Letter from Berlin

WHO SHOULD PAY FOR ANTI-OBESITY DRUGS?

The recent introduction in Germany of prescription remedies (*Orlistat* and *Sibuttramin*) for weight reduction has led to a lively discussion in the media about who should pay for these drugs. This is of obvious interest in a health system that is entirely based on a mandatory health insurance scheme, where every one pays a certain amount to the system and expects to get maximum medical care for all medical problems.

According to current estimates, almost half of the entire German adult population are either overweight or frankly obese by World Health Organization standards. As every overweight individual is aware, long term weight reduction by will power alone remains notoriously unsuccessful. The situation is aptly described by the term 'yo-yo effect', which may well be a cardiovascular risk factor in its own right.

Clearly, an inexpensive, potent, safe and well tolerated pharmacological treatment that will ensure long term stability of body weight either by promoting loss, or perhaps by even just preventing further weight gain, is something every obese person in the world is waiting (and probably praying) for. Now that the first drugs that may fulfil some, but certainly not all, of these criteria are hitting the market, the question regarding who is to pay for this treatment is of obvious importance in an insurance-based health system. At current costs, we are talking about nearly DM 200 (about Rs 5000) a month for a treatment that may have to be carried on for life.

At this point, we must stop to consider what is so special about obesity, when compared to other cardiovascular risk factors such as hypertension, hypercholesterolaemia or diabetes. The cost for treating these 'traditional' risk factors is reimbursed by the health insurance system and, as far as I am aware, there has never been any wide criticism of this state of affairs. If we compare obesity to hypertension, there are several similarities. Both are major risk factors for cardiovascular diseases, are promoted by an 'unhealthy' lifestyle, are amenable to non-pharmacological intervention (at least in the short term) and are generally life-long conditions that require long term management. Of course, we know that dietary salt restriction lowers blood pressure in most hypertensives, but in real life, it is so much simpler to prescribe a cheap and effective thiazide than spend hours on dietary counselling and patient education, which have yet to be proven beneficial in morbidity and mortality trials. As for obesity, there is not a single study demonstrating that long term weight management (over years and decades) by modification of lifestyle is feasible or effective in a relevant proportion of affected individuals. I am not talking about the lucky few who have the will power to make new year resolutions and actually stick to them, and live happily ever after.

But despite these obvious similarities, I believe that the situation with obesity is not fully comparable to that of hypertension. While epidemiological data do suggest that obesity is a major risk factor for cardiovascular disease and other disorders, there is yet no randomized controlled intervention study proving that weight reduction actually decreases morbidity or mortality. Similarly, although there are data indicating that the new anti-obesity drugs (in combination with mild caloric restriction) may significantly reduce weight and improve surrogate measures such as glucose and lipid control, there is no proof that this will indeed result in a reduction in 'hard' end-points. Until then, in the present era of evidence-based medicine, there is certainly a strong argument against expanding insurance coverage to include the costs of anti-obesity drugs. This does not mean that such drugs should not be used for the treatment of obesity. It only means that the cost for such a treatment should not be borne by the health insurance system until such evidence becomes available. Clearly, it is up to the drug companies to prove that their compounds are not only safe and effective, but also contribute significantly to reducing obesity-related morbidity and mortality.

ARYA M. SHARMA

Letter from Mumbai

AN UNUSUAL FORUM FOR A DISCUSSION ON MEDICAL ETHICS

Mumbai is fortunate in having some excellent bookshops for the discerning reader. One of these, Crossword, near the Mahalaxmi temple, has two added attractions. Its coffee shop dispenses some of the finest brew in town. Believing that bookstores should also arouse social and cultural consciousness, Crossword organizes discussions and debates on topics relevant to the books it sells. One such discussion, on 9 March 1999, centred around the book *Stillborn—A medical thriller* by Rohini Nilekani (Penguin Books, New Delhi, 1998, Rs 200).

Ms Nilekani has turned from reporting for a periodical to the 'lonely business' of writing a book whilst managing a home and bringing up two children. Research over several months into current trends for controlling fertility and studies with tribals on B.R. Hills (near Bangalore) provided grist for her mill. She has benefited from the expertise of individuals such as Drs Firuza Parikh, Bhavana Doshi and H. Sudarshan. In the process of writing a thriller, she has touched upon a range of problems in medical ethics.

Her tale revolves around 'a mysterious hunk called Anshul Hiremath' who, on returning from America, has set up a research laboratory with the aim of being the first to produce a successful