NEWS

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ROSS PARRY

bmj.com
Urologist is jailed for manslaughter of woman with kidney infection

Waiting times in English emergency departments reach eight year high

Adrian O'Dowd LONDON

The number of patients having to wait more than four hours for treatment in hospital emergency departments in England has reached an eight year high, the health think tank the King's Fund has reported.[1]

Overall, however, the NHS was performing well in 2011-12, with an estimated £1.5bn surplus for the year, it says, and waiting times for hospital treatment were generally stable, while numbers of hospital associated infections continued to fall, as did waiting times for diagnostic tests.

In its latest quarterly monitoring report on NHS performance, published on 31 May, the King's Fund presented a mixed picture of the NHS's performance, with some positive observations alongside several noted concerns.

The proportion of patients waiting more than four hours in emergency departments rose by more than a quarter over the past year to reach its highest level since 2004. In total, 226 021 patients waited more than four hours in the fourth quarter of 2011-12 (January to March 2012), 26% higher than in the same period of 2010-11 and a rise of nearly 18% over the third quarter of 2011-12.

The sharp rise in waiting time numbers in the last half of 2011-12 happened despite a pledge by the prime minister last June that they would remain low.[2 3] Nationally the figures still remained within the government's target that no more than 5% of patients should wait more than four hours. However, the number of NHS providers that have admitted breaching this threshold more than doubled from 18 in the second quarter of 2011-12 to 48 in the fourth quarter.

In addition, the report, which was compiled from responses from 60 NHS finance directors, said that 40% of NHS organisations failed to meet productivity targets in 2011-12. This was worrying, given that last year was the first in a four-year period of financial austerity in which the NHS is expected to find £20bn in productivity savings.

The report says that the NHS had ended 2011-12 in a "healthy financial position" and that only four of the 60 finance directors questioned predicted a deficit in their organisation.

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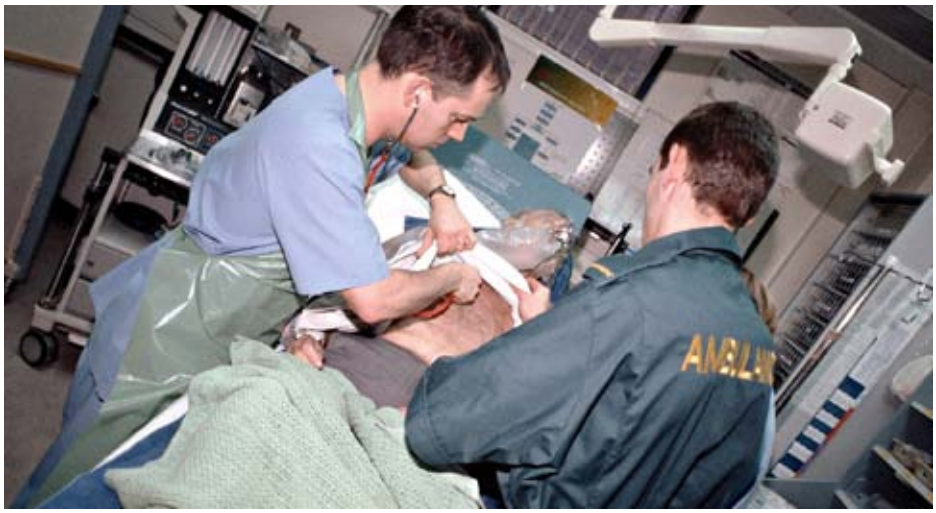
SHOUT/ALAMY

Many patients who go into cardiac arrest have clearly recognisable risk factors

A third of inpatient cardiac arrests could have been prevented

Susan Mayor LONDON

Better assessment of patients when they are admitted to hospital and an improved response when they deteriorate could have prevented cardiac arrest and subsequent resuscitation attempts in a third of cases of arrest occurring in hospitals, concludes an inquiry.

A multidisciplinary team that included consultants in emergency care and cardiology from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviewed data on all adult patients who had a cardiac arrest in hospital and underwent a resuscitation attempt in England, Wales, Northern Ireland, the Channel Islands, and the Isle of Man between 1 and 14 November 2010.[1]

The reviewers considered that the care provided to patients was good in only 29% (154) of the 526 patients they assessed. They found room for improvement in the clinical care of a quarter of the patients (132) and in the organisational care of 13% (70).

Overall, the expert group considered that 38% of in-hospital cardiac arrests could have been avoided if the hospital team had properly managed the patient's care by following recommended procedures.

The reviewers found that assessment of patients on admission was deficient in nearly half (47%) of the cases, including basic elements such as examination, diagnosis, and planning treatment. Warning signs that the patient was deteriorating and that cardiac arrest might occur were present in 75% of the cases. But these warning signs were not recognised in 35% of cases, not acted on in 56%, and not communicated to senior doctors in 55%.

"The recognition of acute illness, response to it, and escalation of concerns to consultants when patients are deteriorating is not happening consistently across hospitals," said George Findlay, a consultant in intensive care medicine at Cardiff and Vale University Health Board, NCEPOD's lead clinical coordinator, and the author of the inquiry report. "Many patients who go into cardiac arrest have clearly recognisable risk factors. But these tend to be missed by junior doctors, which is a lost opportunity to change treatment."

Senior doctors must be involved earlier in the planning of care of acutely ill patients and must help junior doctors recognise the warning signs when a patient is deteriorating, he said.

Clinicians cited earlier treatment, deciding not to attempt cardiopulmonary resuscitation (CPR), and better monitoring as actions that might have improved outcomes. The report found that 52 patients underwent CPR despite an explicit decision against resuscitation.

Cite this as: *BMJ* 2012;344:e3735

Experts attack government plans to cut benefits for addicts who refuse specialist treatment

Zosia Kmietowicz LONDON

Job centre staff in England, Wales, and Scotland are to be given the task of spotting unemployed people who are addicted to alcohol or drugs and referring them for specialist treatment services, the work and pensions secretary hinted on 23 May. Those who refuse rehabilitation will have their benefits cut, government sources suggested.

However, specialist addiction professionals and charities have lambasted the proposal, saying that job centre staff do not have the skills to deal with addicts and that there are insufficient high quality services to offer the level of help some people need.

JANINE WIEDEL/ALAMY

Almost 40 000 people in Britain who claim incapacity benefits have alcoholism

Ian Gilmore, special adviser on alcohol for the Royal College of Physicians, said: "Current treatment facilities for addicts in this country, particularly those with alcohol dependence, are woefully inadequate and we strongly support initiatives to improve this. However, patients must be treated with respect and given genuine choice in their treatment options, and these must be fully respected in any scheme."

Martin Barnes, chief executive of the drug charity DrugScope, called on the government to clarify its plans, saying that there was no mention of benefit sanctions in the drug strategy it launched in December 2010.[1]

"There is no evidence that using the stick of benefit sanctions will help people to positively engage with treatment and support their recovery. Indeed, the risk is that people will disengage from support services, potentially worsening their dependency and the impacts on their families and communities," he said.

"Linking benefit to a requirement to undergo treatment would set a dangerous precedent for people with physical or mental health problems and would be against the principles for healthcare set out in the NHS constitution."

The work and pensions secretary, Iain Duncan Smith, was speaking at a meeting organised by Alcoholics Anonymous at the House of Commons to publicise the organisation's work. He explained that he wanted the new single welfare system to change the support that is currently on offer to addicts from passive to active intervention. Known as universal credit, the system is due to be introduced in October 2013.

Duncan Smith said, "The outdated benefits system fails to get people off drugs and put their lives on track. We have started changing how addicts are supported, but we must go further to actively take on the devastation that drugs and alcohol can cause.

"Under universal credit we want to do more to encourage and support claimants into rehabilitation for addiction and starting them on the road to recovery and eventually work. Getting people into work and encouraging independence is our ultimate goal. Universal credit will put people on a journey towards a sustainable recovery so they are better placed to look for work in future."

Full details of the plans have not yet been announced as Duncan Smith wanted to use the event to highlight the work that Alcoholics Anonymous does in helping people recover from alcoholism. But under the universal credit reforms claimants enter into an agreement that they will look for work in exchange for support from the government while they do so. It is believed that staff in Jobcentre Plus offices will be able to report claimants whom they suspect of being addicts as in breach of the agreement if they do not seek help for their alcohol or drug problems.

A government source is reported in the *Guardian*[2] as saying: "The universal credit will allow staff in Jobcentre Plus offices to say: this person has been unemployed for some time. The staff know if people are addicted to alcohol. They know the people they are dealing with.

"But we want this to be positive and to be about signposting people to superb organisations that can help them. This is about changing their lives. It is very important to support addicts into the workplace."

But if claimants refuse "there will be sanctions," the source said, citing cuts to the jobseeker's allowance as an example.

Analysis from the department shows that almost 40 000 people who claim incapacity benefits have alcoholism as their primary diagnosis. Of these, 13 300 have been claiming the benefits for 10 years or more.

Cite this as: *BMJ* 2012;344:e3694

Pilot study will assess if HPV test should replace cervical smears

Jacqui Wise LONDON

A pilot scheme is to be set up in the United Kingdom to assess the value of using human papillomavirus (HPV) testing as the primary screening test for cervical cancer rather than the currently used cytology or smear test.

The pilot scheme has been recommended by the UK National Screening Committee and aims to establish whether using HPV testing as the primary screen for cervical disease results in better outcomes for women while minimising overtreatment and anxiety.

The NHS cervical screening programme is already in the process of introducing HPV testing for high risk HPV strains in two different ways. The first is through HPV triage, whereby women with borderline or low grade results of usual cervical screening are tested for HPV and, if results are negative, are returned to the routine screening programme. Women who test positive are referred for colposcopy. The second way is by HPV testing after women are treated for cervical abnormalities, as a "test of cure."

The move to trial HPV testing rather than cytology testing as a primary screen comes after studies showed the effectiveness of HPV testing for cervical cancer screening.[1] And a recent cost effectiveness analysis published in the *BMJ* concluded that most European countries should seriously consider switching from primary cytology to HPV screening for cervical cancer.[2]

The committee also recommended increasing the age of first screen for cervical disease to 25 in Scotland and Wales, in line with the age in England and Northern Ireland, and that women aged 50-64 undergo screening every five years throughout the UK, in line with current practice in England.

The committee also announced that the pilot programme for flexible sigmoidoscopy testing would be introduced into the existing bowel cancer screening programme this winter.

Cite this as: *BMJ* 2012;344:e3744

BMA warns that ordinary GPs must not be left out of clinical commissioning

Helen Jaques BMJ CAREERS

The emerging clinical commissioning groups (CCGs) in England must include ordinary GPs in their planning processes, the chairman of the BMA's General Practitioners Committee has said.

Speaking at the annual conference of local medical committees in Liverpool on 22 May, Laurence Buckman emphasised that CCGs are membership organisations and must seek the views of the GPs in their constituent practices.

"CCGs are our creatures, not just another version of the PCTs [primary care trusts] they replace," he said. "GPs should be telling them what to do, not the other way round."

To facilitate GPs' involvement, local medical committees—the groups that represent GPs—must work with CCGs and not "withdraw themselves from engagement" on the basis of their opposition to the government's healthcare reforms, said Buckman. "The General Practitioners Committee has to try to deter the potential for harm within CCGs whilst ensuring that GPs are democratically involved in CCGs, and LMCs [local medical committees] are able to act as the voice of all GPs," he said. "Ordinary GPs must be there."

The conference passed a motion calling for CCGs to consult with local medical committees on any decision that affects providers of general practice. The motion's proposer, Andrew Holden, from Hampshire and Isle of Wight Local Medical Committee, pointed out that politicians and organisations seeking the view of GPs tended to turn to bodies such as the National Association of Primary Care when instead they should be talking to local medical committees.

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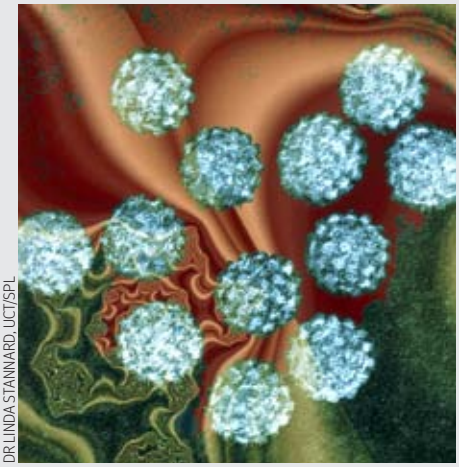
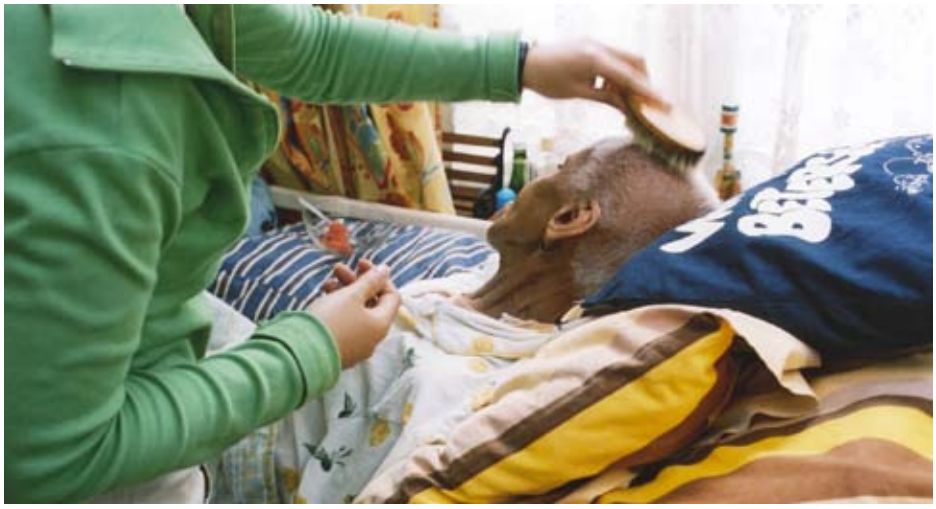


DR LINDA STANNARD, UCT/SPL

HPV is found in over 99% of cervical cancer cases



HENNY AILIS/SPL

Social care accounts for just 5.5% of the £140bn spent by the state on the elderly in England each year

Raid NHS budget and well-off older people to boost social care funds, Nuffield Trust says

Ingrid Torjesen LONDON

The government should reallocate some NHS funding to pay for the social care of elderly people in England, a report from the Nuffield Trust recommends.[1] It also suggests removing welfare benefits from well-off older people and increasing taxes on them to make more funds available.

The report considers where to find the funds for the additional social care recommended by the Dilnot commission last year.[2]

The commission led by the economist Andrew Dilnot looked at how to provide more support for the many people—often on very low incomes—who no longer receive publicly funded social care because of stricter eligibility criteria and at how to reduce the unfairness of a system in which some people have to sell their homes to pay for care. It proposed a lifetime cap on individual contributions and argued that a degree of certainty on what social care would be funded was needed. This would enable people to prepare financially for their old age and would encourage the development of insurance products for unpredictable high costs.

It has been widely reported that the government baulked at the cost of implementing the recommendations, estimated to be an extra £3.6bn a year on social care by 2025-26. And, even without the reforms, estimates produced for the Dilnot commission indicate that spending on social care will rise from £14.5bn in 2010-11 to £23bn by 2025-26.

The Nuffield Trust's report recommends that the Department of Health consider transferring some of the projected £1.5bn underspend by primary care trusts in 2011-12 to social care to extend eligibility and also to support more preventive work.

It adds that the financial implications of implementing Dilnot's recommendations could be minimised by raising the cap on individual contributions proposed by the review; improving productivity of social care services; and considering transferring elements of the NHS budget to fund a reformed social care system.

Dilnot recommended capping the amount that elderly people have to pay towards their own social care costs, proposing £35 000 as a "fair" figure. But the Nuffield Trust report suggests the higher £50 000 cap proposed by Dilnot to free up £600m a year. It also suggested raising the proposed annual contribution that people in residential care make towards living costs from £7000 to £10 000 to free up a further £300m.

Social care currently accounts for 5.5% of the £140bn spent by the state each year on elderly people in England. More than a third is spent on the NHS, and almost 60% is spent on social security benefits, including state pensions and disability benefits. The report suggests shifting some of the health budget towards social care and using some of the money that currently goes to welfare benefits for better-off older people, such as the winter fuel allowances.

If the costs of social care cannot be met by redistributing the overall sum of state support for elderly people, the report says that more funds will need to be raised from taxation. "The government should explore options to direct the burden of any tax increases onto wealthier older people," it says. The government has acknowledged that the social care funding system is in need of reform and is set to publish a white paper on the topic this year but has committed itself only to "a progress report on funding reform."

Cite this as: *BMJ* 2012;344:e3761

IN BRIEF

Doctors protest as Canada slashes healthcare coverage for refugees: Canada's government is ending most prescription benefits and all vision, dental, and other supplemental benefits for refugees and people claiming refugee status on 30 June. Eight national organisations representing health professionals have jointly asked the government to reconsider.

Government plans to boost English patients' involvement in treatment decisions: The Department of Health for England has published proposals to ensure greater shared decision making over care and more choice for patients.[2] It said that, regardless of their condition, patients should have more say in decisions about their care in primary care; before a diagnosis; at referral to secondary care; and after a diagnosis had been made.

Emergency action plan is launched to rid world of polio: The Global Polio Eradication Initiative has launched an emergency action plan to boost vaccination coverage in Nigeria, Pakistan, and Afghanistan—the three remaining countries where polio is endemic—to the levels needed to stop transmission. Outbreaks in China and west Africa that originated in Pakistan and Nigeria have highlighted the risks of resurgence. Failure to eradicate polio could result in an estimated 200 000 paralysed children a year worldwide within a decade.

Scottish parliament agrees 50p minimum price for alcohol: Cut price alcohol could be outlawed in Scotland as early as April 2013 after the parliament overwhelmingly passed a bill on 24 May to introduce a 50p minimum price per unit of alcohol. It is estimated that the policy could save 300 lives a year and result in 6500 fewer hospital admissions,[1] but critics have argued that the measure is illegal under EU law and that Scotland would face legal challenges from manufacturers.

An eighth of new mothers in England smoke: A total of 13% of women who gave birth in England in 2011-12 classed themselves as smokers at the time of delivery, down from just over 15% in 2006-7. New mothers were most likely to be smokers in the north east (21%) and least likely in London (6%), show data from the NHS Information Centre for Health and Social Care.[3]

Cite this as: *BMJ* 2012;344:e3756

Doctor who helped find bin Laden is sentenced to 33 years in jail

Nigel Hawkes LONDON

A Pakistani surgeon who helped the US Central Intelligence Agency in its search for Osama bin Laden has been sentenced to 33 years in jail for treason.

Shakil Afridi was found guilty by the tribal justice system in the Khyber district under regulations dating back to the era of British rule. The Frontier Crimes Regulations under which he was charged cover offences against the state, conspiracy, or attempts to wage war against the state, and offences of working against the country's sovereignty. Had he been tried under Pakistani national law, a guilty verdict would have carried the death penalty.

QAZI RAUF/AP/PA

Shakil Afridi: the US cut aid to Pakistan after he was jailed

Afridi, 48, the former surgeon general in Khyber, had assisted the CIA in its search for bin Laden by setting up a fake hepatitis B vaccination programme with the aim of obtaining DNA samples from the compound where bin Laden was living to confirm his identity.[1] US officials have said that he did not know bin Laden was the target. The ruse failed, though the *Guardian* reports that nurses in the scheme obtained a mobile phone number for a person in the compound. The CIA matched the user's voice with that of bin Laden's courier, Abu Ahmed al-Kuwaiti.[2]

US military authorities have acknowledged that Afridi assisted the CIA and have defended his actions. "The doctor was never asked to spy on Pakistan," a US official told the *New York Times*.[3] "He was asked only to help locate Al Qaeda terrorists, who threaten Pakistan and the US. He helped save Pakistani and American lives."

Experts call for greater transparency on safety of implants as MPs begin inquiry into their regulation

Adrian O'Dowd LONDON

The public wants and should receive much more information on implants as part of published data on the outcomes of surgical procedures, MPs have been told.

The parliamentary science and technology committee held its first evidence session on 23 May as part of its inquiry into regulation of medical implants. The inquiry follows the scandal last year over discredited and now bankrupt French manufacturer Poly Implant Prosthèse (PIP), which used non-medical grade silicone in breast implants that were given to around 47 000 women in the UK.[1 2]

MPs asked witnesses their opinion of a suggestion that it would be helpful to extend the national joint registry to include all implants. The registry was set up in 2002 to collect data on hip and knee joint replacement implants and surgery.

Stephen Westaby, consultant cardiac surgeon at the John Radcliffe Hospital in Oxford, said: "I think registries are very good, and all grade 3 implants are worth having registries for."

Fellow witness Carl Heneghan, GP and reader in evidence based medicine as well as director of the Centre of Evidence-Based Medicine in Oxford, said: "We can keep the existing register, but you need to think who is going to run that and the nature and structure of it and the independence of it."

Thomas Joyce, reader in biotribology at the University of Newcastle, also giving evidence, said: "I think the registry should be expanded to all artificial joints—but for all implants I am not sure, because it depends on the implant."

The witnesses said the PIP scandal had provoked fears about the overall safety of implants in the United Kingdom, but the problem had been exaggerated.

Westaby defended the record of the UK's devices regulator, the Medicines and Healthcare products Regulatory Agency (MHRA), saying: "The MHRA supervises the UK very carefully. In my view, the MHRA is very much underresourced."

However, fellow witness Suzette Woodward, director of patient safety for the National Patient Safety Agency, said: "The MHRA do send out alerts to the service that alert it about certain concerns around use of devices or medicines. There is something around the timeliness of that and they could be speeded up."

She said "implementation and compliance" were a problem. "There is a big gap between what we tell them should be happening and what they actually do."

Westaby added: "Primary device failure is extremely rare in the NHS."

The inquiry continues.

Cite this as: *BMJ* 2012;344:e3709

AQEEL AHMED/AP/PA

The compound where Osama bin Laden lived with his family in Abbottabad

Hilary Clinton, the US secretary of state, has sought Afridi's release, and two leading senators, the Democrat Carl Levin of Michigan and the Republican John McCain of Arizona, denounced the court's sentence. "What Dr Afridi did is the furthest thing from treason," they said in a statement. "It was a courageous, heroic, and patriotic act which helped to locate the most wanted terrorist in the world—a mass murderer who has the blood of many innocent Pakistanis on his hands."

After the sentencing, the US Senate appropriations committee voted unanimously to cut aid to Pakistan by $33m from next year's budget.

Cite this as: *BMJ* 2012;344:e3712

Drug companies and publishers set out 10 steps to enhance credibility of industry sponsored trials

Bob Roehr WASHINGTON, DC

A coalition of drug companies and major medical journal publishers has recommended 10 steps to help refurbish the tarnished credibility and enhance the quality and transparency of the reporting of industry sponsored clinical trials. The 10 steps were published in the May issue of the *Mayo Clinic Proceedings*.[1]

The Medical Publishing Insights and Practices Initiative (MPIP) was established in 2008 by leading drug companies and medical publishers as an ongoing collaboration (www.mpip-initiative.org). The recommendations grew out of a meeting held in New York in November 2010.

The initiative's first recommendation is that research should be grounded in the asking and answering of questions of scientific and clinical importance, within the context of regulatory requirements for approval of a drug or device.

"Credibility is compromised when clinical research is intended for marketing purposes rather than advancing scientific and medical knowledge," the authors wrote. The paper urges sponsors and authors to "enhance transparency and credibility by better explaining . . . the decision-making process underlying the research endeavor."

While acknowledging the challenge of publishing negative, confirmatory, or inconclusive results, it emphasised that all trial results must be made public to comply with the law in many countries, fulfil ethical obligations to trial participants, and assure that scientific knowledge is as complete as possible.

Authors must disclose potential conflicts of interest, it said. Efforts should be made towards standardising the criteria and formats for reporting those interests and towards creating a centralised, publicly accessible disclosure database.

The report noted the need to educate authors on how to develop good quality manuscripts for publication and pointed towards efforts such as CONSORT (consolidated standards of reporting trials (www.consort-statement.org)) and the initiative's own toolkit (http://bit.ly/K2UuqY) as possible guidance.

A further recommendation is that "all parties must continue to work toward zero tolerance of ghostwriting and guest authorship" and give full and accurate recognition of those who contributed to the research and the paper.

Consensus needs to be reached on the type and format of adverse events reporting, while weasel words such as "no unexpected adverse events" should be avoided. Papers need to be more candid about the limitations of studies to detect rare adverse events because the number of patients is small or the duration of observation is short.

Cite this as: *BMJ* 2012;344:e3767

Doctors opposed to NHS reforms set up National Health Action Party

Ingrid Torjesen LONDON

A group of doctors and public health experts, disillusioned by the government's changes to the NHS, are setting up a new political party because they don't think that any of the existing parties defend the health service effectively.

The National Health Action Party is the idea of the oncologist Clive Peedell, who ran from Aneurin Bevan's statue in Cardiff to the Department of Health headquarters in London earlier this year to protest against the Health and Social Care Bill and NHS privatisation.[1] He will lead the party jointly with the former MP Richard Taylor, a retired consultant who won a seat in the House of Commons in 2001 as an independent, campaigning for Kidderminster Hospital to retain its accident and emergency facilities. Taylor lost the seat in 2010 to the Conservative Mark Garnier.

Speaking to the *BMJ*, Taylor said that voters needed "an alternative to the Tories" and were "disillusioned by the Liberal Democrats" and that "Labour doesn't seem much better," because it effectively started the current reforms with its rush towards privatisation.

As an MP Taylor sat on the Commons health select committee that in 2009-10 investigated three important issues—patients' safety, commissioning, and value for money in the NHS—and produced reports on two of them. "These told the government everything it needed to do to improve the health service," he said.

Taylor predicted that the new party's manifesto would follow the recommendations of these investigations and that the party might, if necessary, push to "reverse a number of things." He added that the problems in the NHS started with the invention of the internal market in the 1990s and the split between commissioners and providers. And he pointed to a report that the Department of Health had been "too scared to publish," mentioned in the select committee's report on commissioning, which said that the cost of administrating commissioning amounted to 14% of the NHS budget.

Cite this as: *BMJ* 2012;344:e3734

DAVID JONES/PA

Retired consultant Richard Taylor won a seat in the Commons in 2001 as an independent

US baby boomers may be screened for hepatitis C

GAMMA-KEYSTONE/GETTY IMAGES

Many baby boomers do not perceive themselves to be at risk

Bob Roehr WASHINGTON, DC

One in 30 US baby boomers is infected with hepatitis C and doesn't know it. They should all be tested for the virus at least once, said the US Centers for Disease Control and Prevention (CDC).

The recommendation is contained in draft guidelines released on 18 May. They are expected to be finalised after a brief comment period.

Current guidelines recommend testing people who have had risk of exposure to the virus through activities such as injecting illicit drugs; piercing or tattooing with improperly cleaned equipment; a blood transfusion or organ transplant before 1992 when screening was introduced; haemodialysis; and birth to a mother with hepatitis C.

The CDC said it was recommending the change for several reasons, the first of which is that studies have shown most US citizens simply do not perceive themselves to be at risk for the disease because of activities they might have engaged in decades ago.

Baby boomers, those born between 1945 and 1965, are five times more likely to be infected with hepatitis C than other adults, according to the CDC. Most are likely to have been infected before screening of blood products was introduced in the early 1990s.

HIV prevention activities, such as needle exchange programmes for injecting drug users and education on the need to thoroughly sterilise equipment between patients, also reduced the rate of new infections of the more readily transmissible hepatitis C.

Several decades often elapse between infection and manifestation of clinical symptoms of liver disease, which is becoming more prevalent. Liver disease from hepatitis C now kills more than 15 000 US citizens every year.

"With increasingly effective treatments now available, we can prevent tens of thousands of deaths from hepatitis C," said CDC director Thomas Frieden.

The newest generation of drugs, protease inhibitors approved in the spring of 2011, can cure about three quarters of hepatitis C infections when combined with older treatments. The fact that biological agents must be injected regularly and generally cause flu-like symptoms are major factors that decrease patients' adherence to treatment.

"Identifying these hidden infections early will allow more baby boomers to receive care and treatment, before they develop life threatening liver disease," said Kevin Fenton, who heads up the CDC hepatitis programmes.

He estimates that testing baby boomers for the virus could identify 800 000 additional people with hepatitis C. A total of 3.2 million Americans are believed to be infected, though most do not know it.

Another factor contributing to the guidelines change is new, more accurate, and portable tests for hepatitis C infection.

Epidemiologists have long thought that the risk of sexual transmission of hepatitis C was so low as not to be a concern. But that was on the basis of studies in heterosexual couples.

Over the past decade, firstly in Europe and more recently in the US, clusters of sexual transmission of hepatitis C have been identified in men who have sex with men.

Many are identified through the flu-like symptoms of acute infection that occur soon after exposure to hepatitis C.

Cite this as: *BMJ* 2012;344:e3707

Targets set to cut deaths from non-communicable diseases by a quarter by 2025

Anne Gulland LONDON

Health ministers and senior officials from 194 countries have agreed to cut the number of premature deaths from the four most prevalent non-communicable diseases by a quarter by 2025.

The voluntary target was set at the 65th World Health Assembly in Geneva last week, eight months after world leaders signed an agreement to tackle the causes of the four major non-communicable diseases—diabetes, lung disease, cancer, and cardiovascular disease—at the United Nations General Assembly.[1]

However, at the UN meeting leaders failed to set any targets or goals for tackling the diseases, which cause 63% of the world's deaths, four fifths of which are in low and middle income countries.

As well as agreeing to cut premature mortality by 25%, the assembly, the governing body of the World Health Organization, also pledged to agree targets to tackle four risk factors associated with the major non-communicable diseases: hypertension, tobacco smoking, physical inactivity, and dietary salt. However, reaching agreement on these targets has been pushed back to October.

The assembly will also consider adding further targets relating to alcohol, obesity, fat intake, cholesterol, and health systems' responses, such as availability of essential drugs for non-communicable diseases.

A document accompanying the resolution says that the indicators and targets were chosen on the basis of a number of criteria: they had to be highly relevant epidemiologically and to public health; to fit with major global and regional strategies; to be evidence based and feasible public health interventions; to be achievable, especially in low and middle income countries; and to be measurable.

The baseline for the targets is 2010, and progress will be reviewed every five years until 2025. WHO has called on member states to give greater priority to surveillance in the prevention and control of non-communicable diseases, such as by increasing budgetary allocations for surveillance.

Margaret Chan, WHO's director general, told assembly delegates that the organisation was giving its responsibilities on non-communicable diseases its "highest priority."

Cite this as: *BMJ* 2012;344:e3768