

### REMEDIES FOR THIRD WORLD DISEASES

SIR,—Dr Garattini (June 11, p 1338) highlights the obstacle that the profit motive sets in the way of Health for All by the Year 2000. Diseases once well known in today's industrialised countries are still endemic in the third world, and the term "tropical diseases" is inappropriate for illnesses determined only partly by geography and mainly by socioeconomic conditions, such as the diarrhoeal and respiratory diseases that rank first among the killing diseases worldwide.

The answer is not only a matter of drugs: the approach needs to be global, and not limited to health intervention alone. In that sense industrialised countries have a major responsibility, for it is they who have the financial and technological resources. Development, however, will not take place without using local resources, and that relies almost entirely on national and international political will. Indeed, as Garattini points out, lack of money is not the main reason behind the ability of developing countries to implement appropriate health policies, including drug development, production, purchase, and distribution.

The WHO's Special Programme for Research and Training in Tropical Diseases, in which Italy participates with growing interest and financial contributions, is not intended to provide the answer but rather to trigger other initiatives. Even so, at the programme's joint coordinating board, some delegations have repeatedly pointed out the need to redirect funds to developing countries:<sup>1</sup> since 1975 almost half the funds have gone to finance projects in industrialised countries (and one-fifth of the total budget in just one country<sup>2</sup>). The development of safe and effective new drugs, vaccines, and other technologically appropriate tools for preventing and treating endemic diseases must be multifaceted. Development cooperation, both multilateral and bilateral, should promote, in the medium and long term, the development of local research and production capabilities; in the short term it should assure proper access of people in developing countries to essential drugs, including new ones.

Industrialised countries, through development cooperation policies, may favour the establishment of joint ventures between national industries and enterprises in developing countries, as foreseen, for example, by the 1987 Italian law on development cooperation. Similarly the stimulus for consistent investment in the development of drugs or vaccines may come from special agreements between governments and the pharmaceutical industry. An example of this is the agreement signed last year between the Italian Ministry of Foreign Affairs and a leading national industrial group for the development of the antimalarial vaccine.

New drugs for use in third world countries are needed and the potential for their development exists—but only via political commitment worldwide to readjust the imbalance in financial resources can this potential be realised.

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1. UNDP/World Bank/WHO. Tenth session of the joint coordinating board (WHO Headquarters, Geneva, June 24 and 25, 1987). TDR/JCB(10)/87.3.

2. UNDP/World Bank/WHO. TDR management summary report (Dec 31, 1987).

### PREVENTION OF DISEASE IN THE THIRD WORLD

SIR,—Brother Meehan and Professor McCormick (July 16, p 152) are right in emphasising the importance of understanding local customs and local languages when working in the third world but I cannot agree that "Aspiring health workers in the poor world should spend time learning the language rather than attending a potted course in tropical diseases". I have worked in Ecuador, where I learnt as much of the language as I could, but without my knowledge of surgery and tropical diseases I would have been of little use. More recently I worked briefly in Sierra Leone. There it is essential to know about lassa fever, schistosomiasis, and even

malaria, if only to avoid being invalided home. There are fourteen native languages in Sierra Leone. Learning all of them would be a formidable task.

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### NEW APPROACH TO CAPITATION FEES

SIR,—Your Parliamentary correspondent (June 4, p 1290) reports the submissions of Professor Maynard and Professor Culyer to a House of Commons committee, suggesting an innovative system of capitation payment with the "gatekeeper" general practitioner having incentives to manage patient care budgets. The submission stated that other countries have few lessons to offer Britain. One overseas arrangement that is worth noting is the Health Service Organisation (HSO) that exists in the Province of Ontario. HSOs, which receive capitation funding from the government plan, exist side by side with government insured fee-for-service practice; patients have complete freedom to move from one arrangement to the other. The incentives of capitation for the physician to keep patients satisfied and healthy exist, and there is no limit to the number of members that an HSO can enrol. In addition there is an ambulatory care incentive payment which is a monetary payment to the HSO if there is a demonstrated saving of hospital costs.

Since 1986 there has been no extra billing of patients in Ontario. There is no private medical insurance in Canada; the situation is essentially one of competing arrangements within a universal state-funded system.

The fact that observers of competitive market models of health care are not aware of this Canadian model is excusable. Most citizens of the province are also not informed of its existence.

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### NOTIFYING DRUG ADDICTS

SIR,—Dr Skrabanek (May 21, p 1155) infers that in complying with the requirements of the Misuse of Drugs (Notification of, and Supply to Addicts) Regulations 1983, doctors are acting as police informers. Information derived from the addicts index is maintained in the strictest medical confidence and is not made available to any other agencies, including law enforcement agencies. Notifications are directed to the chief medical officer at the Home Office, on the basis of a doctor-to-doctor communication. The purpose of the index is twofold—as an epidemiological tool, it provides an indicator of incidence, prevalence, and geographical distribution of drug misuse which is used in planning drug misuse and AIDS services more effectively; and to reduce duplication of prescribing to the same patient.

Inquiring doctors may be given information (on a call-back system) as to whether a named patient is currently notified, and the name of the previously notifying doctor. Any further information can only then be exchanged on a doctor-to-doctor basis with regard to clinical management of the patient.

Compliance with notification is even more important in the light of AIDS, so that the size of this potential risk group can be assessed, and facilities put in place to provide targeted health education and harm reduction services in areas of high prevalence.

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### ALCOHOL INTAKE IN THE UK

SIR,—Commentary from Westminster in your issue of June 25 does not provide a balanced view of House of Commons attitudes towards alcohol and some of the statistics provided were so selective as to be very one-sided. For example, your Westminster correspondent says that the UK spends more (7.3%) on alcohol than on clothes, cars, hospitals, and schools. That figure was for 1984/85; by 1987 the figure had fallen to 6.7%, the same as in 1966. In 1950 it was 7.7%. He correctly states that wine consumption has risen nearly 3000% since 1945 (an all-time low following the war)