Despite amendments health bill should be withdrawn, says BMA

Zosia Kmietowicz LONDON

The BMA has said it will launch a public campaign to call for the withdrawal of the Health and Social Care Bill because of continuing concerns among doctors about key aspects of the changes planned for the health service despite amendments after the government’s listening exercise.

At a council meeting on 20 July the BMA rejected the idea that the government’s proposed changes to the bill will substantially reduce the risk of further marketisation and privatisation of the NHS. It said that the government was misleading the public by repeatedly stating that there will be no privatisation of the NHS.

In a statement issued after the meeting Hamish Meldrum, chairman of council at the BMA, said: “Whilst the BMA recognises there have been some changes following the listening pause, there is widespread feeling that the proposed legislation is hopelessly complex, and it really would be better if the bill were withdrawn. We will continue to critically engage with government and with the parliamentary process to try to achieve this, whilst continuing to seek further amendments to the bill.”

A survey of 500 GPs conducted by the Royal College of General Practitioners after the government’s proposed amendments to the bill has found that 85% are still not reassured by the revisions. Almost half of GPs do not believe the revised model of clinical commissioning groups will improve patient care, and 60% said they did not want to be involved in a commissioning group board.

At its meeting the BMA agreed that it will continue to oppose any bill that seeks to break down the NHS family and treat healthcare as a commodity to be bought and sold.

It called for assurances from the government that there will not be a substantial increase in commercial sector involvement in the NHS in the same way that there is a policy that schools should not make a profit. Services for the NHS should be provided by public bodies or organisations controlled by professionals who also practise in them, it said.

Cite this as: BMJ 2011;343:d4794

Doctors must report unfit colleagues, MPs’ report says

Helen Jaques BMJ CAREERS

Doctors could risk losing their licence if they fail to report fitness to practise concerns about their colleagues, MPs have recommended.

In its first annual review of the functions of the General Medical Council, the House of Commons Health Committee has called for the regulator to send “a clear signal” to doctors that they are at as much risk of being investigated for failing to report concerns about a fellow doctor as they are from poor practice on their own part.

Senior doctors and clinical team leaders in hospitals would be most accountable, but there would be “questions asked of everybody,” said Stephen Dorrell MP, chair of the health committee.

“Every practising doctor and nurse knows that in addition to their obligation to care for their patients, they have an obligation as professionals to report to their professional body any concerns they have about the quality of care being delivered by their colleagues as a result of what they know or should have known,” said Mr Dorrell.

“We look to the GMC to ensure that failure to act is regarded as a serious breach of professional obligation.”

The committee raised the example of Mid Staffordshire NHS Foundation Trust, where, according to the GMC, between 120 and 150 doctors would have known about the problems at the hospital but few raised concerns through the proper channels. Doctors whose own practice was blameless but who failed to act are now under investigation by the GMC.

Paul Flynn, deputy chairman of the BMA’s Central Consultants and Specialists Committee, said, “It would be contrary to natural justice to be held to account for something you genuinely didn’t know about, but perhaps those who stick their heads in the sand and deliberately don’t look for problems should be held to account for it.”

However, doctors should first report concerns to their local governance systems before taking the “quite significant step” of going to the GMC, he adds.

“Something that gets as far as the GMC in terms of poor professional performance is evidence of a failure of the system,” he said.

“There do need to be robust local systems that have got their early warning radar switched on.”

The health committee acknowledged that in some cases doctors who have raised concerns about their colleagues have been subject to suspension, dismissal, or other sanctions and has committed to examining this issue in more detail in due course.

The report, Annual accountability hearing with the General Medical Council, is at www.publications.parliament.uk/pa/cm201012/cmselct/cmhealth/1429/142902.htm.

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Minister denies councils will use health funding for filling potholes

Adrian O’Dowd LONDON
Local authorities will not be able to use public health funding for questionable purposes such as filling in potholes in roads once they take control of public health budgets, MPs have been told.

MPs on the parliamentary health select committee tackled government witnesses as part of their final evidence session of the ongoing inquiry into public health on 19 July.

Several concerns about how public health money will be spent once it passes into the control of local authorities as part of the NHS reforms had been brought to the committee’s attention.

MPs asked about fears that local authorities would spend public health funds on what might seem to be obscure activities and claim they were in the interests of public health.

Rosie Cooper, Labour MP for West Lancashire, said it was going to be a difficult time financially for local authorities in the next few years because of trimmed budgets. “We have had public health academics and people working with unitary authorities who have described 20 mile an hour zones outside schools as a public health measure.

“However, we need to get to the point at which filling in potholes will become a ‘public health exercise’ because it saves lives, and in reality, that there will be some measure of local authorities using the public health ring fenced budget to fulfil their core function.”

Public health minister Anne Milton, giving evidence, said: “I know there is nervousness, but there is also an opportunity to be more imaginative about how you improve the public health.

“The point is that there will be an outcomes framework [for public health] and that is going to be critical. That is central government’s lever on it and that is the protection.

“I think that once local authorities have public health in their remit, there will be enthusiasm from the authorities themselves and not just because they can get their hands on money they didn’t previously have, but because most people genuinely want to improve the public’s health.”

MPs pressed her on the likelihood of some councils diverting money from public health for other things.

“It would be naive for us to sit here and deny that that is a possibility because public bodies have got awfully good at what is known as gaming the system,” she replied.

“The meaningfulness and the measurableness of the outcomes are going to be very important, and this money is being given to local authorities on the back of compliance with the local outcomes framework.

“There are incredibly imaginative schemes out there already that local authorities are doing to improve the public’s health that, on first appearance, you would not normally associate with public health but have been incredibly effective.”

Ms Milton argued that the shift for public health responsibility back into local government was one of the best ways of tackling areas where people had the poorest health outcomes.

“Public health has a proud tradition and history within local government,” she said. “This way, you harness action at every single level.”

David Harper, director general of health improvement and protection at the Department of Health, also giving evidence, said: “Ministers are very much of the view that this is an opportunity to open up public health to everybody. It is not being driven from the national health service.”

Cite this as: BMJ 2011;343:d4669

Trusts paid private firms £100m to treat waiting list patients

Helen Mooney LONDON
The NHS has handed over tens of millions of pounds to private companies to treat patients who have not received treatment within 18 weeks of GP referral, according to recently published figures.

The figures show that primary care trusts (PCTs) have handed over about £100m to private firms in a bid to offer treatment to patients who under the rules of the NHS constitution have challenged waiting times.

The results of an investigation by Pulse magazine found that 55 PCTs in the country have paid out nearly £40m (€45m; $65m) to private firms after complaints made under the terms of the NHS constitution—a figure which suggests a total NHS pay out of £100m.

A total of 20 000 patients in the 55 PCTs have been treated using private companies including BMI, Spire Healthcare, and Care UK for procedures in specialties such as orthopaedics, gynaecology, cardiology, and for diagnostic scans for suspected cancers. NHS Eastern and Coastal Kent paid private companies £12.9m last year.

Despite the fact that the government stopped the performance management of PCTs against the 18 week referral to treatment target in May last year the NHS is obliged to uphold the rights of the NHS constitution given to patients in April 2010. The constitution states that patients are entitled to NHS treatment “within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible.”

Cite this as: BMJ 2011;343:d703

Research on animals with human material needs more scrutiny

Matthew Limb LONDON
UK scientists are calling for a new body of experts to be set up to advise on “sensitivities” raised by a fast moving area of biomedical research—the use of animals containing human material.

A report by the Academy of Medical Sciences says techniques will soon test the boundaries of what the public finds acceptable. A working group of scientists looked into the scientific, social, ethical, safety, and regulatory aspects of research using animals containing human material.

Cite this as: BMJ 2011;343:d4703
Extending patient choice is inviting private providers to get a stake in NHS, warn critics

Adrian O’Dowd  LONDON
The government is extending its patient choice programme to include some community and mental health services from next year, but the move has prompted criticism that it will allow more private providers a stake in the NHS.

Health secretary Andrew Lansley has announced that from April of next year patients in England, who have so far been able to choose where to have non-urgent hospital care, will also be able to choose within other types of service.

New guidance from the Department of Health outlines how patients, guided by advice from their GP, will be offered a choice of “qualified” providers who meet NHS quality, prices, and contracts. There will be a phased implementation of the change during 2012-13.

These providers could be NHS, independent sector providers, or voluntary or third sector organisations. The idea is to boost quality by introducing competition.

The services that will be open to choice are:

- services for back and neck pain
- adult hearing services in the community
- continence services
- diagnostic tests closer to home
- wheelchair services (children)
- podiatry services
- leg ulcer and wound healing
- talking therapies (adults)

Every area of England will be expected to offer more choice in a minimum of three services by September 2012. The number of services will be expanded further from April 2013 to include maternity services and speech therapies.

Mr Lansley said: “This is a big day for patients—real choice over how and where they are treated is becoming a reality. There is often confusion about these policies—a mistaken idea that competition is there for the sake of it, or to increase the independent sector’s role in the NHS.”

The Department of Health also published its official response to a consultation on this issue, which says providers will be paid a fixed price determined by a national or local tariff; competition will be on quality, not price; and a national qualification process will be established to ensure providers meet NHS quality standards.

The announcement, however, was criticised by some. Hamish Meldrum, BMA chairman of council, said: “What we would question is the assumption that increasing competition necessarily means improved choice.

“When competition results in market failure in the NHS, the ultimate consequence is the closure of services, and the restriction of choice for the patients.”

Patients Association trustee, Roswyn Hakesley-Brown, supported more patient choice, but said: “Despite assurances from the Department of Health, patients and the public are still concerned that moving to ‘any qualified provider’ will result in private companies cherry picking services, causing fragmentation of the NHS, and leaving the NHS to deliver the more expensive and complex services.”

Jacky Davis, founder member of the campaigning group Keep Our NHS Public, said: “They have very dishonestly used the example of children’s wheelchairs to explain an agenda which is about opening the doors to any private provider which will, by and large, be the large multinationals.”

**Operational Guidance to the NHS: Extending patient choice of provider is at www.dh.gov.uk.**

**Liberating the NHS: greater choice and control—Government response—Extending patient choice of provider is at www.dh.gov.uk.**

Cite this as: BMJ 2011;343:d4683

It says two categories of research require further scrutiny from the proposed new national body that should advise the Home Office within the existing framework of legislation.

One, described as a “very narrow range of experiments,” should not be licensed now because they raise “very strong ethical concerns.” These experiments include transplanting human derived neural cells into monkey brains that could engender human like behaviour, breeding of animals with human derived germ cells that could produce human or true-hybrid embryos, and allowing any “mixed embryo” to develop beyond 14 days.

Another category should be “approached with caution” but might be permitted if, after further oversight, these experiments are deemed safe, ethical, and have strong scientific justification, says the report. This includes adding human genes or cells to non-human primates and experiments that substantially alter animals’ behaviour or appearance so as to affect characteristics like “speech” or skin texture perceived as “uniquely human.”

Martin Bobrow, who chaired the academy working group and is professor emeritus of medical genetics at Cambridge University, said there was no evidence that activity that shouldn’t be permitted was happening already in the UK.

He said the aim of the report was to get ahead of the debate and raise discussion with the public and government rather than react to developments once they had taken place.

Professor Bobrow said: “This is not stuff which is miles away. The technology is in existence. This is a proactive attempt to look at an area of medical science which is interesting, important, and growing.”

Robin Lovell-Badge, who heads the division of stem cell biology and developmental genetics at the Medical Research Council’s National Institute of Medical Research, referred to television adverts portraying “talking meerkats.” “We all laugh when we see that, but we think the public would not be so happy if we were doing that in the labs,” he said.

The report, **Animals containing human material, is at www.acmedsci.ac.uk.**

Cite this as: BMJ 2011;343:d4730
Generic prescribing is expected to save Spain €2bn a year

Aser García Rada MADRID
Spanish doctors will be required to prescribe generically wherever possible when a new law comes into force in the next few weeks—a move that health minister Leire Pajín has said will save the health service €2bn (£1.7bn; $2.9bn) a year.

Another €400m will be cut from the country’s drugs bill by implementing other strategies. For example, 15% is being cut from the price of drugs that have been on the market more than 10 years and whose patent has expired but for which there is not yet a generic equivalent. Mechanisms for deciding on public funding for new drugs are also being strengthened.

These measures, agreed on 21 July during the interterritorial council of the national health service, a periodic meeting between the ministry and health authorities of the 17 autonomous communities, aim to cut the country’s public deficit and prevent regions, such as Galicia, from taking their own decisions on drug budgets.

The government has already taken several steps to cut the drugs budget—which accounts for about 20% of the health budget—over the past year. These include cutting the price of drugs (in Spain, the ministry sets drug prices) and promoting the use of generics, which have already saved around €2.5bn, said Ms Pajín.

US body lists women’s services that all insurers should provide

Bob Roehr WASHINGTON, DC
Basic preventive health services should include eight interventions specific to women that were identified as gaps in coverage, according to a study from the US Institute of Medicine (IOM).

Health insurance plans must begin to provide basic prevention services free of additional charge under healthcare reform provisions of the 2010 Affordable Care Act. The Department of Health and Human Services requested the study before making its final rules on what package of services must be covered under that provision of the law.

It asked the IOM to identify gaps in existing guidelines for prevention services as outlined by standing advisory committees to the department, and also to recommend a process for regularly updating what must be included in the basic package of prevention services.

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Spain’s local health services owe suppliers—mainly drug and medical technology manufacturers—somewhere between €9bn and €15bn with some regions delaying payments by more than 600 days.

However, some commentators believe the new measures are unlikely to lead to the level of savings predicted by the government because some regions, such as Andalusia, already require doctors to prescribe generically. However, a spokesman from the Ministry of Health insisted that its calculations are correct.

Cite this as: BMJ 2011;343:d4803

Family asks court to let “minimally aware” woman die

Clare Dyer BMJ

The family and the former partner of a woman in a “minimally aware” state are asking the High Court in London to rule that she should have artificial feeding withdrawn and be allowed to die.

Her older sister said the 51-year-old woman, named only as M, would prefer death to being permanently dependent on others for her care.

The case is the first in which the court has been asked to allow artificial nutrition and hydration to be discontinued where the patient is deemed to be not quite in a persistent vegetative state. The official solicitor, representing the patient, opposes the application, arguing that she has some awareness.

M, a former hairdresser, was struck with viral encephalitis as she was about to go on holiday with her partner, S, in February 2003. The couple had been together since their early twenties.

S wept as he told the court: “It’s not about us at all. We have no ulterior motive. We just know who she was and her opinions.”

M’s older sister, known as B, also wept as she insisted that it was cruel to keep her alive. “I know in my heart of hearts that she would not want to live like that.”

Staff at the care home where she lives say they have seen slight signs of awareness in M, such as appearing to react to people and moving her hand in time to music.

Caroline Harry Thomas, for the official solicitor, argued that it would be illegal to withdraw artificial nutrition and hydration from someone who was medically stable and in a minimally conscious state. The case continues.

Cite this as: BMJ 2011;343:d4772

Reforms of benefit are seen as attack on the disabled

Nigel Hawkes LONDON

The government’s reforms of incapacity benefit are widely seen as an attack on the disabled and a means of saving money rather than an attempt to help people back into work, a commons committee has concluded.

It blames the media for describing recipients as “workshy” or “scroungers” but also warns the government to take care with the language it uses so as not to lend support to the belief. It accepts that the government’s aim is the praiseworthy one of helping people back into employment, but says this has not been properly communicated, leading to fear and anxiety among vulnerable people.

Claimants who are assessed and found fully capable of work are told they have “failed” the assessment, the report by the Work and Pensions Committee says, reinforcing the message that the tests are designed to detect fraudsters. In fact, failing the assessment is a successful and desirable outcome because it finds that a claimant is fit for work. The government needs to explain that the finding does not equate to denial or disbelief about the existence of an illness or health condition.

Chris Grayling, the employment minister, was given a hard time by several members of the committee when he gave evidence in June, Labour’s Glenda Jackson claiming the policy had been sold as “attacking the workshy.” But the report finds that any such impression is the result of poor communication rather than deliberate intent. Mr Grayling told the committee he was “bemused” by some of the tabloid stories.

There are 2.6 million people on incapacity benefits and its successor, employment and support allowance (ESA), costing a total of £13bn (£14.7bn; $21bn) a year. The last government introduced a scheme for testing all new applicants, the work capability assessment (WCA), contracted to Atos Healthcare until 2015. Since the current government took office, changes have been made to the scheme and an independent review carried out.

Mr Grayling told the committee that as originally implemented, WCA had been “a flawed process” but that the new version was better.

The report accepts that the process is showing signs of improvement, but that further changes might be needed. Atos routinely overbooks appointments by 20%, on the basis that 30% of those called for assessment do not turn up.

The committee believes that non-attendance is lower than that and calls on Atos to review its procedures. Atos should also try harder to get the assessment right first time, to reduce the cost of appeals, many successful, that now runs at £50m a year.

The role of WCA is poorly defined, the committee says. Is it an eligibility test for benefits or a diagnostic test to assess a person’s ability to work? “It is not yet clear it is quite achieving either of these effectively.”

The government also began in April to reassess those who were on incapacity benefit before ESA was introduced, and remain on it, with a view to moving them on to either ESA or job seeker’s allowance.

Cite this as: BMJ 2011;343:d4786

“Failing” the assessment is a desirable outcome because it finds a claimant is fit for work, and does not equate to the denial or disbelief about the existence of an illness or health condition, the report says.
Israeli court allows amputation against wishes of mother

Tamara Traubmann TEL AVIV

Doctors at Sheba Medical Center, in Ramat Gan, Israel, amputated the hand of a child, despite her mother’s objection, after surgeons were given the go ahead by the family court in Tel Aviv. The operation was needed to remove a malignant tumour that threatened the child’s life.

The hospital reported that the operation, performed on 19 July, was successful and the girl was feeling well. The 13 year old child is the daughter of immigrants from Ethiopia, and lives with her mother in the south of Israel.

The girl and her mother sought medical care eight months ago because of a sharp pain in the girl’s arm. She was hospitalised at the Sourasky Medical Center, Tel Aviv, and was diagnosed as having osteosarcoma.

Dror Levin, director of the paediatric hemato-oncology clinic in which the girl was hospitalised, said in a document which was filed to the court that the tumour had a high risk of metastasising, especially to the lungs. When the original treatment, multiple courses of chemotherapy, proved ineffective, the doctors announced the need to amputate the girl’s hand.

Her mother opposed the amputation and requested a different treatment. “I brought her to you so that you would cure her, not amputate her hand,” she told Channel 2 news, adding that “the hands of rapists and thieves are cut off.” According to a report filed to the court by the social services, the child said that she does not want to undergo surgery, but understands she has “no other choice.”

On 17 April, the doctors and the Ministry of Welfare turned to the family court in Tel Aviv, requesting approval to amputate the girl’s hand. Without treatment, the disease was 100% fatal, wrote Dr Levin in the request.

Judge Yehoram Shaked ruled that “no parent has the right to take action or withhold action that may lead to the death of his/her child,” and added: “It is with a heavy heart that I write this ruling. I would not exaggerate in saying that cases like these make a judge lose sleep. Safeguarding a life supersedes all other matters, and if the minor must sacrifice her hand in order to save her life—it will be so.”

Cite this as: BMJ 2011;343:d4771

Chronic diseases among the over 40s in China are set to double in 20 years

John Zarocostas GENEVA

The rate of the four leading causes of ill health in China—cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and lung cancer—will “double or even triple over the next two decades” in people aged over 40 years if effective prevention and control strategies are not implemented, warns a report from the World Bank.

The report says changes in the dietary patterns, unhealthy behaviours, pollution associated with urbanisation, and China’s ageing population are contributing to the increase in risk factors of non-communicable diseases.

In addition, about 200 million people in China are overweight or obese, it says, with prevalence of both increasing “at an alarming rate among adolescents.”

At 54% the rate of smoking among Chinese men aged 15-69 years is among the highest in the world and the average salt intake among Chinese people is more than 12 g per day—twice the maximum daily intake recommended by the World Health Organization.

Projections suggest that diabetes will be the most prevalent of the non-communicable diseases with the estimated number of cases rising to 64.2 million in 2030 from 36.1 million in 2010.

The prevalences of other common chronic diseases are also expected to rise over the next 20 years: for lung cancer from 1.4 million to 7.3 million, and for stroke from 4.1 million to 8.9 million.

Activists call on Bahrain to release doctors and remove security forces from hospitals

John Zarocostas GENEVA

Human rights activists have called on Bahrain’s security and military forces to stop immediately the harassment, intimidation, arrest, torture, and ill treatment of medical staff working in health facilities.

A report from Human Rights Watch concludes that the Bahrain government should “end its campaign against the medical community, cease the detention and persecution of medical professionals solely for exercising their rights to freedom of assembly and expression,” and allow unhindered access to medical treatment for all. The government should also conduct an investigation of the alleged violations, says the report.

Since mid-February, when anti-government protests began, the New York based rights advocacy group has documented attacks by security forces on doctors, and the arrest of more than 70 medical personnel for exercising their rights to freedom of assembly and expression, and preventing them from treating and caring for patients.”

Cite this as: BMJ 2011;343:d4771
Final push is needed to tackle last 1% of polio, board says

Jacqui Wise LONDON

The global campaign to stop polio transmission by the end of 2012 needs one last push, an independent report concludes.

The Global Polio Eradication Initiative (GPEI) was set up in 1988 by the World Health Organization, Unicef, Rotary International and the Centres for Disease Control and Prevention in partnership with governments and the Bill and Melinda Gates Foundation. In November 2010 the World Health Assembly convened an Independent Monitoring Board to analyse progress towards the goal of the eradication of polio.

The board’s report says between 1988 and 2000 there was a 99% reduction in worldwide cases of polio; however this has been followed by a decade of stalemate despite spending of over $800m (£496m; €563m) every year.

Liam Donaldson, former chief medical officer for England and chair of the independent monitoring board, said: “Polio is a very resilient disease, and tackling the remaining 1% of cases is proving difficult. We believe polio eradication is still feasible, but more urgency is needed to complete the task.” Speaking at a press conference in London, Professor Donaldson added: “Polio eradication is on a knife edge. Success would be a public health triumph, but failure would have enormous consequences.”

The report says that, of the four countries endemic for polio, there has been excellent progress in India and very good progress in Nigeria and Afghanistan. But in Pakistan the trend is the other way with a 62% increase in confirmed cases between 2009 and 2010. In Pakistan 54 polio cases have been confirmed so far this year, double the number recorded in the first half of 2010. The report says: “We are concerned that Pakistan risks becoming the last global outpost of this vicious disease.”

In Nigeria there was good progress in 2010, with polio cases cut by 95%. The report warns, however, that political commitment waned during this year’s election with the result that there were five times as many cases in the first half of 2011 as there were in 2010. Northern Nigeria is singled out as of high strategic importance because the virus can easily spread from there to surrounding countries with weaker immunisation coverage.

The report says the programme is performing poorly in controlling polio in countries where polio transmission has resumed, such as Chad, the Democratic Republic of Congo, and Angola. In Chad 80 cases of polio have been detected so far in 2011. The country has produced an emergency action plan, and WHO and Unicef have sent out a team of 100 staff to support implementation of the plan. In the Democratic Republic of Congo there have been 59 cases of polio in 2011 so far. The board says there needs to be more political engagement on the issue, including from the country’s president.

Another area of concern highlighted in the report is that the Global Polio Eradication Initiative is weak in anticipating and preventing outbreaks in high risk countries previously free of polio. There have been outbreaks in 14 countries since the start of 2010. While these have mostly been extinguished quickly, Professor Donaldson says it is still worrying that there were these 14 “surprises.” “We want these tinderboxes removed so they don’t start a fire,” he said.

The report says polio eradication is still possible in the near-term if there is enhanced political commitment, secure funding, and the GPEI has a clear plan to deal with areas of weakness in the programme. It says the funding gap is the single greatest threat to success. The GPEI says $1.95bn is needed in 2011 and 2012 to stop polio transmission. So far $1.36bn has been pledged, leaving a shortfall of $590m.


Cite this as: BMJ 2011;343:d4685