

## The end of our National Health Service

There is a crisis in the National Health Service (NHS). The publication of the Health and Social Care Bill last week heralds dramatic changes for the NHS, which will affect the way public health and social care are provided in the UK. Those changes alone will have huge impact, but it is the formation of an NHS Commissioning Board, and commissioning consortia, that will once and for all remove the word “national” from the health service in England. The result, due to come into force in 2013, will be the catastrophic break up of the NHS.

Maintaining the status quo in the NHS is not an option. The NHS is not delivering the care that patients need. Patients with cancer, for example, are less likely to survive in the UK than in Australia, Canada, Sweden, or Norway. Michel Coleman and colleagues' *Lancet* Article, published last month, reports that the survival of patients with primary colorectal, lung, breast, or ovarian cancer is lower in the UK than in other countries with similar wealth, universal access to health care, and good cancer registration data. Survival is, they argue, “the key index of the overall effectiveness of health services in the management of patients with cancer”.

Despite the huge sums of money pumped into the NHS over the past few years—particularly into the salary budget for staff—translation into benefits for patients is hard to identify. Moreover, the unyielding mountain of bureaucracy that is integral to the NHS stifles innovation, such that it is difficult to design the services needed for local populations.

Will the changes outlined in the Health and Social Care Bill solve these problems within the NHS and improve care for patients? The truth is that we do not know. What we do know is that putting general practitioners (GPs) in charge of commissioning health services for their patients is similar, in some respects, to the fundholding experiment in the 1990s. The principle then was that GPs controlled the budgets to buy the specialist care their patients needed. Fundholding took years to implement, but evidence on short-term or long-term benefits for patients is lacking. In the current Bill, health outcomes, including prevention of premature death, will be the responsibility of the NHS Commissioning Board, which has been asked to publish a business plan and annual reports on progress. That

business plan is urgently needed to allow transparent appraisal of how the Board plans to monitor patients' outcomes.

The UK coalition Government has now been in power for about 8 months. Neither the Conservatives nor the Liberal Democrats included the formation of an NHS Commissioning Board, or GPs' commissioning consortia, in their health manifestos on which the electorate voted. The speed of the introduction of the Health and Social Care Bill is surprising, especially given the absence of relevant detail in the health manifestos. The Conservatives promised, if elected, to scrap “politically motivated targets that have no clinical justification” and called themselves the “party of the NHS”—a commitment that seems particularly hollow now.

Since its establishment in July, 1948, the aim of the NHS has been to offer a comprehensive service to improve health and prevent illness, available to all in England and Wales (and then extended throughout the UK), which is largely free of charge. Health care for all, for free, has been the common ethos and philosophy throughout the NHS. On July 3, 1948, in an editorial entitled “Our Service”, *The Lancet* commented: “Now that everyone is entitled to full medical care, the doctor can provide that care without thinking of his own profit or his patient's loss, and can allocate his efforts more according to medical priority. The money barrier has of course protected him against people who do not really require help, but it has also separated him from people who really do.” Now, GPs will return to the market place and will decide what care they can afford to provide for their patients, and who will be the provider. The emphasis will move from clinical need (GPs' forte) back to cost (not what GPs were trained to evaluate). The ethos will become that of the individual providers, and will differ accordingly throughout England, replacing the philosophy of a genuinely national health service.

Health professionals cannot say that no change is needed—it most certainly is. But there is sufficient uncertainty and concern about the changes outlined in the Health and Social Care Bill to pause, to learn from the past, and to consider what the changes mean for patients' outcomes. As it stands, the UK Government's new Bill spells the end of the NHS. ■ *The Lancet*



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For the **Health and Social Care Bill** see [www.parliament.uk](http://www.parliament.uk)

For **Coleman and colleagues' paper on cancer survival** see **Articles** *Lancet* 2011; 377: 127–38

For the **Lancet editorial on “Our service”** see *Lancet* 1948; 252: 17

## Statins—should we adjust the risk:benefit ratio?



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The prevailing opinion that statins are an elixir for long life was challenged with the recent publication of the Cochrane review, *Statins for the primary prevention of cardiovascular disease*. After analysing 16 trial arms with 34 272 participants, the authors found no evidence of harm, and mortality, composite cardiovascular endpoints, and revascularisations were reduced. But they concluded: “caution should be taken in prescribing statins for primary prevention among people at low cardiovascular risk.”

The conclusion seems at odds with the findings. However, the authors found the evidence of insufficient quality to allow them to conclude differently; many trials included patients with a previous cardiovascular event, and the authors state that poor reporting of adverse events and selective reporting of outcomes contributed to their failure to draw a positive conclusion. They state that the evidence is “impossible to disentangle without individual patient data”.

The authors’ conclusion is also at odds with the recent Cholesterol Treatment Trialists’ (CTT) Collaboration meta-analysis, published in *The Lancet*. Individual patient data from around 70 000 patients with no previous cardiovascular disease were analysed, and showed that statins significantly reduced the relative

risk of a cardiovascular event by 0.75 per 1 mmol fall in LDL cholesterol.

Unfortunately, the media are quick to forget, and have reported the Cochrane’s headline-grabbing details with scant regard for the preceding evidence. This approach will have left many patients at best bewildered. The media have also largely ignored the Cochrane authors’ conclusion that the results support guidelines from the UK’s National Institute of Health and Clinical Excellence, which recommends statins are considered for primary prevention in patients with an annual incidence of cardiovascular events of over 2%.

So what should general practitioners (GPs), who are faced with increasing numbers of low-risk patients worried about mildly raised cholesterol, do? The Cochrane review has muddied the water, but the available evidence shows that statins are safe, and evidence from the CTT Collaboration also shows that reductions in cholesterol per se can produce benefits. So, the simple answer is that GPs should do what they always have done—clearly explain the risks and benefits to patients so that the patient is able to choose the strategy that is best for them.

■ [The Lancet](#)

For the Cochrane review see *Cochrane Database System R* 2011; 1: CD004816

For the NICE guidelines see <http://www.nice.org.uk/TA094>

For the Cholesterol Treatment Trialists’ (CTT) Collaboration meta-analysis see [Articles Lancet](#) 2010; 376: 1670

## Abortion in the USA



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Since its legalisation in 1973, abortion has become one of the most common surgical procedures in the USA. Nearly half of the country’s pregnancies are unintended, of which almost half are terminated by abortion.

The US abortion rate has now stalled after a 30-year decline. So concludes a new report from the Guttmacher Institute entitled *Abortion incidence and access to services in the United States, 2008*. The report shows that, in a comparison of 2008 with 2005, abortion incidence (1.2 million), abortion rate (19.6 vs 19.4 in 1000 women aged 15–44 years), and abortion ratio (22 per 100 pregnancies) have all remained unchanged. The same was true for the number of abortion providers (close to 2000), and the accessibility of abortion (a third of US women still live in a county with no abortion provider).

The good news is that a shift has occurred towards drug-induced abortion, which is less risky than surgical intervention. 17% of all non-hospital abortions in 2008, compared with 14% in 2005, relied on mifepristone and

methotrexate. Drug-induced abortion early in pregnancy is also up by 25% (161 100 in 2005 vs 199 000 in 2008). The bad news is that the nationwide frequency of harassments toward abortion clinics has increased. For non-hospital providers, it rose from 82% in 2000 to 89% in 2008, and is most likely to occur in clinics in the midwestern and southern states.

Abortion is an expensive procedure, costing between US\$400–600. Nearly half of US abortions are done in women whose income falls below the federal poverty line. About half of these women are insured by the federal health plan for the poor but, by law, funds cannot be used for an abortion unless the mother’s life is in danger. The USA must do much more to provide accessible and affordable legal abortion services for women, as well as education about birth control for both men and women so that abortion rates continue to decline. ■ [The Lancet](#)

For the Guttmacher Institute report see <http://www.guttmacher.org/pubs/journals/4304111.pdf>

## Health in southeast Asia

Neglect of human rights that compromises health outcomes, the combination of high population density and domestic livestock that encourages zoonoses, claims over viral sovereignty, and an emphasis on health tourism that creates dual standards of care: too often health in southeast Asia is in the news for the wrong reasons. Today's *Lancet* reports good news from the region as well as disappointments, and provides opportunities to improve care locally by analysing how a variety of health systems in different settings within the region are responding to rapid socioeconomic change and shifting threats to health. The six theme papers in the Series on health in southeast Asia<sup>1-6</sup> show a range of responses to public health challenges, some of which might inform policy in other countries at similar stages of development. This is the first *Lancet* Series to focus on a region. In doing so, health professionals from different disciplines in the ten member countries of the Association of Southeast Asian Nations (ASEAN)—Brunei, Myanmar, Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand, and Vietnam—collaborated to identify common themes and individual approaches to problems that challenge health systems locally and around the world.

The strength of southeast Asia is its diversity: social, geographic, religious, and economic. But these same factors can also be weaknesses that limit intercountry cooperation on levels deeper than superficial self-interest. Health care offers a path to better mutual understanding by developing and sharing best practice and, as local capacity is developed (eg, the Mekong Basin Disease Surveillance Network), to forge more meaningful and substantial surveillance and clinical links between countries to improve health across the region. The Series addresses aspects of concern to all health systems: the burden of disease, prevention, and treatment;<sup>1-4</sup> human resources for health;<sup>5</sup> and financing.<sup>6</sup>

Other topics were too controversial, for example, human rights. To advocate for health based on human rights was an agreed goal of WHO's 6th Global Conference on Health Promotion, held in Bangkok, Thailand, in 2005. Human rights are also enshrined in the 2008 ASEAN charter, to which all ten countries in the Series subscribe. But they are too often absent

in health and the social determinants of health in southeast Asia. For example: limited sanitation to marginalised rural ethnic minorities in Vietnam and discrimination against people with HIV/AIDS in Cambodia. Addressing the social determinants of health, such as sanitation, education, nutrition, and equitable access to care are fundamental to improving the health of the population.

There are examples of hope. Six ASEAN countries—Cambodia, Indonesia, Laos, Philippines, Thailand, and Vietnam—are signatories to the International Covenant on Economic, Social and Cultural Rights, which forms a core for health-related rights. The Philippines and Vietnam recognise the right to health in their constitution. The Philippines also makes access to information a right in law (as does Thailand) and has legislated for access to essential medicines. Another marker of good practice is Malaysia's charter for patients' rights. In Myanmar, the release from prolonged house arrest of pro-democracy advocate Aung San Suu Kyi, as the Series went to press, may herald a change in attitude that could allow greater external collaboration to improve the country's health performance.

To establish a rights-based approach to health and improve health outcomes in southeast Asia requires not only political will and investment, but also leadership by health professionals. In doing so, health professionals must stand apart from the politics and narrow interests that have too often fettered, rather than fostered, progress in the region. This leadership needs to come from within the members of ASEAN, so that regional identity and focus is clear (by contrast to the WHO regions that subdivide southeast Asia). Until public health trumps private wealth, progress in health across the region will be disjointed and inequitable. Only by placing human rights at the heart of development will the right of the region's 580 million people to the highest attainable standard of health begin to be realised.

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*The Lancet* thanks Lincoln Chen, who facilitated the Health in southeast Asia Series, and acknowledges generous support to the contributing authors from The Rockefeller Foundation, China Medical Board, and Atlantic Philanthropies.



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Published Online  
January 25, 2011  
DOI:10.1016/S0140-6736(10)62192-7

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See *Online/Series*  
DOI:10.1016/S0140-6736(10)62049-1,  
DOI:10.1016/S0140-6736(10)62004-1,  
DOI:10.1016/S0140-6736(10)61506-1,  
DOI:10.1016/S0140-6736(10)62035-1, and  
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## Addressing the complexity of cardiovascular disease by design

Published Online  
January 15, 2011  
DOI:10.1016/S0140-6736(10)62240-4  
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Myocardial infarction and its main determinant, coronary artery disease, together the major cause of death and disability worldwide, are strongly heritable.<sup>1</sup> From a genetic standpoint these diseases are classified as complex, because they do not segregate in affected families following the patterns of Mendelian genetics (ie, autosomal dominant, recessive, or X-linked). Their inheritance is therefore believed to arise from several different genetic variants, which interact among themselves and with environmental exposures.

Genome-wide association studies have made major steps in deciphering the genetics of such complex traits as cardiovascular diseases. These hypothesis-free scans of the human genome, which simultaneously interrogate a large proportion of known common single-nucleotide polymorphisms (SNPs; common is defined according to the HapMap project<sup>2</sup>—ie, with a minor allele frequency above 5%), have identified several hundred SNPs associated with common diseases.<sup>3</sup> In coronary disease, nine studies have found 14 chromosomal loci at which one or more common SNPs are associated with coronary artery disease or myocardial infarction or both (table).<sup>3,4</sup> Interestingly, almost all studies consistently reported an association for non-coding SNPs at the 9p21.3 locus next to *CDKN2A* and *CDKN2B*, which can be considered the most widely and consistently replicated genetic risk factor for coronary artery disease and myocardial infarction.<sup>4</sup>

Despite the achievements of genome-wide association studies, much of the genetic risk that underlies the development of coronary artery disease and myocardial infarction is unexplained by common risk-SNPs.<sup>4</sup> Large meta-analyses of data from genome-wide association studies that include several thousand patients and controls are underway but, even with sample sizes in the order of 100 000, are unlikely to explain more than 15–20% of the heritability of coronary artery

disease and myocardial infarction.<sup>5</sup> The application of next-generation DNA sequencing with the improved catalogue of low-frequency genetic variation provided by the 1000 Genomes Project<sup>6</sup> promises to reveal much of the unknown heritability of complex traits, and to unravel the interplay between common risk-SNPs identified by genome-wide association studies and all surrounding genetic variation in determining the predisposition to common diseases.

However, even if it was possible to re-sequence the entire genome in several cases and controls with coronary artery disease and myocardial infarction, the phenotypic complexity of these disorders would still represent an obstacle to a full understanding of the underlying genetics. Indeed, the transition from a normal artery to myocardial infarction involves several pathological processes: the initiation and progression of an atherosclerotic plaque and its rupture, arterial thrombosis, and infarction of cardiac tissue. Each process is probably influenced by particular genetic risk factors. By contrast with this complex scenario, genetic association studies have rarely addressed the issue of different genetic risk factors contributing to either coronary artery disease or myocardial infarction.

In *The Lancet*, Muredach Reilly and colleagues<sup>7</sup> address the heterogeneity of these different cardiovascular phenotypes in genome-wide association studies. The investigators adopted an original study design and criteria for the definition of cases and controls, tailored to show genetic predisposition to angiographically defined coronary artery disease (study A) or myocardial infarction in the context of coronary artery disease (study B). In study A, they compared individuals affected by coronary artery disease with individuals without stenosis at coronary angiography, thereby circumventing the relatively high prevalence of coronary atherosclerosis

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