The objectives also included analysis of procurement prices and prescription and dispensing practices.

Dr. Madhur Gupta shared the major findings of the study and said that there was a huge increase in the footfall because of the scheme. She also added that the study indicated that despite the medicines being provided free of cost, they were not compromised on the parameter of quality. e-Aushadhi which is a web based application was a crucial and key success factor in enhancing the efficiency of the public procurement system she stated. The availability of medicines in various health units were very good though it was not 100% in any district she informed. A very effective online public procurement system was in use in the state and the study very clearly highlighted that Rs. 3200 million was allocated in year 2013-14 towards the scheme as against Rs. 1020 million in year 2011-12. Household's out of pocket payments declined from 85% in 2004-05 to nearly 75% in 2011-12. According to the survey the availability of medicines were around 70% at PHC and CHC level and 88% at district hospital level she informed. 97.3 % of the medicines prescribed were found to have generic names. The study also highlighted that the average duration of stock out was 86 days. She added that the drugs prescribed to patients were prescribed rationally. As far as procurement prices were concerned she said that it was found that the market prices for the drugs were 300% greater than RMSC procurement prices.

Dr. Madhur Gupta then talked about the impact evaluation mission of free diagnostic scheme in Rajasthan and Madhya Pradesh which was being carried out jointly by Government of India and WHO along with Prayas. The objective of the study was to examine the status of implementation of free diagnostics scheme at public health facilities in terms of preparedness of various key parameters for delivery of free diagnostics services. She mentioned some of the preliminary recommendations from the impact evaluation such as, strengthening primary health care facilities and rationalization of distribution of patients at different tier of health care to reduce patient load at tertiary level, improving human resources and infrastructure development, digital/electronic patient registration and linkage with free medicines and free diagnostics schemes in order to reduce work burden, establishing regular monitoring and grievance redressal mechanisms. She emphasized on the fact that the free diagnostic service was a step towards “Right to treatment” and was promoting universal health coverage in the states. Optimum utilization of public health resources was enhanced as a result of implementation of the scheme. There was a decrease in out of pocket expenditure on health by decrease in expenditure being incurred on diagnostics she stated. The study also concluded the fact that the health seeking behavior was promoted on account of increased access and affordability to treatment.

Dr. Raman V.R., Public Health Foundation of India (PHFI)

Dr. Raman V. R started his presentation by discussing the complex and cumbersome health care system including different health care provisioning institutions. He said that the health system in India was way too complex when analyzed in detail. He talked about basic institutional requirements for health systems in order to ensure access to free medicines. Talking about the role of the state Dr. Raman said that the state needs to frame a policy first and then look after its funding, EDL, governance, quality testing, grievance redressal and finally its regulation and for doing all this it must establish a corporation. He explained that the major role of a corporation was to deal with the state's needs and technology assessment. Corporation also should be efficient enough to handle various other areas covering cost control, quality control, storage oversight, access oversight and rational use training and promotion he pointed out. He further talked about the warehouse and said that the stock management, logistics and facility store oversight were to be dealt under the warehouse management. After a brief introduction of the basic institutional requirements





for health systems with focus to ensuring access to free medicines, Dr. Raman put up a question and asked if these complex needs could be addressed within the insurance frame work?

Dr. Raman then moved ahead with his presentation and talked about in detail about RSBY in the context of provisioning of free medicines. He said that with regard to institutional provisions for insurance, there was no clear separation of government's regulatory role and RSBY's execution role. There was no universal approach and hence patient's entitlements were limited to empanelled facilities. Dr. Raman further discussed about the limitations of RSBY in the context of provision of free medicines. He very clearly said that at the policy level, RSBY was projected as healthcare provision model whereas at operational level it simply became a contract and payment management affair. He added that RSBY was operating through reimbursement to hospitals against rate contracts for treatment packages for specific procedures. Hospitals were expected to provide drugs either directly or through internal purchasing as part of the treatment package however the drug entitlements of patients were not specified and neither were costs mentioned leading to provider centric and unilateral decisions where patients had no say. There was no coverage for extra-package drug requirements leading to out of pocket spending. The pre-post hospitalization drug requirement was unmet. He also discussed weak monitoring system under RSBY. He said that RSBY did not have direct monitoring systems at different levels. Medical doctors in Third Party Administrators (TPAs) were responsible for overall monitoring of service provision. Mandate was to simply verify the lines of treatment procedures against packages and not about drugs. There were no review of drug provisions as the information on drugs and its supplies were not collected in the software. At the state RSBY centers, cursory review of data was done. He also mentioned about the patient education and grievance redressal systems which were built but with namesake institutional structures and powers at the top of the pyramid. He emphasized on the fact that there existed no manuals or provisions to check the visited interests and unethical practices especially in the private sector under RSBY.

Dr. Raman also discussed the structural issues in insurance mechanisms. He said that cost cutting due to partial financing resulted in removing the most essential components from the design. The efforts to simplify complex structural requirements made the schemes disabled or defective by design. Dr. Raman said that the doctors and the hospitals were power centers in the rural areas and insurance made them further more powerful and poor further more vulnerable. The patient education and grievance redressal systems were just in letters and not in spirits. He thus concluded that the insurance system was way more cumbersome for ordinary citizens.

Dr. Raman towards the end of the presentation discussed some recommendations in order to strengthen the public health systems and services. He said that there was a need for adequate HR for all the institutional mechanisms and other instruments at various levels. Better monitoring and grievance redressal mechanisms needed to be framed. He also urged the need for massive education, awareness and capacity building of community members. He added that private sector needed to be included to fulfill universal health coverage commitments but not as an alternative to public health system. He concluded his presentation by saying that people's movements, politicians and officers should form an alliance for protecting health systems and for reforming the insurance based models.

Dr. Amit Sengupta, JSA

Dr. Amit Sengupta began by discussing the health issue with the perspective of integrating public health facilities with various other components related to it. He said that after hearing everyone in the forum it was quite clear that the main aim was to ensure availability of free medicines in all the public health care facilities. However, there was still lack of ideas to make it practically possible and how to bridge the gaps hindering its success he said. He cleared the fact that providing free medicines in public hospitals alone was just one part of the solution because in reality 70-80% of the population availed treatment from private sector. The solution regarding private hospitals must be the real concern he pointed out. He emphasized on the fact that the challenge was not to provide medicines free of cost in public hospitals but to integrate the campaign for free drugs in public facilities with the older ongoing campaign for ensuring access to free medicines over all even by moving outside the public sector.



He further talked about insurance schemes and discussed three fundamental aspects related to it. The first being risk pooling where a large number of people were brought under insurance and only a few ended up actually requiring insurance cover. The second was financial pooling where a lot of finance was involved, where again only a very small amount was actually spent by the insurance company. Last but not the least was the financial support. He questioned why was such a scheme required which pooled up such huge amount of finances and ended up giving so little in return? He concluded his session by saying that insurance was not the solution for providing better health care facilities and solutions were needed to replace it with better alternatives.

Closing Session

Closing Remarks

Dr. P.K. Anand, Senior Consultant, NITI Aayog

Dr. P.K. Anand started his address by talking about different parameters of happiness. He gave a summary of a study which was conducted by some economists to find out what made people happy. After the whole survey it was found that an individual's health stood in the second place on the parameter of happiness. Talking in the context of free medicines and diagnostics, Dr. P. K. Anand said that there was always an increase in demand every time something was made available free of cost. He highlighted the fact that expenditure on health had brought a lot of people below poverty line. He discussed some complexities which a poor man had to face in order



to get medicines free of cost. He added that a decision of a person belonging to a BPL family to visit a hospital in itself was a tough task and after he reached the hospital if he had to spend even a single rupee out of his pocket he would prefer not to visit the hospital the next time even if he went through a heart attack. There was a need for better assurance that if a person visits a government hospital, he would not have to spend anything on his treatment including both medicines and diagnostics he emphasized. He said that one must understand that a very large population in the country was not in a condition to even spend a single penny out of pocket for the health expenditure and thus a totally free treatment assurance was the only way to promote people to come and take up services from the public health facilities.

He stressed on the need for a system which actually delivers. He asked for a systematic scheme taking together all the available resources and different institutions in one well designed mechanism. He regarded cost and service delivery as the two main elements which should be given utmost importance. He emphasized that investments in health care must be increased and the money should be accurately used for the purpose it had been allotted for. He mentioned monitoring as another crucial area which required revision. He said that punishments for negligence and discrepancies in service delivery must also be made more stringent so that it discourages further malfunctioning in any area related to health.

Dr. P. K Anand then moved ahead and talked about health insurance schemes. He said that there were two important things related to insurance which required serious concern. One was moral hazards and the other adverse selection. He said that there were various insurance models but each one of them promoted insurance for the most earning member of the family leading to no insurance to the female and aged members of the family. He said insurance scheme covering all the members of the family should be promoted. Dr. P.K Anand also said that the policy framing and implementation should include people from all the walks of life only then the real problems and better solutions would come through. He thus concluded his address and thanked organizers for holding a national forum on such an important agenda.

Vote of Thanks



Ms. Tushita Mukherjee from Prayas marked closure of the two days forum by thanking the participants and the speakers for their presence and enormous contribution in the discussions. She also thanked the organizing team for their efforts in putting up all the necessary arrangements for the program.

C. ANNEXURE



ANNEXURE - 1

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BMS	Bachelor of Medical Science
BMSICL	Bihar Medical Services and Infrastructure Corporation Limited
CDSCO	Central Drugs Standard Control Organisation
CGHS	Central Government Health Scheme
CHC	Community Health Centres
CMHO	Chief Medical and Health Officer
CPA	Central Procurement Agency
DAC	Drug Advisory Committee
DDC	Drug Distribution Center
DDCs	Drug Distribution Centres
DDWs	District Drug Warehouses
DMHS	Directorate of Medical and Health Services
DPCO	Drug Price Control Order
DRAs	Drug Regulatory Authorities
DTC	Drug and Therapeutic Committee
EDL	Essential Drugs List
EML	Essential Medicines list
FEFO	First- Expiry- First- Out
FRUs	First Referral Units
GMP	Good Manufacturing Practices
HIV	Human Immunodeficiency Virus

**ISID**

HLEG	High Level Expert Group
HR	Human Resource
IDA	International Development Association
IMA	Indian Medical Association
IPD	In-door Patient Department
IPR	Intellectual Property Rights
ISID	Institute for Studies in Industrial Development
IT	Information and Technology
JSA	Jan Swasthya Abhiyan
KDLWS	Karnataka Drugs Logistics and Warehousing Society
KMSCL	Kerala Medical Services Corporation Limited
Lts	Lab Technicians
MCH	Medical College Hospitals
MCI	Medical Council of India
MDGs	Millennium Development Goals
MMJRK	Mukhya Mantri Jeevan Raksha Kosh
MNDY	Mukhya Mantri Nishulk Dawa Yojana
MPE	Medical Practitioners Act
MR	Medical Representatives
MRP	Maximum Retail Price
MSF	Medecines Sans Frontieres
NABL	National Accreditation Board for Testing and Calibration Laboratories
NHSRC	National Health System Resource Center
OAE	Own Account Enterprises



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OoPE	Out of Pocket Expenditure
OPD	Out-door Patient Department
OSMC	Odisha State Medical Corporation
PHFI	Public Health Foundation of India
PPP	Public Private Partnership
RBSK	Rashtriya Bal Suraksha Karyakram
RMSC	Rajasthan Medical Services Corporation
RMSC	Rajasthan Medical Services Corporation
RSBY	Rashtriya Swasthya Bima Yojana
SDGs	Sustainable Development Goals
SDH	Sub District Hospital
TNMSC	Tamil Nadu Medical Services Corporation
TPAs	Third Party Administrators
TRIPS	Trade Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
USG	Ultra Sonography
WHO	World Health Organisation



ISID



ANNEXURE - 2

Program

Day 1 (Wednesday), 2nd March 2016

Time	Details
09:30-10:00	Registration
10:00-10:45	Opening Session Welcome and Introduction <i>Prof. M.R. Murthy, Director, ISID</i> Objectives <i>Dr. Narendra Gupta, Prayas</i> Background <i>Dr. Amit Sengupta, JSA</i> Key note address <i>Mr. Sudhansh Pant, Joint Secretary (Policy), Dept. of Pharmaceuticals</i> Vote of thanks
10:45-11:00	Tea
11:00-1.00	Free medicines and diagnostics to all - current status in different states of India Objective: <i>Provide an overview of the access to medicines provision/schemes in different states</i> Chair: <i>Dr. Dinesh Abrol, ISID</i> Panelists <i>Dr. Pawan Kumar, Govt. of Delhi</i> <i>Dr. Rajesh Bharadia, Govt. of Rajasthan</i> <i>Dr. Durbha Rohini Kumar, Govt. of Bihar</i> <i>Dr. Dileep Kumar, Govt. of Kerala</i> <i>Dr. B.K. Swain, Govt. of Odisha</i>
01:00-01:45	Open floor
01:45-02:30	Lunch



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Time	Details
02:30-03:30	<p>Positioning access to free medicines and diagnostics as a priority national agenda</p> <p><i>Objective: The context within which free and universal access to essential medicines and diagnostics should be prioritized and provisioned by the central govt.</i></p> <p>Chair: Dr. Christiane Fischer, MEZIS</p> <p>Panelists</p> <p>Mr. Oussama Tawil, Country Director, UNAIDS Ms. Leena Menghaney, MSF Dr. Gopal Dabade, AIDAN Mr. Gopakumar, Third World Network</p>
03:30-03:45	Open floor
03:45-04:00	Tea
04:00-05:15	<p>Differential pricing of medicines, drug price control order, Jan Aushadhi scheme and access to medicines</p> <p><i>Objective: The dynamics of drug pricing in India and its influence on access to medicines</i></p> <p>Chair: Prof. J.K.Das, Director, NIHFV</p> <p>Panelists</p> <p>Mr. Amitava Guha, JSA Dr. Dinesh Abrol, ISID Mr. Anand Grover, Lawyers Collective Dr. Mira Shiva, AIDAN</p>
05:15-05:30	Open floor
05:30-05:40	Wrapping up the day
Day 2 (Thursday), 3rd March 2016	
09:30-09:40	Welcome and recap
09:40-11:00	<p>Role of private health care sector and pharmaceuticals in ensuring universal access to essential and life saving medicines</p> <p><i>Objectives : Exploring provision of free medicines in private health care sector and the role of pharmaceuticals</i></p>



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	<p>Chair : Dr. S.S. Agarwal, President, Indian Medical Association (IMA)</p> <p>Panelists :</p> <p>Dr. Rakesh Biswas, Professor and HoD, Dept. of Medicines, LN Medical College Hospital, Bhopal Dr. Shailender Hooda, ISID Dr. Narendra Gupta, Prayas</p>
11:00-11:15	Open floor
11:15-11:30	Tea
11:30-12:45	<p>Ensuring free drugs and diagnostics within the paradigm of health insurance and PPPs</p> <p><i>Objective : Examining scope for ensuring access to free drugs and diagnostics through insurance schemes and PPP models</i></p> <p>Chair : Dr. Sanjiv Kumar, Executive Director, National Health System Resource Centre (NHSRC)</p> <p>Panelists:</p> <p>Dr. Madhur Gupta, WHO Dr. Ravi Duggal, Anusandhan Trust Dr. Raman V. R., Public Health Expert Dr. Amit Sengupta, JSA</p>
12:45- 01:00	Open floor
01:00-01:30	Evolving framework for action and way forward: Brainstorming and group discussion
01:30-02:00	<p>Closing remarks:</p> <p>Dr. P.K.Anand, Senior Consultant, NITI Aayog</p>
02:00-02:15	Vote of thanks
02:15	Lunch

ANNEXURE - 3

List of Participants

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ISID

प्रयास
PrayasNATIONAL TECHNICAL FORUM ON NEED OF
FREE MEDICINES AND DIAGNOSTICS TO ALL

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ISID



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ANNEXURE - 4

Presentations by Speakers

Dr. Rajesh Bharadia

RAJASTHAN MEDICAL SERVICES CORPORATION



WELCOMES YOU



PRESENTATION ON
IMPLEMENTING FREE MEDICINE SCHEME
IN UJLU


LESSON FROM RAJASTHAN

by :- Dr. Rajesh Bharadia
(Maheshwari)
DPC OIC DDW RMSC Udaipur Raj.



IMPLEMENTATION OF THE SCHEME

- 1- Constitution of NMSU & centralized procurement
- 2 At Dist. Level Supply of storage Racks, Lifts, Pallets etc. to DDW
- 3 Direct Supply of medicine by supplier to DDW through RMSC
- 4 Free Distribution of medicines to Patients from DDWs



MEDICINE PROCUREMENT, SUPPLY & DISTRIBUTION

```

    graph TD
      A[ANNUAL DEMAND GENERATION From Facilities (HIL/PHC)] --> B[CMO OF DISTRICT]
      B --> C[DDWS/JAIPUR]
      C --> D[RMSC]
      D --> E[TELEDER]
      E --> F[QUANTITY-BASED ORDERING SYSTEM TO DDW]
      F --> G[DDW DDW - UDAIPUR]
  
```

By Dr. Rajesh Bharadia



```

    graph TD
      A[QC PASS] --> B[Supply to facilities as per Indent (ONLINE/DEPT)]
      B --> C[Supply From DDW as per supply Counter of Emergency Indent]
      C --> D[Vendor Entry of In Store Stock Issue to BDC of Facility]
      D --> E[Issue to Patient as per prescription]
  
```



RMSC - Rajasthan Medical Services Corporation
MNSU - Ministry Manoj Kishore Mehta Yojna
HLC - Drug & Therapeutic Committee
DDW - District Drug Ware House
BDC - Drug Distribution Centre
IA - Informatic Assistant





BENEFICIARIES



- 1- OPD Patients of Govt. Hosp.
- 2- IPD Patients of Govt. Hosp.
- 3- Patients of **Thalassemia & Hemophilia**
- 4- **All Govt. Officers, Employees & Pensioners**
- 5- BPL, Family & old age Pensioners, widows, handicapped etc will cont. to get **MMJRK** benefit.



WHAT WILL AVAILABLE ?



- Commonly used essential medicines & Injections
- **Surgical Items** Needle, Dispo, Syringe, Gauze, Gloves, RT Sm etc.
- **Sutures**



RMSC

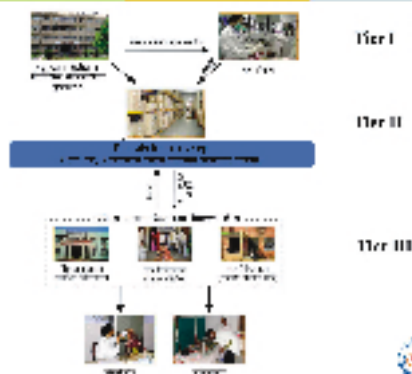


- Transparent tender process
- Quality medicine procurement at minimum rate
- Direct supply to DDW
- Distribution after **Quality testing** only



FORMERLY SUPPLY TO DISTRICT HOSPITAL

Sl. No. of Patients	Maximum Billable	Types of Patients	Fee	Maximum Billable (Type of Patients Fee)
25,000	25,00,000	OPD	100/-	25,00,000
10000	10,00,000	IPD	1000/-	10,00,000
10000	10,00,000	Emergency	1000/-	10,00,000
10000	10,00,000	OPD	1000/-	10,00,000
10000	10,00,000	Emergency	1000/-	10,00,000
10000	10,00,000	Emergency	1000/-	10,00,000
10000	10,00,000	Emergency	1000/-	10,00,000
10000	10,00,000	Emergency	1000/-	10,00,000



DDW



- One in each Dist.
- Direct supply of medicines
- Storage of medicines as per norms
- Quarantine & Quality Check
- Distribution to all institutions
- Passbook System





3. Setting up of requisite and unique infrastructure at healthcare institutions

Each DDW created @ Rs 2.25 lacs

- 1 Gas machine
- > Scales/Balms
- > Refrigerator
- > Computer with printer
- > Stationery

Total Number of DDWs 15160

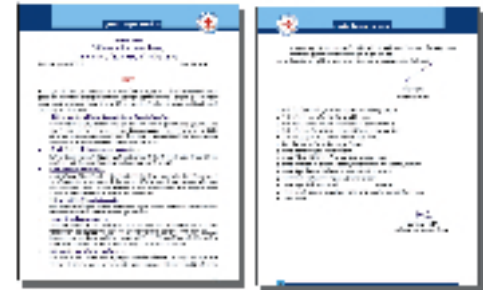


DDW Udaipur

HR

- D. JBL (1) (D.M. RESUM)- 1
- Pharmacist - 2
- IA - 2
- Peaches - 4

2. Prescription by generic name.



Union Minister of Health has signed the order for disbursement.

Drug Distribution Center (DDC)



The Drug Distribution Centers have been established based on GDP and IFU load of each institution.

- Total 15160 DDCs have been set up across the state.



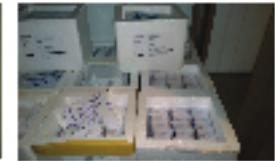


Table with 5 columns: S.No, Name of the organization, Address, Contact No., and Website. The table lists various organizations involved in the project, including ISID, Prayas, and others.

S.No	Name of the organization	Address	Contact No.	Website
1	ISID
2	Prayas
3
4
5
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15



To know the Standard Treatment Guidelines & Essential Drug List

STG
 Standard Treatment Guidelines (STG) are a set of evidence-based clinical practice guidelines developed by the Ministry of Health and Family Welfare, Government of India. They provide a clear and concise summary of the best available evidence for the diagnosis, management, and prevention of various common and life-threatening conditions. The STG are designed to be user-friendly and accessible to healthcare providers at all levels, from primary care to tertiary care. They are updated regularly to reflect the latest evidence and changes in clinical practice.

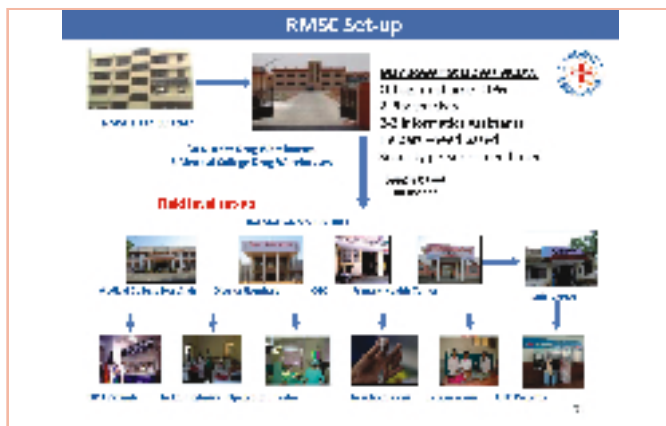
EDL
 The Essential Drug List (EDL) is a list of medicines that are considered essential for the health of the population. It is developed by the World Health Organization (WHO) and is used by many countries as a guide for the selection of medicines for their national drug policies. The EDL is based on the principle of equity, which means that all people should have access to the medicines they need for their health. The list is updated periodically to include new medicines and to remove those that are no longer considered essential.



4. Sensitization & Orientation of the prescribers.

NINOT Inceptor - Seminars, Conferences & Dealer meetings





- ### Unique Features of Scheme in Rajasthan
1. Presence of internet using 1.1.1.1 protocol in all.
 2. Existence of essential medicines for production of generic drugs.
 3. Setting up of the state procurement for less than 1000 rupees.
 4. Centralized and decentralized of the medicines.
 5. Construction of PPO (Pharmacy & Therapeutic monitoring).
 6. Departmental Tender for Pharmaceuticals & diagnostics sub-block.
 7. All India supply list & health care system.
 8. Drug Monitoring through new software (DRUG) reporting system – developed jointly through MNDY.
 9. MNDY based on drug monitoring & feedback system.
 10. "Pharmacy 5.0" range of drug dispensing.
 11. New drug & vaccine supply management.
 12. In-house management through the state health application.



- ### Challenges of the Journey so far
- Population 70% in an population, longer waiting times (increase in both OPD/ IPD patients after MNDY/MBJP schemes)
 - Cold chain maintenance (in summer temp rises upto 50°C)
 - High patient load in tertiary care centers & shortage of Doctors/Pharmacists.
 - Issues related to pillerage, breakage, deterioration, drugs becoming obsolete etc., leading to adverse media reports at times.
 - Issue of Drug Expiry
 - Incidents of Sandals
 - Anticipated high procurement rates more Corporations less BARGAINING POWER

- ### Achievements of MNDY
- Free availability of Quality medicines – Above 90% in Urban area & 87 to 90% in Rural area
 - Increase in OPD – About 50% increase in OPD Pts
 - Increase in IPD – About 20% increase in IPD Pts.
 - Supply Defence – Regulars Supply of Medicines to All Institutions by supply centers
 - High Patient Satisfaction Level – Patients are Satisfied & getting free medicines in OPD & IPD

Motivation By Honour

Udaipur Dist. Has been awarded No. 1 in Rajasthan for Implementation & Achievements under MNDY.

The Credit goes to **TFAM WORK**.



ISID

प्रयास
Prayas



NATIONAL TECHNICAL FORUM ON NEED OF
FREE MEDICINES AND DIAGNOSTICS TO ALL



THANKS

&

Welcome If any query
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RMSU Udaipur Raj.



Dr. Durbha Rohini Kumar

Free Diagnostic and Medicine Services in Bihar

GoB is committed to provide the services free of cost to all people coming to public health care facilities

With Resolution 383 (L2) dated 5.7.2006 to provide Bihar for Andrology, Gynaecology, Paediatrics, Pathology services

- With Resolution no. 2403 dated 27.10.1996 for supply of free medicine services under BMJL (Bihar) for the first phase. And for free medicine policy
- With Resolution no. 483 (2) dated 09.11.2006 for free services under BMJL (Bihar) for the second phase medicine & diagnostics

Challenges- Free Medicine Services

- Selection of Medicines
- Streamlining procurement process (Decentralised Vs Centralised)
- Vendor selection
- Storage
- Quality Control
- Distribution to last mile
- Cost effective Generic Drugs in non public health sector

Initiatives by GoB

- CML formulated
- Established BMJCL
- Introduction of procurement
- Decision for a Akshayini rollout
- Established RW (13), District Drug Ware Houses
- NAHL accredited Labs
- Distribution Channel upto DDW (Out sourced)
- Generic drug shops

ESSENTIAL MEDICINE LIST

HEALTH FACILITIES	NO. OF DRUGS	NO. OF PH. DRUGS
HEALTH SUBCENTRE (5-12 POPULATION)	25	120
DISTRICT HOSPITALS (100000)	11	112

As per Govt decision the existing State FML is undergoing a revision process to identify facility wise EML for the State

Diagnostic Policy of Bihar

Diagnostic Services

Free lab services for all patients coming under PMJ (Bihar) at Government Hospitals

- | | |
|----------------------|--|
| • TB check Centres | • CHD Govt. hospitals |
| • SSI Centres | • CHD Govt. hospitals |
| • TB Medical Centres | • CHD Govt. hospitals |
| • CT Scans | • CHD Govt. hospitals and Medical Colleges |
| • MRI Services | • Medical Colleges |

Challenges- Free Diagnostic Services

Outsourcing Vs In-house resourcing

Issues of outsourcing

- Limited staff due to loss of agencies
- Limited staff due to cost
- Financial stability of agency
- Monitoring
- Quality of service
- Infrastructure available for necessary

Issues of in-house

- Cost
- Staff
- Infrastructure

Initiatives by GoB

- Planning to both MNS offering for ICF services
- Training of UG for providing basic pathological services
- Efforts to provide in purchase of basic pathological services by all TCs
- In 2013 a survey was conducted in 145 PHUs were equipped with 1000 microscopes, 2000 TBX with 1000 serum separator and 700 POCs from each district have been provided with one set of basic diagnostic facility.
- X-Ray facilities are being provided in 443 public health care facilities
- Ultrasonid facilities are being provided in 182 public health care facilities
- Proposal for Ultra Modern Diagnostic Centers at regional level (3) and Medical Colleges (6)

Current Status of types of tests being provided

Sl. No.	Type of Test	2011-12		2012-13		2013-14		2014-15		Total	
		No. of PHUs	No. of Patients	No. of PHUs	No. of Patients	No. of PHUs	No. of Patients	No. of PHUs	No. of Patients		
1	Microbiology	10	100	15	150	20	200	25	250	70	700
2	Hematology	5	50	10	100	15	150	20	200	50	500
3	Chemistry	10	100	15	150	20	200	25	250	70	700
4	Immunology	5	50	10	100	15	150	20	200	50	500
5	Pathology	10	100	15	150	20	200	25	250	70	700
6	Other	5	50	10	100	15	150	20	200	50	500
7	Total	45	450	65	650	85	850	105	1050	300	3000


THANK YOU

Dr. Dileep Kumar




**Free generic drug Distribution in
KERALA**
dr.dileep.(General manager)





- Fully Government owned company established in 2007, registered under companies act 1956.
- Commencing with effect from 1st April, 2008.
- Under the Department of Health & Family Welfare, Govt. of Kerala
- Central procurement agency for all public health care institutions under Govt of Kerala.
- Catering 14000 Health care institutions



BOARD OF DIRECTORS

Dr. K. Hanumanth IAS
Chairman, KMSCL & Secretary to Government Health, Family Welfare

Sri. Gopinath IAS
Managing Director, KMSCL

S. J. Paul G B IAS
Member, Health Finance, & M&A


Sri. Hanumanth P
Deputy Controller, Kerala

Dr. Anandakrishnan S
Director of Health Services

Dr. A. Anand Beena
Director of Medical Education

Dr. Jayaraman Nambiar
Prof. and Head, College of Pharmaceutical Science

Sri. M. P. Prabhakar
Special Secretary, Kerala Drug Control Services




Key Objectives

- Transparent procurement process
- A strong regulatory mechanism to ensure quality, safety and efficacy of medicines.
- Uninterrupted supply of medicines in sufficient quantities to public health facilities utilizing modern supply chain tools.
- Enabled monitoring system
- State of the art drug storage.



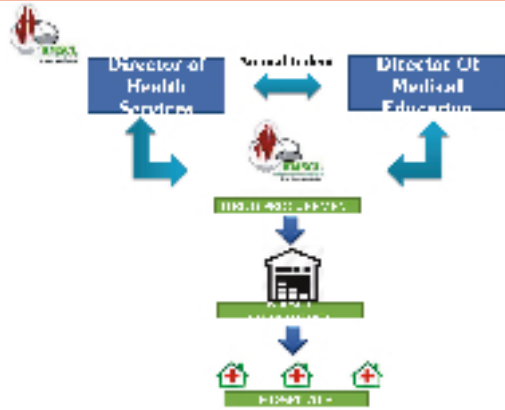
Free Generic Drug Distribution scheme

- State sponsored scheme
- Started in 2012
- 320 Crore Budget per year
- 585 items which is covering all items in NLEM
 - 428 Drugs including 69 Anticancer drugs
 - 157 consumables
- 1400 Health facilities ranging from Medical Colleges to PHC



free Generic Drug Distribution scheme

- Separate tendering templates for PHC, CHC & FRUs
- PHC & CHC316 Items
- Medical colleges & institution with oncology units.....585
- Heretics included anti hemophilic factors 03 in oncology extra to FDI



DRUG PROCUREMENT & Distribution

- Purchasing power of over 300 Crores through grant in aid from Govt of Kerala
- Procurement through a Tender process only.
- Strict regulations regarding 03 year Market standing, GMP & Turn over criteria for ensuring good quality products in the time frame
- IT enabled Supply chain management

QUALITY CONTROL

- Large amount of testing provided as per file
- Handles over 10,000 samples a year in an in-house testing lab.
- Strict quality control regime.
- Over Rs. 2 Crores spent on quality control.
- Minimize procurement due to illegal entities and spurious labels.
- A suite of 8 NABL – accredited laboratories.
- 40 Products & 01 Company Blacklisted in Jan

Key Features

- All the batches supported by test analysis reports furnished by Independent NABL Accredited Drugs Testing Laboratories-Central Drug Testing Laboratory
- Minimum 80% shelf life from the date of manufacture when supplied in the Corporation
- Samples will be drawn for quality testing periodically throughout the shelf life period

Black listing for ensuring strict Quality control

- If two or more batches of a product fails in quality, that product will be black listed
- If two or more product of a company fails in Quality..The company will be black listed for 03 years from participating in tenders
- Any company which is being black listed by any other corporation is not presented from tender participation

Core Competency

Inventory Management - Rs.320 Cr

Warehousing - 21 Scientific Warehouses with IT enabled FIFO mechanism

Quality monitoring

Vendor Management-207 Vendors with experience To & From Govt. In 2016

Customer based mechanism with Toll free number



- First - Expiry- First- Out (FEFO)**
- Inventory management method that prioritizes the handling & issuing of date sensitive inventory.
 - Regardless of the date of entry acquisition, inventory with the earliest expiration date is handled first.
 - With FEFO, the logistical controls need to shield life differences in a smart way in order to reduce product loss & out stock levels, while increasing quality & safety.
 - KMSSCL only accept the drugs having a minimum shelf life of 60%

- Inter warehouse Transfer**
- Inventory management employed for maintaining the optimum number of each inventory unit.
 - They generally arise emergency requirement of a particular ward/department/ hospital/ emergency and disaster situations.
 - Reduce Stock holding of drugs.

- IT enabled Inventory management**
- IT enabled supply chain management.
 - Issue based only on FEFO to eliminate stock getting obsolete.
 - Effective inter warehouse transfer of slow moving and non working items.
 - Online Drug Distribution Management upto facility level enabling centralized monitoring of inventory in all Institutions.

- Drug Distribution Management System (DDMS)**
- Central system - vendor, Govt, Govt and item wise complete database for internal monitoring.
 - Department/center has provision to edit & validate.
 - Issuing of drugs to Institutions - Online Purchase Order (PO) system in place through DDMS.
 - Vendor Management: Supplier to enter the shipment details of the items such as warehouse, invoice date, lot no, manufacturing date, expiry date, quantity, batch, expected date of delivery, mode of delivery etc against each warehouse as per the PO.



Drug Distribution Management System (DDMS)

- To supply into multi facilities as Warehouse Manager oversees inventory planning
- To supply of medicines in First Expire First Out (FEFO) manner
- The provision of redistributing the items like moving drug shortage or other issues across through the system.
- To ensure Quality control process is followed as software
- Supply schedule and management directly visible to warehouse



Scientific Warehouse

Need for Scientific Warehouse

- To avoid soiling and moisture damage
- To avoid deterioration of stock
- To Minimize exposure of packaging materials to contaminants, rodents, insects, dust and shelf
- To prevent or reduce damage, loss of stock
- To prevent mixture of generics and brand

Storage Environment

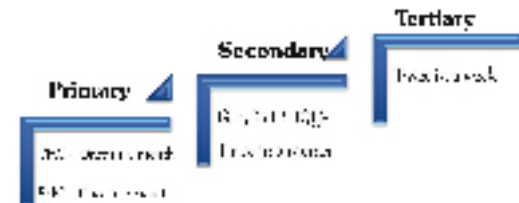
- Adequate temperature
- Sealed containers
- Clean and dry area
- Limited access
- Cold storage in files
- Adequate spacing to ensure integrity of lab tested drugs



Warehouse



Supply Schedule for continuous replenishment of institution stock by direct monitoring to reduce local purchase



Vendor Management System

- Vendor management - Online - To ensure excellent and mitigate risk to gain increased value from their vendors through the e-catalog system.
- Ensure the right products are delivered at the right place at the right time.
- Collaborative and Organized approach
- Shorting of lead time and supply.



Grievance Redressal Mechanism

- Toll free number 18001-202-202.
- This initiative was first in the country
- The queries on drugs, their availability in health care facilities, quality issues and other drug related informations are addressed by Supply Chain Management Department only via toll free number.

CHALLENGES

- Difficulties in the implementation Generic prescription practice among Doctors
- Assurance standards treatment Guidelines in line with the EDL
- Strict Regulatory mechanism needed for preventing Irrational combinations in the market
- Patient information issues regarding the quality of generic drugs
- High pricing, for the life saving drugs

Free Diagnostic facilities in Kerala

- Almost all PHCs are equipped with primary health Lab with semi auto analyser
- CT Scan facility with tele radiology facility is there in At least one secondary care centre under DHS in all Districts & all Medical colleges DMF
- MRI Scan in three Medical Colleges & two district hospitals through LSIGD Funds

Free Diagnostics

- AS of now all diagnostic services are free to all children under 18 through for SC health conditions under RHC
- All the health issues under the age of 18 are taking care of by "ARDEYAK RANAAM" State sponsored scheme
- Apart from that under TIADOLAM/Cancer Suraksha & TSBY schemes also the children are getting free diagnostics & treatment.

Free diagnostic services

- All BPL & SCST patients are also receiving free diagnostics in all Health facilities
- These with BSY Cards are getting free diagnostic services under the insurance
- All pregnant ladies get the entire free diagnostic services under ISS
- The angle of some of Kerala's health care schemes, the reserved money out of others is being used for free treatment & diagnosis of the medical disorders/ Renal ailments & Transplant medicine upto 200000/-
- Under KHL the treatment of leishmaniasis is lifelong

Free Diagnostic Services

- "Karnataka Arogya Jeevanam"
An umbrella where all the schemes will be converged to provide free diagnosis & treatment.
TSBY/CHIS plus by Labour Dept./ Sarvwa Benevolent Fund by lottery Dept./ TI ADOLAM & Cancer Suraksha by KSSM / Aranyakirana by State Government & centrally sponsored schemes like RDSK/RDSK/JSSK
CMDF-a supporting its umbrella
CSR opportunity for companies also provided

Dr. B.K. Swain



Odisha State Medical Corporation Ltd
**"A Wholly owned company
of the Govt. Of Odisha"**

Its Progress.....

www.osmc.gov.in

About OSMC

- Public Ltd. company incorporated under the Companies Act 2013 by the Govt. of Odisha.
- Regd office: 25 Okhila 3
- Date of Incorporation: 08.11.2013
- Authorized capital: Rs. 10 Crores
- Registered capital: 100% paid up by Govt. of Odisha
- Formed for the purpose of implementing the "Free Medicine Distribution Scheme"

www.osmc.gov.in



Objective

- Improve access to essential medicines
- Reduction of financial burden (low cost) of medicines
- Reduction in morbidity and Mortality
- Improve overall health status of public in Odisha
- Free of cost
- Quality
- Essential medicines
- Local diseases (upto 1000) to Government Health facilities

www.osmc.gov.in



Key Function of the corporation

- Timey Procurement of quality medicines, surgical and diagnostic equipment and lab instruments, computer hardware devices
- Manage central drug warehouse to store, to supply, to reach facilities, then procure, control, selection, inventory Management System.
- Monitor functioning of 1000 Distribution Centers, set up across health facilities & use computerized flow and feedback system
- Ensure smooth and maintenance of medical equipment across health facilities.

www.osmc.gov.in



Functional Divisions

- HR and ADMIN.
- Finance
- Procurement
- Quality Assurance
- Logistics and Supply Chain
- IT Cell
- Equipment maintenance

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Chronology of events for FreeMedicine Distribution Scheme

- Sensitization Workshop for Manufacturers and Suppliers organised on 5th January 2015
- First e-Tender floated on 12th January 2015 which is also the first e-tender under 18-BW Govt.

www.osmc.gov.in



Odisha State Medical Corporation



- Corporate Building Inaugurated on DL 28.07.2015 by Hon'ble CM

Dr. Tejendra Prasad



Operationalisation of NIRAMAYA

- Free Medicines Distribution Scheme (NIRAMAYA) was launched on 28.04.2015 by Hon'ble CM.

- Operationalisation of 10000 PHU and 10000 PHU on 14 May 2015



Dr. Tejendra Prasad



" NIRAMAYA" FREE MEDICINE DISTRIBUTION SCHEME"



Dr. Tejendra Prasad

Strengthening of Drugwarehouses



- All Districts, MC and municipal Corporations, Ware house area 5000 sqm - 187
- All ECH holding warehouse of 1000 to 2000 sqm - 0
- All PHU holding Ware house of 1000 to 1500 sqm - 0

Dr. Tejendra Prasad



Strengthening of Drug Warehouse

- All the warehouses are being installed with heavy duty racking



Dr. Tejendra Prasad

Essential Drug List

- Essential Drug List prepared basing on category of Institution
- Total Items in EDL 570
- Total Items in Non-EDL
 - Antibiotics & others 122
- Primary Health care Institution 297 Items
- Secondary Health Care Institution 487 Items
- Tertiary Health care Institution 563 Items
- Surgical sutures 175 Items

Dr. Tejendra Prasad

DD Infrastructure Supported by NHM

Category	No. of DDCs	Capacity
Sub-centres	184	4 per DDC
PHCs	28	8 per PHC
Primary Health Centres	42	20 per PHC
SC Health Centres	87	4 per DDC
CHCs	377	1 per CHC
Other Health Centres	64	1 per unit
Total	725	

Dr. T. S. Prasad, Prayas

Status of Drug Distribution Counter



Functional DDCs	Count
Sub-centres	184
PHCs	28
Primary Health Centres	42
SC Health Centres	87
CHCs	377
Other Health Centres	64
Total	502

Dr. T. S. Prasad, Prayas



DDC at Capital Hospital



Dr. T. S. Prasad, Prayas



Assuring Quality

- Drugs are sent from supplier and kept in Quarantine.
- Random Samples sent from each batch and sent to 22 empanelled NABL Certified Laboratories.
- Based on test reports Drugs released to retail supplier.



Dr. T. S. Prasad, Prayas



Logistics Management



- DDC has 50 GPS enabled uniformly branded vehicles for all remote Districts for delivery of the Drugs upto PHC level to provide the stock upto to the rural DDCs.

Dr. T. S. Prasad, Prayas



Logistics Management

- 50 vehicles with 107 Material Handlers
- To cover 377 CHCs once in every month
- 1307 PHCs/ Other Hosp. & All Urban Health centres in every 2 months.

Dr. T. S. Prasad, Prayas

Responsibility

- Responsibility of OSVC - Annual indent analysis, Procurement, Warehousing, and transportation up to PHC level
- Management DDCs by I & FW Dept.
- Monitored & Review functionalisation of IT ICs through IT enables software - e-Aushadhi
- For operationalisation of DDCs Govt has created 598 posts of pharmacists

Dr. Tushar Chandra



e Aushadhi

- Dedicated IT Centre Functional at OSVC.
- Online Stock Management upto DDC level and DDC
- JIT - no stock management at PHCs and all indirect consuming units to be captured.



Dr. Tushar Chandra



Status of procurement of EIF

Category	Quantity	Value (Cr)
1. Aushadhi (Free)	5	0.00
2. DDC (Free)	1	0.00
3. Aushadhi (Paid)	1	0.00
4. DDC (Paid)	1	0.00
5. Aushadhi (Total)	7	0.00
6. DDC (Total)	2	0.00
7. Aushadhi (Total)	7	0.00
8. DDC (Total)	2	0.00
9. Aushadhi (Total)	7	0.00
10. DDC (Total)	2	0.00

Dr. Tushar Chandra

Status of procurement of EIF

Category	Quantity	Value (Cr)
1. Aushadhi (Free)	5	0.00
2. DDC (Free)	1	0.00
3. Aushadhi (Paid)	1	0.00
4. DDC (Paid)	1	0.00
5. Aushadhi (Total)	7	0.00
6. DDC (Total)	2	0.00
7. Aushadhi (Total)	7	0.00
8. DDC (Total)	2	0.00
9. Aushadhi (Total)	7	0.00
10. DDC (Total)	2	0.00

Dr. Tushar Chandra

Budget

- State Budget -----200 Cr
- NIM 60 Cr
- TIF 100 Cr
- Funds released to districts for decentralised procurement - 10 to 20 percent of total drug budget

Dr. Tushar Chandra

Patients Benefited

Month	DDI, Medical College & Tertiary Hospitals	BCHs	Total
May 2015 to Jan 2016	4414186	508861	5525047

Dr. Tushar Chandra





ISID



Way forward

- Fully computerised DDC at CHC by March 2016
- Manual functioning of DDCs at PHC by March 2016
- Assured diagnostics at level of institution under process

Dr. S. Srinivasan

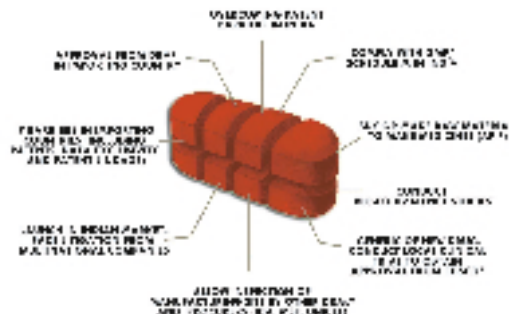
Thank You



Dr. S. Srinivasan

Ms. Leena Menghaney

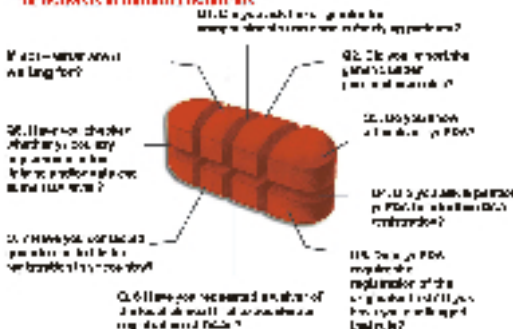
Think it's easy becoming a **generic drug** in India?
Think again



Regulatory strategy - Focus on two DAAs

- SQF first and then an NSD
- SQF + DAC is a priority
- FDAs tend to get confused when both SQF/LDV and SQF + DAC are pushed for registration.
- FDAs are conservative and dealing with not one but three new drugs at the same time is not something they welcome

Regulatory barriers to DAA treatment - Some questions for eMeds in different countries



If drug is unregistered and HCV+ has advanced liver disease

- Ask originator company for evidence—regulation compliance use grounds. Most of global companies have such programmes. If not willing to extend to developing countries. (Patent issue)
- On for a patient who needs the drug urgently, in particular to DAA, under personal use rules. Most FDAs allow customised allow sale.
- E.g. India's JG (CDSCO) allows some patient import for unmet medical need
- e.g. Customised - Australia, U.S, Malaysia allow patients or their family to carry 6-month's medicine into the country

2 key issues that will accelerate registration of DAAs

- Requirement for originator to be registered first (Thailand) but most FDAs rules allow generics to be registered directly but prefer to process originator dossier first.
- Requirement for local trial—phase III in the country before the new drug is registered. Requesting waiver is important as originator not interested and generics find this requirement expensive to meet.



Case study - India - registration of 30F one OAC in 2010 Briefing document for FDA

City: Bangalore
Date: 2010

At the time of the case study, India was still a developing country and the regulatory system was not as advanced as in high-income countries. The regulatory system was still in its infancy and the regulatory process was not as streamlined as in high-income countries.

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Raising awareness

City: Times of India, 2010 August -
Request for use of generic medicines

The article discusses the possibility for multiple generic drugs to be marketed in India. It highlights the challenges faced by generic manufacturers in India, such as the lack of a strong regulatory framework and the dominance of multinational pharmaceutical companies. The article also mentions the need for a regulatory reform to allow generic manufacturers to compete effectively in the Indian market.

On September 20, 2010, the pharmaceutical company, GlaxoSmithKline (GSK) filed a request for use of generic medicines in India.

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For open registration by Apex Committee 24.12.2010

Sl. No.	Drug Name	Generic Name	Remarks
1.	30F one OAC	30F one OAC	The Apex Committee has decided to allow the registration of 30F one OAC in India. The Apex Committee has decided to allow the registration of 30F one OAC in India. The Apex Committee has decided to allow the registration of 30F one OAC in India.

Indian civil society demands DCV local trial waiver

The article discusses the demand for a local trial waiver for DCV in India. It highlights the challenges faced by generic manufacturers in India, such as the lack of a strong regulatory framework and the dominance of multinational pharmaceutical companies. The article also mentions the need for a regulatory reform to allow generic manufacturers to compete effectively in the Indian market.

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Asian civil society requesting waiver of local clinical trials for OACs in India

The article discusses the demand for a local trial waiver for OACs in India. It highlights the challenges faced by generic manufacturers in India, such as the lack of a strong regulatory framework and the dominance of multinational pharmaceutical companies. The article also mentions the need for a regulatory reform to allow generic manufacturers to compete effectively in the Indian market.

Treatment Action Group's letter to CDSCO to accelerate Dasiglucan's registration in India

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DNDI addressing on DCM's pan-genotype use to treat Chronic Hep C

Genetic diversity has led to the development of DNDI's pan-genotype treatment for Chronic Hepatitis C. The development of DNDI's pan-genotype treatment for Chronic Hepatitis C is a significant milestone in the development of a single treatment for all genotypes of Chronic Hepatitis C. The development of a single treatment for all genotypes of Chronic Hepatitis C is a significant milestone in the development of a single treatment for all genotypes of Chronic Hepatitis C.

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Results 2015

Registration of Sofosbuvir in Jan 2015
Registration of Ledipasvir in November 2015

By Jan 2016 generic companies marketing the combination

Treatment will cost ₹ 4000 (approx) for 12 weeks of treatment for 1 patient

Acknowledgement to those who challenged patent applications in India - led to acceleration of development of generics opening up an opportunity for us to push for registration

Dr. Manoj Kumar, MPP, New Delhi

www.prayas.in

CANARA NEWS

By December every district and taluks would have generic medicine stores and 24x7 pharmacy centers -U T Khader Minister for Health.

14 November 2014

Generic drug outlets to come up shortly in all districts: Khader.

THE HON'BLE Secretary

Minister for Health and Family Welfare U.T. Khader has said that generic drug shops would be opened in all the districts shortly. Ten districts would get the shops within three months and the rest, shortly thereafter.

"These generic drug outlets would be air conditioned to ensure the quality of drugs. They will be equipped with a software that could give generic alternatives to brand-based prescriptions. They will be set up outside government hospitals so that out-of-patients can also make use of them. The outlets will be open round-the-clock seven days a week. In order to ensure quality, only medicines from the first companies should be sold in the outlets," Mr. Khader said. People would save a lot of money when purchased generic drugs instead of those under brand names, he added.

Generic drug stores in all the wards District by January - U T Khader: 16th December 2013

www.prayas.in

16th December 2013
 The Hon'ble Minister for Health and Family Welfare, Government of Karnataka, has said that generic drug stores will be opened in all the wards of the state by January 2014.

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Pharmaceuticals in Health Care Delivery

Missour Record
 18 26 July 2013

August 2015

Dr Kathleen A Holloway
 Regional Advisor in Essential and Other Medicines, World Health Organization, Regional Office for South East Asia

In Collaboration with

Dr Manjun Gupta, Technical Officer
 Pharmaceuticals, WHO India Country Office,
 New Delhi

WHO report - Karnataka

There was evidence of stock-outs from both facilities and warehouses. Distribution of drugs is based upon last year's consumption and senior staff estimates are inaccurate due to a lack of a systematic method and not taking into account stock-out periods.

WHO report - Karnataka

It was recommended that the manpower shortage be rectified as a matter of urgency that the Standard Operating Procedures (SOPs) be established for all various procedures and committees that drug schedules be enforced more strictly, and that a unit be established to monitor drug promotion activities.

WHO report - Karnataka

With the advent of free drugs schemes in 2002 plus the advent of the National Rural Health Mission in 2005, access to essential medicines at government health facilities has improved although there are still some reports of stock-outs and patients having to buy their medicines in private retail pharmacies.

..

WHO report - Karnataka

In one warehouse visited, the in-charge was also working in the district hospital and the chief pharmacist had been on deputation from another facility for 3 years.

The two warehouses visited were piled high in the ceiling with drugs and there was lack of information on stock levels at facilities. Were the KPLWS to be a Medical Services Corporation, it would have greater autonomy to hire staff

..

WHO report - Karnataka

The lack of staff in general, the lack of regular staff dedicated specifically to the KPLWS and the reliance on contract staff is likely to contribute to stock-outs.

..

WHO report - Karnataka

It appeared that no standard formula is used for estimating need and stock-out periods are not taken into account. In theory 2 months buffer stock is required but in practice this appears to not be followed by many facilities and warehouses.

..

WHO report - Karnataka

The lack of systematic method for drug procurement is not likely result in appropriate rates according to need. Under-use or over-use in past years will lead to under- and over-use rates respectively.

Easy availability of drugs may lead to over-demand and irrational overuse of medicines and/or frequent stock-outs, all of which may distort expected trends.

..

WHO report - Karnataka

It was mentioned that some facilities do not know when their supplies will come. Both warehouses and facilities complained that they were not always sent what they needed for.

..

WHO report - Karnataka

"STOCK - OUTS"

Review of the stock-out status of the KD LWS on 25.7.2015 revealed a significant number of stock outs on that day. Overall, 24% of items were out of stock in 67% or more of the warehouses and only 23% of items were available in all warehouses.

WHO report - Karnataka

With a shortage of staff, no standard method for quantification, no common electronic management information system operating at district warehouses and facilities and with the late procurement process this year, such stock-outs are likely.

WHO report - Karnataka

It appeared that many doctors regarded the FM as a basic set of drugs that could be afforded by the state, rather than a set of essential drugs that could cover the majority of the health care conditions.

WHO report - Karnataka

Most of these injections were a cotenac injection which constituted the second highest amount (1%) of the drug budget.

Most patients did not need an injection and such use risks harm to patients (side-effects) and is wasteful.

Doctors and patients demanded injections and that they would return the next day if not given one.

WHO report - Karnataka

Other very common examples of inappropriate prescribing included the following:

- Ranitidine or omeprazole to counter dolofenac or ibuprofen or even carisostatrol!
- Metronidazole and a fluoroquinolone for acute diarrhoea
- Use of newer generation antibiotics such as ceftriaxone and cefixime rather than the older antibiotic for upper respiratory tract infections, even in PHCs.

ACCESS TO MEDICINES IN KARNATAKA

A baseline study

September 2017

By

Public Health Foundation of India (PHFI),
New Delhi

Study Secretariat, Leasarsmane, Bangalore

PHFI study Karnataka study



PHFI study – Karnataka Drug Procurement

- 2013-14 the order of drugs finalized, the agency received only 25-26% of total drugs finalized. This coupled with extended procurement time (48 days to 150 days) has been the main reason for delayed supply of medicines.
- No policy on return of unused medicines.
- No transport of medicines from district warehouse to its respective public facilities. The pharmacist has to make the arrangements.
- 50% of facilities had drugs stored on the floor.

PHFI study – Karnataka Management of Availability of Drugs

- 19 of 55 P-C (35.81%) - No Pharmacist
- 1 Bijapur District 18 of 23 PHC (60%) - stock-out of Anti-Hypertensive. No drugs to treat diabetes. No OHS workers.
- Over use of D-drops

PHFI study – Karnataka.

Did you receive all indented drugs?

82.95% = Did Not get medicines indented



PHFI study - Karnataka

- Do you always get the indented or you also receive non-indented drugs?
- 43.67% got other than indented drugs.**



PHFI – study Karnataka AVAILABILITY OF PHARMACISTS

Was the Pharmacist available during the time of visit?

23% of the places visited there was no Pharmacy.



CAG Report 2007-12

- 1) Poor planning of drug procurement.
- 2) Procuring drugs from suppliers that did not meet technical specifications.
- 3) Procuring drugs in an excess of requirement – true dumping of drugs.
- 4) Drugs were procured from KAP (51% to 61%) – even though the prices of these drugs were higher than other states and despite non-availability of multiple drugs from KAPL.

Under the current government health policies, the primary cause of ineffectual and unavailability of essential medicines is the poor quality of public spending on health in Karnataka rural areas.

The capital public spending on health (2006-07)

Karnataka	Madhya Pradesh	Tamil Nadu
Rs. 60.40 Cr.	Rs. 60.55 Cr.	Rs. 60.43 Cr.

Annual expenditure on health services in Karnataka is Rs. 1000 crore. The annual expenditure on health services in Madhya Pradesh is Rs. 1200 crore. The annual expenditure on health services in Tamil Nadu is Rs. 1100 crore.

With over Rs. 6000 Cr. spent on medicines and supplies during 2010-11, Karnataka's per capita government expenditure on medicines is significantly lower as seen in the chart below:-

Per Capita (Rs.) state wise government drug expenditure (2010-2011)		
Karnataka	Tamil Nadu	Madhya Pradesh
22.1	66	72.3

ISID-ILRC-Serwanita, based on state-level Budget Documents and Demands for Grants. <http://bit.ly/1dlyu8w>

So there is an urgent need to increase the budget for health and also for making medicines FREE to all.

Civil Society - Response

- 1) Logistika - <http://www.logistika.org>
- 'From what we have observed, many PHCs do not yet have adequate or timely stock of vaccines and medicines. Materials frequently stock out, leading to sub-treatment.'
- 2) IPH - <http://iphindia.org> - had several rounds of meeting with State Health Minister

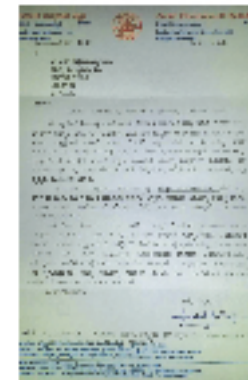
- 3) Drug Action Forum - Karnataka
- Met then Health Minister Aravind Limbavalli - BJP.
- Met Medical Education (Dr. Sharadprekash Pillai) & Health Minister (U. Khadar) of Congress.
- Met all political parties during elections (April 2013) - Congress, JD (S) & BJP.
- Each one reacted differently!!

Dharwad Generic Drug House



Dharwad Generic Drug House

ENALPRIL 5 mg, 10 tablets	
रुपये 36.64/-*	Generic Cost Rupees 5.75/-
ATENOLOL 50 mg, 14 tablets	
रुपये 43.15/-*	Generic Cost Rupees 6.25/-



Free Medicines for Karnataka.....



THANKS A LOT!



ISID

प्रयास
Prayas



Mr. Gopa Kumar

A2M : Global Challenges

K M Gopakumar
TMM

A2M at the Time of Austerity

- No more developing country problem
- Greece
- UK

Access : International Law and Policy

- Right to health
- Right to science

SDG 3

- Good Health and Well Being
- Nine targets
- Four means of implementation

Policy Incoherence

- Human rights Law and Trade law

Challenges

- Technology
- Regulation
- PR



Technology

- Fill the technology gap
- More public investment
- Technology assessment

Regulation

- Who?
- How?
- Timeliness?
- Appropriateness

IPR

- Patent, DB and Trademark
- Use of flexibility and bottlenecks
 - Law
 - Policy
 - Structural

Way Forward

Ensure insurance by removing the international law and policy
Bring coherence in the international law and policy making
Reform existing international IP and trade regime
Implement new R&D framework

Mr. Amitava Guha



Price control in Past

First Drug Prices Control Order (DPCO) in 1979

Based On cost of production (selling prices were calculated over 378 formulations and 14 bulk drugs)

Formula for selling price:

$$MRP = (RM + PM - PC) \times (1 + MAF/100)$$

When MAF is 100

$$MRP = (RM + PM - PC) \times 2$$

Enough scope for earning profit

Access to Essential Medicines

- Healthcare Cost is one of the main reasons for impoverishment
- 2.8 Cr people came below poverty line due to spending in medicine in 1993-94
- 3.4Cr. People are pushed below poverty line due to expenses for medicines In 2011-12

Impact of price control

DPCO Year	Drugs under Price Control	% of Market In Price Controlled Category	Markup (profit) allowed
1979	347	85.0%	10%, 15% and 20% in three categories termed "Essential", "Semi-essential" and "Non-essential"
1987	44	50.70%	10% and 15% in two categories, subsequent years categories with 10% markup
1993	74	25.00%	10%
2012	343	44.00%	Market based

Changing DPCO

- NDA Govt. decided In 2002 to wipe out prices control on medicines in steps. This was challenged In the court and case reached in the Supreme Court.

.....Consider and formulate appropriate criteria for ensuring essential and lifesaving drugs not to fall out of price control...

[Union of India & Others Vs K. G. Anand case In Supreme Court]

MARKET BASED PRICING

- Pharmaceutical Pricing Policy, 2013 decided to shift from cost based policy to market base
- DPCO accordingly declared 'Drug Prices Control Order, 2013 applicable to all formulations under NLEM, 2011
- Ceiling Price
"prices of brands of a formulation having 1% or more averaged and added retail margin of 16% will be the MRP"

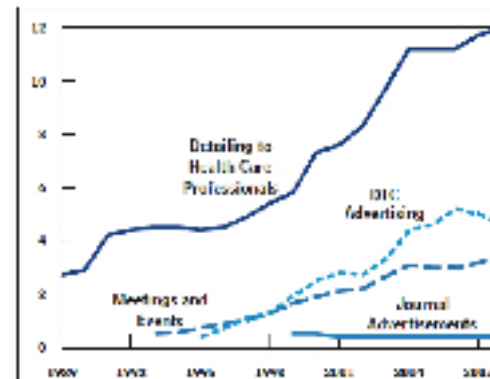
Weak attempt to extend DPCO

- NPPA notified extension of DPCO to 608 medicines which are not in NLEM
- It covered Cardiovascular and anti-diabetics
- Impact on sales: Rs. 350 crore
- Total impact raised to 2.58% only

PROMOTION OF MEDICINES

WHY PROMOTION

- ESSENTIAL MATERIALS DO NOT NEED PROMOTION
- ALL MEDICINES ARE NOT ESSENTIAL
- ESSENTIALLY NEEDS TO CREATE ARTIFICIAL DEMAND
- PROMOTION IS NECESSARY FOR CREATING DEMANDS
- LARGEST AMOUNT OF IRRATIONAL MEDICINES ARE SOLD IN INDIA



Free Samples: No so free

- Samples raise health care costs by promoting the use of expensive products. In the US, prescription costs grew 5-fold from 1990 to 2006 and are set to approach US\$200 billion annually. A substantial fraction of the increase is attributed to a growing reliance on expensive, brand-name medications.

Source: OC, Drug I, Drug II, 2006. Courtesy of the author to reduce pharmaceutical companies' and/or doctors' costs and to reduce the burden on patients. See Page 49-50-51

Bribing or Consultation Fee

- We need to understand the extent of how drug companies use their consultants and physicians. India's data that indicate doctors can earn up to \$400 in India.

Costing Edge, which works closely with drug company executives and is not able to purchase drugs for \$8000. A publicly available summary of one research shows that some doctors can earn more than \$10000 per year in off-invoice fees. A research also presenting to other reports suggests that it among the pharma dominated "hidden" search is more than public. Usually these spending are on listed a consultation or honorariums by companies.

OC, 2006. Drug I, Drug II, 2006. See Page 49-50-51

Physician - Industry Relationship

A number of 2007 physicians in a study by an independent, not-for-profit, non-advocacy organization, found marketing and promotional activities to be an average of 25% of their business. Some would be better off in the field.

- 77% reported some type of relationship with the pharmaceutical industry and 66% of that relationship involved receiving cash or gifts
- 10% of cash had no samples
- 75% of cash was used for other non-research
- 48% of cash was used for gifts, 20% for travel with a spouse and 10% for other non-research activities
- 28% received payments for consulting, going to dinners, attending conferences, etc.

Marketing was more than twice as likely to bring physicians to a conference payment.

Physician Payments Sunshine Act of 2009

Physician Payments Sunshine Act of 2009, a bill on "Transparency and Reporting on Physician Ownership or Investment Interest".

2008 of the 78 Cos disclosed payments 37 requested that some or all of their data be listed as trade secrets; these companies reported \$2.4 million in spending, or 83% of the \$2.9 million that was reported. Of the \$2.9 million, \$1.8 million was for the top 100 individual recipients, and \$861,912 was for food; \$479,306 went to psychiatrists, and \$445,304 was spent on marketing of drugs used to treat diabetes.

Penalties for Violation

Company	Penalty	Judge	Amount
Abbott	\$250,000	10/10	\$100
Amgen	\$250,000	10/10	\$100
Novartis	\$250,000	10/10	\$100
Roche	\$250,000	10/10	\$100
Merck	\$250,000	10/10	\$100
Johnson & Johnson	\$250,000	10/10	\$100
Boehringer-Ingelheim	\$250,000	10/10	\$100
Novartis	\$250,000	10/10	\$100
Roche	\$250,000	10/10	\$100
Amgen	\$250,000	10/10	\$100

VIRTUALLY UNREGULATED AREA

There is no law or regulation for promotion

Resulting:

A brief work in analyzing about 150 top selling medicines in the year 2007 gave the figure that Rs. 136,91,39,356 are promotional medicines which constitute 37% of sales of these 150 medicines

THREE 'C's OF PROMOTION

- **CONVINCE:** Using tall claims with cooked up evidences
- **CONFUSE:** Use tailored data, sponsored trials, funded papers
- **CORRUPT:** Inducement direct paying for Rx Gifts ranging from pen to car
Pleasure trips to any where

Corruption is legitimised

Govt. & Promotion

There were some reports in the news papers in the recent past, regarding promotional expenses made by the Pharma Co. administration reports suggest that some unethical marketing practices are being followed by certain pharma companies, keeping in view the seriousness of the allegations made in the media reports, this department felt the need to take up matters in the interest of the consumers/patients as such promotional expenses if being expenses to doctors had direct implication on the pricing of drugs and its availability

Amendment No. 1737 to the Bill passed on 27 December 2009



ISID



CODE OF ETHICS

MC: Notification of 10 Dec. 2009

All India - A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity.

GOVT' AFFORD

- ↓ The Govt. then came with a draft 'Code of Marketing Practice for Indian Pharmaceutical Industry' in June 2011. The code was kept voluntary for the industry to implement.
- ↓ The Central Board of Direct Taxes issued a notice to the pharmaceutical companies informing that promotion expenses would no longer be kept out of taxes. It clarified that the tax law doesn't not allow pharma firms to show spending incurred on gifts to doctors as deductible expense under the Income Tax Act. This implies such expenses would now have to be booked under profits by pharma companies and hence, would be rendered taxable.

THAT'S ALL

THANK YOU

Dr. Dinesh Abrol

DPCO 2013 AND FREE MEDICINES AND DIAGNOSTICS SCHEME

Dr. Dinesh Abrol, ISID
March 23, 2014
New Delhi

Introduction

- Implementing the scheme of free medicines and diagnostics requires attention on number of pre-requisites and its provision because it is a long journey by the already weak health system.
- 1) Regulatory control
- 2) Unregulated production of medicines
- 3) Inadequacy of health facilities
- 4) Medicines decrease in number and quality
- 5) Lack of R&D
- 6) Unregulated production of generic medicines
- 7) Lack of coverage of essential medicines, lack of standardisation of medicines, availability of quality medicines
- 8) Presence of corruption and HPP
- 9) Lack of equity control

DPCO 2013: Issues and Concerns

- Issues and concerns/ challenges are determined by market structure, existence or absence of the degree of competition, nature of entry barriers, and measures of market concentration. These include:
 - excessive entry barriers, excessive concentration, excessive entry barriers, price in a amount of market power, price gouging, market regulation and product differentiation, product quality with physician support.
- DPCO 2013 offers the formula of market cap to help in undertaking price regulation and ensure the fulfilment of the public interest. However, the scope of price control is limited and 24% hospitals are outside the scope of price control.
- Public procurement and production control based on the formula is the way to go forward to meet success with the free market conditions in the market.

Many essential medicines remain outside the coverage of DPCO 2013

- Coverage of the impact of the DPCO 2013 on the availability of essential medicines and those who have a turn of 4% in the market to know that the price impact is more on the DPCO 2013. It includes the drugs being consumed and controlled in the market.
- A decrease in price of medicines sold to government and through public health and through social insurance and because are going to be through the regulated market. It is not clear if the price of medicines will be reduced.
- There is the issue of the availability of essential medicines going to be addressed under DPCO 2013. It is not clear if the availability of essential medicines will be addressed, it is going to be the availability of essential medicines of the DPCO 2013. It is not clear if the availability of essential medicines will be addressed.
- There is the issue of the availability of essential medicines going to be addressed under DPCO 2013. It is not clear if the availability of essential medicines will be addressed, it is going to be the availability of essential medicines of the DPCO 2013. It is not clear if the availability of essential medicines will be addressed.

Industrial policy

- Free independence in market of essential drugs is a growing challenge. Monopolies are growing in the sector, market leaders have been successfully creating price walls.
- FSUs and small and medium scale units to pay a role in the consumer policy are being asked to their development.
- CoHS and other such schemes need to be made to HPP to use.
- Clinical cooperation is being monopolized by big business.
- Evidence exists that HPP model will be raising the costs of free medicines and diagnostics systems.
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- Evidence exists that HPP model will be raising the costs of free medicines and diagnostics systems.

Monopolies

Company Name	Market Share (%)
1. Sun Pharmaceutical	15.2
2. Dr. Reddy's	12.8
3. Cipla	10.5
4. Lupin	8.7
5. Divis	7.9
6. Zeeva	6.3
7. Hetero	5.1
8. Biocon	4.8
9. Aurobindo	4.2
10. Paddock	3.9
11. Jubilant	3.5
12. Natco	3.1
13. Divi's	2.8
14. Sankar	2.5
15. Aarti	2.2
16. Alkem	1.9
17. Hetero	1.7
18. Divi's	1.5
19. Sankar	1.3
20. Aarti	1.1
21. Alkem	0.9
22. Hetero	0.8
23. Divi's	0.7
24. Sankar	0.6
25. Aarti	0.5
26. Alkem	0.4
27. Hetero	0.3
28. Divi's	0.2
29. Sankar	0.1
30. Aarti	0.1
31. Alkem	0.1
32. Hetero	0.1
33. Divi's	0.1
34. Sankar	0.1
35. Aarti	0.1
36. Alkem	0.1
37. Hetero	0.1
38. Divi's	0.1
39. Sankar	0.1
40. Aarti	0.1
41. Alkem	0.1
42. Hetero	0.1
43. Divi's	0.1
44. Sankar	0.1
45. Aarti	0.1
46. Alkem	0.1
47. Hetero	0.1
48. Divi's	0.1
49. Sankar	0.1
50. Aarti	0.1
51. Alkem	0.1
52. Hetero	0.1
53. Divi's	0.1
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57. Hetero	0.1
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316. Alkem	0.1
317. Hetero	0.1
318. Divi's	0.1
319. Sankar	0.1
320. Aarti	0.1
321. Alkem	0.1
322. Hetero	0.1
323. Divi's	0.1
324. Sankar	0.1
325. Aarti	0.1
326. Alkem	0.1
327. Hetero	0.1
328. Divi's	0.1
329. Sankar	0.1
330. Aarti	0.1
331. Alkem	0.1
332. Hetero	0.1
333. Divi's	0.1
334. Sankar	0.1
335. Aarti	0.1
336. Alkem	0.1
337. Hetero	0.1
338. Divi's	0.1
339. Sankar	0.1
340. Aarti	0.1
341. Alkem	0.1
342. Hetero	0.1
343. Divi's	0.1
344. Sankar	0.1
345. Aarti	0.1
346. Alkem	0.1
347. Hetero	0.1
348. Divi's	0.1
349. Sankar	0.1
350. Aarti	0.1
351. Alkem	0.1
352. Hetero	0.1
353. Divi's	0.1
354. Sankar	0.1
355. Aarti	0.1
356. Alkem	0.1
357. Hetero	0.1
358. Divi's	0.1
359. Sankar	0.1
360. Aarti	0.1
361. Alkem	0.1
362. Hetero	0.1
363. Divi's	0.1
364. Sankar	0.1
365. Aarti	0.1
366. Alkem	0.1
367. Hetero	0.1
368. Divi's	0.1
369. Sankar	0.1
370. Aarti	0.1
371. Alkem	0.1
372. Hetero	0.1
373. Divi's	0.1
374. Sankar	0.1
375. Aarti	0.1
376. Alkem	0.1
377. Hetero	0

Importance of public procurement

Sl. No.	Particulars	2014-15	2015-16	2016-17	2017-18
1	Central Government	1,10,000	1,20,000	1,30,000	1,40,000
2	State Government	2,00,000	2,20,000	2,40,000	2,60,000
3	Union Territory	50,000	55,000	60,000	65,000
4	Local Bodies	10,000	12,000	14,000	16,000
5	Other	5,000	6,000	7,000	8,000
6	Total	3,75,000	4,13,000	4,51,000	4,89,000

Innovation Essential Medicines and Price Control

- Market led price control with encouragement which is making more the amount of investment
- Subsidies in the form of equity in favour of essential medicines needs targeted capital based incentives
- Patented medicines need to be produced and distributed by the government through Jan Aardid which are in difficult ways to make and companies leaving the market stage for patenting and cooperation with the aim of ensuring production, if reduction of conditional price reduction.

Concluding remarks

- Effective from 2020 in respect of medicines with the monitoring and use of some of the mechanism of free medicines and Diagnostics
- Both the health care needs to be made a strong regulatory and financial state should be legally subject to social control
- Attention must be given to the inclusion of cost price procurement mechanism in the case of essential drugs
- India should be needed to be needed by the states to the development of local industry for medicines industry
- Price control properly needs to be informed to all doctors, patients and retailers
- Encouragement of production of medicines by the industry and retail on country widely with the availability of the essential medicines
- Implementation of measures and strategies

Dr. Rakesh Biswas

An integrated Private-Public approach to universal healthcare?

Good, bad and ugly

Rakesh Biswas
 Dept of Medicine
 IN Medical College, Bhopal, India

The Good?

Medical colleges in India

Total number

Year	Total	Private	Govt	Other	Total
2011	35	11	24	0	35

Private and Governmental medical colleges

Year	Private	Govt	Total
2011	11	24	35

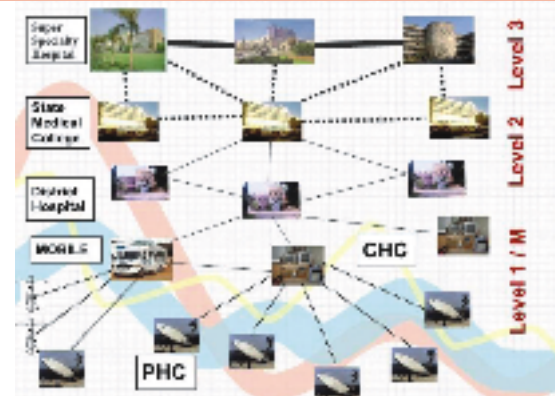
A Greater Role of

Medical Education and Learning

in Universal Healthcare?

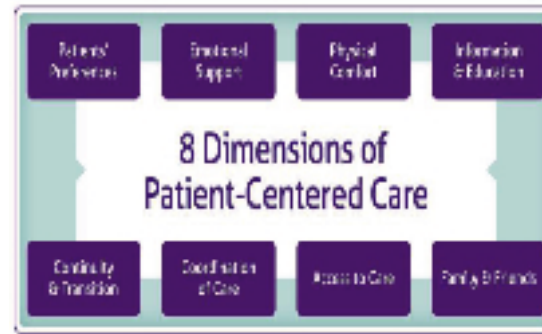
Private Medical College collaboration toward universal healthcare?

- Role of private medical college students and faculty
- Role of other health profession students and faculty
- Role of a global-learning-ecosystem toward local caring and clinical audit



Who is the prime beneficiary of Medical education?

- 1) Student
- 2) Faculty
- 3) Patient
- 4) Practitioner



The Bad

Current Medical Education

- Based on rote memorization of arcane facts
- No emphasis on developing skills to solve real patient problems
- No integration between education and practice

The Ugly

Current Medical Practice

- Malpractice?
- Lack of transparency and accountability?
- Lack of clinical audit and patient centeredness?

Solutions?

An ecosystem for open-accountable Patient-centred-healthcare

Enter: patient-formation-community-orientation managers' POCMs

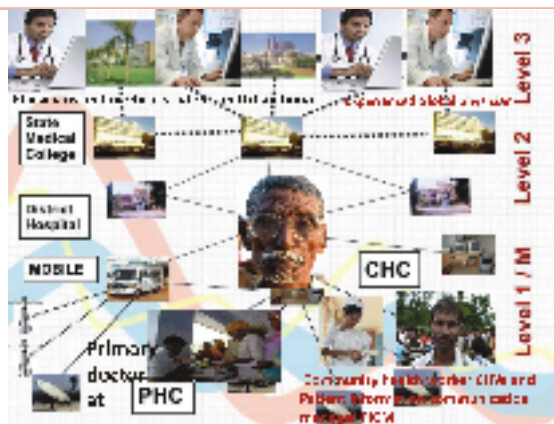
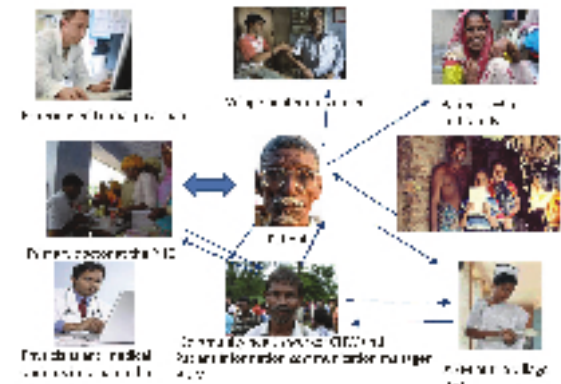
Focus: Create informational awareness in the community with 40000 patient-formation managers

Serve as effective clinical auditors and install check mechanisms to benefit both doctors and patients

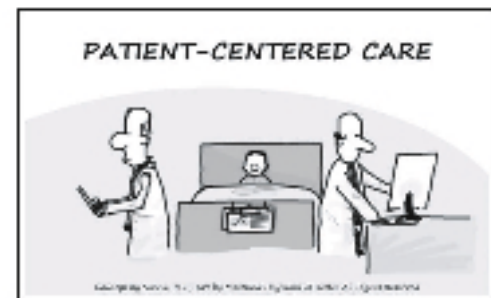
Participatory learning ecosystem pilot

Pilot project currently serves both urban and rural-remote areas in two locations in India

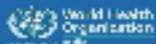
Patients receive access to a local and global network of 1000+ health professionals through their 'information communication managers' POCMs.



What it is not!




Dr. Madhur Gupta



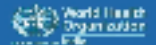
ACCESS TO MEDICINES AND HEALTH TECHNOLOGIES: ROLE OF FREE MEDICINE AND FREE DIAGNOSTIC SCHEMES IN INDIA
The Case of Rajasthan and Madhya Pradesh

Dr Madhur Gupta, MD DM
Technical Officer, Pharmaceuticals
WHO Country Office, India
madhur.gupta@who.int




Access to medicines: still elusive to a large segment of its population

Despite India being referred to as "pharmacy of the global south", access to medicines is still elusive



Key Barriers to Access to Medicines

1. Gross inadequacy of government spending on healthcare
2. Inefficient procurement systems
3. Inefficient medicine distribution mechanism
4. Unaffordable market prices
5. Irrational prescription and use of medicines





Rajasthan Free Medicines Scheme




Rajasthan Free Medicine Scheme: State Government's commitment to provide the essential medicines free of cost to public healthcare facilities

- Rajasthan Free Medicine Scheme was launched by the Government of Rajasthan in 2014
- Free Medicines Scheme was launched in 2014 to provide essential medicines free of cost to public healthcare facilities in Rajasthan
- The scheme was launched to provide essential medicines free of cost to public healthcare facilities in Rajasthan

Key features of the scheme

- Significant increase in government expenditure on medicines
- Establishment of the Rajasthan Medical Services Corporation (RMSCO) to procure essential medicines and coordinate supply chain systems
- Procurement based on a two-bid system involving technical and financial tenders
- Setting up an "e-sukra" platform for electronic management information system to facilitate smooth flow of information and chain from procurement to distribution and dispensing of medicines



Goal and Objectives

Goal: To analyze current patterns of financing, selection, procurement & distribution, pricing, prescribing and dispensing of essential medicines

Objectives:

- To examine budgetary allocation for medicines in various functional risk problems related to medicines;
- To examine the current procurement and distribution system and practices of essential medicines in public health facilities;
- To analyse procurement prices in study states;
- To study the availability of essential medicines at public facilities;
- To analyse prescription and dispensing practices.

Methodology

In order to capture the socio-economic diversity of the state, 10% of the total districts were selected based on economic and geographical indicators.



Methodology

- Secondary data analysis
- Key Informant Interview
- Facility survey
- Sampling:
 - Probability proportional to size
 - Three stage sampling: selection of state, selection of districts and selection of facilities

Sample description

	Sample size	Total districts/facilities	% of total
Sample districts @ 10%	10	100	10.00
Sample district hospitals	10	34	29.41
Sample CHCs @ 30%	30	100	30.00
Sample PHUs (LHCs @ 4)	65	1617	4.08
Sample medical college	1	7	14.29
Total public facilities sampled	117	1718	6.79
Total private facilities sampled	45	NA	NA
Total sample size	157	NA	NA

Prescription audits

- Data from a random sample of prescription slips were captured on the day of the facility visit (roughly 20-30 slips per facility)

Outcome Indicators:

- Average number of medicines per prescription
- Percentage of medicines prescribed by generic name
- Percentage of medicines prescribed from essential medicines list
- Percentage of prescriptions when an antibiotic, injection and syrups were prescribed
- Percentage of fixed dose combinations versus single agents

MAJOR FINDINGS

Specific objectives

- Examine status of free diagnostic and diagnostic schemes at public health facilities
- Determine health facility capacity, service availability, quality, infrastructure needs, and health care provider skills for delivery of free diagnostic services
- Identify gaps in IT infrastructure, human resources, medical equipment, supplies, and pharmaceutical products in relation to efficient delivery of free diagnostic services
- Assess how well to what extent free diagnostic services impact ODFL on health

Preliminary Recommendations from Impact Evaluation of FDM

- Strengthen primary health care facilities and rationalise distribution of patients at different levels of health care to reduce patient load at tertiary care
- Improve human resources, infrastructure development
- Digital/electronic patient registration and linkage with free medicines and free diagnostics schemes in order to reduce work burden
- Establish Regular monitoring and grievance redressal mechanisms

Conclusions

- Health care services are more accessible now due to free diagnostic and medicine services. This is especially true for
- Utilization of public health services, availability of healthcare services and health care providers are limited.
- Decrease in out-of-pocket expenditure has led to decrease in second care being incurred on diagnosis
- Health care seeking behavior is a function of awareness, access and affordability of health care services
- Improvement of primary health facilities, to strengthen government health care system, diagnostic services to all is an immediate need and priority of the NITI Aayog and the Government of India.

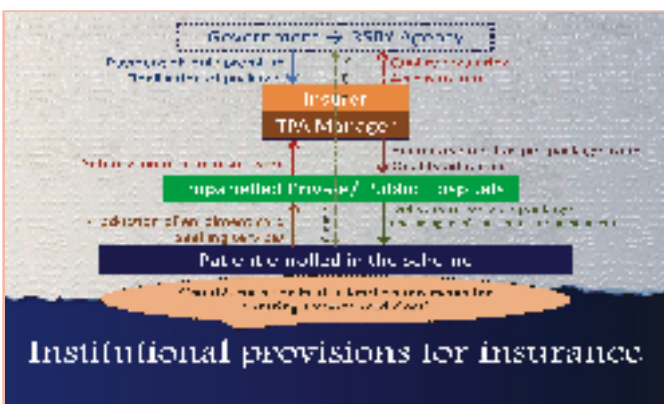
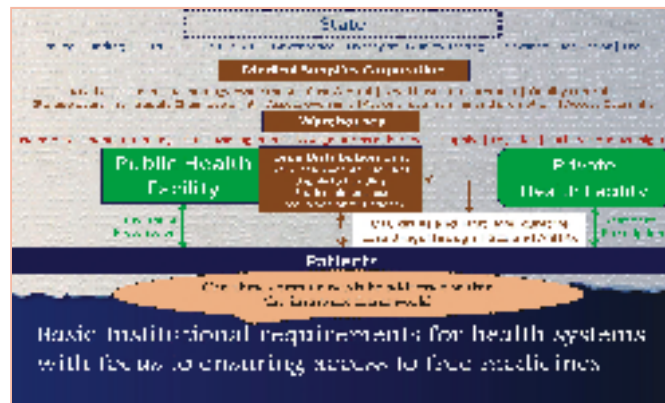
Thank You

ajayamadh@who.int

Dr. Raman V. R.

Ensuring Free Medicines for All in India:
 Institutional and structural issues in the Health Insurance Schemes

K. Srinivas Reddy
 Director
 Public Health Insurance in India
 "Health Insurance for All"



Access to medicines is a key factor of the success of health insurance

- Public systems during a health emergency have a key role to play in ensuring the immediate availability of medicines for specific populations
- The main issue is the availability of medicines for different directions of drug procurement, leading to procurement from different directions
 - The procurement of drugs from different directions is a complex process and involves different systems having to be coordinated
 - Co-ordination of procurement from different directions is a complex process and involves different systems having to be coordinated
- Drug procurement model of the public health system is a complex one and should be supported by the policy
 - Need for a policy to ensure that the procurement of medicines is a complex one
 - Need for a policy to ensure that the procurement of medicines is a complex one

Limitations of RSBY in the context of provision of free medicines

Weak monitoring institutions

- RSBY covers a large diverse population system in different levels
- Medical claims are a large resource for the health insurance providers
- Insurance providers are not able to monitor the provision of medicines
- Information on drug supply and utilization is not available in the form of drug utilization
- Access to RSBY services is the primary concern of the insured and the insurance providers
- The health insurance system is a complex one and should be supported by the policy

Limitations of RSBY in the context of provision of free medicines- 2

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- Need for a policy to ensure that the procurement of medicines is a complex one

Structural issues in insurance mechanisms— institutional protection missing

Free medicines for all, not as yet another welfare scheme, but primarily as a measure to strengthen public health systems and services, as part of a JPO agenda

- To the priority areas of all health systems, including, but not limited to, adequate FPKs, adequate community health workers
- Specialised programmes to address chronic diseases
- Economic strategies, including reduction of out-of-pocket payments
- Access to medicines via the existing distribution systems, and FPKs, is not
- Private sector included as full FPKs, community health workers are not the core of public health systems

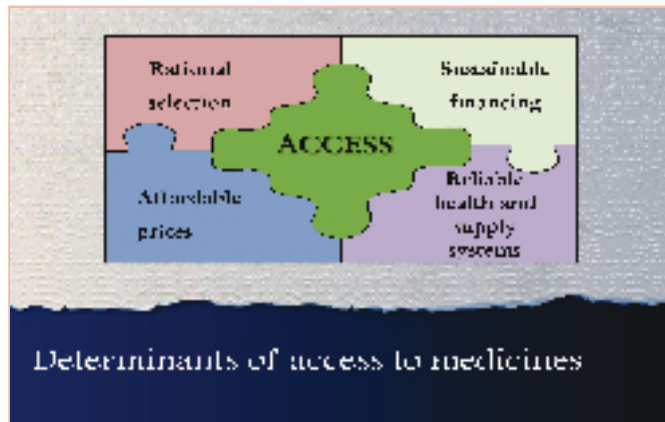
Massive education, awareness and capacity building of communities, community and civil society, as well as active promotion of streamlining for implementation and accountability.

Way forward



MEDICINES FOR ALL IN 2025

Thanks
for your kind
participation







*One of the first duties of the physician is to
educate the masses not to take medicine.*

- William Osler (1849-1919)



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