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## Generic substitution of drugs is set to be introduced in 2010

**Andrew Jack** FINANCIAL TIMES

UK doctors will be drawn into new efforts to boost cost effective prescribing in the next few months as part of a deal agreed this month between the government and industry.

The newly revised pharmaceutical price regulation scheme (PPRS), designed to cut the overall NHS drug bill by about 5% in its five year life, will result in two initiatives to change current prescribing practice.

The first initiative, to be phased in by 2010, introduces generic substitution, which is designed to save costs directly by ensuring that pharmacists switch from any branded drugs named on prescriptions to cheaper generic alternatives unless a doctor ticks a box to insist on the branded drug.

The second initiative, to be tested in pilot programmes from next year, will experiment with paying doctors to encourage them to prescribe newer, more effective drugs even when they are more expensive, in line with the latest guidance from the National Institute for Health and Clinical Excellence (NICE).

Industry estimates that about 17% of prescriptions cite a specific drug by brand, with the result that 17% of dispensed drugs are branded. But with generic substitution, whereby a pharmacist can substitute the generic equivalent, the proportion should fall.

In negotiations with the government, industry preferred substitution to the originally proposed idea of imposing a flat 1.1% price cut on branded drugs for which the patent had expired as well as a cap on the price of these drugs at 50% more than their generic equivalents.

More importantly, industry has reached agreement for measures designed to stimulate and reward innovative drug development through "prescribing incentive schemes"; payment by results; and publication of the uptake of "clinically and cost effective medicines," locally, nationally, and internationally.

The new PPRS is staggered, with an initial 3.9% cut to the price of patented drugs due to start in February 2009.

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YOUNG LEVY/PHOTOFEST/ALAMY

Hospital costs for dying patients should be used for the home care many people would prefer

## Resources must be diverted to allow people to die at home

**Clare Dyer** BMJ

Thousands of dying patients a year are unnecessarily admitted to hospital in England even though the money spent could be used to provide the care at home that most people want at the end of their lives, according to a report this week from the National Audit Office.

The watchdog for public spending blamed the lack of 24 hour response services and poor coordination between health and social care services for condemning many people who would prefer to die at home to ending their lives in hospital.

Research indicates that between 56% and 74% of people would prefer to die at home. But 58% of all deaths occur in hospital, although the figure varies between 46% and 77%, depending on the primary care trust.

The audit office's examination of patient records

at Sheffield Primary Care Trust found that 40% of patients who died in hospital in October 2007 did not have medical needs that required them to be treated in hospital, and nearly a quarter of these patients had been there for more than a month.

They concluded that £104m (€122m; \$158m) of the £1.8bn cost of caring for patients with cancer in the last year of their lives could be redistributed by reducing emergency hospital admissions by 10% and cutting the average length of stay by 25%, or three days.

Although data for other conditions are not available, the report said that there is likely to be similar scope to reduce hospital time and to divert resources to caring for people in the places where they prefer to end their lives.

Last July the Department of Health published a strategy, aimed at improving provision

for patients approaching death and their families and carers (*BMJ* 2008;337:a871). This included around the clock, rapid response, community nursing services; improved coordination between local authorities and primary care trusts; end of life training for health and social care staff; and specialist outreach services.

But it was a "very ambitious and challenging strategy as to how end of life care should be," without a time frame for delivery, said Karen Taylor, director of health studies at the audit office. She said that the office's recommendations, which were accepted by the Department of Health, were designed to provide "impetus and added weight" to the strategy's proposals.

See Personal View, p 1297

End of Life Care is at [www.nao.org.uk](http://www.nao.org.uk).

Cite this as: *BMJ* 2008;337:a2750

## UK government hopes to introduce new "fit note" in 2009

Ann McGauran LONDON

A package of support to help people stay in work, including a new "fit note" to stop them drifting into extended sick leave, was announced by the government this week.

The plans, jointly launched by the work and pensions secretary, James Purnell, and the health secretary, Alan Johnson, come in response to Carol Black's report this March into the health of the United Kingdom's population of working age. The Black review said that the cost to the UK economy of ill health in working age is at

least £100bn (€120bn; \$150bn) a year (*BMJ* 2008;336:631).

The government's report says that the fit note is more user friendly and will help employers and employees have better access to timely information about when and how to return to work.

A pilot of the electronic sick note is already underway in Wales. Throughout England, Scotland, and Wales a draft of the revised certificate has also been tested with more than 500 GPs. Based on the evaluation's findings, the government will formally consult on the regulations that are needed to change the certificate early in 2009. It intends to introduce a revised medical certificate later next year.

After its successful pilot, the national education programme to improve the way GPs deal with health and work matters will come

into effect from April 2009 for all GPs who practise in Great Britain.

Other proposals include pilots for "fit for work" services to support people on a period of extended sickness absence to return to work and an independent National Centre for Working Age Health and Well Being.

Further measures include a three year extension of NHS Plus, which operates a network of 115 occupational health units, and a review of the health and wellbeing of the NHS workforce in partnership with employers and staff.

The government will also pilot an occupational health helpline for smaller businesses. *Improving Health and Work: Changing Lives* is at [www.workingforhealth.gov.uk/Government-Response](http://www.workingforhealth.gov.uk/Government-Response).

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## HIV testing should rise in areas of high prevalence



ED FREEMAN/STONE/GETTY IMAGES

Gay men accounted for 41% of new HIV diagnoses

Oona Mashta LONDON

Screening for HIV should be automatically offered to new patients aged 15-59 in general practice and hospitals in parts of the United Kingdom with a high prevalence of the infection to try to reduce the rising number of new cases, says the Health Protection Agency.

An estimated 77 400 people had HIV in the UK in 2007, with 28% unaware of their infection, the agency's annual reports on HIV and other sexually transmitted diseases among gay men, have found.

All new patients aged 15-59 who register with a GP should be offered an HIV test along with patients admitted to hospital in areas where there are at least two HIV cases per 1000 population, the agency recommends. There should also be routine HIV screening in tuberculosis clinics.

The agency is endorsing the new national HIV testing guidelines produced by the British HIV Association, the British Association for Sexual Health and HIV, and the British Infection Society.

In 2007 there were 7734 new diagnoses of HIV compared with 7334 reported in 2006, when a total of 73 000 adults had the infection.

Valerie Delpech, head of HIV surveillance at the Health Protection Agency's centre for infections, said, "Diagnosing HIV infections earlier will reduce transmission of this infection, as those unaware of their status pose a greater risk to future sexual partners.

"Late diagnosis also has a major impact on disease and life expectancy and it is vital that people are diagnosed early.

"It is very worrying that so many people remain unaware of their HIV status. Wider HIV testing in high prevalence areas in the UK is urgently needed to reduce the number of undiagnosed infections."

Areas with high prevalence include London, especially Lambeth; parts of the south coast, including Brighton, Bournemouth, and Eastbourne; and Manchester and Blackpool.

Also included are areas that have had more recent increases, such as Luton, Watford, Slough, Crawley, Northampton, Nottingham, and the Midlands.

HIV cases acquired through heterosexual contact in the UK have increased from 11% in 2003 to 23% in 2007, as a proportion of all infections acquired heterosexually in this period. The incidence of HIV among gay men continued to rise, with 3160 men testing positive in 2007 and most acquiring their

infection in the UK. Forty one per cent of all new diagnoses were in this group; compared with 55% through heterosexual contact; and 4% in other ways, mainly through injecting drug use and mother to child transmission.

Almost a third of people are being diagnosed at a point after which treatment should have begun (CD4 cell count <200/mm<sup>3</sup>), which means that they are missing out on the benefits associated with early diagnosis, including prolonged life expectancy.

Dr Delpech said, "Access to testing must be made easier."

HIV in the United Kingdom: 2008 is at [www.hpa.org.uk/hivuk2008](http://www.hpa.org.uk/hivuk2008). Sexually Transmitted Infections and Men Who Have Sex With Men in the UK: 2008 is at [www.hpa.org.uk/hivmsm2008](http://www.hpa.org.uk/hivmsm2008).

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## Scotland sets six



GUSTO IMAGES/SPL

No one in Scotland should wait more than six weeks for magnetic resonance imaging

# More staff training needed to promote breast feeding when babies leave neonatal care



PICTURE PARTNERS/ALAMY

**The proportion of women who express breast milk for babies in neonatal care is higher than that among all mothers who express milk for preterm infants who cannot yet suckle**

**Daloni Carlisle** LONDON

Mothers of babies in neonatal units could and should be encouraged to provide breast milk for their infants, Mary Renfrew, professor of mother and infant health, is to tell a Unicef conference in Glasgow on 26 November.

Professor Renfrew, who is presenting results of her as yet unpublished review of breast feeding in neonatal units, will call on the Department of Health to include preterm infants in its policies to support breast feeding.

Her review of 48 research papers on breast milk in neonatal units highlights the barriers to women initiating milk production, expressing it for preterm infants who cannot yet suckle, and maintaining breast feeding on discharge from hospital.

She told the *BMJ* that rates of initiation

of breast milk production for mothers with babies in neonatal units are more than in the general population, but few mothers breast feed at home once their baby has left neonatal care.

Professor Renfrew said, "It is a combination of units not enabling close contact between mothers and infants, lack of staff training, and staff shortages."

Her review found that tackling the first two of these could substantially raise breastfeeding rates cost effectively.

Studies have not considered whether increasing staffing levels would also make a difference, said Professor Renfrew.

She said, "We now have incontrovertible evidence that what infants in neonatal units need more than anything to reduce infection

and for growth is their own mother's fresh breast milk. But until this point the health service has not really believed that."

Breast milk is crucial to prevent necrotising enterocolitis, the main cause of death from infection in neonatal units, she said.

The matter is also one of health inequities because mothers from poor backgrounds are more likely to have a preterm baby who needs neonatal care than wealthy mothers.

Survival rates are higher and infection rates lower in units that provide good support for mothers and high rates of breast feeding, such as the Rush University Medical Center in Chicago in the United States or the University Hospital of North Staffordshire in the United Kingdom.

Professor Renfrew said, "At the very least we would like to see these babies included in the wonderful policy initiatives that have been developed over recent years, which have seen promoting and supporting breastfeeding become mainstream public health policy."

Professor Renfrew will also call for more research in this area. She said, "We found real problems with the research studies, particularly in the UK context. We have now written a research agenda to address some of the really critical research questions." In particular, more evidence is needed on more specific health outcomes.

The research was funded by the National Institute for Health Research Health Technology Assessment Programme.

Cite this as: *BMJ* 2008;337:a2671

## week target for diagnostic tests from April 2009

**Bryan Christie** EDINBURGH

Waiting times for eight diagnostic tests are to be cut to a maximum of six weeks in Scotland from April after the success of an improvement programme.

The current nine week target has been met throughout Scotland as a result of a £50m (€60m; \$75m) diagnostics collaborative programme, which has led to changes in how the service is managed and delivered. The number of patients who wait longer than nine weeks fell from 10 638 in

July 2006 to just two this July.

The performance of the diagnostic service has been reviewed by Audit Scotland. It welcomes the improvements that have been made but says that further sustainable improvements "will be challenging."

The new waiting time target was announced by the Scottish government and applies to eight tests—magnetic resonance imaging, computed tomography, non-obstetric ultrasound, barium enema, upper gastrointestinal endoscopy, sigmoidoscopy,

colonoscopy, and cystoscopy.

The Audit Scotland report says that the improvements in Scotland have resulted from several changes, including extending the working day; pooling consultants' waiting lists; mapping the patient's journey to remove bottlenecks; taking direct referrals from GPs to avoid outpatient appointments; and introducing guidelines to manage inappropriate referrals.

Patients who have endoscopy are getting better quality of care, and hospitals performed well in how

quickly they carry out computed tomography and magnetic resonance imaging in inpatients, the review says.

The time taken to report radiology and laboratory test results also varied. The report says that there is scope for more efficient use of resources. It also says that the NHS needs better information to manage these expensive services and to compare the efficiency of services throughout the country.

**Review of NHS Diagnostic Services** is at [www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk).

Cite this as: *BMJ* 2008;337:a2709





Transplant recipients in the US are more likely to be insured than donors

## Uninsured people get poor

Jeanne Lenzer NEW YORK

A study of US organ donors and recipients shows a “dirty little secret.” Transplant donors are far more likely to be uninsured than are the recipients, according to the coauthor Steffie Woolhandler, associate professor of medicine at Harvard Medical School (*International Journal of Health Services* 2008;38:641-52).

The researchers examined the insurance status of 1447 organ donors, both live and

cadaveric, and 4962 transplant recipients from the national inpatient sample database, a nationally representative sample of all US hospital stays.

They found that 16.9% of the donors were uninsured compared with 4.6% of other hospital inpatients, whereas only 0.8% of the recipients were uninsured.

The finding that most transplant recipients were insured had previously been known. However, “our finding

## Doctors in South Dakota must warn women who seek abortion they are terminating human life

Janice Hopkins Tanne NEW YORK

Doctors in South Dakota must tell every woman who seeks an abortion that the procedure “will terminate the life of a whole, separate, unique, living human being”; that she “has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States constitution and the laws of South Dakota”; and that she faces the risk of depression, suicide, infertility, and risks to future pregnancies if she has an abortion.

The “informed consent” law, which came into effect in June, was denounced this week in an editorial and a perspectives article in the *New England Journal of Medicine* (2008;359:23, doi:10.1056/NEJMe0809669 and 2008;359:2189-91, <http://content.nejm.org/cgi/content/short/359/21/2189>)

The editorial argued that the law constituted “an affront to the first amendment rights of physicians and an embarrassment to the people of South Dakota . . . If states are permitted to mandate ideological speech about abortion, what is to stop them from doing the same for end of life decisions, contraception, stem cell therapies, vaccination, or any procedure or treatment that does not conform to the political ideology of the statehouse?”

“Doctors have an ethical responsibility to provide their patients with accurate medical information. But can a patient trust any interaction with his or her physician knowing that the physician’s very words have

been mandated by the state?”

“The South Dakota requirements . . . signal a new step in states’ efforts to restrict abortion,” wrote Zita Lazzarini, a law professor at the University of Connecticut, in Farmington, and a faculty member at the Center for Law and the Public’s Health at Johns Hopkins Bloomberg School of Hygiene and Public Health, Baltimore, Maryland.

The informed consent law, passed in 2005, requires doctors to use a script to warn women of the risks of abortion (box). Women have to sign each page of the document, and doctors have to certify that the women understand it.

Planned Parenthood of Minnesota, North Dakota, and South Dakota, an organisation providing reproductive health services, challenged the law on the grounds that it violated doctors’ right to freedom of speech, guaran-

teed by the first amendment to the constitution. A Supreme Court decision made in 1977 said that although a state can require doctors to provide women with information, it cannot disseminate an ideology, Ms Lazzarini wrote.

A South Dakota judge prevented enforcement of the law by an injunction, but in June an appeal court ruled that the law’s definition of a human being was not ideological and lifted the injunction.

Planned Parenthood’s challenges to other provisions of the law were referred back to the lower court. Roger Evans, the organisation’s senior director for public policy, litigation, and law, told the *BMJ* that he expected that the lower court might call for further hearings, strike down the law, or uphold it within weeks.

Cite this as: *BMJ* 2008;337:a2707

### South Dakota’s 2005 “informed consent” law for abortions

Before an abortion is performed all pregnant woman must be told:

- That the abortion will terminate the life of a whole, separate, unique human being
- That the woman has an existing relationship with the unborn human being which is protected by the laws of South Dakota
- That by having an abortion, her relationship and constitutional rights with regards to that relationship will be terminated
- A description of all known medical risks of abortion, including depression and psychological distress, more risk of suicide, death rates due to abortion, risk of infection, haemorrhage, effect on subsequent pregnancies and infertility
- The probable gestational age of the unborn child and their development at that age
- Medical risks associated with carrying the child to term.

Source: *New England Journal of Medicine* 2008;359:2189-91

## deal from organ donation in the US

that uninsured patients frequently serve as organ donors is both new and poignant," the authors write. "The US healthcare system denies adequate care to many of the uninsured during life. Yet, in death, the uninsured often give strangers the ultimate gift."

The authors say that one possible reason organs are taken disproportionately from the uninsured is that donors, who tend to be younger than

recipients, are also less likely to be insured.

In addition, live donors might be afraid of losing their health insurance if they donate an organ to a relative or friend, Dr Woolhandler said.

Explaining why most recipients are insured, the lead author, Andrew Herring, an emergency medical resident at Highland Hospital in Oakland, California, said, "If you lack the financial resources to afford a transplant either through

insurance or otherwise, few centres will consider you as a candidate.

"The 1984 National Organ Transplant Act stipulates that transplants should be equally available to all Americans, regardless of their ability to pay. Unfortunately, the healthcare system is presently not funded adequately to make this a reality."

See [www.pnhp.org/organ\\_donors](http://www.pnhp.org/organ_donors).

Cite this as: *BMJ* 2008;337:a2704

## First patient is given bioengineered bronchus transplant

Alison Tonks MANCHESTER

Surgeons in Spain have successfully transplanted a bioengineered human airway into a 30 year old Colombian woman with a collapsed left main bronchus, caused by tuberculosis. The new airway, bioengineered from a donor trachea, was used to replace the woman's diseased bronchus on 12 June.

A report in the *Lancet* describes the woman as fully recovered, with normal lung function, a good quality of life, and no complications (2008 Nov 19, doi:10.1016/S0140-6736(08)61598-6). She takes no immunosuppressant drugs, the graft is functioning normally, and there are no signs of rejection.

Claudia Castello is the first recipient of the new kind of graft, developed by a European team of scientists from Bristol, Padua, and Milan. They began with a 7 cm segment of trachea from a 51 year old woman who had died of a brain haemorrhage. After stripping the trachea of all its potentially antigenic cells, the scientists reseeded the cartilage scaffold with cells from the recipient—a culture of epithelial cells from her own right bronchus for the inside of the graft and chondrocytes transformed from her own stem cells for the outside. They grew both types of cell in specially adapted cultures before being transferred to the graft over four days in a newly developed bioreactor.

Mrs Castello was breathless at rest before her pioneering surgery. Her left main bronchus had collapsed and previous attempts at stenting the airway had failed, says the



Claudia Castillo with her surgeon, Professor Paolo Macchiarini, after her trachea transplant

report. Faced with the prospect of a total left pneumonectomy, which carries a high mortality and would have left her with a compromised quality of life, Mrs Castello agreed to the experimental graft.

Paolo Macchiarini did the transplant operation at the Hospital Clinic, Barcelona, and the patient went home from hospital 10 days later after an uneventful recovery. Four months after surgery she could walk up two flights of stairs without stopping and care for her children without help.

A pneumonectomy is still possible should the graft fail, but the report's authors think clinical failure or restenosis is now unlikely. The new bronchus remains patent and, critically, has its own blood supply.

"We are terribly excited by these results," says Professor Macchiarini. "Just four days after transplantation the graft was almost indistinguishable from adjacent normal bronchi."

Cite this as: *BMJ* 2008;337:a2676

## FDA opens offices in China to regulate exported drugs

Susan Mayor LONDON

The US regulatory agency the Food and Drug Administration has opened its first branches abroad—in Beijing, Guangzhou, and Shanghai—to improve the safety of products imported from China into the United States.

The new branches are part of a strategy, called "beyond our borders," to improve the safeguards applied to food and drugs that are imported into the United States, acknowledging the increasingly global market. Further branches of the FDA are planned in India, Europe, Latin America, and the Middle East.

Michael Leavitt, secretary of the US Department of Health and Human Services, travelled to China to open the new branches. "We're opening up a new era, not just new offices," he said. "By having a presence in other parts of the world we can work more closely with manufacturers and other governments, better share practices, and further ensure that quality and safety are built into food and consumer products at the point of manufacture."

Eight senior FDA officials with experience as inspectors and technical experts in foods, drugs, and medical devices will work with regulatory agencies in China to inspect products to be exported to the US. They will also certify third party inspectors to approve the quality of exports. Their responsibilities will include inspecting local facilities and providing guidance to local manufacturers on US quality standards.

The initiative follows concerns about the safety of several products imported from China to the US in the past year, including toothpaste that contained diethylene glycol, and allergic reactions and deaths associated with heparin manufactured from materials that originated in China.

The US imported more than \$2000bn (£1400bn; €1600bn) worth of products through more than 300 ports of entry in 2007. The FDA predicts that this will rise as international trade grows.

Andrew von Eschenbach, the FDA commissioner, concluded, "The globalisation of the food supply and medical product manufacturing has demanded that we do things differently."

See [www.hhs.gov/news/press](http://www.hhs.gov/news/press)

Cite this as: *BMJ* 2008;337:a2700



## IN BRIEF

**United Nations appeals for \$7bn in aid:**

The United Nations has launched its humanitarian appeal for 2009, seeking \$7bn (£4.7bn; €5.5bn) from donors to provide urgent life saving support, including health and emergency food aid, to 30 million people in emergencies in 31 countries. The appeal estimates the health needs of the Democratic Republic of Congo at nearly \$76m, Somalia \$43m, Iraq \$83.7m, Zimbabwe \$45.4m, and Chad \$16.7m. It says that \$267.2m in new funds are needed by Sudan for health and nutrition.

**Fall in landmine**

**injuries:** The number of worldwide injuries from antipersonnel mines and other explosive remnants of war, including cluster bombs, fell by 9%

in 2007 compared with the previous year, with 5426 reported. The *Landmine Monitor Report* for 2008 reports that civilians made up most casualties, and almost half of them were children.

**Number of Dutch patients with multimorbidity rises:**

The proportion of primary care patients with four or more chronic diseases has increased by 300% in the two decades since 1985, according to a study based on 13 500 men and women in the Netherlands (*European Journal of General Practice* 2008;14(suppl):S28-32). This leads to more complex medical problems for which general practitioners need guidelines, say the researchers.

**Spain to test cocaine vaccine:**

At least 10 Spanish public hospitals will test a new cocaine vaccine on 164 drug users starting in 2009, the Spanish Health and Consumption Ministry has announced. The vaccine aims to inhibit the stimulant effects of cocaine through the immunological system.

**GPs' leader to chair evidence**

**portal:** The committee that decides what evidence based information will appear on the NHS Evidence portal is to be chaired by David Haslam, president of the Royal College of General Practitioners. The portal, which is due to launch in April 2009, will provide NHS staff and patients with evidence on treatments, procedures, high quality care, commissioning, and diagnostics.

Cite this as: *BMJ* 2008;337:a2716

## Smoking ban in Netherlands is widely

**Tony Sheldon** UTRECHT

The Dutch health minister, Ab Klink, has announced tough measures to enforce the smoking ban in the hospitality sector after a rebellion among small cafes in city centres threatened to spread across the country.

Almost all the cafes in the centre of Den Bosch, in the south of the country, were defying the ban this week and were photographed returning ashtrays to tables. Similar action is reported in Nijmegen, Tilburg, and Utrecht, with as many as 12 000 cafes involved.

In response Mr Klink wrote to MPs saying, "Let there be no misunderstanding. The cabinet takes this seriously. In this country laws are to be followed and that goes for everyone."

He announced that in addition to the administrative fines imposed by the Food and Consumer Product Safety Authority, the

law of "economic offences" will now come into force. This means that higher fines can be imposed more swiftly in cases of "structural contravention."

Ultimately cafes could be temporarily shut. The food authority's 200 controllers will be able to call on the support of the police and criminal investigators. Mr Klink said there will be a direct "tit for tat" policy.

Mr Klink also held talks with the industry body Royal Horeca Netherlands but refused its demands for government compensation for the owners of cafes.

The industry body will meet on 9 December to decide whether to withdraw support for the smoking ban, which, it argues, has caused "chaos" and "disastrous consequences," with a 25% drop in turnover, threatening 1500 cafes with closure.

Meanwhile a national demonstration to

## Zimbabwe faces a "health disaster," as hospitals close



ZADHR

**Health workers in Harare protested earlier this month over the state of the public health system**

**Ryan Truscott** HARARE

Zimbabwe's health minister, David Parirenyatwa, has admitted that he is "scared" by the cholera epidemic in the country, which has killed more than 290 people since September.

Last week the World Health Organization said that more than 6000 people had been infected in the outbreak.

The highly contagious diarrhoeal disease has now spread to nine of Zimbabwe's 10 provinces.

Médecins Sans Frontières said that if left unchecked, cholera could threaten the lives of 1.4 million people in Harare.

Mr Parirenyatwa told the local press that the lack of clean piped water meant that it is impossible to control the cholera outbreak. "As the minister responsible for health, I am very scared, especially during this rainy season," he said.

The outbreak comes at the worst possible time for inflation battered Zimbabwe, where a strike by health workers about poor pay has led to the unofficial closure of almost all public hospitals.

Douglas Gwatidza, the chairman of the Zimbabwe Association of Doctors for Human Rights, said that doctors had warned the government that a cholera outbreak was imminent. He said that the country now faced "a major health disaster."

Dr Gwatidza said that Harare's two main hospitals, the 1000 bed Parirenyatwa and the 500 bed Harare Central, were not taking new patients.

One medical source said that Harare Central was down to just four patients; Parirenyatwa had fewer than 100. Police and the army were manning Parirenyatwa last weekend, according to a report in the state media.

The association has warned that the closure of maternity wards means that many pregnant women will die because they can no longer receive emergency obstetric care.

A caesarean section at one of Harare's private clinics can cost anything between \$1500 (£1000; €1200) and \$5000, which is beyond the reach of most people.

See Views and Reviews, doi:10.1136/bmj.a2637

Cite this as: *BMJ* 2008;337:a2710

## flouted despite fines

save small cafes is scheduled for 29 November in The Hague.

The law banning smoking in enclosed public spaces, based on European employer protection legislation, came into effect in the Netherlands on 1 July. Fines were only issued after a three month warning period. More than 500 fines have been imposed, with some cafes being fined two or three times.

Lies van Gennip, director of the antismoking lobby Stivoro, thinks that the typically careful Dutch approach to tackling political and social questions has gone wrong. By allowing industry time to adjust, a small number of cafes have taken the opportunity to defy the law, and others have joined in.

"A very emotional discussion has now broken out and the healthcare arguments are pushed into the background, which is very un-Dutch," she said.



Many cafes in the Netherlands are defying the smoking ban

The "good news," she adds, is that the proportion (28%) of Dutch adults who smoke looks set to fall in 2008. Stivoro has recorded three times the normal number of quitters in the months before the ban.

A report on environmental tobacco smoke

by the Dutch Institute of Public Health cites research that shows that the Netherlands is 14th in a league table of 30 European countries' tobacco control measures. The UK comes first ([www.rivm.nl/rapporten/260601005.html](http://www.rivm.nl/rapporten/260601005.html)).

Cite this as: *BMJ* 2008;337:a2679

## Global forum recommends developing countries have greater say in setting research priorities

**Robert Walgate** BAMAKO

Developing countries should have more say in the research that takes place in their territories, an international meeting has concluded.

The conclusion of the Global Ministerial Forum on Research for Health also recommended that health research in developing countries should be broadened to cover social and other determinants. The forum was held in Bamako, Mali, last week and was attended by representatives from 59 countries.

The forum also endorsed four recommendations of the high level task force on scaling up research and learning on health systems of the director general of WHO.

Ok Pannenberg, senior health adviser for the World Bank's Africa region, told the *BMJ*, "Research for health [a more embracing concept than 'health research'] has moved to a higher level.

"Goethe said new knowledge is not enough—we must apply it—and that willingness is not enough—we must act. These results will play a big role over the next four years in the working of the bank."

The forum's conclusion "explicitly calls on the bank to do its share of this kind of research," said Dr Pannenberg. This will

be mostly research on implementation and development economics, but "we also subscribe strongly to impact evaluation research and operational research—how to do things better," he said.

The call "will go to all the bank's staff concerned with research, and [the health sector] will get a strong boost from it," said Dr Pannenberg. He added, "All the developing countries here bought into the agenda. So it changes the research for health process from being supply driven to demand driven.

"We will expand our agenda on health systems research. There will be a larger component on research for health with each of the countries with which the bank does business—through the health sector and through the science and technology sector."

Tim Evans, WHO assistant director general for information, evidence, and research, considered the call a "ringing endorsement" of WHO's approach to health systems research expressed by the draft report of its task force. The report called for the creation of a "high profile agenda" of research and learning, engagement with policy makers in designing research programmes and applying research results, strengthen-

ing country capacity for such research, and increased funding. "The time for health systems research is now," said Mr Evans.

The call to action represented "an enormous opportunity to put countries in the driving seat," said Mr Evans. It also emphasised the health sector's own responsibility "to tap society's research," he said.

Carel IJsselmuiden, the director of the Council of Health Research for Development, one of the meeting's six organising partners, said, "Mexico 2004 [the previous Ministerial Forum on Health Research] stood for health systems research. Bamako will stand for the beginning of the end of vertical programming in health research—and health." Julia Hasler of Unesco welcomed calls to educate and train and the emphasis on research ethics.

But there was disappointment about intellectual property, which was largely overlooked. Tido von Schoen-Angerer, director of the campaign for access to essential medicines at Médecins Sans Frontières, complained that the forum had failed to mention explicitly WHO resolution 61.21, the global strategy and plan of action on public health, innovation, and intellectual property.

Read Fiona Godlee's blog, <http://blogs.bmj.com/>  
See Editorials, p 1249

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