bmj.com Plan for a minimum price for alcohol in Scotland heads for defeat
UK news New UK guidelines highlight role of testosterone in sexual disorders, p 692
World news Incidence of breast cancer falls with less HRT use, Canadian study shows, p 690
For the full versions of articles in this section see bmj.com

Insider criticises FDA's decision not to withdraw rosiglitazone

Deborah Cohen BMJ

The decision of the US Food and Drug Administration to place more restrictions on GlaxoSmithKline's diabetes drug rosiglitazone (Avandia) rather than withdraw it has drawn criticism from senior officials within the agency.

In simultaneous statements last week both the FDA and the European Medicines Agency (EMA) suggested that the drug was associated with important safety concerns and that data pointed to a raised risk of cardiovascular events, such as heart attack and stroke, in patients taking rosiglitazone.

Unlike the EMA—which said that the "benefits of rosiglitazone no longer outweigh its risks" and recommended its suspension from the market in Europe—the FDA has recommended a package of measures to try to determine the safety of the drug and further restrict its use.

The US drug regulator does not have the legal means to suspend a drug, although it did not rule out removing the drug from the market at a later date. In Europe suspension means that rosiglitazone's manufacturer, GlaxoSmithKline (GSK), has scope to "provide convincing data" to identify a group of patients in whom the drug's benefits outweigh the risks.

The FDA will implement a risk evaluation and mitigation strategy. This will mean that rosiglitazone will be available to new patients only if they are unable to achieve glucose control with other drugs and are unable to take Takeda's pioglitazone (Actos), the only other drug in this class. Current users of rosiglitazone who are benefiting from the drug will be able to continue using it if they choose to do so.

REUTERS

Dr David Graham: "The FDA decision was . . . not in the best interests of patient safety and public health"

Doctors will have to attest to and document their patients' eligibility; and patients will have to review statements describing the cardiovascular safety concerns associated with this drug and acknowledge that they understand the risks.

David Graham, associate director for science and medicine at the FDA's Office of Surveillance and Epidemiology, was critical of the FDA's response. "The FDA decision was disappointing, was not in the best interests of patient safety and public health, was not evidence based, and was inherently self contradictory," he told the *BMJ*.

"By calling for a REMS [risk evaluation and mitigation strategy], with restricted distribution, FDA is implicitly stating that the health benefits of Avandia exceed its risks for patients who will receive Avandia under the REMS system. This is a demonstrably false assumption, because there are no subgroups of patients with diabetes for whom the cardiovascular and mortality risks of Avandia are not increased compared with Actos. There are also no studies that show unique meaningful health benefits with Avandia. So how could anyone conclude that the benefits exceed the risks?"

Cite this as: *BMJ* 2010;341:c5333

New rules will allow EU patients to report drug concerns directly

Rory Watson BRUSSELS

Patients will be better informed about drugs and be able to report any adverse effects directly to national authorities, after the European parliament overwhelmingly agreed new legislation on 22 September.

Under the new pharmacovigilance requirements, which will apply across the European Union, national web portals will have to be established to provide the public with information on medicinal products and any known side effects. The portals will contain assessment reports, summaries of product characteristics, information leaflets, and advice for patients on how to report any concerns they might have.

The national portals will be linked to the EU's EudraVigilance database. This will receive all pharmacovigilance information from marketing authorisation holders and national authorities. Its contents will be fully accessible to national and European regulators and, "to an appropriate extent," to healthcare professionals and the public.

Linda McAvan, the British Labour member of the European parliament who steered the legislation through the parliament, said, "It is very clear that we need to work together. With a pool of 500 million people, it is much easier and quicker to pick up an adverse reaction than when working alone at national level."

Closer scrutiny will also be given to drugs containing a new active substance. These will receive marketing authorisation but be closely scrutinised when they go on sale. They will be identified by a black symbol with the words, "This medicinal product is subject to additional monitoring."

Cite this as: *BMJ* 2010;341:c5344

NICE consults on first national guideline on ovarian cancer

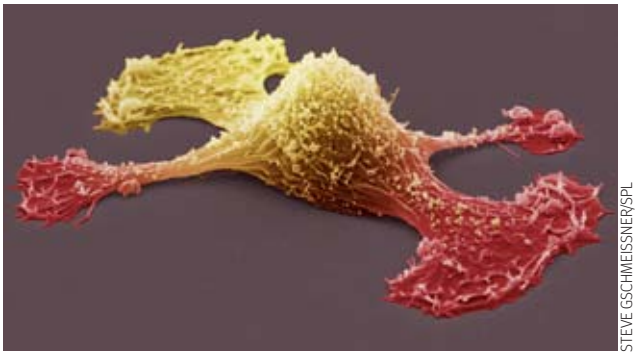
Susan Mayor LONDON

GPs should initiate tests for ovarian cancer for women with frequent and persistent abdominal symptoms to reduce the delays in diagnosis that currently contribute to poor survival, says draft guidance on the cancer for the NHS in England and Wales.

"Overall survival rates for ovarian cancer are low," said Fergus Macbeth, director of the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE), which has developed the new guideline. "Only around one in three women will live for at least five years after diagnosis. This is mainly because women who develop ovarian cancer and their GPs often only realise something may be seriously wrong when the cancer is advanced."

Women can experience delays at any of the steps from visiting their GP to seeing a specialist, getting a diagnosis, and receiving treatment, he added. "This guideline will seek to overcome these hurdles to ensure women receive a diagnosis and subsequent treatment in a more timely manner. The earlier the cancer is identified, the more likely treatment is to be successful, because it tackles the disease at a less advanced stage."

To achieve earlier diagnosis, the draft guideline, which was sent out for consultation on Friday 24 September, recommends that tests for ovarian cancer should begin in primary care for any woman (particularly those over the age of 50) who reports having frequent and persistent abdominal distension, difficulty in eating or feeling full, pelvic or abdominal pain, or increased urinary urgency or frequency.



STEVE GSCHMEISSNER/SPL

An ovarian cancer cell showing pseudopodia protrusions

The guideline recommends measuring serum concentrations of CA125 in women with symptoms that suggest ovarian cancer, as around half of all women with early stage ovarian cancer have raised concentrations of this protein. Those whose concentrations are >35 U/ml should undergo ultrasonography of the abdomen and pelvis.

When ultrasonography indicates that ovarian cancer is present, patients should then be assessed with computed tomography of the pelvis, abdomen, and thorax to establish the extent of disease.

SCIENCE SOURCE/SPL

Scientist Rosalind Franklin, who died of the disease aged 37

Magnetic resonance imaging should not be used routinely to assess women with suspected ovarian cancer, the guideline advises.

In terms of treatment, the guideline draws on the latest evidence to recommend that systematic retroperitoneal lymphadenectomy should not be included as part of standard surgery for suspected ovarian cancer in women whose disease appears to be confined to the ovaries.

Frances Reid, director of public affairs with the charity Target Ovarian Cancer and a member of the guideline development group, said, "The guidance, backed by a robust evidence base, has the potential to help GPs make informed decisions about referrals and tests using up to date knowledge."

She warned that a recent survey by the charity showed that one third of women with ovarian cancer had waited more than six months for an accurate diagnosis, underlining the need for better testing and referral.

The draft guideline, which is available for consultation until 19 November, is at www.nice.org.uk/guidance/index.jsp?action=folder&o=50894.

Cite this as: *BMJ* 2010;341:c5296

Incidence of breast cancer falls with less HRT use, Canadian study confirms

Susan Mayor LONDON

The incidence of breast cancer in postmenopausal women in Canada has fallen as their use of combined hormone replacement therapy (HRT) has decreased, shows a study published on 23 September.

The publication in 2002 of results from the Women's Health Initiative—showing that long term use of combined HRT was associated with a higher risk of breast cancer—led to major reductions in its use, followed by a decrease in the incidence of breast cancer in several countries (*BMJ* 2009;338:b2116).

The new study analysed data from several Canadian registries and a national health survey of women aged 50-69 years to see whether a similar decline had occurred in Canada (*Journal of the National Cancer Institute* doi:10.1093/jnci/djq345). The researchers looked at information on numbers of prescriptions for HRT between 2001 and 2006 and self reported use of HRT, the incidence of breast cancer, and rates of mammography. Their results showed that the period with the greatest reduction in use of HRT correlated with a major reduction in the incidence of breast cancer.

The greatest reduction in use of combined HRT in women aged 50-69 occurred between 1 January 2002 and 31 December 2004, with the percentage of women taking it falling by nearly two thirds from 12.7% to 4.9%. Over the same period the incidence of breast cancer fell by 9.6% (from 296.3 per 100 000 women in 2002 to 268 per 100 000 women in 2004). From 2000 the proportion of women in this age group who reported undergoing mammography in the preceding two years remained stable at around 72%.

The authors, led by Prithwish De, assistant professor in epidemiology at the Canadian Cancer Society, Toronto, wrote: "The results support the hypothesised link between the use of HRT and invasive breast cancer incidence and indicate that the sharp decline in breast cancer incidence in 2002 is likely explained by the concurrent decline in the use of HRT among Canadian women."

The drop in use of HRT may be explained, at least in part, by the media coverage of results of the Women's Health Initiative.

Cite this as: *BMJ* 2010;341:c5307

Increased competition threatens to undermine potential benefits of white paper, says BMA

Zosia Kmietowicz LONDON

Positive elements of the government's plans for the NHS in England—such as giving more control to patients and frontline clinicians and a stronger focus on public health—are under threat from other aspects that seek to accelerate competition in the health service, the BMA has warned.

In its response to the *Equity and Excellence: Liberating the NHS* white paper (*BMJ* 2010;341:c3796, 14 Jul) the BMA says it is interested in exploring proposals for most services to be commissioned by consortiums led by GPs.

It says it believes that successful commissioning can be achieved if other clinicians, such as hospital consultants, are also brought into the process and if the public and patients are involved. It also says that consortiums must have sufficient management and administrative support to take on the additional responsibilities.

But the BMA warns that proposals to encourage further competition in the NHS—such as extending choice to "any willing provider" and giving Monitor, the regulator of NHS foundation trusts, a duty to promote competition—risk shifting the focus onto cost rather than quality. The plans will also undermine opportunities to collaborate more across primary and secondary care, it says.

Hamish Meldrum, chairman of council at the BMA, said that although he supports some aspects of the white paper, others are "potentially damaging."

"The BMA has consistently argued that clinicians should have more autonomy to shape services for their patients, but pitting them against each other in a market based system creates waste, bureaucracy, and inefficiency. Doctors want to build on the founding principles of the NHS and to maintain and improve services, despite the hugely challenging financial climate. However, they can only succeed if they can work in partnership with others in a cooperative environment," he said.

Dr Hamish Meldrum said some proposals are "potentially damaging"

The BMA's response also questions whether the white paper's aims to reduce bureaucracy and empower clinicians could have been achieved with less disruptive structural changes, particularly given the current squeeze on resources.

In addition, it expresses serious concerns about the aim for all trusts to have foundation status by 2013-14 and questions whether there is any evidence that significant numbers of staff wish to work in social enterprises.

The BMA's response can be found at www.bma.org.uk.

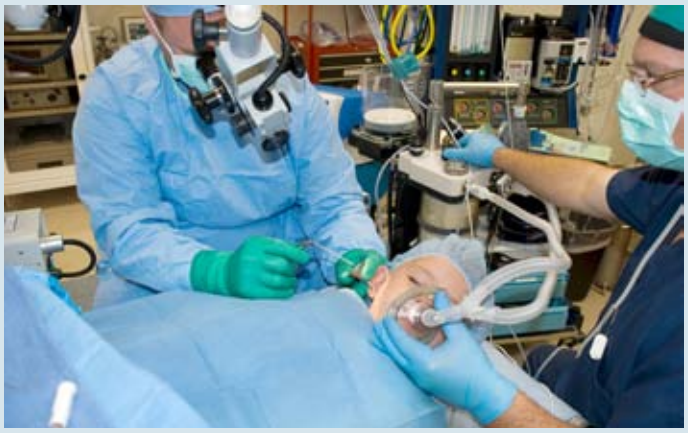
Cite this as: *BMJ* 2010;341:c5384

US insurance companies drop child only health policies

Janice Hopkins Tanne NEW YORK

Many large US health insurance companies are ceasing to offer health insurance policies that cover only children. Their action is a response to requirements of health reform legislation that came into effect last week.

The new regulations, which apply only to new policies written after 23 September, require health insurers to cover children with pre-existing conditions in their child only policies.



BUTCH MARTIN/ALAMY

Child only insurance policies are sometimes bought by parents who have lost their own insurance but want to ensure that their children are covered

The US secretary of health and human services, Kathleen Sebelius, said it was "a critical issue" that all Americans, including children, "have access to health coverage when they need it, including a prohibition on denying coverage to children because of pre-existing conditions." She said that in March America's Health Insurance Plans (AHIP), the industry group that represents health insurance companies), had committed itself "to working with us to implement this important provision."

In a letter dated 24 September to Karen Ignagni, head of AHIP, and to Scott Serota, head of the Blue Cross and Blue Shield Association, a large insurer with plans in many states, she complained: "Regrettably, it appears that some of your members are now turning a blind eye and declining to sell new child-only policies in lieu of offering coverage to children with pre-existing conditions . . . The Administration is determined that children and families receive the full benefits provided to them in the Affordable Care Act [the health reform act]."

Child only insurance policies are a small part of the health insurance market, covering perhaps 100 000 to 700 000 children. They are sometimes bought by parents who have lost their jobs and their accompanying health insurance; the parents may decide to go without health insurance themselves but wish to cover their children.

Health insurance companies are worried that parents will wait until a child is ill before purchasing health insurance and may drop the insurance after the child recovers.

The large California insurer Anthem Blue Cross, among other companies, announced that it was suspending sales of child only policies. Of the new rules it said, "While some carriers may continue to offer child-only policies, other carriers have dealt with this lack of clarity [around the new legislation] by choosing to discontinue new business sales of their child-only policies . . . Unfortunately this has created an unlevel competitive environment. As a result, Anthem Blue Cross has decided to suspend the sale of child-only policies indefinitely."

The company said that its policy would apply to all states in which it operates unless a particular state requires that child only policies be offered. Only Maine and New York do, as do Ohio and Virginia during open enrolment periods (when anyone can sign up for insurance).

Cite this as: *BMJ* 2010;341:c5378

IN BRIEF

Stronger warnings are needed on risks of alcohol: European experts in oncology, public health, and nutrition have urged doctors to give clearer messages that drinking any amount of alcohol increases the risk of cancer. Speaking at an Amsterdam conference hosted by the Dutch Institute for Alcohol Policy, they cited a growing body of research, ranging from a WHO meta-analysis to a recent paper in the US journal *Pediatrics* (2010;125:e1081-7).

Four in 10 urban US gay men don't know their HIV status: A fifth of gay or bisexual men in major US cities are infected with HIV, and nearly half (44%) don't know whether they are infected, says a report in *Morbidity and Mortality Weekly Report* (2010;59;1201-7) by the Centers for Disease Control and Prevention. Younger, poorer, and ethnic minority men were more likely to be infected.

NICE citizens council supports use of incentives for better health: Two thirds (20 of 32) of a UK National Institute for Health and Clinical Excellence advisory group that is made up of members of the public voted in favour of incentive schemes that encourage a healthy lifestyle, such as supermarket vouchers for pregnant women who give up smoking. The public can comment on the views of the Citizens Council (www.nice.org.uk/aboutnice/howwework/citizenscouncil/reports.jsp).

EU consults on strengthening rules on tobacco: The European Commission is inviting input on how to strengthen existing European Union tobacco legislation to increase the public's awareness of the dangers of smoking. The consultation runs until 19 November (http://ec.europa.eu/health/tobacco/consultations/tobacco_cons_01_en.htm).

Call to quantify risk of infertility after chlamydia infection: More research is needed to assess the relative risks of infertility resulting from *Chlamydia trachomatis* infection and how best to manage it, say new guidelines from the British Fertility Society. The guidelines, published in *Human Fertility* (2010;13:115-25), say that there is currently a lack of solid evidence for estimating the relative risks of long term adverse reproductive consequences.

Cite this as: *BMJ* 2010;341:c5338

New UK guidelines highlight role of testosterone in sexual disorders

Zosia Kmietowicz LONDON

Men and women should be routinely asked about their sex life, say new guidelines on the management of testosterone deficiency and sexual disorders.

Doctors behind the guidelines say that patients and doctors lack awareness of and are reluctant to discuss sexual problems and that the importance of sexual function for general health needs to be more widely recognised.

The guidelines have been developed by the British Society for Sexual Medicine in collaboration with a number of other organisations, including the British Menopause Society, the Royal College of Physicians, the Royal College of Pathologists, and the Society for Endocrinology (*Maturitas*, doi:10.1016/j.maturitas.2010.07.011).

They recommend that patients routinely be asked whether they have any concerns about their sex life during appointments such as those for contraceptive advice, smear tests, and menopausal assessment or for certain other problems, such as depression.

Extra attention should be given to people at an increased risk of sexual problems, including women with premature menopause, vaginal dryness, depression, or a history of sexual abuse and men with diabetes, osteoporosis, chronic opiate use, cardiovascular disease, or depression.

Testosterone testing in women is not recommended, because tests are not sensitive enough to detect the low concentrations in women and the normal range in women has not been established. However, assessing testosterone deficiency in men should be made over several consultations, say the guidelines. The diagnosis should be based on symptoms such as poor morning erection, low sexual desire, and erectile dysfunction, combined with a measure of testosterone concentrations in blood.

Geoff Hackett, one of the coauthors and a consultant in sexual medicine at the Good Hope Hospital in Birmingham, said that low testosterone contributes to erectile dysfunction in about 20% of men and that it is the sole medical cause of sexual problems in 10%.

Half the men who are getting repeat prescription of sildenafil from their GP are failing to achieve adequate sexual function, Dr Hackett told a press briefing on 24 September, and for many the reason is low testosterone concentrations.

The guidelines say that all women with problems of sexual desire or arousal should be offered psychosexual counselling or sex therapy and that oestrogen, testosterone, or tibolone (a synthetic steroid often used in postmenopausal women) should be offered, as appropriate.

Cite this as: *BMJ* 2010;341:c5305

See FEATURES, p 698

DR P MARAZZI/SPL

Low testosterone contributes to erectile dysfunction

UK supermarket is granted licence to sell Viagra to reduce internet sales and increase screening

Jacqui Wise LONDON

Tesco has been granted permission to sell the erectile dysfunction treatment sildenafil (marketed as Viagra) in 300 pharmacies in its supermarkets across the United Kingdom without the need for a prescription from a GP.

The Medicines and Healthcare Regulatory Agency confirmed that sildenafil remains a prescription only drug and is not available over the counter—instead Tesco has been granted permission to dispense the treatment under a special licence called a patient group direction.

These licences are granted in situations where they offer an advantage to the care of patients without compromising their safety and also where they provide an opportunity for general health screening. The agency says that Tesco is registered with the Healthcare Commission and meets the statutory requirements for such directions, which include ensuring that the drug is supplied only by pharmacists.

Shona Scott, commercial manager for

More than 30 health quangos may be axed by UK coalition government to save money

Nigel Hawkes LONDON

A leaked Cabinet Office document indicates that around 30 health related advisory committees and non-departmental bodies are to be abolished in the UK coalition government's "bonfire of the quangos."

Among high profile casualties are the Human Fertilisation and Embryology Authority, the Human Tissue Authority, the Human Genetics Commission, the Council for Healthcare Regulatory Excellence, and the Joint Committee on Vaccination and Immunisation, if the list published last week by the *Daily Telegraph* (www.telegraph.co.uk, 24 Sep, "Quango cuts: 177 bodies to be scrapped under coalition plans") proves accurate.

ROBERT JUDGES/REX

Ruth Deech, a former head of the HFEA

The demise of the Health Protection Agency, whose functions will be taken over by the promised Department of Public Health, and the Appointments Commission, which handles public appointments to the NHS and other government departments, had already been announced by ministers (*BMJ* 2010;341:c4074).

Non-departmental bodies have flourished in the United Kingdom in recent years. Last year the Taxpayers' Alliance, which campaigns for lower taxes, produced a list of 1162 such bodies, employing 700 000 people and costing £64bn (€75bn; $100bn) a year. But that list included such bodies as JobCentre Plus, the Courts Service, and the NHS strategic health authorities. The bodies for the axe in the *Daily Telegraph*'s list are far more modest in scale and cost.

For example, many of the health bodies listed are advisory committees with small or negligible budgets. And the more prominent casualties—the Human Fertilisation and Embryology Authority, the Human Tissue Authority, the Human Genetics Commission, the Council for Healthcare Regulatory Excellence, the Health Protection Agency, the Joint Committee on Vaccination and Immunisation, and the Appointments Commission—employ between them fewer than 3500 people, at a cost of around £300m a year. More than 90% of this sum is attributable to the Health Protection Agency, which will continue to need as many staff and as large a budget regardless of its change of name.

The Cabinet Office refused to elaborate.

Ruth Deech, a former head of the Human Fertilisation and Embryology Authority, questioned whether its abolition would save any money. Its functions would still be needed, she said.

"It only costs £5m, and it's not taxpayers' money," she told Radio 4's *Today* programme. "Most of that £5m comes from the patients. Now if you redistribute the functions, you're not going to save anything."

Many of the axed quangos will not be surprised to hear their fate.

Cite this as: *BMJ* 2010;341:c5297

HFEA investigates websites matching sperm donors to would-be mothers

Clare Dyer BMJ

The UK Human Fertilisation and Embryology Authority (HFEA) is investigating websites that match up sperm donors with women who want to conceive, to see if they are breaking the law.

The move by the HFEA follows the conviction at Southwark Crown Court in London of Ricky Gage and Nigel Woodforth, who made £250 000 (€295 000; $400 000) from their company Fertility 1st, which couriered sperm from donors to women who were trying to conceive. The pair face a possible jail term when they are sentenced in October.

They fell foul of a law that makes the procurement of gametes, including human sperm, illegal without a licence from the HFEA.

Websites matching sperm donors with would-be mothers have proliferated as a cheaper and quicker alternative to licensed fertility clinics. Since the law was changed in 2005 to give children born by sperm donation at licensed clinics the right to find out the identity of their fathers, there has been a shortage of sperm donors in the UK, meaning higher costs and longer waits for treatment at clinics.

But the HFEA warns that the health safeguards provided by clinics are absent for those who resort to websites. The authority's chairwoman, Lisa Jardine, said, "We understand why women may use these sites. Getting access to fertility services can be difficult, and there can be some very strong emotional pressures when trying to start a family. But unlicensed internet sites like these are exploiting women. We will continue to work with the police to prevent more women from being exploited by those who choose to break the law."

D PHILLIPS/SPL

Some websites, such as Co-ParentMatch.com and Feeling Broody.com, operate not by providing sperm directly but by pairing men with women who want to become pregnant.

A spokesman said that the HFEA, which has no powers to prosecute, would be writing to websites it believed were breaking the law. Unlike donors who provide their sperm through licensed clinics, men who father children through websites are considered the children's legal father and risk being made responsible for child support.

Cite this as: *BMJ* 2010;341:c5353

pharmacy services at Tesco, said, "The service is available to men aged between 40 and 65 years. They will have to complete a questionnaire, and we will then carry out a blood pressure test, diabetes screen, and cholesterol test. Provided that they are suitable we will discuss their options and can sell them an effective treatment."

The cost of the consultation and eight tablets will be £52 (€60; $82).

Sildenafil has been available from 30 pharmacies in the Boots chain since last year after a successful pilot scheme in Manchester in 2007. Boots charges £55 for the initial consultation and four tablets.

A spokeswoman for the Medicines and Healthcare Regulatory Agency said, "The majority of clinical care should continue to be provided on an individual, patient specific basis. PGDs [patient group directions] can be used to meet the needs of patients who may not be identified before presenting for treatment and can provide an opportunity for health screening as well as providing treatment for the clinical condition to which the PGD relates."

She added: "On a wider issue, some men are embarrassed to seek treatment for erectile dysfunction. This is not simply a lifestyle issue; erectile dysfunction is a recognised medical condition which in turn may be caused by a number of underlying medical factors. The supply of Viagra under a PGD which has been developed within a clear regulatory framework and under the supervision of a named pharmacist is far preferable to acquiring supplies via the internet.

Cite this as: *BMJ* 2010;341:c5294

US paediatricians call for a total ban on tobacco advertising and limits on alcohol and drug advertising

Janice Hopkins Tanne NEW YORK

The American Academy of Pediatricians has called for a total ban on tobacco advertising in all media, limits on alcohol advertising, and limits on content related to tobacco, alcohol, prescription drugs, and illegal drugs on television and in movies for children.

In a policy statement published on 27 September the academy said, "Two legal drugs—alcohol and tobacco—pose perhaps the greatest danger to children and teenagers. Both represent significant gateway drugs and are among the earliest drugs used by children and teenagers" (*Pediatrics* doi:10.1542/peds.2010-1635).

The academy, which has 60 000 members, issued recommendations for paediatricians and called for action in the community, in legislatures, and by related industries.

It said that paediatricians should encourage parents to limit children's unsupervised watching of television and their access to television programmes that often show substance misuse and to films that show smoking and drinking. It also said that paediatricians should ban magazines with cigarette and alcohol advertising from their waiting rooms.

In the community, paediatricians should encourage schools to teach children media literacy and imbue scepticism toward advertising.

Paediatricians should encourage Congress to ban tobacco advertising in all media that children might see, as several European countries have done, the academy said. In the United States cigarettes may not be advertised on television or radio but may be in newspapers and magazines. There is limited advertising on billboards.

They should also encourage Congress to require the alcohol industry to report spending on advertising in media that have many children and adolescent viewers and encourage the industry to limit its advertising in such places. Congress should also pass strict laws regulating digital advertising that targets children and adolescents.

The academy also encouraged its members to discuss advertising of prescription drugs with advertising agencies, drug companies, and public health groups. The entertainment industry must be more sensitive to the effects of films and television on children. Advertising of erectile dysfunction drugs should not appear before 10 pm and should not be "overly suggestive."

Cite this as: *BMJ* 2010;341:c5286

GARY GARDINER/BLOOMBERG VIA GETTY IMAGES

Advertising may be responsible for up to 30% of adolescent tobacco use

Raising price of alcohol works better than prevention programmes, US review says

Janice Hopkins Tanne NEW YORK

Raising the price of alcohol by taxation reduces drinking and also significantly reduces negative, costly outcomes associated with excessive drinking more effectively than prevention programmes, concludes a review of published research over the past 50 years.

A previous study by the same researchers at the College of Medicine of the University of Florida, Gainesville, found that a 10% rise in the price of alcohol resulted in a 5% reduction in drinking.

In their current study they say that doubling the average US state tax on alcohol would result in about a 35% reduction in the number of alcohol related deaths, an 11% reduction in fatal automobile crashes, a 6% reduction in sexually transmitted diseases, a 2% reduction in violence, and a 1.4% reduction in crime (*American Journal of Public Health* doi:10.2105/AJPH.2009.186007). The only association they found not to be significant was with a reduction in suicide.

The lead author, Alexander Wagenaar, professor of health outcomes and policy at the University of Florida, told the *BMJ* that the retail price of beer, wine, and spirits varies widely across the United States. He explained that there is a federal tax but also local taxes levied by each state, which may be set at different rates on beer, wine, and spirits. In some cases, state taxes are lower on wine produced within the state than on wine imported from other states or from abroad.

In general, he said, alcohol tax rates in the United States are historically low, presenting an opportunity for governments to increase tax revenue and to reduce numbers of alcohol related injuries, illness, deaths, and related costs, including the cost of health and automobile insurance and law enforcement.

Most alcohol tax rates were set in the 1960s and 1970s. "Almost all taxes are on a [dollar] per gallon basis and are not automatically adjusted for inflation," Professor Wagenaar said. "A 5% inflation rate, for example, means the tax goes down 5%."

Raising alcohol taxes is appealing because there is political opposition to increasing income and property taxes as a way to boost revenue as budget deficits continue to rise. Furthermore, increasing taxes on tobacco products has had positive results.

Dr Wagenaar said, "Simply adjusting decades old tax rates to account for inflation could save thousands of lives and billions of dollars in law enforcement and healthcare costs."

The authors reviewed 50 studies containing 340 estimates of the effect of alcohol tax or price change on alcohol related morbidity and mortality. The studies came from the United States, Canada, Finland, Spain, the United Kingdom, Denmark, and Switzerland.

Cite this as: *BMJ* 2010;341:c5373

UN summit launches new initiative for women and children's health

Peter Moszynski LONDON

One of the key events at this week's millennium development goals summit was the launch of a new Global Strategy for Women's and Children's Health, to which stakeholders have pledged more than $40bn.

"We know what works to save women's and children's lives, and we know that women and children are critical to all of the MDGs [millennium development goals]," UN secretary general Ban Ki-moon said. "Today we are witnessing the kind of leadership we have long needed."

SETH WENIG/AP/PA

President Obama addresses the UN summit

He said: "Success will come when we focus our attention and resources on people, not their illnesses; on health, not disease. With the right policies, adequate and fairly distributed funding, and a relentless resolve to deliver to those who need it most—we can and will make a life changing difference for current and future generations."

The strategy outlines interventions focused on the most vulnerable and hardest to reach women and children: "the poorest, those living with HIV/AIDS, orphans, indigenous populations, and those living furthest from health services."

It states: "Significantly improving and sustaining women's and children's access to an affordable package of life-saving health interventions will require strengthened health systems with sufficient skilled health workers at their core. All the partners involved will need to integrate, working across diseases and sectors."

If fully funded, the strategy should save the lives of more than 15 million children under 5; avert 33 million unwanted pregnancies; and prevent 740 000 women from dying from complications relating to pregnancy and childbirth. A further 88 million children under 5 would be protected from stunting, and 120 million would be protected from pneumonia.

Several international organisations, including Unicef, United Nations Population Fund, UNAIDS, the World Health Organization, and the World Bank, are collaborating to mobilise political and operational support.

The Global Strategy for Women's and Children's Health **is available at www.who.int/pmnch/activities/jointactionplan/en/index.html.**

Cite this as: *BMJ* 2010;341:c5276

A third of those in need of antiretrovirals in poor countries can now get them

John Zarocostas GENEVA

Last year saw important gains in expanding access to HIV treatment and care in several low and middle income countries, but interventions need to be scaled up to help millions of people access antiretrovirals, says a new global report.

At the end of 2009 5.25 million people with HIV in low and middle income countries received antiretroviral treatment, a rise of 30% from December 2008, says the report by the World Health Organization, UNAIDS, and Unicef.

Despite these gains, the heads of the three agencies warn in a foreword to the report: "More than five million people needing antiretroviral therapy do not have access to it. Far too many people access health services in late stages of HIV disease and are unable to receive maximum benefits from treatment. Recent surveys suggest that more than half of all people living with HIV remain unaware of their infection status."

Gottfried Hirschall, WHO's director for HIV and AIDS, said, "By starting treatment earlier and improving adherence within the first year we can save more lives."

Coverage of antiretrovirals in sub-Saharan Africa reached 37% of those in need in 2009 (3.91 million people), up from 28% (2.95 million people) in 2008. Latin America and the Caribbean registered the best regional performance of access to antiretrovirals, with an average coverage of 50%, up from 48% in 2008. In east, south, and South East Asia access rose to 31% in 2009, from 25% in 2008.

However, coverage was poorer in Europe and central Asia, at 19% (up from 15% in 2008), and in north Africa and the Middle East, where it was 11% in 2009 (slightly up from 10% in 2008).

The study says that eight low and middle income countries achieved the goal of 80% coverage of patients in need of antiretrovirals: Botswana (83%), Cambodia (94%), Croatia (80%), Cuba (95%), Guyana (>95%), Oman (>95%), Romania (81%), and Rwanda (88%).

Fifteen countries, including Botswana, Guyana, and South Africa, were able to provide more than 80% of HIV positive pregnant women with antiretrovirals to prevent transmission to their babies.

Overall, 53% of pregnant women in poorer countries who needed services to prevent mother to child transmission received them in 2009, it says. Similarly, the report documents that 14 countries, including Brazil, Namibia, and Ukraine, provided antiretroviral treatment to more than 80% of the HIV positive children in need.

Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector—Progress Report 2010 **is available at www.who.int/hiv/pub/2009progressreport/en/index.html.**

Cite this as: *BMJ* 2010;341:c5393

Spreading the word

TOMOMARI TAKAO/MAINICHI SHIMBUN

Zosia Kmietowicz LONDON

Having lost five children of her own through HIV, Marie was determined that others did not suffer in the same way. She now works as a community health worker and counsellor for Camnafaw, which is funded by the International Planned Parenthood Federation's Japan Trust Fund for HIV and AIDS.

The photograph of Marie is included in an exhibition called Exposures to celebrate 10 years of the fund, which is at the Japanese embassy, 101 Piccadilly, London W1J 7JT, until 12 October.

Cite this as: *BMJ* 2010;341:c5380