place with the express charge to review protocols for design and ethical considerations.

It seems fair to assume that those who fund research want to realise the maximum benefit from the research; therefore funding agencies would do themselves a favour by providing the fairly modest funds required to launch an international effort to register clinical trials.

KAY DICKERSIN

Department of Epidemiology,
The Johns Hopkins University,
School of Hygiene and Public Health,
Baltimore MD 21205

1 Sterling T. Publication decisions and their possible effect on inferences drawn from tests of significance or vice versa. *Journal of the American Statistical Association* 1959;54:30-4.
2 Smart RG. The importance of negative results in psychological research. *Can J Psychol* 1964;5:225-32.
3 Simes RJ. Publication bias: the case for an international registry of clinical trials. *Journal of Clinical Oncology* 1986;4:1529-41.
4 Dickersin K, Chan S, Chalmers TC, Sacks HS, Smith H Jr. Publication bias and clinical trials. *Controlled Clin Trial* (in press).

A test for manpower planning

SIR,—It was good to read Dr J Parkhouse's outspoken criticism of the continued concentration of senior registrar posts in London, now perpetuated by a formula giving a weighting of 30% to the number of medical and dental students in the region (10 October, p 868). We in the provinces recognise the role of national centres like the Royal Postgraduate Medical School and Maudsley Hospital but do not regard the London teaching hospitals as "a national training resource" for graduates. The quality of senior registrar training is related not to the number of students but to the strength of graduate training programmes; and we are quite capable of training our own senior registrars.

It might be helpful to spell out the effects of the maldistribution of senior registrar posts which now exists in most specialties. Firstly, junior staff in the deprived regions have greater difficulty in obtaining senior registrar posts because they have to apply in other regions against local competition. Secondly, fewer consultant staff have the stimulus of training a senior registrar. Thirdly, since senior registrars are men and women in their late 20s and 30s, often with young families, they put down roots in their region of training, so that the deprived regions tend to receive consultant applications from those the training regions choose not to appoint.

The Thames health authorities recognise these advantages; otherwise they would not continue to fund extra posts they can ill afford. But we have long ago recognised that health care should be fairly distributed in Britain. The same should be true of the training posts which control the quality of medical manpower.

IAN BROCKINGTON

Department of Psychiatry,
Queen Elizabeth Hospital,
Birmingham B15 2TH

SIR,—Dr J Parkhouse paints a gloomy view of any attempt to rationalise the distribution of medical staff in the training grades, and nowhere is this felt more acutely than by those in research posts. In February this year a questionnaire was sent to Medical Research Council clinical scientific staff. Of those in the training grades on limited term contracts, 88% held honorary clinical contracts at registrar or senior registrar level, but only 45% of these posts had been accredited for training purposes. When questioned about career intentions, 47% intended to return to full time NHS posts whereas only 19% hoped to remain in research (MRC, university, etc); but a striking 76% of those intending to leave research would have preferred to remain in research posts if they had been able to do so.

It was also possible to compare the results of this questionnaire with another one of 13 years earlier. The honorary contract allocation then was broadly similar, but when questioned about long term career intentions only 5% intended to return to full time NHS posts, contrasting with 29% intending to remain in research and 47% in both; 86% expressed satisfaction that their career hopes had been fulfilled, but this optimistic outlook is no longer borne by those in post now.

In commenting about manpower allocations the JPAC report states that reliable data have been particularly hard to come by, but it is clear that not all current research post holders want to be squeezed back into the tightly controlled senior registrar manpower allocation. We hope that during its next session the committee will indeed examine this question more closely and perhaps return the sense of balance and optimism held not so very long ago.

GARY BUTLER

MRC Clinical and Population Cytogenetics Unit,
Western General Hospital,
Edinburgh EH4 2XU

Hospital and community health service costs: England and Scotland compared

SIR,—We welcome the timely contribution of Drs Alastair C A Glen and John K M Hulbert to the debate on the relative levels of funding of hospital and community health services in England and Scotland (19 September, p 707). Their proposed adjustments to our original estimates of inequalities between countries[1] should be considered carefully, however, before they are adopted in policies on distribution of health care resources.

Firstly, local authority rates paid by hospitals are just one input cost that varies across Britain. Compensation for such variations eliminates the managerial incentive inherent in a RAWP type budgetary control to adopt cost minimising input mixes and simply perpetuates existing inefficiencies in health service provision. Research has shown that managers have responded to other uncompensated variations in input costs by adopting more efficient input mixes.[2]

The case for an adjustment for sparsity of population in resource allocations remains unsubstantiated. Distance from point of delivery of care and population density have only a minor effect on National Health Service unit costs, and Wood concluded that the importance of spatial inequality should not be overstated.[3]

The inclusion of private medical care provision in RAWP estimates undermines the "needs" based concept of the RAWP formula. Findings from a study of provision of hip replacements in the private sector suggest that such provision has little effect on the unmet need for hip replacements.[4,5] Reducing National Health Service provision on account of observed private sector activity would therefore reduce resources by a greater amount than the reduction in needs. Notwithstanding this point, the proposed adjustment, on the basis of the proportion of the population with private medical insurance, fails to recognise that about 30% of private sector provision is for uninsured people.[6]

Drs Glen and Hulbert cite several studies that illustrate "the limited effectiveness of the all ages standardised mortality ratio" as a proxy for morbidity but fail to consider the more recent comprehensive review of RAWP,[7] which concludes that "no other measure of need has been proposed which is superior to (standardised) mortality data" to adjust for morbidity differentials. Furthermore, we fail to see why the adjustment for morbidity using standardised mortality ratios should be compromised by the use of average bed utilisation rates for the United Kingdom.

Finally, we agree with the concern expressed about the failure to allow for inequalities between countries in provision in other elements of the health and personal social services programme. Anyone reading the whole of our original paper, however, would be aware of our arguments for subjecting the health and personal social services budget as a whole to a RAWP type policy so that perverse incentives for shifting demands between the separate elements of the health care budget might be avoided.

Despite the tenuous grounds on which the adjustments to our original estimates have been made we note that Scotland still seems to receive significantly more resources in relation to needs than England. We hope that these findings may encourage the health departments of the United Kingdom to devote a similar amount of attention to allocation of resources between countries as has already been devoted to the current rather narrow and parochial review of the English RAWP formula.[8]

STEPHEN BIRCH

Medical Care Research Unit,
University of Sheffield,
Sheffield S10 2RX

ALAN MAYNARD

Centre for Health Economics,
University of York,
York

1 Birch S, Maynard A. *The RAWP review: RAWPing primary care: RAWPing the United Kingdom*. York: University of York Centre for Health Economics, 1986. (Discussion paper 19.)
2 Akehurst RL, Blackburn K. Geographic cost variations in the North West Regional Health Authority. *Hospital and Health Services Review* 1979;75:400-5.
3 Wood PW. *Geographical equity and inpatient hospital care: an empirical analysis*. Aberdeen: University of Aberdeen Health Economics Research Unit, 1984. (Discussion paper 05/84.)
4 Nicholl JP, Williams BT, Thomas KJ, Knowelden J. Contribution of the private sector to elective surgery in England and Wales. *Lancet* 1984;ii:89-92.
5 Birch S. Policy implications of contracting out care: the case of total hip replacements. *Hospital and Health Services Review* 1985;81:281-4.
6 Williams BT, Nicholl JP, Thomas KJ, Knowelden J. Analysis of the work of independent acute hospitals in England and Wales, 1981. *Br Med J* 1984;289:446-8.
7 Mays N, Bevan G. *Resource allocation in the health service*. London: Bedford Square Press, 1987.
8 Department of Health and Social Security. *Review of the resource allocation working party*. London: HMSO, 1986.

Training doctors and surgeons to meet the surgical needs of Africa

SIR,—Messrs D A K Watters and A C Bayley (26 September, p 761) suggested in the title of their paper that they were embarking on a plan for the whole of Africa, but in the article they concentrated on only east and central Africa. As an anaesthetist, may I say that training surgeons alone can never meet the surgical needs of any continent. Anaesthetists must also be considered to be vital components of any such long term plan if it is to be successful.

Secondly, if Messrs Watters and Bayley are proposing a short term plan, aiming at training surgeon cum regional anaesthetists (who would primarily be taught regional and local anaesthetic techniques), a thorough training in resuscitation still needs to be emphasised. Furthermore, the three months allocated to anaesthesia in the proposed two years' training for district hospital doctors is far from being practical. At least six months are needed to impart some meaningful drills in resuscitation and training in some anaes-