statins have different side effects. Furthermore, pharmacological agents that held great promise for cardiovascular protection, such as hormone replacement therapy, have proved to be ineffective. If such profound differences exist between drugs in the same class, is it prudent to consider angiotensin receptor blockers and angiotensin converting enzyme inhibitors, drugs from two different classes, similar? Levy has recently provided some insight into how the angiotensin type II receptors may have harmful as well as beneficial effects.[10]

Has the time has come for clinicians, scientists, pharmacologists, and ethicists to review the unexpected effects of angiotensin receptor blockers on myocardial infarction and determine whether this should be part of the discussions between doctors and patients when starting treatment? In the interim, clinicians need to remember that treatment with valsartan at the initial dose used in the VALUE trial (80 mg) was associated with a significant increase in the incidence of myocardial infarction compared with amlodipine at the initial dose of 5 mg, although the incidence of cardiovascular death did not differ. Antihypertensive efficacy should not be confused with vascular protection, and until the results of large comparative trials such as ONTARGET/TRANSCEND[11] are available, it may be naive to consider that angiotensin receptor blockers are like angiotensin converting enzyme inhibitors but without the cough. Indeed, a recent comparison of these two classes of agents in diabetic nephropathy, has revealed a lack of benefit of angiotensin receptor blockers on mortality, despite renal protection.[12]

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The Mexico Summit on Health Research 2004

Fine words, few actions

See also News p 1258

The time: four days, 25 working sessions, six round tables, six joint plenaries and "networking" lunches. The people: hundreds of international delegates, 29 ministers of health, and 29 ministerial representatives. The result: three firm action points, seven vague ones. The reason: political expediency.

The Mexico Summit on Health Research was a historic gathering of health ministers—let's not quibble that only 29 bothered to turn up—and just as many ministerial representatives. The ministers spoke with passion, and surprising understanding, of challenges facing health systems research. The advocates—public health specialists, researchers, and technocrats from the World Health Organization—put their case to ministers with clarity, and surprising persuasiveness.

But what will the millions of poor people in our world make of the Mexico Agenda for Health Research, a document agreed by health representatives from 59 states? What will they make of the call for action that makes only three points that can be immediately translated into actions?

The first of these is a commitment to producing national research agendas. The world's poor could say: "Thank you, but you have been promising us these for 20 years. How do we know that this time it is different, and how do we know that research agendas will make a difference any time soon?"

What then about the commitment to supervise a network that will coordinate the various clinical trial registries and make them talk to each other and the world in a transparent manner? The world's poor could say: "Thank you, but much of the research that affects our lives is not clinical trials. Trial registration is a good start but how do we know that this good practice will spread to the majority of health systems research any time soon?"

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The final concrete action is an administrative plan to revisit this issue at future meetings that will review the millennium development goals and a second ministerial summit in 2008. The world's poor could say: "Thank you, but we have heard of many meetings and learnt of many promises. Meetings are an opportunity to raise awareness and agree collective action but how do we know that these meetings will move beyond platitudes?"

The world's poor, of course, will probably say none of this because they struggle to have their voice heard. They also failed to be represented in the group that drafted the agenda for the ministers to agree, haggle over, and sign off—a glaring omission, affecting the perceived authenticity of the agenda. Much of the talk at this meeting was of demand led solutions, pull not push. In that context an agenda drafted largely by representatives of the rich, and not the poor, was a folly.

A second folly is to tie everything under the sun to achieving the millennium development goals. At this meeting we learnt that, for example, creation of a clinical trials register and national research agendas will help us achieve the millennium development goals. In that case, perhaps watching *The Simpsons* will too? A better solution would be to link the implementation of proved but underused interventions to the millennium development goals—for example, we know that six million child deaths could be avoided if proven strategies were properly implemented—and measure future initiatives, such as national research agendas and trial registries, by a different yardstick.

But this meeting is by no means a failure—far from it. There is a will—which will be tested at next year's World Health Assembly—and what is needed is a way of fulfilling it. Tim Evans, the assistant director general at WHO responsible for turning these fine words into firm actions, made it clear that all those gathered at Mexico are accountable to the world's poor. Performance measures must be in place to judge the success of this year's summit when the next one comes around in 2008, he said. Fine words—and now for action.

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Standards for Better Health: fit for purpose?

No: it's not clear what they are based on and the timescale is too short

The Healthcare Commission is about to consult on measures for assessing the performance of healthcare providers in England. The standards against which it will be making these assessments were laid down in July by the Department of Health in *Standards for Better Health*.[1] Despite their potential impact on service development, and on the ability of the commission to make valid and reliable assessments, the standards have received little attention. Yet they deserve to—for they provide a weak basis for assessment and improvement.

The standards' main aims are to assure safe and acceptable services through compliance with minimal "core" standards; promote development by continuous improvement against optimal standards; reduce the burden of unhelpful standards and guidance; and underpin fair, responsive, and effective services. They consist of both core standards, which are assumed to be met already by all provider organisations, and developmental standards, which are to provide goals for service improvement.

The standards are presented in seven domains designed to cover the full range of health care (see box). These domains—a mixture of quality attributes, management, and public health—do not match any existing conceptual models such as the NHS Performance Assessment Framework,[2] the EFQM Excellence Model,[3] international external evaluation,[4] or assessment templates from Canada[5] and Australia.[6] Within the domains there is no apparent architecture (policy, structures, procedures, resources) or hierarchy (to differentiate between standards and criteria). The standards themselves are inconsistent in depth, scope, and specificity. For example, protecting whistleblowers gets as much attention as the entire management of health records. The domain of clinical and cost effectiveness has nothing on costs, waste, or utilisation. Several other single issue items would be better as criteria than as separate standards (MRSA, child protection, and under-representation of minority groups).

As for content, key features of organisation and management are bundled into unmeasurable concepts. General references to best practice, principles of clinical governance, and financial management (two lines) undermine the standards as a tool for development or assessment. Moreover, many long-standing NHS priorities are not included. For example, one standard requires healthcare organisations to "make information available to patients and the public on their services," but not on their performance.

The standards repeatedly refer to the need for evidence based clinical practice and local planning but give no basis for their own authority. Without such references it is difficult to see where the standards came from, what they replace, or how they will "reduce the burden of unhelpful standards and guidance on the

The seven domains

Safety
Clinical and cost effectiveness
Governance
Patient focus
Accessible and responsive care
Care environment and amenities
Public health

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