

Editorials

Treating asthma in developing countries: a problem of inaccessible unavailable essential medication

E Parry

Some people regard insulin dependent diabetes in a villager from a developing country as the equivalent of a death sentence because it will be impossible to ensure a supply of insulin.¹ Is severe asthma any different? Indeed, in their paper in this issue of *Thorax* Watson and Lewis² show that appropriate medication is either unavailable, inaccessible through cost, or inappropriately prescribed.

What is the physician to do when the country where the asthmatic patient lives has \$10 (or very much less in some countries) to spend per capita per year on health? The dilemma has been addressed from many angles. The need for an assured list of appropriate drugs led to the Essential Drugs Programmes, championed by WHO, so that there would be basic remedies at the first level of primary care, a more generous list for the district hospital, and an additional list of specialist drugs for the few referral or specialist hospitals. The system has worked well in theory and has now enlarged its goals to include appropriate prescribing.³ But this begs the question of access to drugs, limited in supply by the poverty of the country or the poverty of the patient. The days of free drugs have effectively gone; under the inflexible structural adjustment programmes of the World Bank government spending has had to be slashed and the most unkind cuts have been felt in the welfare services of health and education.

A further scheme was devised by UNICEF – the Bamako initiative⁴ – in which a revolving fund for drugs would be established through an initial supply of foreign exchange and the drugs would be sold at cost price at health centres. The proceeds would be used to buy further drugs and a revolving fund would operate. Again good, perhaps, in theory, but deeply flawed in practice because management skills were often deficient, money was not recycled for drugs, and the poor who could not pay were excluded anyway.⁵

Watson and Lewis received more replies from rural than from urban doctors. Their questionnaires were sent to expatriates working largely in Voluntary Agency hospitals and they are a privileged group. Any visitor to the rural fastnesses of developing countries knows well that if there are any drugs they will be found in such voluntary hospitals; even so, Watson and Lewis' data demonstrate a dire state of supply and of access to appropriate drugs – the reality away from the voluntary hospitals will be far worse. The template for supplies to the smaller rural district hospitals is the essential drug list, but shortages will mean that specialist drugs for asthma are largely restricted to the specialist hospitals. But where does this leave the rural

asthmatic patient? If the drugs are only held centrally, will a long journey have to be made to a distant specialist hospital at potentially great expense? In a study of rural diabetics in northern Ethiopia it was found that over 36% had to travel at least 80 km (Alemu S *et al*, unpublished data, 1997). The cost of such journeys could be catastrophic, and this raises a further dilemma for the physician. The patient may be willing to pay the cost of a follow up appointment⁶ but may be unable to meet the cost without having to sell productive assets or sacrificing other essential costs such as clothes, food, and education.⁷ The pathetic gratitude and agreement of the rural asthmatic patient may conceal the expectant gloom of the sale of cherished cattle or even land.

One solution to the dilemma of costly drugs was for a major pharmaceutical house to give, over many years, all the ivermectin needed in the Onchocerciasis Control Programme. Another is giving its latest antimalarial drug to specific countries under specific conditions of prescribing. But for asthma this would be impossible. There is no obvious solution to the daily dilemma of how to acquire and maintain a supply of appropriate drugs. One strategy, however, can be adopted; those who care for the patients can be taught how to manage cases well with what is available. Such training and supervision can be given during follow up at health centres so that the best habits of care and management can be nurtured, and so that the few drugs are used as efficaciously as possible.⁸

In the future, as populations grow older and patterns of disease change, the problem may get worse, and this is an even stronger argument for doing what can be done as well as possible, and thus sustaining the highest standard of attainable care.

*The Tropical Health and Education Trust,
1 Park Square West,
London NW1 4LJ, UK*

E PARRY

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