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Eight Years and Counting—What Can Americans Do?

THE SEARCH FOR President Bush's "new world order" and the World Health Organization (WHO) agenda, "Health for All by the Year 2000," are neither theoretical nor rhetorical. In two previous articles, "International Health Beyond the Year 2000"[1] and "International Health,"[2] I reviewed the major challenges and some solutions to global health problems.

If the United States adopts global leadership in efforts to improve the health of people everywhere, 1992 could be a pivotal year.[3] Health for the "global person" could translate into "the new diplomacy"; better health could be the new lingua franca replacing the arms race and the cold war. The total US budget is about $1.5 trillion for fiscal year 1992; the WHO budget for fiscal year 1992 is only $735 million, less than the budget of the US Public Health Service's Centers for Disease Control in Atlanta, Georgia.[3] One suggestion is that US assistance to the WHO can be provided as extrabudgetary funds—a special contribution above and beyond its regular assessment of 25%.[3] President Bush and Congress may reduce the armed services budget by $50 to $100 million during the next five years. This peace-time "fallout" of extra funds could be used to improve health both at home and globally. In its new role as leader in efforts to improve the health of all people, the United States would have to put increased pressure on the European Economic Community, Japan, Taiwan, Singapore, and other economically strong nations to contribute more to the WHO's dwindling resources as AIDS, cholera, floods, drought, and earthquakes continue to wage their own wars on humanity.

Elsewhere in this issue, Alfred Sommer, MD, adroitly outlines global health priorities, including those affecting people in the United States, and emphasizes maximizing quality years of life at a cost society can afford.[4] He identifies the organization and use of health resources as the pivot. Dr Sommer emphasizes the need to maintain close communication with other health professionals who have a common agenda; he rightfully calls for eliminating the divisive barriers hindering close relationships among global health professionals. Moreover, the International Health Medical Educational Consortium (IHMEC) has also mandated reorienting medical school academic agendas to reflect society's demands and realities.[2] Dr Sommer calls for the same efforts by the schools of public health,[4] which for nearly 100 years have given top priority to the health needs of society. IHMEC task forces are currently addressing issues of clinical sites, curriculum, career track and certification, communication, and liaison in a comprehensive effort to ensure that candidates not only have health profession experience but have also "looked after sick people."

Because both dollars and human resources are scarce, we must use plain economic sense and social justice and put increased pressure on our academic health centers to return to their primary mandate of working for public and societal good.[5-7] Academic institutions must claim the "three-legged stool" of cost, access, and quality of care.[6] Those of us in public health and medical schools must care for this "stool" and ensure that it also sprouts a fourth leg of societal priorities with equity. We must become part of the "new world order" instead of reluctant players.

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Meta-analysis Redux—Steroids and Meningitis Revisited

THERE ARE MANY CLINICAL SITUATIONS for which firm therapeutic recommendations cannot be made based on existing data. Sometimes these situations can be identified by the fervor of the discussions surrounding them. Loud, data-free arguments, by necessity based on belief rather than a critical appraisal of relevant literature, frequently occur when new therapies become available or are applied to new uses and before there are enough trials to give clear answers to clinical questions. When more data become available, quieter deliberations are the rule as clinicians try to sort out what to do in the face of sometimes conflicting information from different studies.

Elsewhere in this issue, Geiman and Smith use the techniques of meta-analysis in an attempt to sort through the available data and make a recommendation concerning the use of corticosteroids as adjunctive therapy for the treatment of pediatric patients with bacterial meningitis.[1] Their excellent analysis offers a useful summary of the information available from clinical trials in this area. Their recommendations for use are somewhat firmer than I think the data allow at this time.

In the pediatric studies included in their meta-analysis,[1] early[2] and late[3] neurologic sequelae and moderate or more severe bilateral hearing loss[2] were significantly diminished by dexamethasone therapy in only one trial each. When