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1004 Screening for chronic kidney disease
Cannot be recommended in people without risk factors, says Bryce Kiberd
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1005 After the abolition of the National Patient Safety Agency
The patient safety incident database must continue as a source of national learning, says John Scarpello

1006 The future role of NICE
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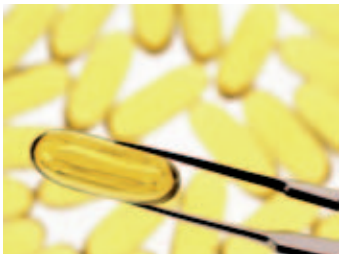

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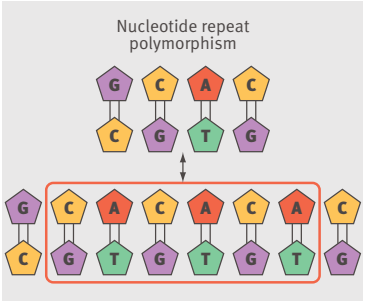

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RCS ENG PHOTOGRAPHIC UNIT

PICTURE OF THE WEEK

Prototypes and components of the first multichannel cochlear implants developed in 1978 by Professor Graeme Clark. The implants became the first means of providing speech understanding to profoundly deaf children and adults and more than 200 000 people have benefited. For this innovation Professor Clark was awarded the Lister medal at the Royal College of Surgeons on 4 November.

THE WEEK IN NUMBERS

80 000 Number of incidents reported by NHS staff to the National Patient Safety Agency every month
(Editorial, p 1005)

1 in 1250 Additional cases of haemorrhagic stroke among people taking vitamin E supplements
(Research, p 1033)

1902 Year the Boveri-Sutton chromosome theory of inheritance was published
(Clinical Review, p 1037)

1/3 Proportion of enoxaparin doses of 60 ml or greater that were prescribed outside hospital in the UK
(Practice, p 1047)

QUOTE OF THE WEEK

"NICE must now work to devise ways of streamlining its production of guidelines so that advice incorporating new products can be available at their launch"

Joe Collier, emeritus professor of medicines policy, St George's, University of London
(Observations, p 1027)

QUESTION OF THE WEEK

Last week's poll asked, "Does choice matter more to politicians and patient advocates than it does to patients?"

66% said yes (total 333 votes cast)

This week's poll asks, "Should rationing of drugs be done by individual doctors or by a national body?"

bmj.com Cast your vote

EDITOR'S CHOICE

A future for NICE, and the world's poorest children

Clashes could arise between primary and secondary care doctors, because secondary care doctors are those more likely to start patients on the drugs that GP consortiums will say they can't afford

Given the conflicting messages emanating from the government, it would be great if we could tell you exactly what the future holds for NICE, but we can't. As Rebecca Coombes says in her Q&A on the subject (p 1025), we should know more once the government releases its consultation document, probably by the end of this month. In the meantime, we've assembled the opinions of a range of commentators.

In their editorial Alan Maynard and Karen Bloor describe the coalition government's response to the agency as "puzzling" (p 1006). On the one hand the recent white paper talks of broadening NICE's scope. Yet it also introduced a cancer drug fund to "help patients get the cancer drugs their doctors recommend," apparently regardless of the views of NICE.

They discuss the shift to value based pricing of drugs, in which prices directly reflect their value in improving patients' length and quality of life. "Who will evaluate 'quality' and how will these estimates be used to negotiate prices?" they ask. "Will NICE lead this process or at least provide evidence for it?"

In his best-of-all-possible-worlds Observation, Joe Collier regards the government's new proposals as "logical, defensible, and welcome" (p 1027). He envisages a new government body, called something like the "Commission on the Value of Medicines," which will calculate the drug price that will reflect value. Operating at a national level, this body was first mooted in the Office of Fair Trading's critical 2007 report on the current pharmaceutical price regulation scheme. NICE would be one of a range of agencies advising this new commission: "thus the same people, using the same information, and with the same skills as now would be producing economic evaluations."

In her Q&A, Rebecca Coombes suspects that patients will have fewer rights under the new system and that conflicts could arise between doctors working in primary and secondary care. Previously, NICE's rulings were mandatory on primary care trusts. Now it looks like the government won't compel GP consortiums to make a particular drug available; there will simply be an agreed drug price that the NHS will be willing to pay.

Clashes could arise between primary and secondary care doctors, because secondary care doctors are those more likely to start patients on the drugs that GP consortiums will say they can't afford. (To read how such conflicts played out in Germany recently, see Roswitha-E Goetze-Pelka's letter, doi:10.1136/bmj.c6309). Coombes quotes the BMA as saying that "GPs will hate being in the position of having to say no . . . It is at odds with their patient advocate role and they will struggle. It is much easier to blame a third party, such as NICE."

Viewed from much of the world these problems look like luxury. Save the Children's Justin Forysth explains the challenges for his organisation's main international campaign next year (p 1022)."Every year over 8 million children die under the age of 5 years. The stark reality is that there is often no doctor or drugs on hand to treat a child with pneumonia or diarrhoea. As a consequence, 3.5 million children die each year from diarrhoea or pneumonia, and 90% of under 5s die from a small number of diseases, including malaria and measles."

It's why the *BMJ* and our sister journal, *Archives of Disease in Childhood*, have chosen Save the Children as their Christmas charity this year. Using feature articles, blogs, and films, we'll be telling you more about Save the Children's campaign to secure the health of the child. And we'll be telling you how to get involved in the campaign and how to donate. Save the Children would like us to raise £30 000—that's less than 2p from each reader of our print and online journals.

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Career Focus, jobs, and courses appear after p 1056

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