Essential medicines in palliative care

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"Essential Medicines, the WHO has an essential meds list? Really?"

I first became aware of World Health Organization (WHO) essential medicines through the work of Charles Olweny, the Director of Medical Oncology at the Royal Adelaide Hospital. Charles, the first Ugandan director of the Uganda Cancer Institute, was the primary author of the first edition of the WHO's essential drugs in Oncology.[1] Charles now serves as Chancellor of the Ugandan Martyr's University and Chairman of the Board of the Uganda Cancer Institute. Determining the essential chemotherapy medicines needed today in low- and middle-income countries has become somewhat more difficult with the increase in both number and cost of many of the current "effective" agents.

Why does cost matter? The WHO has included affordability in its definition of essential medicines:[2]

> Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford.

Medicines used in palliative care have been included in the essential medicines list since it was first issued in 1977. Among them have been symptom control medicines, co-analgesics, and analgesics, including two opioids: morphine and codeine. However, the article by Harding et al.[3] in this issue of *Palliative Medicine* clearly illustrates that morphine is NOT available at all times, in adequate amounts and in the appropriate dosage forms in East Africa. Only 8% of the 120 facilities stocked morphine, hardly available "at all time in adequate amounts." This is true in many countries of the world. Despite morphine's long-standing place on the essential medicines list, immediate release morphine has only just become available in Bangladesh.[4] This is a great advancement but with the product costing approximately 15 US cents per 10 mg tablet, the price is hardly one that can be afforded by most in that community.

But the focus on palliative care medicines is increasing. In 2013, almost 30 years after that first oncology list, the WHO released an Essential Medicines for Pain and Palliative Care.[2] Why has it taken so long? Inclusion of a separate palliative care list has been in process since 2007. The International Association of Hospice and Palliative Care (IAHPC) developed a Palliative Care list at the request of the WHO. A five-step process was used in developing the list, the initial two steps being the compilation of the most common symptoms together with the medicines used to treat them. Using a modified Delphi process of more than 300 palliative care clinicians and a meeting in Salzburg of representatives of 26 pain and palliative care organizations, the IAHPC list of Essential Medicines for Palliative Care was constructed.[5] That list consisted of 33 medicines used to treat 21 symptoms.[6]

Based on this list, in late 2012, WHO asked the IAHPC to prepare a summary of available evidence in support of a List of Essential Medicines for Palliative care. In all, 11 symptoms (anorexia, anxiety, constipation, delirium, depression, diarrhea, dyspnea, fatigue, nausea and vomiting, pain, and respiratory symptoms) were identified with 15 medications found to be essential for the treatments of these symptoms (Table 1). A similar process was undertaken for essential medicines for palliative care in children.[7]

There is an important clarification to realize about this process. At this stage, no new medicines have been added to the essential medicines list. A palliative care list has been crafted out of the essential medicines currently on the list. Why aren't all 33 medicines in the IAHPC list included rather than just 15 medicines on this list? This is related to the degree of evidence. The WHO Essential Medicines Committee seeks, what it considers to be, scientific evidence where as the IAHPC list was based on expert opinion. This is a calling for the palliative care community to complete the scientific research needed for the inclusion of all "essential" palliative care medicines on the WHO essential medicines list. Included among these should be the expanded armamentarium of opioids in the IAHPC list, including oxycodone, fentanyl, and methadone with the caveat that a country should ensure the availability of immediate-release morphine prior to working on access to these three additional analgesics. They also urge the need for special training on the clinical use of methadone as part of making this medicine available within a country.[5] The IAHPC list of opioid analgesics was used in the recent Global Opioid Policy Initiative (GOPI) studies.[8]

Table 1. Current WHO Essential Medicines for Palliative Care.

Steroids and NSAIDs	Medicines for other symptoms in palliative care
Acetylsalicylic acid	Amitriptyline
Ibuprofen	Cyclizine
Paracetamol	Dexamethasone
	Diazepam
Analgesics	Docusate sodium
Codeine	Fluoxetine
Morphine	Haloperidol
	Hyoscine butylbromide
	Lactulose
	Loperamide
	Metoclopramide
	Midazolam
	Ondansetron
	Senna

WHO: World Health Organization; NSAIDs: nonsteroidal anti-inflammatory drugs.

Are these lists important? While they may have little relevance in high-income countries with few issues in medicine availability, the essential medicines list has real significance and potential impact in low- and middle-income countries. This is becoming more and more important for the vast majority of the world's population who will be inflicted with diseases other than cancer, but equally important to the increasing number of people with cancer around the globe, estimated to grow to 24 million in 2035, with most living in low- and middle-income countries.[9] The inclusion of palliative care in the essential medicines list is another step forward in the increasing relevance of palliative care in the health of the world

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