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Benefits of contract may not be known for years

Adrian O'Dowd LONDON

The government has admitted that it will have to wait years before it discovers whether there are real productivity gains from the new consultants' contract.

NHS leaders also told the House of Commons Committee of Public Accounts last week that lessons had been learnt from mistakes made when the contract was introduced, such as not piloting it before implementation. They were giving evidence as part of the committee's inquiry into the consultants' contract.

The session was prompted by the publication earlier this month of a report from the government's spending watchdog, the National Audit Office (*BMJ* 2007;334:865, 28 Apr).

Edward Leigh, the Conservative MP for Gainsborough and the committee's chairman, said that that report had been damning, and he asked why the contract cost £715m (€1.1bn; $1.4bn) in the first three years—£150m more than estimated—"without any discernable increase in productivity."

Giving evidence, David Nicholson, chief executive of the NHS, said that the negotiations over the contract were complex and that the Department of Health had underestimated the cost.

"I don't accept that it's a mess," he said. "This was a new contract that we tried to implement over a relatively short space of time. The key thing about it is the potential it gives local management to connect consultant workload with what patients need."

"It is too early to tell yet whether we are going to get many of the productivity gains that we wanted," he said. "This is a long term solution to something that has been going on for many years."

The National Audit Office's report can be seen at the publications section of www.nao.org.uk.

JOHN STILLWELL/PA

Blair trumpets Labour's investment in NHS

Lynn Eaton LONDON

Prime Minister Tony Blair has trumpeted his government's investment in the NHS over the 10 years since he came into power and has hit out at the media for always focusing on the negative.

"The single most difficult thing is to get a sense of balance," he told an invited audience of health service managers, doctors, nurses, and NHS leaders at a breakfast meeting on Monday at the health charity the King's Fund in London. His comments came days before he was due to announce the date of his handover to his successor, Gordon Brown, the current chancellor of the Exchequer.

The prime minister was speaking almost 10 years to the day since he won the election in 1997 and set in train a series of reforms, including the introduction of the private and independent sector as alternative healthcare providers to the NHS and giving patients a choice of provider.

"We've obviously got a great deal of work to do to take people with us on these reforms," he said. "However, I personally think that [these reforms] will stay in place. I can't see any government turning their back on that."

Mr Blair spoke after various speakers, including James Johnson, chairman of the BMA, gave a brief overview of the state of the NHS in the last decade. All speakers acknowledged the investment in the NHS over that period. Annual growth over the decade has averaged 6.6%, whereas for the whole of the period 1949-50 to 1999-2000 average growth was 3.4%.

"There is not a single person [who has spoken] who hasn't acknowledged the improvements," said Mr Blair as he began his speech. He cited the "real improvement" in waiting times, which, he said, had been the main problem when Labour came into power.

He raised his concerns at proposals, mooted by Gordon Brown among others, of an independent board for the NHS that might enable the NHS to distance itself from political interference.

"I would be very worried if it became a means to avoid taking decisions," he said.

In response to questions, he admitted that it might have been better to have had fewer reorganisations.

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IN BRIEF

More doctors and fewer managers are working for NHS: The NHS workforce census shows that 3267 more doctors are now working for the NHS than there were in September 2005 and that the number of managers has fallen by 2508 full time equivalent posts. The overall number of people working for the NHS has fallen by 17 000 since September 2005.

Death toll from indoor air pollution is heavy: Reliance on solid fuels is one of the 10 most important threats to public health, says the World Health Organization. In the 21 most badly affected countries, nearly 5% of mortality and disease is caused by indoor air pollution. In 11 countries, including Afghanistan, Angola, Bangladesh, Burkina Faso, China, the Democratic Republic of the Congo and Ethiopia, indoor air pollution causes 1.2 million deaths a year.

Doctors should report faulty medical equipment to reduce mortality: The UK Medicines and Healthcare Products Regulatory Agency is asking healthcare professionals to report medical equipment that has developed faults or does not perform as intended (adverse incident hotline: 020 70843080; or go to www.mhra.gov.uk). Currently the agency handles 8500 incidents related to faulty medical equipment each year, approximately 1500 of which result in serious injury or death.

Relief agency pulls out of Afghanistan: The Italian non-governmental organisation Emergency (www.emergency.it), which ran three hospitals and 25 first aid posts in Afghanistan, has left the country for security reasons, after being publicly accused by the head of the Afghan secret services of supporting the Taliban.

Industry will regulate non-surgical cosmetic treatments: The Department of Health has asked the cosmetic surgery industry to improve the safety of cosmetic treatments that include botulinum toxin and dermal fillers. The umbrella group Independent Healthcare Advisory Services, whose members include many of the major cosmetic surgery providers, will take the lead in establishing a self regulatory scheme.

UK junior doctors' application site closes: The website of the medical training application service (MTAS) closed earlier this week after a security lapse. For regular updates on the debacle concerning MTAS see http://blogs.bmj.com/category/comment/mtas.

Number on UK transplant waiting list reaches new high

Roger Dobson ABERGAVENNY

The number of people in the United Kingdom waiting for an organ transplantation reached an all time high of 7234 in March this year.

But although the number of patients waiting for an organ has never been higher, the number of transplantations being carried out has also reached a record level. In the 12 months to March this year a total of 3074 transplantations had been carried out, 10% more than in 2005-6.

The UK Transplant Authority says that more organ donors are urgently needed to keep pace with the rising number of people awaiting a transplantation.

"The number of patients awaiting a transplant is greater than ever before, and it is vital that if people wish to help others live after their death they make their intentions known by talking to their families and joining the NHS organ donor register," said Chris Rudge, the authority's managing director.

He said the record number of patients getting organs showed that the authority's policy of investing in programmes to increase the number of donors is working. Some 1.1 million more people joined the register during the year, taking the total to more than 14 million.

The latest figures from the authority, for 2006-7, show that transplantations of almost all types of organ were up on the previous year, although the 2400 cornea transplantations were 100 fewer than in 2005-6.

Since 2001 the total number of transplantations has risen by 16%, but over the same period the number of patients on waiting lists has risen by 30%. The authority says that the greater demand for transplantations is due to an ageing population, an increase in kidney failure, and scientific advances that allow more patients to benefit from a transplant.

The figures also show that although the number of non-heart beating donors has risen by 280% since 2001, the number of heart beating donors—the main source of organs—has fallen by 10%. The authority defines heart beating donors as those who die on a ventilator in a hospital intensive care unit, and it says that this group of patients is more affected by improvements in road safety, advances

Some executed US prisoners may have suffocated

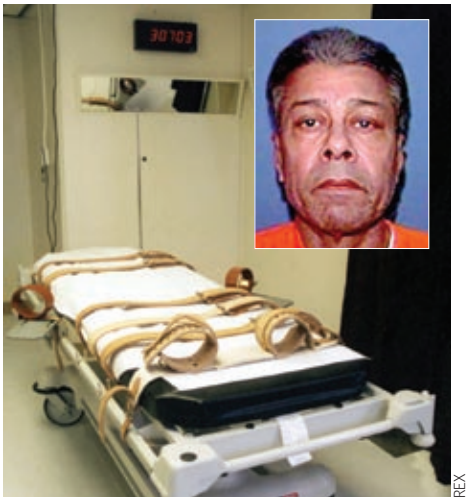
Anne Harding NEW JERSEY

Condemned prisoners who are killed by lethal injection may often suffocate while still conscious and be aware of what is happening to them, shows a new analysis of data on US executions. The analysis provides new evidence that the punishment may be cruel and unusual and thus unconstitutional.

This is likely to be what occurred in the botched 2006 execution of Angel Diaz, write Teresa Zimmers of the University of Miami Miller School of Medicine and colleagues (*PLoS Medicine* 2007;4:e156).

Mr Diaz, who took 34 minutes to die while wincing, shuddering, and gasping for air, was later found to have 30 cm burns on both antecubital fossae. Florida's medical examiner concluded that the drugs had been delivered subcutaneously rather than intravenously.

"The conventional view of lethal injection leading to an invariably peaceful and painless death is questionable," Dr Zimmers and her team conclude.



REX

Florida's execution chamber. Inset: Angel Diaz

About a dozen of the 37 states that impose the death penalty have suspended executions because of concerns about the constitutionality of lethal injection. The new study is likely to be used in legal challenges to the practice, said Bryan Liang, executive director of California Western School of Law's Institute of Health Law Studies. Although the study is not the "final word" on whether lethal injection is cruel and unusual, he said, the researchers "were thorough."

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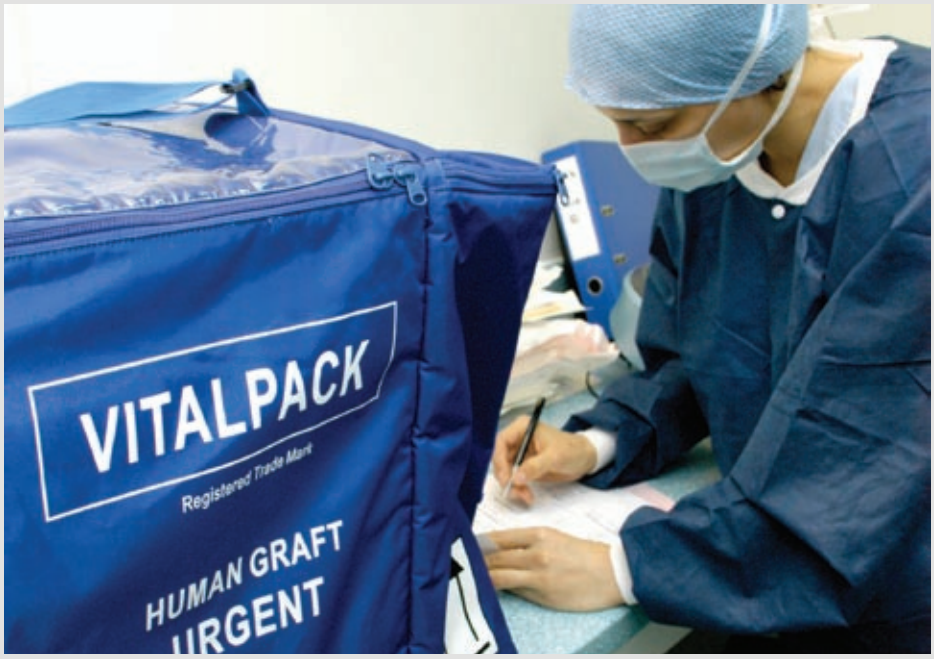

AJ PHOTO/SPL

A donor kidney, the most common and safest organ to be transplanted, is packed up for delivery

in treatment, and the prevention of strokes in younger people.

Over the last six years the authority has invested £14m (€21m; $28m) in hospital based programmes to increase opportunities for donation and widen access to transplants. The programmes include 25 living kidney donor schemes, which enable a patient to receive an organ from a living friend or relative.

See www.uktransplant.org.uk.

Health secretary should resign over job applications debacle

Lynn Eaton LONDON

Angry junior doctors called for the resignation of the health secretary, Patricia Hewitt, and the minister of state for quality in the health department, Lord Hunt, after what the BMA's chairman described as a "difficult" meeting of the association's Junior Doctors Committee in London on Saturday.

Delegates were so angry and frustrated that they were turning on each other, James Johnson told the audience at a breakfast briefing on Monday at the health charity the King's Fund.

But the BMA leaders managed to fend off a vote of no confidence at the Saturday meeting. Instead the anger was turned on government ministers, who, said the committee's deputy chairman, Tom Dolphin, had been warned of the pending disaster over the medical training application service (MTAS).

Dr Dolphin, who proposed the motion calling for the two ministers' resignation, said it was important that the ministers accepted responsibility for the situation that had developed. "The government was warned," he said. "They need to accept responsibility and to resign."

The more than 200 delegates at the meeting mandated their representatives to continue to attend talks with the MTAS review group, led by Neil Douglas, president of the Royal College of Physicians of Edinburgh. They also agreed that the chairwoman of the Junior Doctors Committee, Jo Hilborne, should argue for all doctors throughout the UK to be interviewed for each of their four chosen posts, so they are treated the same as those in Scotland, Wales, and Northern Ireland.

"They need to accept responsibility and to resign"

They also want all training under the Modernising Medical Careers (MMC) scheme to be postponed for a year until the MTAS problem was sorted out.

For up to date news on MTAS go to http://blogs.bmj.com/category/comment/mtas/.

US health experts consider a centre for effectiveness

Bob Roehr WASHINGTON, DC

The possibility of setting up a centre to evaluate the effectiveness of health care in the United States was discussed at a Capitol Hill policy forum in Washington, DC, last week.

The participants at the forum, which was organised by the Alliance for Health Reform and the Commonwealth Fund, thought that such a centre could be useful because of the escalation in spending on health care—in absolute terms and relative to the economy—and because health outcomes in the US were often poorer than those in other industrialised democracies that spent far less on health.

The forum's moderator, Stuart Guterman, from the Commonwealth Fund, said that the forum's consensus was that better information and better decisions were needed.

The health economist Gail Wilensky, a senior fellow at the international charity Project Hope, said that other countries are ahead of the US when it comes to evaluating comparative effectiveness. But they tended to focus on drugs and to review existing literature, not conduct their own research.

For a US centre Dr Wilensky envisages "a model that is quite different," focusing on medical conditions, not on specific interventions, and including the full spectrum of preventive and treatment options. It would also conduct its own research into efficiency, directly and through grants and contracts.

She said that such a centre "should be close to government, but maybe not too close." Both the political left and right have concerns about vulnerability to political pressures.

Unlike most European single payer healthcare systems, the US has many players making healthcare policy decisions—and that was not likely to change any time soon, she said. The new entity should include all stakeholders in its governing and advisory boards, and ideally it would be funded through a variety of mechanisms and sources.

Steven Pearson, director of the Institute for Clinical and Economic Review at Harvard University, drew on his experience during a sabbatical year he spent at the UK National Institute for Health and Clinical Excellence to illustrate the importance of including all stakeholders in setting the standards for evaluating an intervention.

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Nearly all English practices are set to run their own budgets

Zosia Kmietowicz LONDON

Almost all general practices in England have signed up to practice based commissioning and are preparing to draw up plans to take control of their own budgets.

Figures from the Department of Health show that as of March this year 96% of practices have been receiving incentive payments—a nationally negotiated "directly enhanced services payment" or a local alternative—which commits them to practice based commissioning.

Although the payments mean only that practices need to start making plans for commissioning, the government wants to see all GPs adopting practice based commissioning by 2008.

The government believes that widespread use of the system will reduce admissions to hospital, because under the scheme GPs are able to keep at least 70% of the savings they make by directly commissioning services. They can then use the savings to develop specialist services within their own practices by investing in diagnostics, equipment, specialist care, or staff.

Uptake of the incentive payments has been increasing steadily since the scheme was launched in April 2005. In May last year uptake was only 40%.

Evidence from early adopters of practice based commissioning shows that practices have cut the number of patients referred for hospital treatment by between 25% and 33%. A 25% reduction in referrals across the country would mean 2.5 million fewer hospital appointments.

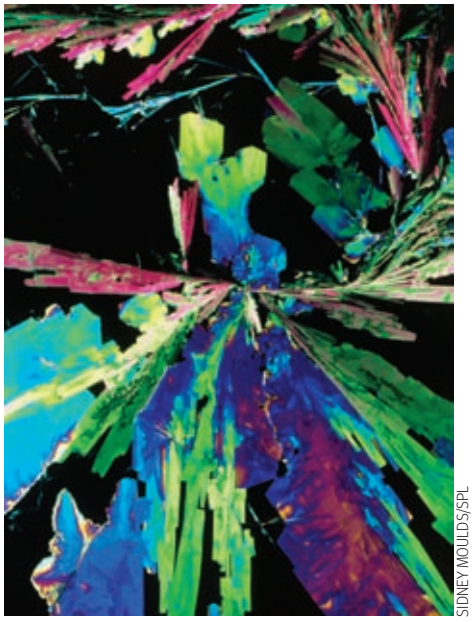
Cost effectiveness of heart drugs varies widely, study says

Roger Dobson ABERGAVENNY

The cost effectiveness of treatments for coronary heart disease varies more than 100-fold, a new study shows.

It found that the cost for each life year gained of aspirin and β blockers (pictured) for secondary prevention after a heart attack worked out at less than £1000 (€1500; $2000), whereas the cost of statins used for primary prevention in men aged 35–44 was around £70 000 (*Quarterly Journal of Medicine* 2007;100:277-89).

"Large amounts of NHS funding are being spent on relatively less cost effective interventions, such as statins for primary prevention, angioplasty, and coronary artery bypass graft surgery. This merits debate," say the authors, from the University of Liverpool and Liverpool School of Tropical Medicine.



SIDNEY MOULDS/SPL

They estimated that, in 2000, medical and surgical treatments prevented or postponed 25 888 deaths in patients with coronary heart disease aged 25-84 years, generating 194 929 extra life years between 2000 and 2010 (range 143 131 to 260 167).

In the study the authors worked out the number of life years gained from 2000 to 2010 for individual treatment categories, including acute myocardial infarction, secondary prevention after acute myocardial infarction or revascularisation, unstable angina, chronic angina, heart failure in hospital and in the community, and primary prevention using statins.

Their results show that aspirin and β blockers for secondary prevention after myocardial infarction or revascularisation for angina and for heart failure were highly cost effective at less than £1000 per life year gained.

Other secondary prevention treatments, including cardiac rehabilitation, ACE inhibitors, and statins, were reasonably cost effective (at £1957, £3398, and £4246 per life year gained, respectively), as were coronary artery bypass graft surgery (£3239 to £4601) and angioplasty (£3845 to £5889).

Primary angioplasty for myocardial infarction was intermediate (£6054 to £12 057, depending on age), and statins in primary prevention were much less cost effective (£27 828, but as much as £69 373 in men aged 35–44).

Publicly available performance tables do not make surgeons

Susan Mayor LONDON

A new study shows that the introduction of publicly available performance tables in the United Kingdom showing mortality after major cardiac surgery by individual surgeons did not result in fewer procedures being performed on high risk patients, as critics had predicted. The study also shows an association between the introduction of the tables and a decrease in mortality.

The study, published online in *Heart* (http://heart.bmj.com, doi: 10.1136/hrt.2006.106393), analysed data that were collected prospectively from all NHS centres in northwest England that undertake cardiac surgery. The data covered 25 730 patients undergoing coronary artery bypass grafting for the first time between April 1997 and March 2005. Figures were for 30 different surgeons in four major NHS sites.

The researchers compared surgery carried out before and after individual cardiac surgeons' outcomes became public in 2001, to determine whether some surgeons had become more averse to risk, operating only on patients with a lower risk of complications or death. They also assessed the effect of the introduction of the tables on patients' mortality.

They used the EuroSCORE risk scoring system for patients undergoing cardiac surgery to divide them into low risk (EuroSCORE 0-5), high risk (6-10), and very high risk (>11) patients. Analysis of data before and after public disclosure of surgeons' performance showed that the number of high risk patients undergoing cardiac surgery rose rather than fell—from 449 (14% of all patients who underwent surgery) before public disclosure to 547 (17%) afterwards (P<0.001). The number of patients at very high risk who underwent surgery also rose slightly, from 41 (1.3%) to 47 (1.4%). The proportion of patients aged over 80 and of

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Abortion does not raise risk of breast cancer, US study finds

Janice Hopkins Tanne NEW YORK

Neither induced abortion nor miscarriage increases the risk of breast cancer, a large prospective US study has found.

Results of previous case-control and retrospective studies have been inconsistent. Anti-abortion groups in the United States have claimed that having an abortion increased a woman's risk of breast cancer by 30%, and anti-abortion counsellors used the argument to dissuade women from having an abortion.

The researchers, from Harvard University, say that about a quarter of US women aged under 45 years have had at least one induced abortion (*Archives of Internal Medicine* 2007;167:814-20).

They wrote, "In this cohort of young women, we found no association between induced abortion and breast cancer incidence." They found no relation between the incidence of breast cancer and number of abortions, age at which the woman had an abortion, whether she had had a previous pregnancy, and the time between a previous pregnancy and an abortion.

The researchers found that among women who had had one or more induced abortions the hazard ratio for having breast cancer was 1 (95% confidence interval 0.9 to 1.2), after they adjusted for known risk factors for breast cancer. Among women who had had one or more spontaneous abortions the hazard ratio for breast cancer was 0.9 (0.8 to 1). Breast cancers in the study group were mostly in premenopausal women.

The study looked at the association between breast cancer and induced or spontaneous abortions in 105 716 registered nurses who were aged 25 to 42 at the beginning of the study and were free of cancer.

Previous studies had retrospectively asked women with breast cancer if they had had an abortion. The current study's lead author, Karen Michels of Brigham and Women's Hospital and Harvard Medical School in Boston, told the Reuters news agency that women with breast cancer, searching for reasons for their disease, are more likely than other women to report having had an abortion.

In retrospective studies, women with breast cancer, searching for reasons for their disease, were more likely to report having had an abortion

Information in the study was collected anonymously at the outset and updated every two years. However, women may have under-reported abortions, which were illegal in the United States until 1973, during part of their reproductive years. The women were followed up from 1993 to 2003.

Overall 15% of the nurses said they had had one or more abortions, and 21% said they had had one or more spontaneous miscarriages. Of the women in the study 1458 (about 1.4%) developed breast cancer. The researchers reviewed medical records and found that breast cancer was histologically confirmed for 99% of the women reporting breast cancer whose records could be found.

The authors say that a full term pregnancy before the age of 35 reduces a woman's lifetime risk of breast cancer, perhaps by speeding up breast cell differentiation. They wrote, "An incomplete pregnancy may not result in sufficient differentiation to counter the high levels of pregnancy hormones that may foster proliferation. However, the biological mechanisms are uncertain, and a prematurely terminated pregnancy may not affect breast cancer risk at all."

In 2003 the US National Cancer Institute convened an expert panel to review the evidence for an association between induced or spontaneous abortion and the risk of breast cancer. The panel concluded that no link existed.

avoid high risk cases

those with kidney disease, a recent heart attack, or peripheral vascular disease all increased significantly. In contrast, the number of patients at low risk who underwent surgery fell slightly, from 2694 (85%) to 2654 (82%).

Observed mortality fell from 2.4% in 1997-8, before disclosure, to 1.8% in 2004-5 (P=0.014)—even though the expected mortality (based on EuroSCORE) rose from 3.0 to 3.5 (P<0.001), indicating that more complicated cases or more elderly people were being taken on. Overall, the ratio of observed to expected mortality decreased from 0.8 to 0.5 (P<0.05).

DANIEL AGUILAR/REUTERS

Women celebrate abortion bill victory

Zosia Kmietowicz LONDON

Women in Mexico City demonstrate in support of a bill passed by the city's legislative council last week that will legalise abortion in the first 12 weeks of pregnancy. Previously abortions were allowed in the city only in cases of rape, if the woman's life was at risk, or if the fetus showed severe defects. The city's legislative council voted 46 to 19 in favour of the bill. Opponents of the bill said they will challenge it in the courts.

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C difficile infections rise—but MRSA rates drop

Michael Day LONDON

The number of infections of *Clostridium difficile* in the NHS in England rose again last year. Hospitals saw 55 681 cases among patients aged over 65 years—up 8% on the 2005 figure, says the Health Protection Agency.

The latest figures come two months after it was revealed that *C difficile* and methicillin resistant *Staphylococcus aureus* (MRSA) had killed record numbers of patients in 2005. In that year *C difficile* was mentioned on 3807 death certificates—up 69% on the 2004 figure, the Office for National Statistics said. MRSA was a factor in 1629 deaths, a rise of 39%.

The Health Protection Agency noted that the latest increase in the number of *C difficile* cases was smaller than the 17% jump seen in 2005. And there was also evidence of the tide turning against MRSA bacteraemia. A total of 1542 MRSA bloodstream infections from October to December 2006 represented a 7% fall from the figure for the previous quarter.

However, Katherine Murphy, director of communications at the Patients Association, said: "This is no reason for celebration. The number of deaths from *C difficile* is equivalent to a packed jumbo jet crashing every month.

"When is a [NHS] chief executive actually going to lose his or her job over this?"

The Healthcare Commission's chief executive, Anna Walker, said the apparent decline in the rate of MRSA infection was encouraging.

"However, the figures for *C difficile* are less encouraging," she said. "Although the increase is slower, it is still on the rise. This will cause concern to patients.

"We fully recognise that outbreaks of *C difficile* are not easy to control. But we also know that trusts can minimise the spread of infection by following rigorously established guidance on infection control."

A government memo leaked earlier this year predicted that ministers would miss the deadline set in November 2004 for halving the rate of MRSA infection by April 2008.

The memo said that *C difficile* was now "endemic throughout the health service, with virtually all trusts reporting cases."

The government's chief nursing officer, Chris Beasley, said: "Many trusts that have received help from MRSA improvement teams have seen significant reduction in infection. We are determined to see these national reductions replicated for *C difficile*."

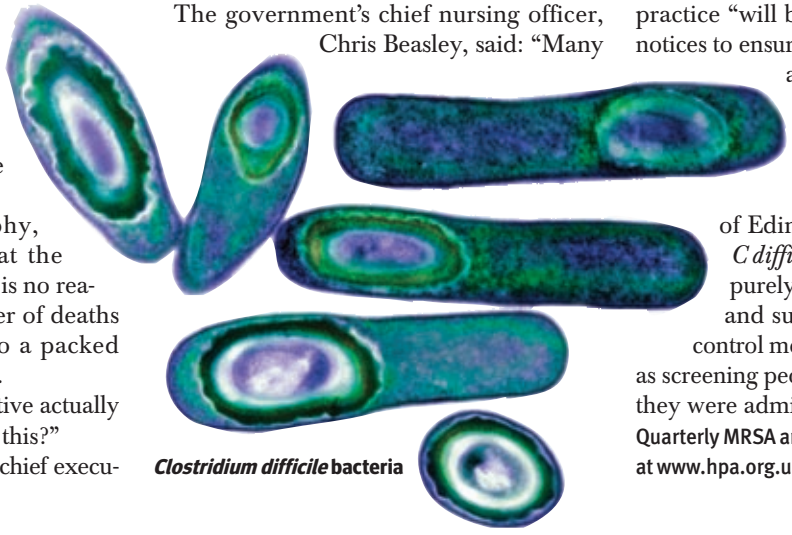
The Conservative party blamed the continuing rise in the number of *C difficile* infections on the thousands of job losses in the NHS in the past 12 months, particularly among nursing staff.

The Liberal Democrats' health spokesman, Norman Lamb, said that tougher action was needed "to deal with the many hospitals that are not meeting acceptable hygiene standards."

From May the Healthcare Commission will start sending "hygiene hit squads" into NHS trusts. Trusts found to be in breach of good practice "will be issued with improvement notices to ensure that they take the appropriate remedial action."

In a *BMJ* editorial last month, however, John Starr, reader in geriatric medicine at the University of Edinburgh, questioned whether *C difficile* should be thought of as purely a hospital acquired infection and suggested that other infection control measures might be needed, such as screening people in the community before they were admitted (*BMJ* 2007;334:708).

Quarterly MRSA and *C difficile* figures are available at www.hpa.org.uk.



***Clostridium difficile* bacteria**

BIOMED IMAGING LAB/SOUTHAMPTON HOSP/SPL

US health insurance firm settles lawsuit brought by 900 000 doctors

Fred Charatan FLORIDA

The biggest health insurance company in the United States, Blue Cross Blue Shield, has been forced to settle a class action lawsuit brought by 900 000 doctors who claimed that they were not being fairly paid for treating patients.

The lawsuit, filed in the Southern District of Florida in Miami in May 2003, alleged that numerous insurance plans run by Blue Cross Blue Shield, which covered 77 million patients, "had conspired in a massive scheme to defraud doctors in violation of the [1970] federal Racketeer Influenced and Corrupt Organization Act (RICO)."

The Tennessee Medical Association, which filed the original class action lawsuit in 2002 against Blue Cross Blue Shield of Tennessee in Tennessee State Court, said in a statement, "The provisions of the settlement call for BCBST [Blue Cross Blue Shield of Tennessee] and other plans to pay more than $128m [£64m; €94], but more importantly to physicians the settlement will set into motion a series of important business practice changes that bring the estimated value of the entire settlement consideration to well over $1bn."

The lawsuit claimed that insurance plans "had conspired in a massive scheme to defraud doctors"

The changes called for are in the health insurers' systems for processing reimbursement claims from the doctors. These systems look at doctors' claims and often reduce them by combining or rejecting charges.

Insurers maintain that such systems check for redundant or excessive billing so as to cap medical costs. The doctors and their medical societies say that the insurers conspired to systematically cheat them out of full payment.

The Blue Cross Blue Shield group has promised to change certain practices and among other points has agreed to:

- Implement a definition of medical necessity, which ensures that patients are entitled to receive medically necessary care as determined by a doctor in accordance with generally accepted standards of medical practice, and
- Use clinical guidelines that are based on credible scientific evidence published in peer reviewed medical literature.

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RAY REMIORZ/AP/PA

Access to health care in Afghanistan is improving

Tessa Richards BMJ

An independent evaluation of health services in Afghanistan carried out by Johns Hopkins University has shown that access to care and key health indicators have improved over the last three years.

Speaking at a press conference in Kabul last week to draw attention to the study, Mohammad Amin Fatimi, the country's minister of public health, said that the data provided "clear signs of health sector recovery." Access to health care is markedly better in secure provinces than in insecure areas, such as Helmand (above).

Further evidence of this recovery came from a conference on health research held earlier in the week to mark the opening of Afghanistan's first public health institute.

"This was a landmark event," said Egbert Sondorp, senior lecturer at the London School of Hygiene and Tropical Medicine, who has been working in Afghanistan for several years. "It's the first time since 2001 that health researchers and others concerned with service provision have been able to come together to share results and exchange expertise."

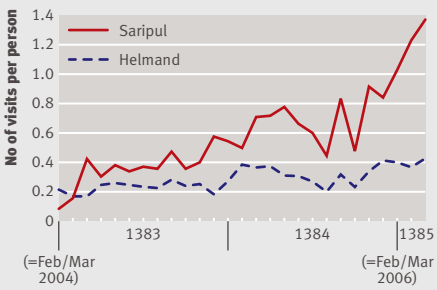
The conference also debated the smuggling of drugs. Currently brand name formulations of antibiotics and a range of basic drugs, including paracetamol, are being smuggled into the country illegally because obtaining them in generic formulations through the normal government channels is so slow and cumbersome.

One of the major challenges for Afghanistan's health sector is providing primary care services at a cost that poor people can afford. Currently, Dr Sondorp said, an estimated 30% of the population have to sell assets to pay for their medical care.

The establishment and roll-out of a basic package of health care in Afghanistan, delivered primarily by non-governmental organisations, began in 2004 (*BMJ* 2006;332:718-21).

The Johns Hopkins survey of 600 publicly financed health facilities between 2004 and 2006 shows that this package has improved access to care for most of the population but that it is still not reaching people in remote rural areas and provinces where security is poor. The survey found that infant mortality fell from 165 deaths per 1000 in 2001 to 135 in 2006; and provision of antenatal care increased from 5% of women in 2003 to 30% in 2006.

ACCESS TO STATE HEALTH CLINICS IN A SECURE PROVINCE (SARIPUL) AND AN INSECURE PROVINCE (HELMAND) IN AFGHANISTAN*



** Data are given for months in the Afghan calendar*
***Source:** Ministry of Public Health, Afghanistan*

Nations support stockpile of H5N1 vaccine by WHO

John Zarocostas GENEVA

Rich and developing countries—and vaccine manufacturers—have backed calls by the World Health Organization to try to establish a stockpile of vaccine against the H5N1 strain of influenza in humans. They also want to see a mechanism to ensure wider access to a vaccine by poor nations in the event of a flu pandemic.

At a one day meeting at WHO headquarters in Geneva last week, stakeholders also agreed to the setting up of expert groups to focus on how to create, maintain, fund, and use an H5N1 vaccine stockpile. WHO said that it would continue to consult with appropriate partners and member states on developing a mechanism for access to a vaccine.

"I think it is a very important step in the process towards shoring [up] better access for poorer countries to vaccines that will be required in the event that they are affected by or at risk of an influenza pandemic," said David Nabarro, the UN's global coordinator for pandemic preparedness.

Although no target figure for the stockpile of H5N1 vaccine has so far been agreed, during a WHO meeting in Indonesia in March officials from developing countries said that they were looking at coverage of roughly 1% of their populations—enough to cover health workers, police, and other essential staff.

Margaret Chan, WHO's director general, noted: "We have taken another crucial step forward in ensuring that all countries have access to the benefits of international influenza virus sharing and pandemic vaccine production."

But Dr Chan earlier warned delegates at the meeting that current vaccine manufacturing capacity "is woefully inadequate to meet worldwide demand." She added: "The issue of access to vaccines has acquired an urgency that we cannot fail to address.

"For a trivalent pandemic vaccine, annual manufacturing capacity is about 500 million doses. For a monovalent vaccine this figure increases to 1.5 billion doses. This is still not enough."

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