should be set in relation to the priorities and constantly reviewed. In other words, the WHO should follow standard practices followed by effective organisations.

Although major reform is unlikely with Nakajima in post, he has begun to prepare the ground for reform. It began in January with important budgetary shifts and the setting up of various working groups, one of which will look at limitations on the terms served by the director general and regional directors and methods of appointing new ones. If the World

Health Assembly in May will agree to a limit of two terms for the director general (meaning that Nakajima would have to go at the end of this term in 1997, when he will be 69) and to the WHO not trying to do everything, then there is hope for the WHO. But if Nakajima wins a third term the future is bleak.

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Copenhagen's challenge

To balance budgets without unbalancing lives

With the end of the cold war comes an urgent need to address what the United Nations' secretary general, Boutros Boutros-Ghali, defines as a "new crisis in human security."¹ The symptoms are worsening internal conflicts, urban slums, rising social tensions, and the disaffection of large numbers of people from their societies, governments, and institutions. Internationally, population growth, increased numbers of refugees, the weapons trade, drug trafficking, and the threat to the biosphere from overconsumption and pollution all call for a shift from providing security through arms to providing it through social development.

Underlying many of these problems is the increasing economic division between rich and poor people. In Brazil, for example, the wealthiest fifth of the population receives 26 times the income of the bottom fifth.² This may be an extreme case of national inequality, but globally the contrast is even starker—the richest fifth have 150 times the income of the poorest fifth—the disparity having doubled over the past 30 years or so.

At next week's world summit for social development in Copenhagen the UN will examine some of the seemingly intractable social and economic problems that are devastating parts of our planet. On the eve of the UN's 50th birthday the summit will bring together around 100 heads of state to discuss three main themes: the eradication of poverty, the creation of jobs, and the fostering of social integration. The intention is to build on the commitments made in previous summits (children's rights, the environment, human rights, and population) and formulate an integrated plan of action to encourage governments and the private sector to invest in people.

Do summits achieve change or are they just expensive talk-shops? The UN Convention on the Rights of the Child has undoubtedly brought benefits to British children³—for example, the Children Act 1989. But the "earth summit" in Rio de Janeiro left unresolved a key issue—whether the North would commit additional aid to the South to implement environmentally sound policies. Since then Northern governments have cut back on their official development assistance, which fell from \$60bn in 1992 to \$55bn in 1993. This threatens the implementation of Agenda 21⁴—"the earth's action plan"—which was a principal outcome of the conference in Rio. The plan pointed clearly to the need to address current imbalances in the global patterns of consumption and production.⁵

Every UN meeting is beset by a strong conflict of interest between North and South, and this one will be no exception. The South hoped that the objective of eradicating poverty

would be properly funded, but these hopes have been dashed by concerted opposition from Japan, the United States, and the European Union.⁶ Many people fear that the summit is in danger of collapsing under the weight of its unimaginably ambitious agenda—"a wish list" covering economic problems (poverty and inequalities in income), social concerns (equality between the sexes and homelessness), and welfare issues (the rights of children, elderly people, disabled people, and refugees).

A key battle will be fought over structural adjustment programmes imposed by the International Monetary Fund and World Bank on governments as part of a package to relieve debts. These programmes have meant hardship for people throughout the Third World in many aspects of their lives—health, education, work, and culture.⁷ The North, however, is reluctant to be drawn into the debate on adjustment, counterclaiming that the social ills of poor countries are due to poor government planning, lack of market mechanisms, corruption, and restrictions on human rights.

Preserve spending on health

Modern adjustment programmes are equipped with safety nets supposedly to protect the worst hit people, but they often do not work because governments do not have the money to fund them. The "20/20 initiative" promoted by Unicef, the World Health Organisation, and other UN bodies calls on donor and developing countries to increase their spending on basic social services, including health care, to 20% of total official development assistance and 20% of national budgets respectively. In addition, there is a longstanding commitment for donor countries to increase official development assistance to 0.7% of their gross national product—a pledge that many, including Britain, have failed to keep but that is referred to in the draft declaration of the conference. The people of the South need a definite commitment that spending on health, food, shelter, education, and water supply will be protected.

Cuts in government spending, dictated by adjustment, usually mean cuts in the provision of health care and the introduction of "user charges" for health care. For example, researchers claim that the effects of such cuts are beginning to show in indicators of health status in Zimbabwe for the first time since independence.⁸ The number of women dying in childbirth in Harare more than doubled in the first two years after the introduction of an economic structural adjustment programme. While it is difficult to prove a causal relation between these events, the *prima facie* case is compelling. User

fees seem to have reduced attendance at rural health facilities in Ghana⁹ and treatment for sexually transmitted diseases in Kenya.¹⁰ The World Bank itself acknowledges a problem when user fees reach 1% of annual household income.¹¹

The South pays back debt at enormous social cost, and this contributes to the dismantling of its health and educational systems. By 1990 over \$50bn a year was pouring from indebted developing nations to their creditors.¹² If the summit is serious in its desire to relieve poverty, says the Group of 77 nations, the collective voice of the South, then African debt must be cancelled and the debts of other poor countries reduced by a target date.¹³ The draft declaration of the conference also calls for urgent consideration to be given to the relief of multilateral debt (owed to the World Bank and International Monetary Fund).

UN conferences are often the lowest common denominator for international action. As doctors, how can we promote the summit's undoubted good intentions? Firstly, we can increase public awareness of the urgent need to reduce poverty, both nationally and internationally, emphasising its deleterious effect on health. Health issues will not receive sufficient attention at the conference and need to be highlighted in future. Through universities and research institutions, understanding of the causes of poverty and the effectiveness of antipoverty campaigns can be improved.

Finally, integration of the results of social science and health research into economic decision making should be encouraged so that balancing budgets does not unbalance the lives of people.

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Patterns of disease: diabetes mellitus and the rest

We should be investigating the relations between diseases

See pp 555, 560

As early as 400 BC Indian doctors observed that diabetes was a disease of well fed people. In 1895 Bose wrote "Amongst the Zemindars and Talookdars, who consider it a pride and honor to lead an indolent life, diabetes is a common disorder."¹ In 1962 my 76 year old Aunt Nina attributed her diabetes to being old, fat, and inactive.

Much of what I have read about epidemiology of diabetes in the past 20 years has merely refined what my Aunt Nina said about her non-insulin dependent diabetes. We have learnt more about its causes and have more precise estimates of the relative risks of developing it as a function of age, obesity, level of physical activity, and, from Rimm and colleagues' paper in this week's journal, cigarette smoking and alcohol use (p 555).² But substantial advances in our understanding of its epidemiology and that of other non-communicable diseases have been rare.

The epidemiology of diabetes has recently seen a change of focus—apparent in the paper by Perry and colleagues in this issue with its examination of the interrelations between diabetes and other risk factors for coronary heart disease (p 560).³ Although Lilienfeld and Lilienfeld defined epidemiology's concerns as "the patterns of disease occurrence in human populations and the factors that influence these patterns,"⁴ this is not how we have investigated diabetes or in fact any non-communicable disease. We do not look at diseases within populations; instead we look at a disease, "our" disease. For 40 years we have been diabetes epidemiologists, cancer epidemiologists, cardiovascular epidemiologists, and AIDS epidemiologists. Few researchers have cut across disease boundaries and examined more than one disease. Fewer still have tried to examine the patterns of diseases in a population.

An important exception was Omran with his development of the concept of the epidemiological transition. His classic paper, which has received relatively little attention since it was published in the early 1970s, showed clearly the existence of both patterns of diseases and processes that produce these patterns.⁵ Moreover, the changing patterns of disease are very predictable. Omran charted the rapid fall in infectious diseases with rising socioeconomic status. Increasing life expectancy then unmasked chronic diseases, which occur in a distinctive pattern. Initially, deaths from trauma increase. Next comes a peak of non-insulin dependent diabetes, not initially associated with a rise in coronary heart disease. Coronary heart disease emerges after diabetes, and cancer five years after the others have emerged.

This pattern is almost universally seen and is almost universally ignored. An episystems approach, which investigates the processes and patterns of diseases, could lead to important insights.⁶ For example, we need to evaluate the complex interrelations not only between diabetes and cardiovascular disease but also between diabetes and cancer, rheumatic fever, and polio.

Evolutionary biology may provide the best model. This discipline has been important for understanding and predicting the rise and fall in species. Species are constantly in transition, with the numbers of one species rising and those of another falling. This symphony of change is orchestrated by the environment, which interacts with the genetic background of plants and animals. Different species change in response to each other as the result of conditions affecting both of them. They also change as the result of environmental conditions tending to "run together," yielding strong interrelations in the ecosystem. Darwin described "how plants and animals