An Industry More for Profit and Less for Health

A crisis of confidence has developed in the pharmaceutical industry in recent years because the profit motive has become paramount. The result is overmedication — and this when the developing world is seriously short of drugs for the most common ailments. A new book, reports Gemini News Service, says the time is ripe for the industry to be a real part of the solution for better health care rather than being part of the problem.

—by Annette Nielsen

THROUGH aggressive marketing the pharmaceutical industry has shown itself to be hugely profitable. Yet so relentless has been this pursuit of profit it faces today a crisis of confidence.

Drugs have been released before thorough research into side-effects; known side-effects kept secret; over-inferior and downright dangerous products sold in the developing world.

There is now a consensus that for both the developing and industrialised worlds aggressive marketing policies have led to overmedication.

Ironically, rather than overmedication, one of the main problems for the developing world is a serious shortage of drugs necessary for the most common ailments.

In 1977, under the directorship of Dr. Halfan Mahler, the World Health Organisation (WHO) started to compile an essential drugs list to be the basis of drug- buying by the public health sector. It comprises 200 drugs considered adequate to meet more than 90 per cent of the pharmaceutical need of developing countries.

The pharmaceutical industry has systematically opposed this concept, particularly where it applied to the private health market. This is a problem in most developing countries where the private health care market is far larger than the public market.

These issues are discussed in a book just published, A Healthy Business, World Health and the Pharmaceutical Industry*, by Andrew Chetley, a Canadian-born research and development consultant.

In what could be called the golden era of the pharmaceutical industry from the end of World War Two to the mid-Sixties the industry researched and developed a range of drugs that have contributed to general health advancement.

A number of seemingly miraculous drugs, such as antibiotics, were deemed to be the answer to all health problems.

They laid the foundation for the way the industry is structured today — namely, as a profit-orientated industry in the business of selling drugs rather than promoting health.

Malnutrition and infection constitute the greatest threat to the people of the developing world. Today many deaths are due to conditions that can be prevented by relatively simple and inexpensive measures.

For example, the most effective treatment of diarrhoea is oral rehydration. It is both inexpensive and simple to produce.

Yet drug companies still promote anti-diarrhoeal products containing an antibiotic as the most effective treatment. These drugs are expensive and unnecessary.

They also exacerbate the extraordinary misuse of antibiotics during the past 30 years, resulting in the existence of virulent bacterial strains resistant to antibiotic treatment.

Most people in developing countries still live in rural areas. However, the development of a Western-style, hospital-based high-technology medical service predominate in most countries.

Even in the West this system is proving expensive and ineffective in terms of improving overall health.

In the developing world, it would be more effective to transform this system to village conditions, stressing low-cost intervention.

The drive towards ever-bigger profits has forced countries to formulate comprehensive drug policies — another trend that has met with consistent opposition from the industry.

Several countries have tried to make a more rational drug policy work. Norway has shown the way towards enforcing the essential drugs list within its public health care system. Bangladesh has tried, with some success, to develop a workable national drug policy.

Such policies are fraught with problems. Pharmaceutical companies often have ear of governments and development aid can be made dependent on buying drug products.

Drug policies can be difficult to enforce and drug inspectors cannot overcome the work involved. Drugs not on the essential drugs list can be smuggled in from neighbouring countries.

The last two years has also seen a weakening of the principles behind the essential drugs list, as WHO has come under the directorship of Dr. Hiroshi Nakajima.

Although the industry baulks at any infringement of its right to market any drug on any market, Chetley argues that if the industry faces up to the real health challenges of today and tomorrow, there is no reason why it should lose out.

Time is ripe for the industry to be a areal part of the solution for better health care, rather than being part of the problem.

In some parts of the pharmaceutical industry, there is an understanding that if the industry is to survive it must begin to respond to its critics and alter its drug policy.

In the case of Ciba-Gieger, problems involving two of their drugs, including Entero Vioform and the company's role in the Rhine pollution in 1986, contributed to changing the company approach to marketing and attitude to criticism.

Ciba-Gieger is now willing to work with its critics, and has, for example, had great success with its publication of a kit on diarrhoea control, that stresses or..l rehydration. Ethics can also mean good business.

Today 50-70 per cent of drugs being researched and developed have no advantage over existing products.

The WHO has set the target of "Health for All by the Year 2000." As millions in the developing world still die of disease and illness that have been all but eradicated in the western world, radical changes must come about to turn the tide of misery.

— GEMINI NEWS.

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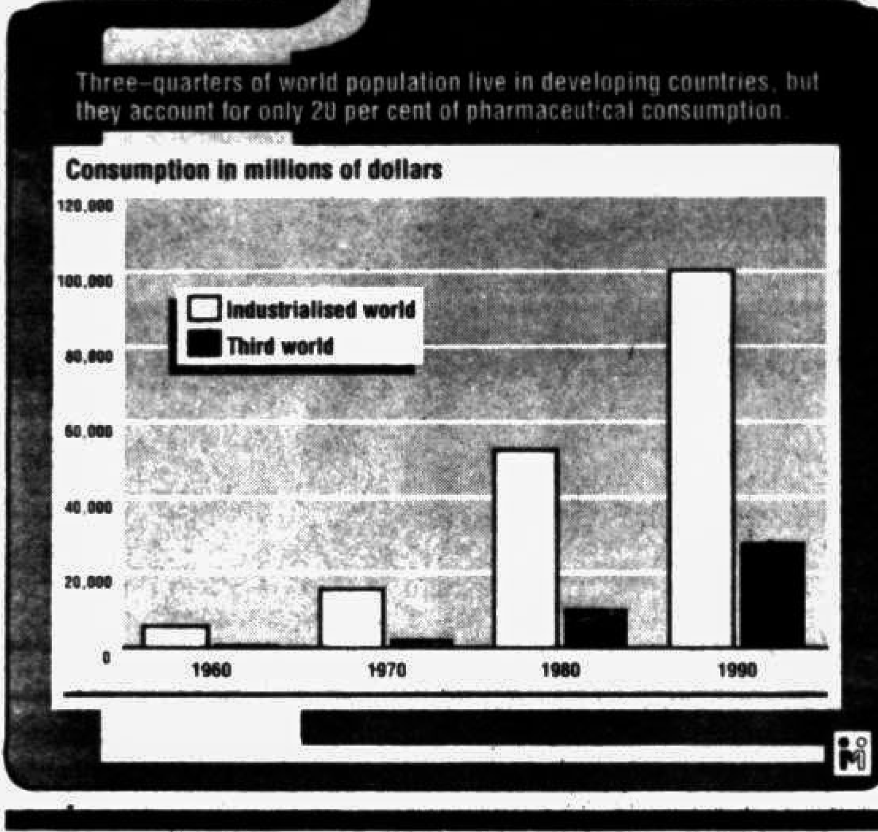
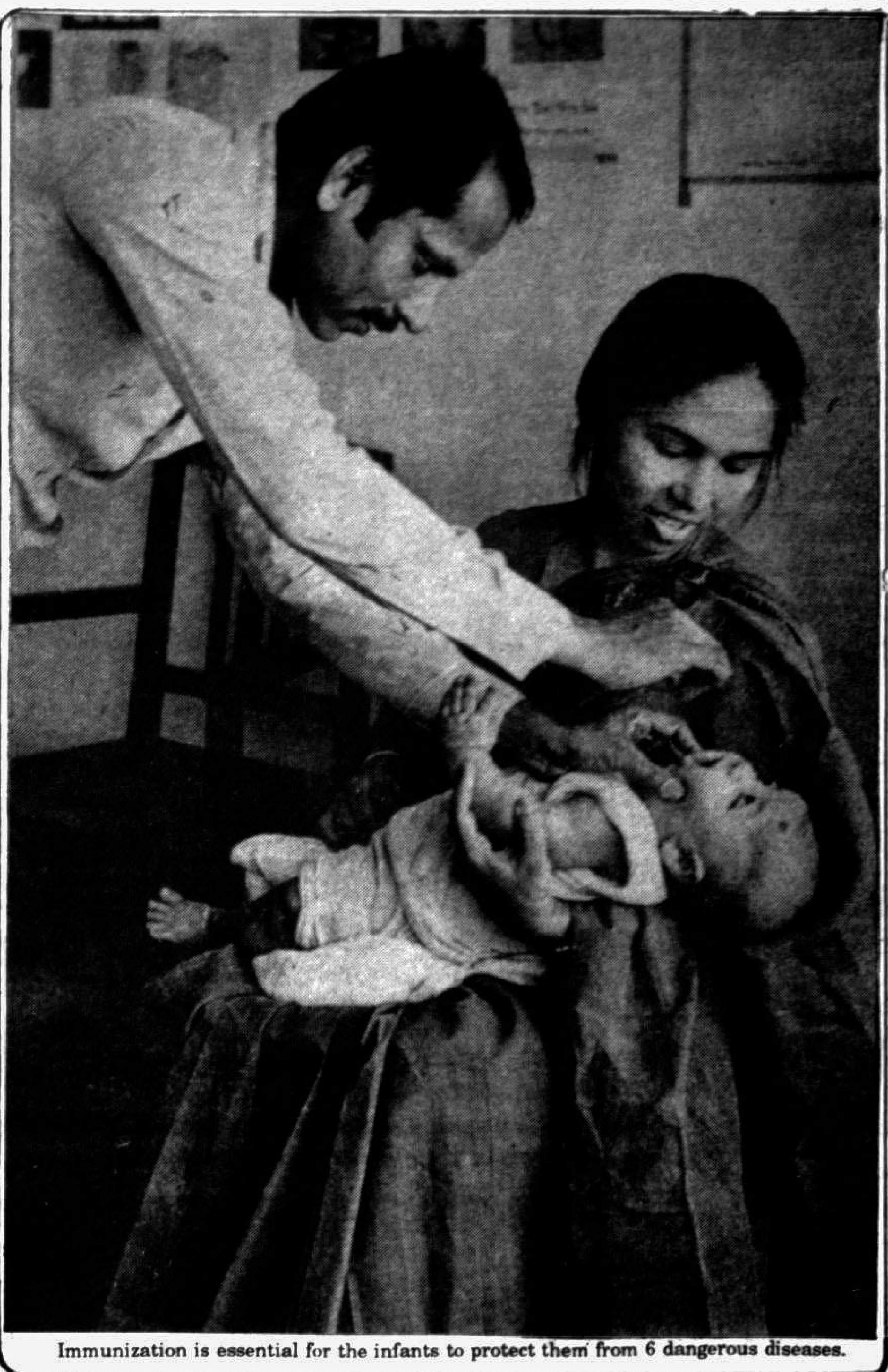




Immunization is essential for the infants to protect them from 6 dangerous diseases.

Can Heart Attacks be Prevented ?

Md. Ariff and Fedai Mawla

AS a result of positive actions against the important risk factors for coronary heart disease (smoking, elevated blood cholesterol level, obesity, physical inactivity, hypertension, diabetes), the past decade has seen a notable decline in the mortality rates for CHD in several developed countries. The rising trend for CHD morbidity, and mortality in developing countries like Bangladesh can be halted by timely community action.

Several well controlled studies in a number of countries have established the nature and relative importance of the risk factors for coronary heart disease (CHD). Prevention of coronary heart disease is now a reality and a proven public health measure, both at individual and community levels. Intervention to control these risk factors have been eminently successful in a number of well known projects, involving sizeable populations.

Can community health education reduce the risk factors for CHD? This question was answered by the Stanford Study (1972-75), involving the communities in three townships in Northern California, USA. Intensive mass health education was imparted against CHD risk factors in two townships over a period of two years. No such educational programme was arranged for the third town. Interviews were held before the intervention (with intensive mass education against the CHD risk factors), and at the end of the first and second years after the study was begun. At these interviews knowledge and behaviour of each individual regarding diet and tobacco smoking were ascertained, the blood pressure was measured, the blood cholesterol level determined and the body weight recorded. At the end of the study, it was seen that CHD risk had increased in the control population and decreased in the study population — there was a difference of 23 to 28 per cent between the two groups. Thus it was concluded that health education was effective in reducing the risk factors for CHD.

In the ten year long North Karelia Study in Finland (1972-82), following mass community action against the risk factors and advice on avoidance of these factors, it was found that there was a two-fold decline in the CVD mortality in the study population, as compared to the rest of Finland. The results of this intervention study was so encouraging that these community health education activities were gradually extended to the whole of Finland. Incidentally when the study was initiated, the North Karelia district had one of the highest mortality rate for cardio-vascular disease in the world. In fact the people of North Karelia had petitioned the Government of Finland for some kind of intervention.

In the Oslo Diet Smoking Intervention Study (1973-1978), it was seen that cessation of smoking and dietary change to reduce cholesterol levels in a 40-49-year-old apparently healthy male population, who had been smoking and had high cholesterol levels (but had normal blood pressure), produced a 47 per cent lower incidence of fatal and non-fatal myocardial infarction and sudden death in a randomly selected intervention group of 604 out of 1232 males, screened earlier. This indicated that a sizeable reduction in CHD mortality through the control of two inportant risk factors (smoking and high blood cholesterol level) was indeed possible. Like the intervention group, the control group of 628 males were 40-49 years old, had high cholesterol levels, had been smoking and had normal blood pressure. This study had been conducted over a period of five years.

In another study in the USA (Lipid Research Clinics Study), it was determined that lowering of serum cholesterol levels did prevent attacks of CHD. A cholesterol level lowering drug (cholestyramine) was administered to a group of American men, 35-59 years, with primary hypercholesterolemia (Type II hyperlipo-proteinemia). The control group was given a placebo. It was found, at the end of an average follow-up of 7.4 years, that there was a 24% reduction in mortality from CHD and a 19% reduction in non-fatal myocardial infarction. This study created enthusiasm for the drug treatment of men with high cholesterol levels.

Coronary Heart Disease (CHD) In Women

Females below the age of 50 have a much lower rate of mortality from CHD than males of corresponding age groups, presumably because the female hormone estrogen exerts a protective action against atheromatous deposits in the coronary arteries. Naturally, this protective action ceases after menopause and the mortality from CHD increases. It has been observed that females, who use oral contraceptives (combinations of estrogens and progesterone) and also smoke, have a higher risk of CHD than pre-menopausal women of the same age group, who use oral contraceptives but do not smoke. It has therefore been recommended that women, who use oral contraceptives must not smoke, or Female smokers should choose some form of contraception other than the oral pills.

Chileans Join List of Cholera Victims

There's been no cholera in Chile since 1886. Than, over 28,000 people died. Now a new epidemic has struck. No one is quite sure where it has come from — probably not from Peru where a serious epidemic is now raging. Gemini News Service reports that suspicion has fastened on fish and seafood and on the water supply that irrigates local horticulture. by Luis Tricot.

EDMUNDO Castillo, a quiet and gentle-looking old age pensioner, became famous one day recently. It wasn't because he won the pools or inherited a distant millionaire relative's legacy : it was because he contracted cholera, the first person in Chile to do so.

Edmundo became infected just 11 weeks after the disease started to spread in neighbouring Peru, where it has now reached serious proportions.

Since then it has spread to five other South American countries. Preventive measures adopted in Brazil, Colombia, Ecuador, Chile and Bolivia, have proved to be insufficient to stop the bacterium from invading these fertile new territories.

The "Vibrio Cholerae", which comes from Asia, is an orally transmitted disease. A person can only be infected if he or she drinks water contaminated with the excrement or vomit of disease carriers, or by eating food contaminated by dirty water.

This is particularly worrying for the Chilean authorities since it is a fact that at least 6,000 hectares of horticultural production in the metropolitan region is irrigated with contaminated water.

"Used water" is the euphemism normally used to describe canals and rivers whose waters are infected through contact with the city's sewage system.

Now the Minister of Health has prohibited the consumption of fresh vegetables, especially lettuces, cabbage, carrots, cauliflower and others. These can only be eaten if previously cooked.

The prohibition also applies to fish and seafood. Indeed, it was the consumption of raw fish that triggered off the epidemic in Peru.

Nonetheless, in an apparent effort to stop panic from spreading among the population, President Fujimori himself publicly ate shellfish at a fish market. This ambiguous attitude on the part of the Peruvian government has not done much to help the campaign aimed at controlling cholera.

So far, 146,877 people have been infected and 1045 have died. In Ecuador, 59 people have died.

The Chilean authorities are adamant that every possible step has been taken in order to prevent cases from occurring. But the measures taken have brought angry reactions from small vegetable producers, fishermen and seafood traders.

Fish prices have dropped dramatically and sales are down by nearly 90 per cent. The news is as bad for vegetable sellers.

A fish trader said : "I have about $100 worth of sea produce here. Do you know how much I've sold today? $5 worth."

At Santiago's fish market the scene was pathetic : there was no one around to buy fish. People are scared, and fish traders are angry. They have staged demonstrations that have been broken up by police with teargas.

The traders threw tonnes of fish and shellfish on to the streets, and vegetable sellers did the same with their produce.

There are around 4,500 small vegetable growers in the region and many of them fear bankruptcy. Juan Figueroa, the Minister of Agriculture, has already stated that there will be no compensation for losses.

Santiago's inhabitants have actually been eating contaminated lettuces for decades, but no one ever did anything about it. Not even when, back in February, thousands of neighbouring Peruvians became ill and hundreds died.

The last time Chile experienced a cholera epidemic was in 1889. Over 28,000 people died at that time, and it took at least three years to eradicate the bacteria from Chile's soil.

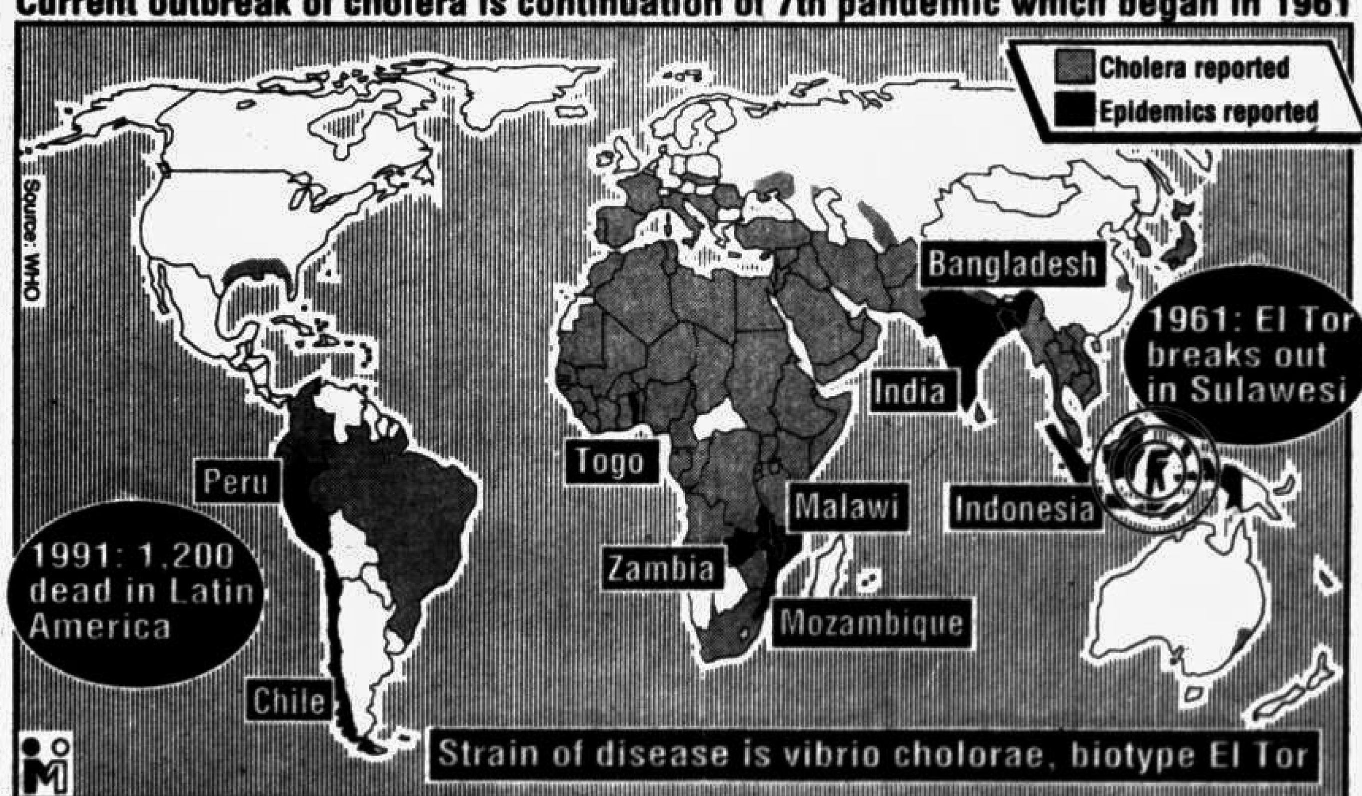
The disease spread from Argentina on that occasion. But on this occasion, and contrary to all expectations, it appears that the cholera did not come from the north, from Peru. Edmundo Castillo has not left Santiago : he contracted the disease by eating contaminated food when he and his family were celebrating his 58th birthday.

The government has allocated over $2 million to combat the epidemic. But the cleaning of the contaminated water alone would cost many times that.

In the meantime, Chileans will have to forget about salads and seafood.

— GEMINI NEWS.

Luis Tricot is a Chilean journalist writing and broadcasting on Latin American affairs.



SARPV : A Spark of Light

By Md. Ariff and Fidai Mowla

HE did not consider himself to be one of the disabled till 1981, when he was rejected a government job on physical grounds. Having completed his studies he applied for a government job — qualified in the written examination and Viva-Voce but finally was told that he was physically unfit. For the first time he realised that he was not quite like other normal people and his disability was a problem. He was very hurt and began thinking about other disabled persons. After long pursuance and effort was thus born an organization named Social Assistance and Rehabilitation for the Physically Vulnerable (SARPV), situated at Zakir Hussain Road, Mohammadpur. The building in which SARPV took its shape looks old and dilapidated from outside but you can feel the rythm of life inside. The person we mentioned in the beginning is Mr. Shahidul Huq, the Secretary General of SARPV.

Mr Huq said that the handicapped were considered a burden of the society and thus they have become objects of sympathy and pity rather than getting the chance to develop themselves — so that they could lead meaningful lives. The society must help them set up their lives according to their needs. Unlike developed countries — our country does not provide any security or economic support to the handicapped to live a decent life.

According to him and his long experience a physically handicapped in a poor family has to be an earning member (begging etc.), in a middle class family a handicapped child is considered to be a burden — and in a rich family an addition to their existing expenses.

The main objective of SARPV is to establish these physically handicapped persons in the society, to establish a base so that they can live in the society as normal human beings and to create opportunities for them so that they can live a better life economically. SARPV was established in 1989 but it actually started operating from June '90. SARPV provides training to the physically handicapped on repairing and maintenance of electronics and household appliances. There is also arrangements for physiotherapy and in some cases necessary medical aid is provided. But lack of money is a problem for SARPV. That is why it had to wait long before taking any such action. It may be mentioned that SARPV started on its own and later it received funds from Australian High Commission and CUSO.

There are about 10 students of different ages attending training courses in SARPV. They attend regular schools in the morning. In the afternoon they come to SARPV for training. Four of them did not go to school before but now they do. They represent both the low income group as well as the middle class. From 3-30 p.m in the afternoon they are provided physiotherapy by Dr. Abdur Rahman of CRP. From 4 p.m to 4:45 p.m. they attend theoretical classes and 5 p.m to 6:30 p.m they have practical classes. They are now learning to assemble radio and two-in-one but SARPV has further plans to introduce other electrical appliances. The first batch is supposed to complete their training by June this year.

SARPV is keeping in touch with local producers of electrical appliances to procure some assembling job. For that, quality job should be ensured. SARPV appointed two representatives from two different organizations to evaluate their training programme. Both were satisfied with the quality of training. The training center is run by one programme officer — one technician and one engineer. SARPV further wants to open a shop for repairing electrical appliances. That will help them develop some economic strength. Asked how he finds out the handicapped Mr. S. Huq replied that a survey was conducted by the initiative of SARPV to make a list of handicapped persons in Dhaka.

SARPV mainly works for the handicapped of Mohammadpur area. About the students he said, "They attend school in the morning and come here in the afternoon. It is quite a pressure on them. Some of them require medical aids immediately, some have problems coming to the center. Yet with all odds they seem to enjoy learning trades in the center."

SARPV aims to march forward and have many plans regarding its future. SARPV wants to introduce more items in its training programme. It has plans for establishing workshop for manufacturing physical aids and equipment for handicapped people, while it wants to have medical service center of its own. SARPV also feels the need to crate recreational facility centres, physiotherapy center and gymnasiums for the development of physical and mental health of the physically vulnerable people.

SARPV emphasizes on development of a social security system for the disabled. In other words, it wants to take every possible measure to uplift the socio-economic condition of the physically vulnerable people.

(Courtesy : In Touch)