Health care in US ranks lowest among developed countries, Commonwealth Fund study shows

Bob Roehr WASHINGTON, DC
The United States ranked last across a range of measures of health care in a comparison of 19 industrialised countries, despite spending more than twice as much per person on health as any other of the countries, says a report published last week.

The report shows improvements in some areas since the previous rating two years ago but found that other countries had improved more quickly. It analysed 37 measures, including access to care, quality of care, and health outcomes.

Overall, said Karen Davis, president of the Commonwealth Fund, the charity that developed the report, “the US scored far short of the best performance, either in other countries or within the best performing hospitals in the US.” She added, “It is a demonstration that we are losing ground.”

Cathy Schoen, a senior author of the report, said that the overall US score had fallen from 67 to 65, on a scale of 100, over the past two years. Although modest improvements were shown in efficiency and equity, these were offset by falls in quality and in healthy lives, a measure that is based on preventable mortality and limitations in patients’ activity.

Access to care was the single most important factor contributing to the US’s decline. “We are being pulled down by rising numbers of uninsured and underinsured,” said Ms Schoen. “And the trend is getting worse. (This is before the slowdown in the economy.) It is moving up to the middle class.”

If the US attained the same performance indicators achieved in other industrialised countries, Ms Schoen added, “we could save at least 100,000 lives per year and at least $100bn [£50bn; €63bn].”

The report tied much of the problem to a weak base of primary care doctors. Patients do not have easy access to them, it said, and their numbers are too small and are projected to shrink, with looming retirements.

Christine Cassel, president of the American Board of Internal Medicine, said that most of the US system is “hamster care . . . that pays people to do more, not for results.” It is a running wheel that keeps healthcare workers going in circles, she argued.

“Accountability, not just for quality but also for managing resources,” will be crucial to reform, she said. It was important to move from a physician centred to a team centred approach to health care.

Why Not the Best? Results from the National Scorecard on US Health System Performance, 2008 is available at www.commonwealthfund.org.

Cite this as: BMJ 2008;337:a889

Violence and overcrowding characterise many mental health wards

Andrew Cole LONDON
A comprehensive survey of England’s mental health wards has identified high levels of violence, overcrowding, and impersonal care, and 11 of the 69 trusts surveyed failed to meet minimum standards.

The health watchdog the Healthcare Commission also found that many detained patients are leaving the wards without permission and putting themselves or others at risk. During a six month period patients were recorded leaving the ward on 2745 occasions for an average of three days.

The commission examined in detail the performance of 554 mental health wards in England that provide almost 10,000 beds for patients between the ages of 18 and 65.

Overall it scored eight trusts as excellent, 20 as good, 30 as fair, and 11 as weak (meaning that they fell below minimum standards). The commission has almost completed follow-up visits to all the trusts rated as weak, and action plans are now being implemented.

It also found that the best performers were more likely to be smaller units and that those scoring poorly were more likely to be larger and serving an urban population. Overall the bed occupancy rate was 87%. But the highest rate was Walsall Teaching Primary Care Trust, which had 106%.


Cite this as: BMJ 2008;337:a959
**IN BRIEF**

**Trust refutes reports of performance related pay:** Imperial College Healthcare Trust has denied press reports that it is moving towards performance related pay for doctors who produce the best surgical outcomes. A spokesman said that they were trying to improve the measurement of outcomes but that these could lead to more resources for the whole clinical team and not pay rises for individual surgeons.

**Global goal for basic sanitation will be missed:** The world is “badly” off track and will miss by a wide margin the millennium development goal of halving by 2015 the estimated 2.5 billion people—38% of the global population, mostly in South Asia and sub-Saharan Africa—who have no access to basic sanitation, a report by the World Health Organization and Unicef has found. But, it says, better progress has been made towards the target for access to safe drinking water.

**MRSA decreases in England:** Bloodstream infections of meticillin resistant *Staphylococcus aureus* fell by 30% last year, according to the latest figures for England, which show the greatest annual reduction for the past five years. The quarterly figures on healthcare associated infections show a 49% reduction from 2003-4. The number of infections of *Clostridium difficile* fell by 32% in comparison with the same quarter last year.

**Survey confirms burnout rates in doctors:** High rates of burnout have been found among family doctors in Europe, according to a survey of 12 nations (Family Practice 2008 Jul 11; doi: 10.1093/fampra/cmn038). Of the 1393 doctors 43% scored high for emotional exhaustion, 35% for depersonalisation, and 32% for feelings of low personal accomplishment, with 12% scoring high burnout in all three.

**US Senate supports AIDS programme:** The US Senate has reauthorised funding for an international AIDS effort—the President’s Emergency Plan for AIDS Relief—overcoming strong opposition from conservatives who wanted to scale back the proposed increase and impose tighter ideological controls. The programme lifts travel restrictions on visas and immigration for those who are HIV positive.

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**Joint guidelines call for speedier assessment of patients with stroke**

**Henry Creagh LONDON**

All patients suspected of having had a stroke should be admitted as quickly as possible to an acute stroke unit and, if appropriate, given thrombolytic treatment, say new guidelines for the United Kingdom.

Patients who have had transient ischaemic attacks (“mini-strokes”) should no longer have to face the risk of having a full acute stroke while they wait, sometimes weeks, for assessment, the guidelines state.

Two sets of guidelines were launched on Wednesday 23 July, one from the Royal College of Physicians and the other from the National Institute for Health and Clinical Excellence (NICE). Both documents highlight the fact that one in 10 deaths in the UK are caused by stroke and that every year an estimated 150,000 people have a stroke. Stroke is the third largest cause of disability, with 250,000 people living with severe disabilities resulting from the condition.

The NICE guideline (soon to be summarised in the *BMJ*) covers the acute stage of stroke and transient ischaemic attacks and quotes evidence that the speed of diagnosis and treatment can have a huge effect on patients’ outcomes. It says that patients whose transient ischaemic attack is diagnosed quickly are much less likely to go on to have a full stroke. All patients should undergo the face, arm, speech test (FAST), it says, and patients with acute stroke should be taken to a specialist hospital unit that has computed tomography available at all times.

The Royal College of Physicians’ guideline, which is the third edition of the national clinical guideline for stroke, incorporates the NICE guideline and also covers recovery, rehabilitation, secondary prevention, and long term care. It contains 21 main recommendations, one of which is that hospitals that accept acute stroke patients should have specialist units to care for them.

These units should have specially trained staff who can deliver thrombolysis, nursing staff who are trained in managing acute stroke, imaging and laboratory services, and specialist rehabilitation staff. Patients who are not suitable for transfer home should be treated in a specialist rehabilitation unit, the guideline says, and patients who have been discharged home should also have access to rehabilitation services.

Tony Rudd, chairman of NICE’s Guideline Development Group and joint chairman of the Intercollegiate Stroke Working Party, said, “At last the impact of stroke is being recognised, and politicians and clinicians are accepting that stroke is a treatable disease.”

He said a lot of work was needed in a “radical restructuring of the health service” but that this process was already under way in England after the Department of Health’s publication of its national stroke strategy last year.


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**Watchdog says councils are unprepared**

**Adrian O’Dowd MARGATE**

More falls prevention schemes should be adopted as part of the effort to prepare for an ageing population in England, says the public service watchdog.

Most councils are ill prepared to meet the challenges or grasp the opportunities for a population that is ageing, said the Audit Commission in its report published this week.

This large scale study involved interviews and assessments of documentary evidence from local authorities, interviews with 235 people at councils, a mystery shopper survey of 49 councils conducted by four older researchers, and 15 focus groups with 175 older people in 10 areas.

The research team found that only a third of councils are well prepared for an ageing population, although another third are making progress.

The government’s 2005 strategy for older people, Opportunity Age, designed to improve the...
End of life strategy offers home based nursing care 24 hours a day for dying patients

Susan Mayor LONDON

All NHS trusts in England must provide rapid response community nurses and palliative care outreach services round the clock to enable people who want to die at home to receive the care they need, a 10 year strategy review from the Department of Health recommended this week.

The strategy—the first of its kind—sets out the new services, changes to existing services, and training and standards required to improve care for adults approaching the end of their lives. It aims to increase the number of people able to die in their own homes. Surveys of the general public show that between half and three quarters of people would prefer to die at home, but only about 18% currently do so.

Alan Johnson, the secretary of state for health, said: “The strategy is aimed at transforming end of life care. The priority is to improve community services to enable all adults, regardless of their condition, to die in the setting of their choice.”

Primary care trusts will be required to work with local authorities to ensure that rapid response community nursing services are available in all areas for 24 hours a day, seven days a week. A recent pilot study of the Marie Curie Delivering Choice programme showed that provision of community link nurses to help the speedy discharge of palliative care patients and coordinate home care and the introduction of a community based rapid response nursing team increased the number of people able to die at home (BMJ 2008;336:912-3).

The new strategy recommends a whole systems approach for planning and commissioning end of life care, based on a care pathway approach. This will include improved strategies for identifying people approaching the end of life and initiating discussions about preferences for end of life care. It will also require care planning based on assessment of individual needs, coordination of the care provided, and delivery of high quality services in all locations where people may choose to die.

Greater openness about death and dying and improved communication skills are needed to put the recommendations into action, the strategy acknowledges. To achieve this, the Department of Health will work with the National Council for Palliative Care to develop a national coalition to raise the profile of end of life care and to change attitudes to death and dying in society. Workforce training will be introduced for health and social care staff to improve their ability to identify patients approaching the end of life and to discuss the type of care they would prefer.

Teresa Tate, consultant in palliative medicine at Barts and the London NHS Trust, medical adviser to Marie Curie Cancer Care, and a member of the strategy development group, said: “Most people want to die at home. But often this doesn’t happen because it is never discussed. One of the aims of the strategy is to generate an openness so that people can talk about death and dying.”

The strategy is supported by a budget of £286m (£358m; $568m), in addition to current funding.

The Department of Health is working with strategic health authority staff already working in end of life care to develop quality standards against which primary care trusts and care providers can be assessed on how they implement the strategy’s recommendations. See Editorial, p 185; also BMJ 2008;336:958-9. End of Life Care Strategy: Promoting High Quality Care for All Adults at the End of Life is available at www.dh.gov.uk/publications.

Cite this as: BMJ 2008;337:a871

for increasing demand from England’s ageing population

quality of their life, has had limited effect so far, says the report.

Older people—classed by the government as over 50—are a growing part of the population and will make up more than one in three of the population by 2029, and almost 40% by 2029.

Most council services, however, focus on the minority who require social care, excluding the majority who may end up isolated and vulnerable if ignored, warns the report.

Councils need to identify ways of working more closely with older people and local partners, such as NHS organisations, to make more efficient use of public and community services as well as targeting spending where it will have the biggest impact.

The report cites a successful falls prevention scheme in Dudley as a good example to follow. The comprehensive falls prevention programme, which began in 2003, is run by Dudley Primary Care Trust and Dudley Council and was born out of the realisation that falls were the principal reason for attendance at hospital.

The Dudley programme identifies risk, and looks at taking referrals from GPs, hospital staff and social care professionals, Age Concern, and directly from older people. Don’t Stop Me Now—Preparing for an Ageing Population can be seen at www.audit-commission.gov.uk.

Cite this as: BMJ 2008;337:a872
Progress cannot be made in fighting HIV epidemic

Peter Moszynski LONDON
Unless governments act to end the abuses of human rights that encourage the spread of HIV, little progress will be made in fighting the global epidemic, a coalition of AIDS and human rights organisations warned in a statement published this week.

The coalition, led by Human Rights Watch and including more than 400 other groups, called on the organisers of the International AIDS Conference, being held from 3 to 8 August in Mexico City, to make human rights a central theme.

“Ahead of the 17th International AIDS Conference, governments are still violating the rights of people living with or at high risk of HIV infection,” said José Miguel Vivanco, director for the Americas at Human Rights Watch.

“Governments have done little to fulfil their frequent promises to end HIV related rights abuses. But until they act to end such abuses, even the best planned policies to treat HIV and stop the spread of AIDS will fail,” he said.

The campaigners claim that despite commitments to address HIV related abuses of human rights, the Mexican government, though host of this year’s conference, “has fallen short in implementing these promises.”

Sex workers in Mexico have reported discrimination and violations of human rights, including physical abuse, at the hands of police, civil servants, health workers, and employers, they said.

And people with HIV, men who have sex with men, and transgendered people also experience high levels of stigma and discrimination.

The coalition pointed out that, outside Africa, nearly a third of all new HIV infections occur among injecting drug users. “Yet effective measures to reduce HIV infection, such as needle exchange programmes and medication assisted treatment with methadone, are banned by law in many countries or undermined by abusive police practices,” it says.

In prisons “the paucity of HIV prevention and effective drug treatment services only heighten HIV and other health risks. All too often a sentence of imprisonment also leads to infection with HIV and/or tuberculosis.”

Richard Elliott, director of the Canadian HIV/AIDS Legal Network, said, “It is a tragic irony that those at highest risk of HIV often receive the least attention. In many countries drug users are the majority of people living with HIV but the smallest group receiving antiretroviral treatment.”

HIV services geared towards men who have sex with men and towards sex workers are especially hampered by punitive laws. In many countries police confiscate condoms from AIDS outreach workers and use them as evidence of sex work or sodomy, the coalition warned.


Cite this as: BMJ 2008;337:a900

Human and animal agencies must work to prevent spread of infections

Roger Dobson ABERGAVENNY
Agencies that deal with human and animal health worldwide need to cooperate more, says a new parliamentary report, which warns that three quarters of newly emerging infections in humans come from animals.

It also wants the UK government to press for better surveillance of threats around the world that involve animal diseases, with a reporting system similar to that for monitoring diseases in humans.

The report says that with a new and potentially deadly infectious disease emerging somewhere in the world every year, more investment in international surveillance is vital if pandemics are to be avoided.

The report, from the House of Lords Intergovernmental Organisations Committee, comes after a six month inquiry that looked at the effectiveness of intergovernmental efforts to control the spread of infectious diseases around the world.

“The last 100 years have seen great advances in public health and disease control throughout the world, but globalisation and changes in lifestyles are giving rise to new infections and providing opportunities for them to spread rapidly,” said Clive Soley, chairman of the committee.

“It is vital that there is sufficient surveillance of disease outbreaks to limit their spread,” added Lord Soley. “We were particularly concerned about the link with animal health. Three quarters of new human infectious diseases start in animals. We urgently need better surveillance systems to deal with this problem.”

The report says that international arrangements for detecting outbreaks of infectious disease in animals are separate from those for human diseases and less comprehensive. Very often, it says, animal diseases are identified only after they have jumped the species barrier to infect humans.

“In the case of, say, a pandemic of avian influenza the time gained through detecting—or lost through failing to detect—the emergence of a virulent strain of the virus in poultry before it has had the chance to infect humans could make all the difference in averting a global disaster,” says the report.

The committee recommends that the UK government press for a new event reporting system similar to that of the new international health regulations for human health, which was adopted by member states of the World Health Organization in 2005 and which came into force in June last year.

The report also recommends that the government urgently consider how greater priority can be given to systems of infectious disease surveillance and response in developing nations.

The committee calls too for a shift in international health spending, from efforts targeted at a particular disease towards those that encourage more investment in health services in developing countries.

Diseases Know No Frontiers: How Effective are Intergovernmental Organisations in Controlling their Spread? is available at www.parliament.uk.

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Senator asks US psychiatrists’ group about drug company funding

Janice Hopkins Tanne | NEW YORK
A leading member of the US Senate has asked the American Psychiatric Association to account for money it has received from drug companies.

Leading psychiatrists have previously been criticised by Charles Grassley, a Republican senator from Iowa, because of incidents of incomplete disclosure of funding (BMJ 2008;336:1327, 14 Jun). Senator Grassley said in a letter to the association, “It is alleged that pharmaceutical companies give money to non-profits in an attempt to garner favor in ways that increase sales of their products.”

The senator is the leading Republican member of the Senate’s Committee on Finance, which oversees medical care for 80 million Americans who are covered by the government health insurance programmes Medicare, for people over 65, and Medicaid, for people on low incomes.

He asked the association, which represents 38 000 psychiatrists, to provide him with “an accounting of industry funding that pharmaceutical companies and/or the foundations established by these companies have provided” to the association. Funding, Senator Grassley said, included grants, donations, and sponsorship of meetings and programmes.

He asked for the information to be received by 24 July 2008. He also asked the association to describe its policies for accepting industry funding and to explain what, if any, restrictions the association allowed.

Nada Stotland, president of the association, said that the association was assembling the requested material “in a timely manner.” She said that her organisation was a leader in regard to disclosure and “supports full transparency and disclosure of relationships between medicine and industry.”

As an example, she said that doctors working on its task force to update the manual of psychiatric disorders were required to disclose significant financial relationships with companies that had an interest in psychiatric diagnoses and treatments.

Senator Grassley’s letter is available at http://finance.senate.gov/sitepages/grassley.htm
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Three jailed for selling phoney drug to cancer patients in Germany

Annette Tuffs | HEIDELBERG
A court in the central German town Kassel has sentenced three men to jail for fraud because in 2000-1 they sold and administered a food supplement, which they claimed was a cure for cancer, to more than 150 terminally ill cancer patients. All the patients subsequently died.

The verdict was given this week after a 16 month trial.

A doctor, a businessman, and a journalist had persuaded dying people that a Russian food supplement, Galavit, was able to stop their cancer. Patients had to pay about €8500 (£6800; $13 500) for the treatment course, which was administered in a rented ward of a rehabilitation hospital near Kassel in Bad Karlshafen.

The 64 year old businessman Falko Dahms who organised the operation was sentenced to seven years, the medical doctor Eike Rauchfuss who administered the treatment was given five years eight months, and the journalist who published the false news of the “wonder drug” was sentenced to three years.

Two other businessmen members of the group were given suspended jail terms and heavy fines. The defence lawyers claimed that there was no proof of the ineffectiveness of Galavit and had demanded an acquittal. After the sentence they announced that they would appeal.

At the end of a 16 month trial the court concluded that it was sure that Galavit did not cure cancer, even if the drug’s lack of efficacy could be scientifically proved only by clinical trials. The accused men must have known that Galavit would not work, the judge said, and had a duty to tell the patients, but they had encouraged false hopes among the dying, which was “especially odious.”

Excitement over Galavit began in the West in 2000, when the convicted Falko Dahms set up a “health institute,” marketing Galavit as a secret discovery by Russian space scientists. It had allegedly been used to treat successfully 300 cosmonauts and thousands of Russian cancer patients. Stories were spread in the popular press and on television shows.

Cite this as: BMJ 2008;337:a875
German genetics society condemns doctors who took part in eugenics programme in Nazi era

Ned Stafford HAMBURG

On the 75th anniversary of Nazi Germany’s approval of the “Prevention of Progeny with Hereditary Diseases Act,” the German Society of Human Genetics has strongly condemned eugenics, a philosophy advocating improvement of human hereditary traits by intervention.

The statement, issued in both German and English at the 20th International Congress of Genetics in Berlin, also acknowledges that “German physicians, geneticists, and other scientists were actively involved in preparing the contents of the law, formulating its pseudoscientific basis, and implementing its compulsory measures.” The law was approved on 14 July 1933, months after Adolf Hitler took power.

In an interview with the BMJ, society chairman André Reis said that issuing the statement in Berlin, where Nazi policies were planned and coordinated, and reading it before a distinguished group of geneticists from around the world was not an accident.

“This statement is not just for Germans, but for an international audience,” said Dr Reis, head of the Institute of Human Genetics at the University of Erlangen-Nuremberg. “Some people think things have not changed in Germany.”

Charles H Langley, cochairman of the international programme committee of the congress, said that the strongly worded statement marking the 75th anniversary of the Nazi law was an important moment for Germany and the international genetics community. Noting that most in attendance were born after the second world war, Langley, a professor at the University of California-Davis, said: “I think the foreigners here heard the words and were reminded of historic events.”

This year’s international genetics congress was the first to be held in Germany since before the Nazi era. “That was in 1927,” he said. “The congress was held here in Berlin because Germany was a centre of genetics research.” After the second world war, the German genetic community was ostracised by the global community because of the Nazi collaboration, he said.

A new generation of German geneticists was reaching out to the international community during the 1980s and 1990s, he said, adding that the decision to return the congress to Berlin signals full acceptance of German genetics by the international community. Some 400000 people were forcibly sterilised by the Nazis, says the Human Genetics Society.


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European Commission proposes moves to increase tax on cigarettes and reduce influence of tobacco industry

Rory Watson BRUSSELS

The European Commission has proposed increasing the minimum rate of excise duty on cigarettes by 50% as part of its wider public health strategy of discouraging smoking in the 27 member bloc.

Announcing the initiative this week, Laszlo Kovacs, the taxation commissioner, said: “Today’s proposal supports the EU policy to reduce tobacco consumption and narrow the differences in price levels of tobacco products within the EU.”

He quoted the World Bank, which maintains that price increases in tobacco products are the most effective way of preventing smoking, especially among young people. The commission pointed out that a 10% price increase could reduce cigarette consumption in high income countries by 4% on average.

Under the proposal, the current minimum
WHO returns to face major problems with displaced Iraqis

John Zarocostas GENEVA

The World Health Organization announced on Thursday 17 July that in late June it had re-established, after a five year absence, a permanent international staff in Iraq to help the country meet urgent humanitarian needs and to strengthen its fragile healthcare system.

International personnel of United Nations agencies left Iraq after a suicide attack at the UN’s Iraq headquarters in Baghdad in August 2003 left 22 dead and 150 wounded.

“WHO will intensify its recovery and relief assistance to Iraq and help its people obtain the health care they deserve,” said Eric Laroche, WHO’s chief for health action in crises.

Two of the agency’s international staff recently went back to Iraq, and there are plans to increase this number to about 10 by the end of this year, WHO officials said.

“Our day to day dealings with the government and other health partners will be vastly improved by having a permanent international presence here,” said WHO’s country representative for Iraq, Naeema Al-Gasseer.

She said that a key priority for the agency is to avoid a cholera and typhoid outbreak again this summer, and she noted that a very robust surveillance system is now in place that monitors both population and water quality.

“This is our immediate, urgent priority; and our focus, again, is the internally displaced, the vulnerable, because they are the ones at highest risk,” Dr Al-Gasseer said.

A mid-year report on Iraq by the International Organization for Migration said that better security has slowed the level of new displacements of people to a trickle but notes that 2.8 million internally displaced Iraqis “continue to face dire living conditions, with mediocre access to shelter, food, health care, water, and other basic services.”

“Hypertension, heart disease, diabetes, skin and intestinal infections, and anaemia, along with ailments due to malnutrition, are rife, with women and children particularly vulnerable to them,” the report says. "Iraq Displacement & Return: 2008 Mid-Year Review is available at www.iom.int."

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Iraqi children clean a bucket of water at a polluted pond in a camp for displaced people, Najaf

describes “hell on earth” following rape and assault in Darfur

than the increasing number of war related wounds she encountered while working in the rudimentary emergency department of a regional hospital. But then a local girls’ school was attacked by the Janjaweed militia, and her life was changed for ever.

Nothing had prepared her for the brutality and inhumanity she encountered, nor for the mass rape of schoolchildren. “I couldn’t understand how a true human being could do something like this to children. And I couldn’t explain to them why this had happened. They were just young children.”

She supplied details of the attack to aid workers and journalists investigating the incident, which led to her arrest. She was bound, dragged to the outskirts of the village, and gang raped. Her captors told her it was a lesson in what rape really meant. They said that if she wanted to complain to outsiders she should experience it first hand so she would be qualified to “go and tell the foreigners about rape.”

She eventually escaped from Darfur and was able to secure passage to the United Kingdom by selling her family jewellery.

She has found the strength to speak out through weekly sessions at the Medical Foundation for the Care of Victims of Torture and then worked with the campaigning groups Waging Peace and the Aegis Trust. She also spoke of her own experiences in dealing with the British immigration system.

Although the UK authorities didn’t dispute her story or her well documented physical and psychological scars, her application for asylum was initially refused on the grounds that it was safe for Darfuris like her to return to Khartoum.

“[I just couldn’t believe it]” she told the BMJ. “They agreed that I had been horribly abused but said that I would be safe in the capital. Fortunately everyone now realises that this was not merely the work of uneducated Arab militias; they were acting on government orders.”

Dr Bashir appealed for British doctors to join her in rebuilding Darfur if and when peace returns to the region. “Now that I have asylum I hope to be able to work in the UK, but if the crisis stops we’ll need a massive effort to rehabilitate the area—so if peace comes I want to return to Sudan. I will finally find myself when I am working for my people.

“Before the war one of the biggest problems faced by our people in Darfur was lack of services. Now they all live in displaced camps and everything is provided. It will be very difficult to persuade them to leave.”

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excise duty of €64 (£51, $100) per 1000 cigarettes would rise to €90 by 2014. The increase would not lead to any changes in the United Kingdom, which already has the most expensive cigarettes in Europe—a packet of 20 cigarettes costs €8.12. Nor would the increase affect Ireland, where a packet of 20 cigarettes costs €7.45, or France (€5.30), or Germany (€4.71).

But the effect would be considerable among the European Union’s central and eastern European members, where a packet of 20 cigarettes often costs less than €2. The commission estimates that in Poland the 47% price increase that would result could cut consumption by one fifth.

By presenting the proposal, the commission is taking a calculated gamble because any changes to the existing rules, which go back some 30 years, must be agreed unanimously by all 27 EU governments, some of which dislike Brussels’ interference in fiscal matters.

But Kovacs is hoping that the prospect of continued high tax revenues coupled with a fall in the public health costs of tobacco related diseases may be a sufficient incentive to win the governments’ support.

Measures are also being put in place to implement the Framework Convention on Tobacco Control—the world’s first international public health treaty.

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