social services continues to fall—down 40% since 1993.[7] There has been a great deal of policy commentary on this transfer of financial responsibility from the state to older people in the lower to middle income range, who may be struggling to afford to purchase care and are often deterred by payments.[8 9] Asking people to pay for elements of their care assumes that they will exercise choices in ways that maximise their own wellbeing, largely uninfluenced by social and other considerations, but this is often not the case.[10]

Such evidence begs the question: do we want a system that offers greater equity of access to help ensure that care needs are met, as the majority commissioners argued? Or do we continue to leave this to the market as the government decided for those with means? There are different distributional effects, for both finance and provision, in the two positions. The minority commissioners and the government argue that they have maintained a level of private finance, to the tune of £1.1bn, from those individuals with means so they can focus a publicly funded safety net on those without. The main counterargument, from the majority commissioners, is that the current settlement seems to be unfair compared with NHS policy—equal needs are clearly not being treated equally[11]—and in our own research we have found that 60% of the public believe this situation to be unfair.[12]

So, in the ever more complicated policy jungle boundaries between public and private finance and provision of traditional welfare services are becoming increasingly blurred. Within this blurring, though, important trade offs are being made. The lesson from long term care shows that New Labour tends to favour greater equity of finance to equity of access when it is given the choice

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A firm foundation for senior house officers

Foundation programme will provide a focused educational experience

Modernising Medical Careers highlighted changes that will reform the senior house officer training grade in the United Kingdom.[1] Implementing these long overdue reforms has wide ranging implications for all training posts,[2 3] as outlined in the latest guidance on all training programmes in *The Next Steps*.[4] The main thrust is for doctors to begin their careers with a two year foundation programme. Thereafter they move on to specialist training grades running through to consultant level. This "run through" period would be shorter than the current training period and competency based.

Introducing the foundation programme represents a fundamental change for the senior house officer grade. From August 2005 all medical graduates will undertake an integrated planned programme of general training. The first year will be similar to the current preregistration year and will include full registration. The second year offers doctors further generic skills training in a mixture of specialties. The end point is to have competent doctors who are able to recognise and manage acutely sick patients and are ready to enter specialist training.

Many hospital departments currently rely on the service commitment of 20 000 doctors in the senior house officer grade. Some will be hard pressed to release more service time of junior hospital doctors and their supervisors to create time for education. Thankfully, some helpful resources are available to increase educational value in service, such as the thoughtful *Liberating Learning*, which works along similar principles to the "one minute preceptor model."[5 6]

Uncertainty surrounding the future contribution of overseas doctors, who currently make up a sizeable proportion of the senior house officer workforce, also affects planning for service provision in hospitals and at what point they enter training grades.

In order to enter the "run through" training grade, senior house officers will now have to demonstrate to an educational supervisor that they have achieved the foundation programme competencies. These are similar to those contained in the publication *Good Medical Practice*.[7] They will have a record of in training assessment (RITA) similar to that already in use in specialist training.

Among many challenges to achieve the goals of the foundation programme are the practical issues in creating enough foundation year 1 posts for the foundation year 2 posts and allowing space in foundation year 2 for overseas doctors who already have registration.

Issues about the curriculum and competency framework need addressing. What assessment methods will be used to decide if a doctor has achieved the competency? Who is best placed to make that assessment? It clearly does not always have to be the consultant, but it does

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have to be someone who is qualified and trained to make that judgment. Those supervising foundation year doctors need ongoing training in assessment and appraisal of clinical and non-clinical competencies.

Any assessment will have a failure rate and also an appeals process, so departments will want to know that their own systems are robust even when following the contents of the national curriculum for foundation programmes.

Medical schools should innovate in preparing for the foundation years. Increasingly, students are sitting final examinations up to six months before they qualify. This offers an ideal opportunity to develop the foundation competencies, especially those of working with non-medical colleagues.[8] By harmonising the learning objectives and competency frameworks in this period of advanced clinical practice medical schools can facilitate a focused start to the foundation programme.

Overemphasis on asking foundation programme doctors to develop specialist skills may well cause the programme to backfire. Despite pressure to train doctors for more complex tasks in shorter times, we should not target any individual doctor's foundation programme at only one career path. To do so could erode the real strength of the foundation programme, which is to ensure that all doctors have attained a broad competency level in patient care and that those competencies can be demonstrated. The foundation year 2 ethos is to give doctors greater exposure to more specialties, as previous studies have shown that a substantial number of doctors change their career preference during the senior house officer period.[9 10] Broad based programmes of the foundation years are intended to "support movement of doctors into and out of training and between training programmes."[11] Any progression along the path of specialist training should be seen as an opportunity, not a requirement. The postgraduate medical education and training board (PMETB) has ruled out prospective approval for specialist training in foundation year 2 but indicated that individuals may apply retrospectively to accredit time spent in foundation year 2 in their specialty.

High quality career advice should be delivered as a service that starts at medical school and extends throughout training. We risk high attrition rates if students and junior doctors continue to lack a robust career guidance package. Doctors will have to apply for "run through" specialist training mid way through foundation year 2, when they may still lack postgraduate exposure to the very specialty they are considering.

The foundation programme will cause logistic problems as we strive to reform the senior house officer grade from its rudderless, open ended, service driven, current status to a focused educational experience. The current pilot programmes will reveal something about how foundation programmes meet the original intention of providing "individually tailored programmes to meet specific needs," and their evaluation must be widely disseminated.[10]

Challenging though it is, the foundation programme offers an opportunity to reshape the delivery of health care. Doctors in training need to be convinced of the benefits of the new scheme, and all those who will deliver this new agenda must be trained to do so. Short term costs must be borne if we are to achieve the longer term vision of quality assuring the holistic competence of the future medical workforce.

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Tackling the next influenza pandemic

"Ring" prophylaxis of close contacts with antivirals may be an effective strategy

Recent efforts have been directed towards preparing rapid effective responses to epidemics of smallpox and severe acute respiratory syndrome (SARS). We must now hasten the preparations for another inevitable threat—the next global influenza pandemic. Currently contingency plans are largely based on rapid vaccination of susceptible populations; other measures, such as treatment with antiviral drugs, serve only as adjuncts.[1] In practice, however, technical constraints on vaccine production—foremost among these the time required to initiate mass vaccine production during a pandemic—will limit the effectiveness of this measure in the first stages of the pandemic.[2] Recently a systematic review by Cooper et al addressed the effectiveness of neuraminidase inhibitors in the treatment and prevention of influenza.[3] The authors concluded that the prophylactic use of these drugs can lead to a reduction of 70-90% in the risk of laboratory confirmed symptomatic flu, depending on the strategy adopted and the population studied. Neuraminidase inhibitors have also shown efficacy in preventing transmission of influenza in institutions and community

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