Government needs to “grasp the nettle” and close hospitals

Ingrid Torjesen LONDON
Around 20 hospitals in England need to close because they are a financial drain on the NHS and will hamper efforts to improve the overall quality and safety of NHS care, health leaders are arguing.

The government is coming under mounting pressure to “grasp the nettle” and not stand in the way of reconfigurations requiring hospital closures for financial and clinical reasons.

Peter Carter, chief executive of the Royal College of Nursing, said at a meeting of the think tank Reform on 15 June that the government needed to end the political taboo of hospital closures and to be prepared to shut down or merge poorly performing hospitals.

The Daily Telegraph reported him as saying, “In our metropolitan areas we have far too many acute hospitals. That’s a drain on the system and it has got to change” (www.telegraph.co.uk, 17 Jun, “Failing hospitals should close, says nurses’ union leader”).

His comments were backed by Chris Ham, chief executive of the healthcare think tank the King’s Fund, in an article in The Observer (http://observer.guardian.co.uk, 19 Jun, “Politicians have ducked all these issues for far too long”).

Professor Ham wrote that the move towards providing more care closer to patients’ homes and concentrating some specialist services in fewer hospitals meant that some services could not be sustained. “Up to 20 hospitals, around 10% of the total in England, may not be financially sustainable and will have to be merged or taken over.

“Governments have ducked these issues for too long, while MPs have ignored clinical and financial evidence to keep local hospitals open. It is time for politicians to grasp the nettle.”

Professor Ham said that the existing process for reconfiguring services was “not fit for purpose.”

The secretary of state for health is the final arbiter of the Independent Reconfiguration Panel (IRP), “The time has come to distance politicians from these decisions. Giving the IRP responsibility would avoid delays and ensure they are taken on clinical and financial grounds rather than for political reasons.”

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Access to stroke prevention surgery varies widely in UK

Ingrid Torjesen LONDON
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Jacqui Wise LONDON
Some patients who need carotid endarterectomy undergo it within two days of symptoms, while others wait almost two months, an audit by the Royal College of Physicians and the Vascular Society has found.

Surgeons say that government stroke targets will not be met unless transient ischaemic attack (TIA) is routinely recognised as an emergency needing a rapid response, and the National Institute for Health and Clinical Excellence has set a target of two weeks from symptoms to treatment. The audit found that only 40% of NHS patients are operated on within that timeframe, up from 33% the previous year.

The government’s national stroke strategy has set a target of 48 hours from symptoms to surgery to be achieved by 2017, and David Mitchell, chairman of the Vascular Society’s audit committee, warned that achieving this will be a major challenge, as those standards are met for only 2% of NHS patients. “The clinical community needs to collectively redouble its efforts and refine the pathway of care,” he said.

The third report of the carotid endarterectomy audit shows that time to stroke prevention surgery has been cut. The median number of days from symptoms to surgery was 21 in the latest report, an improvement on 28 the previous year. Of those patients who did not meet the 14 day timeframe, the reasons cited were failure to call 999, go to a hospital accident and emergency department, or visit a GP (25% of patients); a delay in referral to specialist stroke centres or TIA clinics (41%); a lack of vital carotid imaging equipment (13%); and limited availability of staff or operating theatre time (17%).

For the first time the data are presented by individual NHS trusts, and these show considerable variation in performance across the UK. In some trusts 80% of patients are operated on within the two week timeframe recommended by NICE, whereas in others the figure is zero. In the future, data will be presented for individual surgeons.

Mr Mitchell said, “Setting realistic targets is essential if we are to improve care for patients with TIA.”

He added: “We know that if patients do not receive surgery within 48 hours, it reduces the likelihood of death or disability. The audit shows that the target of 48 hours is justifiable and achievable.”

Cite this as: BMJ 2011;342:d3882
“Serious neglect” is found in home care of elderly people

The Equality and Human Rights Commission says that the care of elderly people in their own homes is so poor that it breaches basic human rights.

In gathering the evidence for the inquiry the commission surveyed NHS local authorities, primary care trusts, and private sector providers of home care. Some 54% of local authorities completed the survey, along with 250 home care providers, and the commission received 503 written submissions from individuals, organisations, and care staff.

The commission uncovered many examples of soiled beds or clothing for a long time or failing to ensure that an older person is able to eat or drink is serious neglect and should be treated as such.

“Providing personal care for older people should not be about completing tasks in whatever is the quickest or cheapest way . . . Despite commitments made by both the previous and current government, soiled beds or clothing for a long time or failing to ensure that an older person is able to eat or drink is serious neglect and should be treated as such.

“Providing personal care for older people should be about completing tasks in whatever is the quickest or cheapest way.”

Alcohol consumption limits should be lowered for over 65s

Government guidelines on safe limits for drinking should be lowered for people aged over 65 years to 1.5 units a day for men and 1 unit a day for women, the Royal College of Psychiatrists recommends.

“Our Invisible Addicts”, written by the college’s working group on older people’s substance misuse, says that physiological and metabolic changes associated with ageing mean that the current safe limits are too high for elderly people. It says that binge drinking should be defined for this age group as more than 4.5 units in a single session for men and more than 3 units for women.

Launching the report, Tony Rao, consultant in old age psychiatry at South London and Maudsley NHS Foundation Trust, said, “For a given volume of alcohol, the rate it is got rid of from the bloodstream is a lot lower in older people. Also older people tend to have a range of other health problems and may be taking many other prescription medicines that interact with alcohol.”

Illana Crome, professor of addiction psychiatry and chairwoman of the working group, said, “Forty percent of NHS dispensed prescriptions are to the over 65s. It doesn’t take much alcohol on top of prescribed benzodiazepines to make someone confused and wobbly and then have a fall. They then end up in hospital with a fractured femur.”

Professor Crome said that a lack of awareness means that GPs and other healthcare profession-
basic rights to dignity, respect, and autonomy are still being breached.

“The biggest threat to the human rights of older people receiving care at home is from cuts to adult social care budgets, and it is very unclear whether tightening eligibility criteria to care will allow local authorities to continue to meet their human rights obligations.”

Sally Greengross, a commissioner at the Equality and Human Rights Commission, said, “Against a backdrop of budget cuts and public sector reform, local authorities are playing an ever decreasing role as direct providers or funders of care and support, with the majority of older people receiving care from private and voluntary sector organisations or individuals. The complex web of provision has left older people and their families unclear whether and how their human rights will be protected. Equally we believe that those providing, commissioning, or regulating care are unclear of their legal responsibilities and how to discharge them.”

Cite this as: BMJ 2011;342:d3904

NICE will retain drug approval role in government U turn

Ingrid Torjesen LONDON

GP's in commissioning groups in England will not have to make decisions on whether individual drugs are cost effective and whether they should be available on the NHS, after an apparent U turn by the government on its plans to downgrade the role of the National Institute for Health and Clinical Excellence (NICE) in recommending drugs.

Under the health secretary’s original plans, laid down in the draft Health and Social Care Bill, NICE would still have appraised new products but would no longer make a recommendation as to whether they should be funded by the NHS. Instead the government planned to introduce value based pricing in 2014 and negotiate the price that the NHS pays for drugs on the basis of the evidence on their therapeutic benefits.

Individual GP commissioning consortiums (or clinical commissioning groups as they are now to be called) would have then had to decide whether drugs were sufficiently cost effective to be used and should be funded locally. GPs would have, in effect, then been responsible for rationing treatments, rather than NICE, a prospect that many were unhappy with.

Under the current system, the pharmaceutical price regulation system (PPRS), the government negotiates with the drug industry every five years and allows drug companies to set drug prices freely but caps their overall profits. This system has operated for 50 years.

Although the role of NICE has been reconsidered, value based pricing will still go ahead. The government’s response to the NHS Future Forum listening exercise, published last week (BMJ 2011;342:d3777), states that it will uphold all patient rights in the NHS Constitution, including “the right to drugs and treatments recommended by NICE, which we will retain after the introduction of value-based pricing for new drugs from January 2014.”

The Department of Health for England was unable to provide specific details of how a drug will be evaluated, approved, and priced for the NHS after 2014, saying that final details are still being worked out.

Andrew Dillon, NICE’s chief executive, said, “We are pleased to see that NICE will continue to play a key role in helping to ensure that patients receive the best possible care on the NHS.”

Laurence Buckman, chairman of the BMA’s General Practitioners Committee, said that central decision making on whether a drug should be available on the NHS was much better than allowing clinical commissioning groups to each make their own decision.

He added, “It means that you will get consistent prescribing across England, and that is important. It means that you will stop the concept that we have been very worried about of internal health tourism, where people travel between consortia in order to get one that will give them what they want.

“This way—and may I say this is my interpretation—all consortia will have to make available medications that NICE recommends, and that must be a good thing.”

Cite this as: BMJ 2011;342:d3862

Andrew Dillon: “We are pleased to see that NICE will continue to play a key role”
Misprescribing is widespread among German doctors

Ned Stafford HAMBURG

German doctors often overprescribe or misprescribe drugs, says a new report commissioned by one of Germany’s largest public health insurers.

The annual pharmaceuticals report by Barmer GEK concludes that German doctors often prescribe highly addictive sleeping pills, antipsychotics to people with Alzheimer’s disease, and so-called third generation contraceptive pills instead of second generation pills, which the report says are safer.

Gerd Glaeske, of the Centre for Social Policy Research at the University of Bremen and the report’s main author, told the BMJ that the report is the only one in Germany to compare drug prescriptions with doctors’ diagnoses. It is based on prescriptions and diagnoses of nearly nine million people insured through Barmer—about 13% of Germany’s insured population.

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The report also broke down how the nearly €4bn (£3.5bn; $5.7bn) spent in 2010 by Barmer for drugs was allocated. It found that 30% of drug spending goes on just 0.8% of the insured population, 50% on 3.2%, and 80% on 15.2%.

“We have a huge asymmetry in our health system,” Professor Glaeske said. “Only a few account for much of the cost.”

On the basis of the data the report estimates that 14% of Germany’s alcoholic people are prescribed benzodiazepines, sedatives often used to treat insomnia or anxiety. Some people are first prescribed the drug while being treated for alcoholism in a clinic, while others receive prescriptions as outpatients. When asked why doctors would prescribe the drug to alcoholic patients, Professor Glaeske said, “I really don’t know. Maybe they are not aware of the danger and do not know about the addictive potential.”

The data also show that one in three people with Alzheimer’s disease are prescribed antipsychotics, meaning that patients with the disease are about six times as likely to be prescribed antipsychotics as the rest of the population. The report says that the death rate of people taking antipsychotics can be as much as 1.7 times that of people who don’t take them.

Antipsychotics are increasingly being used in understaffed German nursing homes “to keep patients quiet and from wandering around,” Professor Glaeske claims. “From my point of view, this is a misuse of antipsychotics. I call it violence against the elderly.”

The study found that of the 20 top prescribed contraceptive pills in Germany, eight are third generation pills that can increase the risk of thromboembolism in comparison with second generation pills, said Professor Glaeske. He noted that key studies comparing third generation pills that contain drospirenone with second generation pills containing levonorgestrel had been published recently in the BMJ (2011;342:d139).

The report says that three to five women per 100 000 who don’t take contraceptive pills are at risk of developing thromboembolism, a proportion that rises to 20 per 100 000 among women taking second generation pills and 30-40 per 100 000 taking third generation pills.

“The second generation pills are much safer, much better,” he said, adding that doctors seem to be influencing by drug companies’ marketing strategies to prescribe third generation pills.

Barmer GEK’s report (in German) is at www.barmer-gek.de.

New Zealand agency is under threat in trade talks

Ray Moynihan BYRON BAY

The United States is using a fresh round of talks on free trade to try to water down New Zealand’s tough approach to negotiating low prices with drug companies.

The talks are part of the proposed Trans-Pacific Partnership agreement, which will involve nine countries in the Asia Pacific region, including the United States, New Zealand, and Australia, and will cover trade in intellectual property, pharmaceuticals, and other commodities.

The prices that the New Zealand government pays for drugs are among the lowest in the developed world, and the drug industry, much of which is based in the US, is using the trade talks to push for reforms in how those prices are set.

Last month a group of 28 US senators wrote to President Barack Obama urging him to protect US companies’ interests during the current trade talks, specifically mentioning the drug industry. The senators’ letter argued that the US biopharmaceutical industry would gain little if, in foreign countries, “the authorities responsible for pricing and reimbursement are able to set the terms of sale through arbitrary and non-transparent means.”

Although the letter didn’t name New Zealand, the senators were understood to be making a direct reference to the country’s drug purchasing authority, Pharmac, which has developed an international reputation for negotiating low price deals (BMJ 2010;340:c2441).

Created almost 20 years ago, the publicly owned Pharmac has to purchase drugs for the national formulary within a tightly capped budget rather than an open ended funding system of the type that other nations use. Central to its ability to stay within budget is the agency’s right to say no, to walk away from negotiations if a drug price is too high, and to substitute another product.

Medicines New Zealand, the body representing the industry, argues that it wants more transparency in the process and clear guidelines on how Pharmac makes its decisions.

The general manager of Medicines New Zealand, Kevin Sheehy, told the BMJ that companies also want to see the internal cost-benefit analyses of their drugs that Pharmac compiles and would like the opportunity to present their case directly to the influential committee of experts that advises the agency.

Pharmac’s chief executive, Matthew Brougham, told the BMJ that drug companies already had “unfettered access” to his organisation’s staff and that he didn’t see any value in allowing companies to present directly to the advisory committee. As to the demand to see Pharmac’s internal cost-benefit analyses, he said that they were already available.

Although Pharmac is unable to comment on how the trade negotiations may affect its work, Mr Brougham said that his organisation’s ability to choose which drugs to purchase was the key to staying within budget. “Any rules or regulations which undermine our ability to choose reduce our ability to negotiate even handedly with industry,” he said.
NICE recommends same day surgery for hip fracture patients

Susan Mayor LONDON

Patients with hip fracture should have surgery the same day or the day after hospital admission and undergo a coordinated programme to prevent long term disability and complications, recommends guidance from the National Institute for Health and Clinical Excellence.

Current outcomes for the 70,000 to 75,000 people each year in the United Kingdom who have a hip fracture are poor, with about 10% dying within one month and one third dying within 12 months of the fracture. Most of these deaths are not caused by the hip fracture itself but by pre-existing illness, so the new guideline proposes measures to diagnose and treat comorbidities in addition to prompt surgery.

Some patients currently wait several days before surgery, leading to poorer outcomes. “There is very clear evidence that significant delay is counterproductive,” explained Cameron Swift, emeritus professor of healthcare of the elderly at King’s College School of Medicine, London, and chairman of the guideline development group. He added, “Outcomes can be improved—both clinically and in terms of reduced complications and length of hospital stay—by earlier surgery. The consequences for patients and the health service are far worse if hip fracture management is delayed and disjointed.”

The guideline group found that in some centres patients with hip fracture have not been given the priority they require because of negative perceptions about the risks of surgery in patients with comorbidities and about the potential for good outcomes and also because of organisational factors in terms of adding these patients to planned trauma operating lists.

To overcome these problems the guideline recommends that correctable comorbidities, such as anaemia and volume depletion, are identified and treated immediately so that surgery is not delayed. Patients needing hip fracture surgery should be scheduled on a planned trauma list, and consultants or senior staff should supervise their operations.

The occurrence of hip fracture often signals underlying ill health, so the guideline recommends that acute hospitals introduce comprehensive, ward based hip fracture programmes.

A multidisciplinary team, including orthogeriatricians, surgeons, and anaesthetists, should jointly manage a coordinated programme for hip fracture patients, says NICE. This will facilitate early surgery and prompt mobilisation and rehabilitation starting the day after surgery, with the goal of ensuring that patients are able to return to where they were living before their fracture. Many patients with hip fracture fail to regain their previous level of mobility and have to go into long term residential care.

“The guideline aims to streamline the management of hip fracture and make acute hospitals more older patient friendly,” said Professor Swift. “Prompt surgery and a coordinated hip fracture programme for each patient from the moment they arrive at hospital through to rehabilitation and discharge will deliver better quality care and a more efficient service.”

NICE’s guidance on management of hip fracture in adults is at www.nice.org.uk/guidance/cg124.

See PRACTICE, p 1413.

Cite this as: BMJ 2011;342:d3905

US “Bad Ad” campaign results in just five warning letters in its first year of operation

Jeanne Lenzer NEW YORK

A scheme to reduce false and misleading advertising by drug manufacturers is drawing praise and criticism.

In May 2010, the US Food and Drug Administration’s Center for Drug Evaluation and Research launched a “Bad Ad” programme with the goal of “encouraging health care professionals to recognize and report suspected untruthful or misleading drug promotions.”

During the first year of the programme’s operation, the number of reports received by FDA tripled from an average of 104 reports per year to 328 reports. Healthcare professionals submitted 188 reports, consumers submitted 116, and 24 came from individuals working for industry.

To date, the agency has issued five warning letters asking companies to stop making their false or misleading claims.

The drugs were advertised in direct mailings to healthcare providers, on websites, and on YouTube videos. False or misleading advertisements included claims that a topical steroid for children with eczema would not cause adrenal-axis suppression (Derma-Smooth/FS Body Oil, fluocinolone acetonide 0.01%, Hill Dermaceuticals); claims that a product could treat or cure migraines, arthritis, hangovers, prostate cancer, and high cholesterol (Cell Pro 7, Cellular Rx); and the “omission and minimization of risk information” about a product used to treat hepatitis C (Infergan, interferon alfacon-1, Three Rivers Pharmaceuticals).

The FDA said the measure of the programme’s effectiveness is not the number of warnings issued by the agency but “to raise awareness in the medical community of misleading promotion.”

Peter Pitts, president of the Center for Medicine in the Public Interest, wrote in the online magazine Medical Progress Today that “FDA’s ‘Bad Ad Program’ is a bad idea . . . An already overworked and understaffed [agency] simply does not have the bandwidth to actively pursue leads.”

Cite this as: BMJ 2011;342:d3821

A group of 28 US senators wrote to President Obama urging him to protect drug companies’ interests during the current trade talks

News

1385
Number of midwives is critically low in many poor countries, study shows

Peter Moszynski LONDON

Up to 3.6 million deaths would be avoided each year if midwifery services in 58 developing countries were upgraded by 2015, says the United Nations Population Fund.

Each year some 358,000 women die in pregnancy or while giving birth, two million newborns die within the first 24 hours, and there are 2.6 million stillbirths because of “inadequate or insufficient healthcare,” says a report launched by the fund at this week’s triennial congress of the International Confederation of Midwives in Durban, South Africa.

Most of these countries were “suffering from a crisis in human resources for health,” the report says. Women in these countries gave birth to 81 million babies in 2009, 58% of the world’s total.

The “inequitable state of the world” is evident in the “disproportionate number of deaths in these countries: 91% of the global burden of maternal mortality, 80% of stillbirths and 82% of newborn mortality,” says the report. These figures “partly reflect the distribution of the global workforce: less than 17% of the world’s skilled birth attendants” are in the 58 countries, which have about 40% of the world’s population (just under three billion of the world’s nearly seven billion population).

It warns that unless an additional 112,000 midwives are trained, deployed, and retained in supportive environments, 38 of the 58 countries surveyed might not meet their target to achieve 95% coverage of births by skilled attendants by 2015, as required by the United Nations’ millennium development goal on maternal health. The world is short of 35,000 midwives.

Of these 38 countries 22 need to double the midwifery workforce by 2015; seven need to triple or quadruple it; and nine—Cameroon, Chad, Ethiopia, Guinea, Haiti, Niger, Sierra Leone, Somalia, and Sudan—need to “dramatically scale up midwifery by a factor of between 6 and 15.”

If adequate facilities were available so that complications could be dealt with at their onset, many deaths could be averted: 61% of all maternal deaths, 49% of stillbirths, and 60% of newborn deaths. The report further says that if midwives were in place and could refer women with the most severe complications to specialised care, up to 90% of maternal deaths could be prevented.

Babatunde Osotimehin, executive director of the United Nations Population Fund, said, “The report points to an urgent need to train more health workers with midwifery skills and ensure equitable access to their lifesaving services in communities to improve the health of women and children.”


Cite this as: BMJ 2011;342:d3881

Chinese children with lead poisoning are routinely denied testing and treatment

Jane Parry HONG KONG

Children with dangerously high blood levels of lead from industrial pollution are routinely denied testing and treatment, and their family members and journalists reporting on cases are intimidated and harassed, says a report by US based Human Rights Watch.

The report, My Children Have Been Poisoned, is based on interviews with 52 parents and grandparents of children with lead poisoning in villages where there are smelters or other polluting industrial facilities in four Chinese provinces—Henan, Hunan, Shaanxi, and Yunnan, with additional research in Shanghai and Beijing.

Parents reported inconsistencies in test results. Blood tests conducted locally and paid for by local governments produced normal blood lead levels, whereas tests on the same children conducted in other towns outside the area of contamination produced results showing dangerously high levels of lead. Many of the government sponsored tests reported blood levels of 25 μg/dL or below,
Sex selection in Asia causes health problems in women

John Zarocostas GENEVA

Gender biased sex selection, widespread in many parts of Asia, has serious and profoundly debilitating effects on the mental and physical health of women, says a report by five United Nations agencies.

Selection in favour of boys “is a symptom of pervasive social, cultural, political, and economic injustices against women, and a manifest violation of women’s human rights,” it says.

“The increasing availability of technologies such as amniocentesis and ultrasonography has facilitated an increase in the occurrence of sex selection,” concludes the report, compiled by the World Health Organization, Unicef, UN Women, and other agencies.

The discovery of a female fetus, it argues, can lead to its abortion, and it claims that sex selection can also take place after birth through neglect or infanticide. Furthermore, failure to produce a boy may lead to rejection by the marital family or even death, it says. “Women may have to continue becoming pregnant until a boy is born, thus putting their health and their life at risk.”

The report points out that the biologically normal sex ratio at birth ranges from 102 to 106 male babies per 100 female babies, but sex selection favouring boys in many parts of southern, eastern, and central Asia results in a ratio as high as 130 boys for every 100 girls.

Chinese census data show that the sex ratio at birth rose from 107:100 to 120:100 between 1982 and 2005. Similarly, sample surveys in India indicate that the number of boys born per 100 girls rose from 109 in 1982-4 to 113.6 in 2003-5. Data from central Asian countries such as Azerbaijan and Georgia show similar trends.

Rupert Colville, a spokesman for the UN high commissioner for human rights, said that the “son preference” bias fuels a culture of discrimination and violence and must be dealt with urgently by all segments of government and society.

In the past 30 years five Asian countries—China, India, Nepal, Vietnam, and South Korea—have introduced restrictions on the use of technologies for sex selection purposes. These range from laws that ban the determination and disclosure of the sex of the fetus (except for medical grounds) to laws that prohibit abortion for sex selection.

However, the report says that it is difficult to implement restrictions on the use of technologies and cautions that restriction may have harmful effects for women who need such technologies and services for valid medical purposes. Efforts to limit sex selection, it adds, “should also not hamper or limit access to safe abortion services.”

The report makes recommendations for action to tackle the problem, including collection of more reliable data, guidelines on the use of medical technologies for health professionals, and policies that tackle inheritance, dowry, and other barriers.

On a brighter note the report says that in South Korea, where the sex ratio at birth rose from an estimated 109 boys per 100 girls in 1985 to 115 in 1994, there has been a recent fall to 107.

Avn Amin, technical officer at WHO’s department of reproductive health and research, told the BMJ that South Korea put together a package of measures that helped the decline. These included enforceable laws banning sexual selection and changes to labour and inheritance laws that removed impediments against women.

Preventing Gender-Biased Sex Selection is available at www.who.int/publications.

Cite this as: BMJ 2011;342:d3880

The local governments’ cut-off point for compensation. China’s Ministry of Health, the World Health Organization, and the United Nations Environment Programme all consider a blood lead level of 10 μg/dL detrimental to children’s health.

One mother in Henan told Human Rights Watch that a test paid for by the government at the local Chinese Centers for Disease Control clinic produced a result of 25.5 μg/dL. “My daughter is not well. She is really skinny, she doesn’t eat, and she doesn’t study well. I took her to the doctor in a different town a few weeks later and they did another lead test. Her result was over 40 μg/dL,” she said.

Despite the villages in the four provinces being far apart, interviewees shared similar experiences. Many reported being denied access to treatment and being told by health workers and government officials to rely on dietary changes to treat their children, including advice to give their children more milk, apples, garlic, and eggs.

Attempts to seek treatment were met by intimidation from local government officials and police. Journalists seeking information about clusters of children with lead poisoning were also forced by police to leave affected areas. Most of the children had to return to their villages where they continue to be exposed to lead from nearby smelters and industrial facilities, the report states.

The report is at www.hrw.org/node/99451.

Cite this as: BMJ 2011;342:d3814

Children in Fenxiang county are among the few who receive treatment for lead poisoning in China.