World Health Organization

EML at 42 (1977 – 2019)

Nicola Magrini, MD

Secretary,

WHO Expert Committee on the Selection and Use of Essential Medicines

EML at 42 (1977 – 2019)

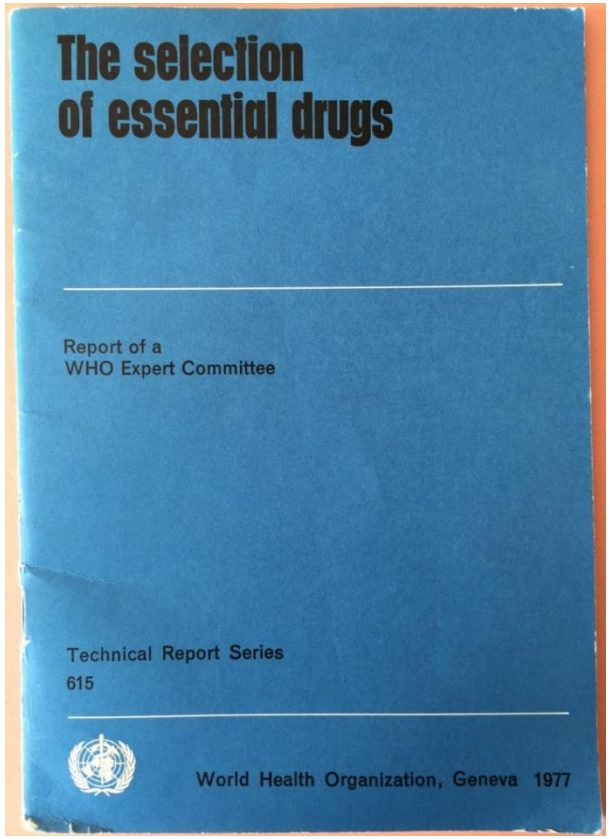
EML strategy to improve access - 2018-2023

1. Essential medicines … linking selection to UHC
2. Next update 2019 and how to improve access
3. Supporting Countries to develop and implement NEMLs

40 years of EML (1977 – 2017)

World Health Organization

36 pages, 20 references



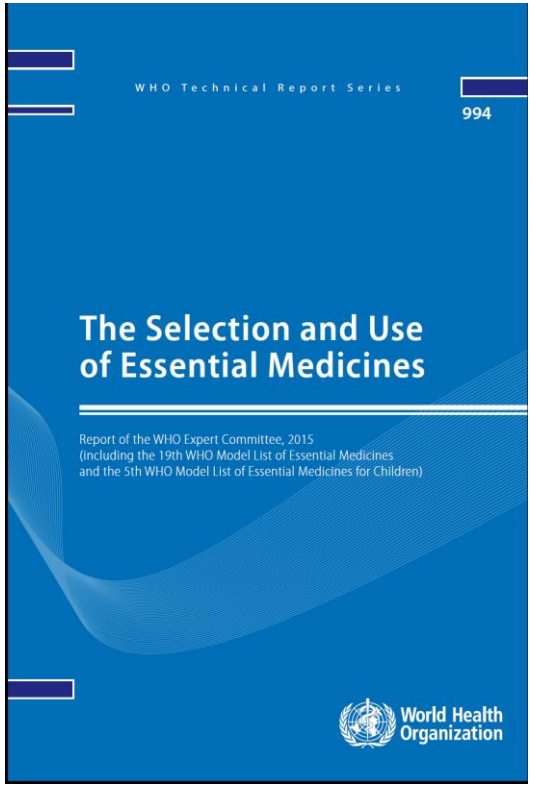
1977 1st Model list published, approx. 200 active substances

The first list was a major breakthrough in the history of medicine, pharmacy and public health

Médecins sans Frontières, 2000

20th EML & 6th EMLc - 2017

- 20th EML: **433** medicines
  - 6th EMLc (children): **314** medicines

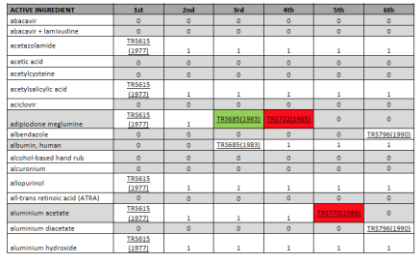


602 pages, >800 references

eEML: database & formats

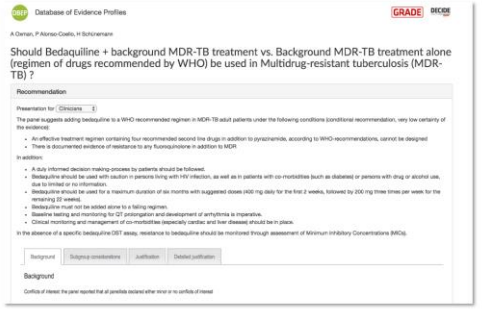
World Health Organization

Search..



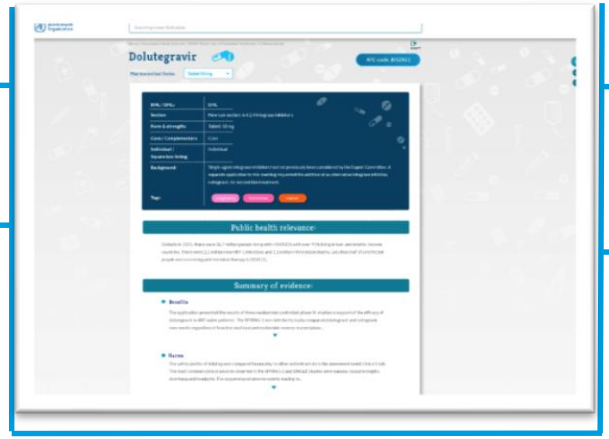
ELECTRONIC DATABASE

ONLINE SEARCH ENGINE

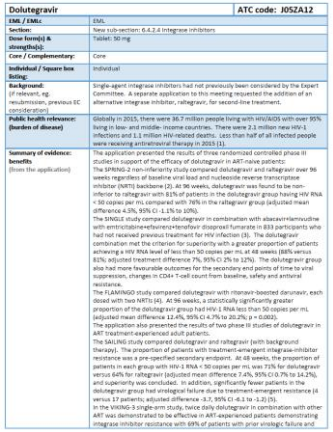


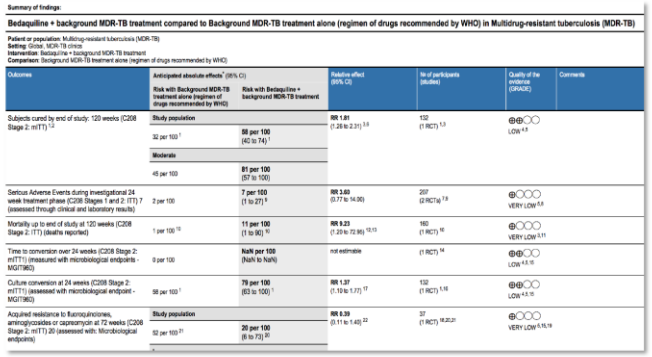
LINK TO WHO GUIDELINES

TEMPLATE



EVIDENCE SYNTHESIS





EML at 42 (1977 – 2019)

EML strategy to improve access - 2018-2023

World Health Organization

1. Essential medicines … linking selection to UHC
   - EML role and guiding principles: a short overview
   - Priority areas and how to better align EML and GLs

2. Next update 2019 and how to improve access

3. Supporting Countries to develop and implement NEMLs

The Lancet Commissions

World Health Organization

Essential medicines for universal health coverage

Veronika J Wirtz*, Hans V Hogerzeil*, Andrew L Gray*, Maryam Bigdeli, Cornelis P de Joncheere, Margaret A Ewen, Martha Gyansa-Lutterodt, Sun Jing, Vera L Luiza, Regina M Mbindyo, Helene Möller, Corrina Moucheraud, Bernard Pécoul, Lembit Rägo, Arash Rashidian, Dennis Ross-Degnan, Peter N Stephens, Yot Teerawattananon, Ellen F M 't Hoen, Anita K Wagner, Prashant Yadav, Michael R Reich

5 challenges for EM policies
1. Adequate financing
2. Affordability
3. Quality and safety
4. Optimal uses
5. Missing EM

Executive summary

Essential medicines satisfy the priority health-care needs of the population. Essential medicines policies are crucial to promoti
ment. Sus
mentions
quality and
all" as a ce
(UHC), an
the need
treatment
The rec
medicines
on the Ra
tatives ar
prehensive
later, *The*
Policies c
progress h
be addres
inform fu
medicines
contribute to the global sustainable development agenda? This report addresses these questions, with the intent to reposition essential medicines policies on the global development agenda.

inequitable and inefficient, and its reduction is a target for UHC. Furthermore, the Commission fo
that the available data on pharmaceutical expenditu
new
that
asic
and
was
t or
onal
the
and
d to
ines
rity
of
per
sion
confirmed that many people worldwide do not have access to even a limited basket of essential medicines. Countries should adapt the Commission's model to their national contexts to create a locally relevant estimate as a

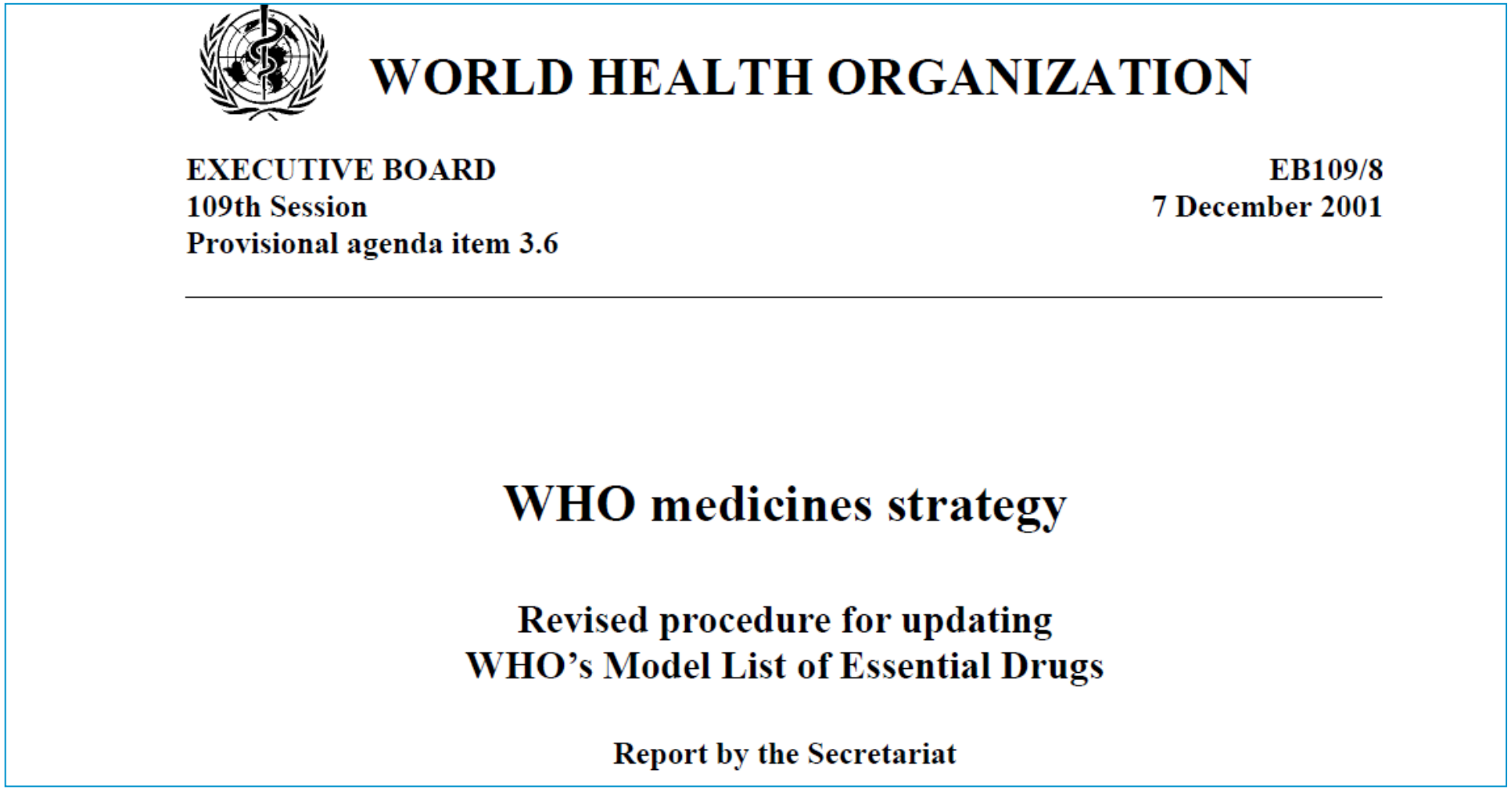
> These five core challenges for essential medicines policies are not new. Indeed, over the past few decades the global health community has sought to address them at all levels. However, finding long-lasting sustainable solutions has proved difficult. National and global economic and political interests have strongly influenced the development and implementation of essential medicines policies, which have implications for public health, economic development, and trade. As a result, essential medicines policies are often highly contested, at both national and global levels.

S0140-6736(16)31905-5, http://dx.doi.org/10.1016/S0140-6736(16)31904-3, http://dx.doi.org/10.1016/S0140-6736(16)31903-1, and http://dx.doi.org/10.1016/S0140-6736(16)31906-7

*Joint first authors and commission co-chairs

Department of Global Health/Center for Global Health and Development, Boston University School of Public Health, Boston, MA, USA (V J Wirtz PhD); Global Health Unit, Department of Health Sciences, University Medical Centre Groningen, University of Groningen, Groningen, Netherlands (Prof H V Hogerzeil FRCP, E F M 't Hoen LLM); Division of Pharmacology, Discipline of Pharmaceutical Sciences

The EML reform in 2001: more explicit criteria



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD
109th Session
Provisional agenda item 3.6

EB109/8
7 December 2001

WHO medicines strategy

Revised procedure for updating WHO's Model List of Essential Drugs

Report by the Secretariat

World Health Organization

A more transparent and evidence-based process (EB109/8 2001)

Revised procedure for updating and disseminating the Model List

6. At its meeting in 1999, the Expert Committee proposed that the methods for updating and disseminating the Model List be revised because of (1) advances in the science of evidence-based decision-making; (2) the increasing link between essential medicines and guidelines for clinical health care; and (3) the high cost of many new and effective medicines. The Expert Committee concluded that current procedures do not define the range of conditions covered with adequate specificity, nor are the reasons for inclusion recorded with sufficient clarity.

EML criteria (EB 109/8, 2001)

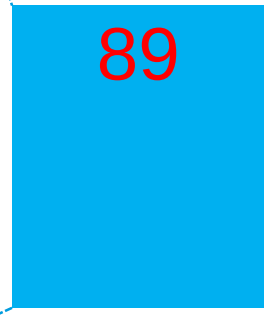
- Disease burden and public health need/relevance
- Sound and adequate data on the efficacy (on relevant outcomes), safety and comparative cost-effectiveness
  - *Role of evidence: quality (GRADE), publication bias*
  - "Absolute cost of the treatment will not constitute a reason to exclude a medicine from the Model List that otherwise meets the stated selected criteria"
  - "*Affordability changed from a precondition into a consequence of the selection*" (Hogerzeil, *BMJ*, 2004)

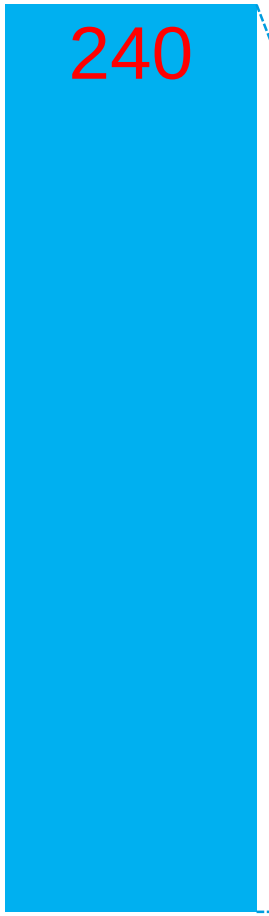
EML medicines and WHO technical Dpts GLs

World Health Organization

WHO guidelines

N. of EML drugs	
HIV	20
Hep C / B	11
TB	24
Malaria	18
Contraception	16
Subtotal	89
NTD	15
MCH	---





NO WHO GL

N. of EML drugs	
NCD	130
Cancer	65
AB/AMR	45

Essential medicines … linking selection to UHC

Comprehensive coordination: WHO GLs, priority areas, …

1. Connection with relevant WHO GLs:
   - HIV, HepB/C, TB and Malaria
   - Reproductive Health
   - Paediatric GLs – specifically on AB
   - Cancer pain
2. Priority areas/chapters in need of a comprehensive update
   - Cancer – EML on a leading role
   - AB/AMR – EML on a leading role
   - CV/Resp
   - Neurology/MH
   - Dialysis
   - Other areas: Rheumatoid arthritis, inflammatory bowel diseases
3. Closer look at high-priced (newly approved) medicines

EML at 42 (1977 – 2019)

EML strategy to improve access - 2018-2023

World Health Organization

1. Essential medicines … linking selection to UHC
   - EML role and guiding principles: a short overview
   - Priority areas and how to better align EML and GLs
2. Next update 2019 and how to improve access
   - Priority areas: WGs and how to expand access
   - EML rejections and prioritisation
3. Supporting Countries to develop and implement NEMLs

EML 2017 preparatory Working Groups

AB/AWARE

- 1st and 2nd choice AB for 23 syndromes
- Dosages and duration
- New Antibiotics (7)
- AWARE in selection/NEML, GLs and stewardship
- AWARE Index

Cancer

- Guiding principles: magnitude of benefits
- Individual drug review epxanded to the group (enzalutamide and abiraterone)
- TKI inhibitors from South Asia
- Immunotherapies for cancer

WHO EML AWaRe categories: Access, Watch and Reserve

World Health Organization

ACCESS: EML 1st and 2nd choice AB for 23 syndromes

- For each syndrome/disease the recommended AB for empiric treatment:
  - 1st choice AB - recommended option(s)
  - 2nd choice AB - alternative options when 1st choice not available

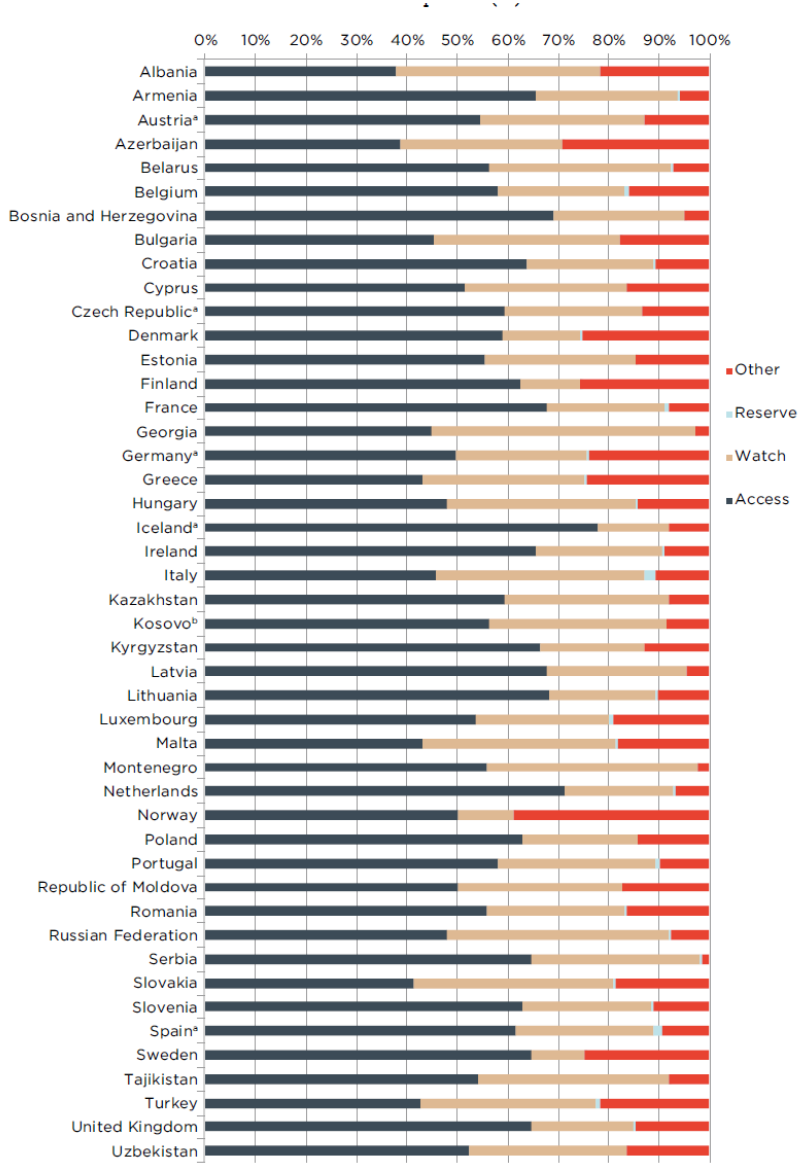
WATCH: AB *classes* with higher resistance potential recommended only for specific indications that should prioritized as key targets for stewardship programs. It includes the highest priority agents on the list of **Critically Important Antimicrobials (WHO CIA)** that should not be used prophylactically in agriculture and food producing animals.

RESERVE: last resort AB or tailored to specific patients or when other options have failed

EML AWaRe 2019: next steps

- Additional syndromes/indications/recommendations:
  - SAP – surgical AB prophylaxis (WHO GL)
  - Dental infections, medical prophylaxis
  - Thyphoid fever
  - New antibiotics reviewed (7) and classified in AWARE
  - Dosages (paed) and optimal duration
  - Modelling on thresholds for gonorrhea (currently 5%)
- Guidance template (electronic) & eEML/AB platform
  - 1st and 2nd choice AB for all syndromes/diseases
  - Algorithms when NOT to prescribe AB
- New AWARE iteration
- AWARE in guidelines for implementation and stewardship

WHO AB Global Report 2018 and AWARE



[a] Only community consumption reported.

Lancet ID Jan 2019

Consumption of oral antibiotic formulations for young children according to the WHO Access, Watch, Reserve (AWaRe) antibiotic groups: an analysis of sales data from 70 middle-income and high-income countries

Yingfen Hsia, Mike Sharland, Charlotte Jackson, Ian C K Wong, Nicola Magrini, Julia A Bielicki

Summary

Background The 2017 WHO Model List of Essential Medicines for Children (EMLc) groups antibiotics as Access, Watch, or Reserve, based on recommendations of their use as first-choice and second-choice empirical treatment for the most common infections. This grouping provides an opportunity to review country-level antibiotic consumption and a potential for stewardship. Therefore, we aimed to review 2015 levels of oral antibiotic consumption by young children globally.

Methods We analysed wholesale antibiotic sales in 70 middle-income and high-income countries in 2015. We identified oral antibiotic formulations appropriate for use in young children (defined as child-appropriate formulations

Lancet Infect Dis 2018

Published Online
December 3, 2018
http://dx.doi.org/10.1016/S1473-3099(18)30547-4

See Online/Comment
http://dx.doi.org/10.1016/S1473-3099(18)30557-7

Paediatric Infectious Diseases

Lancet ID

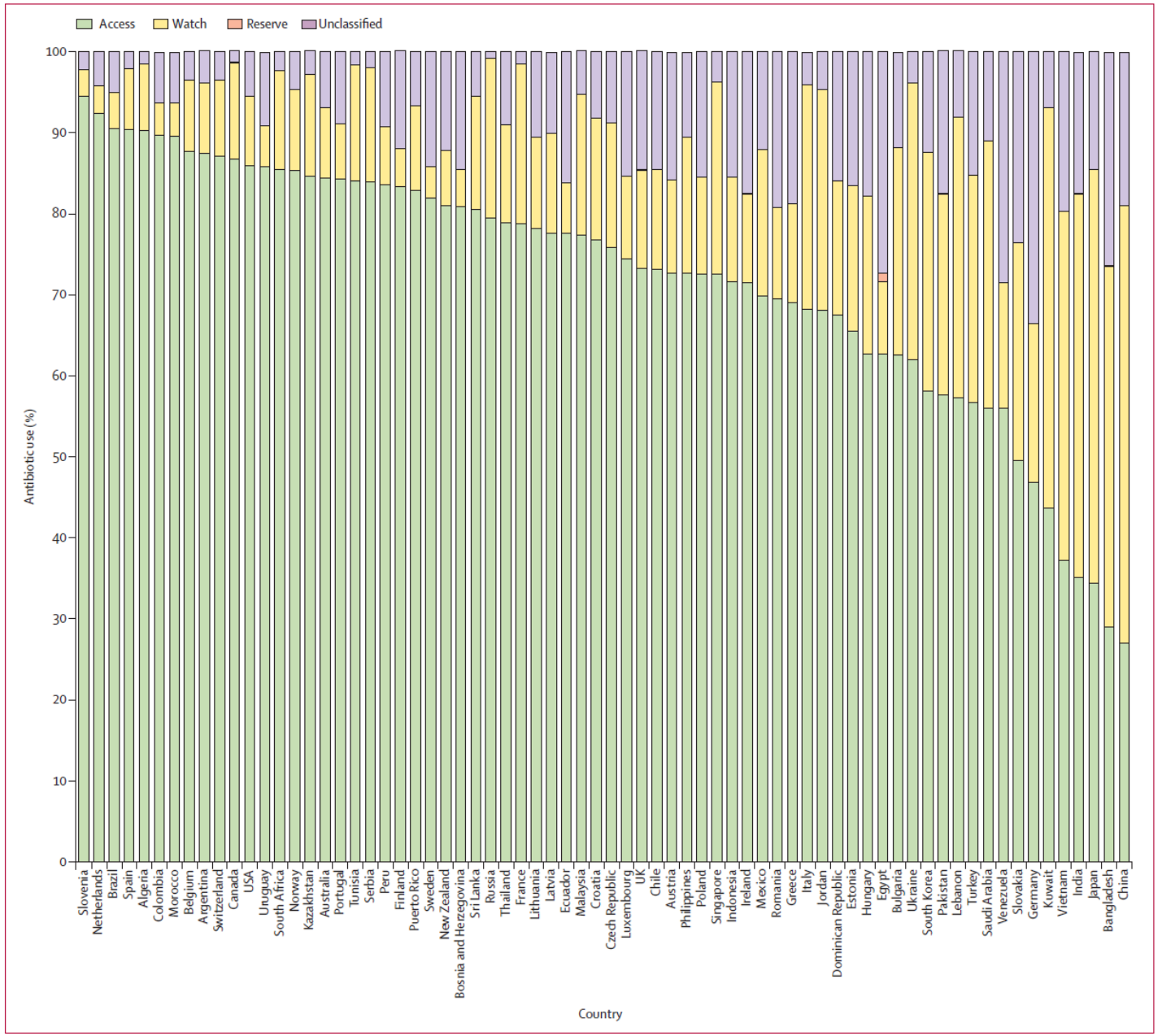


Figure 1: **Percentage antibiotic use of child-appropriate oral formulations according to WHO AWaRe grouping**
Only core Access antibiotics have been included in the Access group. AWaRe=Access, Watch, Reserve.

VOLUME 34 · NUMBER 1 · JANUARY 1, 2016

JOURNAL OF CLINICAL ONCOLOGY

REVIEW ARTICLE

World Health Organization

Proposing Essential Medicines to Treat Cancer: Methodologies, Processes, and Outcomes

Lawrence N. Shulman, Claire M. Wagner, Ronald Barr, Gilberto Lopes, Giuseppe Longo, Jane Robertson, Gilles Forte, Julie Torode, and Nicola Magrini

Lawrence N. Shulman and Claire M. Wagner, Dana-Farber Cancer Institute; Lawrence N. Shulman, Partners In Health, Boston, MA; Claire M. Wagner and Julie Torode, Union for International Cancer Control; Jane Robertson, Gilles Forte, and Nicola Magrini, World Health Organization, Geneva, Switzerland; Ronald Barr, McMaster University, Hamilton, Ontario, Canada; Gilberto Lopes, Centro Paulista de Oncologia e Hcor Onco, São Paulo, Brazil; Gilberto Lopes, Johns Hopkins University, Baltimore, MD; and Giuseppe Longo, Azienda Ospedaliero-Universitaria Policlinico di Modena, Modena, Italy.

ABSTRACT

Purpose

A great proportion of the world's cancer burden resides in low- and middle-income countries where cancer care infrastructure is often weak or absent. Although treatment of cancer is multidisciplinary, involving surgery, radiation, systemic therapies, pathology, radiology, and other specialties, selection c
challenging in resource
International Cancer Co
medicines to be includ
Children, as well as a r

Methods

Experts identified 29 c

Results

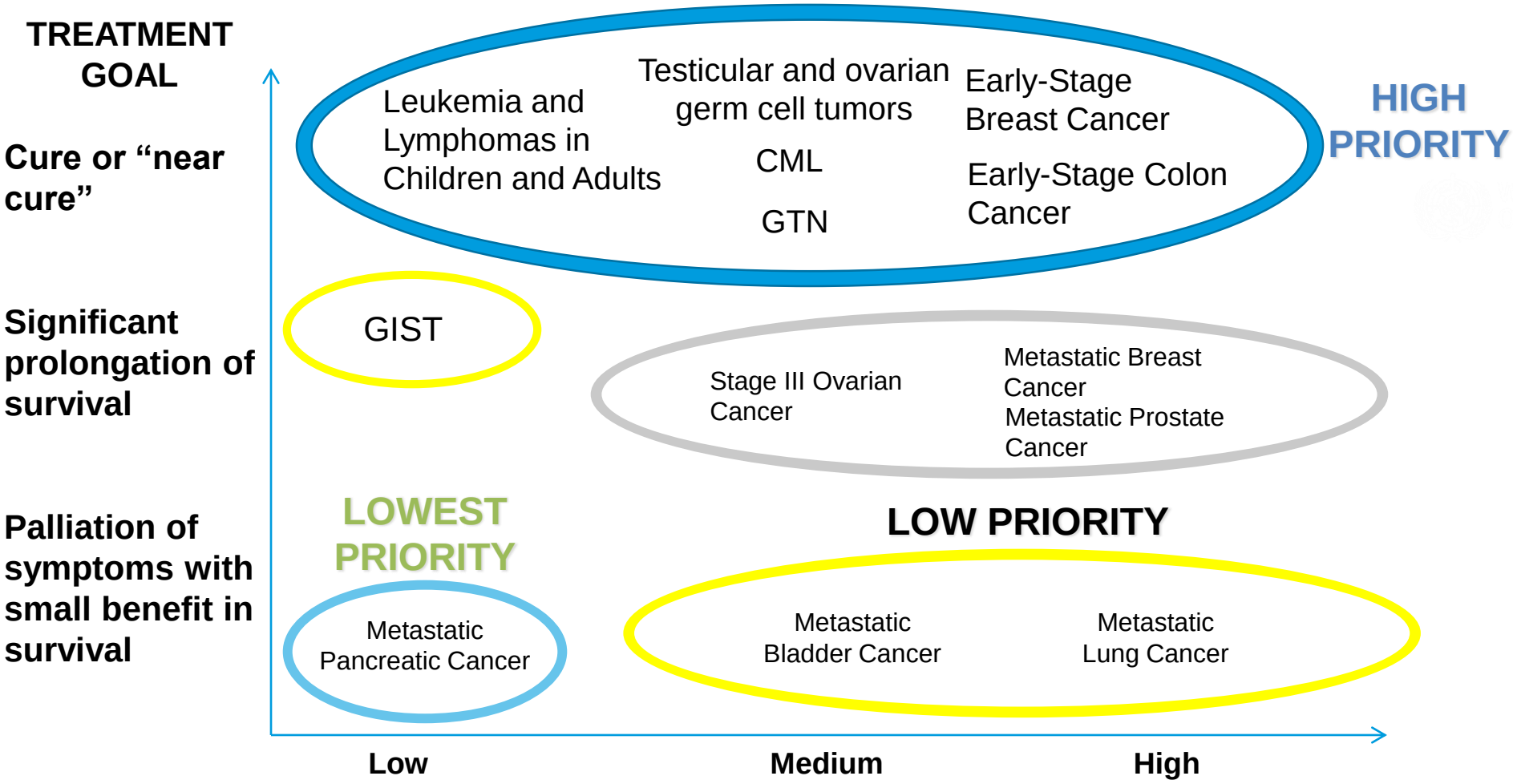
Briefing documents were created for each disease, along with associated standard treatment regimens, resulting in a list of 52 cancer medicines. A comprehensive application was submitted as a revision to the existing cancer medicines on the WHO Model Lists. In May 2015, the WHO announced the addition of 16 medicines to the Adult EML and nine medicines to the Children's EML.

Conclusion

The list of medications proposed, and the ability to link each recommended medicine to specific diseases, should allow public officials to apply resources most effectively in developing and supporting nascent or growing cancer treatment programs.

J Clin Oncol 34:69-75.

Methodology to Develop Proposal for Revisions



Slide credit: Dr. Gilberto Lopes

New EML cancer medicines main criterion: magnitude of absolute benefit

Imatinib: vast majority of patients in remission at 7 yrs

Rituximab (large B cell lymphomas): 15% absolute increase in survival rates (from 50-55% to 70%)

Trastuzumab: early stage breast cancer: up to 13% increase in survival in high risk women (from 37% to 50% survival rates at 3-6 yrs)

Same approach (using absolute efficacy estimates) applied to all proposed regimens

EML 2017
Cancer & cancer pain

World Health Organization

Recommendations	Rejections/standby
Dasatinib *(CML)* Nilotinib *(CML)* Zoledronic acid *(bone metatsteses)*	Enzalutamide (standby) Trastuzumab emtansine (standby)
Fentanyl (transdermal) Methadone *(already listed for substitution treatment)*	TKIs, crizotinib (standby) Tramadol (cancer pain)

WHO EML 2017
Cancer medicines

- The Committee did not recommend listing for:
  - enzalutamide for metastatic prostate cancer;
  - tyrosine kinase inhibitors (erlotinib, gefitinib and afatinib) and ALK inhibitor (crizotinib) for non-small cell lung cancer;
  - trastuzumab emtansine for metastatic breast cancer.
- The Committee considered that listing of these medicines was premature and recommended the establishment of an EML cancer medicines working group to coordinate comprehensive evaluation of cancer medicines for the EML.

WHO EML 2019

Cancer medicines

The Expert Committee recommended the establishment of an EML cancer medicines working group to coordinate comprehensive evaluation of available treatment options, across treatment lines and including recently approved medicines.

The working group should support WHO in establishing guiding principles, clarifying what constitutes a clinically relevant therapeutic effect, for granting the status of essential medicine to a cancer medicine.

The IMS Institute is now the IQVIA™ INSTITUTE for Human Data Science

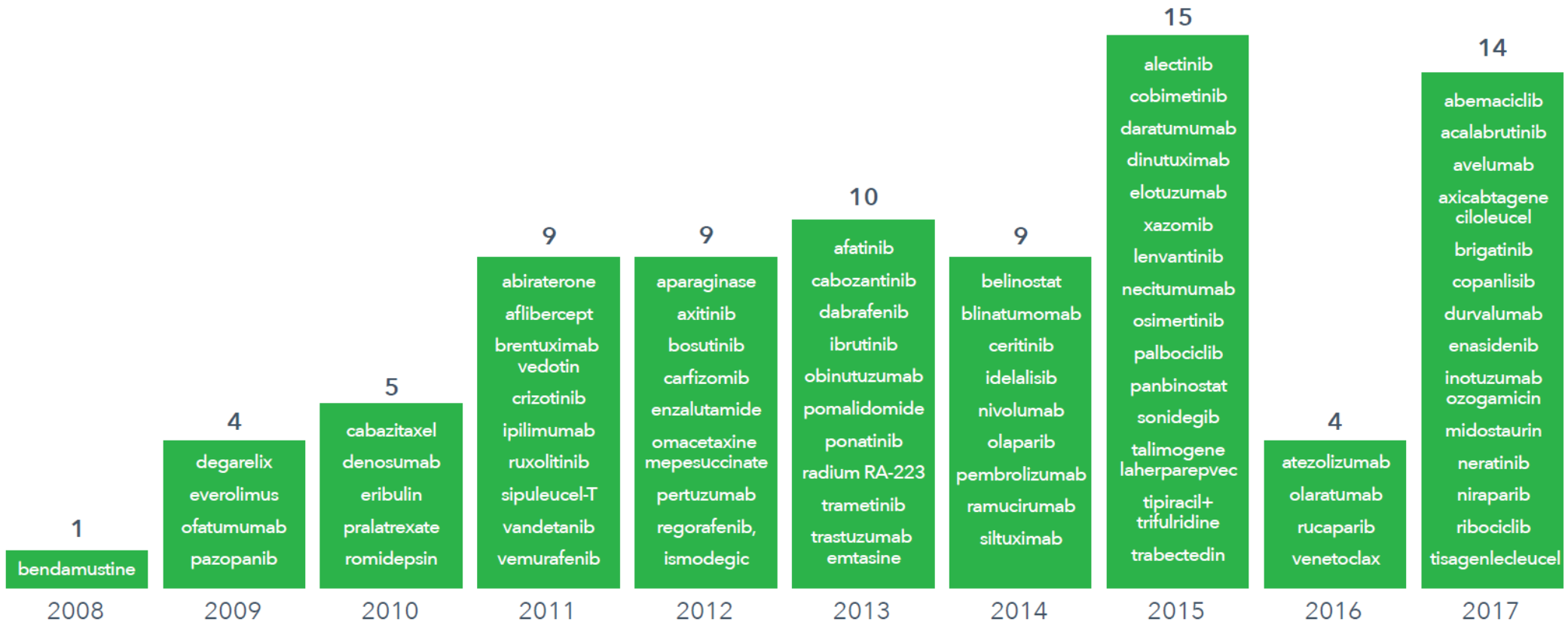
APRIL 2018

Medicine Use and Spending in the U.S.

A Review of 2017 and Outlook to 2022

There have been 52 new cancer medicines launched in the past five years including 33 in the past three years

Chart 29: Oncology New Active Substances By Year of First Launch in the United States



Source: IQVIA Institute, Mar 2018

WHO EML Cancer Medicines Working Group (CMWG)

Report of the meeting 22 – 23 March 2018

Geneva, Switzerland

World Health Organization

Essential Medicines. The CMWG aims to obtain relevant input from experts to guide the selection of optimal cancer medicines under consideration for inclusion in the Essential Medicines List (EML).

- There was agreement on the usefulness and relevance of current magnitude of benefit scales for cancer medicines (ASCO-VF and ESMO-MCBS): these two scales have promoted the involvement of the oncology community (clinicians, researchers) and cancer patients in discussing the value of new cancer medicines and have fostered better understanding of what it is meant by relevant clinical benefit.

- The discussion on what is a clinically relevant magnitude of benefit was examined comparing ASCO-VF and ESMO-MCBS scales. Data from recent cancer trials were used to evaluate medicines recently approved by FDA and EMA using both scales: only a minority of newly approved medicines provide data on survival and quality of life. Indeed clinically relevant data are often lacking at the registration phase.

- It was noted that for the vast majority (i.e. 75%) of cancer medicines approved over the last 15-20 years, there has been a lack of definitive evidence of substantial clinical benefit for patients at registration.

- The CMWG recommended WHO endorse the need to have overall survival as the main eligibility criterion of a medicine proposed for EML listing. Further the CMWG recommended endorsement of an interval for overall survival of at least 4-6 months for first-line treatments as a general guiding principle.

- Among the considerations that supported the 4-6 months overall survival interval were:
    - a strong clinical and ethical conviction that for OS less than 3 months, the benefits seem weak, marginal or not relevant (depending on cancer types);
    - a 3-month survival threshold has been endorsed by both ASCO and ESMO scales, with different implications in their respective scales;
    - clinical trials estimates tend to overestimate the benefits because of patient selection, risk of bias and spurious findings. Patients included in clinical trials often differ from those seen in real life settings: benefits in patients seen in everyday practice might be less convincing as compared to those selected in trials. Trials often have important methodological limitations, leading to biased estimates of intervention effectiveness. Single studies are often exposed to type I error. Finally interventions studied in trials might not be directly transferable in LMICs as capacity of centers to deliver essential medicines and manage related toxicity might be diminished.

EML 2019: cancer medicines

- EGFR tyrosine kinase inhibitors: erlotinib, gefitinib, afatinib
- Medicines for metastatic prostate cancer
- Anti PD-1 immune-checkpoint inhibitors: Pembrolizumab, Nivolumab, Atezolizumab
- Pertuzumab
- Trastuzumab emtansine
- Medicines for Children with Cancer
- Aprepitant
- Arsenic trioxide
- Pegaspargase
- Rituximab and Trastuzumab sc

«Late papers» contributing to EML discussion

IFPMA

21 March 2019

Dr. Mariângela Simão
Assistant Director-General
Prequalification and Technology Assessment
World Health Organization
Avenue Appia 20
1202 Geneva, Switzerland

Dear Dr. Simão,

We would like to thank the WHO Secretariat for sharing the Cancer Medicines Working Group (CMWG) meeting report and the technical report on temporal trends in clinical trials and the benefit of new cancer therapies. We recognize the efforts of the CMWG to bring greater transparency around the criteria for inclusion of oncology medicines in the Essential Medicines List (EML), however we are concerned with several of the core pillars outlined in these reports. Therefore, we would like to take this opportunity to address some of these concerns in the points outlined below.

1. Having overall survival (OS) benefit of 4-6 months as the main criterion for inclusion on the EML will potentially leave out many therapies with great clinical value.

The strategy of listing medicines based on the magnitude of their OS benefit in clinical trials should be put into context. Many treatments offer clinical benefits beyond OS, detectable and measurable on the level of novel clinical endpoints (reflecting the specificities of innovative treatments), including, very importantly, patient reported quality of life[1]. Nonetheless, as explained below in point 2, many of these results will in fact be translated into real clinical benefit when used in a clinical setting and given the necessary time to generate data.

How to prioritize essential medicines for cancer

Tito Fojo, MD, PhD on behalf of
WHO Essential Medicines List Cancer WG 2018-9
Professor of Medicine
Department of Medicine
Division of Hematology / Oncology
Columbia University
New York, New York

Background

With citizens of the entire world as its constituents regarding matters of health, the challenges faced by the World Health Organization as it tries to help provide the best possible cancer care are understandably complex. Viewed by some as a personal tragedy but not a societal health challenge, the importance of cancer medicines was first addressed as a problem of low- and middle-income [LMI] countries in need of World Health Organization support in 1977 when the first essential medicines list was published including some essential medicines for cancer. Recognizing the diverse income structure of the world's countries and the challenge a diagnosis of cancer presents to any human, the World Health Organization has tried, through its list of *Essential Medicines*, to highlight cancer therapies it considers valuable because they can meaningfully change outcomes for cancer patients throughout the world.

While in developed countries one often encounters a clamoring for the latest novel therapy that "cures" cancer, in fact as the data will show, with only rare exceptions, novel therapies are increasingly not novel and rarely curative; indeed, the majority provide only marginal benefits. Furthermore, it is often incorrectly assumed that developed countries, with well-funded health care systems can afford to pay for such novel therapies with marginal improvements at what many consider exorbitant prices. A long overdue reconciliation will soon force even the richest countries to confront the unavoidable truth that budgets are not infinite, much more public good can be reaped from many less expensive options and that investing in prevention and vaccinations can deliver much more, albeit in the future. These tenets, long recognized by the World Health Organization, provide the foundation for much of what follows.

With this monograph we hope to provide background that will help the reader understand some of the variables that must be considered in deciding what constitutes an Essential Medicine. **It is designed to complement the report of a working group of international experts convened by the World Health Organization in its Geneva Headquarters on March 22/23 of 2018.** The charge for that working group was to begin the process of identifying the cancer therapies that would be added to the 2019 Essential Medicines List and define guiding principles for EML candidates.

EML at 42 (1977 – 2019)

EML strategy to improve access - 2018-2023

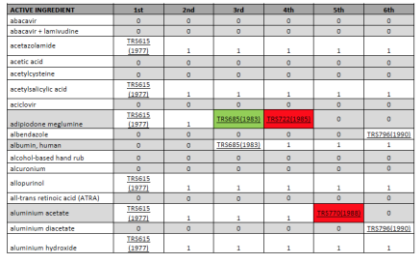
World Health Organization

1. Essential medicines … linking selection to UHC
   - EML role and guiding principles: a short overview
   - Priority areas and how to better align EML and GLs
   - Impact of standing Working Groups: AB/AWARE and Cancer
2. Next update 2019 and how to improve access
   - Priority areas (WGs and GLs)
   - EML rejections and prioritisation
3. Supporting Countries to develop and implement NEMLs
   - DB of NEMLs and eEML (and e-AWARE)
   - Reimbursement and procurement
   - Inputs from countries & drug utilisation
   - Other priorities: insulins and …

eEML: database & formats

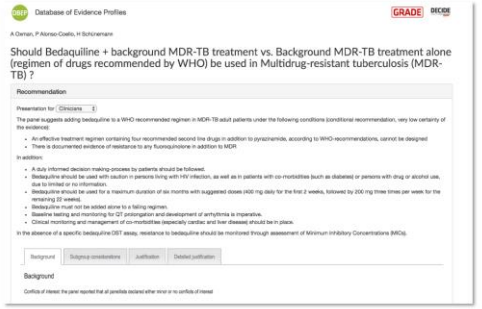
World Health Organization

Search..



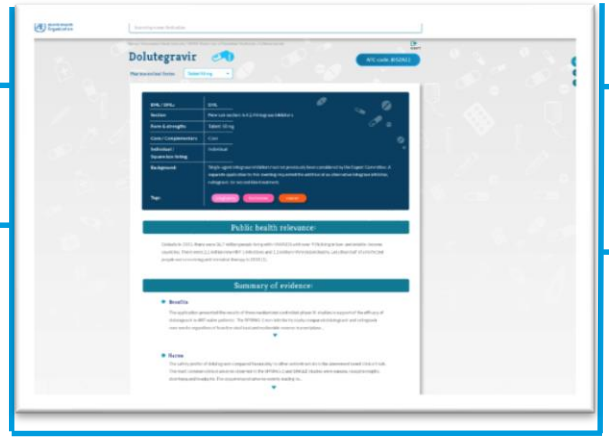
ELECTRONIC DATABASE

ONLINE SEARCH ENGINE

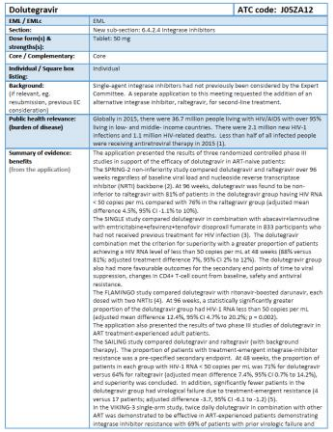


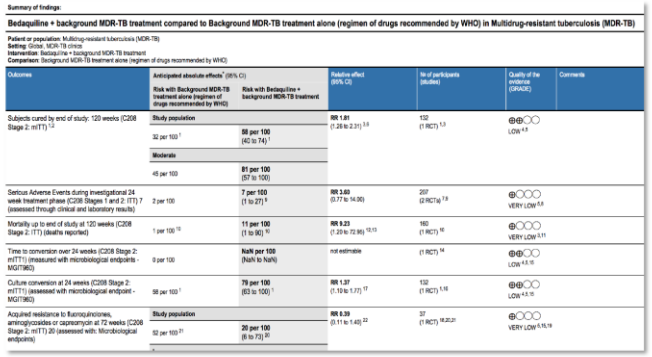
LINK TO WHO GUIDELINES

TEMPLATE



EVIDENCE SYNTHESIS





Essential medicines … linking selection to UHC (2/2)

EML and reimbursement/coverage, EML and DU, eEML

1. EML as a guide to procurement:
   - Square box examples (qualified therapeutic equivalence)

EML 2017 - Non-communicable diseases

World Health Organization

Erythropoiesis-stimulating agents

Complementary List

☐ *erythropoiesis-stimulating agents**	***Injection: pre-filled syringe*** *1000IU/ 0.5 mL; 2000IU/ 0.5 mL; 3000IU/ 0.3 mL; 4000IU/ 0.4 mL; 5000IU/ 0.5 mL; 6000IU/ 0.6 mL; 8000IU/ 0.8mL; 10 000IU/ 1 mL; 20 000IU/ 0.5 mL; 40 000IU/ 1 mL* ** the square box applies to epoetin alfa, beta and theta, darbepoetin alfa, and their respective biosimilars*

EML consultation with countries: objectives
(end of January 2019)

World Health Organization

- There is a need to facilitate feed-backs and **inputs from** countries
- Countries should propose priorities and hot topics (for which they request WHO EML to respond or take a position on)
- WHO EML to propose a simple/facilitated process for countries (in parallel with the standard application process)

Support to countries: access to EM

Use / DU

EML

Selection

Coverage/UHC

Procurement & therapeutic equivalence

Shortages

EML: other priorities

Insulins

Migrants

Why insulin access is a global priority

World Health Organization

- Insulin was discovered in 1921 and first used in 1922 - yet remains unavailable and unaffordable to many patients globally
- Insulin is essential medicine needed daily for the survival of people with Type 1 diabetes and increasingly also in Type 2 diabetes
- Discuss an EML independent working group on the issue of access to insulin to
  - Strengthen supply & improve delivery of care
  - Evaluate current health system challenges
  - Discuss insulin inclusion in WHO prequalification program and pooled procurement mechanisms
  - **… think how to celebrate insulin 100 years in EML/WHA 2021**

Evidence-based clinical guidelines for immigrants and refugees

Kevin Pottie MD MClSc, Christina Greenaway MD MSc, John Feightner MD MSc, Vivian Welch MSc PhD, Helena Swinkels MD MHSc, Meb Rashid MD, Lavanya Narasiah MD MSc, Laurence J. Kirmayer MD, Erin Ueffing BHSc MHSc, Noni E. MacDonald MD MSc, Ghayda Hassan PhD, Mary McNally DDS MA, Kamran Khan MD MPH, Ralf Buhrmann MDCM PhD, Sheila Dunn MD MSc, Arunmozhi Dominic MD, Anne E. McCarthy MD MSc, Anita J. Gagnon MPH PhD, Cécile Rousseau MD, Peter Tugwell MD MSc; and coauthors of the Canadian Collaboration for Immigrant and Refugee Health

Competing interests: See end of document for competing interests.

Coauthors of the Canadian Collaboration for Immigrant and Refugee Health: Deborah Assayag, Elizabeth Barnett, Jennifer Blake, Beverly Brockest, Giovani Burgos, Glenn Campbell, Andrea Chambers, Angie Chan, Maryann Cheetham, Walter Delpero, Marc Deschenes, Shafik Dharamsi, Ann Duggan, Nancy Durand, Allison Eyre, Jennifer Grant, Doug Gruner, Sinclair Harris, Stewart B. Harris, Elizabeth Harvey, Jenny Heathcote, Christine Heidebrecht, William Hodge, Danielle Hone, Charles Hui, Susan Hum, Praseedha Janakiram, Khairun Jivani, Tomas Jurcik, Jay Keystone, Ian Kitai, Srinivasan Krishnamurthy, Susan Kuhn, Stan Kutcher, Robert Laroche, Carmen Logie, Michelle Martin, Dominique Elien Massenat, Debora Matthews, Barry Maze, Dick Menzies, Marie Munoz, Félicité Murangira, Amy Nolen, Pierre Plourde, Hélène Rousseau, Andrew G. Ryder, Amelia Sandoe, Kevin Schwartzman, Jennifer Sears, William Stauffer, Brett D. Thombs, Patricia Topp, Andrew Toren, Sara Torres, Ahsan Ullah, Sunil Varghese, Bilkis Vissandjee, Michel Welt, Wendy Wobeser, David Wong, Phyllis Zelkowitz, Jianwei Zhong, Stanley Zlotkin.

Editor's note: See Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.090313/-/DC1, for affiliations and contributions of coauthors.

This document has been peer reviewed.

Correspondence to: Dr. Kevin Pottie, kpottie@uottawa.ca

CMAJ 2011. DOI:10.1503/cmaj.090313

KEY POINTS

- Clinical preventive care should be informed by the person's region or country of origin and migration history (e.g., forced versus voluntary migration).
- Forced migration, low income and limited profi English or French increase the risk of a decline i and should be considered in the assessment an of preventive care.
- Vaccination (against measles, mumps, rubella, diphtheria, tetanus, pertussis, polio, varicella, hepatitis B and human papillomavirus) and screening (for hepatitis B, tuberculosis, HIV, hepatitis C, intestinal parasites, iron deficiency, dental pain, loss of vision and cervical cancer) should be routinely provided to at-risk immigrants.
- Detecting and addressing malaria, depression, post-traumatic stress disorder, child maltreatment, intimate partner violence, diabetes mellitus and unmet contraceptive needs should be individualized to improve detection, adherence and treatment outcomes.

World Health Organization

Consider also the WHO EML in our approach to immigrants and refugees health

VIEWPOINT

Cost, Effectiveness, and Value
How to Judge?

Michael D. Rawlins, MD
London School of Hygiene and Tropical Medicine, London, England.

Universal health coverage is a global aspiration supported by both the World Health Organization[1] and the United Nations.[2] The World Health Organization has defined universal health coverage as ensuring that "all people obtain the health services they need without suffering

The costs of an intervention are, in theory, easy to define.

…

The evidence of the effectiveness of an intervention might seem easy to define.

The resources available to finance health care in in-

confidential discounts that payers in many developed countries negotiate and are often substantially less than the list price. In developing countries, payers should similarly negotiate for lower prices for products from developed countries

an intervention
authorities, for
e of clinical ef-
nts before they
are marketed. But, again, there are difficulties.

We need less research, better research, and research done for the right reason

Doug Altman, BMJ 1994

Essential medicines selection
Essential Medicines List and Formulary
Pharmacoeconomics
Selection of medicines in emergencies
WHO Expert Committees
Links
About

22nd Expert Committee on the Selection and Use of Essential Medicines– applications for:

Additional medicines

- Fixed-dose combination antihypertensives - EML
- Bedaquiline - MDR-TB in children - EMLc
- Glecaprevir + pibrentasvir - EML
- Fexinidazole - EML and EMLc
- Sumatriptan - EML
- EGFR tyrosine kinase inhibitors - EML
- Pertuzumab - EML
- Trastuzumab emtansine - EML
- Multiple micronutrient powders - EMLc
- Alteplase - EML
- Diazoxide - EMLc
- Carbetocin - EML
- Dolutegravir + lamivudine + tenofovir DF - EML
- Dabigatran - EML
- Direct oral anticoagulants (DOACs) - EML
- Multiple sclerosis disease modifying therapies - EML and EMLc
- Medicines for multiple myeloma EML
- Escitalopram - EML
- Methylphenidate - EML and EMLc
- Medicines for metastatic prostate cancer - EML
- Pegasparagase - EML and EMLc
- TNF-alfa inhibitors - EML and EMLc
- Tiotropium - EML
- Dolutegravir - EMLc
- Anti PD-1 immune-checkpoint inhibitors - EML
- Aprepitant - EML and EMLc