

TOWARDS A MEDICINES TRANSPARENCY ALLIANCE

1. Following on from the UK Government's 2006 International Development White Paper, and drawing on lessons from the successful Extractive Industries Transparency Initiative (EITI), the UK is exploring the potential for an international Medicines Transparency Alliance (MeTA).

Medicines	Essential health commodities, such as drugs, vaccines, contraceptives, diagnostics and laboratory supplies
Transparency	Improving information access and scrutiny to support the development of viable, efficient medicines markets and supply systems that benefit all developing country consumers
Alliance	Stakeholders from public, private and non-profit sectors working together to effect significant positive change

'The UK will: Build on the experience of EITI to help developing countries improve transparency and value for money in public procurement, and develop international proposals to increase scrutiny of public spending in the defence, construction and health sectors to help fight corruption.'

UK White Paper 2006 'Eliminating world poverty: making governance work for the poor'

The Challenge¹

2. One third of the world's population lacks access to essential medicines². Pharmaceuticals are the largest health sector expenditure after personnel costs in most low-income countries, and can constitute 50–90% of out-of-pocket spending on health for poor households. The impact of these costs can be critical, contributing to further poverty and indebtedness. Improving the availability and affordability of essential medicines of assured quality is therefore key to increasing access to healthcare and improving health outcomes for poor people.³

3. However, in many countries, weak governance and a lack of transparency in medicines regulation, procurement, distribution and sales contribute to high levels of inefficiency, and increase vulnerability to corruption and fraud. Issues include bribery, theft and diversion, supply of counterfeit and substandard medicines, and 'rent-seeking' behaviour – where the mark-ups at different points along the supply chain are unnecessarily high. This increases the cost of quality assured medicines and reduces their availability, undermining health services and outcomes. It also harms those that supply medicines and other health-related goods and services – increasing their operational costs, reducing their competitiveness and damaging their reputation.

4. Increased transparency in procurement can help cut corruption, improve efficiency and increase value-for-money. The significant increases in aid to developing countries, which include major commitments on health and access to medicines – particularly for HIV/AIDS, TB and malaria – mean greater resources will flow through health procurement and supply systems in developing countries. Differential pricing, generic substitution, subsidies and other initiatives are also

¹ This document is intended to stimulate discussion and will be revised iteratively based on feedback received. It does not represent a statement of policy.

² WHO Medicines Strategy 2004-2007

³ see *Increasing access to essential medicines in the developing world: UK Government policy and plans* June 2004, for more information on the UK's strategy and efforts in this area

reducing the supply cost of many medicines. It is vital that these advances benefit patients and service users and are not lost to inefficiency or corruption in the supply chain. Increasing consumer and civil society awareness around medicine quality, availability and pricing is therefore particularly important.

An International Response

5. In response to these challenges, the UK Government, the World Health Organisation (WHO), Health Action International (HAI) are working with others – including developing country governments, the pharmaceutical industry and civil society organisations – to facilitate international support for, and commitments to, transparent working practices on the part of all stakeholders engaged in medicines registration, procurement, distribution and sales. The principal objective is to support national efforts to enhance transparency and build capacity in medicines policy, procurement and supply chain management. The added value of this initiative would entail explicit commitments from international actors in support of national efforts, coupled with focused technical and financial support to strengthen transparency and accountability. Such national efforts would seek to improve access to information about medicine quality, availability and pricing, with strong civil society and consumer involvement in scrutiny and debate.

6. **What might MeTA look like?** MeTA is likely to be launched as a global alliance including all key stakeholders, with pilots in at least four countries, from mid-2007 onwards. The aim is to secure as pilots countries that have already started to address transparency in medicines regulation, procurement, distribution and sales, and whose experience may provide lessons in how best to reduce vulnerability to corruption and increase access to affordable, quality assured medicines. A first step would be a commitment – at a high political level – to prioritise the issue. Based on consultation to date, it is envisaged that in participating countries MeTA might include:

- Supporting countries to **extract and collate data** on medicine quality, availability and pricing along the supply chain;
- Facilitating agreement by pharmaceutical companies (global and domestic) to disclose their own data on quality, availability and price. Triangulating those with tender data;
- Supporting countries to undertake studies assessing the level of transparency and good governance in medicines regulation and procurement;
- Helping countries establish and maintain a **multi-stakeholder working group or forum**, engaging the public, private and non-profit sectors. Such as forum could be active in developing MeTA at the country level, scrutinising and discussing the data generated, and using this to inform development of policy and regulation;
- Working with countries to produce country-specific MeTA **reports**, which would bring data together and further analyse and contextualise issues related to quality, availability and price, and to disseminate these reports through the media and public interest groups;
- With support from a dedicated research ‘observatory’, developing and building awareness of guidelines and case studies on good practice, as appropriate; pooling information from different countries to build a global resource.

These early ideas will be refined further through detailed consultation with a range of Low Income Countries (LICs) and Lower Middle Income Countries (LMICs), and other stakeholders, during the first half of 2007.

7. MeTA would build on the existing efforts of developing country governments – with assistance from donors, WHO and others – to strengthen national procurement and supply systems, and to tackle corruption. It would also build on existing efforts to promote transparency in the health sector by WHO⁴, HAI⁵, and the World Bank, and

⁴ see <http://www.who.int/medicines/areas/policy/goodgovernance/home/en/>

on Transparency International's recent work on corruption and health⁶. Other linkages include those to: work across line-ministries – e.g. in Ghana – to tackle issues in trade, customs, revenue and other non-health policy areas that impact on access to medicines; initiatives in Kenya, Ghana and elsewhere to enhance the role of local 'chemical sellers' (informal pharmacies) in ensuring medicine availability and affordability, through regulation and franchising; work on gathering and analysing drug price data, for example MSH's International Drug Price Indicator Guide; regional bulk procurement initiatives for essential medicines (see paragraph 17 below); work to tackle the prevalence of counterfeit and substandard medicines; disease-specific initiatives to assist countries with procuring and managing health commodities such as the Global TB Drug Facility; financing mechanisms such as the Global Fund, the GAVI Alliance and UNITAID; initiatives designed to subsidise specific, critical health commodities in short supply and/or suffering low uptake, such as the Gates / World Bank work on ACT⁷ subsidies.

Why transparency matters

8. To understand how greater transparency in medicines regulation, procurement, distribution and sales could facilitate improved access to medicines in developing countries, we must explore where **market inefficiencies** currently lie – i.e. how the market 'fails' in terms of efficiency and equity to match broader societal needs – and where **weak health sector governance** also has an impact.

9. First, **information asymmetry** is particularly acute within the medicines market, and more so in many developing countries where consumers often have limited access to education and information, and government capacity to regulate the sector optimally is weak. This asymmetry exists on several different levels, for example:

- Information asymmetry **between the producer, the wholesaler/distributor and the healthcare provider or seller**: The price at which medicines are offered, and that ultimately paid by the importer or wholesaler, is not commonly put into the public domain. Nor are data regarding sales volumes. This weakens the hand of those procuring medicines – and renders assessment of on-costs and availability issues down the supply chain more difficult. In addition, some producers may supply counterfeit, date-expired or otherwise substandard products.⁸ Wholesalers and distributors may knowingly sell on such products, falsify product information or supply smuggled goods, relying on the inability of their customer to detect this.
- Information asymmetry **between the patient/consumer and healthcare provider and/or seller**: the consumer often has little knowledge of the different prevention or treatment options available – or their cost relative to their potential benefit. This can lead to 'over-treatment' by the healthcare provider – e.g. prescribing and/or selling unnecessary products, or promoting a more expensive product when an equally effective cheaper version is available. A conflict of interest may exist where providers rely on margins from drug sales to supplement low official remuneration. Where consumers buy medicines themselves, often without prescription, they have limited ability to tell whether medicines are quality assured. A classic '**market for lemons**' can ensue for generic products, whereby a lack of information about the relative quality of products can mean consumers assume all are of average quality, and tend towards cheaper options. In the medicines market, this allows counterfeits and substandard medicines to gain a foothold if priced 'competitively', and quality assured suppliers may leave or never enter the market. Clearly, ensuring both consumers and health professionals are better informed would make a difference.

⁵ see <http://www.haiweb.org/medicineprices/>

⁶ see The Global Corruption Report 2006 at http://www.transparency.org/publications/gcr/download_gcr

⁷ Artemisinin-based Combination Therapy for treatment of malaria

⁸ Supply of product that is 'close to expiry' has long been a problem in managing donations of medicines, too.

10. Second, the **signals from the market back to producers** are weak or inconsistent. This is due in part to poor demand forecasting – at facility level and nationally. Contributing factors include: uncertainty over the introduction of new products, ‘just in time’ ordering and purchasing often due to lack of funds, and the unpredictable allocation of development assistance (both in terms of funding levels and earmarking) by donor agencies and INGOs.⁹ Finally, whilst disease prevalence can often be predicted fairly well, consumer choices cannot. The consequences were seen dramatically in the case of Sanofi-Aventis, which – based on global forecasts – produced a surplus of 10 million artesunate tablets in 2006. As the Center for Global Development has said: “For products that have long lead times and short shelf lives, weak forecasting wastes money and erodes good will.”¹⁰ Increasing transparency, predictability and stability in the medicines market is therefore key to attracting and retaining quality suppliers. Indeed, experts concerned with demand forecasting agree that the availability of reliable information is the principal challenge they face.¹¹

11. **Imperfect competition:** Even where medicines are off-patent, the market for some therapies may be oligopolistic – i.e. a small group of manufacturers controls the lion’s share of the market. Attempts at product differentiation may, in effect, produce a near-monopoly market – i.e. where medicines are not perfect substitutes for one another.

12. Manufacturers may apply differential pricing, at levels that are influenced by the purchasing power of different buyers. Producers generally seek to segment different markets and advocate for confidentiality around the prices (and rebates) they negotiate with different buyers. In LIC markets, manufacturers have been encouraged to sell at prices ‘close to the cost of manufacture’.¹² However, research shows there continues to be wide variation in prices, even in similar markets,. In a market where competition is necessarily limited, the dissemination of information regarding product quality, availability and price to consumers – both patients and those buying on their behalf (e.g. procurement agents) – is even more important.

13. **Collusion** may also exist between players at different levels in the supply chain, for example where a manufacturer has a direct relationship with a prescribing and/or dispensing health facility (such as a teaching hospital or NGO facility). In many countries, local manufacturers have ‘reverse integrated’ from wholesale and distribution into production, so several local companies may control a large part of the essential medicines supply system. Joint inflation of sales prices may occur. This situation can be exacerbated by inappropriate regulatory and procurement policies and practices, sometimes associated with state capture. There is ample scope for wholesalers and distributors to apply sizeable mark-ups to maximise their profits – indeed, survey work undertaken by HAI has shown this ‘rent-seeking’ is a major factor in inflating medicine costs before they reach the consumer.

14. There are also significant issues within **governance and health systems** in many countries. The pervasive and acute information asymmetries outlined above, and societal concern about public health and equity of access to healthcare, mean that medicines supply chains are highly regulated. Public financing and provision play a major role. Medicines regulation and supply chain management is technically demanding, and many countries lack the fiscal and human resources to conduct these functions efficiently. The area is also prone to state capture by industry and professional interests, and to abuse of official powers and discretion. This abuse

⁹ International Non-Governmental Organisations

¹⁰ http://blogs.cgdev.org/globalhealth/2006/07/costs_of_poor_f.php

¹¹ *Information Sharing and Gathering as a Public Good: Draft Recommendations for Working Group Review* (August 2006) Draft prepared by Dalberg Associates for the Center for Global Development Demand Forecasting Working Group

¹² see, for example, the report of the UK Working Group on Increasing Access to Essential Medicines in the Developing World (2002) at <http://www.dfid.gov.uk/pubs/files/accessmedicines-report281102.pdf>

often leads to anti-competitive measures and practices. These risks are greater where mechanisms for public accountability are weak.

15. Concern over health governance issues is long-standing, specifically the potential for: corruption in regulatory and procurement systems, leakage in public sector supply chains, informal user charges, and informal private economic activity by public sector healthworkers. In this sector, it is often difficult to distinguish inefficiency from corruption. Transparency, information sharing, and standardization or harmonization within and across countries can increase efficiency, lower the costs of regulation and reduce the risk of corruption. WHO, the World Bank, USAID, the IADB and Transparency International have all recently commissioned reviews or other studies in this field that summarize the evidence.¹³

16. A key issue is the **efficiency and effectiveness of public procurement** systems, specifically whether procurement agents obtain the best prices. World Bank programme evaluations across a range of countries have demonstrated substantial price reductions through introduction of transparency and competition in the public procurement of drugs, including in Albania, Macedonia, Brazil and the Philippines.¹⁴ Price reductions have been achieved through transparent inter-country or inter-local government pooled procurement in the Philippines, the Organisation of Eastern Caribbean States, and the Gulf Cooperation Council. Some regional cooperation arrangements (e.g. among South Pacific nations) have demonstrated price gains through disclosure and exchange of drug price information, without fully pooled procurement.¹⁵ The evaluation of such arrangements identifies transparency in implementation as a prerequisite for success.¹⁶ Civil society participation in monitoring public procurement is now a requirement under law in the Philippines, and implementation of this and other procurement reforms by the Department of Health has resulted in significant and sustained improvement in its ranking in transparency perceptions surveys.

17. **Weaknesses in regulatory systems** can lead to many problems, particularly with respect to medicine quality. In Nigeria, over 50% of drugs in the market were found to be counterfeit or substandard prior to reform, and many credible suppliers had left the market (see discussion of the 'market for lemons' above, paragraph 9). An 80% reduction in counterfeit and substandard drugs was achieved through reforms that increased transparency of drug regulation, alongside systematic enforcement, public education campaigns and the use of public participation mechanisms.¹⁷ Counterfeit and substandard anti-malarials were once widespread across the Mekong region (38% of drugs in the market prior to intervention). A regional monitoring system was established with the support of the U.S. Pharmacopeial Convention Inc., based on sample testing for substandard anti-malarials and sharing of information between and within countries, which led to swifter notification and removal of counterfeit and substandard products.

¹³ See, for instance, the following articles:

- T. Vian 'Sectoral Perspectives on Corruption: Corruption and the Health Sector', MSI/USAID, Nov 2002;
- O. Azfar 'Corruption and the Delivery of Health and Education Services' IRIS Center, University of Maryland, College Park, (undated, c. 2002)¹³;
- Jillian Cohen et al 'Corruption and Pharmaceuticals: Strengthening Good Governance to Improve Access' in *The Many Faces of Corruption*, ed. J. Campos, World Bank, forthcoming 2007;
- WHO <http://www.who.int/entity/medicines/areas/policy/goodgovernance/Transparency4CountryStudy.pdf>

¹⁴ Jillian Cohen et al. Forthcoming 2007 "Corruption and Pharmaceuticals: Strengthening Good Governance to Improve Access" in *The Many Faces of Corruption*, ed. J. Campos. World Bank.

¹⁵ Such approaches are known as 'informed buying' or 'co-ordinated informed buying'.

¹⁶ Center for Pharmaceutical Management. December 2002. "Regional Pooled Procurement of Drugs: Evaluation of Programs". Submitted to the Rockefeller Foundation. Arlington, VA: Management Sciences for Health.

¹⁷ Akunyili, Dora. 2005. "Counterfeit and Substandard Drugs, Nigeria's Experience: Implications, Challenges, Actions and Recommendations." Paper presented at World Bank Meeting for Key Interest Groups in Health, Washington, DC, March 11, 2005.

18. The **selection** of medicines is also important. National drug lists and formularies need to be kept up to date, and prescription practice must keep pace with new developments (particularly where drug resistance is an issue). For example, Bulgaria's reimbursable drug list included second and third generation antibiotics while excluding older, but still effective, antibiotics that are available as generics.¹⁸ WHO model essential drugs lists and clinical guidelines for prescribing are used by many countries, to avoid 're-inventing the wheel' and as a credible independent standard that can limit inappropriate exercise of official discretion in the selection of essential drugs for public supply or reimbursement.

19. **Fraud** is also a widespread problem. As health insurance schemes are now being introduced in many LICs, the potential for fraudulent claims must also be addressed. Lessons can be learnt from high- and middle-income countries. For example, there has been US\$12 billion in judgments and settlements for drug cases under the US False Claims Act since 1986, though this figure is likely to underestimate substantially the full extent of fraudulent claims. In LICs to date, fraud which conceals theft or product diversion has been a major problem. In Uganda, the introduction of special markers and standard **theft** prevention measures in public warehouses reduced such leakage.¹⁹ Accurate information regarding stock volumes at different points in the supply chain is, of course, key to the detection of theft and diversion and can assist in targeting prevention measures.

20. **How MeTA might help:** As currently envisaged, MeTA would facilitate the collation and dissemination of data on medicine quality, availability and pricing. It would also provide support to civil society and governments in their use of this data. As such it could have a direct impact on correcting information asymmetries and on sending signals to the market. It would support the development of a market environment in which collusion and rent-seeking are more easily identifiable and potentially more difficult. It would have a less direct impact on the broader enterprise development environment necessary to encourage new entrants, but could help identify points in the medicines supply chain most in need of strengthening and may therefore facilitate provision of TA (for example, to support infrastructural development).

21. **On governance,** MeTA could have a positive impact in all the areas mentioned above. By increasing and standardising data disclosure, supporting information analysis and exchange, and enabling public scrutiny of medicines regulation, public financing and supply chain management, MeTA could help facilitate the detection and reduction of inefficiency, corruption, fraud and theft. MeTA could also reduce the multiplication of efforts through many global and national initiatives aimed at tackling these concerns, and it could bring together global constituencies to support the many local reform-oriented leaders and professionals in individual countries.

Key issues for consideration

22. The initial response to the MeTA concept has been very positive. However, there is much further consultation and analysis to be done. The initiative remains at an early stage of its design. Some of the key issues that must be resolved are set out below – as questions, with limited responses. **These questions and responses are intended to stimulate debate and feedback** – which we hope you will contribute.

¹⁸ Meagher, P., O. Azfar, and D. Rutherford. 2005. "Governance in Bulgaria's Pharmaceutical System: A Synthesis of Research Findings." U.S. Agency for International Development, College Park, MD (August).

¹⁹ Cohen, J. et al. (Forthcoming 2007) *Op. Cit.*

How would MeTA engage a wide range of stakeholders?

23. Securing a broad MeTA membership will depend on the incentives for different groups of stakeholders to engage. Analysis at this stage suggests MeTA could provide benefits for all stakeholder groups. For example, through this type of alliance:

- *Developing country governments* may have increased opportunity to: secure political support from donor governments and other agencies; secure real commitments to action from donors, civil society and the private sector; strengthen inefficient procurement and supply systems (and save potentially significant public sector resources); build their reputation for commitment to good governance and financial probity; access financial and technical assistance; increase access to medicines (and healthcare more broadly) and improve public health outcomes.
- *Donor governments* may have increased opportunity to: improve aid effectiveness; fulfil their fiduciary responsibilities to ensure that aid resources (and hence tax revenues) are not lost through fraud, corruption or mismanagement; demonstrate their commitment to good governance and to making markets work for the poor; demonstrate their support of responsible business practices; make a significant contribution to realising MDG 8 Target 17 on access to medicines and to other health-related goals and targets.
- *Civil society organisations* may have increased opportunity to gain access to: quality data; space for advocacy and scrutiny; a 'seat at the table' – greater engagement in policy-making processes, and improved dialogue with public and private sector organisations; greater financial and technical support.
- *Pharmaceutical companies (innovator and generic) and other manufacturers* may have increased opportunity to: put accurate data on quality and prices into the public domain, and thus assist in tackling the trade in counterfeits; take a proactive role in improving transparency and access, and thus protect themselves against reputational risk and threats to their licence to operate; receive clearer signals from the market in developing countries (e.g. through improved demand forecasting); sell into a more predictable environment, with less pressure for inappropriate behaviour (e.g. collusion, paying bribes) and greater assurance that differential prices actually benefit the target population.
- *Wholesalers, distributors and retailers* may have increased opportunity to: tackle wasteful practices and reduce vulnerability to corruption within their own operations, whilst their competitors do the same; see increased efficiency in market operations; contribute to and benefit from a more transparent policy and operational environment (including the potential streamlining or removal of taxes and duties).
- *International organisations* may welcome the opportunity to: improve health and development outcomes; advance the good governance agenda and promote ethical pharmaceutical procurement and supply; introduce norms, standard setting and technical guidance into a more receptive environment.

24. These various stakeholder groups will also bring different and complementary things to MeTA. For example:

- *Developing country governments* can: give leadership; demonstrate political commitment; create the enabling space for local action; formulate and implement policy responses; address regulatory issues; co-ordinate local stakeholders to help develop and support a shared national strategy; undertake necessary health sector reforms; enhance the transparency of public procurement and medicines distribution.
- *Donor governments* can: broker international commitment; help create the enabling space internationally; offer political, technical and financial support; facilitate the sharing of knowledge, lessons and good practice.
- *Civil society organisations* can: represent the consumer / patient / citizen; provide scrutiny; hold governments to account; raise awareness amongst the general

public, including through data dissemination; engage the media; advocate for change.

- *Pharmaceutical companies (innovator and generic) and other manufacturers* can: give their support and commitment to greater transparency; disclose data; take appropriate follow-up action.
- *Wholesalers, distributors and retailers* can: give their support and commitment to greater transparency; disclose data; take appropriate follow-up action.
- *International organisations* can: provide the normative framework; offer technical guidance and skills; provide some financial support; assist in programme planning and implementation; facilitate the sharing of knowledge, lessons and good practice between countries.

25. As consultation on MeTA evolves, many organisations are expressing interest in joining the proposed alliance. Stakeholders have many **opportunities to shape the initiative**, through consultation meetings, technical workshops and preliminary scoping studies at country level. A high-level stakeholder event is planned for 18th April 2007 in London, followed by a launch event in May. It is anticipated that Phase One of MeTA will entail a piloting of multi-stakeholder approaches towards improving information access and use in participating countries, with support from other alliance members. This phase is expected to last 12 to 18 months, and will allow emerging lessons to be captured to inform MeTA's evolution.

How would alliance members 'sign up' to MeTA?

26. The credibility of MeTA depends – at least in part – on the level of commitment to positive change demonstrated by its membership. Sign up by members to a set of core principles would likely be a minimum requirement, as it is for the EITI. However, there are additional options that could be explored, for example: publication of an organisation-specific 'plan of action' or set of commitments; participation in an annual meeting, which would be an opportunity for MeTA members to report on progress against their plans, make further commitments as appropriate, share lessons and examples of good practice; independent auditing of organisations' plans and/or progress reports. Again, this is similar to the approach adopted for EITI. Auditing would in any case be required for any data (on price, availability and quality) that had not been otherwise validated by a third party. Founding members will need to explore these and similar options over the coming months and refine during Phase One.

How might MeTA be governed?

27. There is clearly a need for some kind of light governance structure for MeTA, but there is a desire to avoid cumbersome global arrangements. It is anticipated that each participating country will operate a multi-stakeholder forum of some sort, to engage those supportive of increased transparency. This will need to be supplemented by a core group of global members. Suggestions on how to keep this light and manageable, while remaining representative, are welcome.

How might the impact of MeTA be measured?

28. A 'logical framework' is being developed as part of the MeTA design phase. This will be used to identify and help manage risks, to ensure that planned activities contribute directly to desired outputs, and to assist in monitoring progress against agreed indicators. It is intended that progress in achieving desired outcomes within participating countries will be measured, wherever possible, using existing monitoring frameworks – such as those developed for national development plans, health sector strategies and donor-financed Sector Wide Approaches (SWAs), national drug programmes, and other national strategies such as those for tackling corruption.

Should MeTA have any kind of disease focus?

29. MeTA's ultimate aims are to facilitate the development of efficient and viable medicines markets in developing countries, and to support the strengthening of medicines procurement and supply chain management systems in ways that benefit consumers, particularly the poorest. Taking a whole-system approach, and using the essential medicines concept as a frame for MeTA activities, is fundamental to this.

30. Indeed, as financing streams, procurement mechanisms and secure supply chains are being put in place for disease-specific programmes – primarily for HIV/AIDS, TB and malaria, and increasingly for reproductive health – there is an even greater need to ensure the quality, affordability and availability of other more 'neglected' health commodities. The conditions that cause greatest child mortality are diarrhoea (22% of deaths) and pneumonia (21%) for which there are a wide range of causes, and where we need to improve access to established treatments and care strategies, alongside better prevention. Chronic illness is also a growing challenge in LICs and LMICs.

31. Nevertheless, HAI (for example) has found a need to focus data collection on a core group of thirty representative medicines, to keep surveys manageable and to facilitate inter-country comparison. Countries undertaking HAI surveys have added twenty other medicines that are particularly important locally, for example those prioritised to address domestic public health concerns.

How might MeTA link most effectively to other initiatives?

32. The interaction between MeTA and other global and national initiatives is key to its potential impact. It is critical that MeTA combines with other economic, political and social activities to draw suppliers of affordable, quality assured medicines into developing country markets, and to ensure those medicines are made available to all consumers through a strong and efficient distribution network.

33. The data put into the public domain by MeTA members will benefit all the initiatives outlined in paragraph 7 above. There may be specific linkages that could be forged – greater exploration is required. MeTA could also spawn new activities. It is hoped that greater data availability and public debate will facilitate the engagement of patient groups and consumer protection organisations in related policy-making processes, and will strengthen their ability to hold others to account. New CSOs or initiatives could evolve. Freely available data could also assist regional trade blocks wishing to engage in 'informed buying' or 'co-ordinated informed buying' practices (see paragraph 17 above). Finally, the cumulative evidence around the challenge, and identification of solutions, facilitated through MeTA may also draw new funders and providers of technical assistance into supporting access to medicines.

34. **We would welcome your views** on the issues covered by this paper – specifically, on the areas that any global alliance on medicines transparency should address and how such an alliance might operate. Please contact: Danny Graymore or Michael Borowitz at DFID (d-graymore@dfid.gov.uk or m-borowitz@dfid.gov.uk) or Emma Back (emma.back1@hotmail.com).