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## Barker & Burstow's care packages for England

A tale of two markets pointing in the same direction

**Steve Iliffe** professor of primary care for older people, University College London, London, UK [s.iliffe@ucl.ac.uk](mailto:s.iliffe@ucl.ac.uk)  
**Jill Manthorpe** professor of social work, Social Care Workforce Research Unit, King's College London, London, UK

The market in social care has failed. This is the conclusion of two reports on social care from different perspectives, the Barker report and the Burstow report.<sup>1 2</sup> The Barker report is the product of wide discussion following the publication of an interim report<sup>3</sup> and explicitly rejects an unplanned and under-resourced social care market. The Burstow report explores the problems of providing acceptable housing based care services, draws on third sector and commercial experiences, and is an implicit cry for help.

The Barker report depicts relations between health and social care as opaque, inefficient, inequitable, and weighted towards individual rather than collective responsibility. Noting that the Poor Law still casts a long shadow, it argues that social care needs to be more generous and to be based on the principle of solidarity. This requires the allocation of an increased proportion of gross domestic product to social care. The option of developing insurance products that people could buy to prepare for their future care needs is dismissed as unrealistic given the insurance industry's lack of interest and the public's antipathy.

The report proposes making personal care for people with substantial and critical needs free, requiring an additional £3bn (£3.8bn; \$5bn) initially, rising to £14bn by 2025. It proposes a decade long, staged, taxation funded reform of social care. The first steps would be to make the winter fuel allowance and free TV

licences available only to those on pension credit, increase National Insurance contributions for people aged 40 or older and for the higher paid, and reintroduce contributions for those working beyond state pension age. Demographic changes will demand additional funding, to come from new wealth and property taxes, and a review of (the seemingly voluntary) inheritance tax.

Charging for NHS services is rejected as an erosion of its founding principles that is likely to adversely affect health and unlikely to yield significant sums. The only exception to this resistance to copayment is the prescription charge, which the

**Demographic changes will demand additional funding, to come from new wealth and property taxes, and a review of (the seemingly voluntary) inheritance tax**



The Poor Law's long shadow

report thinks should be reduced to £2.50 an item—“less than the price of a posh coffee”—but with many fewer exceptions; currently only 9.4% of prescriptions are paid for. Finally, the Barker report wants a single ringfenced budget for social care, the bulk of which would be derived from the NHS budget plus local authority social care funding and the attendance allowance; it would be disbursed by a single local commissioner, most probably based in local government.

The Burstow report reflects the concerns of the care home industry, which is profitable for some providers<sup>4</sup> but not others and has problems with low skill levels, high staff turnover, low pay, variable quality care, and a poor image as the residence of last resort (although many of its residents are content). Since the care home industry has three times as many beds as the NHS—with 90% owned and operated by commercial chains, owner managers, and not for profit organisations<sup>4</sup>—this description alone suggests that the market is failing. Burstow reviews the range of residential arrangements that could be offered by the care home industry to make it attractive to the public as well as being a powerful resource for the NHS and social services. The care home industry, once rebranded, could provide a comprehensive spectrum of accommodation, from village-style “housing with care” to step-up and step-down round the clock support, and palliative care.

The Burstow report proposes a transparent charging system in which residents, families, or the public sector would pay rent for accommoda-

tion; service charges for cleaning, gardening, and the like; and costs for personal or nursing care. This reconfiguration, it emphasises, will not occur without bigger and more reliable funding streams of the kind proposed in the Barker report, plus relaxation of planning permissions, incentives for expansion and diversification, and more support with training. The report calls for public investment at a level beyond the industry's capacity to generate funding.

### Care homes: an NHS franchise?

The Burstow report reminds us that the care home industry has enormous importance for an ageing society and a health service struggling to deal with this. Its call for public funding should be taken seriously, perhaps through an NHS franchise that will support care homes by reducing their trading risks, enhancing staff pay and terms and conditions, and offering training and management support.

The Barker report's proposals go beyond establishing a new settlement for health and social care. If implemented it could change the NHS from a centrally run industry to one under local government control. Its ideas will, of course, be resisted by those who stand to lose from higher taxation, by those wedded to centralised management of the NHS, and by medical and allied professionals discomfited by the rising budget of social care. The recent Labour Party proposals to create a “whole person care” system were generally received negatively by NHS leaders,<sup>5</sup> highlighting that new settlements are more than matters of money.

Provenance and peer review: Commissioned; not externally peer reviewed.

Competing interests and references are on [thebmj.com](http://thebmj.com).

Cite this as: *BMJ* 2014;349:g5879

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**The next big question is do we encourage all women planning pregnancy to adopt these healthier lifestyles or do we limit our attempts to those presently at higher risk?**

## Unhealthy lifestyles and gestational diabetes

Another good reason for young women to quit smoking, eat better, and exercise

**Sara J Meltzer** associate professor of medicine and obstetrics and gynecology, McGill University, M9.22, McGill University Health Centre-Royal Victoria Hospital, 687 Pine Ave, W Montreal, QC, Canada H3A 1A1 [sara.meltzer@mcgill.ca](mailto:sara.meltzer@mcgill.ca)

Gestational diabetes mellitus is a growing problem in developed and developing countries.<sup>1, 2</sup> In a linked paper, Zhang and colleagues report important information to help women protect themselves before and during pregnancy and reduce the enduring harm to both mothers and babies associated with gestational diabetes.<sup>3</sup>

The true incidence of gestational diabetes is difficult to know. There are wide regional and ethnic variations, and the criteria for diagnosis have been highly variable.<sup>4</sup> This inconsistency has led WHO to reassess the diagnostic criteria for gestational diabetes. In 2013, WHO recommended screening for gestational diabetes (universally when possible) with the 75 g oral glucose tolerance test, with threshold values for diagnosis recommended initially by the IADPSG (International Association of the Diabetes and Pregnancy Study Groups): fasting plasma glucose concentration of  $\leq 5.1$  mmol/L, 10.0 mmol/L one hour postload, and 8.5 mmol/L two hours postload.<sup>5</sup> Any one value at or above the threshold values would indicate gestational diabetes.

It would considerably improve evaluation of therapeutic interventions and long term outcomes if all investigators and studies used the same diagnostic thresholds, recognizing that there might be different country specific criteria used in a screening step before the diagnostic test. Some commentators are concerned that the new thresholds would lead to a surge of diagnoses and that health systems would struggle to cope with the inevitable increase in case load and costs.<sup>6</sup>

We know that treatment for gestational diabetes works. In studies using WHO 1999 criteria, treatment reduced the risk of macrosomia by up to 52%.<sup>7</sup> A recent study from Spain of cohorts of women before and after adoption of the WHO/IADPSG criteria for diagnosis found an increase in prevalence (from 10.5% to 35.5%).<sup>8</sup> Despite treatment of larger numbers of women with diet, monitoring, and insulin in the approximately 20% of women not adequately controlled with diet, there

were enough perinatal complications avoided to provide a cost advantage.<sup>8</sup> It seems clear that, when possible, we should be screening, diagnosing, and treating women with gestational diabetes.

Evidence suggests that women with gestational diabetes have a dramatically increased risk of subsequently developing type 2 diabetes (relative risk 7.4) compared with women without gestational diabetes<sup>9</sup> and that the lag time between the index pregnancy and type 2 diabetes seems to be shortening.<sup>10</sup> Importantly, the offspring of affected mothers also seem to be at greater risk for obesity, metabolic syndrome, future gestational diabetes, and future type 2 diabetes than the offspring of unaffected mothers.<sup>11</sup>

Clearly, if there are modifiable risk factors that can decrease the proportion of women getting gestational diabetes and the need for treatment, this would be the best possible scenario. Such modification could also reduce or delay the maternal long term risks for type 2 diabetes and possibly avert similar risks in their offspring. Both these outcomes would be cost saving for health systems.<sup>12</sup> Identification of behaviors and habits that could protect women from gestational diabetes would be an important step towards reducing the burden of this condition and surely preferable, for both women and healthcare providers, to treating abnormal glucose concentrations once diagnosed.

Zhang and colleagues analyzed data collected prospectively from the beginning of the Nurses' Health Study in 1989 until 2001, when most of the nurse participants had passed reproductive age (70% were aged  $>40$ ).<sup>3</sup> Women who had a diet rich in cereal grains and healthy fats (based on an "Alternative Health Eating Index 2010" diet score in the top two fifths), regularly exercised moderately vigorously for least 150 minutes a week, and did not smoke were 41% less likely to develop gestational diabetes compared with other pregnant women. This figure rose to 52% if they began their pregnancy at normal weight. Importantly though, not smoking, eating well, and exercising were associated with substantial benefit even for women who were overweight or obese before pregnancy. Unfortunately, even in this motivated group of health professionals, just

16% of women reported all four lifestyle factors associated with low risk.

Zhang and colleagues found a 43% increase in risk of gestational diabetes among current smokers but no increased risk among former smokers—another good reason to encourage women planning pregnancy not to smoke.<sup>3</sup> Perhaps not surprisingly, the greatest increase in risk was associated with pre-existing overweight or obesity, such that women with a BMI above 33 were over four times more likely to develop gestational diabetes than women who had a normal BMI before pregnancy.

### Cohort mostly white nurses

A well recognized limitation of this cohort is that participants are predominantly white and all nurses. It is important for future research to determine if the apparent effect of lifestyle is the same in other ethnic groups or in populations that are less well educated about health. In the absence of a large randomized controlled trial evaluating adjustments in lifestyle before pregnancy, which might or might not be conclusive, the observational work by Zhang and colleagues provides us with valuable information.

The next big question is do we encourage all women planning pregnancy to adopt these healthier lifestyles or do we limit our attempts to those presently at higher risk? It is likely that a population health initiative strongly encouraging all women planning a pregnancy, including those at high risk, to eat better, stop smoking, and take more exercise would provide the world's population with the largest effect for effort. Lifestyle modification is notoriously difficult, but not impossible. When combined with aggressive screening, diagnosis, and treatment, perhaps we can help to slow or even reverse current trends in obesity, metabolic disease, and cardiovascular risk that continue to rise steadily as part of a cycle.<sup>13</sup> Although successful modification of diet, exercise, body weight, and smoking habits are not easy for anyone, the findings of Zhang and colleagues should give health professionals and women planning a pregnancy the encouragement they need to try even harder.

Provenance and peer review: Commissioned; not externally peer reviewed.

Competing interests and references are on thebmj.com.

Cite this as: *BMJ* 2014;349:g5549

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► In January 2014 senior doctors and health campaigners urged the government “to stop dancing to the tune of the drinks industry and prioritise public health.” The call was linked to an investigation by The *BMJ* into the UK government’s consultation into introducing a minimum unit price for alcohol. Read the investigation and other related articles at [bmj.com/content/alcohol-pricing](http://bmj.com/content/alcohol-pricing)

## Minimum unit pricing for alcohol

Europe to follow Canada’s lead, if the courts allow

**Tim Stockwell** director, Centre for Addictions Research of BC, University of Victoria, British Columbia, Canada  
[timstock@uvic.ca](mailto:timstock@uvic.ca)

Rarely has a public health policy attracted as much national attention as minimum unit pricing for alcohol, the harm reduction strategy at the centre of an intense and unresolved debate in the United Kingdom. Indeed, the Scottish parliament’s 2012 legislation to introduce minimum unit pricing is now being contested in a European Union wide legal battle. In a linked paper Brennan and colleagues’ report estimates that introducing minimum unit pricing in England would be 40 to 50 times more effective than the government’s recent policy of a ban on below cost selling as a means of tackling problems caused by cheap alcohol.<sup>1</sup>

The concept of minimum unit pricing in the United Kingdom involves setting a floor price, such as £0.50 (€0.62; \$0.81) for a “unit” or 8 g of alcohol (approximately half a pint of beer, a small glass of wine, or measure of spirits). From a public health perspective it has elegance and an evidence base: the harm from alcohol is directly related to the dose taken by people and populations,<sup>2</sup> price powerfully determines dose,<sup>3</sup> and cheap alcohol is sought by the heaviest drinkers.<sup>4</sup> Furthermore, cheap alcohol is highly responsive to changes in price, and minimum pricing in Canada has been associated with significant reductions in alcohol related harm.<sup>5</sup>

Despite the obvious fact that setting a floor price guarantees a profit margin, alcohol industry led challenges to the Scottish parliament’s 2012 legislation<sup>6</sup> to introduce minimum unit pricing have gone all the way to the Court of Justice of the European Union. Other EU jurisdictions interested in implementing minimum unit pricing (such as the Republic of Ireland, Estonia, and regional governments in the United Kingdom) will likely have to wait until late 2015 for a ruling as to whether public health can trump free trade in this matter.

The UK Prime Minister David Cameron once publicly committed to supporting a minimum unit pricing of 40p. His government has instead responded to the problems of cheap alcohol with a ban on the sale of “below cost” drinks. In practice, this means that alcoholic beverages cannot



DAVID CHESKIN/PA

be sold for less than the value of the tax paid on them (excise tax plus value added tax, or VAT in the United Kingdom). As Brennan and colleagues show, the total tax payable can fall to as low as 6p a unit for some ciders and 22p for some beers—much lower than proposed levels of minimum unit pricing.<sup>1</sup>

Brennan and colleagues modelled the comparative effects on public health in England of these two alcohol policies.<sup>1</sup> They estimated, not surprisingly, that a ban on below cost selling has roughly 2% of the impact of a minimum unit pricing of 40-50p in terms of reduced alcohol consumption and related harms. Their modelling is complex but boils down to two simple evidence based principles: the higher the minimum or floor price set for alcohol, the greater the reduction in population consumption,<sup>3 7</sup> and the greater the reduction in consumption, the greater the reduction in alcohol related harms.<sup>8</sup> In Brennan and colleagues’ model, these relations play out differently for different segments of the population. The heaviest drinkers, especially those on low incomes, have the most to gain from minimum unit pricing.<sup>9</sup>

How far can we trust the Sheffield Alcohol Policy Model used in this study? The somewhat dense technical supporting material tells us that many of the assumed relations are estimated on the basis of thorough systematic reviews of relevant literature. While there are some leaps of faith, the analysis is essentially grounded in the simple fact that a ban on below cost selling will increase the price of just 0.7% of alcohol units sold in England, whereas a minimum unit pricing of 45p would increase the price of 23.2% of units sold.

One way of evaluating the accuracy of Brennan and colleagues’ estimates would be to compare predicted effects against those observed in a country where minimum pricing has already been implemented.

### Canada drier

In Canada, all 10 provinces have some form of minimum pricing, whether for off-premise sales, on-premise sales, or both. The Sheffield team applied their model to the provinces of British Columbia and Ontario to estimate the benefits to public health of increased minimum prices.<sup>10</sup> The model estimated that for every CA\$0.89 (£0.49, €0.62, \$0.80) per unit increase in minimum price in British Columbia, 39 deaths and 244 hospital admissions would be prevented in the first year, with additional benefits 10 years later.<sup>10</sup> However, in studies based on real observations in British Columbia, a minimum price of CA\$0.86 per unit was associated with an estimated reduction of 92 deaths<sup>11</sup> and 1212 hospital admissions,<sup>5</sup> with additional benefits just two years later. It would seem, therefore, that the estimated benefits of minimum unit pricing in the Sheffield model are highly conservative.

One puzzling aspect of this story is why there has been such industry opposition to minimum unit pricing. In Canada, groups representing distillers, wineries, and brewers support increased minimum prices.<sup>12</sup> Minimum pricing was actually introduced in Canada to protect government revenue and stabilise markets, not for any health objective. Could it be that minimum unit pricing in the EU would set some dangerous precedents for commercial vested interests? Firstly, there would be a highly public demonstration that controls on alcohol pricing improve public health outcomes. Secondly, perhaps of greater concern to industry, a door would open allowing public health arguments to be used more broadly to restrict trade in other commodities that damage people’s health, such as tobacco and fast food.

Either way, the outcome of the case pending at the European Court of Justice will have major implications for the future of public health in Europe.

Provenance and peer review: Commissioned; not externally peer reviewed.

Competing interests and references are on thebmj.com.

Cite this as: *BMJ* 2014;349:g5617

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Read about The *BMJ*'s climate change campaign at [bmj.com/content/climate-change](http://bmj.com/content/climate-change)

Also to play for is the substantial health dividend of more active and sustainable low carbon lifestyles: lower rates of obesity, heart disease, diabetes, and cancer

## Climate change

### WHO should now declare a public health emergency

Fiona Godlee editor in chief, *The BMJ* [fgodlee@bmj.com](mailto:fgodlee@bmj.com)

When *The BMJ* started publishing articles on climate change, some readers told us to stick to our knitting. "What did this have to do with medicine?" they asked. And wasn't climate change a myth, a result of natural climatic variation, nothing to do with human activity? There were surely more immediate challenges that *The BMJ* should be focusing on.

We listened politely but carried on, convinced of the threat to human health and survival. With others we set up the Climate and Health Council ([climateandhealth.org](http://climateandhealth.org)). We published articles ([thebmj.com/content/climate-change](http://thebmj.com/content/climate-change)), co-hosted conferences and seminars, lobbied funders, talked to politicians, and worked with the BMA and the royal colleges, all the time worrying that this was not enough. Our hope was to encourage doctors and other health professionals to take a lead in tackling climate change.

Now we have gone a step further, with an article that contains no medicine or healthcare at all (Analysis, p 17).<sup>1</sup> Why? Because if doctors are to become effective advocates against climate change, better understanding of the science will help us.

As most readers will know, the news is not good. The Intergovernmental Panel on Climate Change (IPCC) has concluded in its fifth report that the world is getting hotter and that human activity is mainly to blame. Global average temperatures have risen by about 0.5°C in the past 50 years and by 0.8°C from pre-industrial times. The effect of these higher temperatures on weather systems is already being felt. The IPCC says it is highly likely that global warming is causing climate change, characterised by more frequent temperature extremes, heavier rainfall events, other extreme weather events, and rising sea levels.

The headlines should come as no surprise, but the detail may prove instructive. Higher seas mean more frequent and extreme tidal surges, coastal flooding, and the salination of vital fresh water supplies. Warmer air carries more moisture, leading to more extreme rainfall events. But warmer air also reduces the amount of moisture in the soil, contributing to soil erosion and flash flooding.

As for the main underlying cause, the IPCC is clear: it is the accumulation of anthropogenic carbon dioxide in the atmosphere. Other gases and aerosols are also to blame, especially methane and nitrous oxide, and particulate black carbon. But carbon dioxide is long lived. Once released

into the atmosphere it stays around for centuries. Deforestation makes this worse.

What of the future? The IPCC has modelled four scenarios according to the extent and nature of future greenhouse gas emissions. The best case (the so called RCP 2.6) is one in which emissions are cut radically, starting almost immediately. Even then global warming would continue, leading to average temperatures of almost 2°C above pre-industrial levels. The worst case (RCP 8.5) is "business as usual" with unabated emissions, which would lead to a further 3.7°C rise by 2100 above the average at the beginning of this century and more than 4°C higher than pre-industrial levels. As our Analysis authors explain, regional variations mean that in some parts of the northern continents temperatures would increase by more than 10°C.

#### Crossing the "afterlife" threshold

Writing last week in the *Lancet*,<sup>2</sup> Andy Haines and colleagues emphasised that such huge temperature rises, and the consequent climate instability, would take us into what is being called the "afterlife" threshold, "where the impact on humanity is so great as to be a discontinuity in the long-term progression of humanity." In other words, the effects would be catastrophic.

If climate change is a symptom of a planet in distress, what is the disease? Speaking last month in Geneva, Christiana Figueres, executive secretary of the UN Framework Convention on Climate Change, was uncompromising. The disease is "our unbridled dependency on fossil fuels," which shows no sign of abating. Despite the rhetoric from the world's major polluters at last week's United Nations meeting on climate change in New York,<sup>3</sup> rates of carbon emission are accelerating. Our Analysis article explains that the amount of carbon we can still afford to emit if we are to stay below 2°C of warming (our "carbon budget") will be exceeded in the next 25-30 years.

Calls for organisations to disinvest from fossil fuels and reinvest in renewable energy are gaining momentum. The president of the World Bank, Jim Yong Kim, himself a doctor, propelled this idea into the mainstream by suggesting in a speech at the World Economic Forum that carbon emissions could be tackled through divest-

ment and taxation.<sup>4</sup> Groups such as the Global Climate and Health Alliance ([www.climateandhealthalliance.org](http://www.climateandhealthalliance.org)) have been quick to take up the call. Archbishop Desmond Tutu has called divestment a moral imperative.<sup>5</sup> The BMA agreed to divest at its annual meeting in June, and major universities and funding bodies have also signed up, the Rockefeller family and the World Council of Churches being among the most recent.<sup>6</sup>

Figueres was speaking at the first WHO conference on health and climate, where health ministers joined delegates from intergovernmental and non-governmental organisations in an extraordinary show of consensus. All agreed with WHO director general Margaret Chan's assessment that climate change is the greatest threat to public health and the defining issue of the 21st century. The conference gave a clear warning: that without adequate mitigation and adaptation, climate change poses unacceptable risks to public health worldwide.<sup>7</sup>

In this unequal battle with big business and political inertia we have a crucial card to play: the knowledge that much of what we need to do to tackle climate change will bring substantial benefits to health. Burning fossil fuels causes about seven million premature deaths from indoor and outdoor air pollution. Smog in Beijing and other major cities is alerting the public and waking up our politicians in ways that the more invisible threat from carbon dioxide emissions has failed to do. Healthcare is itself a major emitter of greenhouse gases and has a responsibility to get its own house in order to avoid the paradox of doing harm while seeking to do good.<sup>8</sup> Also to play for is the substantial health dividend of more active and sustainable low carbon lifestyles: lower rates of obesity, heart disease, diabetes, and cancer.<sup>9</sup>

WHO has shown important leadership on climate change but has stopped short of declaring a global public health emergency. This may be understandable with Ebola raging. But it is what WHO should now do. Deaths from Ebola infection, tragic and frightening though they are, will pale into insignificance when compared with the mayhem we can expect for our children and grandchildren if the world does nothing to check its carbon emissions. And action is needed now.

Competing interests and references are on [thebmj.com](http://thebmj.com).  
Provenance and peer review: Not commissioned; peer reviewed.  
Cite this as: *BMJ* 2014;349:g5945  
● ANALYSIS, p 17; NEWS, p 5