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The printed journal includes an image merely for illustration

Panos Pictures

Health equity funds in Cambodia

Bruno Meessen and colleagues (Dec 23/30, p 2253)[1] compare the experience of health equity funds (HEFs) in Cambodian hospitals with the overall abolition of user fees in public health structures in Uganda. Médecins Sans Frontières (MSF) was involved in the cited equity fund in Sotnikum district hospital, Cambodia, between 2000 and 2003 (report available from the authors on request) and we want to complement the reported results.

The success of the Sotnikum HEF in improved targeting of exemption at hospital level critically relied on at least three factors: (1) sufficient funding from a third party source, external to the health structure and the health system; (2) an independent agent (in this case a local non-governmental organisation) determining inclusion based on clear agreed criteria; and (3) HEF funding being complementary to pre-existing health-care services with sufficient financial and human resources. Informal fees were outlawed and sanctioned strictly.

From an implementation perspective, the question is how large the proportion of people unable to afford the existing fees should be before it becomes more sensible to abolish fees for all. In 2003, the HEF in Sotnikum hospital took charge of 40% of patients, which could be sufficient to tip the balance. Elsewhere in Cambodia, MSF initially applied an HEF for AIDS patients but soon moved to abolish fees altogether, maintaining compensation of transport costs, because social assessment showed the bulk of patients unable to pay.

The current limitations of HEF in the contexts in which we intervene have not allowed MSF to replicate it elsewhere. In our experience, exemption systems based on individual entitlements are complicated and protect few people (report available from the authors on request). They compare poorly to general exemption or those based on large categories (eg, children), which are easier to apply and to verify. Therefore MSF's operational policy implies abolition of user fees for all patients.

We declare that we have no conflict of interest.

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The need for strong general health services in India and elsewhere

The Lancet's series on health system reform in Mexico features a plea for a "diagonal approach" by Jaime Sepulveda (Dec 2, p 2017),[1] referring to the dichotomy between horizontal health services and vertical control programmes. Although this dichotomy is indeed sometimes artificial and vertical programmes might be necessary in certain circumstances, we plead for caution with such semantic mollification.

The common thread in vertical programmes is that planning, funding, and monitoring take place at the central or international level. Implementation is typically left to peripheral health workers who must respond to central pressure rather than to local needs.[2] Vertical programmes can be an important asset for health systems by reducing a specific disease burden in the short term. However, long-term sustainability requires the presence of functional, permanent health services. Moreover, vertical control strategies are often determined by biological transmission control concepts, rather than by the entitlements of citizens to health care. By virtue of their earmarked resources, scientific interest, and performance-based incentives they tend to dominate national policymaking.[3]

In India, the mushrooming of vertical health programmes—family planning, polio eradication, disease surveillance, lymphatic filariasis—has led to disruptions in health-care provision.[4] For instance, priority was given to polio eradication while coverage of routine immunisation dwindled[5] and diseases such as diphtheria re-emerged. Finally, most people still die from diseases not targeted by vertical control programmes, such as diarrhoea, respiratory infections, or diabetes.

For the **Indian Prime Minister's speech at the inauguration of the National Rural Health Mission**, see http://pmindia.nic.in/speech/content.asp?id=101

The Indian prime minister has announced a return to horizontal health strategies. Strengthening health systems has also been reaffirmed as an important strategy of WHO. We hope that such renewed commitments to the entitlement of citizens to health care will become the central driving force to resource allocation for health at national and international levels.

We declare that we have no conflict of interest.

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Dental caries and social deprivation

Robert Selwitz and colleagues (Jan 6, p 51)[1] provide an excellent pictorial illustration of the gamut of factors involved in the development of dental caries. Among them, we believe that sociodemographic status and water fluoridation are very important. To highlight this point, we present data from Walsall, one of the most deprived districts in England. Experience of dental decay among 5-year-old children reveals that the highest rate is for people in the north of Walsall and the lowest for those in the east. This pattern coincides with the levels of socioeconomic deprivation (figure).

Water fluoridation was started in Walsall in 1987 and since then the overall decay rate reported among 5-year-olds has decreased from 1·9 teeth per child to 0·8 teeth per child in 2004. Consequently, the proportion of 5-year-old children with no experience of dental decay has increased from 57% to 70% during the same period.

We strongly believe that the new dental contracts in England[2] should make provision for subsidising the costs of dental care so as to enable people from lower social classes to access services. This, along with education of parents and children to inculcate good dental hygiene practices and making efforts to fluoridate water across all regions of the UK, will go a long way in preventing the development of dental caries.

We declare that we have no conflict of interest.

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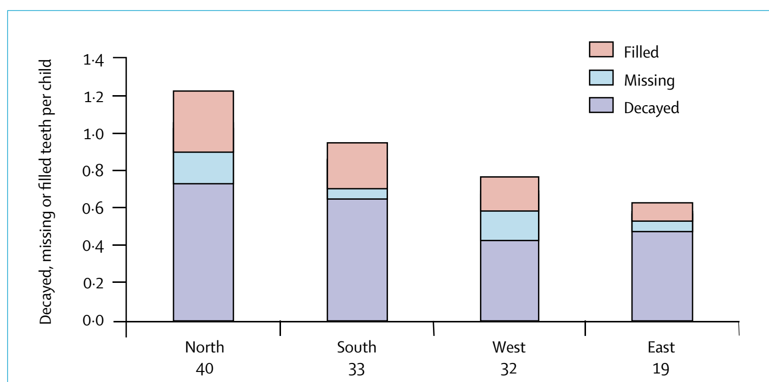

Figure: **Experience of dental decay in 5-year-old children between Walsall localities for the year 2006**
IMD=indices of multiple deprivation (higher the number, greater the deprivation).

Hospital management of Mumbai train blast victims

We were interested to read the article by Christopher Aylwin and colleagues (Dec 23/30, p 2219)[1] and the accompanying Comment (p 2188).[2] We wish to share our experience in managing the serial suburban train blasts in Mumbai, India, on July 11, 2006 (table).

King Edward VII Memorial Hospital is an 1800-bed tertiary-care teaching hospital funded and managed by the Municipal Corporation of Greater Mumbai. The hospital houses several faculty, resident doctors, medical students, nursing staff and students, technicians, ambulance drivers, and support staff, which serve as a ready resource during mass casualties.[3,4]

The proximity of our hospital to two of the seven blast sites resulted in the maximum number of casualties being brought to this hospital. The first blast took place at 1624 h.

There was no prehospital triage, which explains the much greater surge rate in the first hour than at the Royal London Hospital. Also, because the Mumbai train network is above ground, the time lost before getting the victims to the hospital was shorter. In-hospital triage was done by a surgical junior consultant on call, leading to a low over-triage rate (8%). Stable patients were sent to an area away from but close to the emergency department, similar to the Royal London Hospital experience. We further improved resource use by transferring patients with isolated system involvement to the respective intensive care units. As with the London experience, no laboratory tests apart from blood grouping and cross-matching were requested. However, we used radiological investigations extensively and avoided unnecessary surgical interventions. The triage area was cleared in 90 min and the emergency