

Any effort to strengthen capacity must recognise the current context of global health: 87% of the \$2 trillion spent on health care globally is spent on 16% of the world's population⁶; 10% of the global burden of disease attracts 90% of global expenditure on health research.⁷ Over the past 20 years the structural adjustment programmes of the World Bank undermined health systems⁸ and public health.⁹ Recent attempts by the World Trade Organization to "outlaw the use of cross subsidisation, universal risk pooling, solidarity, and public accountability in the design, funding, and delivery of public services" may further undermine health care in many countries.¹⁰ As J K Galbraith warned many years ago, it is time for privileged people to move beyond self satisfied complacency.¹¹

The creation of a global alliance for health ethics by the international donor community to pursue the vision outlined here could be tapped to influence the policies of international organisations. Its trainees would be opinion leaders to whom others turn for advice.¹² They could form a global network of ethics opinion leaders which could help shape policy directions for the World Bank, World Trade Organization, and other international organisations, and thereby help to ameliorate the maldistribution of expenditure on health and health research.¹³

If this vision of capacity strengthening proved effective in research ethics the model could be extended to other issues in global health ethics such as genomics and biotechnology, priority setting in health systems, women's health, end of life care, and others, as well as to sectors other than health.

By 2010 strengthened ethics capacity would advance the cause of ethical research in the world far

more than even another revision of the Helsinki Declaration. Ultimately, strengthening ethics capacity will facilitate health research and help redress one of the greatest ethical challenges in the world—the unconscionable inequities in global health.

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Prescribing warmer, healthier homes

British policy to improve homes should help both health and the environment

Few people choose to live in cold damp homes that they cannot afford to heat well enough to protect their health. Yet for millions of British households this is the reality of poor quality housing, inefficient heating systems, and inadequate building insulation standards stretching back over generations. Last month, however, the British government launched a 10 year strategy to end fuel poverty in vulnerable households.¹ This encourages doctors and others to "prescribe" a warmer home for patients receiving benefits.

Over four million British households suffer fuel poverty,² defined as needing to spend over 10% of their income on energy to maintain an adequate standard of warmth. Millions more are close to it. In high cost areas, such as Devon and Cornwall, the problem is aggravated by the further 10% of state pension income required for water and sewerage charges. Comparative studies show that British and Irish housing standards are worse than those in other comparable European countries.³ The only sustainable solution is through massive improvement in housing generally, and heating and insulation in particular.

The government's strategy to end fuel poverty in vulnerable households by 2010⁴ is an important step

towards improving housing quality and also achieving the targets on reducing energy consumption set at the Kyoto summit on the environment.⁵ Improvements in energy efficiency have taken place in social housing in recent years, but the new target is to bring 400 000 additional households in England up to reasonable standards by 2004. In the private and private rented sector action is also underway through the new "warm front scheme," which aims to provide grants to remove 800 000 English households receiving benefits from fuel poverty by 2004. Identifying vulnerable people in cold damp houses is where doctors and other healthcare professionals can help: anyone in a household receiving a wide variety of social security benefits can refer themselves or, with consent, be referred by a doctor or nurse to the warm front team. The team will organise a survey to identify the insulation improvements necessary, which will then be carried out by approved contractors. For many people aged over 60 central heating may also be provided, funded by grants of up to £2000 per household. The arrangements vary slightly in Scotland, Wales, and Northern Ireland, and there are also local authority

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and energy company schemes available, which can be tapped for some people not receiving benefits.

For such a major public health problem there has been little methodologically sound research into the links between cold damp housing and ill health, although the available medical evidence has been well reviewed.⁶⁻⁸ In particular, few controlled intervention studies have been done despite the opportunities afforded by major housing regeneration programmes. After an initial pilot study this year a major evaluation study is promised. The Acheson inquiry into inequalities in health accepted the evidence linking cold damp housing and health and recommended policies to improve housing and, in particular, to improve insulation and heating systems.⁹

Cold damp houses are associated with premature mortality, physical and mental illness, and impaired quality of life. They aggravate a wide range of medical conditions, increase suffering, and make it harder to care for vulnerable people at home, thus adding to the burdens on the National Health Service. The effects are widespread across the population, though elderly people, those with chronic disabling conditions or asthma, and families with small children are the groups most immediately and obviously affected. Among the major preventable medical problems partially caused, or aggravated, by cold damp houses are the 25-45 000 excess winter deaths,¹⁰ far more than in colder countries such as Norway.¹¹ The effects on the NHS are seen in the annual winter crises, with their effect on hospitals and waiting lists. When the temperature falls resistance to respiratory disease falls and vascular complications are increased, leading, for example, to increases in the incidence of myocardial infarction.¹²

An NHS pilot study installing central heating in the homes of asthmatic children in Cornwall was associated with improvement in symptoms and reduced time off school.¹³ The English house condition survey shows fewer people in energy efficient homes reporting chest, rheumatic, and general health problems than those in colder homes.² The absence of controls and confounding variables prevents reliable quantification of the extent of health improvements, economic savings, and environmental protection from implementing the fuel poverty strategy. Nevertheless, the strategy has the potential to provide beneficial outcomes across the board. Its effects on employment, national energy consumption, and greenhouse gases are economically beneficial. Poor households may take

some of the savings due to energy efficiency in the form of extra warmth and comfort; others might improve their diet or reduce their social isolation. School students in fuel poor homes might be able to study warmly away from the distractions of the living room and its TV. But it needs engagement from the health service if those most likely to benefit are to be given priority and the programme expanded to meet the need. One useful extension would be to provide grants to pregnant women before birth, rather than only after birth when they become eligible for income support.

Local implementation should be reviewed by winter task forces and included in every health improvement plan and primary care trust plan. Doctors and other health professionals are well placed to identify patients whose illnesses are aggravated by cold damp homes. They know who has chronic disease and who has to spend long hours at home. This non-pharmacological solution is easily accessible and doctors should act as advocates for it.

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Reducing deaths among drug misusers

Tighter legal controls on drug prescribing are not the answer

Rising drug related deaths alarm treatment providers, legislators, and society. The recent report from the Advisory Council on the Misuse of Drugs, *Reducing Drug Related Deaths*, suggests that lax prescribing is responsible for a significant proportion.¹ It supports recent national guidelines on managing drug misuse, emphasising the supervised consumption of controlled drugs.² On the same theme,

the UK Home Office proposes extending the licensing system for addiction prescribing to cover all controlled drugs except NHS prescriptions for methadone mixture.³ Yet an expansion in the licensing system is likely to reduce accessibility of treatment and so increase drug related deaths. We believe that a clinical governance based solution would more successfully enhance treatment quality, safety, and accessibility.