AIDS spreads eastward

While the AIDS epidemic may be slowing in Western countries, the view to the east is threatening. "In some Asian countries there has been a dramatic rise in seroprevalence during the past year, suggesting that the spread of the pandemic may be far greater than we thought," said Dr Michael Merson, director of the World Health Organisation's global programme on AIDS, speaking at the seventh international AIDS conference in Florence. Infection has spread extraordinarily rapidly in India and Thailand. In just three months WHO has doubled its estimate of the number of people infected in the whole of Asia from 500 000 to one million.

"Our projection to the mid-1990s is for three million infected people in south and South East Asia. By the year 2000 we will see more than a quarter of a million cases of AIDS each year in Thailand and India. By 2000, 90% of infections with HIV will occur in heterosexuals in developing countries. This will have a major impact on development and child survival," said Dr James Chin, an epidemiologist from WHO.

"In India we are sitting on top of a volcano. Madras, Bombay, Calcutta, and Delhi were first affected, but now AIDS is in many parts of the country, including an especially high rate in Manipur on the border of the Golden Triangle," said Professor Vulimiri Ramalingaswami of the All India Institute of Medical Sciences. In October 1989 only one blood sample from the area gave a positive result on testing, but eight months later 54% of 1500 blood samples were positive. From the drug trading area of the Golden Triangle AIDS could spread to Myanmar (formerly Burma), Laos, Vietnam, and southern China. Thailand already has a serious epidemic.

Prostitution is a big problem in India. Swaminathan Sundararaman of the Institute for Social Affairs said, "Prostitution occurs for economic reasons or due to coercion. Vaginal sex is easily available, but there are religious proscriptions against oral sex. Anal sex is often requested, and the cost is the same as for vaginal sex (about £1). Prostitutes don't think about condom use for protection because condoms have always been promoted in India only for family planning."

Prostitutes often move along main roads used by truck drivers, where there are no facilities for washing. "They have no power to negotiate safer sex. We need to reach their clients, the truck drivers." His organisation distributes keyrings containing condoms to truck drivers.

"In Thailand the situation is very serious," Dr Merson said. The prime minister's office recently raised its estimate of the total number of Thais infected from 300 000 in December 1990 to 400 000. It estimates that about 6% of men with sexually transmitted diseases and more than 15% of prostitutes are seropositive. The seropositivity rate among recruits to the Thai army rose from 2% to 6% between June and December 1990.

The epidemic in Bangkok is mainly due to intravenous drug misuse, according to Dr Don Des Jarlais, a New York expert on drugs who is a member of the US National Commission on AIDS. He compared drug misusers in Bangkok and New York: the seroprevalence in both cities has stabilised at about 50%. "In Bangkok, 90% of drug injectors are males. The problem is that they pay for prostitutes, who can then transmit the disease." The main risk factors for drug addicts are imprisonment and sharing injection equipment when in prison.

The only good news was that there has been a rapid change to safer behaviour in Bangkok recently. "Now 92% of Bangkok drug addicts use safer injection techniques—sterile needles are not free but can be bought in pharmacies." In contrast, in Dr Des Jarlais's native New York, "risk reduction for addicts means buying sterile injection equipment on the black market because needles are not legally available without a prescription."—JANICE HOPKINS TANNE, contributing editor, *New York* magazine

RON GILLING/PANOS

Seropositivity for HIV trebled among Thai army recruits last year

Hazardous waste

General practitioners are in a prime position to pick up evidence of exposure to hazardous waste and may be the first to suspect a problem, says a BMA report published this week. All doctors need more training in environmental medicine to recognise adverse effects when they occur. Doctors should also take a lead by disposing responsibly of hazardous clinical waste.

The report, prepared by the BMA's board of science and education, presents evidence of the ill effects of contaminated water, food, land, and air. The board calls for a national environment protection executive to oversee all aspects of managing hazardous waste and to draw up a national strategy for waste.

Too little epidemiological research on waste is done in Britain compared with the US, says the report. British cohort studies on people working with waste would improve the accuracy of risk estimates. And a freedom of information act, which Britain lacks at present, would mean that data on toxic substances could no longer be withheld on grounds of commercial secrecy or national security.—FIONA GODLEE, *BMJ*

BMA. *Hazardous waste and human health.* Oxford: Oxford University Press, 1991. Price £6.99.

Headlines

Fall in "worst" waiting lists: As a result of the work of the Inter-Authority Comparisons and Consultancy Team led by John Yates the number of patients waiting over a year between December 1989 and March 1991 fell by 43% and those waiting under a year fell by 5%.

Adoptions abroad: Revised guidelines from the Social Services Inspectorate set out the criteria that local authorities should use to assess people hoping to adopt children from overseas. The same criteria should apply to them as apply to people hoping to adopt children from the United Kingdom. There should be a maximum of six months for preparing, counselling, and assessing prospective adopters.

Call for boycott of General Electric: International Physicians for the Prevention of Nuclear War has joined CND in calling for a boycott of General Electric, which they are urging should stop producing nuclear weapons. General Electric is the largest supplier of medical equipment in the United Kingdom, with 37% of the market.

First aid ignorance: Only a quarter of the 4000 motorists questioned by St John Ambulance recently knew how to deal with victims of road accidents. Fewer than 200 had taken any form of first aid course in the previous three years. The organisation recommends a two hour course for all motorists with refresher courses every two years.

Vote for longer drug patents: The life of drug patents in Britain (currently 20 years by law but about 10 years in practice) may be changed to 16 years if a proposal by the European Commission is upheld. The British government's plan for a reduction to 13 years, overruled recently by a Commons committee, may now fail.

Manifesto for the disabled: Thirteen charities have produced a manifesto to try to get a fairer deal for Britain's six million disabled. They call for action on legislation against discrimination, disability benefits, community care, health services, employment and training, and leisure and access.

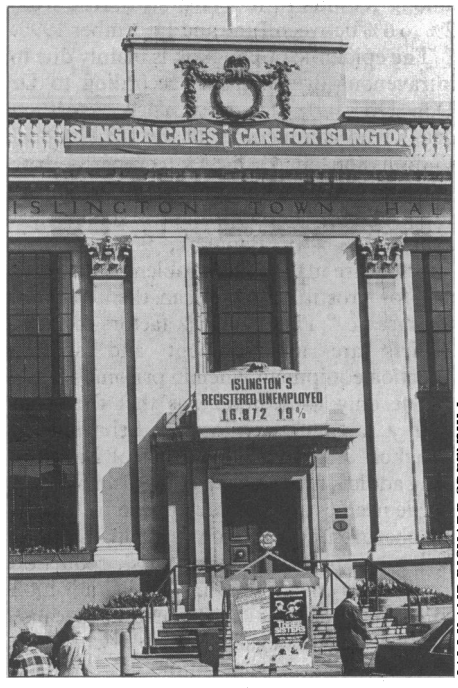
Women's health: Women's health is being promoted actively in the United Kingdom as well as the US (p 1560). The Department of Health has just published a guide to women's health services, both NHS and voluntary. Free copies are available from Women's Health Freepost, Bristol BS3 3YY.

Local authorities and health: think tank proposals

Local authorities would combine responsibilities for health and social care, rendering district health authorities and family health services authorities redundant, if recommendations by the Institute for Public Policy Research were adopted.

The institute's latest social policy paper, *Health before Health Care*, starts with the now ritual assertion that recent health policy has been dominated by an unhealthy concentration on health services. It prefers the concept of "health field" rather than health care systems because "health improvement (or gain) cannot be achieved by health care services alone." It demands "a reorientation of the role and scope of public policy and an acknowledgment that many other services and sectors have a vital contribution to make." The World Health Organisation targets for Health for All by the Year 2000 are enthusiastically endorsed, as is the Public Health Alliance's report *Beyond Acheson: an Agenda for the New Public Health.*

Under the new proposals separation between purchasers and providers would be retained, with local authorities becoming the purchasers (or commissioners) of care. The new arrangement would avoid "the difficulties inherent in basing funding and organisational responsibilities on a distinction between health and social care which is difficult to define and sustain." Needs assessment would provide information on where changes to health and social services were required. Local groups would be directly involved, ensuring that "service strategies are not profession-led but are user-driven with the focus on outcomes which result in health gain, rather than on service development and norms which may be wholly inappropriate."



SALLY AND RICHARD GREENHILL

Should local authorities care for health too?

NHS provider units would become the local arms of the NHS Management Executive, which would be reconstituted as a "next steps" agency. (The next steps initiative was launched in 1988 to improve management in the civil service.) Self governing trusts and budget holding general practices would go. General practitioners would continue to be self employed but would have a contract with the local authority.

What is currently the NHS Policy Board of the Department of Health "would presumably operate under a Cabinet health and social care committee recognising the wide range of central government departments and functions involved in the health status agenda." A single department would have to take clear responsibility for pushing through such an agenda. Though the Department of Health would be one candidate for such a task, "a more radical option might be to give that lead role to the Department of Environment reflecting its twin responsibilities for local government finance on the one hand and the environment on the other."

The authors, who are all associated with the Nuffield Institute for Health Services Studies at the University of Leeds, "make no pretence that [they] have found the perfect solution to the alleged health 'crisis.'" They are unsure whether the term crisis is correct, but "the pathologies to which it refers are not in our view susceptible to a solution through a strategy of 'more of the same.'"—TONY DELAMOTHE, *BMJ*

Health before Health Care is available from the Institute for Public Policy Research, 30-32 Southampton Street, London WC2E 7RA, price £7.50.

Telling it from the hip

An 82 year old German man with bilateral osteoarthritis of the hips has been helping in designing better prosthetic joints. In April and August 1988 the man received two artificial hip joints at the Oskar-Helene-Heim Hospital of the Free University of Berlin. Inside the necks of both prostheses sensor units had been installed to measure temperatures and spatial forces acting on the hip joint during walking and other exercise. A tiny radiotransmitter passed the collected data to a computer nearby.

Dr Georg Bergmann, reporting on his team's research in Berlin, explains that the sensors were intended to provide more and better information on what is going on in prostheses under physical and thermal stress. The aim is to establish a baseline for further research on and improvements in the design of prostheses.

Attempts have been made before to obtain data on the forces placed on human joints. Since 1966 British and American orthopaedic surgeons and bioengineers have tried implanting such sensors into artificial hip joints. But the battery packs and telemetry units used did not fit into the joint and had to be implanted into soft tissue. Measurements were limited to a single force component in the direction of the prosthetic neck.

Advantages of the new miniaturised im-

ULRIKE PREUSS/FORMAT

High tech could help their hips

plant are obvious. All of its parts fit into the hip joint, it needs no toxic batteries, and it does not have to be removed later. The sensor's circuitry, radio transmitter, and internal power source—a secondary inductive coil—are encapsulated in a metal cylinder 25 mm long and 8 mm in diameter. Three semiconductive strain gauges outside the cylinder are connected to the inner wall of the prosthesis to pick up information on the three dimensional forces acting on the hip. Another sensor registers temperatures inside the femoral head. The collected data are transmitted by four channel telemetry to a receiver outside the patient's body. A computer processes the signals and prints graphs indicating hip loads as a percentage of body weight. An external primary power coil fixed to a belt around the patient's thigh provides the energy to activate the capsule.

Research on the hip sensor has already yielded some interesting results. At walking speed peak loads on the hip joint reached 300-355% of body weight. During jogging at about 6 km/h average loads at 475% of body weight were found. Peak loads at running speeds are, presumably, still higher, but the doctors did not ask their elderly patient to try running.

The study also showed that soft shoes or walking on soft ground do not reduce maximum forces on the hip joint during normal walking. Impact forces on the hip depend much more on how a person walks than on the properties of the ground or shoe.

Finally, the temperature measurements have provided new insights into the function of hip prostheses. The peak temperature in a ceramic femoral head, as was used in the study, may reach 42·5°C. Metal heads could become some 2°C hotter. The biological consequences of this must still be investigated but Dr Bermann warns, "It seems certain that jogging long distances with an implant with a metal head must be avoided."—HELMUT L KARCHER, science writer, Munich

Equal treatment for equal need

Many studies have concluded that the rich receive a greater share of NHS spending than the poor and than their general level of illness suggests they should. This conflicts with one of the tenets of the NHS—that everyone is entitled to equal treatment for equal need. But new research from the Centre of Health Economics at York University suggests that rich and poor differ very little in their share of NHS spending compared with their general level of ill health.

Measuring "equity" (and even arriving at an agreed definition of what is meant by the term) is difficult. Previous studies, however, have compared the proportion of the NHS budget spent on different income groups in the population with morbidity in these groups. They found that the less well off in the population had more illness and that, even though they received a proportionately greater share of NHS spending, it was not enough to match their high morbidity (fig 1).

When the authors of the new study used the same methodology they too found that, for different measures of ill health there is inequity in NHS spending that favours the rich.

But there is a problem with this methodology. Previous results are overturned if a different and, it is claimed, a more sophisticated methodology is used. The problem lies in the fact that because there are relations between, for example, age and the level of NHS spending and because the age structures of different income groups vary, failure to standardise the NHS expenditure data can lead to underestimates of the shares of NHS spending devoted to lower income groups.

The researchers in York adopted an approach similar to that used by epidemiologists when standardising crude mortality for age and sex variations. By standardising each income group's share of NHS spending by using variables such as age, sex, and morbidity they produced a new distribution of the shares of NHS spending by income group.

Figure 2 shows a typical pattern of spending after standardisation. If all income groups received a share of NHS spending in strict proportion to their share of morbidity as well as to their age and sex structures then all the bars on the graph would be the same height (that is, at a standardised 20%), but the figure shows inequity—but now favouring the poor.

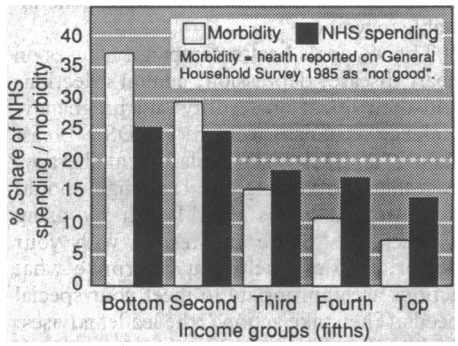


FIG 1—*Morbidity and NHS spending by income group, 1985*

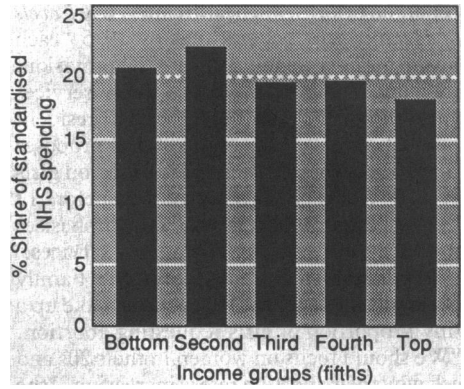


FIG 2—*NHS spending by income group standardised for age, sex, and various measures of ill health (1985 data)*

When private health care spending is included in the equity analysis, the distribution of spending is less skewed towards the poor because most of the spending on private health care is for the rich. The researchers note that while total spending in the private sector is relatively small, it substantially affects the distribution of health care in Britain.

The researchers also looked at equity in terms of the financing of health care in Britain (which, given the high proportion of funding from general taxation, boils down to a study of the tax system). They concluded that the distribution of tax payments contributing to the NHS is broadly similar to the distribution of gross income.

Though still open to refinements, this new method of assessing equity—especially since the introduction of the NHS reforms—should prove to be useful in monitoring governments' commitments to equal treatment for equal need, regardless of ability to pay.—JOHN APPLEBY, economic correspondent, *BMJ*

An Empirical Study of Equity in the Finance and Delivery of Health Care in Britain. Discussion paper 85. Centre for Health Economics, University of York, price £4.50.

Abortion rates still rising

The number of women having abortions in Britain has more than tripled since the introduction of the 1967 Abortion Act. Nearly a quarter of the abortions performed in 1989 were on women who had already had one termination, compared with 8% in 1977. These figures are included in a report by the Office of Population Censuses and Surveys (*Population Trends* 1991;**64**:19-29), which concludes that changing attitudes to abortion among both doctors and the public have contributed to the rise in the abortion rate. The largest increase in rates has occurred among women aged 20-24.

The proportion of terminations under nine weeks has doubled since the late 1960s while those taking place between 13 and 16 weeks has halved.

This is a trend of which the Faculty of Public Health Medicine approves. In its first

report on priorities in health care—*UK Levels of Health*—it advocates that by 1995 "each health authority should ensure the provision, free under the NHS, of abortion services appropriate to the needs of its resident population." By the year 2000 it proposes that 90% of the abortions performed on girls aged 15 years should be performed before 13 weeks' gestation. The report also emphasises the need for better family planning services.

According to Ruth Grigg of the Family Planning Association, 15 year olds make up a tiny proportion of girls requesting abortion. "We should focus on women in their 20s and ask why their abortion rate is increasing," she says. "One reason is that this generation of women is the first to have grown up in an atmosphere of legal abortion. The figures show that it took women a long time to get used to abortion being legal and to use this service. Abortion still has a stigma attached to it."

Another reason for the rising abortion rate, according to Ruth Grigg, is the lack of availability of emergency contraception. "Family planning services are still not seen as a priority," she argues. "We should have weekend clinics to dispense the morning after pill. We tell women that they must treat unprotected sex as an emergency and if necessary call their general practitioners to get postcoital contraception."

Britain lags behind other European countries in its abortion laws. France offers abortion on demand for women up to 12 weeks pregnant. A recent Harris poll showed that most British people would support a similar change in British legislation (22 June, p 1484). This would mean a woman would not have to ask her general practitioner for permission to have an abortion.—LUISA DILLNER, *BMJ*

UK Levels of Health, is available from the Faculty of Public Health Medicine, 4 St Andrew's Place, London NW1 4LB, price £5.90.

Women's health campaigns in US

Women's health issues are suddenly hot news in the United States, with health promotion and research campaigns being started by the American Medical Association (AMA) and the National Institutes of Health (NIH). Unlike previous campaigns against smoking and cholesterol, for which the push came from doctors and scientists, support for women's issues came from politicians.

"We have enough women in Congress to have clout," says psychiatrist Margaret F Jensvold, who spoke about depression at the launch of the AMA's campaign. The Congressional Caucus on Women's Issues is headed by representatives Patricia Schroeder and Olympia Snowe and is composed of about 150 members of Congress. The fact that women now hold two top posts in public health—Dr Bernardine P Healy is the new director of NIH and Dr Antonia Novello is the surgeon general—probably helps too.

JACKIE CHAPMAN/FORMAT

Men are still in front in the race for health in the US but this is set to change

Women have been excluded from many studies on the grounds that they might get pregnant and the treatment might harm the fetus. "Also, scientists see women as more complicated than men. The menstrual cycle is a confounding factor, and scientists like to have as few variables as possible," says Dr Jensvold. She heads the Institute for Research on Women's Health and is suing her former employer, the National Institute of Mental Health, for sex discrimination against her as a researcher.

"In AIDS research women's participation in clinical trials has been low, yet clinical trials are the best hope for survival," said Dr Deborah J Cotton of the Harvard School of Public Health at the AMA's launch. Furthermore, the standard case definition of AIDS does not include cervical cancer, vaginal candidiasis, or pelvic inflammatory disease.

Even for heart disease, the leading cause of death in women, "very little research specific to women has been undertaken . . . the perception of the disease as a man's disease causes many physicians, as well as patients, not to accept the possibility of heart disease in women," says Elaine D Eaker, head of the cardiovascular health branch at the Centers for Disease Control.

The AMA's women's health campaign is only the second such project it has launched—the first was "Count Out Cholesterol," which started in 1989. Medical research has often focused on men, says the AMA's council on ethical and judicial affairs, and the results "may not always be safely generalisable to women."

The women's health campaign focuses on heart disease, depression, genital infections and their effect on fertility and pregnancy, violence against women, AIDS, breast cancer, and oestrogen replacement therapy. A leaflet introducing the campaign should help women assess their health by using a checklist. "Share the results with your doctor, who can help you determine what actions are appropriate to meet your special needs. Then take action," the leaflet advises. It also offers discounts on video programmes on exercise, preparation for childbirth, and relief of back pain and on products from the campaign's sponsors (which include companies making frozen food, breakfast cereals, sanitary products, drugs, and a women's magazine). Campaign activities will include local medical and dental health awareness events and radio and television reports.

The National Institutes of Health, in response to Congressional pressure, has proposed tough new rules that require applicants for new grants to include women in their research studies unless the study is of an exclusively male disorder. Researchers can apply for additional new grants to improve the balance of existing projects—for example, by recruiting more women to studies. The institute's director, Dr Healy, has already announced a $500m 10 year women's health initiative to study problems affecting older women—cancer, heart disease, and osteoporosis.

The campaigns come at a time when there is considerable public interest in women's health. Last week NIH held public hearings at which 75 organisations pleaded for research into disorders that particularly affect women. Next year NIH will sponsor a national conference to recruit and encourage women in scientific careers.—JANICE HOPKINS TANNE, contributing editor, *New York* magazine

GMSC achieves joint review on contracting

A joint review committee of the Department of Health and the General Medical Services Committee is to monitor the effects of the contracting arrangements on all patients. The initiative for the review came from the GMSC, which at its meeting in May called for a full evaluation of the first wave of fundholding practices before the second wave proceeded. The committee was concerned at stories of fundholders purchasing services on a basis that was disadvantageous to patients in non-fundholding practices (25

May, p 1279). The GMSC's chairman, Ian Bogle, wrote to the secretary of state and a meeting was arranged with departmental officials. The new committee will comprise the committee's negotiators and officials.

Announcing what he called "a considerable triumph" and something that would not have been possible a few months ago, Dr Bogle told the local medical committee conference last week that the committee's remit would be wide and would look at all the effects of the NHS reforms. It would evaluate the problems created by and experienced by all doctors, whether they were fundholders or not.

Dr Bogle expects the evaluation to highlight where things are going wrong and hopes that there will be no more new fundholders until the monitoring has taken place. This is not the view of the department, which plans to push ahead. But it accepts that modifications may have to be made. Several independent evaluations of fundholding are taking place, and information from these will be made available to the review committee.

"This is not a change of policy and we have not changed our views," Ian Bogle emphasised to the conference and to the press. Representatives endorsed this view by supporting a statement made by the GMSC in September 1990 that fundholding in general practice would be detrimental to patients' interests and the NHS and resolving that it was unethical to give preferential access to hospitals to patients of fundholding practices (p 1610). Nevertheless, all agreed that the review committee was a step in the right direction and, coupled with the modifications to the general practitioner contract that Ian Bogle reported, shows that relations with the department have taken an upturn.—LINDA BEECHAM, *BMJ*

Australian medical research council revamped

A reshuffle of Australia's National Health and Medical Research Council (NHMRC) has broadened the body's representation and lessened the influence of the medical profession. With the new appointments the Minister for Health, Brian Howe, has focused the council's attention more closely on the problem of Aboriginal health and on ethical issues.

The council now includes a representative nominated by the Aboriginal and Torres Strait Islander communities, and a new health ethics committee has been set up, chaired by Ms Robyn Layton, a lawyer and former judge. Ms Layton headed the former National Bioethics Consultative Committee, which was disbanded and incorporated within the NHMRC.

The council's 29 members now include businessmen and consumer specialists as well as doctors and nurses. As a further indication of the increased "community" input to the council, three non-medical professors—of law, philosophy, and sociology—have been appointed.

Thirteen of the council are women, including Dr Diana Horvath, its chairperson. "The boundaries of health are getting broader," she says. "By adding more minds to the membership its perspectives will be wider. The changes will give us a richness and assist in alteration of directions."

Last August parliament decided that the council would become an independent statutory body. At the moment the council is only an arm of the Department of Community Services and Health, which can be disbanded without debate in parliament.

Mr Howe has pursued this goal despite opposition from within the bureaucracy and some medical researchers (13 April, p 867). Dr Horvath is playing down the importance of the change, saying that the former situation was "only a quirk." But observers are expecting the council to become more assertive with its new status.

Mr Howe's own influence in government was greatly enhanced after his election as deputy prime minister early in June. He succeeded the treasurer, Mr Paul Keating, who unsuccessfully challenged for the post of prime minister.

Mr Bob Hawke survived as prime minister mainly because of the support of the left wing of the Labor party, of which Mr Howe, a former Methodist minister, is titular leader. Traditionally the deputy prime minister is given free choice of portfolio and Mr Howe could well have accepted the vacant treasurership. He opted, however, to remain in Community Services and Health and his admirers in the medical world (excluding the Australian Medical Association, which has no love for any Labor minister) breathed a sigh of relief that the instability afflicting the government as a result of the leadership challenge did not spill over into their interests.

Meanwhile, in New South Wales the Liberal/National party has squeaked back into power as a minority government following a long drawn out counting of votes from the election of late May. The premier, Mr Nick Greiner, was chastened by the result, which was expected to give him a comfortable majority, and he completely reshaped his ministry.

The former minister for health, Mr Peter Collins, who had unsuccessfully fought a campaign within the cabinet against tobacco sponsorship and advertising (13 April, p 867), became attorney general. His former portfolio was split into Health and Community Services (Mr John Hannaford) and Hospital Management (Mr Ron Phillips).

Mr Greiner's rationale is that health policy and management matters can be handled better in separate departments, but there is widespread scepticism that this can work effectively. The antismoking lobby, for one, is not convinced that its cause will be advanced by the split of responsibilities.—PETER POCKLEY, science writer, Sydney

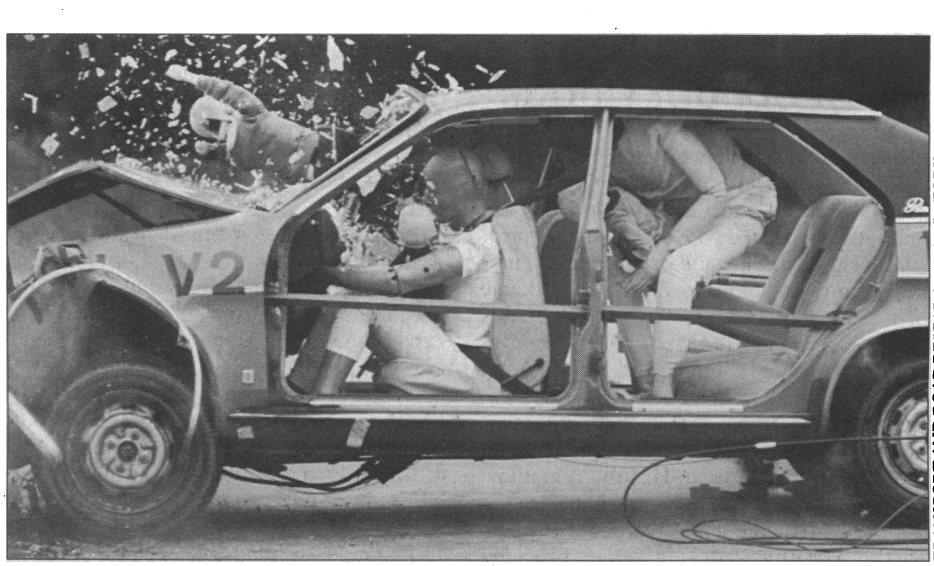
Belt up in the back

Adults in Britain are now twice as likely to be injured in the back of a car as in the front, because more than 90% of them have used front seat belts regularly since 1983. From 1 July adults will have to wear seat belts, if available, in the rear seats of cars and taxis. Children under 14 have been covered by similar legislation since 1989; those aged 14 and over will count as adults under the new rules.

Only 11% of all adult rear seat passengers use belts, although 20% of those who travel in cars with belts fitted are thought to wear them. The regulations will apply to 12 million cars already fitted with rear seat belts but not to those manufactured between October 1981 and October 1986 that have only anchorage points.

In 1989, 20 924 adults were injured in the rear seats of cars—3520 of them seriously—and 336 were killed. The new regulations should prevent up to 100 deaths and 1000 serious injuries each year. This would include the 11% of all injuries to occupants of cars that occur when unrestrained rear passengers are thrown forward on to those in the front. The Parliamentary Advisory Council for Transport Safety has calculated that an extra 50 lives a year could be saved initially if belts were fitted compulsorily in cars that have the necessary anchorage points.

The maximum fine for not using an available rear seat restraint, unless exempted on medical or certain other grounds, will be £100.—DAPHNE GLOAG, staff editor, *BMJ*



TRANSPORT AND ROAD RESEARCH LABORATORY

They'll all be wearing seat belts from next month

NHS coding centre opens

Classification systems are not the most exciting of subjects, yet they are crucial to organising information and making it accessible. This is as true of clinical codes and clinical data as it is of a library. For that reason the recent opening of the NHS Centre for Coding and Classification in Loughborough marks an important step in the NHS's new commitment to information recording, processing, and exchange.

In 1988 the joint computing group of the General Medical Services Committee and the Royal College of General Practitioners started examining coding systems for data from primary care. It found that most of the existing systems were designed solely for aggregating and analysing data and could not be used to enter a detailed enough diagnosis to form part of a clinical record.

There was one exception: the Read Clinical Classification, devised and developed by Dr James Read, a general practitioner in Loughborough, includes thousands of codes covering diseases, symptoms, investigations, drugs, referrals, and occupations. The joint computing group recommended its use for general practice and commended it for use throughout the NHS, and last year the Department of Health bought the copyright to the Read codes (*BMJ* 1990;**300**:1092). The classification system will now be maintained and developed further at the new coding centre, whose director is Dr Read.

The codes themselves are free, but users pay a fee (regulated by the Department of Health) to cover installation, support, upgrading. Two large suppliers of computers to general practitioners already use the Read codes and others are expected to follow soon. Hospitals are also increasingly using the Read codes as their initial codes, with automatic translocation to ICD 9 for statistical purposes. The establishment of the new centre should further promote the use of the Read system as a universal classification throughout the NHS. Today Britain: tomorrow the world?—LUISA DILLNER, *BMJ*

Urbanisation the worst of both worlds

Urban slum dwellers in developing countries suffer the worst of both worlds—the health risks associated with Third World poverty and those associated with the Western world, such as heart disease and drug misuse. Their plight and ways to improve it was the theme of a session of technical discussions at this year's World Health Assembly in Geneva, entitled "Strategies for Health for all in the face of rapid urbanisation". Britain was heavily represented—Sir Donald Acheson, chief medical officer, chaired the discussions, and staff from the Urban Health Programme at the London School of Hygiene and Tropical Medicine and Liverpool members of the Healthy Cities initiative provided background information.

LEWIS/NETWORK

Mexico City, where expanding population is shrinking prospects for health

In the past planners viewed urban dwellers as rich and well provided for compared with their rural counterparts. Improvements in health services focused on primary health care in rural areas. Now planners are realising that although hospitals in cities are expensive, they leave many of the urban population without access to health services. More importantly, lack of investment in urban planning and development has led to cramped and polluted living conditions for many.

Failing agricultural economies, rural population growth, and industrialisation are some of the pushes and pulls leading to the rapid growth of cities in many developing countries. "Megacities" include Mexico City, whose population is now about 20 million and is predicted to reach 31 million by the end of the century, and Calcutta, which will have over 16 million. National planners and international policy advisers have tended to neglect these demographic changes.

Now the poverty in some cities is becoming too obvious to ignore, with the burgeoning population leading to massive problems in sanitation, water supplies, rubbish disposal, and health service provision. Problems pile up for municipal authorities with limited funds, and national ministries are unsure how to collaborate with each other or how to help the urban poor. Slum improvements cost money—sewers and water systems require large investments for installation and recurrent budgets for maintenance. Many countries cannot make such improvements.

Integrated development in health services, urban infrastructure, water supply, waste disposal, and social programmes requires decentralised management. And the rapid expansion of the urban population demands effective population control policies.

Action is needed now on urban primary health care. Existing hospital resources could be used to reach out to poor communities but are already overstretched: new outpatient clinics in poor areas of cities may be more sustainable.—PAUL GARNER, Urban Health Programme, London School of Hygiene and Tropical Medicine

Learning on the job

A quarter of Britain's senior house officers took no study leave last year. Those who did take leave took only half their entitlement and incurred a third of the expenses claimed by consultants on study leave. These results, from a survey by the Standing Committee on Postgraduate Medical Education (SCOPME), show huge variations in the uptake and costs of study leave.

The committee's working group sent questionnaires to all hospital doctors and dentists who were eligible for study leave in 15 health districts. The questionnaire asked about the number of days taken in study leave in the previous year, the cost incurred, and whether locums were used. Although less than half replied, the survey has revealed such wide discrepancies among specialties and grades that a prospective study is now under way.

"Although the response rate was poor, especially from the juniors, some major things do stand out," claims Dr Eddie Josse, chairman of the working group. "We felt there was enough meat in the document for it to be published. Postgraduate deans have had no information on the uptake and costs of study leave and they are now holding the budgets at district level."

The results of the survey will come as no surprise to juniors. Senior house officers and registrars in obstetrics and gynaecology and paediatrics take 25% less study leave than their counterparts in anaesthetics, psychiatry, and dentistry. Overall, locum cover was obtained for less than a fifth of the time. In psychiatry a locum was used for only 3% of days.

Senior registrars were the most expensive grade to send on study leave, spending £670.39 a year. Associate specialists spent the least at £144.50 and took the least amount of study leave, with nearly half taking none at all.—LUISA DILLNER, *BMJ*

Uptake and Costs of Study Leave is available from the Standing Committee on Postgraduate Medical Education, 26 Park Crescent, London W1N 3PB.

Labour commits itself to science and technology

The Labour party earlier this month committed itself to a national strategy for science and technology that would appoint a minister for science and increase investment in science and technology from the current 1·8% of gross domestic product to 2·5%. The party's document—*Pushing Back the Frontiers*—does not, however, say how long it would take to reach such levels of funding and does not contain any costings, as the government has pointed out.

Labour has three objectives for its strategy: to achieve good quality science that would be widely taught and understood; to ensure that science and technology are well linked to applications, sustaining innovation, and enhancing economic performance; and to ensure that Britain has the knowledge and capability to anticipate and respond to the challenges of the future.

Science education would be improved at all stages, but in particular the present "jungle of qualifications" for those over 16 would be replaced in England and Wales by a single advanced certificate of education and training. Young people would thus be able to choose a wider range of subjects, mixing science and technology with others. The career prospects of both science teachers and researchers would be improved, and the University and Polytechnics and Colleges Funding Councils would be combined into one higher educational funding council. Centres of excellence would be encouraged.

The Advisory Council on Science and Technology would be replaced by a council on science, technology, and research, and the functions of the present Advisory Board for the Research Councils would be covered through a committee of the new council. Individual research councils would be encouraged to negotiate their budgets directly with ministers. Labour also intends that there would be a minister and an office for science, technology, research, and statistics within the Cabinet Office. The Royal Society would be invited to give wholly independent advice on scientific issues of major importance—like global warming, AIDS, and bovine spongiform encephalopathy—but there would also be an independent office of technology assessment under the general supervision of a new select committee on science, technology, and research, which would also pursue its own inquiries.

The document shows how Britain's funding of research and development has been overtaken by that of France, Germany, and Japan in the past 25 years and pledges to increase overall funding of research and development. Funds would also be diverted from defence research and development, and a scheme would be introduced to give a 25% tax credit for increases in research and development over a base year.

Neil Kinnock, leader of the Labour party, is quoted in the front of the new document: "In a country with a £20 billion balance of payments deficit that has lost its share of world and domestic markets and desperately needs not only to increase but to sophisticate and modernise its production in order to live, the absence of a strategy to promote expansion and continuity in the sciences is crippling."—RICHARD SMITH, *BMJ*

Pushing Back the Frontiers: Labour's Policy Statement on Science in the Service of Society and Industry is available from the Labour party, 150 Walworth Road, London SE17 1JT.

Primary care in the Third World

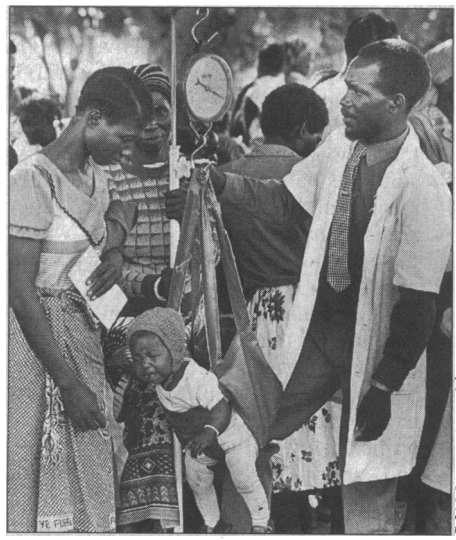
Few doctors choose to work in the villages of the Third World. Action in International Medicine (AIM), a new association of doctors with support from more than 60 medical colleges worldwide, hopes to change this.

According to Dr Andrew Pearson of AIM, doctors trained in the developing world either work in the teaching hospitals in cities or emigrate. Up to 90% of the population gets its primary health care from casualty departments—after queuing for up to eight hours.

AIM is currently establishing projects in Brazil and Zambia to train doctors in primary health care, with trainees rotating between teaching and district hospitals. When fully qualified, general practitioners will be accorded wages and status compatible with those of hospital consultants.

The World Health Organisation recommends a ratio of one general practitioner to 10 000 patients in the developing world. According to Dr Pearson, who has recently been in Zambia, there are not yet enough general practitioners for this to be achieved. "Now there are training schemes which teach doctors how to be generalists. A GP is usually in charge of a district hospital and may have to deal with caesarean sections, orthopaedic trauma, and the administration. A tertiary referral centre might be 100 miles away."

AIM's other projects include sending medical textbooks to developing countries and compiling a register of retired doctors with some overseas experience who can act as advisers.—LUISA DILLNER, *BMJ*



RON GILLING/PANOS

Primary care is better, on balance

Dementia in Scotland

This month, three years after the Scottish Health Authorities Review of Priorities for the Eighties and Nineties (the SHARPEN report) accorded the highest priority to the development of services for people with dementia, current provision has been criticised as grossly inadequate in a report from the charity Scottish Action on Dementia.

Of the estimated 80 000 sufferers in the community, only 8000 get any specialist help and fewer than 15 000 benefit from the home help service. The report estimates that the informal care provided by relatives in Scotland saves the government about £1·2bn.

Long stay care in hospital also comes in for criticism. Reports from the Mental Welfare Commission for Scotland "bear continuing witness to an unjustifiable scandal in the quality of life for some elderly people with dementia in NHS long stay care."

The report acknowledges that some progress has been made in the past five years but, despite the recognition that the highest priority should be given to developing both community and hospital based services, it says there is "gross underfunding by many health boards and local authorities; significant shortfalls in others."

The government has recommended that services should be developed by using money released from savings elsewhere. But the report argues that "it is unrealistic to expect that major developments for this very large and growing group could possibly be funded in such a way." It notes that separate funding from the Scottish Office has been provided to develop services for people with AIDS and asks that a similar initiative be considered for people with dementia.

The report also calls for earlier support to prevent crisis admissions to long stay care; better information and counselling; and an expanded range of community services.

"If dementia sufferers and carers continue to endure lives of isolation, grinding anxiety, and physical exhaustion, it will not be from lack of knowledge—but from our lack of commitment as a nation to setting up the services they need," the report concludes.

The charity's chairman, Angus Mitchell, says, "Services remain grossly inadequate across the country and are threatened by spending cuts. The urgency of the problem cannot be overemphasised given that the number affected by the disease will rise to 100 000 in the next 10 years."—BRYAN CHRISTIE, health correspondent, *The Scotsman*

Dementia in Scotland: Agenda for Action is available from Scottish Action on Dementia, 33 Castle Street, Edinburgh, price £5.

Late delivery of BMJ

We apologise that readers may have received last week's *BMJ* a day or two late. The delay was caused by machine problems at our mailing house.

Refining the reforms

Mr Waldegrave must be feeling more confident than he seems. For a start, he got the better at last of Labour's Robin Cook at question time in the Commons and won the approval of Tory backbenchers, one of whom, in another sporting metaphor, called out "game, set, and match." The next day he capped it by announcing agreement with the General Medical Services Committee on a joint NHS review committee into general practice fundholding (p 1560).

To a bystander it seemed that this might give Mr Waldegrave something to crow about at the expense of his critics and that he might claim at least tacit recognition that the reforms are permanent. An immediate platform was to hand because Mr Waldegrave was due to appear before the select committee on health. One could imagine Kenneth Clarke allowing himself just a hint of swagger. But peace with the profession has been the Waldegrave way, and he is not inclined to seek provocation. In the event he approached it with all the modesty at his command.

A Tory member of the health committee offered him a cue by suggesting that the agreement with the GMSC was something of a breakthrough. The health secretary rose to it only implicitly by making it clear that there had been no concession on his part. General practice fundholding is, in his view, a bigger success than was expected.

The chairman of the committee, Nicholas Winterton, welcomed the new joint approach and wondered if a further extension of fundholding was being postponed until the results of the evaluation were known. "No," said Mr Waldegrave. "It means working together to take the policy forward. There are a lot of people in the queue to become fundholders and I am being battered by general practitioners in smaller practices to be fundholders. I would be very happy to see the scheme grow as fast as general practitioners want it to grow. It will remain voluntary."

Mr Waldegrave said that the scheme is producing benefits for patients, with general practitioners providing more care out of their budgets in a variety of innovative and surprising ways. The joint review, he said, would be about seeing how to spread the benefits across all patients and assessing other aspects, with the GMSC representing the interests of fundholders and non-fundholders together. He would be considering how practices with list sizes smaller than 9000 might join the scheme.

"I welcome the sense of cooperation and partnership that is developing," the secretary of state said, coupling it to the previous week's agreement with hospital consultants on fundholders' referrals. This, he claimed, put to rest for ever the notion of a two tier health service. "Anybody who wants to say that has to argue with the Joint Consultants Committee," he added.

Mr Waldegrave confirmed that a general practitioner fundholder or any other purchaser was free to negotiate a deal with a provider who had capacity lying idle without interfering with other treatment or waiting times. In areas with many fundholders there was a possibility that they might be competing against district authorities as purchasers. He agreed that there could be a problem, though it was more theoretical than real. Fundholders were mostly buying services that are not the "meat" of the local health strategy. Mr Waldegrave saw an advantage in the closer relationship developing between fundholders and the acute sector: "They have hospitals on the telephone. There has never been integration like this before."

The secretary of state announced one other refinement of the NHS reforms. This is to set up five regional centres to monitor the business plans and finances of NHS trusts. As outposts of the NHS Management Executive they will be able to keep a closer and more constant watch on the new trusts. The main worry came from a Conservative MP who was anxious that this might amount to creeping control over trusts by the regions.

This would counter the famous "lie" about trusts opting out of the NHS. Will the attack now revert to its original form, that trusts are under too tight central control by the NHS? Mr Waldegrave is in serious danger of confusing his critics. But having disposed of the "two tier" NHS and at the same time secured a BMA presence on board his reform flagship, he may be entitled to feel that it was not a bad week's work.—JOHN WARDEN, parliamentary correspondent, *BMJ*

The Week

Last week British politics was dominated by disputes about the draft treaty on European economic, political, and monetary union. Mention of federalism produced apoplexy, and for a time it seemed as though the debate was being conducted entirely by two former prime ministers. As we went to press the present prime minister went off to Europe to discuss the matter.

Among all these debates about the national interest, however, the subject of health has not cropped up at all. It should have. The question seems no longer to be whether to include health in the treaty but how and when.

The proposals currently on the table suggest that the European Community should focus (apparently exclusively) on preventive medicine and health education. For once all 12 member states are agreed that they do not like the idea of bureaucrats in Brussels dictating how their health care should be financed and delivered. On some issues sovereignty clearly still is important. Those against amending the treaty are concerned that once health is formally on the agenda it will be hard to stop the ball rolling into the sensitive subject of health care provision. They argue that cooperative ventures within Europe—for example, on cancer prevention—have worked well so far.

Those who support inclusion of health care in the treaty have three main and convincing arguments. Firstly, they point out that the European Community has already had a considerable impact on health by virtue of directives shaped and approved by ministers of trade and agriculture. The free movement of health professionals and legislation concerning the food industry are two good examples. Needless to say, policy has been dictated by the needs of free trade and European farmers rather than by health needs. And health ministers have been left on the sidelines: they have been meeting each other annually only since the early 1980s.

Secondly, there are practical advantages to bringing the health dossiers under one roof. Currently several different directorates are concerned with health and coordination is poor. The lack of a unified focus in Brussels also means that groups with an interest in health in the member states may have to deal with more than one government department.

Thirdly, a formal brief for health would enable the European Community to develop a clear health policy which might in the long run help smooth out some of the present inequalities in health care.

A decision on whether or not there will be a European Community mandate for health is unlikely to be made until the end of this year—and perhaps not even then. But things are already on the move in Brussels. On 4 June health ministers attending the council meeting in Luxembourg were asked to nominate someone to advise the commission on health and join a committee that would meet regularly and help develop a European health policy.

As former British prime ministers have been trying to tell us in their different ways, Europe will increasingly affect all our lives. The challenge for those concerned about health is to get in on the act—and find out what is happening in Brussels. It is our health that is at stake.

HART