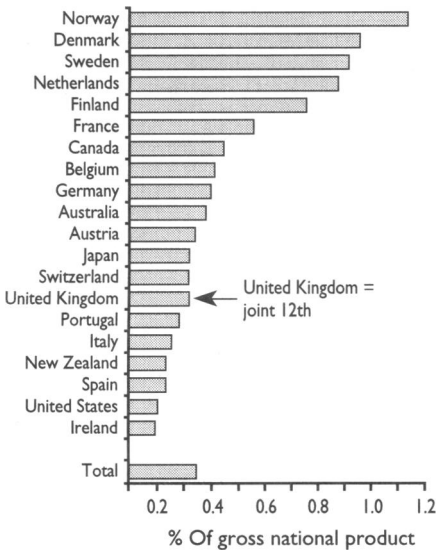
industrial nations failed to make any appreciable progress towards relieving the South's crippling debt burden, which now exceeds £1000bn. For the poorest countries of the world this failure is a cause for real despair.[1] The lethal interaction between deepening poverty and environmental degradation is set to continue, especially in Africa. Political will to find a solution is lacking as the British government offered little resistance to Japanese objections. The summit ended weakly with an affirmation of the 1989 Trinidad Terms, which have been so diluted that they have contributed little to the tiny amount of debt cancellation in 17 countries.

Plummeting commodity prices and rising interest rates mean that sub-Saharan Africa now owes more than it earns. Over the past decade debt has almost quadrupled from 28% to 109% of gross national product, bleeding the continent of $10bn in annual interest repayments alone—four times as much as it spends on its health service. With infrastructure collapsing and the average living standards (already the lowest in the world) falling, the leaders at the summit made no commitment to respond to Africa's special needs. They ignored the fact that African debt can never realistically be repaid in the present climate of unfair trading conditions and the International Monetary Fund's monetarist policies which dominate the continent's economies.

Despite media hype about a breakthrough in the general agreement on tariffs and trade the progress on trade will benefit rich countries more than poor. Agreements on textiles, clothes, and agricultural products, which are important to the Third World, were glossed over. Very poor countries will be forced to open their markets to foreign competition as they watch the relative value of their current trade practices diminish. The summit also failed to tackle the crisis in commodity prices, which is at the heart of Africa's deepening economic problems.



Overseas development aid as percentage of gross national product in 1991, by country[2]

On aid the summit agreed to enhance development assistance, but Britain made no commitment to increase its share of aid, which has fallen sharply over the past decade. Britain now gives less than half the 0·7% of gross national product suggested by the UN and stands twelfth in the league table (figure).[2]

This ought to be a time of hope for Africa as democracies tentatively grow and decades of armed conflict gradually resolve. Peace and democracy, however, remain fragile. As Mary Robinson, the president of the Republic of Ireland, said, "the fact that one billion people in the world simply do not have the means to exist from day to day diminishes us all."[2]

DOROTHY E LOGIE

Bowden,
Melrose TD6 0ST

1 Logie DE, Woodruffe J. Structural adjustment: the wrong prescription for Africa? *BMJ* 1993;**307**:41-4. (3 July.)
2 Christian Aid. *British overseas aid.* London: Christian Aid, 1993. (Aid report No 8.)

Health loses out to the arms trade

EDITOR,—Dorothy E Logie and Jessica Woodroffe give a cogent analysis of the devastating impact on health, and the social fabric on which this depends, of Western financial institutions' structural adjustment policies in Third World countries.[1] I wish to point to another element of this crisis.

Average spending on arms per capita in the Third World is $38, compared with average spending on health of $12; much of the weaponry is wielded by entrenched elites against the deprived masses of their own countries.[2] While structural adjustment has meant a systematic slashing of budgets for health, education, and social services, there has been no insistence that military expenditure should likewise be reduced. This telling omission reflects the enormous profits that the global arms industry generates in the West and also the tacit insistence of Western governments that the alliances they choose with those in power in the Third World are not to be deflected by human rights considerations.

Ten years ago the Brandt report noted that the most dynamic transfer of sophisticated equipment and technology from rich to poor countries was arms. Three quarters of British exports of arms in 1991 went to the Third World. In 1985 world military expenditure topped $1000bn, a sum greater than the combined gross national products of China, India, and all African countries south of the Sahara.[3] The annual budget of the World Health Organisation amounts to only three hours of spending on arms. And despite the rhetoric about restraint after the Gulf war the United States earned $41bn from arms in 1991 (10% of all exports). Half of all scientists in the developed world are involved, directly or indirectly, in arms technology.

We have scarcely begun to count the costs for the poorest people on earth of this malign interaction between militarism and structural adjustment. We can hope that articles like Logie and Woodroffe's will stimulate health professionals to testify to what they witness in their clinics worldwide and thus help pressurise Western policymakers to confront the human consequences of their philosophies.

DEREK SUMMERFIELD

Medical Foundation for Care of Victims of Torture,
London NW5 3EJ

1 Logie D, Woodroffe J. Structural adjustment: the wrong prescription for Africa? *BMJ* 1993;**307**:41-4. (3 July.)
2 Sivard RL. World military and social expenditures. *World Priorities* 1987:28-31.
3 Sidel V. Socioeconomic effects of the arms race. *Prev Med* 1987;**16**:342-53.

Traditional medicine has much to offer

EDITOR,—Dorothy E Logie and Jessica Woodroffe conclude that dogmatic persistence with certain economic ideologies is the wrong prescription for Africa: "structural adjustment" is resulting in a serious erosion of health care services in Zimbabwe, and the resulting "brain drain" of health staff is raising fears that the health service is in danger of collapse.[1] It is surprising that the authors do not mention African traditional medicine; this has been providing preventive and, occasionally, curative health care for over 1000 years and in Zimbabwe has achieved formal recognition by the government as a provider of health care (the Zimbabwe National Traditional Healers Association is the local equivalent of the General Medical Council).[2]

Traditional medicine is the principal, and often the only, form of health care for most Africans; up to 80% of all episodes of illness are treated mainly by traditional healers.[3] Traditional healers, like general practitioners in the United Kingdom, are ideally placed to treat the psychosocial problems that afflict most people seen in primary care, not least because provision of health care is inseparable from people's religion and philosophy of life.[4] Furthermore, for some health problems traditional health care is more cost effective than official health care.[5] Thus further collaboration between traditional and modern medicine is vital if Africa is to achieve the World Health Organisation's goal of health for all by 2000.

I and colleagues in Zimbabwe are engaged in an epidemiological study of primary care in Zimbabwe (including primary care centres and faith and traditional healers); descriptive studies of explanatory models will lead on to epidemiological and outcome studies of different types of care, and we hope that we will identify which patients benefit from the different services.

Doctors should reconsider the flaw in their attitudes to the developing world—that everything developed in the West is inherently preferable to the local alternatives—and should be less dismissive of things non-scientific or traditional.

VIKRAM PATEL

Institute of Psychiatry, London SE5 8AF

1 Logie DE, Woodroffe J. Structural adjustment: the wrong prescription for Africa? *BMJ* 1993;**307**:41-4. (3 July.)
2 Chavunduka GL. ZINATHA: the organisation of traditional medicine in Zimbabwe. In: Last M, Chavunduka GL, eds. *The professionalisation of African medicine.* Manchester: Manchester University Press, 1986:29-50.
3 Chizuwie J, Ukoli F, Okojie O, Isah E, Eriator I. Traditional practitioners are here to stay. *World Health Forum* 1987;**8**:24.
4 Mutambirwa J. Health problems in rural communities in Zimbabwe. *Soc Sci Med* 1989;**29**:927-32.
5 Jilek WG. Traditional medicine relevant to psychiatry. In: Sartorius N, de Girolamo G, Andrews G, German G, Eisenberg L, eds. *Treatment of mental disorders: a review of effectiveness.* Washington: American Psychiatric Press, 1993:341-83.

Overpopulation and overconsumption

EDITOR,—In his editorial on overpopulation and overconsumption Richard Smith fails to look beyond the appearance of the global problems.[1] Discussions of these issues usually start from the assumption that there are too many people and not enough resources to go around and proceed to the conclusion that the population must be smaller.

Overpopulation and overconsumption have become overused and ill defined terms. As with so many social concepts today, their meaning has become more implicit than literal and the assumptions therein are subjected to little critical investigation. For instance, certain areas of the world are relatively overcrowded, which places serious strains on the existing infrastructure, but this does not mean that the world is overpopulated. Certain population groups consume a proportionately larger share of resources, but this does not lead to the conclusion that overconsumption is the main problem.

A population may or may not place strains on the economy. The inability of an economy to provide a certain standard of living may be due to an absolute shortage of realisable resources—in which case the population becomes unsustainable—or to the structural faults of that economy—in which case the ability of that society to change its economic organisation becomes the deciding factor.

Though I agree that "deforestation, soil erosion, water shortages, and desertification" are typical of many Third World areas today, I disagree that the main cause is population growth. Population growth is not the single determinant of a society's wellbeing. The starvation visited on some of the richest rice growing areas in Asia during the colonial years was more to do with their harsh

exploitation by the imperial powers than any population explosion. Today, as Third World countries become more marginalised in the world economy and less able to maintain debt repayments it is their desperation, poverty, and stagnation that determine their inclusion in the "developing" world. While the world economy leaves millions with no access to clean water or medical or food supplies and pays Western farmers to leave productive land fallow, Smith highlights the "evidence . . . that many women are crying out for access to contraceptives."

Population must be kept "on the agenda . . . from the United Nations to the village council," but until the prevailing assumptions are replaced with critical scientific, social, and political investigation there will be no solutions.

ANDREW M WELCH

Unit of Health Care Epidemiology,
Department of Public Health and Primary Care,
University of Oxford,
Oxford

1 Smith R. Overpopulation and overconsumption. *BMJ* 1993;**306**: 1285-6. (15 May.)

Health care in London

Political motives fuel assault on London

EDITOR,—There has been considerable discussion in the *BMJ* about the effects of the Tomlinson report on health care in London,[1] and, particularly, about the findings of Brian Jarman.[2] The general consensus of correspondence has been that Tomlinson was grossly misinformed. I have also sensed, however, that doctors working outside London see this as some kind of local squabble.

It needs clearly stating that the assault on London is an assault on the whole health service. If St Bartholomew's, St Thomas's, and Charing Cross Hospitals can be closed anything can be closed. The methods by which this is being done have a purely political logic. A report is hurriedly prepared, amid various versions of secrecy, by hired placemen. The responses are formally noted but not acted on. After the publicity about the government's response to the Tomlinson report[3] everything has gone underground and implementation groups have been set up. These meet, listen to contributions, but take no notice. They are encouraged to consider services as if starting afresh on a green field site, and wholly unrealistic proposals can therefore be made without any consideration of the financial consequences.

For example, the proposal to close the accident and emergency department at St Bartholomew's Hospital is based on grossly inaccurate data and a map of small parts of London plotted by people with tunnel vision; it is viewed with horror by all local general practitioners, the police, residents, and people working in the city. The dominant myth that London has 15% of the country's population but uses 20% of health funds takes no account of London's costs, tertiary referrals, or the extensive inflow of non-Londoners to London's services.

Hurried reports, ignored comments, backstage decision making, and the overriding political principle of privatising the health service will spread outside London. And don't think you will get the funds "released" by closures in London: they won't exist.

T H TURNER

Division of Psychiatry, Hackney Hospital,
London E9 6BE

1 Tomlinson B. *Report of the inquiry into London's health service, medical education and research.* London: HMSO, 1992. (Tomlinson report.)
2 Jarman B. Is London overbedded? *BMJ* 1993;**306**:979-82. (10 April.)
3 Department of Health. *Making London better.* London: DoH, 1993.

Number of beds in Tower Hamlets in February 1993 (planning population 172 000) compared with number needed

Service	King's Fund's estimates of beds available	No needed according to norms in Britain	Actual No in Feb 1993	25% extra recommended by NE Thames RHA*	Shortfall
Hospital:					
General medicine	141 (0·82/1000)	76 (0·44/1000)	75 (+up to 10 in admission ward)		-1 to +9†
General surgery	101 (0·59/1000)	79 (0·45/1000)	50		-29
Care of the elderly	182 (1·06/1000)	238 (1·38/1000)	229	60	-9 to -69
Community:					
Nursing home	156 (0·91/1000)	466 (2·71/1000)	15		-141 to -451
Welfare home		720	350	180	-370 to -550
Total shortfall					-539 to -1100

*North East Thames Regional Health Authority recommended that districts in inner London should be allowed 25% more beds for care of the elderly and in welfare homes than the norms in Britain.
†If all 10 allocated beds are taken up there are nine extra beds; if none are taken up by general medicine shortfall = -1.

Playing with numbers

EDITOR,—The debate about the future of London's health services has polarised between staff in threatened units, who oppose Tomlinson's reforms, and a much larger alliance of those in London's primary care services and those in provincial hospital services, who think that they might benefit from the consequent redistribution of resources. It would be a tragedy if the solution were to be arrived at by such crude arithmetic. The proposed closures of hospitals in London are based on two assertions: that London has too many hospital beds and that specialised units should always be located in general, rather than single specialty, hospitals.

I have never heard a doctor in London testify that getting a patient admitted to hospital was as easy as would be expected if there were too many beds, nor has anyone satisfactorily shown that London's hospitals are full of people who would not be there if community or primary care facilities were improved. The alleged excess of beds in London is a mathematical abstraction rather than a medical one—and one that has not fully recognised that capital cities and large conurbations may be sufficiently different from the provinces for simple comparisons to be invalid.

Should highly specialist units always be part of general hospitals? Being able to establish a team from the various disciplines and specialties of a general hospital has undoubted advantages, but should this be an invariable rule? One of the lessons to be learnt from the managerial changes in the NHS is that units should concentrate on what they are good at—in other words, decide what their "core business" is and then marshall all their resources for that. It may therefore be appropriate to have a small number of specialist units in which the core business is working at the frontiers of national and international progress. The assumption that the transfer of such units to a management dedicated to more general aims will not be to the detriment of standards may prove to be folly.

I hope, therefore, that the indecent haste that has characterised the introduction of many of the recent reforms of the NHS will not be maintained in the "rationalisation" of London hospitals. Though there has been no shortage of committees and working parties considering London's health services, the proposed solution remains untried theory and alterations and modifications should be considered. To get it wrong would be not just a disaster for Londoners but to the detriment of medical standards generally.

M F H BUSH

Allington NHS Trust,
Ipswich IP1 3PY

Elderly people forced out of Tower Hamlets

EDITOR,—Acute and long stay beds were reviewed last February as part of the planning for a low technology ward in Tower Hamlets.[1] The table shows the specific requirements in acute general medicine, surgery, and care of the elderly and for nursing home and welfare beds for the planning population of 172 000.[2,3]

The district was 79-94 beds short for these services, depending on the criteria used, but we hoped that the 29 surgical beds would be reprovided in 1993-4. Provision outside the hospitals was shown to be the real problem. Altogether, 466 nursing home beds were needed on the basis of norms for the United Kingdom and 156 on the basis of estimates by the King's Fund; we have 15. Welfare homes should provide 720 places whereas we have 350 (data from social services). Overall, therefore, Tower Hamlets lacks between 500 and 1100 long stay beds.

Social services controllers tell me that each year Tower Hamlets struggles to "export" about 230 people for long stay care to homes all over England. Survival averages three years, so that about 690 people are being looked after away from their community. Twenty to 45 patients overflow from acute medicine at any time, so we are managing our acute beds well in the face of the lack of accessible beds in the community in our area.

A statement of this bed situation was given to executives of both the health authority and the Royal London Trust. I have received no criticism of the figures, and the low technology ward will open with 20 additional beds in September.

I wonder whether the local population realises that elderly and disabled citizens are being forced to move away from Tower Hamlets for residential care. I hope that the Community Care Act will provide more opportunity for patients who would wish to be cared for nearer their homes and families to say so and result in improvements in the nature of provision.

Finally, it cannot be appropriate to close more hospital beds in a district in this situation.[4] This cannot be done without increasing the problems of caring for local people who are acutely ill, and I hope that it will not happen until the problems outside the hospital's control have been solved, not swept under the carpet.

B J BOUCHER

Medical Unit,
Royal London Trust,
London E1 1BB

1 Jarman B. Is London overbedded? *BMJ* 1993;**306**:979-82.
2 King's Fund Commission on the Future of London's Acute Health Services. *London health care 2010.* London: King's Fund, 1992.
3 Boyle S, Smye C. *Acute health services, London: an analysis.* London: King's Fund, 1992.
4 Tomlinson B. *Report of the inquiry into London's health service, medical education and research.* London: HMSO, 1992.

Correction

Reducing serum cholesterol

An editorial error occurred in this letter by Uffe Ravnskov (10 July, p 125). The last two figures on the x axis should be 100 and 225, not 80 and 85.