When did medicines become essential?

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Expanding access to essential medicines has become one of the most visible challenges of global health delivery. Only a half-century ago, however, the role of medicines in international public health was far less obvious. Indeed, the original 1946 Constitution of the World Health Organization (WHO) barely mentioned medicines.[1] How did access to drugs assume such a central role within global health efforts?

The answer is not simply that the drugs of today work better than those of the mid-20th century. When Halfdan Mahler warned the 1975 World Health Assembly of the "urgent need to ensure that most essential drugs are available at a reasonable price",[2] his words spoke to the changing social and political realities of world health as much as any material shift in epidemiology or therapeutics. Essential drugs depicted a shift in WHO's therapeutic priorities from standard-setting towards the business of "getting drugs into bodies".[3] When, in 1977, WHO published a list of 186 "essential drugs" defined as "basic, indispensible and necessary for the health of the populations",[4] this simple act of list-making shifted a set of commodities from the private sphere into a public health commons, and reopened older debates on the relationship between international health and trade that dated back to the original 1948 World Health Assembly. Delegations who had then wished to see WHO "provide essential medical supplies...to countries which do not produce these commodities" were opposed by others insisting that medicines, "like other commodities, should now be obtained through the normal peacetime economic machinery".[5,6] Until the mid-1970s, WHO had compromised, working actively to ensure the supply of a few drugs such as chloroquine, penicillin and streptomycin that were linked to vertical campaigns while leaving the remaining pharmacopoeia to the laws of the market.

By the mid 1970s, however, a new majority of decolonized countries called upon the World Health Assembly to improve the supply of medicines for their struggling health systems. Many of these countries' public health budgets were overwhelmed by the cost of importing brand-name drugs, often of dubious quality.[7,8] Medicines subsequently became a key issue in the politics of the new international economic order after the Fifth Conference of Non-Aligned Countries adopted a resolution in Colombo in 1976 arguing that all Member States act *en bloc* within WHO and the United Nations to actively promote essential drugs policies.

Even for those who agreed that drugs were central to international health efforts, separating "essential" from "inessential" drugs was methodologically and politically challenging. Pharmaceutical manufacturers insisted that there was no such thing as an "inessential" drug, and only agreed to cooperate with the programme after clear assurances that the concept would be limited to the public sector of developing countries. While the selection criteria for the first list of essential drugs was based on pragmatic concerns for safety, efficacy, relevance and cost, a transparent mechanism for drug selection would not be articulated until 2002.[9] Questions regarding the role of cost-effectiveness and intellectual property, as well as the inclusion of contraceptives, abortifacients, palliative medicines, chemotherapy and drugs for risk-factor reduction would simmer throughout the programme's operation.

In 1988, Hiroshi Nakajima had replaced Mahler as Director-General and the essential drugs programme was relocated away from his office. While the programme continued to work closely with countries during this period to form national drug policies, it operated under a significantly lower profile.

In subsequent decades the essential medicines concept was pushed back into the international health debate from outside the WHO. Advocacy groups decried lack of access to drugs as morally unacceptable once combination antiretroviral therapy had transformed HIV infection from a death sentence to a potentially-manageable condition. Nongovernmental organizations increasingly circumvented the sovereignty of countries and patent-holders in their efforts to bring drugs to needy populations and to motivate innovative therapies for neglected diseases. Thus reinvigorated, essential medicines rejoined clean water, adequate housing and a safe food supply as part of a short-list of necessities for basic humanitarian conditions.[10]

Placing essential medicines at the centre of global health priorities is not without its risks. The geography of access is closely linked to other structural determinants of inequality, few of which can be fixed merely by providing a pipeline of medicines.[11] Access to essential medicines is therefore a necessary condition but is not sufficient on its own for the amelioration of broad health disparities in global health. On the other hand, to truly engage the social factors that determine the development, production, regulation, distribution, utilization and consumption of essential medicines is to engage with the project of understanding health disparities and the challenges of strengthening health systems at the most detailed level. As essential medicines programmes continue to expand, it is crucial that they have the resources and leadership to realize this vision in the broadest sense possible. ■

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