WHO urges "coverage for all, not coverage of everything"

Phyllida Brown, *London*

Governments must ensure that good health care is accessible to everyone, but they should not attempt to provide all possible treatments, according to the World Health Organisation's annual report. The report was launched this week as the UN agency's member states gather for their annual assembly on 17 May.

The report suggests that governments must provide cost effective services to prevent and treat their nation's most pressing health problems, and so reduce the disproportionate burden of disease on the poor and help economic growth. But it marks a significant shift in the WHO's stance from its declaration in 1978 that health was "a state of complete physical, mental, and social wellbeing and not merely the absence of disease" towards a realistic acceptance of the need to set priorities to make the best use of resources for all within society. "Choices have to be made, and they must be made in a way that involves the people," said David Nabarro, head of the WHO's roll back malaria project, at a launch of the report in London.

Nabarro, who previously advised the UK government's Department for International Development on health, said that rationing was often described pejoratively but that its use was a reality. "I, personally, have always taken the view that you cannot think about health care without also thinking about the available resources," he said. In its emphasis on the economics of health, the WHO is echoing the agenda first set out in the World Bank's 1993 World Development Report, *Investing in Health*.

The WHO is calling for a concept of a "new universalism" in providing access to health care. "Universal coverage means coverage for all, not coverage of everything," states the report. Priorities should be set on the basis of the resources available to each government, and the cost of "top priority health interventions" such as childhood immunisations, safe motherhood, and tobacco control.

The report rejects the market approach to health care. Health systems are best financed from central government taxes and by prepayment, and not by charging fees at the point of service, which is unfair and inefficient, it says.

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David Nabarro from the WHO warned that choices must be made

As their populations age, nations face a dual burden of the new "epidemics" of non-communicable diseases and injuries as well as the "unfinished agenda" of infection, malnutrition, and maternal and perinatal conditions. The report identifies four challenges for governments and international agencies: firstly, to focus health systems on delivering those interventions that will have the greatest impact on the poor; secondly, countering major threats to health, such as tobacco and antibiotic resistance; thirdly, developing health systems that offer universal access to services; and fourthly, encouraging health systems to invest in research and development. □

The World Health Report 1999: Making a Difference is available from the WHO at bookorders@who.ch/

UK government finalises restrictions on Viagra prescribing

Annabel Ferriman, *parliamentary correspondent, BMJ*

After a long period of consultation and deliberation, the UK health secretary Frank Dobson announced last week the government's restrictions on prescribing the anti-impotence drug sildenafil citrate (Viagra). Mr Dobson bowed to public pressure with a small increase in the range of conditions for which general practitioners will be allowed to prescribe the drug under the NHS. But men who come into these categories will still make up only about 20% of the total who are impotent.

Mr Dobson originally proposed in draft guidelines issued in January that GPs would be allowed to prescribe the drug only for men who were impotent because of having undergone a prostatectomy or radical pelvic surgery, or who had a spinal cord injury, diabetes, multiple sclerosis, or single gene neurological disease (30 January, p 279). Under the new proposals, six further conditions will qualify for Viagra to be prescribed on the NHS: kidney failure, spina bifida, polio, Parkinson's disease, severe pelvic injury, and treatment for prostate cancer—not just removal of the prostate. These men will be entitled to a prescription for one pill a week.

For other men who are caused "severe distress" by impotence, it is proposed that treatment should be available in exceptional circumstances, but only after a specialist assessment. GPs will be allowed to issue private prescriptions for the drug to their own patients (the pills cost about £6 each) but will be banned from charging for the consultation. They will also be able to prescribe impotence treatments to men not in the approved categories but who were receiving drug treatment for impotence on or before 14 September 1998.

The changes will come into effect from 1 July 1999. Mr Dobson's is a landmark decision, because it is the closest the government has yet come to admitting that certain NHS treatments will have to be rationed. □