The People's Health Assembly

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at no cost to them, the cost being borne by the public purse. We make patients aware of the relative risks and benefits of low dose typical versus atypical antipsychotics—almost all patients choose atypical drugs. Their choice is mainly influenced by the chance of lower extrapyramidal effects, and the novelty of the atypical antipsychotic drugs. Our impression is that if costs were borne personally the decisions would be different. Which atypical drug to start with is largely a tradeoff between expected side effects; there is little reason to believe there are significant differences in efficacy between the atypical drugs. If one atypical drug fails, we try another or suggest a typical antipsychotic in low doses or as a depot. If all these efforts are unsatisfactory, as they often are, we always suggest a trial of clozapine, for it is as yet unequalled in refractory cases. Thus, the paper by Geddes et al and our thoughts leave the clinician on a tightrope act between the persuasiveness of the marketing claims, the precise but somewhat myopic results of idealised clinical trials, and the complex realities of clinical practice.

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1 Geddes J, Freemantle N, Harrison P, Bebbington P for the National Schizophrenia Guideline Development Group. Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. *BMJ* 2000;321:1371-6.
2 Leucht S, Pitschel-Walz G, Abraham D, Kissling W. Efficacy and extrapyramidal side-effects of the new antipsychotics olanzapine, quetiapine, risperidone, and sertindole compared to conventional antipsychotics and placebo. A meta-analysis of randomized controlled trials. *Schizophr Res* 1999;35:51-68.
3 Casey DE. Motor and mental aspects of extrapyramidal syndromes. *Int Clin Psychopharmacol* 1995;10(suppl 3):105-14.
4 Meltzer HY. The role of serotonin in schizophrenia and the place of serotonin-dopamine antagonist antipsychotics. *J Clin Psychopharmacol* 1995;15(suppl 1, Feb):2S-3.
5 Kapur S, Seeman P. Fast dissociation from the dopamine D2 receptors explains atypical antipsychotic action—a new hypothesis. *Am J Psychiatry* (in press).
6 Kane J, Honigfeld G, Singer J, Meltzer H. Clozapine for the treatment-resistant schizophrenic. A double-blind comparison with chlorpromazine. *Arch Gen Psychiatry* 1988;45:789-96.
7 Allison DB, Mentore JL, Heo M, Chandler LP, Cappelleri JC, Infante MC, et al. Antipsychotic-induced weight gain: a comprehensive research synthesis. *Am J Psychiatry* 1999;156:1686-96.
8 Henderson DC, Cagliero E, Gray C, Nasrallah RA, Hayden DL, Schoenfeld DA, et al. Clozapine, diabetes mellitus, weight gain, and lipid abnormalities: A five-year naturalistic study. *Am J Psychiatry* 2000;157:975-81.

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Revitalising the promise of "Health for All"

In 1978, 134 health ministers from around the world signed the Alma Ata declaration that set a deadline for the year 2000 for achieving a level of health that would enable all of the world's people to "lead a socially and econmically productive life."[1] The strategy to achieve the goal would be the implementation of primary health care, with its emphasis on community participation, and tackling the underlying causes of diseases, such as poverty, illiteracy, and poor sanitation. This week, at Gonoshasthya Kendra People's Health Centre (whose pioneering work formed a case study for the Alma Ata declaration), a People's Health Assembly will convene to discuss the failure to achieve "Health for All," and plan what to do next.

Much of the problem lies in the persistence of poverty and a continuing lack of effective health services. Average per capita incomes in sub-Saharan Africa are lower than they were at the end of the 1960s, and half of the region's population must now survive on less than 40p (56 cents) a day.[2] AIDS is ravaging a continent beset by rising levels of malaria and tuberculosis; many health services have collapsed. Child mortality is no longer dropping and in some cases the trends have been reversed. Despite important gains in political freedom in the countries of the former Soviet bloc, the transitions to market economies have often had disastrous consequences and are estimated to have resulted in nearly three million deaths.[3] Latin America and east Asia have endured the fallout from economic crashes, and south Asia has extremely high levels of malnutrition, deprivation, and disease.[4] Poverty and widening disparities in income remain a cause for concern in industrialised countries, even as national wealth continues to grow. Worldwide 800 million people still lack access to health services.[4]

But despite an abject failure to reach the target, we should not ditch the principles laid down at Alma Ata. Its principles were already being applied in several countries before the declaration was written, with impressive gains in life expectancy and other health indicators in Sri Lanka, China, Cuba, Zimbabwe, Costa Rica, and Malaysia.[5] Other studies have shown the importance of community participation in health and demonstrate its ability to reach the maximum number of people, particularly the poorest and most vulnerable.[6]

Yet sadly lip service has too often been paid to the principles of the Alma Ata declaration while in reality primary health care has been starved of resources.[5] The People's Health Assembly hopes this will change. A process before the assembly has gathered case studies and analysis of how primary health care can be successfully implemented and the threats it faces; at this event this learning experience will continue at 200 workshops presented by participants at regional and national meetings. But perhaps most importantly, it aims to kick off an advocacy movement that will defend people's right to health and ensure that the vision of Alma Ata becomes a reality.

Such a movement is badly needed: new threats to health are continually emerging. Globalisation has been accompanied by an increase in income inequalities between and within nations[4–7] and has left governments weak and cowering under fiscal constraints. Basic principles for financing and providing universal

BMJ 2000;321:1361–2

health care are under threat everywhere as health care becomes a commodity and the private sector moves in.[8] Drastic environmental problems, such as the changing climate and the depletion of the ozone layer, threaten essential life supporting systems and are likely to hurt poor and marginalised people first.[9] Virulent diseases emerge and re-emerge. Action by everyone concerned with health is needed on all these fronts.

At the international level the World Health Organization could still act as a beacon of hope in turbulent times, just as it did in 1978. But its position has been weakened over the past two decades, and other organisations, most notably the World Bank, have taken the lead in formulating international health policy, sometimes with malign effects. The WHO needs to assert its principles once more. As a start it could encourage governments, non-governmental organisations, and international agencies to work towards a vision of health for all; stress the need for partnerships between health care and other sectors; and advocate the need for major investments in health, especially increases in human resource development, without which the Alma Ata declaration will remain a statement of intent.

The WHO's partnership with transnational pharmaceutical companies needs to be re-examined, as the inclusion of industry representatives on critical policy committees— especially the drug pricing, vaccine production, health care costing, and selection of the essential drugs list—is rightly viewed with suspicion. The WHO must be an open and democratic organisation that can also respond to the grass roots: listening to the people should not be difficult for Gro Harlem Brundtland, a former politician, and it is regrettable that she is not attending the People's Health Assembly. Her success as director general depends on the growth of popular health movements all over the globe which will be able to back up her call to make health central to the development process.[10]

As a result of the assembly, we hope to see the formulation of advocacy agendas at local, national, and international levels, as well as an increase in the sharing of knowledge and experience between people committed to the principles of primary health care. Above all we feel it is critical that the assembly assembles broad-based networks for change which can implement the vision of Alma Ata more effectively. We hope that the Assembly will prove to be a significant step towards revitalising the powerful vision of "Health for All" and we encourage everyone who shares our fears and aims to join us.

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1 World Health Organization. *The Alma-Ata Declaration.* Geneva: WHO, 1978
2 World Bank. *Can Africa claim the 21st century?* Washington DC: World Bank, 2000.
3 Cornia GA, Paniccia R. *The transition mortality crisis: evidence, interpretation and policy responses.* In: Cornia GA, Paniccia R, eds. *The mortality crisis in transitional economies.* Oxford: Oxford University Press, 2000 p3-37
4 UNDP. Human Development Report 1997. Oxford: Oxford University Press, 1997
5 Mehrotra S. Health and education policies in high-achieving countries: some lessons. In: Mehrotra S, Jolly R. *Development with a human face: experiences in social achievement and economic growth.* Oxford: Oxford University Press, 2000 p63-112
6 Rohde J, Chatterjee, M, Morley D. *Community Health and Development.* In: Rohde J, Chatterjee M, Morley D, eds. *Reaching Health for All.* Delhi: Oxford University Press, 1993 p.7-9
7 Cornia GA. Liberalisation, globalisation and income distribution. United Nations University World Institute for Development Economics Research, Working Paper 157, March 1999
8 Turshen M, *Privatising health services in Africa.* New Brunswick: Rutgers University Press, 1999.
9 United Nations Development Programme. *Human Development Report 1998.* Oxford: OUP, 1998
10 World Health Organization. *Health: a precious asset—accelerating follow-up to the World Summit for Social Development.* Geneva: WHO, 2000.

Economic evaluation and clinical trials: size matters

The need for greater power in cost analyses poses an ethical dilemma

General practice pp 1383, 1389

Randomised trials of health care interventions are increasingly attempting to tackle issues of cost effectiveness as well as clinical effectiveness. A good example of this appears in the two papers describing the clinical[1] and economic evaluation[2] of psychological therapies in primary care in this issue of the *BMJ* (pp 1383,1389). The use of clinical trials as a vehicle for prospective cost effectiveness analysis presents challenges for successful evaluation, and the methods of conducting trial based economic evaluation are still in their infancy.

Several commentators have emphasised that health economists should be involved from the outset in the design of trials that seek to report on cost effectiveness,[3] rather than being asked to add in the economic variables as an adjunct to the main trial (in a so called "piggyback" arrangement).[4] The reason for this is because design considerations are different for clinical and economic analyses.

The tendency of resource use variables to follow a skewed distribution[5] means that cost variables generally have higher variance than clinical outcomes. Furthermore, the fact that most new interventions involve resource shifting such that increased resource use in one area is offset by resource saving elsewhere makes the net cost of introducing such interventions unclear. Finally, many different categories of resource use may be involved, each with different unit cost weights and each showing varying degrees of difference between trial arms. Typically, therefore, comparisons of treatment cost will require greater sample sizes than the corresponding clinical comparison. If the goal of the study is to show that the resulting cost effectiveness ratio is significantly below some upper

BMJ 2000;321:1362–3