

A NATIONAL POLICY FOR THALASSEMIA PREVENTION?

May 8 was World Thalassemia Day. India is the world's thalassemia capital with 40 million carriers and 1,000,000 patients who are on regular blood transfusion. Every year 10,000 babies with thalassemia major are born in India. Roughly 100,000 rupees are spent annually on therapy by each patient, 95% of which is out-of-pocket spending.

Many countries have experimented with various strategies to reduce the disease load. In Pakistan, carrier testing for relatives of patients with thalassemia was made compulsory in February 2017. UAE and Saudi Arabia already have similar laws. Iran has a National Program for the prevention of thalassemia based on carrier detection and counseling, which has shown very encouraging results. The Thalassemia Prevention Program in Sri Lanka has introduced an interesting concept of "safe marriage." School leavers are screened for thalassemia carrier status. People with a mean corpuscular volume (MCV) >80 fL and mean corpuscular hemoglobin (MCH) <27 pg are given a green card. Persons with an MCV < 80 fL or MCH < 27 pg are treated with iron for three months. If MCV or MCH do not rise, they are tested for thalassemia carrier status and given a pink card if confirmed as a thalassemia carrier. Marriage between persons, at least one of whom holds a green card is called a safe marriage. If both persons have a pink card, it is considered an unsafe marriage.

Just providing blood transfusions, chelation therapy and bone marrow transplant options without a strong prevention program seems a lopsided way of handling a mammoth problem. (*The Hindu 7 May 2017*)

LAWYERS PLAN TO SUE UK GOVERNMENT FOR POLLUTION-RELATED ASTHMA

In UK, lawyers are planning an unprecedented class action against the Government for failing to control dangerous levels of air pollution. Since 2010, the levels of nitrogen dioxide are at illegal levels in 90% of urban areas, and are considered to be the culprit for most of the premature deaths. Since there is enough class I evidence that air pollution causes reduced lung growth, ill health and premature deaths, people are agitated that despite 7 years of warning to the government, safe levels of air quality have not been achieved. (*The Guardian 4 May 2017*)

PRESCRIBING GENERICS

The Medical Council of India has released new guidelines stating that "every physician should as far as possible prescribe drugs with generic names and ensure a rational prescription and use of drugs." Close on its heels, a nationwide survey by a social networking platform for doctors 'Curofy', found that 73% of doctors oppose it.

What are the key issues? It is paradoxical that India is the fourth largest pharmaceutical producer and supplies around 20% of global requirement of generic medicines. Yet out-of-

pocket spending by patients in India is a whopping 65.5%. Buying medicines in non-hospitalized patients accounted for 72% (rural) and 68% (urban) health costs according to data from the 71st National Sample Survey. The government is struggling to handle this. One attempt was to introduce Jan Aushadhi stores – pharmacies where only generic medicines would be sold. However, as against some 800,000 retail pharmacies in the country, Jan Aushadhi stores number a little below 3000 – clearly inadequate.

In May 2016, the Drug Technical Advisory Board (DTAB) considered amending Rule 65(11A) of the Drug and Cosmetics Act 1940, so that pharmacists could dispense generic name medicines or equivalent brands of prescribed medicines. But the idea was rejected in view of bioavailability issues.

Two states which have managed to successfully use generic medicines are Tamil Nadu and Rajasthan. With excellent quality assurance systems in place, the public health system in these two states has managed to procure and distribute free generic medicines to the people.

Prescribing in generic name or in other words "International Nonproprietary Name (INN)" is permitted in two-thirds of OECD countries like the US, and is mandatory in others, such as, France, Spain, Portugal and Estonia. Similarly, pharmacists can legally substitute brand-name drugs with generic equivalents in most OECD countries, while such substitution has been mandatory in Denmark, Finland, Spain, Sweden and Italy. In some countries, pharmacists have also the obligation to inform patients about the availability of a cheaper alternative.

A valid concern of prescribing generic medicines is that it shifts decision-making from the doctor to the chemist who may not understand the scientific rationale behind all prescriptions. The understanding that doctors have developed by close observation of patients, of what works and what does not, will also be lost at the chemist level. Another issue is that half the market is flooded with combination drugs, and writing generic names of all the constituents is going to be a big challenge for doctors.

However the Union Health Ministry is already busy in drafting out a detailed regulatory framework to give precedence to generics. It is already mandated that the print size of the generic name will be larger than the brand name for single drug medicines. In India with 90% of the domestic pharmaceutical industry of Rs 100,000 crore comprising of branded medicines, and half of them fixed drug combination, the government has a formidable task ahead.

(*Economic & Political Weekly 29 April 2017, The Indian Express 21 April 2017, The Hindu 18 April 2017*)

GOURI RAO PASSI
gouripassi@hotmail.com