Setting these exciting possibilities against a background of uncertainty and generally poor results for existing techniques defines the dilemma for doctors and patients alike. Visual potential is often lost when keratoprosthesis surgery fails. The chance of regaining vision now must be balanced against the possibility that techniques may soon improve. For younger patients in particular, this equation must be carefully considered. For the present, there are strong arguments for concentrating on keratoprostheses that do not require destructive surgery during implantation. International collaboration is required to improve the quality of outcome data.

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The World Bank

Friend or foe to the poor?

Education and debate p 865

Why should British and other western doctors be interested in the World Bank? This week's *BMJ* includes the first of Kamran Abbasi's articles on the World Bank (p 865),[1] yet with health system reforms, performance reviews, racism in health, plummeting morale, and continued underfunding, haven't we got enough to occupy us? Yes, but what of the plight of the 1.3 billion people living in absolute poverty on less than $1 a day? Their health is as abysmal as their wealth, and until their poverty is relieved their health will not improve. The World Bank's mission statement is "to reduce poverty, and improve living standards by promoting sustainable growth and investment in people."[2] For health workers concerned with the pathology and relief of poverty, knowledge about the bank is as important as anatomy is to surgeons.

Like the Christian churches in the nineteenth century, the bank has enormous influence in former colonies. It helps set, fund, and implement the policies which drive the economies of many nations and billions of people. As well as formulating economic policy and carrying out development projects, the bank has also become the key player in international health. Since 1990 the bank's health, nutrition, and population division has lent $9bn to the health sector and usurped the World Health Organisation's leadership role in developing global health policy.

Given its central role, how is the bank performing? Have the economic policies initiated by the bank improved the health of the poor? What has been the impact of its health policy recommendations? Have projects funded by the bank succeeded in their aims?

Controversy reigns and evidence is mixed in all three areas. In the wake of the 1980s debt crisis, the bank and the International Monetary Fund initiated harsh economic reforms (known as structural adjustment programmes), which included currency devaluation, public expenditure cuts, and a move toward privatisation. The expected economic regeneration often failed to materialise and the reforms provoked a storm of criticism because of their negative social impact. Structural adjustment programmes continue to this day and remain controversial: Latin America and sub-Saharan Africa, epicentres of the debt crisis and beneficiaries of bank and fund programmes for the past 20 years, still faced persisting or rising levels of poverty as they moved into the mid-1990s.[3]

The bank has advocated the use of safety nets to protect the poor during periods of economic crisis and reform as well as the protection of government expenditure on health and education. However, a fundamental need remains for decision makers to assess the likely health and poverty impact of the economic reforms themselves and to adjust their policies accordingly before they are implemented.

For the past decade the bank has also promoted the introduction of market oriented healthcare reforms, including cost sharing mechanisms such as user charges. The latter inevitably compromise the poor's access to health services.[4] These changes were intended to solve the crisis in healthcare financing, yet in many of the poorest countries more is spent on debt repayments than on health. While the bank has pushed for debt reduction, the amounts earmarked for cancellation under the "highly indebted poor countries" initiative designed by the bank and the International Monetary Fund are miserly. Much deeper debt relief, along the lines proposed by the Jubilee 2000 coalition,

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may release new resources which could help rejuvenate cash strapped health sectors.

As Abbasi shows in his article,[1] the bank's individual projects are also under the microscope. An internal review revealed that only 17% of completed bank projects in the health, nutrition, and population division sector contributed substantially to the development of local institutions, and only 44% were likely to be sustainable.[5] Since becoming president in 1995, James Wolfensohn has emphasised the need for better "partnerships" between the bank and its borrowers. However, to build effective partnerships health partners need to make policy and hold budgets together. Change can be achieved here by renewed commitment to listening to and working with local partners, but the objective is compromised by unresolved structural issues. Since the rich nations wield the financial and political power within the bank, their objectives, not those of the poor, dominate the bank's decision making. The possibility of effective partnership is thus undermined by the structure of the institution itself.

More recently, Mr Wolfensohn has proposed a new framework for development which gives equal status to social and environmental as well as economic considerations. To be useful, this framework should be explicit about the extent of the impact of economic change on health and should lead the bank to put health concerns right at the heart of economic policy-making.[6] Is such a shift in perspective possible for the bank? Health professionals in those countries which control the bank have a public health duty to help it do so, by making representations to the bank and by putting pressure upon their governments.

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NICE: a panacea for the NHS?

No, but it should be useful for managing the introduction of new technologies

Harold Wallace Ross, the great editor of the *New Yorker*, had a continuing fantasy that the next person he hired would bring "grace and measure" out of chaos.[1] They never did. But his is a common fantasy, entertained at some time by most employers, secretaries of state, and prime ministers. The National Institute of Clinical Excellence (NICE),* which begins its assault on Olympus next week, makes me think of Ross. I have heard NICE mentioned as the solution of most of the NHS's problems: rationing, poor practice, the failure of good practice to spread, postcode prescribing, the mindless adoption of technology, the absence of a sensible mechanism to introduce new drugs, and variations in outcome. How much can we realistically expect?

Like any other institution NICE will evolve, but it begins with three main functions: appraising new technologies, including drugs, before they are introduced into the NHS; issuing and kitemarking guidelines; and encouraging national audit. Most of its initial energy will be put into the first function, and this is the beginning of explicit, national rationing. It is also the appearance of the "fourth hurdle" in that to become widely used in the NHS new drugs will have to prove themselves not only to be pure, efficacious, and safe but also better in some way than what is currently available. The mess over the introduction of sildenafil (Viagra) into the NHS—the delay and the botched criteria on who would get it[2]—shows that a better mechanism is needed. And the government's focus groups will have told it that the public doesn't like at all the fact that you can get new and expensive treatments if you live on one side of a street in one health authority area but not if you live on the other side, in another health authority.

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So the case is strong for NICE appraising new treatments and technologies, and it seems set to do it well. The discussion document produced by the NHS Executive in January on how NICE appraisal will work promises horizon scanning for new technologies; transparent, rapid, evidence based appraisal that considers effectiveness and cost; input from patients and companies; and a clear outcome.[3] There will be essentially three possible outcomes: use routinely in the NHS; use only in the context of trials; or don't use. Routine use may be recommended for everybody or for particular specialists. It will, however, be for ministers to decide exactly what the NHS should do, and here the system begins to creak.

There seems little point in NICE adopting a transparent process if its recommendations then disappear into a black box at the Department of Health only to emerge in garbled form six months later. Ministers do have the great advantage of accountability, but is the accountability of being a member of a tightly controlled party that gets elected every five years adequate for 1999? And what about the accountability of NICE? Who appointed its first chairman Sir Michael Rawlins, pleasant fellow that he is, and what process was used? There is an inevitable sense that although the government has learnt the rhetoric of transparency, accountability, and evidence based appraisal it would rather avoid living with it day to day.

And although NICE is to make a beginning with rationing (avoiding the words at all costs for fear of startling the horses) it won't achieve much by simply considering what's new. Intellectually sound rationing would mean weighing what's new against what's already there, and it would necessitate finding a way of