

Patient choice stops at inhaled insulin

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When the US Food and Drug Administration and the European Agency for the Evaluation of Medicinal Products licensed Pfizer's Exubera as the first inhaled insulin this year, it was welcomed as the most important development in diabetes treatment since the advent of insulin in the 1920s. Inhaled insulin had shown similar efficacy, but better quality of life scores and patient preference profiles, to short-acting subcutaneous insulin in several randomised studies in patients with type 1 and type 2 diabetes. Data on adverse events led to Exubera being contraindicated for smokers and not recommended for people with underlying lung diseases, such as asthma or COPD. Last week, the UK's National Institute for Health and Clinical Excellence (NICE) released its appraisal document on inhaled insulin, open for consultation until May 10, which concluded that the treatment should not be offered to patients.

NICE supported its conclusion with three main arguments: that the data on quality of life and patient

preferences are insufficient and not generalisable; expert views that "using injected insulin is not usually a concern for the majority of people with diabetes"; and, in a rather curious conclusion, NICE claims that the effect that patients might move on to inhaled insulin earlier and therefore avoid or delay long-term diabetic complications, is "insufficient to provide support for a cost-effective use of this technology".

Inhaled insulin will cost an additional £500 per patient per year. Clearly, it is not suitable for everyone with diabetes. For the group that might arguably benefit most from avoiding or minimising injections—children and adolescents—there is currently insufficient evidence on efficacy and safety. Long-term safety data are still lacking in terms of lung damage and effects on the development of insulin antibodies. With these caveats in mind, however, it should be left to the individual physicians in discussion with their patients to make appropriate use of this new technology. ■ [The Lancet](#)

Time for the World Bank to act on malaria

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Still Pictures

April 25, Africa Malaria Day, provides time to reflect on a treatable and often preventable infection that still affects 500 million people worldwide and kills well over 1 million—mainly African children—yearly. Such shameful figures invite blame and recrimination, the backdrop for two Viewpoints published online today. Amir Attaran and colleagues suggest that the World Bank has reneged on funding and created a smokescreen of misleading figures. In reply, Jean-Louis Sarbib and colleagues state that "Paul Wolfowitz has put the full weight of his leadership behind the Bank's renewed commitment to malaria, with a strong emphasis on results".

Yet malaria was absent from Wolfowitz's policy speech on April 11 in Jakarta. Instead, his address, entitled *Good governance and development: a time for action*, emphasised reducing corruption in recipient governments by increasing the Bank's Department of Integrity staff from 53 to 65. In contrast, Attaran asserts that the number of malaria specialists at the Bank has dropped from 7 to 0. Central to Wolfowitz's vision, as new Bank President, is the need for recipients to develop "transparent and accountable institutions,

strong skills and competence, and a fundamental willingness to do the right thing". Welcome sentiments, on which the Bank might also reflect.

However, the speech held out hope, not so much in its sabre-rattling as in its delivery, which revealed genuine cultural sensitivity and affection for the people of Indonesia, where Wolfowitz had served as Ambassador in his pre-Iraq days. That passion, combined with his reputation as an able manager, could be an asset for enabling health-care delivery in the absence of effective national systems, since in many of the world's poorest areas, the Bank remains the major source of health finance. And it is precisely in these locations that the 2000 Meltzer report on the future of the World Bank recommended that effort should be concentrated.

Malaria accounts for 10% of Africa's disease burden and US\$12 billion yearly in lost productivity. The Abuja declaration of April 25, 2000, calls for halving malaria mortality in Africa by 2010. If the World Bank is serious about being judged on results, as Sarbib and colleagues propose, then the Abuja target provides an excellent opportunity for cost-effective action. ■ [The Lancet](#)

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