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Commentary: The pros and cons of essential medicines for rich countries

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Rising costs of drugs is universal. From 1998 to 2001, prescription costs in the United States and England increased by 62% and 30%, respectively. Could the essential drugs concept help rich countries to control the rise in drug costs? Hogerzeil¹ cites Australia as an example, although experience there is hardly encouraging: spending on medicines rose by 69% between 1998 and 2002,² and the political difficulties of the process have been widely reported.³ But containing costs is not the only aim of the essential drugs concept, which primarily aims to increase access and efficiency and to promote better health and equity. These are also aims in rich countries, which already apply many of the principles of the concept, both to improve care and to manage costs.

The treatment of rheumatoid arthritis illustrates the problem. In the United States, pain and inflammation can be suppressed by ibuprofen at about \$4 per month (£2.46 in the UK NHS). The disease process can be slowed with methotrexate at about \$50 per month. Outcome may further be improved by using leflunomide, \$270 per month, or etanercept, \$1210 per month.⁴

Clinical and economic evaluation of new medicines is part of approval for reimbursement in, for instance, Australia, and effectively in the United Kingdom through the National Institute for Clinical Excellence. But in neither country has this controlled rises in expenditure. Essential drug lists or formularies are already widespread in rich countries—for example, in hospitals, in health maintenance organisations in the United States, and in primary care in the United Kingdom. But there are trade-offs: limitations on choice of drug may save money, but if rigorously applied, some patients will be affected.

In developing countries, people may accept restrictions in return for wider access. In rich countries, where access to most drugs is already wide, people may question the need for restriction except perhaps for very high cost drugs, with discretion on grounds of exceptional need. A rigid nationally imposed list would probably not be acceptable and might be ignored by the private sector. Ultimately, how much a country

spends on publicly funded medicines is a value or policy judgment.

Drug lists need integration into clinical guidelines, which can improve care but not necessarily cut costs. In the United Kingdom, National Institute for Clinical Excellence guidelines and setting national standards have increased prescribing costs. Implementing guidelines is difficult, but information technology may help.⁵ Limiting the influence of pharmaceutical companies on doctors and patients is difficult.

The essential drugs concept expects affordability to follow drug selection, hoping that a manufacturer of an expensive drug will trade a higher volume of sales for a lower cost or be forced by law or public opinion to reduce costs or relax patent protection. This has worked for antiretroviral drugs, but manufacturers can still make profits in rich countries. If rich countries played the same game, would drug development, usually funded from drug sales, slow? A new paradigm of sharing risk between commercial drug developers and public funders would be necessary. Furthermore, many rich countries are major exporters of pharmaceuticals, which bring employment and wealth. Restricting access to new drugs in a home market would not sit well with their industrial policies.

So although the principles of the essential drugs concept are generally accepted and elements applied in rich countries, national application is unlikely to achieve the medical, policy, and industrial aims of these countries. We should learn from the experience of those implementing the concept, but adaptation must be sensitive to different environments.

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