medical discourse and will no doubt continue to appear in manuscripts submitted to the BMJ. We are asking our editors to be vigilant in detecting and rejecting inappropriate use of the “A” word, and we trust that our readers will keep us on our toes by alerting us to instances when “accidents” slip through.

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6 This week in the BMJ: Surveillance of playground accidents can lead to their reduction. BMJ 1999;318 (12 June). http://bmj.com/content/ vol318/issue7198/fulltext.html
7 Waldron G. Accidents at home are no more likely in deprived areas. BMJ 2000;320:1276.

New global health fund

Must be well managed if it is to narrow the gap between rich and poor countries

But then nothing came to us for free. Not even water. It had to be carried a mile and a half, and boiled. “Boiled,” a small word, meant twenty minutes over a roaring fire on a stove that resembled the rusted carcass of an Oldsmobile. “Fire” meant gathering up a pile of sticks in a village that had already been gathering firewood for all the years since God was child, picking its grounds clean of combustibles as efficiently as an animal combing itself for lice. So “fire” meant longer and longer forays into the forest, stealing fallen branches from under the blunt eyed gaze of snakes for just one single bucket of drinkable water.1

The gap between the rich and poor has widened steadily. Estimates based on World Bank data suggest that over 40% of the 614 million people in less developed countries live in absolute poverty and that average life expectancy is now 25 years less than it is in developed countries.2 Ten years ago the countries of the Organisation for Economic Cooperation and Development (OECD) promised to scale up their development assistance. Since then the flow of aid has actually decreased to its lowest level (in relation to members’ combined gross national product) for 20 years.3 Oxfam describes the rich country record on aid as “derisory” and their trade policies akin to “highway robbery.”4 The recent announcement at the World Health Assembly of a massive new global health fund to combat infectious disease in poor countries has therefore attracted much attention.5

Poor countries have the odds stacked against them. Climatic, political, and geographical factors matter. Professor Jeffrey Sachs, a Harvard economist and chair of the World Health Organization’s commission on macroeconomics and health, believes that it is no coincidence that most of the world’s poorest countries are in tropical climate zones. At a meeting last month organised by the Office of Health Economics in London he emphasised that these zones experience much higher rates of infectious disease than temperate zones. He believes that malaria has been the single most important factor in shaping the modern world economy. It is also evident that the HIV-AIDS pandemic, particularly in sub-Saharan Africa, is having an equally devastating impact on economic development as well as on health.6

Tropical countries are further disadvantaged, Sachs suggests, by the fact that they have reduced food output per unit of input compared with countries in temperate zones. Low food productivity is linked with poor nutrition, and the combination of poor nutrition and a high burden of infectious disease leads to high infant and child mortality rates and low life expectancy. If infant mortality rates, the index of malaria transmission, and life expectancy are added to conventional economic indicators—education level, income, size of budget deficit, and inflation—the health related variables are usually the most powerful indicators of economic growth.

Communicable diseases are estimated to be responsible for 77% of the mortality gap and 70% of the gap in disability adjusted life years between the world’s poorest and richest countries.7 Strategies to combat them are likely to be the most effective way of narrowing the health and wealth divide. Recent initiatives, include the Global Alliance for Vaccines and Immunisation (www.who.int/inf-fs/en/fact169.html), Roll Back Malaria (www.rbm.who.int), the International AIDS Vaccine Initiative (www.iavi.org), and Stop TB (www.stoptb.org). But Sachs argues that existing efforts fall well short of what is required. Rich countries do not realise the scale of the human catastrophe associated with communicable disease. Few people in the North have a clear concept of how people live in the worlds

BMJ 2001;322:1321-2
poorest countries. Rich country aid to sub-Saharan Africa was about $850m (£600m) in 1999, which translates to about $1.30 (91p) per African per year. Economic development depends on keeping people alive, healthy, and educated. This can’t be done in tropical sub-Saharan Africa, he warns, because per capita income is only around $310 (£218) a year. It’s not million of dollars worth of aid that poor countries need, he says, but billions—$10-20bn (£7-14bn).

The new global fund plans to raise $7-10bn (£5-7bn) to be donated for HIV-AIDS, malaria, and tuberculosis. So far the response from rich countries has not been overwhelming. The US has pledged a conditional $200m (£141m), the United Kingdom has said it would donate £75m ($84m), and Japan, Canada, and the European Union have voiced support. The fund is likely to be formally established at the G8 summit in Genoa in July, and the need to scale up global development aid is being pushed hard by non-governmental agencies in the run up to the summit. There is also tremendous pressure to end trade practices which protect rich country markets and serve to keep the poorest countries poor. Rich country aid to sub-Saharan Africa, he warns, because per capita income is only around $310 (£218) a year. It’s not million of dollars worth of aid that poor countries need, he says, but billions—$10-20bn (£7-14bn).

To date, donor country institutions, not recipients, have dominated decision making on development aid. As a result most aid has been invested in small scale, disaggregated programmes largely based round single diseases. Little attempt has been made to monitor and evaluate them and woefully little has been done to build up and sustain local health infrastructures. It is of concern, therefore, that it is not clear how and by whom the new fund will be managed, exactly what its objectives are, and how it will relate to existing initiatives. The dominant fear among the representatives of poor countries and non-governmental agencies at the World Health Assembly was that this new public-private partnership fund would (yet again) be donor led. As a result undue emphasis would be put on supplying drugs rather than building up capacity to implement and sustain effective treatment and preventive programmes.

The European Commission and Save the Children UK are among many voices pressing for a completely new model of aid management. This envisages that the fund would apportion new resources annually to poor countries. These countries, some of which would need support, would then be responsible (and accountable) for channeling the money into their existing national poverty reduction programmes. The commission on macroeconomics and health is suggesting that poor countries should draw up proposals for aid and submit them to the fund for review by independent scientific, medical, and managerial experts.

Clearly an open debate is needed on the management of this new fund, which should also address the long standing and deep rooted mutual mistrust between donors and recipients. Getting the management right is crucial. However large it is, the fund is likely to have an impact on global health and wealth inequality only if it is better and more transparently managed than most previous aid packages. Rich countries, who need to be as generous with their aid as they are with their rhetoric, need assurance on this.

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The full text of the 2001 Office of Health Economics lecture by Professor Jeffrey Sachs appears on the OHE web site www.ohe.org. Details of the remit of the World Health Organization’s Commission on Macroeconomics and Health are given on www.cmhealth.org

6 Aid for AIDS. Economist 2000;April 29.

Talks from BMJ editors

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BMJ editors receive a steady stream of invitations to give talks around the world. We would love to accept them all. Such presentations give us a chance to learn, meet readers, and hear what you think of the BMJ and which issues you think we should be covering. Unfortunately time is too short for us to accept all invitations. What we can do, however, is to place copies of our talks on bmj.com, and we are starting to do so this week.

Slowly but surely we will build an archive. The talks are presented in Powerpoint, but we have kept pictures to a minimum to avoid bulky files and copyright problems. Perhaps in years to come we will include sound and video. The talks may be most useful to those who have heard them delivered, and we are starting with talks I gave in Accra and Kumasi in Ghana two weeks ago (on writing for medical journals and the future role of the general practitioner). The talks should, however, be intelligible to those who haven’t heard them, and readers should feel free to use any of the slides themselves.

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See the BMJ’s website for talks on writing papers and the GP’s role