generic substitution is unsafe. The RMI has now responded to the ministry's interchangeable medicines list by running advertisements in medical publications asking doctors to prescribe brand-name medicines and to support research and development, and has written in a similar vein to general practitioners.

The new ministry initiative invites doctors to sign a form giving the pharmacist blanket approval for substitution unless a prescription specifies otherwise. The strategy is aimed at reducing drug costs. Since medicines in New Zealand are already priced according to the cheapest drug in a field, the main beneficiaries of the new policy will be members of the public who often pay premiums for brand-name drugs. Although the RMI has raised the spectre of informed consent in substitution, most consumers are unaware that there may be cheaper drugs than the brand-name products chosen for them by their general practitioner.

It remains to be seen how doctors will respond. The ministry concedes there is some "residual concern" among professional groups and has invited them to inspect their evidence. It is currently engaged in reviewing the medicines legislation and it is possible that routine substitution by pharmacists may be authorised by any new act. Also being reviewed is the issue of advertising prescription drugs directly to the public.

In recent weeks Merck, Sharp and Dohme has tested the limits of the current restrictions with an advertising campaign for Proscar, a treatment for prostatic hypertrophy. Newspaper advertisements with a clip-out coupon were followed by televised advertisements depicting waterfalls (". . . if your torrent has turned into a trickle"). These carried a free-phone number for further information. By the end of seven weeks, 6000 members of the public had responded. It is too early to know whether Merck, Sharp and Dohme has increased its market share, but the company reports that "a lot more men are coming in to see the doctor and lots of doctors are quite happy about that".

Proscar it still not on the drug tariff, so consumers must pay NZ$1500 annually for its use. The official view of Pharmac, the government's pharmaceutical management agency, is that two already subsidised drugs are at least as effective as Proscar.

Advertising prescription drugs directly to the public is not new in New Zealand. Novo Nordisk recently advertised hormone-replacement therapy in a publication delivered free to homes. Such advertising is not illegal, although before the Proscar campaign no pharmaceutical company had used television as a medium. Advertisers are supposed to spell out the efficacy and safety of their product but usually do not; in Proscar's case this information was flashed on the screen in tiny letters for about five seconds.

The proposed new medicines legislation could prohibit such advertising and the Ministry of Health would prefer this. But the ministry reports that few submissions have supported a ban. In an increasingly market-driven health environment, advertising drugs to the public may become a fact of life.

Sandra Coney

Specialist domiciliary care in Australia

A pilot scheme for treating some patients at home by general practitioners and salaried staff specialists has been established in Sydney. If successful, the federal-government-funded scheme could be introduced nationally.

The 12-month A$30 000 pilot programme to be conducted within the inner-city Central Sydney Area Health Service's (CSAHS) division of general practice allows general practitioners (GPs) to request joint visits with specialists to the homes of patients, who would otherwise be transported to hospital by ambulance, at considerable cost.

Eligible patients are elderly or have complex medical, physical, or social problems. The hospital-based specialists, mainly geriatricians, psychogeriatricians, and rehabilitationists, would not be paid any more for these home visits. However, GPs would be paid travelling time and for time spent in telephone consultations with specialists at a flat rate of $91.55 per hour—greater than the Medicare reimbursement for eligible house calls.

Dr Michael Mira, director of the CSAHS's division of general practice, says that the scheme will benefit GPs, who will obtain first-hand clinical experience with specialists because they would be visiting patients together, thereby eliminating communication problems between GP, specialist, and patient. Mira adds that patients would also benefit because of the more personalised and higher standard of care, and that later admission of these patients should also be minimised, along with the $300 per day bed cost.

A concurrent 12-month $100 000 pilot programme involves the broader concept of GPs visiting their patients in hospital at the invitation of any specialist.

These two schemes are separate from the evaluation of "hospital in the home" arrangement, whereby community nurses and GPs collaborate to provide domiciliary care of various types—for example, for people who require intravenous antibiotics. It remains to be seen how much support these innovations receive from GPs.

Peter Harrigan

HIV-1 subtype C in Brazil

Researchers have identified the first four cases of HIV-1 type C in Brazil. This subtype of virus is common in India and known in countries of southern Africa. One case was identified in São Paulo, and the other three in the southern city of Porto Alegre.

According to Ester Sabino, who detected the São Paulo case at the Adolfo Lutz Institute, the finding is important because subtype C might be more easily transmissible heterosexually than other types, in which case it could affect the pattern of AIDS epidemiology in Brazil. In India, where the AIDS epidemic is associated with subtype C, transmission is largely heterosexual, says José Esparza, of WHO's AIDS programme. "In that country, the infection ratio between men and women is 1:1, suggesting that the virus spreads itself much more easily through heterosexual contact", says Esparza. According to him, the ratio in Brazil is 8 or 9 male cases to 1 female. Sabino points out that the likelihood of heterosexual spread is only a hypothesis, and that there might be other factors to explain the transmission pattern in India. "The virus could be spreading itself in this manner because of a high incidence of sexually transmissible disease, which increases HIV infection through sexual contact. There is also the possibility that the Indian population is genetically more susceptible to subtype C".

HIV-1 subtype	Country
A	Central Africa
B	South America (including Brazil), US, Europe, Thailand
C	Brazil, India, southern Africa
D	Central Africa
E	Thailand, Central African Republic
F	Brazil, Romania, Zaire
G	Zaire, Gabon, Taiwan
H	Zaire, Gabon
O	Cameroon, Gabon

The finding, which Sabino expects to present at an AIDS conference in Washington on Jan 28, also bears implications for vaccine programmes. "The majority of vaccines being tested in the world are against subtype B, which is the most common form of the virus in the USA, Europe, and Brazil", says Sabino. Even though it is unknown whether HIV subtypes are relevant for vaccine efficacy, Sabino says it would be best for a population to be vaccinated against the virus that attacks it (panel).

The three cases identified in Porto Alegre are to be published by WHO in *AIDS Research and Human Retrovirus*.

Cláudio Csillag