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Editorial

with a real feeling of partnership between the professionals. With the global crisis of human health resources which will be the topic of WHO for this year, and for a decade of action “Human Resources for Health”, it is vital that all the health professions work together to ensure that maximum use is made of the potential of each profession, and that roles and functions are clearly

viduals an equal chance of treatment regardless of the overall outcome?

Even well-funded health care systems will be confronted with a shortage of antiviral drugs, vaccines, hospital beds and health care professionals for the treatment of avian influenza patients. Who should receive the available drugs, who be vaccinated first, or who get the needed hospital beds? Those who are able to pay the price – which will highly increase? Or the professionals who are responsible for the public health system and for the treatment of infected people? Should the drug be distributed by ability to pay in a free market or in a regulated way for the benefit of the greatest number? The answer is dearly in favour of maximising the overall benefits. Consequently, most pandemic plans give priority to health care workers and other professionals who help to maintain public order. Understandably, it always places a heavy burden on a physician to decide between two patients in the absence of capacitiesy to treat both. Therefore, the World Medical Association has defined a clear priority in its “Statement on Medical Ethics in the Event of Disasters” (1994) [3] When the circumstances do not allow the treatment of every patient who under normal conditions could be treated, the “decision to 'abandon an injured person' on account of priorities dictated by the disaster situation cannot be considered 'failure to come to the assistance of a person in mortal danger It is justified when it intends to save the maximum number of victims.” (3.3.e)

In addition to the ethical problems of allocating scarce resources *within* a health care system, there will be even more dramatic problems regarding the distribution of health services *between* health care systems. It can be expected that people in wealthy countries with highly developed medical systems will have a better chance to survive than those in low-income countries. What can be seen in the HIV pandemic will most probably also happen in a possible – and hopefully never arriving – human influenza pandemic: the survival rates will depend on the wealth of a country, region or group of people within a certain state. Only the pure chance of living in one or the other country leads to tremendous differences in the probability of surviving. A possible human influenza pandemic will show once again the unjust distribution of health services around the world.
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They showed that they could lengthen the

ic rights. The WMA's principal documents in this respect are the Declaration of Lisbon on the Rights of the Patient and the Declaration of Ottawa on the Right of the Child to Health Care. In 1998 the WMA General Assembly adopted a Resolution on Improved Investment in Health Care that, while not mentioning a right to health, nevertheless urged governments and intergovernmental agencies to provide the requisite conditions for the exercise of this right, especially access to good quality health care.

Readers are invited to provide information on other medical association or research activities related to privacy and confidentiality of personal health information to williams@wma.net

–0Nobel Peace

Key Changes in the UK

In future the NHS will have less emphasis on the state's role as provider and more as a purchaser of care. It will be less directive of local services and act more as a regulator, setting the framework for a competitive market in the provision of healthcare.

We will see greater devolvement of managerial responsibility, while retaining central direction through the use of financial incentives and quality standards.

Most importantly there will be plurality of provision with health care delivered by both public and private sectors, still free at the point of use. Independent Sector Treatment Centres have been introduced in secondary care to bring down waiting times and lists, amid many concerns among NHS staff that their introduction risks destabilising existing hospitals which train staff and provide round the clock NHS care in all its aspects.

General Practice is also changing. A new contract for GPs introduced in 2004 contains a Quality and Outcomes Framework rewarding GPs according to the quality of services they provide. General practice is now said to have "over-delivered" causing the contract to cost more than the government expected. GPs are able to point to the high quality care they provide for patients. Nevertheless a national shortage of GPs means that some areas are "under-doctored". The government is opening up the service to commercial providers for the first time. It is providing wider access with walk-in centres and plans to bring more care out of hospitals closer to patients' homes.

There is an ideological debate taking place in the UK over whether the "socialised" model of healthcare is being dismantled and the NHS privatised. The financing of UK healthcare has not changed. The government pledges that money will continue to come from general taxation. We are experiencing a privatisation of provision. The change is in provision and delivery of UK healthcare

Doctors see threats and opportunities in this – more providers means a choice of employers and while there is a shortage of doctors, more freedom to move around. The future picture of health policy is uncertain, but incentives ensure that service provision will change radically.

The NHS has seen a huge increase in funding in the past five years so that by 2007/08 it will have risen to approach 10% of total GDP. Britain will by then be spending on health sums comparable to other countries of the Western world, with the exception of the USA. Certainly in recent years we have seen a marked change in the proportion of GDP we spend on health. Five years into this investment, people are questioning whether there has been commensurate improvement.

People ask where has the money gone. Rectifying the legacy of historic underfunding has absorbed some of it. New technology and new buildings account for more. New contracts for NHS staff account for half of the resources, and incentives to reach government targets have swallowed up an appreciable amount.

Despite higher numbers of doctors, the UK is still relatively low in the league table of practising physicians per 1000 population. Few westernised countries have lower ratios than the UK. Yet we face increasing pressures on the NHS resulting from an increase in the number of elderly people in the population, many of whom will have multiple morbidity.

Challenges for policy makersre00.68 tives of 20 mil call on governments of human resources needed to figh

Laureate Betty Williams joined forces with gl healthcare organizations representing than 20 million health care provic

initiatives to tackle the human resources crisis in TB treatment.

Though 90% of the world's population live in countries that have adopted the internationally recommended strategy for controlling TB, an adequately trained health care workforce is required to fully implement control programmes and save an additional 14 million lives over the next ten years. According to the Stop TB Partnership, it is estimated that US$250 million is needed every year to provide technical assistance to countries to provide the training and strengthening of TB control services to millions of care providers.

To address this, the International Council of Nurses (ICN), the International Hospital Federation (IHF), and the World Medical Association (WMA) their new on-site and distance learning TB training programmes for nurses, hospital managers, doctors and laboratory technicians, which are being rolled-out in the high-burden countries. The World Economic Forum and the International Federation of the Red Cross and Red Crescent Societies outlined their new programs to introduce TB prevention and treatment into the workplace and com-

I am honored to be here, to share my perspective on some of the World Medical Association's initiatives this past year. What was accomplished where we've made progress and the work yet to be done.

Among you, I see many familiar faces. Old friends and new. I am proud to be associated with all of you, who care so much for your patients, practice medicine with such passion and who work so hard to live out and uphold the ethics of our profession.

As WMA president, I tried to be true to that mission. We want medical care everywhere to be the best care anywhere. We promote the highest standards of medical education, ethics and science. And we expect the same from the other players in our respective health care systems – be they in the private or public sectors.

And we have to expect something from our patients, as well.

We cannot speak too much, or too often, of the paramount importance of individual health. It has been said that "He who has health, has hope. And he who has hope, has everything."

In the last century, a mere instant in the timeline of human history, the rapid advance of medical progress and innovations in care has supplied that hope for thousands of millions of people in need.

Herophilus, a physician in ancient Greece, said "When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied."

You cannot put a price tag on hope, but researchers have placed a value on the economic return of investments in better health, higher quality medical care and medical research. It tells us the wealth of nations depends on the health of nations. And it is we, as physicians, who are the instruments used to fulfill those hopes, address those needs and meet those expectations.

The Canadian physician Sir William Osler, who was a philosopher as much as he was a doctor, described the heart and soul of what we do more than 100 years ago, no matter where we live. "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders, but with the exercise of an influence of the strong upon nerr wam thWh 1reidencystmy[uur w a918Tj0in care has sgoD[oinw agin Tc in(Y)mun TDte.s.,[(e
MD, MACP, MACE, October 14, 2005

To me, that idea is represented in the Caring Physicians of the World Initiative.

With the help of the Pfizer Medical Humanities Initiative (PMHI) team, led by Director Mike Magee, we decided to produce a publication profiling physicians among those nominated by National Medical Associations around the world. These are physicians who carry on the tradition of caring ethics and science while practicing or teaching medicine in an array of circumstances, some difficult, some dangerous, all of them a challenge. And all the while, they give of themselves in service to patients or students.

Our national medical associations were interested, but assembling this book would require a lot of resources, including trips to often remote locations to photograph this international array of physicians and learn their stories. Again, the PMHI Team stepped forward with generous support. At the same time, they left all decisions on selection, writing and editing to us. We presented the idea at WMA gatherings throughout 2004, and in November of that year, requests for nominations were sent to national associations.

We asked for rapid response so we could complete the publication within one year and launch the book during the WMA Annual meeting in Santiago, Chile in October, 2005.

The response was overwhelming. Within

In the summer of 2004 the WMA completed a survey of its member associations that revealed that we share many of the same concerns and needs, such as diminished access to quality, safe, affordable medical care, limited patient choice, reduction of professional prestige, and appropriate autonomy and compensation. These are problems for our profession that cross all

Laws to reduce permitted blood alcohol levels for drivers and to control the number of sales outlets have been effective in lowering alcohol problems.

10. In recent years some constraints on the production, mass marketing and patterns of consumption of alcohol have been weakened and have resulted in increased availability and accessibility of alcoholic beverages and changes in drinking patterns across the world. This has created a global health problem that urgently requires governmental, citizen, medical and health care intervention.

Recommendations

The WMA urges National Medical Associations and all physicians to take the following actions to help reduce the impact of alcohol on health and society:

11. Advocate for comprehensive national policies that
    a. incorporate measures to educate the public about the dangers of hazardous and unhealthy use of alcohol (from risky amounts through dependence), including, but not limited to, education programs targeted specifically at youth;
    b. create legal interventions that focus primarily on treating or provide evidence-based legal sanctions that deter those who place themselves or others at risk, and
    c. put in place regulatory and other environmental supports that promote the health of the population as a whole.

12. Promote national and sub-national policies that follow 'best practices' from the developed countries that with appropriate modification may also be effective in developing nations. These may include setting of a minimum legal purchase age, restricted sales policies, restricting hours or days of sale and the number of sales outlets, increasing alcohol taxes, and implementing effective countermeasures for alcohol impaired driving (such as lowered blood alcohol concentration limits for driving, active enforcement of traffic safety measures, random breath testing, and legal and medical interventions for repeat intoxicated drivers).

13. Be aware of and counter non-evidence-based alcohol control strategies promoted by the alcohol industry or their social aspect organizations.

14. Restrict the promotion, advertising and provision of alcohol to youth so that youth can grow up with fewer social pressures to consume alcohol. Support the creation of an independent monitoring capability that assures that alcohol advertising conforms to the content and exposure guidelines described in alcohol industry self-regulation codes.

15. Work collaboratively with national and local medical societies, specialty medical organizations, concerned social, religious and economic groups (including governmental, scientific, professional, nongovernmental and voluntary bodies, the private sector, and civil society) to:
    a. reduce harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;
    b. increase the likelihood that everyone will be free of pressures to consume alcohol and free from the harmful and unhealthy effects of drinking by others; and
    c. promote evidence-based prevention strategies in schools.

16. Undertake to
    a. screen patients for alcohol use disorders and at-risk drinking, or arrange to have screening conducted systematically by qualified personnel using evidence-based screening tools that can be used in clinical practice;
    b. promote self-screening / mass screening with questionnaires that could then select those needing to be seen by a provider for assessment;
    c. provide brief interventions to motivate high-risk drinkers to moderate their consumption; and
    d. provide specialized treatment, including use of evidence-based pharmaceuticals, and rehabilitation for alcohol-dependent individuals and assistance to their families.

17. Encourage physicians to facilitate epidemiologic and health service data collection on the impact of alcohol.

18. Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect on February 27, 2005.

19. Furthermore, in order to protect current and future alcohol control measures, advocate for consideration of alcohol as an extra-ordinary commodity and that measures affecting the

young physicians has been suggested. Bonding means to oblige a person to provide a service in return e,g, for the education they have received. Bonding could also

quality. Burying young physicians under work does not mean that they learn a lot – unless you take frustration as a learning experience. Those senior physicians who believe that their assistants or interns only learn when working long

WHO would also like to see more developments in the areas of innovative high and low tech solutions for prevention at the manufacturing stage and for detection in the distribution chain.

Simple, inexpensive methods to identify fakes can be effective. For example, simple colorimetric assays developed for artemisinins have been used successfully to identify fake artesunate antimalarials.

WHO set up the world's first web-based system for tracking the activities of drug cheats in the Western Pacific Region in 2005. The Rapid Alert System (RAS) communications network transmits reports on the distribution of counterfeit medicines to the relevant authorities for them to take rapid countermeasures. That system should be expanded to include all regions.

Radio frequency identification (RFID) and more sophisticated technologies for product tracking within supply chain management systems are being experimented with in some countries. Means must be sought to make these more sophisticated tools available and workable in developing countries.

Information on fake drug identity and dis-

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manufacters

Concrete measures included in the Treaty could help save 200 million lives by the year 2050 if a progressive 50% reduction in uptake and consumption rates is achieved. Many measures in the WHO FCTC have deadlines and clear guidelines. For example, from the Treaty's entry into force, countries have three years to enforce health warnings on tobacco products, and five years to implement comprehensive bans on tobacco advertising, promotion and sponsorship.

Other measures, such as those regarding illicit trade or cross-border advertising, have not yet been detailed in the Treaty. The COP could decide to develop protocols and specific guidelines and requirements for countries to implement these measures.

- To allow the Conference of the Parties to assess progress made by countries in implementing the measures required by the Treaty through a pilot reporting questionnaire agreed by the Parties during the Conference.
- To establish an ad-hoc group of experts that will study economically viable alternatives to tobacco growing and production, with a view to making recommendations on diversification initiatives for those countries whose economies depend heavily on tobacco production.

The President of the Conference, Ambassador Juan Martabit from Chile said, "The urgency of the problem of tobacco use is shared by all of us, and the commitment from countries and civil society to take action is very strong. I felt the positive spirit throughout the Conference, which clearly contributed to its success, helping countries to reach consensus quickly on the basic issues, so we can concentrate our efforts in the implementation. I am confident we are on track to save millions of lives in the near future thanks to this Treaty."

More information about the first session of the COP, including day to day overview, documents and presentations: www.who.int/tobacco/fctc/cop/en/index.html

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WHO

"Developing point-of-care tests to direct sleeping sickness treatment will greatly simplify patient care, allowing for early case detection, simpler and safer treatment, and higher rates of cure that will improve disease management and could lead to the elimination of the disease as a public health problem," said Thomas Brewer, M.D., senior programme officer, Infectious Diseases division, Global Health Programme, at the Gates Foundation.

Currently, diagnosis of sleeping sickness is made by serologic examinations followed by microscopy, which is laborious, insensitive and costly. FIND's and WHO's efforts will be focused on developing tools that will be simple to use and effective in the remote field conditions that exist where it is most prevalent. In addition to developing appropriate diagnostic technologies, the objectives of the programme include establishing field research sites for clinical studies and evaluating prototype products.

About FIND

The Foundation for Innovative New Diagnostics (FIND) was launched at the

WHO

due to changes in radiation conditions, poor targeting and funding shortages.

- Structural elements of the sarcophagus built to contain the damaged reactor have degraded, posing a risk of collapse and the release of radioactive dust;
- A comprehensive plan to dispose of tons of high-level radioactive waste at and around the Chernobyl NPP site, in accordance with current safety standards, has yet to be defined.

Alongside radiation-induced deaths and diseases, the report labels the mental health impact of Chernobyl as "the largest public health problem created by the accident" and partially attributes this damaging psychological impact to a lack of accurate information. These problems manifest as negative self-assessments of health, belief in a shortened life expectancy, lack of initiative, and dependency on assistance from the state.

"Two decades after the Chernobyl accident, residents in the affected areas still lack the information they need to lead the healthy and productive lives that are possible," explains Louisa Vinton, Chernobyl focal point at the UNDP. "We are advising our partner governments that they must reach people with accurate information, not only about how to live safely in regions of low-level contamination, but also about leading healthy lifestyles and creating new livelihoods." But, says Dr. Michael Repacholi, Manager of WHO's Radiation Programme, "the sum total of the Chernobyl Forum is a reassuring message."

He explains that there have been 4,000 cases of thyroid cancer, mainly in children, but that except for nine deaths, all of them have recovered. "Otherwise, the team of international experts found no evidence for any increases in the incidence of leukemia and cancer among affected residents."

The international experts have estimated that radiation could cause up to about 4000 eventual deaths among the higher-exposed Chernobyl populations, i.e., emergency workers from 1986-1987, evacuees and residents of the most contaminated areas. This number contains both the known radiation-induced cancer and leukaemia deaths and a statistical prediction, based on estimates of the radiation doses received by these populations. As about quarter of people die from spontaneous cancer not caused by Chernobyl radiation, the radiation-induced increase of only about 3% will be difficult to observe. However, in the most exposed cohorts of emergency and recovery operation workers some increase of particular cancer forms (e.g., leukemia) in particular time periods has already been observed. The predictions use six decades of scientific experience with the effects of such doses, explained Repacholi.

Repacholi concludes that "the health effects of the accident are potentially horrific, but when they are added them up using validated conclusions from good science, the public health effects are not nearly as substantial as at first feared."

The report's estimate for the eventual number of deaths is far lower than earlier, well-publicized speculations that radiation exposure would claim tens of thousands of lives. But the 4,000 figure is not far different from estimates made in 1986 by Soviet scientists, according to Dr. Mikhail Balonov, a radiation expert with the International Atomic Energy Agency in Vienna, who was a scientist in the former Soviet Union at the time of the accident.

As for environmental impact, the reports are also reassuring, for the scientific assessments show that, except for the still closed highly contaminated 30 kilometre area surrounding the reactor, and some closed lakes and restricted forests, radiation levels have mostly returned to acceptable levels. "In most areas the problems are economic and psychological, not health or environmental," reports Balonov, the scientific secre-

such as consumption of mushrooms, berries and game from areas still designated as highly contaminated, overuse of alcohol and tobacco, and unprotected promiscuous sexual activity.

What was the environmental impact?

Ecosystems affected by Chernobyl have been studied and monitored extensively for the past two decades. Major releases of radionuclides continued for ten days and contaminated more than 200,000 square kilometres of Europe. The extent of deposition varied depending on whether it was raining when contaminated air masses passed.

Most of the strontium and plutonium isotopes were deposited within 100 kilometres of the damaged reactor. Radioactive iodine, of great concern after the accident, has a short half-life, and has now decayed away. Strontium and caesium, with a longer half life of 30 years, persist and will remain a concern for decades to come. Although plutonium isotopes and americium 241 will persist perhaps for thousands of years, their contribution to human exposure is low.

What is the scope of urban contamination?

Open surfaces, such as roads, lawns and roofs, were most heavily contaminated. Residents of Pripyat, the city nearest to Chernobyl, were quickly evacuated, reducing their potential exposure to radioactive materials. Wind, rain and human activity has reduced surface contamination, but led to secondary contamination of sewage and sludge systems. Radiation in air above settled areas returned to background levels, though levels remain higher where soils have remained undisturbed.

How contaminated are agricultural areas?

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shelter have corroded in the past two decades. The main potential hazard posed by the shelter is the possible collapse of its top structures and the release of radioactive dust.

Strengthening those unstable structures has been performed recently, and construction of a New Safe Confinement covering the existing shelter that should serve for more than 100 years, starts in the near future. The new cover will allow dismantlement of the

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