NEWS

COUGH AND COLD CARE KITS REDUCE ANTIBIOTIC USE

A press release from the American Society for Microbiology says that cough and cold care kits reduce antibiotic use.

A programme in health clinics where physicians offer patients a cough and cold care kit containing over-the-counter medicines appears to reduce unnecessary antibiotic use significantly. Researchers from the Minnesota Antibiotic Resistance Collaborative (MARC) reported their findings at the International Conference on Emerging Infectious Diseases.

'Providing cough and cold care kits does appear to be a useful tool to use with patients who have upper respiratory illness or acute bronchitis to decrease unnecessary antibiotic use,' says Pamala Gahr of the Minnesota Department of Health, a researcher on the study. The kits were initially produced by three local health plans that began distributing them through their clinics during the 2000 - 2001 winter season. They consist of a colourful box filled with pain relievers, decongestant, cough syrup, lozenges, a packet of powdered chicken soup and a teabag. The following year 6 local health plans distributed approximately 31 000 kits.

Gahr and her colleagues compared the percentage of patients with upper respiratory illnesses or acute bronchitis who filled prescriptions for antibiotics after visiting clinics that distributed the kits with those who visited clinics that did not. Patients who visited clinics where the kits were distributed were significantly less likely to fill a prescription for antibiotics within 3 days of their visit.

'The inappropriate use of antibiotics to treat viral illnesses is thought to be a key factor in the rise of antibiotic-resistant bacteria,' says Gahr. Usually, the best course of action in these cases is to treat the symptoms with rest and over-the-counter medication. 'In addition to the study data, we have had a lot of anecdotal feedback from physicians that it was a great idea to have something to give patients when you know they don't need antibiotics.'

While the finding may be statistically significant, Gahr warns that the study size was limited and that further study with a larger sample is warranted. MARC is working in conjunction with the Centers for Disease Control and Prevention's 'Get Smart: Know When Antibiotics Work' public education campaign to help reduce inappropriate antibiotic use.

BIOTECH/PHARMA EVOLUTION REACHES A TURNING POINT

An article in the USA *Financial Times* (12 December 2003) entitled 'Biotech reaches a turning point in its evolution' presented an interesting datum: in 2003, for the first time, the number of drug submissions to the US Food and Drug Administration (FDA) from biotech companies outstripped those from big pharmaceutical companies. Even though pharmaceutical companies may own or license a good portion of these new drugs, the implications of this statistic are still interesting. Biotechs have been previously disparaged for their leaning toward science-based, rather than economy-based, research, sometimes called the 'molecule-in-search-of-a-disease' approach — a trait that has undoubtedly contributed to the high failure rate of such companies. But the flip-side of such a business model is the ability to be more agile and follow where the interesting results may lead. Additionally, the smaller, more nimble biotechs are free to spend a larger percentage of their budget on research — e.g. in 2002 AstraZeneca, the top-spending pharma company, devoted 17.4% of its total revenue on research and development (R&D), while Biogen, the top biotech company, spent close to double that.

And now, in an effort to become more competitive with biotech, the pharmaceutical industry is attempting either to remodel their research to become more 'biotech-like', or to reduce spending on R&D, rather using the funds to buy up smaller biotechs or license the drugs they discover. Either of these pathways should lead to a more profitable business plan for both industries. However, price controls loom as a potential danger to the drug industry, threatening to cut profits and to reduce R&D spending and the development of new medicines.

In the USA, health care costs are responsible for approximately 30% of the national GDP. The proportion spent on prescription drugs has more than tripled since 1990, and will continue to increase. The recent signing of new Medicare legislation is widely seen as a boon for the pharmaceutical industry, as it prevents Medicare from negotiating price discounts and further restricts the importation of cheaper drugs from outside the USA, cunningly skirting the price control issue. However, this is unlikely to be the end of the story, as the legislation does not take effect until 2006, giving opponents ample time to challenge the new law in the courts.

With research becoming increasingly expensive and consumers more frequently balking at rising drug costs, the future of biotech/pharma is somewhat uncertain. But with our uniquely human thirst for both knowledge and money, we will inevitably continue to push back the boundaries of science and medicine, whatever the costs.

S Sanders, PhD (Cantab)

URGENT NEED FOR NEW DRUGS IN SUB-SAHARAN AFRICA, SAYS WMA PRESIDENT

Addressing the Ugandan Medical Association's Annual Scientific Meeting on Infectious Diseases in Kabale, Dr James Appleyard, President of the World Medical Association (WMA), warned that the increasing gap in the health needs of the rich and poor nations was like a ticking time bomb. There was an urgent need to develop new drugs to fight infectious diseases in sub-Saharan Africa, he said.

Yet, despite the urgent need for new medicines, less than 20 drugs had been developed for tropical diseases in the last 25 years or so, all with government support. This compared with 1 377 new drugs for the developed world, where the burden of disease was far less.

Dr Appleyard said that only by developing practical partnerships between governments, industry, universities and non-governmental organisations, as happened in the SARS outbreak last year, would this gross distortion of world priorities be corrected.

He said that children had to bear the overwhelming burden of infectious diseases in poor countries. They were imprisoned in a poverty trap and so prevented from achieving their full potential of physical, mental and economic growth.

Nearly one-third of the children under 5 in Sierra Leone die each year, but children born in Sweden are top of the UNICEF list, with only 3 children dying each year per 1 000 births — a difference of 100-fold.

He said that Uganda had made progress over the last 10 years. An extra 50 000 children under the age of 5 were surviving each year compared with 10 years ago. But much more still needed to be done to prevent and control the common infectious illnesses that were responsible for those deaths in children — diseases such as diarrhoea, measles and malaria, all of which were treatable.

POLIO — IS THIS THE LAST CHANCE FOR ERADICATION?

Two new cases of polio have been confirmed in Benin and Cameroon, and are believed to have originated in neighbouring Nigeria, where approximately 300 cases of polio were recorded in 2003, making this country the worst in the world in terms of polio incidence. Then, on 25 February 2004, a press release from the World Health Organisation (WHO) announced that a case of paralytic poliomyelitis was reported from Cote D'Ivoire, which could be the 8th polio-free country to be re-infected from Nigeria.

The situation in the country has been aggravated in recent months after widespread resistance to polio immunisation among the predominantly Muslim inhabitants of northern Nigeria, who were misled in the belief that the polio vaccine had been deliberately contaminated with HIV virus and anti-fertility agents. Although Nigeria's federal government has declared the vaccines as safe following random testing, members of the public remain reluctant to accept immunisation. The suspension of immunisation campaigns in Kano led to an outbreak of polio in that area. This is in stark contrast to the substantial support polio eradication has received from scientific and religious bodies and multilateral institutions around the world. In October 2003, the Organisation of the Islamic Conference (OIC) unanimously resolved to eradicate polio by the end of 2004. Further to this commitment the United Arab Emirates (UAE) recently announced the first pledge of what will be a multi-million dollar contribution by Islamic Gulf countries. A Medinfo press release issued in February revealed that a further two states in northern Nigeria had refused to participate in the vaccination campaign in West Africa.

Niger, however, a staunchly Muslim country to the north of Nigeria, has launched a synchronised vaccination programme covering the entire country. Parents of children living near the 1 500 km border with Nigeria have been urged to allow their children to participate in the programme.

In 1988, the World Health Assembly, a body comprised of ministers of health from every WHO member nation, established the goal of global eradication of poliomyelitis. Only 677 cases of polio have been reported in 2003 (as of 13 January 2004), representing a greater than 99 per cent reduction in poliovirus. The Global Polio Eradication Initiative (GPEI) is the largest public health initiative the world has ever known. Since 1988, some 2 billion children around the world have been immunised against polio. In 2004, the world has a one-time opportunity to make good on a global investment of $3 billion by ending transmission of poliovirus, now and forever.

Stopping transmission of poliovirus by the end of 2004 is the overriding objective for all six remaining polio-endemic countries — Nigeria, Cameroon, Benin, Pakistan, India and Egypt. Epidemiologically and programmatically, a one-time opportunity now exists to stop transmission of poliovirus, but political will must be galvanised across all levels — international, national, state/provincial and local — in order to immunise every child and capitalise on this opportunity.

The G8 re-inforced its commitment to polio eradication during its June 2003 summit, and pledged to provide the funding needed for polio eradication activities in Africa.

A meeting of ministers of health of affected countries held in Geneva on 15 January 2004 resulted in a statement which concluded, 'We will finish polio before year's end'.

There are, however, serious obstacles to the world's final push to eradicate polio. For example, funding shortfalls required most polio-free countries to stop their polio immunisation campaigns, leaving millions of children more vulnerable to poliovirus infections from endemic countries.

The ministers concurred on an all-out effort to reach every child with the polio vaccine from early in 2004, particularly in Nigeria, India and Pakistan, which together account for more than 95 per cent of all polio cases worldwide. Within these three countries, transmission of poliovirus is further confined to 'polio hotspots', especially in five states and provinces (Kano in Nigeria, Uttar Pradesh and Bihar in India and North West Frontier Province and Sindh in Pakistan) that together are linked to more than 75 per cent of all new cases worldwide in 2003.

To fully implement the bold eradication plans outlined by the ministers of health requires the continued generous support of public and private donors. An additional US$150 million is urgently needed to fill the remaining funding gap for activities during 2004 and 2005.

For further information: Global Polio Eradication Initiative: **www.polioeradication.org**, Rotary International's PolioPlus site: **www.rotary.org/foundation/polioplus/**, The Centers for Disease Control in the USA: **www.cdc.gov**, UNICEF polio site: **www.unicef.org/polio,** WHO home page: **http://www.who.int/**, MEDINFO: Stephen Toovey, cell 082 466 6322, fax (011) 883-6152; Andrew Jamieson, cell 083 610 0546, fax (011) 301-0549.

HEALTH PROFESSIONALS AGREE TO BECOME NON-SMOKING ROLE MODELS

The new code of conduct suggested by the World Health Organisation (WHO) asked health professionals to lead by example, and reduce smoking themselves.

To stem trends in tobacco use, which currently causes nearly 5 million deaths per year, health care professional associations agreed to promote a new code of conduct. The associations, meeting at the WHO, represent members in almost all countries. The code looks at tangible ways to stop the use of a product which will eventually kill half of its regular users. Participants included professional associations representing pharmacists, dentists, nurses, midwives, chiropractors and physicians.

During the discussions, professionals vowed to increase and strengthen tobacco surveillance and cessation programmes, ensure access to tobacco-free health care facilities and implement education and community advocacy programmes. 'When it comes to tobacco use, health professionals have the opportunity to help people change their behaviour. Their involvement is key to successfully curbing the tobacco epidemic,' said Dr Vera Luiza da Costa e Silva, Director of the Tobacco Free Initiative, WHO.

Studies have shown that even brief counselling by health professionals on the dangers of smoking and the importance of quitting is one of the most cost-effective methods of reducing smoking. According to the proposed code of conduct, health professionals shall also lead by example. Smoking prevalence among health professionals in many countries is the same if not higher than the average of the population. They should act as role models for their patients by ceasing to smoke, and by ensuring their workplaces and public facilities are smoke and tobacco free.

The participants agreed that another important role of health professionals is to introduce tobacco control in the public health agenda at country level, supporting the political process through the signature and ratification of the WHO Framework Convention on Tobacco Control (FCTC) by their governments, and supporting the implementation of the Convention by their own members.

PRACTICE MANAGEMENT

BUSINESS PLANNING PART VI

Operational planning

Now that the strategic planning phase has been completed, the participants of the business planning process should have:

A clear understanding of the external environment

- What are the trends influencing the business environment in which the practice operates and what are the opportunities and threats arising from them?
- Who are the stakeholders of the practice and what are their expectations?
- Who are the practice competitors and what are their strengths and weaknesses?
- What is the market that the practice serves or can serve, it's size, growth potential and geography?
- How are the products and services of the practice geared to this market?

A clear understanding of the following internal factors

- The strengths and weaknesses of the practice.
- The lifecycle stage and profitability of each service or product provided by the practice.