thromboembolism.[2] Those with conflicts of interest on the NICE panel include Nandam Gautam (Bristol Myers-Squibb), Aroon Hingorani (Pfizer), Beverley Hunt (Sanofi Aventis, Bayer and Boehringer), Nigel Langford (Sanofi Aventis), Simon Noble (Leo Pharma, Boerhinger Ingelheim, Sanofi Aventis), Annie Young (GlaxoSmithKline), Simon Frostick (Boehringer Ingelheim, Bayer), David Warwick (Boerhinger Ingelheim, Sanofi Aventis), and Nick Welch (Boerhinger Ingelheim).[3]

Are these guidelines worth the paper they are written on?

Benjamin Dean registrar, Oxford Deanery
bendean1979@gmail.com

Competing interests: None declared.

1 Godlee F. Conflicts of interest and pandemic flu. *BMJ* 2010;340:c2947. (6 June.)
2 National Institute for Health and Clinical Excellence. CG92 Venous thromboembolism - reducing the risk: full guideline. http://guidance.nice.org.uk/CG92/Guidance.
3 National Institute for Health and Clinical Excellence. CG92 Venous thromboembolism—reducing the risk: full guideline appendices A-D. http://guidance.nice.org.uk/CG92/Guidance/Appendices/pdf/English.

Cite this as: *BMJ* 2010;341:c3581

POLAND'S MARKET REFORMS

Different view of Polish health policy

Issue can be taken with the conclusions drawn by Watson on the state of Polish healthcare reforms and policy positions adopted by its politicians.[1] I consider only some of the contentious points here.

Polish experts formulated health reform principles in 1990.[2] Far from dictating the direction of reform, the World Bank proposals were in line with domestic objectives and suggested caution about developing a health insurance system,[3] which was largely driven by the need to ring fence funds for health. The initial level of health tax contribution was intended to ensure affordability, and there was no intention to push people towards private care. Private practice and doctors' cooperatives existed under communist rule, with a health divide already present giving better access for the ruling and intellectual elites.

Successive debt clearing exercises have not had the desired impact on the recurring problem of indebtedness.[4] The current government opted for commercialisation to improve financial management. Most public facilities are owned by the local authorities, and, although an option to privatise exists, the political pressure to privatise does not.

Allegations of favouring privatisation against one candidate for the presidency of the republic were declared false by the courts and had to be withdrawn. The president has the power of veto—the danger is that the veto, instead of acting as a check and balance, leads to an impasse.

Jolanta Sabbat independent researcher, Health Policy Exchange, London SW19 4JB **jolanta@hpex.org**

Competing interests: None declared.

1 Watson P. Poland's painful market reforms. *BMJ* 2010;340:c2837. (15 June.)
2 Ministry of Health and Social Welfare. *Directions of change in the organisation and financing of health care*. Warsaw: MHSW, 1990.
3 Wlodarczyk C, Sabbat J. Regional integration of health services in Poland—an ambitious pilot project. *Health Policy* 1993;23:229-45.
4 Sabbat J. *Indebtedness and restructuring of health care institutions in Poland. Poland health brief*. London: Health Policy Exchange, 2009. www.hpex.org.

Cite this as: *BMJ* 2010;341:c3593

GENERIC SUBSTITUTION

Reimbursement requires reform

Generic substitution would be a good thing,[1] but the complexity of the system for reimbursement could cause unintended effects.[1] The Drug Tariff outlines what will be paid to contractors (pharmacists or dispensing general practitioners) for drugs or products supplied on an NHS prescription. A complexity (or perversity) of this system is that the price of a "branded generic" often undercuts the price for the equivalent generic drug in a basket of drugs in the Drug Tariff designated "category M." Branded generics are off-patent drugs sold under a brand name (not the original).

To save money in a cash strapped NHS many primary care organisations and practices now advocate prescribing certain branded generics, but this runs counter to years of effort in the NHS to promote generic prescribing. For this reason, the pricing reimbursement scheme for generic medicines set by the Department of Health currently creates an anomaly that contradicts best practice in the NHS. This pricing arrangement also needs urgent attention because, if generic substitution by pharmacists takes place, it could have the opposite effect than that intended and cause substitution with more expensive products.

Martin G Duerden general practitioner and assistant medical director, primary care, Betsi Cadwaladr Health Board, Princes Park, Colwyn Bay LL29 8PL
martin.duerden@wales.nhs.uk

Competing interests: None declared.

1 Ferner RE, Lenney W, Marriott JF. Controversy over generic substitution. *BMJ* 2010;340:c2548. (1 June.)

Cite this as: *BMJ* 2010;341:c3566

Next goal: consistency of packaging and labelling

Generic substitution[1] has been permitted for several years in Australia but still causes problems for patients. We conducted a qualitative study of 104 Western Australian senior citizens with at least one chronic disease exploring their views and experiences of taking drugs safely. The most important and consistent theme related to generic substitution and problems with drug packaging and labelling.

Different forms of perindopril dispensed to one patient

They expressed considerable doubt about the equivalence of generic drugs because of mistrust of drug companies and the increasing geographical dispersal of drug production. They reported the inconsistent appearance and taste of different generic forms. More important was the problem of inconsistent packaging and labelling.

The figure shows the different forms of perindopril dispensed to one patient. Three concerns exist: the larger font size, and more prominent brand name; the entirely different packaging; and the apparent change in dose because of the change from one salt to another. This patient was taking both salts until adverse effects were identified by the pharmacist.

Generic substitution was rarely discussed in detail with patients by their general practitioner or pharmacist. For most consumers the price of a generic substitute was insufficient to change their preference for a specific brand.

Although the problem is recognised by health consumers and practitioners, it is largely ignored by policy makers seeking to generate financial savings from generic substitution. Tighter regulatory frameworks are needed to ensure not only clinical equivalence but consistency of packaging and labelling to minimise confusion caused by generic substitution, particularly in those taking multiple medicines.

Jon Emery head, School of Primary, Aboriginal and Rural Health Care, University of Western Australia, 328 Stirling Highway, Claremont, WA 6014, Australia
jon.emery@uwa.edu.au
Anne McKenzie consumer advocate, School of Population Health, University of Western Australia, Clifton Street, Nedlands, WA 6009, Australia
Caroline Bulsara research assistant professor, General Practice, University of Western Australia
D'Arcy Holman head, School of Population Health, University of Western Australia, Clifton Street, Nedlands, WA 6009, Australia

Competing interests: None declared.

1 Ferner RE, Lenney W, Marriott JF. Controversy over generic substitution. *BMJ* 2010;340:c2548. (1 June.)

Cite this as: *BMJ* 2010;341:c3570