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chronic obstructive pulmonary disease (COPD), and lung cancer. However, not all causes of death have decreased, and deaths from various cancers, such as prostate and pancreatic cancer and mesothelioma, have increased substantially. Moreover, road traffic injuries now account for an increased proportion of YLLs in all mainland provinces, and there has also been a worrying lack of progress against HIV in many parts of the country.

The shift towards non-communicable disease has occurred in all provinces, but the major causes of death vary greatly. Zhou and colleagues6 suggest that China can in fact be divided into five distinct so-called nations based on the epidemiological characteristics of each. In Shanghai, Tianjin, Zhejiang, Beijing, Hong Kong, and Macao, mortality rates are low and life expectancy is high even compared with high-income countries. In Jiangsu, Hainan, Guangdong, Fujian, Hubei, and Hunan, life expectancy is relatively high because of low rates of ischaemic heart disease and stroke mortality, but rates of cancer and COPD mortality are high. In a third group of mainly northeastern provinces (Shandong, Jilin, Liaoning, Shanxi, Shaanxi, Henan, Anhui, Hebei, Inner Mongolia, Heilongjiang, and Ningxia), life expectancy is in the mid-range of all provinces, with high levels of mortality due to ischaemic heart disease, stroke, and cancers. In the fourth group of provinces, mostly in southwestern China (Jiangxi, Chongqing, Yunnan, Gansu, and Sichuan), life expectancy is lower than average and rates of COPD mortality are relatively high (although with relatively low ischaemic heart disease and stroke mortality). Finally, Tibet, Xinjiang, Qinghai, Guangxi, and Guizhou have life expectancies which are more characteristic of low-income countries.

Zhou and colleagues6 provide a fascinating snapshot of a global power at a crucial stage in its development, and an invaluable detailed assessment of trends in the burden of mortality in China at the provincial level. As the investigators make clear, the large gradients in causes of mortality across the country pose very different challenges to local health systems. This research will give health-care professionals in individual provinces a better understanding of local health burdens, helping them to set their own priorities.

China now faces the challenge of achieving further prosperity in a way that prioritises population health and environmental sustainability. There are encouraging recent signs. The Chinese Government has outlined plans for expansion of the health-care sector during the next 5 years,8 and Premier Li Keqiang has “declared war” on environmental pollution.9 Even more promisingly, China has proposed plans for action to tackle climate change, pledging substantial cuts in greenhouse gas emissions and increases in low-carbon energy generation.10 If these and other commitments are kept, China has an opportunity to show that economic development does not have to be achieved at any cost.

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Reducing child mortality in China: successes and challenges

2015 is the target year for realising the Millennium Development Goals (MDGs). In the past 15 years, continuous progress has been made in reducing under-5 mortality worldwide.1 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.2 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.2 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.2 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.2 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.2 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.2 In The Lancet, Yanping Wang and colleagues2 address whether China is achieving MDG 4, associated with the reduction of child mortality, and outline challenges ahead by systematically assessing the trends in under-5 mortality worldwide.
mortality in 2851 counties in China, from 1996 to 2012.

Wang and colleagues’ data suggest that the under-5 mortality rate in China in 2012 was 13.7 per 1000 livebirths, a 65% reduction from the 2000 level. Therefore, by the end of 2008, MDG 4 had been achieved ahead of the 2015 target date, making China the eighth country to achieve MDG 4 worldwide. China’s accomplishments in reducing under-5 mortality owe credit to rapid socioeconomic development in the country. After reform and the opening up of China’s economy, the country’s gross domestic product (GDP) increased sharply, from ¥365.02 billion in 1987, to ¥58 801.88 billion in 2013; GDP per person increased from ¥382 to ¥43 320 during the same period. As a result of the large-scale actions aimed at alleviation of poverty, the size of poor populations in rural areas of China decreased from 250 million in 1978 to 82.49 million in 2010. The implementation of compulsory education projects also brought about growth of net enrolment rate for school-age children from 95.5% to 99.7%. These socioeconomic developments laid a good foundation for the improvement of children’s health status.

Another contributor to the improvement of children’s health status is the enhancement of health systems, including health financing, human resource development, and health information systems. After the outbreak of severe acute respiratory syndrome in 2003 especially, China expanded investment in the country’s health system. Specifically, in the new round of health reforms from 2009 to 2012, US$124 billion was earmarked for enhancing China’s medical insurance system, establishing and strengthening the health-care service system, and promoting the equalisation of basic public health services including maternal and child health services. In 2003, medical insurance covered only 30% of the national population; at the end of 2012, the coverage rate of medical insurance reached 99% of China’s population, and the universal coverage by medical insurance was almost achieved. Maternal and child health services also improved substantially in China, with the coverage rate of hospital delivery nationwide increasing from 79% in 2003 to almost 100% in 2013. Additionally, as an essential component of the health system, the maternal and child health information system is gradually improving. The annual report and child mortality surveillance systems have been established in the 1980s and 1991, respectively, and cover the whole country, which provides abundant information for Wang and colleagues’ study. In the discussion of the post-2015 health development agenda, an agreement was reached that the post-2015 development agenda should be established on the basis of the MDGs, and include those unattained MDGs according to the principle of coherence. Therefore, the fall in under-5 mortality rates noted in Wang and colleagues’ report can serve as a reference for developing countries to set corresponding post-2015 development targets.

Despite the marked improvements in children’s health, China faces a series of major challenges, especially with regards to regional inequity. As Wang and colleagues’ findings highlight, in 2012, the under-5 mortality rate of the county with the worst performance (104.4 deaths per 1000 livebirths) was 32 times that of the county with the best performance (3.3 deaths per 1000 livebirths). Additionally, 12% of all the counties studied have not yet achieved MDG 4, and are located mainly in the poor areas in west China. Through longstanding efforts, regional differences in maternal mortality in China have been narrowed significantly, and regional equity has been noticeably improved. For future studies, attention should be paid to measures targeting the causes of death of children in the poor regions of China. Specifically, the strengthening of human resources for health and
improvement of service quality in paediatrics should be given priority.

Wang and colleagues’ report also clearly presents the geographic distribution of counties with different levels of progress in reducing under-5 mortality. Thus, more attention should be paid to regions with slow progress, but not just to those regions in the western provinces of China. Wang and colleagues also emphasise the need for improvements in counties with an observed decrease in child mortality slower than the expected rate of decline estimated in the global model.

Notably, by comparing data based on annual reports with data from the maternal and child health surveillance system, Wang and colleagues noted that under-reporting of deaths happens in the maternal and child health surveillance system to some extent. However, the effect that under-reporting might have had on the conclusions drawn from this study needs further investigation and discussion.

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A roadmap for better mental health in New York City

New York City is frequently at the forefront of public health policy. Aggressive action to combat the dangers of tobacco use, including the 2003 Smoke-Free Air Act, tax policy, and educational campaigns, led to steep declines in smoking rates.1,2 Regulations to improve the food environment, such as labelling about calories in 20063 and sodium in 20154 and bans on trans fats in 2008,5 continue to be implemented as a way to tackle a growing obesity epidemic and rise in non-communicable diseases.

In this context, New York City is embarking on a large-scale effort to address mental health (including substance use disorders and misuse), recognising that in the past decade rates of serious psychological distress among New Yorkers have remained stagnant at about 5%.1 2 Using an algorithm from the Substance Abuse and Mental Health Services Administration and data from the New York City Health and Nutrition Examination Survey 2013–14, we estimate that one in five adults in New York City had a mental illness in the past 12 months.6 2 Government, especially City government, can take the lead to address this lack of progress and widespread population health burden.

From the New York City Health and Nutrition Examination Survey 2013–14,7 we estimate that more than half a million adult New Yorkers live with depression—about 172 000 adults have severe depression and 352 000 have moderate depression. Compared with adult New Yorkers without depression, those who have depression are less likely to be employed (39·3% vs 62·5%), three times more likely to report fair or poor general health (54·6% vs 19·0%), and six times more likely to report fair or poor mental health (62·5% vs 10·0%). Yet, less than 40% of adults with symptoms of depression received mental health treatment in the past 12 months, with foreign born and poorer New Yorkers even less likely to receive support. But inequities exist beyond access to quality mental health treatment.

New York City is highly segregated and stressors related to poverty and inequality are concentrated in under-resourced neighbourhoods. For many

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