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Screening for abdominal aortic aneurysm: should we lower the intervention cut-off point?

No; better to tackle common risk factors for chronic disease and social determinants of health

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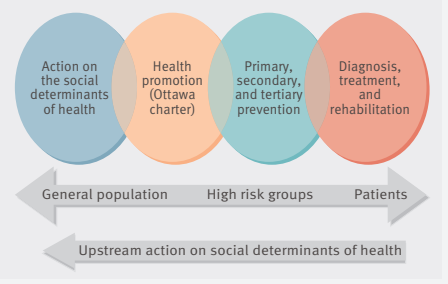
In accordance with the recommendations of the US Preventive Services Task Force and the UK National Screening Committee in favour of screening for abdominal aortic aneurysms (AAAs),[1 2] the United Kingdom's NHS began phased implementation of routine screening for all men at age 65 years. According to the guidelines,[3] about five in every 1000 men screened will have an AAA greater than 55 mm and will be referred for surgery to prevent rupture and related death. In addition, another 35 men will have an AAA of 30-54 mm and will be followed with regular ultrasounds, lifestyle counselling, and medical management. The remaining 960 of 1000 men with an aorta less than 30 mm will be discharged from the programme with no further follow-up. However, in the linked study, Duncan and colleagues present new evidence showing that men with a slightly enlarged aorta (25-29 mm) are also at increased risk of death and hospital admission as a result of chronic disease.[4] These results beg the question—should the cut-off point for a "normal" screening test be lowered to 25 mm or should we retain the current cut-off point of 30 mm?

Making screening policy decisions is a complex undertaking that has evolved over the past 40 years, with an increasing emphasis on results based management, evidence based medicine, and patient choice.[5] The difficulty in establishing screening cut-off points is that risk exists on a continuum and does not increase in a stepwise manner. In the United States there has been great controversy over whether to start breast cancer screening at age 40 or 50 years, and more recently some experts have argued that women are being over-screened and that the harms outweigh the benefits for the great majority.[6]

When determining cut-offs points it is important to ask "what is the added benefit to the person being screened?" Are those with an aortic diameter of 25-29 mm really at higher risk of morbidity and mortality? Are there interventions that can reduce morbidity and mortality in this group? Do the potential benefits outweigh the harms? What are the opportunity costs?



A continuum of strategies is needed to improve population health

In Duncan and colleagues' study, out of 8146 men screened, there were 2.2% aneurysm related deaths in men with an aortic diameter greater than 30 mm (9/414) versus only 0.1% in the 25-29 mm group (1/669) and 0.01% in the under 25 mm group (1/7063). Similarly, there were 63.5% aneurysm related hospital admissions in the over 30 mm group (263/414) versus only 4.5% in the 25-29 mm group (30/669) and 0.6% in the less than 25 mm group (44/7063). Because screening for AAA does not affect overall mortality, but only aneurysm related mortality,[7] and because the repair of small aneurysms provides no added benefit,[8] the number needed to screen to benefit one person in the 25-29 mm group would be much higher than in the over 30 mm group. In addition, all screening is associated with inherent harms. An estimated one in 20 men dies during elective surgical repair of an aortic aneurysm. This may be acceptable for men at very high risk of aneurysm rupture and related death, but for men at lower risk the harms of screening and ongoing follow-up may outweigh the benefits, so greater caution is needed.

Indeed, the current study shows no overall difference in mortality between the less than 25 mm group and the 25-29 mm group after adjusting for known cardiovascular risk factors. Changing the cut-off point for intervention is therefore unlikely to have an effect on overall mortality. Even if the 25-29 mm group has somewhat increased rates of hospital admission for cardiovascular disease, diabetes, and chronic obstructive pulmonary disease, screening for AAA is not the most effective means of reducing this increased risk. It has long been known from autopsy studies that fatty streaks begin to appear in the aorta in adolescence or even in childhood, particularly among people with risk factors such as smoking, impaired glucose tolerance, and obesity.[9] Prevention of chronic disease therefore needs to be integrated,[10] and it needs to start earlier. Efforts aimed at reducing risk factors in the entire population are likely to have a greater effect than focusing on lifestyle counselling for the relatively small proportion of older men with an aortic diameter greater than 25 mm. Screening (which is a form of secondary prevention) is part of a wider continuum of strategies for improving population health that ranges from health promotion and disease prevention to treatment and rehabilitation (fig 1). The best approach is to prevent disease before it occurs by tackling the underlying social causes of poor health.[11] Too often we blame the individual for making unhealthy choices and spend money on costly hospital based interventions, when really we need to change the social and physical environment to "make the healthy choices the easy choices."[12]

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Response on bmj.com

"Severe human rights abuses can become acceptable—even routine—if nobody speaks up, and hierarchical healthcare systems encourage complicity." Mitzi A J Blennerhassett, medical writer, Yorkshire Cancer Network user partnership group, Harrogate, North Yorkshire

Severe human rights abuses in healthcare settings

Doctors should be aware of what constitutes torture to avoid being complicit

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Doctors must act against human rights violations

Pervasive abuses are often dressed up as "good intentions"

Every day healthcare professionals are complicit in serious human rights abuses. Some are the abusers or their assistants, whereas the complicity of others arises from a failure to act on violations that they witness. The responsibilities of doctors in both circumstances should be clear, having been set out by the World Medical Association in the Declaration of Tokyo: "the physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures."[1] Nor shall they "provide any premises, instruments, substances or knowledge to facilitate th[is] practice." Yet, despite clear prohibitions, severe abuses are widespread, even in countries with well developed legal and regulatory systems.[2]

The United Nations Human Rights Committee has specifically identified medical institutions as settings for abuse,[3] even though the medical personnel involved may be unaware that abuse is occurring. But do abuses in health facilities reach the threshold of torture or cruel, inhuman, or degrading treatment? Often they do. Under international law, any "act by which severe pain or suffering, whether physical or mental, is intentionally inflicted . . . by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity" may be torture or cruel, inhuman, or degrading treatment.[4] The concept of intent serves to exclude inadvertent suffering, such as that from medical errors.

Serious abuses that are justified by flawed public health arguments are of particular concern. People who use illicit drugs are especially vulnerable to severe abuse—such as lobotomy, beatings, and forced labour—under the guise of treatment for their addiction.[5] In Vietnam and Laos,[6 7] government funded addiction "treatment" comprises incarceration in squalid "rehabilitation" facilities, forced labour, and corporal punishment.

Abuses may arise when cumbersome bureaucratic restrictions keep doctors from providing appropriate care. The preoccupation of officials with drug control at the expense of patient care often translates into insurmountable hurdles to the administration of adequate pain relief. In Ukraine, oral morphine is unavailable, and arbitrary limits on injectable morphine provide only a small fraction of what patients need.[8] This is contrary to recommendations of the World Health Organization and the International Narcotics Control Board, and UN experts have stated clearly that denial of pain relief constitutes a failure by governments to protect patients against torture and cruel, inhuman, and degrading treatment.[9] Reasons for such inadequacies include governments failing to ensure effective systems to procure and distribute analgesics and to provide appropriate training, and misplaced concerns about the risk of patients becoming addicted. Indeed, fear of addiction leads some doctors to perform surgery without anaesthesia on patients with a history of drug dependency.[10]

Pervasive abuses are often dressed up as "good intentions." In many countries, people with disabilities are confined against their will and given treatment without their consent—for example, with neuroleptics. The special rapporteur on torture has said that in some circumstances the suffering inflicted and the effects on the person's health from this forced and non-consensual treatment may constitute a form of torture or ill treatment.[11] People with physical and intellectual disabilities—along with drug users, women living with HIV, and certain racial and ethnic minorities—are also often forced to undergo permanent sterilisation procedures, often without their consent or even their knowledge. This is a clear violation of the right to be free from torture and ill treatment.[12]

Those who work in healthcare must educate themselves about human rights in medical practice so that they can recognise the problem and be in the front line against abuse in healthcare rather than contributing to it. National regulatory bodies should establish means to identify and act on abuses. International professional bodies could play a greater role. In July 2011 the International Federation of Gynecology and Obstetrics released new guidelines on female contraceptive sterilisation that clearly outlined eligibility and informed consent procedures. In October 2011, the World Medical Association recognised the widespread suffering caused by lack of access to pain relief and adopted a resolution calling on countries to ensure access to essential pain relieving drugs. Much work remains to be done.

Competing interests: Both authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: LG is the coordinator of the Campaign to Stop Torture in Health Care, a coalition of organisations working to combat severe human rights violations in healthcare settings; MMcK is an adviser to the campaign; otherwise, no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years, no other relationships or activities that could appear to have influenced the submitted work.

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Studies of influenza A/H1N1 2009 . . . found that infected pregnant women were at particularly high risk of severe illness [and] poor perinatal outcomes

Immunisation against influenza during pregnancy

The benefits outweigh the risks

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Since the A/H1N1 2009 influenza pandemic, universal immunisation of pregnant women against seasonal flu has been recommended in many areas of the world.[1-3] Despite experience with immunisation against seasonal flu in pregnancy over many years, uptake of influenza vaccine in pregnancy during the 2009 A/H1N1 2009 pandemic was low and immunisation rates among pregnant women generally remain low.[4 5] One commonly cited reason for this is concern among women and clinical staff about the safety of the vaccine during pregnancy.[6]

In a linked research paper, Pasternak and colleagues present findings from an important new Danish national cohort study of women vaccinated against influenza A/H1N1 2009.[7] The study suggests that women who are immunised in pregnancy have a lower risk of fetal loss than non-immunised women. The study provides reassuring information for people who are worried about the safety of the vaccine and evidence of the benefits of vaccination, which were previously only hypothesised. This is particularly important because the influenza vaccination season has just started in the southern hemisphere, where the A/California/7/2009 strain is included in the current vaccine. After a World Health Organization consultation, it has also been recommended that an A/California/7/2009 (H1N1) pdm09-like virus be included in vaccines for use during the 2012-13 northern hemisphere influenza season.

BLOOMBERG VIA GETTY IMAGES

Flu vaccination rates among pregnant women are low

Voluntary reporting systems have also yielded reassuring information about the safety of influenza vaccines during pregnancy.[8 9] Several aspects of the safety of influenza vaccines in pregnancy have been questioned.

Live vaccines are generally not recommended because they carry a theoretical risk to the fetus. The A/H1N1 2009 and seasonal influenza vaccines are, however, inactivated so do not pose this risk.

The presence of thiomersal, which is used as a preservative, has also triggered concerns. However, although trace amounts of thiomersal may be present in some vaccines, early exposure in utero or infancy has not been associated with deficits in neuropsychological functioning in children.[10]

Lastly, the safety of adjuvants, which are included in vaccines to improve the immune response, has been questioned. Again, experience with adjuvanted seasonal influenza vaccines in pregnancy suggests there are no safety concerns. The present study, which included more than 7000 women treated with an adjuvanted vaccine (including squalene, DL-α-tocopherol, and polysorbate 80) provides further evidence to support the conclusion that adjuvants are safe in pregnancy.[7]

Studies of influenza A/H1N1 2009 rapidly found that infected pregnant women were at particularly high risk of severe illness.[11] Subsequently, once cohorts of infected women had been followed through pregnancy, the results suggested that women were also at risk of poor perinatal outcomes.[12] Previous studies had suggested that infection with seasonal flu was associated with increased risks in pregnancy, although the risks were not as high as with A/H1N1 2009. Prevention of infection through immunisation is likely to reduce these risks, and the new study suggests that immunisation against A/H1N1 2009 is associated with a decreased risk of stillbirth.[7] However, this observational study cannot establish causality. The causes of stillbirth are multifactorial, and although the researchers accounted for confounding by the presence of medical comorbidities they did not adjust for obstetric complications so residual confounding is possible.

The current study has other limitations. The study excluded women of fewer than seven weeks' gestation and included only a small number of women who were immunised in the first trimester of pregnancy. The lack of an association between spontaneous abortion and immunisation could therefore be due to the small number of women immunised in early pregnancy. Further research that deals with this question as well as other outcomes, such as congenital anomalies, in the context of longer term safety monitoring is therefore important.

Pasternak and colleagues' study provides even clearer evidence that the benefits of immunisation against influenza outweigh the risks for pregnant women. However, in this national cohort, only 13% of pregnant women were immunised.[7] In the 2010-11 influenza season in the United Kingdom, between a third and a half of eligible pregnant women were immunised.[4] A study in one Australian centre showed an increase in immunisation rates from 30% to 40% in pregnant women after the introduction of a staff and patient educational campaign.[6] Although women who were not vaccinated most commonly cited concern about fetal risk as the reason for non-vaccination, the second most common reason was that medical and midwifery staff had not suggested immunisation.[6] The authors of the Australian study speculated that immunisation rates could have been as high as 78% if immunisation had been offered as part of hospital based antenatal care.

It is clear from other studies that women who are offered influenza vaccination by their healthcare professional are more likely to be immunised and to have positive attitudes towards vaccine safety and effectiveness.[5] It is the duty of all professionals who care for pregnant women to be aware of these findings on the safety of influenza vaccine in pregnancy, and to ensure that pregnant women receive an offer of vaccination that includes accurate evidence based information on risk. Further consideration should be given to the availability of immunisation services within hospital based care settings.

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- NHS whistleblowers are still being gagged, warns Baby P doctor (*BMJ* 2012;343:d8202)
- News: Regulator finds catalogue of failings at Bristol centre exposed by television documentary (*BMJ* 2011;343:d4634)
- Observations: The hardest thing: admitting error (*BMJ* 2012;344:e3085)
- Feature: Whistle while you work: an analysis of NHS foundation trust policies (*BMJ* 2010;340:c2350)

Doctors' duty to report poor practice

GMC guidance can be enforced only in a culture that supports whistleblowers

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The recently relaunched General Medical Council (GMC) guidance, *Good Medical Practice*, requires all doctors to "act without delay if you have good reason to believe that you or a colleague may be putting patients at risk" in principles 6 and 43,[1] which deal with raising concerns about patient safety and the conduct and performance of colleagues. This duty is further explained in new guidance, published in January 2012, which came into effect on 12 March 2012.[2] The new guidance expects doctors to encourage and support a culture in which staff can raise concerns openly and safely, and those with additional responsibilities (such as clinical governance or wider management responsibilities) have "a duty to help people report their concerns and to enable people to act on concerns that are raised with them."[2] It is all very well to say that all doctors have a professional duty to blow the whistle, but what does this mean in practice?

Whistleblowing has been thrown into sharp focus by recent scandals at Winterbourne View, where appalling standards of care were secretly filmed and shown on national television, and in which a whistleblower had been ignored, and at Mid Staffordshire NHS Foundation Trust, where exceptionally high death rates are being investigated by a public inquiry. Both the GMC and the Nursing and Midwifery Council (NMC) have been asked why their members did not act in these circumstances. The GMC has stated that between120 and 150 doctors must have known something was going badly wrong at Mid Staffordshire Hospital. They acknowledged that although some people did blow the whistle and some doctors took appropriate action and followed GMC guidance, a large numbers of doctors did not.[3]

The fact that the GMC has admitted that several doctors were under investigation because they failed to raise concerns about colleagues gives a clear message that doctors are as much at risk of being investigated for failing to report concerns about a colleague's practice as they are for their own poor practice.

However, clear examples of the dangers of challenging colleagues in the NHS are provided by the high profile cases of Kim Holt, Ramon Niekrash, and John Watkinson, all of whom experienced reprisals because they questioned poor practice, systems, resources, or conduct.[4] Ultimately, the attitudes of trust leaders dictate whether whistleblowers are listened to and can safely raise their concerns, and it is the attitudes of leaders and managers that will dictate whether an organisation is open and accountable or closed and silent.

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The Mid Staffordshire public inquiry has questioned the GMC and NMC

How does the individual decide whether and how to raise a concern? Will the information be welcomed and acted on, or will the messenger be ignored or, worse, "shot" in the process? Two decades on from the Bristol Royal Infirmary scandal, where high infant mortality rates were ignored despite warnings by Stephen Bolsin, a consultant anaesthetist, and millions were spent on a public inquiry intended to learn the lessons of what went wrong,[5] these sorts of questions should not still be relevant when the matter being raised relates to patient safety, serious risk, fraud, or malpractice.

Is the threat of disciplinary action enough to stop people turning a blind eye? Should other options be explored first? Organisations can take steps to ensure that they are open, accountable, and supportive of whistleblowers, rather than supportive of a culture of silence. The starting point must be a clear commitment from organisational leadership that the reporting of bad practice is taken seriously, with reassurance that any reprisal against the person raising the concern will not be tolerated. Managers must understand the key "speak up" policy messages and appreciate that it is acceptable for staff to bypass the management line if they have a serious concern about patient safety, risk, or malpractice. It is important to have a clear and easy to follow policy, which names people who are trained to deal with any concerns raised and to do so promptly, competently, and fairly. Auditing and reviewing the operation of the policy, dealing with concerns, and protecting staff who do raise a concern will make all the difference, including, if necessary, taking action against those who victimise whistleblowers. For more information and guidance on whistleblowing in healthcare see the NHS-wide guidance on this matter.[6]

Brighton and Sussex NHS Foundation Trust has recently created the new role of patient safety ombudsman—a member of staff with access to trust leadership who can act as a conduit for concerns and can and will follow up on remedial actions. Other trusts should consider piloting and adopting similar strategies aimed at improving openness and accountability.

The GMC should take the organisational culture into account when deciding whether an individual's failure to speak up should affect his or her professional registration. Only if the organisation has a proven track record of dealing well with concerns raised, promoting the policy messages effectively, and taking action against those who victimise whistleblowers should a failure to speak up be considered a dereliction of duty. It is incumbent on the GMC to prove that its new guidance that places a duty to act on doctors has real teeth. It could merely make a bad situation worse if regulatory processes were implemented on the basis of the guidance without the organisational culture being taken into account.

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A system-wide challenge for UK food policy

Single issue solutions won't prevent diet related diseases with complex causes

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Diet related disease leads to about 70 000 premature deaths in the United Kingdom.[1] The rising prevalence of obesity is a signal that the food system is out of kilter with public health priorities. Ahead of the World Health Assembly (21-26 May in Geneva), which will discuss the World Health Organization's progress on strengthening action for preventing non-communicable diseases, Mytton and colleagues consider the evidence for specific food taxes to improve health,[2] while Hawkes makes the case that global health policies should be embedded within the wider food economy.[3]

Under successive governments, UK policies on diet have relied heavily on more and better education for consumers to make healthy choices, based on the notion that consumer behaviour will shape markets. More recently, basic information campaigns have given way to a social marketing approach, epitomised by Change4Life, a campaign run by the Department of Health in England that offers encouragement and support to achieve a healthier lifestyle. It is well known that putting knowledge into practice needs clear nutritional labelling, although the plethora of current schemes limits the opportunity to deliver consistent messages to consumers. Several "health by stealth" initiatives also exist, including reformulation to reduce salt and remove artificial trans fats. Increasingly, the UK government is accepting that consumer behaviour is shaped by people's life experiences and environments,[4] which suggests the need for a broader food policy.

Food policy cuts across departmental boundaries. . . ..although the Department of Health picks up most. . . costs of obesity, many. . . policy levers for change lie outside its jurisdiction

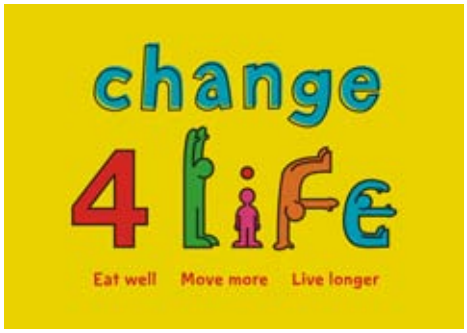
The challenge for government is that food policy cuts across departmental boundaries. The Foresight report on obesity highlighted that although the Department of Health picks up most of the costs of obesity, many of the policy levers for change lie outside its jurisdiction.[5] The same holds true for other diet related diseases. In the UK we now have a cabinet subcommittee on public health, which should help realise the potential of government-wide action to reform the food system along the lines previously set out in the Cabinet Office report *Food Matters*.[1]

The UK has been at the forefront of international efforts to introduce new policies to change dietary habits, and we need to use this experience to shape future actions to tackle problems in the entire food system. For example, introducing nutritional standards for school meals was successful because it stimulated broader changes across the whole of school food policies and encouraged the food industry to improve recipes. Through related activities, such as cooking and gardening clubs, the message has spread to families and communities, and this has encouraged a public debate about food.[6]

In contrast, narrow policies such as restrictions on TV food advertising have led to only limited reductions in the exposure of children to the promotion of foods of low nutritional quality, with marketing spend shifting beyond children's programmes to other outlets, including digital media.[7] TV advertising may be iconic, but it is only the tip of the iceberg in marketing power. As evidence accumulates of a direct effect of food branding on eating behaviour in children,[8] and public concerns about the commercialisation of childhood increase, it is time to revisit this issue to seek a wider societal shift in the balance of food promotions.

As we strive to change the food system local government also has a role to play. The latest draft guidance on obesity from the National Institute for Health and Clinical Excellence, now out for consultation, focuses on working with local communities to transform local food (and physical activity) environments to prevent obesity.[9] In the new public health system local authorities will need to seize the opportunities to link local policies, from procurement of food by public institutions, through work with local food businesses and planners, to interventions by health professionals.

We all find it easier to think of isolated actions—they provide a succinct rallying cry for lobby groups, a neat testable hypothesis for academics, and a clear target for policy



makers—but there is an intellectual inconsistency in accepting poor diets as the product of a complex web of determinants while advocating single issue solutions. The Nuffield Council set out a useful "ladder of intervention" to frame public health actions,[10] but a systems approach is not so much a ladder as an intricate climbing frame, where a whole series of initiatives need to be enacted in concert.

Food policy is a matter for everyone and needs partnerships and alliances at all levels to drive change—individuals making choices for themselves and their families, communities and local government taking action, businesses acting responsibly, and government leading and coordinating action across departments and sectors. The Responsibility Deal Food Network, a government scheme that asks organisations to sign up to encourage and enable people to achieve a healthier diet, represents a new commitment to this way of working in England. The task for the World Health Assembly next week is to build an international coalition that accelerates and unites the whole range of national actions to rebalance the food system and reduce the burden of diet related disease.

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Analysis: Why India needs a national nutrition strategy (*BMJ* 2011;343:d6687)

Analysis: Strengthening primary healthcare in India: white paper on opportunities for partnership (*BMJ* 2012;344:e3151)

bmj.com blogs India's 2012 budget—a paradigm shift in addressing India's undernutrition

Strengthening primary healthcare in India

UK-India partnership offers promise if it connects with existing efforts and stakeholders

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The concept of primary healthcare was brought to the world's attention in a consolidated manner by the Declaration of Alma-Ata in 1978.[1] This asserted that the overall wellbeing of all people could be achieved through a comprehensive primary healthcare approach that takes into account the broader socioeconomic determinants of health and is driven by governments using practical, scientifically sound, and socially acceptable methods. In the following years this approach was criticised by some for being too broad, but the notion of achieving health for all with primary healthcare at the centre has recently been revived.[2] The "white paper" on an India-UK partnership on primary healthcare—published online this week in the *BMJ* and prepared as guidance to the India-UK CEO Forum set up by the prime ministers of the two countries—builds on this approach.[3]

In 1946, in the run up to India's independence, the Bhore Committee recommended a health system for India that was largely consistent with the principles of comprehensive primary healthcare, emphasising prevention, basic healthcare for all, linkages between the different levels of care, and the broader determinants of health.[4] These recommendations were poorly implemented over the subsequent decades for reasons that included relatively poor allocation of public funding for health, inadequate linkages between different social sectors, and incomplete development of the infrastructure needed for comprehensive primary healthcare. Efforts to bring primary healthcare to the forefront have, however, continued, and these include the People's Health Movement,[5] the launch of the National Rural Health Mission in 2005,[6] the *Lancet* India series on universal health coverage in 2011,[7] and a report on universal health coverage for India in 2011 by a high level expert group instituted by the Planning Commission of India.[8] It is essential that primary healthcare in India is strengthened because many basic health indicators continue to be poor—for example, infant mortality in India was 47 per 1000 live births in 2010, with a range of 10 per 1000 in Goa to 62 per 1000 in Madhya Pradesh.[9]

Collaborations and partnerships are essential for large scale improvements in any aspect of society, and the white paper on partnership between India and the United Kingdom on primary healthcare offers such an opportunity.[3] It outlines a strategic analysis and then a set of partnership opportunities, which include collaborative training in primary care across health disciplines; enhancing the status of primary healthcare in India using the experience of the UK's General Medical Council and Royal College of General Practitioners; developing affordable medical technologies that draw on the respective strengths of India and the UK; developing public-private partnerships using the experience of the UK National Health Service; helping develop quality standards and governance arrangements for primary care with inputs from the UK National Institute for Health and Clinical Excellence and the Department for International Development; and collaborative research and development of primary healthcare models and technologies. It ends by suggesting specific actions for the India-UK Forum, including the development of primary healthcare with UK support in a small number of Indian states, which could then be used to guide scale up across other states, and joint exploration by the India-UK governments of commercial opportunities that could arise from the partnership.

The white paper offers an interesting and useful list of partnership opportunities between the two countries to strengthen primary healthcare in India. While implementing these it would be wise to keep the following issues in mind. Firstly, the proposed activities need to be positioned to complement the efforts already going on in India to strengthen primary healthcare, such as the current discussion on implementing the *Report on Universal Health Coverage* commissioned by the Planning Commission of India and further development of the National Rural Health Mission into a National Health Mission.[6 8] Synergy with these larger efforts would probably improve efficiency of the activities proposed by the India-UK partnership.

Secondly, a holistic framework is needed to track how these activities might help the development of primary healthcare in India and assess this effort's impact over time. To ensure sound conceptualisation, monitoring, and assessment of the benefits of these activities to society, the proposed activities need to be placed in an overall framework.[10]

Thirdly, existing India-UK collaborative efforts in capacity building may have useful lessons—for example, two strategic awards by the Wellcome Trust to the Public Health Foundation of India and a consortium of 15 UK universities and institutions have been supporting collaborative capacity building in research and education in public health in India over the past three years.[11 12]

Fourthly, wider discussion among the relevant stakeholders in India to refine and implement the proposed activities would be beneficial. For example, it would be important to engage private providers and those who practise the Indian system of medicine because they are the first point of contact for healthcare for a large proportion of Indians, and engaging Indian academic and policy institutions would increase the likelihood of sustaining the proposed activities.

Fifthly, the white paper generally does not cover the broader determinants of health beyond the traditional health sector. Although it is fine to have a defined scope, it is important to remember that this is not the full scope of comprehensive primary healthcare and expectations should be adjusted accordingly.

Sixthly, the white paper suggests exploration of the commercial opportunities arising from this partnership. Although this could be mutually beneficial to India and the UK, this aspect must be handled wisely so that commercial interests do not outweigh the partnership's goal of working for the public good.

Finally, the partnership proposed in the white paper has to be one of equals. This should include equality between the Indian and UK partners in conceptualisation, development of processes, implementation, and evaluation. The Indian and UK parties will have different, probably complementary, skills to offer to the partnership, which if harnessed with mutual respect would have the best chance of successful outcomes.

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