NHS competition puts survival of social enterprises at risk

Helen Mooney LONDON

Increasing competition in the NHS under the government’s proposals to open up contracts to “any qualified provider” risks putting social enterprise schemes out of business, warns a report from the healthcare think tank the King’s Fund.

The report says that an increasingly competitive NHS marketplace for healthcare providers, including short term contracts for fledgling social enterprises, presents major risks for their survival. It says that the government must continue to offer legal and financial support to fledgling social enterprises if the sector is to grow.

It recommends that NHS commissioners offer longer term contracts to enable social enterprise providers to establish themselves.

Rachael Addicott, the report’s author and a senior research fellow at the King’s Fund, said, “Even at this early stage in the development of the social enterprise sector, it’s apparent that patients and taxpayers could really benefit. However, there is still a lot of work to be done by NHS commissioners, the government, and aspiring social enterprises to turn the vision of a thriving social enterprise sector into reality.”

The government’s white paper on open public services, published last month, restated its commitment to encouraging mutual organisations as part of its agenda for diversifying the provision of public services. But the King’s Fund report found that the low number of staff leaving the NHS to set up new social enterprises doesn’t bear out the government’s hopes for “the largest and most vibrant NHS marketplace for healthcare providers, published last month, restated its commitment to encouraging mutual organisations as part of its agenda for diversifying the provision of public services. But the King’s Fund report found that the low number of staff leaving the NHS to set up new social enterprises doesn’t bear out the government’s hopes for “the largest and most vibrant social enterprise sector in the world.”

The report also found that healthcare providers face “challenges” in establishing themselves as social enterprises. Many cite a lack of the right support to manage staff members’ concerns about changes to their terms and conditions.

In March the health secretary, Andrew Lansley, announced that the government would make £10m (€11.5m; $16m) available this year through the health department’s social enterprise investment fund for NHS staff who want to set up social enterprises to deliver healthcare.

Social Enterprise in Health Care: Promoting Organisational Autonomy and Staff Engagement is available at www.kingsfund.org.uk.

Cite this as: BMJ 2011;343:d4974

France is set to radically overhaul drug regulation

Sophie Arie LONDON

France’s health minister, Xavier Bertrand, has presented a bill to overhaul the country’s drug regulatory system in the wake of the scandal over the continued use of the antidiabetes drug benfluorex in France, long after it was banned in other countries.

The bill aims to crack down on conflicts of interest, restructure the country’s drug regulator, and tighten the process for licensing drugs and for monitoring their effects once in use.

“We will know everything, everything,” the minister told the French media this week, comparing the bill to the US “Sunshine Act” introduced in 1976 to create greater transparency in government.

“All sums [of money] passing from the pharmaceutical industry to those in the health sector—be they doctors, experts, learned societies, or patients’ associations—everything will have to be declared from the first euro,” he said.

“Medicines will no longer go on the market unless they are really beneficial in comparison with what is already available. Above all, if a drug has serious side effects, there should no longer be any hesitation in withdrawing it from the market.”

The controversy over benfluorex (BMJ/2011;342:d1829), marketed by Servier in France as Mediator, arose in 2010 after reports showed that it was being widely prescribed as an appetite suppressant and may have caused at least 500 deaths.

The case has caused deep mistrust of the drug industry in a country with one of the world’s highest rates of drug consumption. It triggered a flurry of investigations into relations between the industry, health policy makers, and doctors.

The new legislation, which will be debated in parliament in September, proposes to introduce fines and penalties for those in the health sector who fail to declare any conflicts of interest.

It will reorganise the national health products safety agency Affsaps (Agence Française de Sécurité Sanitaire des Produits de Santé), which was widely criticised for its failures in the Mediator case. New drugs will undergo much more rigorous approval procedures, and systems will be changed to control levels of contact between the drug industry and doctors and others in hospitals who are involved in deciding which drugs they use.

The French drug industry association, Les Entreprises du Médicament (LEEM), said that the reforms go too far and could deny patients access to potentially helpful new drugs.

Cite this as: BMJ 2011;343:d6979
Peer review system must be overhauled and improved

Adrian O’Dowd, London

The peer review system used by many medical journals before they publish new research is in need of a radical overhaul with more checks, transparency, regulation, and sharing of best practice, recommends a report from MPs.

Prepublication peer review has evolved in a “piecemeal and haphazard” way, says the report, Peer Review in Scientific Publications, published on 28 July by the parliamentary science and technology select committee.

The committee has concluded from its inquiry into peer review that, to allow clinicians and scientists to follow and build on research findings, they should aim for a gold standard of making their data fully disclosed and publically available.

Peer review is vital to the reputation and reliability of medical research, said the committee, but the system is far from perfect, and the quality of peer review varies widely between publications.

The report recommends that publishers, research funders, and the users of research outputs (such as industry and government) work together to identify how best to evaluate current peer review practices so that they are optimised and innovations introduced.

MPs on the committee said that it should be a fundamental aim of the peer review process that all publications were scientifically sound, and the system needed to change because currently the “oversight” of research integrity in the UK was unsatisfactory.

The UK does not have an oversight body for research integrity covering advice and assurance functions across all disciplines, says the report, which recommends that the government establish an external regulator for this purpose.

In addition, all UK research institutions should have a member of staff leading on research integrity.

Andrew Miller, chairman of the committee and Labour MP for Ellesmere Port and Neston, said, “Although it is not the role of peer review to police research integrity and identify fraud or misconduct, it does, on occasion, identify suspicious cases.

“While there is guidance in place for journal editors when ethical misconduct is suspected, we found the general oversight of research integrity in the UK to be unsatisfactory and complacent.”

Concerns existed, said the MPs, about the use of journal impact factor as a proxy measure for the quality of research or of individual articles.

Although funders of research assured MPs during the inquiry that they did not use this approach, the committee still warned that research institutions should be cautious about adopting this measure in relation to assessing researchers for promotion.

Mr Miller added, “There is an element of chance in getting articles accepted in high impact journals, depending on topicality and other factors.

It is important that anyone assessing the quality of work by an individual researcher or research institution considers the value of the published articles themselves.”

Several innovative ways of improving current prepublication peer review practices are suggested in the report, such as the use of preprint servers, open peer review, increased transparency, and online repository-style journals.

The committee also encouraged the growth of postpublication peer review and commentary, saying it was a good opportunity for experimentation with new media and social networking tools.

The report says there should be greater recognition by publishers and employers of the work carried out by reviewers because this work is sometimes considered to be a burden, but a necessary one.

The MPs said that, after a breach in ethical conduct, advice was available from several sources, such as the Committee on Publication Ethics (COPE)—a group set up in 1997 with 6000 members worldwide that provides guidance and advice to journal editors. Advice was also available from the UK Research Integrity Office (UKRIO), set up in 2006 to provide assistance to researchers, research organisations, and the public on issues relating to research integrity, or a “Concordat” style document, which is being prepared by Universities UK and will set out principles on research integrity to which research funders can sign up.

The report, however, says that despite these bodies and guidelines, the overall oversight of research integrity seemed to have become more complicated and confused in recent years.

Peer Review in Scientific Publications is at www.parliament.uk/business/committees-committees-a-z/commons-select/science-and-technology-committee/publications/.

Cite this as: BMJ/2011;343:d4851

Competition in healthcare can help save lives, study finds

Adrian O’Dowd, London

Competition among hospitals in England led to a 7% fall in the number of deaths from acute myocardial infarction over three years, saving around 900 lives, a new study claims.

However, academics and experts on health policy have questioned the interpretation of the study, which was published on 27 July in the Economic Journal (2011;121:F228-60, doi:10.1111/j.1468-0297.2011.02449.x), the journal of the Royal Economic Society.

The researchers looked at the impact of the 2006 introduction of patient choice on 430 000 heart attack patients between 2002 and 2008, using data from hospital episode statistics.

They found that, after the changes in 2006, mortality fell more quickly in more rather than less competitive areas of the country—those with a higher number of potential providers.

Across all areas mortality from acute myocardial infarction fell by around 7%—with 300 fewer deaths a year—during the three year period after patient choice and competition were introduced.

One of the study’s authors, Zach Cooper, a health economist working at the London School of Economics, said, “This research isn’t about public versus private; it’s about illustrating that financial incentives can have a profound impact on hospital performance.”

Anna Dixon, director of policy at the health think tank the King’s Fund, told the BMJ: “I am yet to be convinced that there is a connection between patient choice and these differential rates of improvement.”

Cite this as: BMJ/2011;343:d4898

Radiotherapy is still underused in England, cancer tsar says

Only one quarter of GPs and one third of hospital doctors are aware of the latest and most precise technique—intensity modulated radiotherapy

Cite this as: BMJ/2011;343:d4891
Report backs research on non-human primates but demands closer scrutiny

Geoff Watts LONDON

An independent panel of scientists and animal welfare experts chaired by the Cambridge ethologist Patrick Bateson has given qualified approval to the research use of non-human primates in Britain. But the panel’s report emphasises the need for continuing and even closer scrutiny of the scientific and social justification for experimenting on these animals.

The report was commissioned by the Medical Research Council (MRC), the Wellcome Trust, and the Biotechnology and Biological Sciences Research Council, each of which funds work on primates. All three declared their support for the broad thrust of the report and said that some of its 15 recommendations already formed part of their normal operating procedures.

Panel members made individual assessments of the scientific quality of research initiated during the 10 year period from January 1997 to December 2006. They also rated the welfare costs to the animals used and the likely public benefit of the research.

In the area of neuroscience, which provided the bulk of the material they examined, they said that “the majority of research grants were well focussed on important areas of either neurobiological or medical concern.”

Overall they agreed that “in many cases the use of NHPs [non-human primates] was justifiable even in the context of modern understanding of animal welfare and advances in knowledge that might render some work on living animals unnecessary.”

But speaking at a press conference called to launch the report, Professor Bateson pointed out that there was also a negative aspect to his findings. “In a minority of cases the justification [for using NHPs] was inadequate,” he said. “Some projects were unlikely to be useful.” Such work should not be funded.

Responding to the report, Mark Walport, director of the Wellcome Trust, said, “We are of course disappointed by the small number of studies, around 10%, that failed to deliver benefits.” He went on to point out that when awarding grants it was impossible to predict with total accuracy what work would be useful.

John Savill, chief executive of the MRC, said: “Grant applicants are required to explain how their work will benefit health.”

Professor Bateson conceded that restrictions on the use of non-human primates had been tightened up a great deal, even over the years covered by his study. He was also aware that questioning grant applicants about the immediate medical applications of their proposed studies might be seen as a barrier to basic research.

He emphasised that he would want to support high quality projects with the potential to yield fundamental biological understandings, even if there were no immediately obvious medical benefits.

Professor Walport put forward the example of basic studies on memory and how it works. “It’s obvious that a fundamental understanding of memory is going to have an impact on human health,” he said, and he acknowledged that many questions can be answered using experiments on primates. “But there are still some questions that can only be answered using non-human primates.”

Cite this as: BMJ 2011;343:d4858

Susan Mayor BMJ

Only about two thirds of cancer patients in England who would benefit from radiotherapy currently receive it, an expert meeting organised by the National Radiotherapy Awareness Initiative at the Royal Marsden Hospital in London heard.

Just over half (52%) of cancer patients could benefit from radiotherapy, but only 37% receive it, Mike Richards, national clinical director for cancer, told the meeting.

“We have introduced measures to deal with lack of staffing and resources in radiotherapy and improved previously long waiting times. The next step is improving commissioning.

“We need to get across the message that radiotherapy is one of the major therapies for cancer and can be curative.”

A recent online survey of 41 GPs and 61 hospital doctors registered with Doctors.net.uk showed GPs thought that 38% could benefit, whereas hospital doctors thought 33%.

Chemotherapy was rated as likely to be indicated for 47% of patients by GPs and for 42% by hospital doctors.

Over one third of the GPs and one quarter of hospital doctors considered radiotherapy a secondary treatment for cancer. The GPs saw radiotherapy as more palliative than curative.

Tim Maughan, professor of clinical oncology at the University of Oxford, said, “There is a lack of understanding about the efficacy and tolerability of radiotherapy.

“In fact, major developments in imaging and radiotherapy over the last 15 years mean that delivery is now very much more precise, with greatly reduced risk of side effects.”

Radiotherapy contributes to 40% of cases where a cancer is cured, he said. Adding it to other treatments, such as surgery or chemotherapy, improves five year survival by 16%. Chemotherapy gives a 2% improvement in five year survival.

Only one quarter of GPs and one third of the hospital doctors surveyed were aware of intensity modulated radiotherapy, which the Department of Health wants to be more widely available. Far more were aware of targeted chemotherapy drugs.

Professor Richards said national tariffs will be available for radiotherapy in the next year and should be commissioned at a level above local commissioning groups.

A webcast of the expert discussion is available at www.royalmarsden.nhs.uk/news-events/news/20110728.

Cite this as: BMJ 2011;343:d4871
**From tsar to godfather: Roger Boyle**

**Susan Mayor BMJ**

What really makes a difference when it comes to improving outcomes in the NHS? Certainly not wholesale dismantling of systems and processes that are working well or pitting groups of professionals against each other and inviting commercial providers to pitch for services to reduce costs, argues Roger Boyle.

He retired last week after 11 years as England’s national director for heart disease and stroke, because he disagrees so strongly with the coalition government’s plans for the NHS.

“No reorganisation ever saved anybody’s life. The thing that remains the same, year after year and reorganisation after reorganisation, is the clinician, the patient, and the disease, all in a room together. Everything else is secondary to that.

“What this is in primary, secondary, or tertiary care, it is this relationship—and how it is dealt with—that is absolutely crucial.”

Professor Boyle acknowledges that NHS care must be cost effective, but he considers that the complete dismantling of NHS structures is unnecessary and won’t help improve efficiency.

“I get fed up with people decrying the NHS. We vie with the Netherlands and Scandinavia for having some of the best quality health services in systematic comparisons.

“In terms of value for money, we always come out as being the most efficient, with some of the lowest transaction costs of any developed country in the world. I am not saying we should not be aiming to do better—we must do better in the current financial climate—but we have been making a pretty good fist of it, and we should build on that success rather than demolish it all and start again,” he said.

What advice would Professor Boyle give to the health secretary, Andrew Lansley? “He should talk to clinicians more, and not just the ones he is happy with,” he suggests. “He has visited virtually every hospital in the land over the years. But I think he needs to develop a better understanding of what clinicians do and what really matters in improving patient outcomes.”

The government has also underestimated the need to build a force for good, he suggests. “The notion of a social movement, where everybody is pointing in the same direction, with a clear agenda, is essential. If people feel part of something, they will set to work with a will.”

The widely acknowledged improvements in

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**MPs urge ministers to scrap £7bn NHS care records system**

**Adrian O’Dowd LONDON**

The government should abandon its £7bn (£8.6bn; $11.4bn) care records system, as it is an “unworkable” and costly mistake, claims a report from an influential committee of MPs.

The Public Accounts Committee published a highly critical report on 3 August on the care records system for the NHS in England—part of the £11.4bn national programme for IT in the NHS. The programme was launched in 2002, and the Department of Health has spent £6.4bn on it so far.

The committee focused on delivery of what is meant to be a fully integrated, electronic care records system and took evidence from the Department of Health and its contractors BT and Computer Sciences Corporation (CSC).

Originally the aim was for every patient to have an individual electronic care record that could be easily transmitted between different parts of the NHS. The report says that this has proved to be beyond the capacity of the health department, which has admitted that it will not be able to deliver a universal system, relying instead on individual NHS trusts to develop systems that are compatible.

The report says that the department has failed to demonstrate the benefits achieved for the £2.7bn spent to date on care records systems and should consider whether the remaining £4.3bn to be spent by 2015-16 would be better spent elsewhere.

A big problem was the department’s failure to get the best out of its suppliers. CSC had not yet delivered the bulk of the systems it was contracted to supply and had instead implemented a large number of interim systems as a “stop-gap.” BT had also not delivered on its original contract, and the department had had to agree a revised contract reducing the number of systems but increasing the price for each.

“The Department is clearly overpaying BT to implement systems,” says the report. “BT is paid £9m to implement systems at each NHS site, even though the same systems have been purchased for under £2m by NHS organisations outside the programme.”

The committee criticised the department’s “weak programme management” overall and that it had failed to explain how wider health reforms would affect the future management and governance of the care records system.

The committee’s report is at www.parliament.uk.

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Doctors make the best hospital managers, study indicates

Zosia Kmietowicz LONDON

Hospitals run by doctors outperform those run by managers, indicates a study in Social Science and Medicine (doi:10.1016/j.socscimed.2011.06.025).

Amanda Goodall, a senior research fellow at the Institute for the Study of Labour in Bonn, looked at the top 100 US hospitals in three specialties—cancer, digestive disorders, and cardiovascular care and surgery—as ranked in 2009 by US News and World Report league tables. She then ascertained whether the hospitals’ chief executive officers were doctors or professional managers.

She found that a qualified doctor was the chief executive in 51 of the top 100 cancer hospitals, 34 of the best 100 hospitals for digestive disorders, and 37 of the top 100 cardiac hospitals. And of the 21 hospitals given an “Honor Roll”—those that performed well in at least six of the 16 specialties—16 had chief executives who were doctors.

The study also looked at mean quality scores of the highest ranked hospitals and found that these were 30-40% higher for those led by doctors in all the specialties investigated.

When Dr Goodall removed the 52 hospitals that appeared in two or three of the three top 100 lists, those that performed better among the remaining 160 hospitals were disproportionately led by doctors.

Other research has shown that only 235 (3.6%) of the 6500 hospitals in the US have a medically trained chief executive.

Dr Goodall said the results are equally applicable to the UK. “My instinct would be to say that in general medics playing a bigger role in the management of health service has got to be a good thing,” she told the BMJ.


US proposes major changes to guidance on human research

Jeanne Lenzer NEW YORK

The US government has proposed a raft of changes to current guidelines on studies involving human participants, in a bid to keep pace with substantial change in the nature of such research and the way it is conducted.

If adopted, the changes will be the first in two decades to the “Common Rule” that regulates almost all federally funded human research. They would apply to studies directly funded by the government and all research conducted at institutions receiving federal funds.

The government wants a “single IRB [institutional review board],” to review the safety and scientific integrity of clinical trials conducted at many sites.

Vera Hassner Sharav, president of the Alliance for Human Research Protection, said that local IRBs can offer added protection “because they are responsible to their local community.” Selection of board members may also be important, she said.

Overhaul US licensing of devices, urges Institute of Medicine

Deborah Cohen BMJ

The US Food and Drug Administration needs to overhaul the process by which medium risk devices such as hip implants and x ray machines reach the market, an Institute of Medicine report has concluded.

The so called “510(k)” process, created by Congress in 1976 when regulation of medical devices began, is one of two regulatory pathways through which medical devices reach the market in the United States.

It requires manufacturers only to show that their product is “substantially equivalent” to another. Currently companies do not have to prove the safety and effectiveness of their product in clinical studies.

Thousands of medical devices have consequently received FDA clearance on the basis of equivalence to older devices. Currently over 90% of devices go through this route.

The institute’s report, which follows a long running debate about the adequacy of the 510(k) process, says, “A move away from the 510(k) clearance process should occur as soon as reasonably possible [for moderate risk devices].”

David Challoner, chairman of the committee that reviewed the process, said in a statement, “The public can reasonably be assured that they [devices] are fulfilling their function, but we can’t say that they’re safe and effective.

“It is not clear that the 510(k) process is serving the needs of either industry or patients, and simply modifying it again will not help.”

He added that the process “cannot achieve its stated goals: to promote innovation and make safe, effective devices available to patients in a timely manner.”

There was a danger that products entering the marketplace in another 35 years’ time might be based on a device from 70 years ago, he said.

The report also highlights the need for better post-marketing surveillance: “No premarket regulatory system for medical devices can guarantee that all new medical devices will be completely safe and effective when they reach the market. Robust postmarketing surveillance is essential.” It adds: “The FDA should develop and implement a comprehensive strategy to collect, analyze, and act on medical device aftermarket performance information.”

Responding to the report, Jeffrey Shuren, director of the FDA’s Center for Devices and Radiological Health, said, “FDA believes that the 510(k) process should not be eliminated. But we are open to additional proposals and approaches for continued improvement of our device review programmes.”

AdvaMed, a lobbying group that represents major manufacturers, rejected the findings, saying they would be a “disservice to patients and the public health.”

Medical Devices and the Public’s Health: The FDA 510(k) Clearance Process at 35 Years is at http://iom.edu.

Bupa refuses to pay for “inappropriate” knee arthroscopy

Ingrid Torjesen LONDON

A row has erupted between the UK private health insurer Bupa and a group of the country’s top orthopaedic surgeons, after Bupa accused some surgeons of carrying out knee procedures on patients without good medical reason.

Bupa, which funds around 19 000 arthroscopies every year, undertook a review of knee arthroscopies among its insured customers and found that the standardised event rate was more than twice as high among them as it was among NHS patients. Furthermore, some surgeons were more than three times as likely as others to carry out the procedure on Bupa patients.

Annabel Bentley, medical director of Bupa’s UK Health and Wellbeing Division, said, “We know as well that there are wide variations within the NHS, so the variations could be even greater than that in some parts [of the country].”

Bupa then decided to implement a medical review process for knee arthroscopy to weed out procedures that were not clinically necessary. This required surgeons to complete a form before eligibility for funding was granted. The form gave information such as indications for surgery; whether any imaging had taken place; what, if any, conservative treatment had been tried; and whether there was any clinical evidence of mechanical joint locking.

Dr Bentley told the BMJ, “As a healthcare organisation with a responsibility to its members we are responsible for their funds and for ensuring that we provide funds for appropriate clinical treatments.

“We are allocating funds in line with clinical best practice in accordance with relevant evidence based guidelines. We will pay for a knee arthroscopy when it is in line with clinical best practice; we will not pay when it is poor practice.”

Healthcare in US will consume a fifth of GDP by 2020

Bob Roehr WASHINGTON, DC

Spending on healthcare will consume 19.8% ($4.6 trillion (£2.8 trillion; €3.2 trillion)) of the total US economy in 2020, predict government actuaries at the Centers for Medicare and Medicaid Services. It is the first time that their projections have taken into account the effects of health reform under the Affordable Care Act, passed in 2010.

Health spending grew by only 3.9% in 2010, to $2.6 trillion, a historically low rise but still higher than growth in the overall economy.

The annual rise is projected to increase to 8.3% in 2014, when major provisions of the health reforms kick in and 30 million Americans gain access to health insurance. Over the decade to 2020 health spending is expected to rise by 5.8% each year, and the economy by 4.7%.

“We are projecting an increase in the health share of the GDP [gross domestic product] from 17.6% in 2010 to 19.8% by 2020,” said Sean Keehan, the lead author of the study, at a 27 July news conference. The study is published in Health Affairs (doi:10.1377/hlthaff.2011.0662).

Payments to all health sectors are predicted to continue to grow, though less quickly for hospitals, which will slip from 31% to 30% of health spending. A single percentage of the total represents about $50bn.

The share spent on prescription drugs will edge up from 10% to 11%, Mr Keehan said. Drug use is projected to rise with the expansion of health insurance coverage in 2014, largely to treat chronic conditions such as diabetes and hypertension.

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Cite this as: BMJ 2011;343:d4895
Bupa would not fund arthroscopy for treatment of osteoarthritis without mechanical locking, for example, because there was clear evidence that it was “ineffective and not clinically appropriate,” Dr Bentley said.

The British Orthopaedic Association has urged surgeons to boycott the form, which, it says, undermines surgeons’ clinical judgment.

Peter Kay, president of the British Orthopaedic Association, said, “A pre-authorisation process containing limited clinical information will not address variation and will not stop a poorly practising surgeon, should they exist, filling the form in such a way as to ensure the surgery is funded.”

He questioned why Bupa had refused to make it known to individual surgeons that they had high procedure rates or to “report the surgeons to the medical directors of the hospitals they work in or inform the [regulator] if they have the evidence they claim.”

He suggested that a “blanket process of review of all surgical decisions” failed insured patients and undermined most surgeons who have practised appropriately for years and whose reputations would have largely prompted referral to them in the first place.

Bupa has received 3000 requests from doctors for arthroscopy funding since the review system was implemented in May. In most cases doctors had completed the form, Dr Bentley said. Where they had objected, doctors had been allowed to provide the information through copies of medically relevant letters, records, and scan reports.

She added that a wide ranging review of worldwide guidelines for arthroscopy had been conducted to inform the medical review process, and this would be published shortly.

Bupa introduced a similar review system several years ago for hysterectomy when an audit by the Royal College of Obstetricians and Gynaecologists showed no symptoms in the wombs of some women who had undergone the procedure.

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**UN steps up relief efforts as Somali famine set to worsen**

Tens of thousands of lives are at risk in southern Somalia without additional funds

**John Zarocostas**

United Nations aid agencies have intensified relief efforts to help millions of people at risk in drought and conflict ravaged Somalia, amid fears that all areas of the south of the country could slip into famine.

“The deterioration is considered likely given the very high levels of both severe and acute malnutrition and under-5 mortality,” warned the UN Office for the Coordination of Humanitarian Affairs (OCHA) in a report on 29 July.

On 20 July the UN declared famine in the lower Shabelle and Bakool regions of southern Somalia, after new data showed rapidly rising rates of acute malnutrition and death.

OCHA’s report to donors on the aid needed for the drought in the Horn of Africa warns: “Eight other regions of southern Somalia are at risk of famine in the coming 1-2 months unless aid delivery increases in proportion to the needs.” The Famine Early Warning System Network recently said that a “massive response” is crucial to save tens of thousands of lives in southern Somalia.

Edward Carr, a famine response official at the US Agency for International Development, which funds the network, has stated that if, as the network predicts, “we have famine conditions in play across all of southern Somalia, we could be talking about mortality rates in the range of 2500 deaths a day at some point in July.”

The aid charity Médecins Sans Frontières said at its Marere Hospital in the southernmost region of Lower Juba that its teams are facing “a huge wave of patients,” most of whom have malaria or are malnourished, and that it had about 700 children on therapeutic feeding programmes.

The World Health Organization’s representative for Somalia, Marthe Everard, told the BMJ that since March more than 2585 cases of cholera had been reported, of which 70% were in children aged under 5 years, and that 111 (72%) of the 155 related deaths were also in this age group.

Furthermore, health facilities in the area had reported 4424 cases of suspected measles, including 3597 (81%) in the under 5s, and 71 related deaths up to 10 July.

WHO is running mobile clinics providing essential services and emergency healthcare to internally displaced people in Somalia, and it plans to distribute prepacked kits to health facilities in the drought hit areas of south and central Somalia.

Marisie Mercado, a Unicef spokeswoman, told reporters that the agency was using all means, including flights, to scale up its pipeline of food supplies into southern Somalia.

The UN has said that it needs an additional $1.4bn (£0.9bn; €1bn) from donors to provide immediate help to nearly 12.4 million people across the Horn of Africa, and the UN chief, Ban-Ki-moon, has called for “urgent international efforts to meet the gap.”

The funding shortages are also causing bottlenecks in the delivery of aid in refugee camps in Ethiopia and Kenya, which are struggling to cope with the continuing influx of Somali refugees.

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