Improving access to pharmaceuticals in Brazil and Argentina

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The population of many Latin American countries is having increasing difficulty in accessing needed medicines due to the rise in their unitary cost and the growing number of poor in most countries of the region. A number of countries have taken steps to increase access to pharmaceuticals and have had different levels of success. This article reports on two country-wide programmes: the AIDS programme in Brazil, which has been judged as being highly successful, and the Remediar programme that has been implemented recently in Argentina. Both programmes have significantly increased access to needed pharmaceuticals, and Argentina has done it in a record time. In the discussion, we suggest that pharmaceutical interventions are successful when there is a firm political commitment, they are comprehensive, include the participation of civil society, and use a combination of methods to control the rising cost of medicines, including centralized international competitive bidding processes for drug procurement and reliance on multi-source drugs.

Key words: pharmaceutical interventions, AIDS/HIV, essential drugs, Brazil, Argentina, Remediar

Introduction

In Latin America, pharmaceutical prices and total drug expenditures continue to rise while the number of pharmaceutical units sold decreases. This trend indicates that increasing numbers of people are deprived of needed therapies (López Linares 2001; Anonymous 2003). For the poor, which in many countries of the region comprise about half of the population, access to medications is primarily constrained by unaffordable prices (Tobar 2002). In the region, about 72% of pharmaceutical expenditures are out-of-pocket and the poor spend a much higher share of their income on medicines than more affluent groups (Cohen 2000; Homedes and Ugalde 2001). High prices also negatively impact the adequate use of pharmaceuticals. At times, those who cannot afford a complete course of treatment will purchase a fraction of it (Leyva-Flores et al. 2000), or they will self-medicate and possibly purchase the wrong medicine because of its lower price (DURG-LA 1997).

For these reasons, pharmaceutical interventions to make drugs economically accessible to the population are urgently needed in Latin America. WHO has recommended several strategies to improve the affordability of medicines, including: (1) improving drug procurement methods (appropriate selection of medicines, efficient tendering, and reducing waste by improving storage and distribution); (2) establishing a well-coordinated supply system; (3) promoting the use of multi-source (generic or copies)¹ drugs and increasing the affordability of uni-source (innovative or original) drugs (either through equity pricing schemes or using the safeguards included in the TRIPS Agreement); (4) reducing import duties and establishing a pricing policy; and (5) increasing government funding for priority diseases and for the poor (WHO 2001).

Increasing access to medicines without improving their use can be counterproductive and can result in economic waste, but can also cause adverse drug reactions, iatrogenia and increased antibiotic resistance. As we have reported elsewhere (Homedes and Ugalde 2001), improving the use of pharmaceuticals is a complex process involving all aspects of the medication cycle: from the production of the drug to its final use by the consumer. Multiple actors and processes are involved in ensuring the appropriate use of pharmaceuticals, including drug manufacturers (improper manufacturing, storage and distribution; incomplete and often misleading information for prescribers and consumers), regulatory agencies (registration, quality control, post-commercialization surveillance), prescribers (poor diagnosing and prescribing practices by different health professionals, including pharmacists and pharmacy clerks), drug dispensers (often poorly trained) and patients (often misinformed).

Countries in Latin America have implemented interventions to improve the affordability and use of medicines with more or less success. Most countries have developed essential drug lists and are encouraging the use of multi-source drugs; but health reforms, through decentralization and privatization processes, have fragmented the system and have made it more difficult for countries to negotiate
affordable prices. Decentralized and private entities purchase smaller amounts and are ill-equipped to engage in international competitive bidding procedures. This paper analyzes two of the most far-reaching pharmaceutical interventions implemented by the federal governments of two highly decentralized countries: Brazil and Argentina. The Brazilian initiative aimed at controlling the upsurge of HIV/AIDS, while Argentina responded to a severe economic crisis. The two programmes address different needs, and, therefore, the purpose of the analysis is less to compare the two policies, and rather to identify the features that facilitate or constrain their successful implementation.

Brazil and AIDS

Brazil (population 182 million in 2003) is organized as a Federal Republic, with 26 States (a total of 5508 municipalities) and a Federal District. Its Constitution recognizes the right to health care and, since the early 1980s, it has struggled to maintain a public health system, based on solidarity and equity principles, which is expected to provide universal access to health care. Brazil is among the Latin American countries most intensely affected by the AIDS epidemic and the success of its AIDS programme has been widely recognized. The WHO director, Jong-Wook Lee, requested the assistance of the chief of Brazil's AIDS programme to develop policies for worldwide implementation in the fight against AIDS (Haas 2003). The UNAIDS programme awarded Brazil a medal in recognition of its international leadership in the battle against AIDS and its creativity and ability to respond to the challenge (LatinSalud 2005).

To guarantee the success and sustainability of the HIV/AIDS programme, Brazil implemented a three-pronged strategy that: (1) builds on the capacity of social movements to strengthen prevention activities (early detection of those HIV-positive) and to enhance patients' compliance with treatment protocols; (2) promotes the use of multi-source/generic medicines and the public production of anti-retroviral (ARV) drugs; and (3) includes good surveillance and a well-coordinated system of care that ensures access to appropriate diagnostic and treatment services.

Building on the capacity of social movements

The first case of AIDS was registered in 1982, but initially only the media and some social movements responded to the threat. In 1983 an advocacy group in São Paulo created the first non-governmental organization (NGO) to fight AIDS (GAPA). In 1985, the state government of São Paulo established an HIV/AIDS prevention centre, and the federal government created a National AIDS Control Program (NACP). In 1986, a national NGO to fight AIDS was founded in Rio de Janeiro (Brazilian Interdisciplinary AIDS Association or ABIA) (Oliveira Cruz et al. 2004). ABIA provided legal assistance to people living with HIV and, through case law, established important precedents that helped curb discrimination against HIV-positive people in the workplace and human rights violations, against the same population, in the health care system. Several other Brazilian states and institutions (university hospitals, religious organizations and NGOs) added their efforts.

The initial HIV/AIDS programmes focused on prevention, surveillance, treatment of opportunistic infections, and the development of partnerships between the government and civil society. By the beginning of the 1990s there were more than 10 000 AIDS cases and the World Bank estimated that there would be over 1.2 million HIV-positive Brazilians by the year 2000 (Levi and Vitória 2002). The World Bank backed prevention efforts with two loans of US$160 million and US$165 million in 1994 and 1998, respectively. Brazil added US$240 million in counterpart funding and NGOs were invited to bid for project funds. Between 1998 and 2001, a total of 1681 projects were financed involving 686 organizations. Funded projects aimed at a variety of issues: improvements in condom distribution, mass media campaigns, school education programmes on HIV/AIDS, prevention of mother to child HIV transmission, the protection of highly vulnerable groups (truck drivers, prostitutes and indigenous people), prevention activities in the workplace, and needle exchange programmes among intravenous drug users (Reardon 2002). Partly as a result of these efforts, today the number of people who are HIV-positive is half the World Bank’s projection for the year 2000, or approximately 660 000 cases.

Activists assert that Brazil’s success is due to society’s mobilization. It is through these partnerships that prevention and treatment activities have reached vulnerable and remote communities. Activists point out that on the two occasions when the Minister of Health warned that a budget shortfall would limit access to ARVs, the NGOs forced the Treasury to allocate additional funds. They also mention that civil society, through its international networks, was crucial to the Ministry of Health’s price negotiations with multinational pharmaceutical companies (Paiva et al. 2002; Ortells 2003).

Promoting the use of multi-source/generic medicines and the public production of ARV drugs

Since 1971 the Brazilian government has regulated the production and distribution of medicines, first through its Central Medicine Agency (CEME) and, from 1999, through ANVISA, the national health regulatory agency. In 1991, the government began the free distribution of monotherapy or dual treatment with nucleoside analogues, but by the end of 1996 it had reached only about 20 000 patients. With the arrival of protease inhibitors in 1996, the treatment programme accelerated and the federal government approved Law 9313 mandating the provision of anti-retroviral therapy through the public health system. Currently 100% of those who need ARV treatment (HAART) or about 154 000 of the 660 000 persons living with HIV/AIDS (UNAIDS/PAHO 2004)
are receiving it free. They represent almost half of the worldwide poor who have access to ARVs (Ortells 2003).

The Brazilian initiative was not very well received in foreign scientific circles. The US government denounced Brazil to the World Trade Organization (WTO) for violating the TRIPS Agreement by producing generic drugs (Ortells 2003), although the charges were later dropped. Others feared that the government would not be able to sustain the effort and the policy would result in drug resistant strains of HIV. History has proven that the Brazilians were right.

Several authors have documented a 50% decline in AIDS mortality rates in Brazil (Oxfam GB 2001; Levi and Vitória 2002; Paiva et al. 2002). A recent country-wide study of the trends in mortality and incidence of AIDS (Hacker et al. 2004) demonstrated that AIDS mortality declined abruptly following the introduction of universal access to ARVs, despite continued increases in AIDS incidence; and that survival following the AIDS diagnosis significantly increased. HIV infection rates had remained stable since 1996 (LatinSalud 2005), but more recently have started to decline in all areas of the country except in the south, where there has been limited success in controlling the transmission of HIV among intravenous drug users (Hacker et al. 2004). In addition, AIDS-related hospital admissions have been reduced by 80% (Oxfam GB 2001; Paiva et al. 2002) and the incidence of tuberculosis and opportunistic infections in HIV patients has declined significantly (Levi and Vitória 2002). Major centres for severely immunodeficient patients have experienced declines in the rate of Cryptococcus infections (60%), in CMV infections (54%) and Kaposi Sarcomas (38%) (Bermudez et al. 2004). The Ministry of Health (MoH) estimates that the average number of AIDS-related admissions per patient per year dropped from 1.65 in 1996 to 0.28 in 2001, keeping 358,000 people out of hospital and saving about US$1 billion, outweighing the costs of providing treatment (Tables 1 and 2).2

Only about 4% of the HIV strains have developed resistance to ARVs (Ministerio de Saúde 2002). Additional benefits associated with the free provision of ARV are direct improvements in HIV/AIDS surveillance (increased willingness to be tested) and, when coupled with health education and aggressive mass media campaigns, control of HIV transmission (known HIV status leads to the adoption of partner-protection measures among those HIV-positive).

The cost associated with the provision of ARV was a major threat to programme sustainability, but the MoH lowered the yearly cost of ARV treatment from US$4860 per person in 1997 to US$2530 in 2001 (Oliveira Cruz et al. 2004) and to about US$1000 in 2003 (Levi and Vitória 2002). To achieve its goal, the MoH emphasized the use of multi-source drugs as well as the development of the Brazilian pharmaceutical industry, including state-owned laboratories, and has been using the provisions of the TRIPS Agreement to engage in aggressive price bargaining with multinational pharmaceutical manufacturers.

The Generics Act (#9787) was approved in 1999. Its implementation has fostered competition among producers and has facilitated the reduction of prices, as well as strengthening the local pharmaceutical industry, including the network of 18 publicly owned laboratories operated by different entities such as the MoH, the armed forces, state governments and universities.

### Table 1. AIDS-related hospital admissions in Brazil, 1996–2001

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<tr>
<td>Number of AIDS admissions</td>
<td>25,458</td>
<td>25,157</td>
<td>24,700</td>
<td>25,027</td>
<td>26,655</td>
<td>25,274</td>
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<tr>
<td>Estimated number of AIDS patients treated per year</td>
<td>15,390</td>
<td>31,140</td>
<td>43,823</td>
<td>57,604</td>
<td>69,447</td>
<td>90,400</td>
</tr>
<tr>
<td>Average AIDS admissions per AIDS patient per year</td>
<td>1.65</td>
<td>0.81</td>
<td>0.56</td>
<td>0.43</td>
<td>0.38</td>
<td>0.28</td>
</tr>
<tr>
<td>Estimated number of AIDS admissions per year based on average AIDS admissions for 1996</td>
<td>–</td>
<td>51,511</td>
<td>72,491</td>
<td>96,542</td>
<td>114,876</td>
<td>149,539</td>
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<tr>
<td>Estimated number of AIDS admissions avoided per year</td>
<td>–</td>
<td>26,354</td>
<td>47,791</td>
<td>71,544</td>
<td>88,221</td>
<td>124,265</td>
</tr>
<tr>
<td>Estimated cost of AIDS admissions avoided per year (in US$1000)</td>
<td>–</td>
<td>76,271</td>
<td>138,314</td>
<td>207,057</td>
<td>255,321</td>
<td>359,639</td>
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### Table 2. Ministry of Health expenditures on anti-retroviral drugs, 1996–2001

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<tr>
<td>Cost in millions of US$</td>
<td>34</td>
<td>224</td>
<td>305</td>
<td>336</td>
<td>303</td>
<td>232</td>
<td>–</td>
<td>180</td>
</tr>
<tr>
<td>Number of patients</td>
<td>–</td>
<td>35,900</td>
<td>55,000</td>
<td>73,000</td>
<td>85,000</td>
<td>105,000</td>
<td>125,000</td>
<td>154,000</td>
</tr>
<tr>
<td>% of MoH budget</td>
<td>0.24</td>
<td>1.18</td>
<td>1.82</td>
<td>3.18</td>
<td>2.84</td>
<td>1.6</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Currently, 80% of all the medicine units marketed in the country are locally produced, and Brazilian companies account for 75% of the total sales value (Bermudez et al. 2004). By 1999, Brazilian laboratories produced 47% of the AIDS drugs, representing 19% of programme expenditures; of these laboratories, 92.5% are state owned and operated. In 2001, 63% of the ARVs (43% of expenditures) were produced by local manufacturers (UNAIDS/PAHO 2004). Currently, seven public laboratories produce multi-source versions of eight of the 15 drugs used in anti-retroviral therapy; none of these eight products are protected by patent. Among all the public manufacturers, Far-Manguinhos is crucial to the implementation of MoH policies. It produces 30% of all AIDS medicines used in Brazil, and is responsible for developing the manufacturing process and the reverse-engineering technology (Bermudez et al. 2004).

Brazil's ability to produce drugs locally, Industrial Property Law 9179, and the provisions included in the TRIPS Agreement assist in multinational pharmaceutical bargaining. Article 68 of Brazil's Industrial Property Law 9179 says that if within 3 years of patent registration a firm fails to manufacture a patented product in Brazil, the government can issue a compulsory license to authorize another company to produce the drug, or can import the patented product from the cheapest source (parallel importing). In 1999, the government issued a decree enabling the use of compulsory licenses in cases of national emergency. To date, the Brazilian government has not issued any compulsory license nor is it benefiting from parallel importing, yet these two provisions have been used to force multinational companies to lower their ARV prices. According to the MoH, domestic production has reduced ARV prices by 78%, on average. Negotiation with transnational companies has reduced prices of locally produced ARVs by 70%, and of imported products by an average 25% (Bermudez et al. 2004).

Establishing good surveillance and a well-coordinated system of care

Logistics are crucial to ensure continuity in access to medications and appropriate monitoring of patients. The Brazilian network for providing treatment to persons living with HIV/AIDS is composed of a total of 2015 units: 1126 clinics for sexually transmitted diseases, 381 other outpatient units, 54 homecare services, 79 day care health services and 375 accredited hospitals. ARVs are distributed in 424 AIDS Drugs Dispensing Units (ADDU), most of them located within the services network. There is a network of 73 laboratories that have the capability to measure viral loads, 65 that have the capability to do CD4/CD8 counts, and 12 that are responsible for the surveillance of viral resistance (Bermudez et al. 2004). In addition, there is a system to control the quality of the laboratory services; there is at least one voluntary counselling and testing (VCT) centre per municipality (UNAIDS/PAHO 2004); and about 40 universities collaborate in the training of specialized personnel (Quesada 2002).

At ADDUs patients can receive magnetic cards that help track their treatment regimens (Galvão 2002). In 1998, the AIDS programme implemented a computerized system (SICLOM) to control the stocks of ARVs in ADDUs and adherence to the National Treatment Guidelines, which are reviewed at least once a year (Bermudez et al. 2004). Each day, SICLOM sends a report to the National AIDS Programme in Brasilia, where prescriptions are analyzed and errors are corrected (Galvão 2002). The information generated by SICLOM is also used to ensure continuity of stocks in dispensing centres, and in the training of health care providers.

To monitor the effects of the treatment, another computer program, SISCEL, gathers information from the lab tests and sends them to the National AIDS Programme. These two computer programs, SICLOM and SISCEL, along with the advice of the Therapy Assessment Committees that develop treatment guidelines, are partially responsible for a high level of patient compliance with treatment, about 60–70% (a level comparable to those achieved in developed nations), and for the low levels of HIV strains resistant to ARVs (4% versus 15–25% in Western Europe and the US) (Ministerio da Saúde 2002).

Shortfalls of the programme

The Brazilian programme is not perfect; ABIA's coordinators say that patients' follow-up is compromised by the limitations of the public health system. There are insufficient resources to do the required viral load tests and CD4 cell counts, and to treat opportunistic infections. The antibiotics to combat opportunistic infections are not supplied by the federal government; they have to be paid for by municipal or state governments or by the patients (Ortells 2003). In addition, a study conducted by Harvard University in São Paulo and Santos documented that despite high access to prenatal care, most pregnant women were not offered HIV testing while pregnant. A quarter of HIV-positive women were not informed of the risk of HIV transmission during childbirth or breastfeeding, less than 50% of the women had access to structured counselling, and poor access to psychological support, dental and nutritional care were identified as major problems (Harvard University, AIDS Care Teams 2005).

Argentina’s pharmaceutical intervention: Plan Remediar

Background and characteristics of the programme

For many decades Argentina (pop. 38 million in 2003) was the most vibrant and wealthiest economy in Latin America. For example, in 1995 Argentina’s GNP per capita was over US$8000 while the average for Latin America and the Caribbean was US$3320. For a variety of reasons, in 2002, after 3 years of economic recession, the country entered a severe economic
distributing 21 presentations to 2200 CAPS, out of a
in October 2002 and is scheduled to last until the end
of US$177 million. The distribution of medicines began
funds from the national government (40%), for a total
American Development Bank (IDB) and matching
Remediar was financed with loans from the Inter-
2004b).

Table 3. Number of units of pharmaceuticals sold in retail
pharmacies in Argentina, 1998–2003 (in millions)

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of units sold (millions)</th>
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<tbody>
<tr>
<td>1998</td>
<td>411.00</td>
</tr>
<tr>
<td>1999, beginning of recession</td>
<td>326.10</td>
</tr>
<tr>
<td>2000</td>
<td>315.66</td>
</tr>
<tr>
<td>2001</td>
<td>288.64</td>
</tr>
<tr>
<td>2002</td>
<td>225.57</td>
</tr>
<tr>
<td>2003, beginning of recovery</td>
<td>273.22</td>
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depression (Perry and Servén 2003). By mid-2002,
Argentina’s GNP per capita was only US$4060 and
continued to shrink until well into 2003, when the
economy began to show a slow recovery.

Argentina’s economic crisis left many unemployed. More
than 60% lost their health insurance and the partial
medicines coverage. Pharmaceutical prices skyrocketed,
especially for imported proprietary drugs, and many
people were unable to purchase life-saving medications
for the treatment of chronic diseases (Tobar 2002). The
consequences were devastating for the fast growing
number of poor Argentines. According to the
National Institute of Censuses and Population, in 2002
60% of the population could cover only 64% of their
pharmaceutical needs, even if they allocated all their
health expenditures to the purchase of medication (Tobar
2002). Table 3 shows the reduction in the purchase of
medicines in pharmacies.

In 2002, the government launched Remediar (to find
a solution, to remedy), a programme to provide 36
essential multi-source medicines (in 43 presentations)
at no cost to the estimated 15 million Argentines
who needed and were unable to afford medicines. It was
designed as a national vertical programme in a country
whose health system had been decentralized in the late
1970s.

To select the medicines, Remediar identified the most
common causes of consultation at the primary health care
centres in the country (CAPS). The National Quality
Program assisted in the selection of medicines for these
pathologies, and it was estimated that the selected
products would resolve about 80% of the therapeutic
needs of the consultations attended at the CAPS (Tobar
2004b).

Remediar was financed with loans from the Inter-
American Development Bank (IDB) and matching
funds from the national government (40%), for a total
of US$177 million. The distribution of medicines began
in October 2002 and is scheduled to last until the end
of 2006. The implementation was staggered. It began
distributing 21 presentations to 2200 CAPS, out of a
total of 5300, and UNDP was contracted to carry out
international tenders for the procurement of medicines
(Ministerio de Salud de la Nación de Argentina 2002).

The key features of the programme are (Ministerio de
Salud de la Nación de Argentina 2003, 2004; PROAPS
2003a; Remediar 2003; Tobar 2004a, 2004b):

1. All multi-source drugs are identified with
international non-proprietary names (INN).

2. To avoid waste, all medicines are unit-dose
dispensed.

3. To reduce pilfering and political interference,
Remediar contracts through international tenders
with a private distributor that receives the medicines
from the producers, assembles the kits (botiquines)
and distributes them directly to each CAP. At no
time, except at destination, are the medicines located
in a public institution. Through a satellite positioning
system the distributor knows, at all times, where all
distributing trucks are located. Currently, about
15 000 kits are distributed monthly. The logistic
difficulties of distributing such a large number of kits
in a country with the geographical size of Argentina
should not be underestimated.

4. In each CAP a member of staff has responsibility for
receiving the kits. That person turns in all prescrip-
tions issued since the last delivery together with an
inventory of stock. If the prescriptions and the
inventory are not submitted, the kit is not delivered.
In principle, this information should allow Remediar
to know the stocks of medicine left at the CAPS and
adjust the next kit according to the stock level.
Prescriptions include the name of the prescribing
physician, the amount of medicine prescribed, the
patient’s name and address, and the nature of the
illness. This information permits Remediar to verify
the prescription practices of the attending physician,
the adequacy of the prescription for the patient, and
to audit the prescription at the patient’s home.

5. Remediar carries out audits regularly. From October
2002 to September 2004 Remediar carried out 3253
audits of 2439 CAPS. The audits included visits to
13 200 patients’ homes to verify that the medicine has
been dispensed, and that the amount corresponded
to the prescription.

6. The programme has opened a free telephone line
for enquiries about the programme and to report
irregularities and receive complaints from users. The
telephone number is written on all medicine packages
with the statement that anyone who is asked
to pay for the medicines should call and report it.
This number is also used by the staff of the CAPS
to make inquiries about the programme. As of
September 2004, the number had received 92 000
calls.

7. In addition to its own audits, Remediar is supervised
by the IDB. Four reports written for the IDB are
available on the MoH web page.

8. Remediar has asked Caritas and the Red Cross to
supervise the implementation of the programme.
These two institutions, through their extensive
network of volunteers, visit all CAPS at least once a year and report the findings to Remediar. When Remediar receives calls reporting irregularities, it can ask one of the two institutions to verify their validity. The two NGOs provide this service without cost to Remediar.

(9) To improve prescription practices Remediar has organized one-day training seminars by university-based pharmacologists in different provinces. In 2003, 171 seminars for a total of more than 4000 professionals were completed. Every month, Remediar publishes, on its website, a therapeutic guide, prepared by specialists, for one medical condition such as diabetes mellitus, hypertension and lower respiratory infections.

(10) As indicated, medications are to be dispensed at no cost, but CAPS are also forbidden to charge a fee for the consultation, a practice that was common in some provinces before Remediar. CAPS that continue to charge a fee after enrolling in Remediar are removed from the programme.

Before providing an assessment of the benefits and limitations of Remediar, it is necessary to contextualize the conditions under which Remediar was implemented. Remediar was organized as a crisis programme and had to be launched without the benefit of having all desirable information on hand. The highly decentralized nature of the Argentinean health system (each province has its own MoH) has been an additional constraint in the design of a centralized health programme of the size of Remediar (Consejo Federal de Salud 2004). In Argentina, as in most countries, physicians’ prescribing practices are often inappropriate and very hard to modify. Until prescribing improvements are achieved, the efficient utilization of a standardized kit of medicines will not be easy. Finally, in Argentina the concept of primary health care was frowned upon as providing medical care for the poor, adding difficulties to a programme based on primary care clinics (Tobar 2003).

Within these constraints, Remediar’s achievements include (Tobar 2002, 2004b; PROAPS 2003b):

(1) Excellent targeting: 96% of beneficiaries live under the poverty line, 71% in extreme poverty, and 84% are not covered by any health insurance programme. These figures compare very favourably with other health programmes implemented in the region.

(2) Official estimates indicate that the intervention has had a high distributive impact. Using the Gini index of distribution, the equity of household expenditures for drugs has improved by 60%.

(3) The number of primary care consultations has increased by 25% since the inception of the intervention. The continuous availability of medicines at the centres has increased confidence among their users and has begun to remove the negative image of primary care. Evaluations by Caritas and Red Cross revealed that users have a positive assessment of the programme. The increase in the use of CAPS has decreased the use of hospital emergency rooms.

(4) Until now, the controls developed by Remediar have been able to minimize pilfering and attempts to charge patients for the medicines.

**Limitations and critical views of Remediar**

While the availability of medication is a pre-condition for the success of pharmaceutical interventions, it is not sufficient to guarantee therapeutic benefit. As indicated in the introduction, the adequate prescription, dispensation and use of medicines are equally important to the success of a pharmaceutical policy.

Official information, a few independent evaluations of Remediar and our own field research suggest the following. Firstly, according to official figures, only 60% of the consultations require a prescription (Bernstein and Monsalvo 2004). In 2003, of all medicines that were provided free at the CAPS, only 32% were given by Remediar; the rest were medicines provided by provincial ministries of health or by municipalities. In 2004, the percentages were inverted, and Remediar’s percentage increased to 65% (Remediar 2004). There is no information to assess if provinces/municipalities decreased their supply of medicines as Remediar increased the distribution of medicines. In one province, the public laboratory was producing betalactamics, and when Remediar began to distribute betalactamics, the laboratory had to reduce its production and was left with unused active ingredients, excipients and containers. In the words of its director: “Remediar is a devil and is sending us to hell” (interview with Director of public provincial laboratory, 16 March 2005). A provincial legislator of an opposition party said that Remediar is creating difficulties in improving the public production of pharmaceuticals, in part because the provision of medicines by the national government reduces the pressure on decentralized municipal/provincial authorities to supply medicines to the CAPS (interview, 15 March 2005). It is likely that coordination with the provinces/municipalities would have resolved this issue, but the difficulties of coordinating activities among a national programme and 24 highly decentralized provincial health systems within a fragmented political system should not be underestimated.

Secondly, no information exists regarding how patients utilize the medications distributed by Remediar, if they understand the medication advice given by the physicians and if they comply with it. Without this information, it is not possible to assess the therapeutic impact of a drug distribution programme.

Thirdly, there are no independent evaluations of the impact of the workshops and the literature distributed by Remediar to improve prescribing practices. As discussed below, without them, it will be difficult to improve the content of the workshops and improve prescribing. Changing prescription practices is a long-term endeavour. The difficulty of supplying an adequate amount of
medicines to the CAPS is partly caused by the different prescription practices of physicians.

Fourthly, adjusting the size and content of the kits to the therapeutic needs of each health centre is one of the most difficult unresolved problems for Remediar. Currently, some of the drugs are not consumed and stock-pile on the shelves of CAPS, while other drugs are delivered in insufficient quantities to satisfy the demand.

There are several reasons for this problem: (1) The epidemiological and demographic profiles of the country vary by region; (2) physicians have different prescription practices and efforts by Remediar to homogenize treatment practices have not been sufficient; and (3) the size and composition of the CAPS are very different – some have internists, gynaecologists, neurologists, physical therapists and other specialists, while others only have one general practitioner. A single kit cannot satisfy such a variety of centres. Remediar is aware of this problem and has tried to resolve it by adjusting the provision of about 10 medicines to an estimated demand, and by creating two sizes of kits, but this is still insufficient (Tobar 2004b). The problem is exacerbated by some failures in the delivery of the kits. At the Rosario centre visited by the authors on 15 March 2005, kits had not been delivered during the previous 2 months. In Mendoza in 2003, a Caritas volunteer said: “There are two main recommendations: that the suggestions made by the CAPS be taken into account, and that the distributor let the centres know when the kits are scheduled to arrive” (Casabal and Cabanas 2004, p.17, our translation). One year later, a similar remark was made by a Red Cross volunteer in the province of Entre Ríos: “Negative comments include the lack of information regarding the arrival of the next kit and the prohibition of sending leftover medicines from one centre to another that needs them” (Casabal and Cabanas 2004, p.18, our translation).

Finally, Remediar was born as a programme to resolve a severe crisis. Critics have argued that the programme cannot be institutionalized if it continues to depend on loans from the IDB. Three years after its inception, the leadership at Remediar is not certain if in 2007 the programme will be discontinued or will continue with a new IDB loan or with government financing. Left-leaning critics argue that, as the country recovers from the financial crisis, Remediar should be financed with general revenues from the national budget, and should purchase as many of the medicines as possible from public laboratories instead of buying from profit-oriented pharmaceutical firms. This change would support the public production of pharmaceuticals (interviews with members of a university-based centre, March 17, 2005).

Discussion

Brazil’s HIV/AIDS intervention has run for almost a quarter of a century and has been implemented under several administrations of different political ideologies. It is remarkable that, amid the political changes, the programme has been maintained and all changes made have been to improve the technical quality of the programme and not in response to political whims. In Argentina, Remediar has been implemented under only one administration. Only when a change of government takes place, will it be possible to know if the new authorities introduce modifications based on political expediency and derail or cancel the institutionalization of Remediar. Because of the complexity of social programmes, particularly in the health field, improvements need to be based on technical evaluations and inputs from civil society. If Remediar is allowed to mature and improve it could become an important model to provide access to primary care medicines.

Both countries are decentralized. Brazil is highly committed to providing universal coverage through a unified public health system (SUS) where the federal government continues to dictate some national policies. Brazilian society demands good quality services, has a well-coordinated health delivery system with a high level of uniformity in data gathering, and a good system for the training and supervision of all parties involved, which facilitates the implementation of a vertical programme. In Argentina, each province has its own health system, and the initial organization of the vertical emergency programme had to be highly rigid to avoid pilfering. Under those circumstances, coordination with the provinces was difficult.

The Brazilian programme deals with only one disease and the consequences of not following appropriate treatment protocols are severe and well known. In this case it is easy to standardize treatment protocols and monitor compliance. What is remarkable is that Brazil has been able to organize systems of support and surveillance to such an extent that resistance to ARVs is the lowest in the world. The Argentinean programme deals with a large number of diseases and drugs. Physicians have their own preferences for the selection of the drugs and tend not to verify if patients understand their recommendations. In the short term, efforts by Remediar to encourage physicians to prescribe according to established therapeutic protocols can have only a limited impact, and the programme has not implemented any mechanism to ensure that medicines are properly used by patients.

The two countries have a large number of public laboratories. In the case of Brazil, the success of the HIV/AIDS programme is partially due to the government’s investment in the creation and maintenance of a centralized policy of public production and procurement of medicines. The Brazilian public laboratories are efficient and their research capabilities compare favourably with those of many international firms. Argentinean public laboratories, by and large, have very little capital and are inefficient, and because the system is highly decentralized, there is not a national policy of public production. In Argentina there is a debate about whether or not the public production of pharmaceuticals could
provide better access to essential medicines than Remediar. Within the context of this paper it is not possible to enter into this debate. It can only be said that when Remediar was launched, the public laboratories were not ready to supply to needed medicines. In time, public laboratories may be able to play a significant role in facilitating universal access to pharmaceuticals.

In the two countries, civil society has been actively involved in the implementation and supervision of these programmes. In Brazil, it was spontaneous, self-generated, while in Argentina it was at the government’s request. The participation has played different roles but in both cases it has been important to facilitate transparency and the achievement of the programmes’ objectives. The two cases suggest the importance of NGOs and social movements in the implementation of social policies.

Perhaps one of the most important lessons from these two programmes is that the free provision of pharmaceuticals is one of the best mechanisms for promoting the acceptance of the primary health care concept. In the case of Argentina, the presence of medicines in the CAPS has made the centres more acceptable and attractive to the population. In general, the Remediar programme has been well accepted and appreciated and, in spite of its limitations and flaws, it has resolved an important problem for a large number of Argentinians. If CAPS improve their diagnostic capacity, both physicians and patients will readily espouse primary health care as an important component of the health care system. In Brazil, the success of the HIV/AIDS programme has demonstrated the efficacy of ambulatory care. These programmes have resulted in savings for the public health sector of both countries, as the unnecessary use of emergency services and hospitalizations have been reduced.

Endnotes

1 For a discussion on the definitions of the different types of drugs see Homedes and Ugalde (2005).
2 Note that the savings on hospital admissions in 2001 (US$360 million, Table 1) were higher than the total cost of ARV for the year (US$232 million, Table 2).

References


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