bmj.com Some primary care trusts recommend that GPs limit prescriptions to 28 days
UK news Cut useless medical treatment, says Audit Commission, p 893
World news German parliament considers three bills on preimplantation genetic diagnosis, p 894
For the full versions of articles in this section see bmj.com

Study reveals corporate links of global foundations

Matthew Limb LONDON

Big philanthropic foundations are transforming public health around the world, but their links to food and drug companies pose potential conflicts of interest, says a study.

The research says that some of the corporations benefit directly from grants from foundations, and foundations in turn have investments in the corporations to which they award the grants.

Foundation board members and decision makers also sit on the boards of some for-profit corporations benefiting from their grants.

Three experts on public health examined five of the biggest private global health foundations, including the world's largest, the Bill and Melinda Gates Foundation (*PLoS Medicine* 2011;8(4):e1001020).

At the end of 2008 the Gates Foundation had $29.6bn (£18bn; €20.5bn) of assets under its management. The foundation funds medical research and drug and vaccines programmes in developing countries.

The study says that the Gates Foundation's corporate stock endowment is "heavily" invested in food and drug companies, both directly and indirectly, and that it holds "significant" shares in McDonald's and Coca-Cola.

The foundation also participates in grants that encourage farmers in developing countries to become business affiliates of Coca-Cola. The study also looked at the Ford, Rockefeller, W K Kellogg, and Robert Wood Johnson foundations.

The authors—David Stuckler, of Harvard University and the London School of Hygiene and Tropical Medicine, Sanjay Basu, of the University of California at San Francisco, and Martin McKee, of the London School of Hygiene and Tropical Medicine—write: "We have observed that five major US non-profit foundations have significant investments in food and/or pharmaceutical companies, directors who currently or have previously sat on the boards of those companies, and in several cases, enter in partnerships with those companies."

They say that existing policies to mitigate potential conflicts of interest are insufficient and recommend greater transparency.

Cite this as: *BMJ* 2011;342:d2490

Johnson & Johnson disclosed the payments after it took over De Puy International in 1999

UK company pays £5m order for its corrupt payments to Greek surgeons

Clare Dyer BMJ

A UK based orthopaedic implant company, De Puy International, has been ordered to pay nearly £5m (€5.6; $8.1m) to the UK authorities for making corrupt payments to Greek surgeons to induce them to buy its products for the state health service.

The civil recovery order, obtained by the Serious Fraud Office at the High Court in London, is part of a global settlement with the healthcare products giant Johnson & Johnson—which acquired De Puy International and its US based parent company, De Puy Incorporated, in 1999—by the US, UK, and Greek authorities.

Prices of artificial hips, knees, and other products were inflated to provide around £4.5m in inducements, mainly to surgeons who were influential in deciding what products were used in their hospitals or clinics.

From 1998 to 2007 the Greek government paid an intermediary company acting for De Puy about £33.5m for orthopaedic products. The price of a prosthetic knee in Greece was twice that of the European average, with the Greek taxpayer footing the bill.

The investigation into De Puy's activities in Greece was triggered when Johnson & Johnson made a voluntary disclosure to the US Department of Justice and the US Securities and Exchange Commission. In 2007 the justice department referred the case to the UK Serious Fraud Office.

Under the UK civil recovery order the company will pay £4.83m plus prosecution costs. It will also pay a financial penalty of $21.4m under a deferred prosecution agreement with the US Department of Justice. The US Securities and Exchange will impose a civil sanction of $24.25m plus interest of $6.26m, and the Greek authorities have restrained €5.79m of the company's assets.

A plea settlement agreed by the Serious Fraud Office with a "cooperating defendant," a former director of marketing at De Puy International, John Dougall, said, "Dougall says that the corrupt practice of paying inducements or rewards to orthopaedic surgeons in the Greek public health system was endemic . . . The payments were routinely characterised as 'cash incentives' or so-called 'professional education.' The level of funds made available for 'Prof Ed' purposes was a standardised 20% of the value of end user sale prices."

Mr Dougall pleaded guilty in April 2010 to conspiring to make corrupt payments or give inducements and was sentenced to 12 months' imprisonment, which was later suspended by the Court of Appeal.

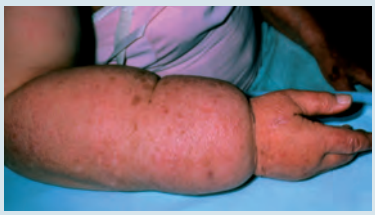
Cite this as: *BMJ* 2011;342:d2408

IN BRIEF

Independent panel to review global fund's finances: Michel Kazatchkine, executive director of the Global Fund for AIDS, Tuberculosis and Malaria, has appointed an independent five person panel to review the organisation's financial safeguards. The decision was taken after $11.2m (£6.8m; €7.7m) of the fund's money went missing in Djibouti, Mali, Mauritania, and Zambia. Former US secretary Michael O Leavitt and former Botswana president Festus Mogae will chair the panel.

Clinical trials gateway opens: People can access a new website that details clinical trials running in the UK, with the launch of phase two of the UK Clinical Trials Gateway. It is being developed by open access publisher BioMed Central in partnership with the National Institute for Health Research (www.ukctg.nihr.ac.uk/default.aspx).

Europe launches consultation on e-health: The European Commission has launched an online public consultation on ways in which information and communication technologies can be used to tackle the challenges facing healthcare systems. The results will feed into the eHealth Action Plan 2012-20 the commission will present before the end of the year. The consultation ends on 25 May. See http://ec.europa.eu/information_society/activities/health/ehealth_ap_consultation/index_en.htm.



DR P MARAZZI/SPL

Cancer charity criticises NHS lymphoedema services: Breakthrough Breast Cancer has published a report claiming that more needs to be done across the NHS to meet the needs of breast cancer patients who develop lymphoedema after their treatment. More information can be found at www.breakthrough.org.uk/constantreminder

NHS Confederation appoints new head: The NHS Confederation has appointed Mike Farrar, a former head of primary care at the Department of Health and current chief executive of North West Strategic Health Authority, as its chief executive. Mr Farrar will take over from acting chairman Nigel Edwards.

Cite this as: *BMJ* 2011;342:d2485

Pathologist in G20 inquest admits that he changed his postmortem report

Clare Dyer BMJ

Freddy Patel, the pathologist who concluded that the newspaper seller Ian Tomlinson died of natural causes at the anti-G20 summit protest on 1 April 2009, has told the London inquest into the death that he changed his postmortem report a year after he produced it.

Dr Patel's first report, dated 6 April 2009, was produced before amateur video footage came to light, a week after the death, which showed Mr Tomlinson being struck on the leg with a baton and pushed to the ground by a police constable. The report found that the death was consistent with natural causes because Mr Tomlinson had coronary artery disease and could therefore have died at any time.

JONATHAN HORDLE/REX FEATURES

Two pathologists disagreed with the findings of Freddy Patel (above), who concluded that Ian Tomlinson died of natural causes

Dr Patel made the change after two other pathologists, Nat Cary and Kenneth Shorrock, disagreed with his conclusions, believing that Mr Tomlinson had died from internal bleeding. Dr Cary suggested Mr Tomlinson, an alcoholic with liver disease, could have been pushed, then fallen with his arm under his body, hitting his liver and causing it to bleed internally.

Dr Patel told the coroner, Judge Peter Thornton, and the jury that he revised his report because he feared the other pathologists had misinterpreted his findings, in his report dated 6 April 2009, of "intra-abdominal fluid blood about 3 litres, small blood clot."

The revised report a year later changed this to "intra-abdominal fluid with blood about 3 litres and small blood clot." He said he had amended it to make it clear that it was not pure blood, but a mixture of blood and ascites, produced by liver disease.

"It was ascites fluid with some blood in it," he told the inquest. The fluid was inadvertently discarded before the other pathologists disagreed with his findings.

The conclusion as to cause of death remained the same in the second report, which stated: "The strike with the police baton . . . was not the immediate cause of his death and, although there is a temporal link, it would not be possible, on a higher standard of proof, to be sure that it contributed to the terminal collapse."

The inquest continues.

Cite this as: *BMJ* 2011;342:d2459

UK government expects private firms to manage

Michael Cross LONDON

Government plans for an "information revolution" in the English NHS will include encouraging commercial firms to manage online health records on behalf of patients, said the official in charge.

Christine Connelly, chief information officer for health at the Department of Health, said that plans to be published later this year would allow patients to take control of—though not to delete—their GP record.

"The intention is to give individual patients the ability to take a copy of their record and load up in a [computer] tool of their choice, and we expect the market to provide these rather than the Department of Health," she told a seminar, organised by Westminster Health Forum.

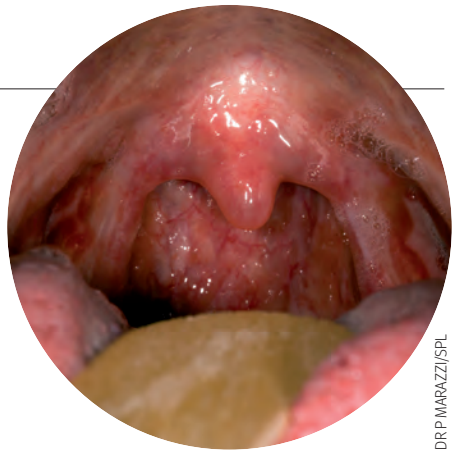
The BMA has warned that encouraging patients to pass on their records to third parties such as internet based health information services could imperil confidentiality.

"Even if a patient legitimately decides to share information contained in their record—for example, with those in an online support forum . . . they will effectively lose control of the future use of that information once published on the internet," the association said in its response to the information revolution consultation document published by the Department of Health last year.

The BMA warned that providers of online health records may not be covered by UK data protection safeguards.

Ms Connelly said that the department had received 750 responses to the information revolution consultation, which closed in January.

Cut useless medical treatments, says Audit Commission



DR P MARAZZI/SPL

Helen Mooney LONDON

Cutting the number of treatments that have low clinical value would save the NHS £500m (€562m; $814m) a year, a briefing from the Audit Commission says.

The figures show what the NHS could save if it carried out fewer ineffective and inefficient treatments. The savings should be spent on treatments that have been shown to work, it says.

The commission looked at several primary care trusts' efforts to decommission treatments that offer low clinical value and found that there was a wide variation in the approaches they took, and in the treatments they targeted.

Examples of the types of treatments that are deemed no longer necessary include:

- Those considered to be relatively ineffective such as tonsillectomy
- Those where more cost effective alternatives are available, such as heavy menstrual bleeding—the treatment often used to be hysterectomy but alternatives exist
- Those where the benefit and risk balance is close, such as some cases of wisdom teeth extraction
- Some cosmetic procedures, such as orthodontics.

The commission concluded that a single approach to defining these low value treatments could help to reduce the duplication of effort between primary care trusts and would help to ensure consistency across the country.

It said that if more primary care trusts used the list of 33 low priority treatments produced by Croydon primary care trust, savings could amount to more than £12m a year for each trust (the full list is on bmj.com).

It estimates that at present trusts have identified about 250 different procedures with limited clinical value.

However, the commission acknowledged that the decommissioning of such treatments was "not always easy."

The report warned that decommissioning "decisions can be controversial and raise ethical questions."

It said that good communication between primary care trusts, general practitioners, patients, and the public was crucial for the successful decommissioning of treatments and that the public would want to know that "appropriate research and reasoned consideration" had influenced decisions about which treatments had low clinical value.

To read the full briefing go to www.audit-commission.gov.uk/sitecollectiondocuments/downloads/20110414reducingexpenditure.pdf.

Cite this as: *BMJ* 2011;342:d2438

patients' online records in information revolution

She said that the government would publish its response "very soon," to be followed quickly by a formal information strategy and later by a strategy for information technology.

The information strategy is expected to outline plans to make more data about performance and outcomes publicly available. The aim is to encourage patients to be more active in shaping their services, Ms Connelly said. "We need to move beyond patient surveys to a real dialogue and we expect that dialogue to be conducted in a very transparent way."

Ms Connelly said that better data flows would be essential to bridge gaps in an NHS with "more independent pieces." She stressed, however, that allowing the flow of data derived from patient records would not compromise the security of records about individual patients' care.

Responding to concerns about the impact of the Health and Social Care Bill on privacy, Ms Connelly said there are no plans to give the new NHS Commissioning Board more access to data than currently enjoyed by primary care trusts. "I do not believe the bill massively increases the power to collect data," she said. In February, the BMA said that the bill "is potentially removing the control doctors, and most importantly, patients, have over their confidential data."

She also dismissed newspaper reports that special steps have been taken for "MPs and celebrities" to opt out of electronic medical records, saying the procedures "are no different to the rest of us." Questioned about members of the royal family, she said she had no knowledge of special treatment but offered to find out.

Cite this as: *BMJ* 2011;342:d2446

PCTs seek to restrict GPs prescribing high cost drugs

Adrian O'Dowd LONDON

General practitioners' ability to prescribe expensive drugs that are officially approved for use on the NHS is being scaled back by primary care trusts to try to save money.

Some doctors are coming under increasing pressure to stop prescribing high cost drugs even though they are approved by the medicines watchdog the National Institute for Health and Clinical Excellence (NICE).

The Department of Health has questioned the development and insisted that GPs are entitled to prescribe medicines based on a patient's clinical need and trusts are legally obliged to fund treatments and drugs recommended by NICE.

A survey with responses from 134 primary care organisations in England, Scotland, and Wales carried out by *Pulse* magazine found that more than half had created new lists of drugs in the past year that they recommended doctors no longer prescribe.

Of the 134 organisations, 73 said that, during the past year, they had either added drugs to so called "red lists," or placed additional restrictions on prescribing in primary care. Red lists contain drugs that can be prescribed only by a hospital consultant and not a GP.

The restrictions covered drugs approved by NICE or other national organisations, and included gliptins for diabetes, denosumab for osteoporosis, and atorvastatin and rosuvastatin for reducing levels of low density lipoprotein cholesterol, which have been approved in some circumstances by the National Prescribing Centre.

Some drugs had been restricted because of "low clinical priority" such as drugs for Parkinson's disease, newer contraceptive pills, erectile dysfunction drugs, and some non-steroidal anti-inflammatory drugs. They were classed as such because the primary care organisation thought there were other drugs available for these conditions that were just as effective and cheaper.

Although the trusts' recommendations are not an absolute ban, they will make it difficult for GPs to prescribe these drugs without being challenged.

Pulse said primary care trusts and health boards were adjusting their formularies as a way of trying to save around £250m (€282m; $404m) from drugs budgets.

Cite this as: *BMJ* 2011;342:d2449

Antismoking groups must not become close to drug firms

Aser García Rada MADRID

The World Health Organization has warned health professionals working in tobacco control not to become too closely involved with drug companies that produce smoking cessation products.

The warning came last month at a meeting on smoking prevention in Madrid that was hosted by the National Committee to Prevent Smoking, which represents most Spanish antitobacco organisations and which was sponsored by Pfizer, GlaxoSmithKline, and McNeil—all of which make treatments to help smoking cessation.

Armando Peruga, programme manager of WHO's Tobacco Free Initiative, advised health professionals "to be independent and guided by scientific evidence."

"We have to keep a distance from the tobacco industry, but we also have to maintain some distance from any other industry that can have a commercial interest in this issue. Today the tobacco industry is starting to joke that we have been sold to the pharmaceutical industry, something we must be aware of," he added.

Asked by the *BMJ*, Dr Peruga explained that the limits to collaboration should be clear. "WHO is working with the pharmaceutical industry in the implementation of policies, but only public health agencies are responsible for policy design. The issue of drugs [for smoking cessation] is [just] one more element [of tobacco cessation strategies] and we have to put it in perspective," said the WHO representative.

In Spain public funding of drugs for smoking cessation is only provided in two autonomous communities: Navarra and La Rioja. Attempts by the National Committee to Prevent Smoking and some political parties to get the public funding of such drugs put into Spain's new smoking law failed (*BMJ* 2010;341:c7429; doi: 10.1136/bmj.c7429).

Some health professionals have advised against increased medicalisation of smoking cessation attempts. *Mi vida sin ti* (My life without you, http://mividasinti.drupalgardens.com/) is an independent internet based organisation launched in January 2011, which involves several professionals who want to avoid the usual messages like "see your doctor to help you stop smoking."

The role of smoking cessation drugs in reducing smoking has been fiercely debated over the past few years. Simon Chapman and Ross MacKenzie pointed out, in a review of medical literature published in *Plos Medicine* in 2010, that two thirds to three quarters of former smokers stop unaided, even though stopping has been increasingly medicalised, with "obvious benefit of pharmaceutical companies" (www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000216).

The authors say most papers on smoking cessation interventions are studies of assisted cessation, most of which are funded by drug companies that are manufacturing those treatments. The authors refer to this as "the inverse impact law of smoking cessation," meaning that the volume of research on medicalised cessation is in inverse proportion to that examining how most smokers actually quit.

Cite this as: *BMJ* 2011;342:d2430

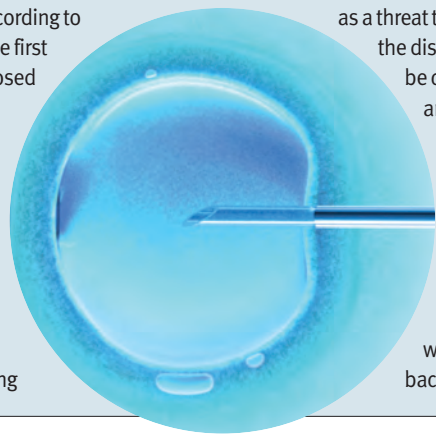
German parliament considers three bills on preimplantation genetic diagnosis

Ned Stafford HAMBURG

Three proposals for a new law on preimplantation genetic diagnosis have been introduced in Germany's Bundestag, with one of the proposals calling for a ban and two others allowing it in certain circumstances. At present the law in Germany is unclear.

No German political party has taken a stand on the issue, instead allowing party members in the lower house to vote according to their conscience. Before the first readings of the three proposed bills on 14 April, 192 of the 622 members of the Bundestag had signed a motion supporting a complete ban.

A total of 215 MPs support a bill that would allow preimplantation genetic diagnosis under certain conditions, including if one or both parents carry a serious hereditary disease. Some 36 MPs support another bill allowing preimplantation genetic diagnosis but with more restrictions.



A major argument of supporters is that tests such as amniocentesis are already allowed on embryos in the womb and that these sometimes result in the mother choosing to have an abortion. Opponents see preimplantation genetic diagnosis as a threat to unborn life, because of the discarding of embryos found to be carrying a genetic disease, and a step towards allowing "designer babies." They also claim that it could lead to an increase in discrimination against disabled people.

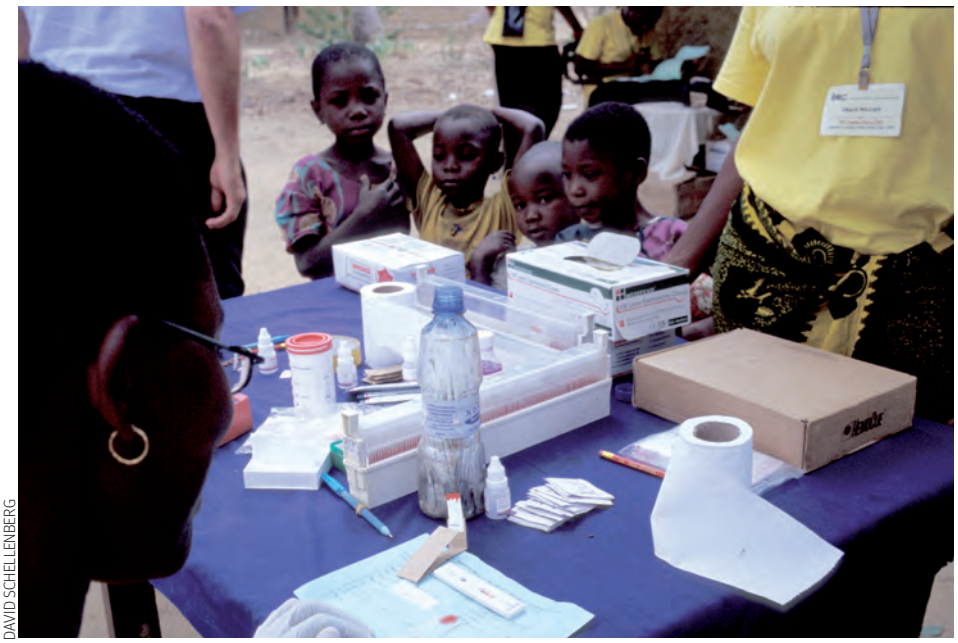
All three bills have support across party lines, with Chancellor Angela Merkel backing a complete ban. A final vote has been tentatively scheduled for 30 June.

Preimplantation genetic diagnosis was officially forbidden in Germany in 1990 under the Embryo Protection Law. However, legal uncertainty remained. The issue was thrown into the legislative arena in July 2010 by a ruling from Germany's Federal Supreme Court concerning a gynaecologist who had treated three couples who had failed to achieve a pregnancy naturally (*BMJ* 2010;341:c3741).

The doctor was charged with performing an illegal abortion after he chose to carry out genetic diagnosis on several human embryos in vitro and discarded those with genetic defects, but he was acquitted.

In subsequent months, as bills for the new law were being drafted, many politicians who would have preferred not to take a public stand on the issue were hoping for a clear signal from the German Ethics Council. But the council, whose 26 members specialise in scientific, medical, theological, ethical, social, economic, and legal issues and whose tasks include preparing opinions and recommendations for political and legislative actions, is divided on the issue.

Cite this as: *BMJ* 2011;342:d2473



DAVID SCHELLENBERG

Children are treated for malaria in Tanzania as part of an intermittent preventive treatment project

Malaria patients "should be tracked back to their homes to identify hot spots"

Geoff Watts LONDON

Progress in controlling malaria is encouraging some countries to consider the possibility of its elimination, said speakers at a briefing on 13 April organised by the London School of Hygiene and Tropical Medicine.

Malaria affects half the world's population and still causes more than 700 000 deaths a year, so elimination is still a challenging goal for many countries. And in countries where the disease is receding, said Chris Drakeley, director of the school's Malaria Centre, the remaining "hot spots" may prove hard to deal with.

Tackling these is vital, not least because in such hot spots resistance to antimalarial drugs can appear. "This realisation will bring about a mind shift in how we approach the problem," said Dr Drakeley. "One key question will be how to trace these hot spots."

He suggested that tracking people back to their homes after local healthcare facilities have diagnosed their malaria will allow the efforts of control staff to be most usefully directed. One idea being tested is the use of SMS text messaging to get help to where it is needed.

David Schellenberg, the school's professor of malaria and international health, pointed out that not all fever is due to malaria. "But most people in malaria affected parts of the world don't have access to good diagnostic facilities," he said.

Easy to use technologies that rely on applying a drop of blood from a finger prick to a small disposable device are changing this. "Malaria diagnosis can now be made available even in remote parts of Africa," said Professor Schellenberg. "You can target your scarce resources on people who really do have the disease. This will also help to improve the management of non-malarial illness."

The devices currently cost around $0.60 (£0.37; €0.42), but mass manufacture should bring the price down. By contrast the currently favoured artemisinin based combination therapy costs around $10 per treatment.

Another relatively recent development known as "intermittent preventive treatment," first used on pregnant women, is now being tested on children. Intended for use in areas where malaria transmission occurs in only a few months of the year, this treatment relies on giving a full dose of antimalarials to all children at set times during the peak risk period, regardless of whether they have been infected. Brian Greenwood, professor of tropical medicine at the school, is impressed by this approach. "There have been several trials that show you can get good protection," he said.

For dispensing artemisinin based combination therapy in Ghana the Mobilize Against Malaria organisation has been using "licensed chemical sellers." These are people who run their own small health outlets and are often the only source of advice on health in rural communities. Mobilize Against Malaria has trained 1000 of them and supports their wider use.

Cite this as: *BMJ* 2011;342:d2472

"Vaccine hesitancy" threatens drive to increase coverage

Matthew Limb LONDON

Global vaccination programmes are on the brink of a successful new era, but they could yet be undermined by challenges, including a potential crisis of public trust, say experts.

A seminar heard how "vaccine hesitancy," poor healthcare systems, and "unfair" pricing must be tackled to stop preventable diseases claiming millions more lives.

The debate, on vaccines and the opportunities they offer for global health, was held at the London School of Hygiene and Tropical Medicine on 13 April.

Speakers included specialists in the fields of vaccines development, immunisation strategy, and international aid and development.

Heidi Larson, of the London School of Hygiene and Tropical Medicine, who leads the school's research programme on public trust in vaccines, said that the growth of scepticism or "anti-vaccinationism" among some communities was a cause for concern.

Dr Larson, who is also attached to the Harvard Center for Population and Development, said, "We've heard a lot about a crisis of public confidence and the emergence of antivaccine groups. We are dealing with a public that is less risk tolerant and more demanding. We have to be more honest about the risks."

Brian Greenwood, professor of tropical medicine at the school, said that despite the "enormous progress" made by vaccination programmes two million children were dying each year from "vaccine preventable" diseases.

He said that because of technological advances some 30 new vaccines to fight infectious diseases should come on stream within 10 years or so. But he added that vaccines still take too long to develop—it could take 20 years from conception to use.

Cite this as: *BMJ* 2011;342:d2479

Polio re-emerged in northern Nigeria (above) after an anti-vaccination campaign