EDITOR'S CHOICE

Saving carbon and money

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There's a certain irony in healthcare's substantial contribution to greenhouse gas emissions, given that climate change has been called the greatest threat to public health of the 21st century. The UK is among the world's lowest carbon emitters relative to gross domestic product, says John Appleby (doi:10.1136/bmj.e376), and is also the only country committed to a legally binding reduction in emissions of 80% by 2050. So that's something to feel good about. Except that it's going to be a huge challenge, and healthcare is going to have to play its part.

Ray Moynihan describes how patients and professionals are taking the initiative, trying to save both carbon and money (doi:10.1136/bmj.d8360). An NHS Sustainability Day is planned for March 28, bringing together a raft of activities across the UK. If you want to find out more or to volunteer to help, join the discussion on doc2doc (<http://bit.ly/ygLy2t>).

Some saving will come from simply turning off lights and machines that are not being used. But there are other big ticket items. Pharmaceuticals account for about 22% of NHS emissions, according to the NHS Sustainable Development Unit. Its director, David Pencheon, says this is because the drugs are highly refined in big factories and then moved around the world. And, he says, "we waste a lot of them."

This high carbon contribution is yet another reason to make sure we make rational decisions on which drugs to use. This week sees the return to the knotty matter of oseltamivir (Tamiflu), the drug on which governments around the world have spent billions of dollars—and tonnes of carbon—because of claims that it reduces transmission, symptoms, and complications of influenza. Two years ago in these pages the drug's manufacturer, Roche, promised to make the trial data available, after Cochrane reviewers declined to judge

oseltamivir's effectiveness on the basis of unpublished Roche-funded trials (*BMJ* 2009;339:b5405). But the Cochrane reviewers believe that what Roche has delivered is inadequate to answer their research question (doi:10.1136/bmj.d7898). Because of a host of inconsistencies in what they have unearthed, they base their latest Cochrane update on only those trials for which they could read the full clinical study report. Twenty-two thousand pages later, they conclude that the drug shortens duration of symptoms, but there's insufficient trial evidence that it reduces complication (*Cochrane Database Syst Rev* 2012;1:CD008965).

In a linked investigation, Deborah Cohen shows how different regulators took different approaches to the data (doi:10.1136/bmj.e458). The European Medicines Agency did not obtain the full study reports on oseltamivir and, along with the US Centers for Disease Control, continues to say the drug reduces complications when given to healthy adults. The FDA analysed more of the data and says this is not the case. The EMA has told the *BMJ* that it plans to start publishing reports for all drugs submitted for approval in the next few years. This will be a huge advance, putting the EMA ahead of its US counterpart perhaps for the first time.

Still, we're a long way from where we need to be. Disagreements between different regulators highlight an absurd situation. In a globalised world, and given the scale of the challenge of data review, regulators need to cooperate and pool their limited resources. Otherwise we will continue to waste money and risk people's health on drugs that don't work.

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