Correspondence

A historical perspective on the rational use of drugs (RUD) in India

Apropos the editorial, ‘Implementing Rational Drug Use – A Success Story’ published in the Indian J Pharmacol, Vol 38, Issue 2, April 2006, we would like to make the following points.

Much before the launch of the Delhi programme, many other states in India had taken similar steps. For instance, the Department of Health, Govt. of West Bengal, had launched a centralised drug and equipment purchase system, on the basis of catalogues prepared by experts (as the concept of EDL[Essential Drugs List] was not yet in existence). The list, made in the early ’70s, had categorised drugs for medical colleges, district and subdivision hospitals, and block and primary health care centres. Currently, the updated EDL (WHO) is used as a parameter for the selection of drugs at different levels of healthcare.

Dr Harsh Vardhan is quoted in the editorial as follows. “I was asked to establish the drug authority in India”. This statement is intriguing. The Drug Authority of India was established by an Act (Drugs and Cosmetics Act, 1940) of Parliament. It is not clear how the health minister of a state can establish the Drug Authority of India. The editorial fails to mention who directed the minister “to establish the drug authority”.

Another statement in the editorial,”…for the successful launch of any programme, for the betterment of the people, three things are warranted. Political will, effective administrative support and a dedicated independent organisation, preferably non-governmental (NGO),” raises several issues. Is the support of a dedicated NGO necessary to launch any such programme? While we do know of the Proclamation of the Drug Policy of Bangladesh (1982) and the Islamic Republic of Iran (1980), we do not know of any “dedicated independent organisation (NGO)” being involved in these programmes in either Bangladesh or Iran. Moreover, these programmes were launched countrywide and not limited to a small state, as it was in the case of Delhi.

It should also be mentioned that the “successful launch of any programme” is no doubt important, but more important is the question of its sustainability. It appears, from the statement of Dr. Harsh Vardhan, that the Delhi programme was about to be reversed, merely by the change of the government in the National Capital Region (NCR) of Delhi.

The editorial states, “In Delhi, 95% of the medicines prescribed are being actually dispensed at all levels of health facilities, primary, secondary and at teaching hospitals. The centralised pooled procurement of essential drugs results in saving up to 30% of the allocated funds”. Further, the editorial mentions “…WHO- India Essential Drug programme, which provided about US$ 3,50,000 to the society over last 5 years…..” These figures make for interesting reading indeed.

According to a well researched document (India Health Report), “The private sector accounts for 82% of all OPD visits at the all India level. The figure for private hospital care is 45%.” It is, therefore, apparent that about 18% of the population, which availed of the government run facilities in Delhi, benefited. Moreover, the Delhi programme did not include the AIIMS (All India Institute of Medical Sciences), one of the largest hospitals in Delhi. On the other hand, the programme hardly impacted the large private healthcare system where the use of useless, unscientific and, at times, hazardous drugs is rampant.

To achieve any tangible benefit (i.e. use of essential drugs and RUD), any such programme must involve the private sector. This, among others, includes the removal of non-essential, useless and unscientific drugs from the market. The Delhi programme is almost silent on this important issue. ‘Political will’ is the will of a political party and not merely the will of an individual. One wonders whether the political will of Dr. Harsh Vardhan’s party was actually considered in this matter. Had it been so, his party, which governed India during that period, would have launched the programme countrywide, not limiting it to just Delhi.

As regards the propagation of RUD in the country, the All India Drug Action Network (AIDAN) was founded in 1982. It has since been active in the campaign for a rational, people oriented drug policy and RUD. In Gujarat, LOCOST (Low Cost Standard Therapeutics), founded in 1983, has been active in the advocacy of a people oriented drug policy and rational therapeutics. In West Bengal, to achieve the goal of RUD, a Rational Drug Campaign Committee was formed by some NGOs and medical practitioners’ organisations, in 1992. Prior to this, an NGO, DAF-WB (Drug Action Forum), was formed in 1984, in West Bengal. Since 1986, the DAF has been publishing an English journal, Drug. Disease, Doctor, to propagate the concept of RUD among medical practitioners. It also regularly brings out material in Bengali, Hindi and Telugu, to create awareness, among the public, on this issue.

In 1994, the FHA (Foundation of Health Action) began
The educational forum, 'Orphan diseases and drugs', (Indian J Pharmacol 2006; 38:171-6) is a very informative article. The various aspects of orphan diseases and drugs have been well covered. A new and interesting term, 'ultra orphan drugs and diseases', was however not included in the article. Ultra orphan drugs is the term designated to drugs which are used to treat exceptionally rare and chronically debilitating or life threatening diseases. Ultra orphan disease is the term designated to diseases with a prevalence of less than 0.18 case per 10,000 population.

A few examples of ultra orphan drugs/diseases are:

1. Imantinib for gastrointestinal stromal tumours.
2. Laronidase for mucopolysaccharidosis type 1.
3. L-carnitine for genetic carnitine deficiency.
4. Anagrelide for essential thrombocytopenia.
7. Agalsidase for Fabry’s disease.
8. Orfadin for hereditary tyrosinaemia type 1.
9. Sacrosidase for congenital sucrase isomaltase deficiency.

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