PostScript

BOOK REVIEWS

Reaching the poor with health, nutrition, and population services: What works, what doesn't, and why

R Davidson Gwatkin, A Wagstaff, S Abdo Yazbeck. International Bank for Reconstruction and Development/World Bank, 2005, $30.00, pp 376. ISBN 0-8213-5961-7

Many public and private health programmes fail to reach the poor. Instead, they disproportionately benefit those who are more economically advantaged. Concern over this inequity is central to the Reaching the Poor Program, a joint project of the World Bank, Gates Foundation, and Dutch and Swedish governments. *Reaching the Poor with Health, Nutrition and Population Services: What Works, What Doesn't, and Why*, by Gwatkin and colleagues, reports on the findings of this larger initiative. It begins with a detailed discussion of the project and the innovative methods used in the evaluation process. Subsequently, it describes the results of a series of case studies on public health programmes in Africa, Asia, and Latin America. In total, 11 quantitative case studies are profiled including the evaluation of six programmes shown to have favoured the poor; two that appear to have had mixed results; two that yielded ambiguous results; and, one that did not benefit the poor at all.

The report itself, with its abundance of data, is an important first step towards building an evidence base and filling in gaps in current knowledge. While the results of the evaluations are mixed, all of the case studies are fascinating and offer many important lessons for readers. Firstly, the careful accounting of successes and failures shows what worked and what did not work in terms of reaching the poor in specific settings. It also shows how well intended initiatives may inadvertently contribute to or even exacerbate inequality and inequity. The report speaks to the complexity of evaluating these kinds of initiatives, and to the difficulties associated with comparing or generalising the results. While challenging us to do better, it argues that there is no universal approach that will work in all settings. Readers are cautioned against blindly duplicating successful initiatives in different settings, and are encouraged to consider innovative ways of adapting these initiatives to their respective local settings.

Despite these important lessons, the text has a serious weakness that is worth mentioning. Specifically, little if any attention is paid to gender and other intersecting forms of social stratification that gender analysis can help to elucidate. This omission contradicts the widely recognised relevance of gender to the issues being discussed; namely poverty, health and illness, and access to health services and products. It may also help to explain why the report seems to offer little insight into *why* certain programmes were pro-poor while others were not—a key question the report does not adequately address despite its title. This brings us to one final point that is worth mentioning. While it is useful to know what services reach the poor, improved focus, and coverage of health services will not in and of itself address health disparities. Ultimately, we must address the structural causes of absolute and relative poverty and in so doing, reduce inequality and inequity, and improve the health and wellbeing of women and men across their life span.

Suzanne R Sicchia

Assessing quality of life in clinical trials, 2nd ed

P Fayers, R Hays. Oxford University Press, 2005.

Health related quality of life is increasingly used as an end point in clinical trials. Particularly, in diseases with a poor prognosis such as metastatic cancer, quality of life may be of major concern. However, clinicians are still reluctant to accept quality of life as an end point equivalent to more ''objective'' end points such as size of the tumour as assessed by imaging or disease free survival in patients with cancer. Having to deal with practical and time consuming issues such as randomisation, informed consent, and the organisation of study medication when enrolling patients into clinical trials, clinicians may consider the assessment of quality of life as an additional burden to themselves and their patients.

Barriers to the acceptance of the notion of quality of life may include difficulties in both the understanding of the underlying concepts as well as in the interpretation of the results. This is not surprising as quality of life is not routinely included in the medical curriculum and clinicians are, therefore, not trained in analysing and interpreting quality of life data, in contrast with other professions such as psychologists or sociologists. *Assessing quality of life in clinical trials* by Fayers and Hays should play an important part in making quality of life concepts accessible to both clinicians and researchers. The book provides an excellent overview on the state of the art and current issues in quality of life assessment and research. It describes how health status instruments are best developed and validated, how they are translated into different languages, how quality of life data may be analysed in an appropriate way, and how the results may be interpreted adequately. Important issues such as the clinical relevance of the observed differences in quality of life between groups or of change over time are discussed. Advice on how to deal, in scientific analysis, with the common problem of missing data is provided. In addition, emerging concepts are introduced, such as preference based measures reflecting the value that patients or the community, or both, place on different health states. The book is generally written in a concise and clear style including a sufficient number of examples as well as a summary at the end of each chapter. However, whereas most chapters are intuitively understandable even for readers without a profound knowledge of statistics and methodological issues, some may require more detailed experience in the analysis of quality of life data.

The book *Assessing quality of life in clinical trials* is certainly a must-have for everyone involved in quality of life assessment. To increase the acceptance of quality of life as an important outcome in clinical research, it is certainly an important goal to impart knowledge about quality of life concepts to all those involved in medical care. However, in the long term, it will be crucial to evaluate how the assessment of quality of life actually improves medical care and how quality of life may be integrated in the decision making process with regard to the care of individual patients.

Jacqueline Müller-Nordhorn

Methods for the economic evaluation of health care programmes, 3rd ed

M E Drummond, M J Sculpher, G W Torrance GW, et al. Oxford University Press, 2005. ISBN 0-19-852945-7

A sketchy outline to the main economic theories forms the introduction to this book. The authors skillfully invoke those theories in the end only to point out that the economic evaluation primarily serves as a pragmatic aid to decision making. The ''blue book'' systematises and summarises recent knowledge on the main types of economic evaluations, thereby providing a useful overview including sources of further readings. Economic evaluation is defined as a comparative analysis of alternative courses of action in terms of both their costs and consequences. The authors make clear that the subject matter of economics is the deployment of real resources whether they cost money or not, for example, time, and that the economic notion of cost differs from the accounting notion of expenditure.

The book is exhaustive and detailed with regard to descriptions of techniques and tools for evaluation of health care programmes. It provides interesting syntheses of new and emerging methodologies. It is less concerned with the theoretical and ethical foundations of these methodologies, which Allan Williams[1] calls libertarian and egalitarian, respectively. This book reminds the readers on the probalistic and normative origins of the utility concept in economics (utility as a preference measure) as compared with the ethical concept of utility as usefulness. Thus, it is aimed at readers familiar with basic health economic concepts and theories so as to recognise different equity criteria, assess transferability of the results, and avoid ideological pitfalls.

An income distribution can affect results of the willingness to pay approach and there is a risk of double counting if the income effects are adjusted for at the same time as the respondents include income effects of disease or treatment in their responses. As human beings tend to adapt to their living conditions subliminal thinking occurs. By analogy, the same should apply to the time preference of discounting rates. The referred popular wisdom that ''a bird in the hand'' is more valued probably applies to the considerations of an ordinary human, with rather small incomes and expected returns. Those with large incomes might hold different views on handy birds.

The authors point out that the economic evaluation only addresses one dimension of health care programme decisions and that questions related to efficacy, effectiveness, and availability should be answered before an economic evaluation takes place. There is an unchallenged assumption that health care inputs and outcomes are spatially and temporally separable and supply inducement absent. In the case of treatments of acute myocardial infarctions those dying outside hospitals are

not counted. In reality the provision and delivery of health care coincides with consumption and cannot be separated, in particular in emergency contexts. Procedures and treatments cannot be stored like products of the manufacturing or drug industries; it is rather a matter of oversupply or undersupply of facilities and personnel in relation to health care needs or demands. It follows that the subjects of cost effectiveness evaluation as conceptualised in the book mainly are elective procedures. The effects of hospital teaching status on the outcome of acute myocardial infarction have been shown to be large. The authors use the classic assumptions of advantages of scale economies and scope economies omitting the recognised fact that there are diseconomies of scale in hospitals.[2] The evidence on the effects of the hospital teaching status and scale on outcomes compared with costs would deserve some comments. It is possible that the economic evaluation would appeal a broader audience if its examples extended behind ''whether drugs or surgery are the most cost-effective ways of treating angina''.[1]

Grazyna Adamiak

References

1 **Williams A**. Being reasonable about the economics of health. In: Culyer AJ, Maynard A, eds. *Selected essays*, Cheltenham, UK: Edward Elgar, 1997.
2 **Dawson D**. Organisational economics. In: Fulop N, Allen P, Clarke A, *et al*, eds. *Studying the organization and delivery of health services. Research methods*, London: Routledge, 2001:124–39.

CORRECTION

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This is an amended version of a correction that appeared in the August issue of the journal (2006;**60**:735)

In our March 2006 issue, Oscar H Franco and colleagues discussed the concept of a fixed dose combination pill, which was referred to as a polypill, a theoretical combination of six pharmacological compounds for the treatment of cardiovascular disease proposed by N J Wald and M R Law in their article, ''A strategy to reduce cardiovascular disease by more than 80%'' (*BMJ* 2003;**326**:1419). We would like to make it clear that Franco *et al's* article was a discussion of the theoretical concept of a fixed dose combination pill as proposed in Wald and Law's article and did not intend in any way to refer to POLYPILL, a term that is currently the subject of trade mark applications by Professor Wald in the USA and Canada. The Editors wish to apologise to Professor Wald for any ambiguity that may have occurred in the wording of this article.

Speaker's corner

Emerging issues in public health information

In recent years, two issues have emerged concerning the collection of public health information: the increasing popularity of mobile cellular telephones (cell phones), and the increasing interest of governments in protecting the privacy and confidentiality of their citizens' health information. These issues have widespread, longlasting, and potentially adverse effects on certain aspects of public health research and practice.

Public health researchers and practitioners have increasingly relied on the use of computer assisted telephone interviewing (CATI) to collect public health information. The use of such telephone surveys is a cost effective method with which to access large samples quickly. However, the popularity of cell phones is emerging as a potential problem in CATI survey design because people in households with cell phones and no conventional landline telephone would be excluded from telephone survey sampling frames based on telephone directories or electronic white pages, thus creating a sampling bias. Although random digit dialling (RDD) can reach cell phone users, the existence of multiple cell phone numbers in the same household would increase the likelihood that a household would be selected to participate in the survey. In addition, refusal rates would probably be higher among cell phone users selected, as they tend to be on the go, and in many countries they must pay to receive incoming calls. One might argue that survey results will not be biased by multiple cell phones in a household as long as that household has a landline, but even this would not be true if the presence of the cell phones would make household members less likely to pick up a call on the landline phone. The increasing popularity of cell phones, therefore, may mean that the usefulness of the telephone/CATI survey technology in collecting public health information may be nearing an end.

Concerns about protecting the confidentiality of individual health information may also affect public health information systems. Public health researchers and practitioners in general have no reason to release confidential health information to the general public. However, they do need access to such confidential information, to conduct studies to identify risk factors and develop prevention and control strategies for the public good. In many countries, recent legislation designed to prevent ''leakage'' of confidential health information has restricted information flow to the extent that public health researchers and practitioners find it difficult to conduct any meaningful epidemiological studies because of an inability to link records. Because public health researchers and practitioners need access to this information to do their job, we hope that new privacy and confidentiality legislation can stop unnecessary information leakage while permitting efficient information flow among public health researchers and practitioners.

Although cell phones have not yet driven conventional telephones out of business, public health researchers need to consider using multi-mode designs for data collection, perhaps a combination of conventional telephone, web based, mailed, face to face, and cell phone surveys. They will also need to address related statistical issues such as how to blend the results of cell phone surveys with the results of traditional surveys, as they tend to reach different population subgroups. The public health challenge is to collect valid and reliable public health data at a reasonable cost and in a timely manner. The solution to concerns about protecting the privacy of individual health information may be as simple as making a law that imposes a stiff penalty on whoever releases or misuses personal data. Public health researchers and practitioners need data and access to confidential information, but if this privilege is misused there can be important financial and legal implications for the society.

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The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Public Health Agency of Canada, the Universities of Toronto and Ottawa, and the US Centers for Disease Control and Prevention.