Furthermore, the fewer reported adverse events with the second-generation DES, as shown in trials like RESOLUTE All Comers\(^5\) and COMPARE\(^11\) challenge the ability of DES, with biodegradable technology to match these results in the first year. 5 or more years could pass before superiority of DES with biodegradable polymer over these second-generation DES is shown.

Although biodegradable polymer technology is scientifically appealing and the long-term results of LEADERS are encouraging, we are not yet in a position to confirm whether biodegradable polymers will replace durable polymer for DES technology.

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The Commission on Macroeconomics and Health: was it the right recipe?

10 years ago, WHO appointed the Commission on Macroeconomics and Health (CMH) to examine investment in health and global economic development. The CMH reported its findings in December, 2001,\(^1\) and provoked two swift reactions from global health researchers: critique of its lack of engagement with the limitations of economic growth driven by globalisation,\(^2\) but also guarded support for its central theme of investment in health is an engine of economic development. This business case for health financing, which continues to dominate health policy discussions, can be strategically useful when engaging with finance ministers. But it also biases towards interventions for which the financial returns exceed the costs. Moreover,
if health is seen as a means to economic growth, it may be vulnerable to sacrifice if other means are considered more important or show greater returns.

Cost-triaging led the CMH to prioritise health investments for their low cost and high impact; partly in consequence, its categorical interventions focused on infectious diseases. This approach was representative of international health at the time, but as chronic diseases progressively eclipse infectious epidemics in many low-income countries, an epidemiological shift is challenging the CMH’s emphasis on vertical programming. Prevention or treatment of non-communicable diseases defies simple intervention. By advocating a categorical approach to targeted programmes, the CMH sided with a selective approach to primary health care reform. The sustainability of this approach has been intensely debated since the 1978 Alma-Ata Declaration. The CMH report promoted the reflexive call for public-private partnerships in health research, and for private financing to help fund its list of priority health problems. The subsequent proliferation of disease-specific global health initiatives has supported many new health programmes, but also created inefficient transaction costs for recipient governments. Furthermore, prioritising public financing for the poor leaves intact private spending by the non-poor. Combined with its call for public-private competition in the delivery of services, the CMH recommendations could be seen to make legitimate the expansion of unregulated commercialisation in health care. The CMH was not silent on the need for investments in other determinants of health, such as education, water, and sanitation, but it was the latter WHO Commission on Social Determinants of Health (CSDH) that focused substantively on these concerns. The CSDH concluded that most global health problems arise from a combination of poor social and economic policies, unfair economic arrangements, and gross inequalities in wealth and power. By contrast, the CMH’s cautious stance on trade matters, including uncritical support for trade in health services despite well argued concerns to the contrary, was seen as indicative of its acceptance of the global economic status quo. The CMH’s silence on tax havens, capital flight, and transfer-pricing, alongside its emphasis on donor assistance rather than a global financial transaction tax to fund development, seem almost negligent in the current global financial crisis. Even as the CMH report recognised how macroeconomic financial crises can imperil health systems, it said nothing of how deregulated global markets create such crises.

Finally, the CMH report failed to consider whether health-driven economic growth would be environmentally tenable. The Sustainable Development Commission argued that it is not. Under the present global economic model, as economies grow, more food, fossil fuel, and water are consumed; yet we are on the cusp of severe food shortages, irreversible climate change, and regional conflicts over water. Whether or not that economic model can be displaced is moot, especially given political efforts to restart economic growth as quickly as possible. These circumstances underscore the limitations of a global health recipe that focuses on short-term interventions that promise the best returns. The CMH recipe is perhaps useful as an appetiser, but we need a much more substantial main course.


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11 Katz A. The Sachs report: investing in health for economic development—or increasing the size of the crumbs from the rich man’s table. Int J Health Serv 2004; 34: 751–73.