Smith and Petticrew have asked that we look at the woods not just the trees, a sentiment with which I wholeheartedly agree. However, when they discuss the differences between the health sector QALY-based thresholds and the life-based transport threshold, they both make a technical error and do just what they caution against by looking at these particular trees.

Their error is the assumption that £30 000/QALY (NICE) is materially different from £1.3 million/life (Department for Transport). Average age of death from a transport accident in England and Wales is about 41 years for men (the majority) and 50 for women. This equates to about 37–38 years of life lost per death or 37–38 QALYs assuming the victims were healthy at death. The cost/QALY is therefore about £35 000/QALY, much the same as the NICE threshold.

The real issue is the question why were these cost/QALY thresholds chosen? We know that humans value things that they have lost more highly than things they have or have never had, which might explain these figures when UK per capita gross domestic product is only £23 000. Health care and transport safety at these levels of efficiency, £30–35 000/QALY, consume more than they produce and are thus arguably luxuries.

Were Smith and Petticrew looking at the woods, rather than the trees of perceived differences in health economic calculations, they would have asked why £30–35 000/QALY when the UK minimum wage is just £11 000/pa and the poverty line £14 500/pa for a family of four. As we all know, poverty kills and kills young. Whilst society seeks to eradicate discrimination in so many forms, the poor are, and have always been, the subject of profoundly discriminatory attitudes and behaviour. Children who inherit genetic diseases can have huge and disproportionate resources committed to the treatment of their rare genetic disorder, often for minimal gain. Children born into poverty can expect little to address the disadvantages they will experience and did not choose. Perhaps we should lobby the WHO to classify poverty as a disease that shortens life then resources might be allocated in an equitable, proportionate manner.

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The empowerment of women and the population dynamics of climate change

Dear editor,

We welcome the focus on climate change and population growth, raised by Stephenson et al. Particularly in the context of reproductive health we agree with the sentiment that rapid population growth jeopardizes both human development and the capacity of poor communities to adapt to climate change is generally well known. While Stephenson et al. have ably addressed several key issues related to climate change and human health, the potential for women as agents of change has been somewhat overlooked.

Specifically while reproductive health is discussed as a means to combat rapid population growth, the significance of empowering women on a global level is omitted. Women can be effective agents of change when addressing global climate change adaptation strategies. To effectively address rapid population growth, a culturally sensitive model for women’s reproductive health services and education is required. Evidence confirms that such services result in the empowerment of women, and fewer births. Additionally, ‘the lack of access to reproductive health services undermines achievement of most if not all of the Millennium Development Goals (MDGs).’ However, reproductive health is still not readily employed as a climate change strategy despite reports indicating that the provision of reproductive health services is the most cost-effective climate change strategy. Therefore, the empowerment of women through the provision of reproductive health services should be a priority. We call on the WHO to promote the recognition that reproductive health services are key to climate adaptation.

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services acts as both a adaptation strategy, and a mitigation strategy, each of which are highlighted by Stephenson et al.\textsuperscript{1} to tackle the challenges of climate change.

A important outcome of the June 2010 G8 meeting in Toronto, Canada was the Muskoka Declaration, which called for a renewed emphasis on maternal and reproductive health. The declaration explicitly states that progress towards maternal and reproductive health has been unacceptably slow. To that end, global leaders have pledged $5 billion USD to be delivered through the Muskoka initiative, to accelerate MDGs 4 and 5, which focus specifically on child and maternal health. Additionally, issues of climate change in developing countries are addressed with the G8 making a commitment to share national strategies and experiences. Although this new commitment provides an opportunity to accomplish the goals of healthy outcomes for the world population and for the planet, it is disappointing that reproductive health and climate change remain unlinked.

In light of the declaration, we agree with Stephenson et al. assertions that ‘population dynamics have not been integrated systematically into climate change science’ and that ‘the contribution of population growth . . . to mitigation and adaptation programmes needs urgent investigation.’ The links between women’s health, population outcomes and climate wellbeing have been established. The time has come to integrate the sexual and reproductive health community into the climate change agenda in order to actualize change that will benefit women, nations and the environment.

References

2 Greer G. To have or not to have: The critical importance of reproductive rights to the paradox of population policies in the 21st century. Int J Gynaecol Obstet 2009;106(2):148–50.