NEWS

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Former head of legal services at Mid Staffs hospital wins £103 000 award

"No win, no fee" system is proving costly to NHS, says Ministry of Justice

Clare Dyer BMJ

Around half the £195m (€233m; $306m) legal costs that the NHS in England paid out in 2010-11 for claimants who won clinical negligence cases went on "no win, no fee" lawyers' success fees and refunds of premiums paid by claimants to insure against the cost of losing, calculations by the Ministry of Justice indicate.

The figures are based on a sample of cases that found that success fees accounted for 34% of claimants' legal costs paid by the NHS and so called "after the event" insurance premiums for 17%.

If the figures for the sample are representative of cases in general—which the ministry said it could not guarantee, nor could it say how large the sample was—lawyers' success fees, paid on top of their normal fees, could be costing the NHS as much as £66m a year.

The number of claims launched against the NHS rose from 5426 in 2006-7 to 8655 in 2010-11. Over the same period the legal costs paid on behalf of successful claimants went up from £83m to £195m.

Under current rules the loser—in this case, the NHS Litigation Authority, which handles negligence claims for the NHS—pays the winner's legal costs. But claimants' lawyers who take cases on a no win, no fee basis are entitled to a success fee, also payable by the authority, to compensate them for the risk of losing and getting nothing. The authority is also liable for the insurance premium taken out by successful claimants to cover the risk of having to pay the authority's costs should they lose.

The ministry has produced the figures as the Legal Aid, Sentencing and Punishment of Offenders Bill, which will radically reform the system, resumes its committee stage in the House of Lords. Under the bill the NHS will no longer be liable for success fees, which claimants will have to find in future from their own compensation. Damages for pain, suffering, and loss of amenity will be increased by 10% as a result.

The NHS will also no longer have to pick up the bill for insurance, which will be unnecessary, as the reforms also provide that the losing claimant will no longer have to pay the NHS's costs.

Cite this as: *BMJ* 2012;344:e777

MOHAMMAD SAJJAD/AP/PA

Medical charity staff have been blocked from running clinics in Pakistan, such as the polio clinic above

Doctor who helped locate Osama bin Laden worked for the CIA

Nigel Hawkes LONDON

The US defence secretary, Leon Panetta, has confirmed that a doctor now in prison in Pakistan was working with the US Central Intelligence Agency on a fake vaccination campaign to help track down the whereabouts of Osama bin Laden.

Shikal Afridi had claimed to be running a hepatitis B vaccination campaign as a ruse to gain entry to the compound in Abbotabad where bin Laden was living. The aim was to obtain DNA samples from those inside the compound that could be matched with bin Laden family DNA held by the CIA.

US officials say that Dr Afridi gained access to the compound but did not see bin Laden or obtain any DNA samples. However, in an interview on CBS News, Mr Panetta, who was director of the CIA at the time, said that Dr Afridi had provided "very helpful" intelligence, the first official US acknowledgment that he had worked for the CIA.

The US launched a raid on the compound without informing the Pakistani authorities, killing bin Laden. Dr Afridi was arrested and remains in prison in Pakistan. Mr Panetta said that he was very concerned. "This was an individual who in fact helped provide intelligence that was very helpful with regards to this operation. And he was not in any way treasonous towards Pakistan," he said.

In October the Pakistani government commission investigating the US raid said that "a case of conspiracy against the state of Pakistan and high treason" should be brought against Dr Afridi. Such a charge carries the death penalty. A senior Pakistani official quoted anonymously by the US news network CNN said this week that the decision whether to charge Dr Afridi had not yet been taken.

Aid agencies have been strongly critical of the CIA's use of a doctor as an intelligence agent, warning that it could hinder humanitarian efforts.

A spokesperson for Médecins sans Frontières told the *BMJ*: "Deceptive use of medical care endangers those who provide legitimate and essential health services. Carrying out an act of no therapeutic or preventative benefit purely for military or intelligence purposes violates medical ethics, which require acting solely on the needs of patients and doing no harm."

Jack Chow, a former US health ambassador, said that to attach a political and intelligence agenda to a medical campaign is to breach trust between doctors and patients.

Aid agencies say that their operations in Pakistan have already been hindered. Save the Children withdrew some of its workers after Dr Afridi falsely claimed that he was working for the charity, and the International Committee of the Red Cross said it shut three clinics in Pakistan because staff were prevented from accessing them.

Cite this as: *BMJ* 2012;344:e785

IN BRIEF

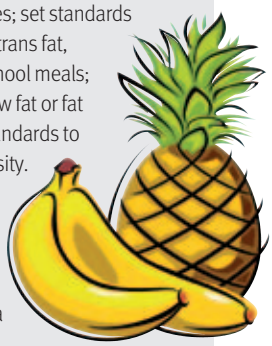
Charity says companies need to deal with alcohol problems: Alcohol Concern wants Vince Cable, the UK business secretary, to call on companies to take more responsibility for alcohol problems in the workplace. The government has calculated that lost productivity and absenteeism because of drinking cost the UK economy 14 million working days and up to £6.4bn (€7.7bn; $10.1bn) each year.

Life expectancy in Spain declines: Spain's continuous rise in life expectancy over the past 50 years has come to an end. During the first quarter of 2011 life expectancy dipped slightly from 78.94 to 78.87 years in men and from 84.91 to 84.82 in women.

Children in more than 25 countries are caught in emergencies: Unicef has appealed for $1.28bn (£0.81bn; €0.97bn) to fund its 2012 humanitarian operations in more than 25 countries. Although the crisis in Somalia and across the Horn of Africa accounts for nearly a third of the total amount, the list of countries includes many longstanding or "silent" emergencies such as in Chad and other countries of the Sahel, the Democratic Republic of Congo, and the Central African Republic.

Public supports a greener NHS: More than 90% of the public interviewed in a survey carried out by Ipsos MORI for the NHS Sustainable Development Unit say they want the NHS to be more sustainable, with a third saying this should happen even if it costs the health service money. Half the public said that they would be happy to accept reissued drugs that had been returned unused by patients and 60% believe that the NHS should use more teleconferencing facilities to save money.

US sets new standards for school meals: The US Department of Agriculture has released new nutritional standards for school meals for the first time in 15 years. The standards double fruit and vegetable servings and increase the variety of vegetables; set standards for content of sodium, trans fat, and whole grains in school meals; require all milk to be low fat or fat free; and set calorie standards to tackle hunger and obesity. Congress prevented the department from limiting French fries and required it to continue to count pizza as a vegetable.



Cite this as: *BMJ* 2012;344:e772

Doctors are divided over whether to demand health bill's withdrawal

Zosia Kmietowicz LONDON

Disagreement among key professional bodies has left the medical profession divided over whether to increase pressure on the coalition government to scrap its planned changes for the NHS in England.

The Royal College of Physicians has announced that it will hold an extraordinary general meeting on 27 February to discuss the health bill after it received the required number of signatures from fellows (20). The fellows also want the college to survey the membership on the health reforms.

Demand for the meeting follows the collapse of talks between the members of the Academy of Medical Royal Colleges on the evening of 24 January when the Royal College of Surgeons of England and the Royal College of Obstetricians and Gynaecologists refused to sign a draft statement calling for the withdrawal of the Health and Social Care Bill.

Royal College presidents: Norman Williams of RCS (left), and Richard Thompson, of RCP, would not sign the statement

The draft statement, which was widely leaked to the press, said that the bill should be withdrawn because without modification it "may widen rather than lessen health inequalities and that unnecessary competition will undermine the provision of high quality integrated care to patients."

A spokeswoman for the Royal College of Obstetricians and Gynaecologists said that it had not seen the draft statement but that its position had not changed: it was continuing to work with the government to improve the health bill.

A spokesman for the Royal College of Surgeons said that the statement drafted by the academy was "confused" and that the college had "opposed it from the very outset" because it did not present a viable alternative to the reforms presented in the health bill. The college did not attend a meeting of the medical professional bodies hosted by the academy, the BMA,

NHS competition "must be used with care"

Nigel Hawkes LONDON

Competition works in healthcare and can stimulate the provision of better services, concludes a new report from the think tank the Office of Health Economics (OHE).

But it isn't a cure all to be used everywhere and for every service, it adds. The key is to use it judiciously where the evidence indicates that it can do most good. The question is not "competition or no competition" but deciding where competition should be used and where eschewed.

The report dismisses claims that competition makes integrated care impossible or that the opening of tendering a service to "any qualified provider" amounts to privatisation of the NHS. Even in the United States, says Jim Malcolmson, professor of economics at Oxford University, who chaired the OHE's commission on competition in the NHS, only 4% of hospitals are for-profit organisations.

The evidence base is limited, Professor Malcolmson said, but it does show that greater competition drives down costs and waiting times. It may also reduce quality, a particular danger where quality is not visible to either doctors or patients.

He said, "So we're not in favour of wholesale competition, but evidence suggests that competition with regulated prices can produce higher quality care at the same cost—and without leading to increasing inequity in access to care. Our message is that competition can help the NHS, but proceed with care."

To help decide when competition is beneficial and feasible, the commission produced a toolkit that managers might use. The questions to be considered include demand density (the density of patients in an area needing a particular service); patients' willingness to travel; and the ease with which they and their doctors can get information about the quality of services. Some constraints are imposed by asymmetries: acute hospitals are better placed to expand into community services by increasing outreach than community services are to take over acute care.

In addition to these economic arguments, admitted Jon Sussex of the OHE, there was a political dimension: some incumbent providers may be too important to fail even if rival providers are equally able and willing to supply the service.

Competition in the NHS **is available at www.ohe.org/page/publications/recent.cfm.**

Cite this as: *BMJ* 2012;344:e800

and the Royal College of Nursing on the night of Thursday 26 January, saying that "it was too political."

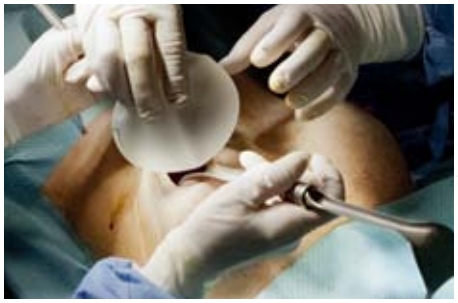
The Royal College of Nursing and the Royal College of Midwives are the only colleges that have declared their outright opposition to the health bill. However, the Faculty of Public Health said this week that it would ballot its entire membership of more than 3000 over whether to change its position of working with the government, after some 200 members attending an emergency meeting on 25 January voted to oppose the bill (*BMJ* 2012;344:e690).

The Royal College of General Practitioners would not say whether it had agreed to sign the academy's draft statement and that its position of working with the bill had not changed, despite a survey of its members showing that 98% of online respondents said that they supported a call for the bill to be withdrawn as part of a joint approach with other colleges (*BMJ* 2012;344:e391).

The meeting on Thursday was widely tipped to be a push for a united front by the medical professional against the reforms. All the BMA would say afterwards was that "there was a useful exchange of information and an agreement to continue the dialogue."

See bmj.com for the Academy's draft statement.

Cite this as: *BMJ* 2012;344:e720



STEPHANE DRAPOT/GETTY IMAGES

Linda McAvan said unique indentification of products could ensure better tracking in future

Europe is updating rules on medical devices after breast implant fiasco

Rory Watson BRUSSELS

Pressure is growing for stricter European controls on medical devices and better traceability after the discovery of defective silicone gel breast implants manufactured by the French company Poly Implants Prosthèses (PIP).

The European Commission, after being questioned by a British Labour member of the European parliament, Linda McAvan, confirmed last week that it is working on updating existing medical devices legislation that came into force in March 2010.

While welcoming the move, Mrs McAvan suggested that because many women are unsure whether their breast implants are defective, unique identification of products could ensure effective tracking in future. With up to 500 000 women (mostly outside the European Union) affected, the Labour MEP also emphasised the need for better international cooperation.

The Belgian Liberal MEP Fréderique Ries also called on the commission to request a study into the possible health risks of silicone implants in general.

The commission had already begun assessing how to update the existing medical devices legislation two years before the French authorities became aware of the defective implants in early 2010 and is expected to present proposals before the end of June.

Among the options being considered are strengthening the designation and monitoring by national authorities of the notified bodies that verify the standards of medical devices and closer coordination among national administrations on vigilance and market surveillance. This could include central reporting of incidents and trend analyses. Thought is also being given to the introduction of traceability requirements by means of a unique device identification for certain products.

Cite this as: *BMJ* 2012;344:e766

DNA methylation may be associated with health inequalities

Bryan Christie EDINBURGH

A study carried out among people living in deprived parts of Glasgow has found that they may have been imprinted at a few weeks after conception with a biological change that leads to ill health in later life.

The finding has been described as "significant" by the research team, which believes that it may help to explain some of the unanswered questions about health inequalities in the city and elsewhere.

The research focused on DNA methylation, the signalling tool that cells use to control gene expression and that is a crucial part of normal development (*International Journal of Epidemiology* doi:10.1093/ije/dyr215). Most DNA methylation is fixed for life from just a few weeks after conception. Lower levels of methylation have been linked to a variety of diseases, including diabetes, cardiovascular disease, and cancer.

The researchers analysed blood samples from 239 people from Glasgow's most deprived and affluent areas and found that DNA methylation was 17% lower among those living in the most deprived circumstances than among the least deprived.

The researchers say: "Our observations provide a potentially novel explanation for accelerated age related disease onset in Glasgow."

The study says that lower levels of DNA methylation could reflect environmental exposures during life or be a direct consequence of developmental programming before birth, or both.

Paul Shiels, senior lecturer in epigenetics at the University of Glasgow, who led the research team, said: "Methylation levels decline throughout everyone's life as part of the natural process of ageing and can be slightly affected in adulthood by external factors such as diet, stress, and lifestyle. Those external factors have a much greater effect on babies developing in the womb, affecting the enzymes which allow DNA methylation to occur, so it's very likely that the significantly lower levels of methylation we're seeing in the most deprived areas of the city are set before birth."

Marcus Pembery, emeritus professor of paediatric genetics at the Institute of Child Health, said that the results should be interpreted with caution. He said, "Evidence is emerging that early experience may indeed be biologically embedded through changes in the epigenome as indicated by associations with gene promoter DNA methylation levels.

"It is very early days; these are only associations, and understanding the causal pathways needs both cheap, high resolution techniques for DNA methylation analysis, gene by gene, and the application of these to birth cohorts followed for many decades."

JEFF J MITCHELL/GETTY IMAGES

The study provides a possible explanation "for accelerated age related disease onset in Glasgow"

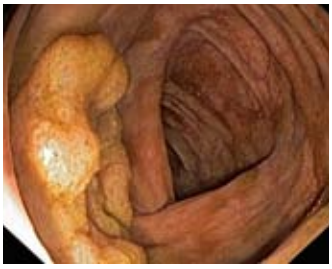
Cite this as: *BMJ* 2012;344:e722

Two tests using sigmoidoscopy may be better than one in bowel cancer screening, finds study

Nigel Hawkes LONDON

Two sigmoidoscopy tests separated by three to five years detect roughly a third more bowel cancers than does a single test, a new study shows. But whether the benefit of detecting the extra cancers justifies the additional costs and the risks of complications, or whether it reduces mortality by a similar degree, remains unknown.

The NHS in England plans to offer flexible sigmoidoscopy screening for bowel cancer to all people from the age of 55, after a trial showed that a single such test conferred a substantial and lasting benefit. The new results, from a US trial, show that a second test increases detection of cancers by 26% in women and 34% in men.



CAMAL/ISM/SPL

A second test increased detection rate from 37.8 to 49.8 people per 1000 screened

The study draws on results from a major US trial that recruited participants between 1993 and 2001. The trial protocol offered flexible sigmoidoscopy on entry and a repeat three years later (subsequently modified to five years). Of the 77 447 people enrolled, 39 442 had two sigmoidoscopies, and the additional cancers detected by this second procedure were analysed by a team led by Joel Weissfeld of the University of Pittsburgh (*Journal of the National Cancer Institute* 2012;104:1-10).

The results show that a single screening identified colorectal cancer or advanced adenoma in 37.8 per 1000 people screened and that the proportion rose to 49.8 per 1000 in those who had a second test. Three quarters of those screened twice had a negative result on the first screen, and among these 18.8% tested positive the second time round. The proportion of participants undergoing further diagnostic interventions, such as colonoscopy, rose from 15.3% of those who had one sigmoidoscopy screen to 22.9% of those who had two.

What matters ultimately is whether sigmoidoscopy screening reduces cancer incidence and mortality, for which data are not yet available. Assuming that there is such a benefit, it may be impossible to distinguish between the effects of the first and subsequent screenings, the authors say. They add, "There are also reasons why repeating a flexible sigmoidoscopy screening may not be beneficial. Although repeated screening increases yields, it also increases the costs of screening, the need for diagnostic intervention, and the risks of complication."

In an associated editorial Noel Weiss and Polly Newcomb of the University of Washington in Seattle say that the size of the study and the large numbers of cancers and adenomas identified provide statistically solid estimates to be incorporated into cost-benefit evaluations of different rescreening strategies.

The NHS screening programme currently offers faecal occult blood tests to all people aged 60 or over. The plan is to offer a single sigmoidoscopy screening to those reaching the age of 55, the offer extending up to their 60th birthday. The blood tests will continue to be offered at 60 whether or not people have chosen to be screened by sigmoidoscopy.

Cite this as: *BMJ* 2012;344:e783

Councils face a £500m shortfall in funding social care for older people

Helen Mooney BMJ

Councils in England are facing a total funding gap of £500m (€600m; $785m) this year on spending for older people's social care.

A new report published by the charity Age UK paints a bleak picture of local authorities struggling with increasingly inadequate levels of funding, combined with soaring need.

The figures show that a £341m reduction in older people's social care budgets this financial year, equivalent to a 4.5% cut, has created the half a billion shortfall. To maintain the same levels of service as in 2010, the report says, the government needs to spend at least £7.8bn this year. However, it shows that councils have budgeted for a spend of only £7.3bn in the face of reductions in funding from central government.

Age UK has warned that the shortfall follows several years of "stagnating" and then "decreasing" spending on social care.

Care in Crisis 2012 **is at http://bit.ly/wjqKSx.**

Cite this as: *BMJ* 2012;344:e715

Dutch microbiologists are censured for delays in pneumonia outbreak

Tony Sheldon UTRECHT

The Dutch Healthcare Inspectorate has filed a rare medical disciplinary complaint against a group of three medical microbiologists, aimed at reaffirming standards of hospital care when tackling outbreaks of infection involving multiple antibiotic resistant bacteria.

The action comes after a highly critical report by the inspectorate into an outbreak of *Klebsiella pneumoniae* Oxa-48 at Maasstad Hospital, Rotterdam. The outbreak continued without proper action for more than a year, infecting more than 100 patients and causing very probably three and possibly a further 10 deaths. Up to 4000 patients risked exposure, having shared a room with an infected patient.

The inspectorate concludes that the "seriousness, extent, and duration" of the outbreak were caused by "inadequate treatment" and lack of cooperation among staff. Medical microbiologists and advisers on infection prevention, though aware of many cases of *K pneumoniae* infection, failed to take the necessary measures.

However, the inspectorate held the whole hospital "culpable," concluding "from observations, conversations, and documents" that it was perfectly plain that failures on many levels played a role and that patients were exposed to great risks.

TOUSSAINT KLUITERS/ANP/NL

Paul Smits, general director of the Maasstad Hospital, talks to the media before his resignation

Doctors can advise "right to die" man without fear of prosecution

Clare Dyer BMJ

Doctors and lawyers may investigate possible means for a man with locked-in syndrome to end his life and may prepare his case without fear of prosecution or action against them by their regulators, the High Court in London has declared.

The unprecedented declaration paves the way for a challenge to guidelines from the director of public prosecutions for England and Wales, which state that doctors and other healthcare professionals who assist a suicide are more likely to be prosecuted than relatives or friends.

The 47 year old man, named only as Martin, who had a brain stem stroke three years ago, is almost completely paralysed and can communicate only by moving his eyes.

Martin is the second person with locked-in syndrome currently seeking the High Court's help to end his life. Tony Nicklinson, 57, has put his case on a different basis: he wants the court to declare that a doctor who gave him a lethal injection would have a defence to a charge of murder under the common law doctrine of necessity (*BMJ* 2012;344:e648, 25 Jan).

Martin's lawyers sought the declaration in his case after the Crown Prosecution Service, the General Medical Council, and the Solicitors Regulation Authority refused to give assurances that lawyers preparing his case and doctors advising them would not be prosecuted for assisting a suicide or face misconduct proceedings.

The declaration will allow Martin's solicitors to seek information from the Swiss organisation Dignitas and make inquiries to identify individuals who might take him there.

Cite this as: *BMJ* 2012;344:e762

The outbreak began in the middle of 2009. By June 2010 several cases of the infection were found among intensive care patients. But it was not until next May, after other hospitals identified *Klebsiella* among patients transferred from Maasstad, that microbiologists carried out further laboratory tests to confirm *K pneumoniae* Oxa-48. Only then did they inform management and launch a crisis team.

The inspector general, Gerrit van der Wal, said that infection control is generally well managed in the Netherlands so it was "almost inconceivable" that in the course of nearly a year measures such as setting up an outbreak team, informing local hospital and nursing homes, and informing the management board did not happen.

Cite this as: *BMJ* 2012;344:e755

TERI PENGILLEY/GUARDIAN NEWS & MEDIA

Cynthia Bower defended the work of the Care Quality Commission since its creation in 2009

NHS watchdog is failing patients and is unfit for purpose, MPs hear

Adrian O'Dowd LONDON

The NHS's main regulator the Care Quality Commission (CQC) is letting down the public with too wide a remit and too little capacity, MPs have been told.

The government, however, has defended the regulators, saying that, despite problems in its performance since becoming operational in 2009, it is fit for purpose and the new system for regulation will not be fully embedded until 2014.

MPs on the parliamentary public accounts committee held an evidence session on 25 January for their inquiry based on a report by the spending watchdog the National Audit Office about the commission, published last December (*BMJ* 2011;343:d7873).

That report concluded that the commission had not so far achieved value for money in regulating quality and safety of health and adult social care in England, that it had missed deadlines for registering health and social care providers, and that levels of compliance and inspection activity were falling substantially.

In a fiery evidence session, MPs asked witnesses about the report's conclusions. Gary Fitzgerald, chief executive of the charity Action on Elder Abuse, said: "As a regulator, it is letting down the public. I don't think people understand what its role is. The CQC's role is far wider than it has capacity to deal with."

Mr Fitzgerald was referring to the fact that the commission was created as a merger of three previous regulators—the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission.

Fellow witness Peter Walsh, chief executive of the campaigning group Action against Medical Accidents, said: "We don't think the CQC is fully fit for purpose at the moment. It has an unwillingness to act proactively to protect patients or service users."

Despite the commission's problems, Anna Dixon, director of policy for the health think tank the King's Fund, also giving evidence, said it was important to keep the commission.

"Let's be realistic about what an external regulator can ever do to assure quality and safety," said Ms Dixon. "At the end of the day, we have to put the focus on professionals who are there interacting with patients and users in care homes and the providers.

"But we should at least give the CQC the resources to do what we ask of it and don't keep adding to its workload. Let it learn, improve, and get on with the job, and certainly don't reorganise it again."

Its chief executive Cynthia Bower, also giving evidence, was asked by the MPs why the commission had undertaken no major investigations in its first 14 months when its predecessor the Healthcare Commission had carried out 16 such investigations in its five year history.

Ms Bower replied: "The nature of regulation has changed. The range of powers we have is very different to the range that the Healthcare Commission had. We are now beginning to undertake investigations into NHS organisations."

Una O'Brien, permanent secretary at the Department of Health, giving evidence, said "I think the CQC is fit for the job that it is there to do."

Cite this as: *BMJ* 2012;344:e695

Indian health ministry challenges report of totally drug resistant TB

Ganapati Mudur NEW DELHI

Sections of India's medical community have decried what they see as an attempt by the Indian health ministry to underplay the country's first report of totally drug resistant tuberculosis and to censure the hospital that reported the infection last month.

Doctors at the Hinduja Hospital in Mumbai described four patients infected with tuberculosis bacilli resistant to all first line and second line drugs conventionally used to treat tuberculosis in the *Journal of Clinical Infectious Diseases* last December (doi:10.1093/cid/cir889).

The health ministry, which independently examined the patients' records, has said that the term "totally drug resistant" tuberculosis is "misleading" and has not been endorsed by the World Health Organization. It has classified the cases as extensively drug resistant tuberculosis.

In a statement, the ministry also said that the Hinduja Hospital had not received accreditation from the government to conduct drug sensitivity tests for second line drugs. It added that a "poor clinical response to treatment has not yet been correlated with diagnosis of drug resistant tuberculosis," without tests in accredited laboratories.

But pulmonary and public health specialists believe the government's response, particularly its focus on the terminology of resistance, seems intended to turn the spotlight away from India's growing problem of drug resistant tuberculosis.

DAVID ROCHKIND

There is little capacity for drug sensitivity testing and treatment in public hospitals, say commentators

"This seems like an attempt to question the messenger," said Bobby John, a doctor and president of Global Health Advocates, a non-government organisation that has been tracking India's national tuberculosis control programme. "The Hinduja Hospital laboratory has certification from the College of American Pathologists. Is it fair to pick on accreditation when something unpalatable is reported?" Dr John said.

India has the world's highest burden of tuberculosis, with an estimated annual incidence of two million patients. Health officials say that the government programme treats more than 70% of these cases and achieves a cure rate of 87%.

Public health experts have in the past expressed concerns about poor laboratory capacity for drug sensitivity testing and the use of inappropriate treatment for patients who fail first line drugs. For example, doctors point out that many patients not cured after initial treatment with rifampicin, isoniazid, pyrazinamide, and ethambutol receive a regimen that adds a single drug, streptomycin, to the original four, breaching standard treatment rules to test for drug sensitivity (*BMJ* 2009;338:b8).

The health ministry estimates that about 50 000 cases of multidrug resistant tuberculosis emerge in the country each year. But until July 2011, fewer than 6000 of these patients had drug sensitivity tests.

Community medicine specialists also say the health ministry has failed to adequately address poor treatment practices in the private sector, which remains one of the biggest drivers of drug resistant tuberculosis in the country.

Cite this as: *BMJ* 2012;344:e702

Governments and drug companies pledge to eliminate 10 neglected diseases

Anne Gulland LONDON

Public and private sector partners—including the governments of the United Kingdom, the United States, and the United Arab Emirates; 13 drug companies; and Microsoft founder Bill Gates—have pledged to work together towards the elimination of 10 neglected tropical diseases by 2020.

The partners signed the London declaration, which is based on the World Health Organization's roadmap on neglected tropical diseases, which itself set a plan to eliminate or control 17 diseases affecting more than one billion people around the world (*BMJ* 2010;341:c5855).

The signatories to the declaration have pledged to ensure the supply of drugs and other interventions to eradicate Guinea worm disease by 2015 and eliminate lymphatic filariasis, leprosy, human African trypanosomiasis, and blinding trachoma by 2020. They have also pledged to control schistosomiasis, soil transmitted helminthes, Chagas disease, visceral leishmaniasis, and onchocerciasis by 2020. In addition, they have pledged more than $785m (£500m; €599m) to support research and development and strengthen drug distribution programmes.

At the launch of the declaration Bill Gates, co-chair of the Bill and Melinda Gates Foundation, which has promised £231m over five years, said, "What's unique about today is that everyone is on the same page. The drug partners need to know there's a roadmap; they need to know that countries are going to orchestrate their health systems to ensure that the drugs get to those in need."

According to the International Federation of Pharmaceutical Manufacturers and Associations the drug companies will donate an average of 1.4 billion treatments each year. The drug industry is also providing access to compound libraries that could lead to new treatments.

The drug companies are also working together on certain diseases. Abbot, Johnson & Johnson, and Pfizer are working in partnership to develop new drugs to treat helminth infections. And the Drugs for Neglected Diseases Initiative, a non-profit drugs development and research organisation, is working with 11 drug companies on licensing and collaboration initiatives.

Christopher Viehbacher, chief executive of the drug firm Sanofis, said that it was "extraordinarily difficult" to get competitors in the drug industry to work together, adding that Mr Gates had "played a critical role" in this.

Cite this as: *BMJ* 2012;344:e773