
SOCIAL AND ECONOMIC VALUE: TWO SIDES OF THE SELF-MEDICATION COIN

Responsible self-medication: a challenge to consumers and industry

Nadine Gasman MD, DrPh, International Public Health Consultant, Mexico

It is a privilege to have been invited to address this audience today. I would like to thank the organisers for being interested in learning and understanding how self-medication is perceived and practised in developing countries and what are the challenges for your industry, our governments and civil society.

As a woman, who has grown up and worked most of my life in developing countries as a public health physician trying to promote the development and implementation of National Pharmaceutical Policies and the rational use of medicines, self-medication is present and touches my personal and professional life continuously.

It does it in very different ways: from complicated issues related to policy advice I give governments to promote appropriate use of medicines, to common calls from family and friends asking if they should take Xenical since they saw it on TV or read in the newspapers that it is a miracle pill. Or the case of mothers advising me to give my 3 year old son acetaminophen to “calm him down when he wakes up cranky or in a bad mood”. These stories may sound funny but they are real-life examples and they influence the way I relate to the subject.

What is the situation in developing countries?

Although self-medication and self-prescription are very useful categories in developed countries, or academic or intellectual settings like the one we are in now, in practice however, in environments where most drugs can be bought without a prescription, the difference between these two categories becomes blurred.

In developing countries where you can buy almost any medicine without a prescription it is difficult to differentiate self-medication from self-prescription since people get these medicines in the same way and in the same places. The problems of inappropriate use of these products, especially antibiotics, are prevalent and represent not only a personal risk but also a public health threat.

It has been widely recognised and demonstrated that – although in many developing countries legislation and regulation to differentiate prescription drugs from OTC exist – in practice the use of the prescription is not enforced and anyone can get almost anything by walking into a pharmacy or buying it in the market.

For example, in a study in Ecuador 51% of the persons that bought prescription-only medicines did it without prescriptions (Price, 1989). A multicenter study of six Latin-American countries where 8 597 people were interviewed after purchasing a medicine in a pharmacy without a prescription or advice from the pharmacists found that 66% were classified as prescription-only medicines and 34% as OTC. Analgesics were the leading group (17%), followed by systemic antibiotics (7.4%) and anti-inflammatory and anti-rheumatic products (6%). In this sample, 5% of the interviewed bought cardiovascular drugs and 2.4% drugs acting on the central nervous system without a prescription. The proportion of OTC varied from 41% in Brazil to 19-29% in the other countries (Drug Utilisation Research Group, 1997).

In Mexico, self-medication is the principal way of treating fever. In a reported study, more than half of the people interviewed used antipyretics and antibiotics. In areas where malaria is prevalent, self-medication was reported in 55% of the interviewed. They used antipyret-

ics, antibiotics, and antimalaria drugs (Leyva, 1997). The same was found in Ghana where the first-line treatment adopted by caretakers when their children were sick involved considerable self-medication with chloroquine and paracetamol (Agyepong, 1994).

In Morelos, Mexico, 68% of the 821 clients attending private pharmacies bought their medicines without a prescription. Analgesics and antibiotics were the therapeutic groups bought most frequently (16% each). Equal number of patients bought antibiotics with and without a prescription (Leyva, 1999).

The situation in other settings

Although it is common in developing countries, self-prescription also happens in developed countries. Studies in Spain showed that 76% of the patients attending urban health centres were already taking medication when they arrived. The most common pharmaceutical groups were analgesics (33%), antibiotics (20%) and anti-flu medicines (18%). The main reason for taking this medication was a previous medical prescription for similar problems and the fact that they had it at home (Moral, 1994). In a clinic for sexually transmitted diseases, 14% of the interviewed had self-medicated; 60% of the patients that had anti-microbial agents detected in their urine denied self-medication (Gordon, 1998).

A recent front-page article in the Los Angeles Times reported that two children of migrants died after taking dipyrone, a prescription drug in Mexico banned in 22 countries, including the US. The reporter was surprised by the lack of information and warnings in the boxes found and bought in Mexico – let alone the fact that the drug is banned in the US market and still widely marketed in Mexico (Weber, 1999).

This is what really happens, medicines are available and used by consumers regardless of their regulatory status. That is what we are confronted with. We all have to work to improve the situation. Nobody can do it alone, we need each other and we have to create a framework that allows building societies that better understand the benefits and risks of the medicines we have.

Self-care in the context of developing countries

We live in a world that is increasingly sharing information, aspirations and behaviours. Most people in developing countries, regardless of their economic condition have today access to radio or TV, and are exposed to all kinds of information about health and medicines. Talk shows are very popular and diseases are common topics. People want to have access to the wonders of the modern global world and are allocating their resources to get them.

The information they receive through the media shapes their beliefs and understanding and when they suffer some of the symptoms they hear about on radio or TV, they act and use this information. They go to the shop, market, supermarket or pharmacy and ask for the advertised product.

This is one of the reasons it is so important that media give accurate and useful messages and that medicines

have information that allows consumers to make good decisions for their health and economy.

I would like to put now self-medication in the broader context of self-care in order to understand the part it plays in the health/illness/care process. We conceptualise self-care as the steps taken to solve, temporarily or definitively, the illnesses or health-related problems of a micro-group, usually a family, without the intervention of an outside provider. It may have the following parts to it (Menendez, 1990):

- The detection of a health problem
- A temporary diagnosis
- The management of a series of diagnostic indicators
- The observation of the development of illness
- The use of criteria to decide if it is serious, mild or an emergency
- Decisions about what to do (which include “doing nothing”, taking something, or applying a therapeutic substance or mechanism).
- Consultation with family members and/or the social network.
- Asking for professional advice or from modern or traditional healers.

Different authors have demonstrated that each social group has a sense and knowledge of what their health problems are, their magnitude and importance. There are studies demonstrating that this knowledge highly correlates with the results of formal epidemiological research.

When self-care is understood as the process by which groups or individuals decide and manage their perceived and felt health needs, self-care becomes the most common action of all social groups. In all societies and cultures, self-care is the first level of care, although it has not been recognised as such and is in many cases neglected.

Self-care starts with the knowledge of each micro-group¹ and implies a continued process of synthesis within the group; it is a selection process that includes different experiences where economic and social factors are influential. This process of synthesis enables people to take care of the most frequent and recurrent situations and includes new techniques, products and beliefs that are integrated into existing knowledge. Part of this synthesis is the inclusion or exclusion of pharmaceutical products for the treatment of real or perceived problems.

Although it has not been systematically assessed and there is not enough research to prove what kind of interventions are the best and which are harmful, experience in different groups and countries shows that self-care interventions have some degree of efficacy. This can be assumed since self-care is not only the most common intervention but also the way by which most daily problems are solved (Aung, 1994).

Today, one of the most important parts of self-care is self-medication. Even in the most remote areas around the world, some Western medicines are available and

¹ This knowledge is understood as the social and technical practices and representations of social groups and healers (medical knowledge and popular knowledge).

widely used. It is hard to find a community in Latin America where there are no Aspirins, Alka-Selzer or Vicks Vaporub. In fact, different studies have shown that self-medication is the most common response to illness (Tejedor, 1994; Moral, 1994).

Although we recognise that individual and micro-group lifestyles influence the health status of a person, socio-economic factors are determinant of individual and collective health and wellbeing. Socio-economic factors such as employment, education, environment, social network and limited – or lack of – access to health services are the factors that make people sick and vulnerable and that create a vicious cycle for the poor.

It is important to underline the importance of these structural conditions as the determinants of health to avoid analyses that end up blaming the victims. Although self-care is the common way to address health problems, it is the social and economic conditions that determine the need for these interventions.

The consumer

People have expectations, desires and are willing to invest their very scarce resources to get some of the most common OTC products found and advertised in Mexico.

They are confronted with little information and advice at the selling points, and in many places with the interests of pharmacy owners and companies that have developed elaborated schemes of marketing to promote their products in the pharmacy. For example, buy 10 get 14, bonuses for selling certain amounts, gifts, discounts, raffles, etc., are not uncommon in our countries, for OTC and prescription drugs.

Sometimes this is the result of the behaviour of an active sales person who is finding new marketing techniques; sometimes he/she responds to a company's pressure to increase sales. Anyway, it is imperative that companies know what happens on the ground in each country where they do business. They have to ensure that their ethical codes are applied everywhere and that breaking them has consequences.

All companies should find as much pride in ethical promotion, advertising and providing complete information to their consumers as they do in high quality standards and control.

Shared values

The consumer's wellbeing should be everybody's objective, and consumer rights should be the common ground for the discussion of important issues such as information and accountability. I hope these are shared values, and if not I would like to propose that we make them share values.

Given the context where we live, the organisation of the health services in different parts of the world and the increased access to information, we need to empower people and give them as much information and opportunities as possible to make good choices for their health. We need to make sure that out of the process of decision making that each micro group or individual uses to get a medicine to solve a health problem, there is a high probability that they make the right choice for their health and economy. We should avoid wastage of scarce (and

sometime vital) resources by having people choose products that are not appropriate for the condition they are bought for as a result of misleading information or advice, and we should ensure that products are as safe as possible.

What to do?

Although there are other vital aspects to the subject such as accessibility, affordability and quality, I would like to focus this section on what we can do in the area where I see the greatest opportunities for success and collaboration: **information and education**. Here consumers, health providers, governments, the media and industry can collaborate and have a positive impact on the health and economy of the people.

The fact that self-care is the first level of care and that there are almost no limits to the array of products people can get without advice in developing countries calls to ensure that:

- The medicines that are available in the market are safe and effective, which requires that all countries have a good and stringent registration system and that industry supports the development of such systems.
- Patients and caretakers have the best possible information about the products that they will use before buying them. This is especially important and is needed in developing countries for both the OTC and prescription markets.
- The advertisements do not contain false or misleading claims.

Prescription-only v OTC medicines

In the developing countries the first issue that needs to be addressed is the differentiation between prescription-only and OTC medicines. The problem of lack of enforcement needs to be acknowledged. There is no doubt that efforts have to be made and pressure put on the regulatory authorities to enforce regulation to honour the prescription control for the groups of drugs that require it. However, we also know that this is unrealistic in the short term for most developing countries.

There are a number of reasons that explain why this is so hard. They range from the cultural aspects related to law enforcement and lack of actual enforcement capacity, to a long tradition of not differentiating between these categories both by the consumers and the pharmacies. Also, people have developed a sense of knowing what they are doing and in other instances they are being practical in environments where medical or health care are scarce or hard to reach for different reasons (geographic, economic, and cultural).

However, the need for this differentiation should not be used to prevent producers ensuring that all medicines have appropriate information, which can be used by the patient/consumer.

Access to relevant and useful information for patients is an important issue to be addressed now. It is imperative that all medicines have the best available information, that standards for the quality of this information are high, and that producers feel and are made responsible for providing it. If producers do not feel responsible, governments should make them responsible.

It is important and urgent to ensure that the potential users of medicines have access to information and advice about what they are buying and taking. Unlike places like Europe, in developing countries this information frequently does not come with the medicine and is not easily available.

In fact, for prescription medicines there are a number of countries where regulation prohibits the inclusion of basic information about the product (such as recommended dosage, side effects, contraindications and interactions) based on the argument that the patient will be advised by the physician and that information promotes excess use.

This is an area on which we all need to work, and although it is a matter of national regulation, industry and consumer groups need to be active and instrumental in convincing authorities and physicians of the importance of having the best possible information on each product.

Quality of Information

Information should be readable and relevant to consumer decisions both for prescription and OTC medicines. However, for OTCs there is the added requirement that it needs to help consumers select a product. To provide quality information involves moving from a content-based approach that has proven not to work for consumers, to a performance-based approach that asks: What actions can people perform as a result of using the information on the labels/leaflets? And develop them to be useful (Kwok, 1999).

With regard to the content of the information, it needs to comply with international and national law and codes of ethics. It needs to be accurate, not misleading, containing only approved indications and making clear what is the frequency and importance of side effects, the most frequent and important adverse drug reactions and their contraindications (WSMI, 1988).

Just as important as the content of the information is the way it is presented to the consumer. Information has to be written in a way and in a language that is understandable and appropriate to each culture, level of education and readability of the potential users. For example, information in very small print makes it hard for people to read the labels or inserts, the use of technical words makes the message hard to understand for most people, lack of precision on the incidence of side effects gives either a sense that these will never or always happen. Finally, if there is a high proportion of people that are illiterate or have very low reading score, the information should be presented in another manner that is clearer and ensures communication.

To provide useful information for consumers will take some effort since it will have to be tested and make it appropriate for each country situation, but it is time to do it now. In fact, I understand that WSMI is involved in a dialogue with consumer advocates and others, to develop universal principles for designing OTC labels and leaflets, which is I believe a very timely effort with the potential of setting useful standards.

The way this information is produced is also important and some authors have identified basic principles that should apply (Kwok, 1999):

The information and labels should respond to what consumers want. Thus, when developing them, consumers have to be asked what they want or understand, and it should not be assumed that we know.

- Agree on the sources of information that will be used.
- Have a system to ensure compliance.
- Encourage consistency among medicines in the same therapeutic category.
- Have a system for updating the information.
- Involve all stakeholders in the process on an equal basis.

Although I have talked mainly about information that should be placed on the labels and leaflets of medicines, it is even more important to follow these criteria, avoid excesses and adhere strictly to the ethical codes in the case of promotion and advertising.

Industry has to act on this and lobby governments for patient information in all countries. Each company has to take a stand in their local associations to ensure that they support and promote this policy.

Industry's responsibility

The responsibility to provide product information rests with the producer of medicines. It has to comply with local laws and ethical codes.

We hear over and over the argument that industry complies with local regulation, and even dubious advertisements and labels have been approved by the regulatory authorities. Taking this stand in some places is minimalist and does not demonstrate interest in honouring consumer rights and ethical codes. I hope you will work to ensure all companies adopt a "maximalist" approach where each producer commits to comply with the highest possible standards, even if in a particular country the law does not require it. It has to use its ethical codes and make special efforts to ensure that each consumer/patient has the required information in a way he/she can understand it and that this information can help him/her decide.

This is especially important in the case of OTCs and in developing countries where, as we have already seen, more than half of the patients self-medicate and resources are so scarce.

Physicians and pharmacists also have to collaborate in this effort. They have to leave their traditional role of using knowledge as a way to differentiate and gain distance and power over their patients, and learn to better understand their patients and consumer needs and empower them to make the best decisions.

I have tried to paint the picture of how it is for ordinary people in developing countries and appealed for action in the interest of their welfare, knowledge and better ability to make their own decisions, in a context where self-care and self-medication are so important. I have also suggested how industry can help, take pride in doing so and bring your unique expertise and resources to add value to the product for everybody's benefit.

I hope I have also appealed, cautioned and awakened you to the effects of not honouring ethics in the context of developing countries.

I believe the focus on consumer rights, so prevalent everywhere, can now be better understood. It comes from the experience of people on the ground – especially when it does not work, which is often. I feel that these rights (Consumers International, 1996):

- Appropriate and accessible health care
- Information and education
- Participation in their own health care
- The right to redress and compensation in the event of injury

are a framework we can share and that each person, especially if he/she is sick, can expect the best possible care and that nobody – providers, organisations, unscrupulous persons or industry – should exploit the vulnerability and desire of health for any purpose.

I firmly believe that such a framework will help us keep our communities and our future generations and economies healthy. It is by doing something simple and practical within our capability that we can change the world a little in the right direction. We can surely work and fight together with this as shared values and contribute a little to a better future with less oppression from illness, anxiety, stress, and economic disadvantage.

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