Every so often an important piece of new thinking about international public health appears. *Investing in Health,* from the World Bank, is such a document. This report reflects recent changes in international health, including AIDS and the diversion of the world’s attention to Central Europe and the former Soviet Union. The dichotomy of tropical diseases for the developing world and non-communicable ones for the industrialised countries no longer applies; cardiovascular disease is now the leading cause of death in the developing world. The report emphasises the health problems of urban areas and dwells on violence, especially towards women; it has a detailed chapter on the economic and social impact of ill-health on the household. It acknowledges the cost effectiveness of an essential drugs policy and demonstrates the negative health (and economic) effects of tobacco. Ten years ago the World Bank would have hesitated to take on the pharmaceutical or tobacco industries, but in the thirteen years since it began lending for health, this organisation has come into its own. Indeed *Investing for Health* marks a shift in leadership on international health from the World Health Organization to the World Bank. Dozens of WHO staff were involved in the background work for the report but it is unmistakably a World Bank product.

The report approaches public health in developing countries from an economic viewpoint, but it is a balanced view, reflecting much new thinking and providing implicit self-criticism. It concedes that in some countries Structural Adjustment Programmes were indiscriminate and failed to preserve important elements of health services. It admits that in health “the market” is not perfect—a big step forward from the dogma of a few years ago. And it provides strong evidence that user fees can be disastrous. In China, when in 1981 drug charges of $30–80 were instituted for tuberculosis, 1–1.5 million cases remained untreated, producing in turn an additional 10 million infections. Many of the 3 million Chinese who died of tuberculosis during the 1980s could have been saved.

The report’s strengths risk being swamped by controversy about its estimate of the “global burden of disease” and the package designed to reduce that burden. This involved estimating, for 131 diseases, the incidence of cases in 1990 by age, sex, and region. A “severity weight” of disability compared with complete loss of life was estimated and then combined with mortality losses, years lost in the future being weighted by their presumed productivity, to produce “disability-adjusted life years” (DALYs). Estimates of cost per intervention in terms of DALYs yield “packages” of basic services, which would cost $12 per person in low-income countries ($4 for public health, $8 for essential clinical services). Delivery of these packages, it is claimed, would reduce the disease burden by nearly one-third. Virtually all of these essential services can be delivered at district hospital level or below. An intervention costing less than $100 per DALY is considered a very good buy. The cheapest, at less than $25, include promotion of breast-feeding, immunisations, salt iodisation and vitamin A supplementation, anthelmintics, smoking prevention, use of condoms, and cataract removal. At more than $1000 per DALY, and therefore not a good buy for most developing countries, are surgical and medical treatment of chronic diseases and cancers and control of dengue fever.

The DALY rankings are based on key assumptions buried in an appendix, the most important of which is discounting, whereby benefits and cost which will occur in the future are adjusted downwards to a present value. Economists will debate endlessly about whether the 3% discounting rate used in the report is appropriate, but do we have the right to discount the future when making decisions affecting the lives of others, some not yet born? To compound the offence, years of life have been productivity-weighted, a low value being attributed to children and the elderly. The marginal cost of a year of healthy life...
Research and effective health care

When Prof Michael Peckham boldly identified the plethora of unproven medical practices in the UK’s National Health Service as a key impediment to the delivery of effective health care—the “medical archaeology”1 of clinical practice—there must have been few observers who were not left excited and optimistic by his vision of a research-based health service. The NHS was to resign its role as the passive partner of medical science and exert its own demands on the research community. The latest report on the Peckham initiative summarises two years of progress towards establishing the administrative infrastructure of this research and development (R&D) strategy. Much has been achieved in defining the lines of communication between funding organisations, regional and central advisory committees, database centres, and health service consumers. For example, the Cardiovascular Disease and Stroke Advisory Group and the Physical and Complex Disabilities Group have established multidisciplinary teams to pinpoint priority areas for research. Reviews of cancer and respiratory illness will follow later this year. And those despairing at the now unexciting, but still optimistic, management-speak tone of this document2 can take comfort in research actually commissioned in the mental health priority area.

The freedom accorded to scientists has been seen as an important strength of the biomedical research community. To support individuals or groups who are performing high-quality research is an essential part of nurturing scientific talent. When this freedom has come under threat researchers themselves feel threatened. The NHS and Department of Health R&D strategy aims to shift the emphasis away from the investigator to a need-driven research programme—and this health services research budget is not trivial at £316 million per annum (1.1% of the NHS total, the aim being 1.5%). The intention is to satisfy the twin goals of a more pragmatic approach to health care research and of cost containment. Competition for funds will intensify as researchers redirect their long-standing research efforts towards those high-priority areas identified by the Central Research and Development Committee. Not long ago the secretary of the Medical Research Council sent shivers down a few spines by referring to the “self-centredness and selfishness” of scientists who wish merely to satisfy their own curiosities without reference to the greater public need.3 But this is not the message coming from medical researchers whose grant applications are alpha-rated but unfunded and who must contend with a completely inadequate career structure. It seems that some guardians of substantial medical research expenditure in the UK are beginning to talk the customer/contractor language last heard in the ill-fated Rothschild experiment of twenty years ago.4

In the UK the Patients’ Charter contains a commitment to reduce waiting lists. But the increase in health service capacity that would be necessary to accommodate this policy is unsustainable with current levels of

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