# Reform of the Irish health service

What is the difference between a health care administrator and a manager? A great deal, if the current debate in the Irish health services is anything to go by.

One of the core findings of the Commission on Health Funding, which conducted a three year inquiry on behalf of the Department of Health, was that the problems bedevilling the Irish health service are not primarily related to funding. Management, or rather the lack of it, is the real problem. Though the commission's report is now nearly a year old, little comment and even less action has emanated from the health minister, Dr Rory O'Hanlon. Several more recent events, however, have put the document squarely back on the health agenda.

The first of these was the recent publication of a comprehensive report on consultants' salaries and conditions, which recommended pay increases of around 50% for consultants holding public contracts. The trade off for this apparent magnanimity (much of which is simply bringing salaries back into line with similar grades in the public sector) is greater accountability of medical staff and its corollary—direct input by medical staff into hospital management and clinical budgeting.

Opinion in the medical profession is split, consultants who have access to large private practices being mainly opposed to the deal and their colleagues outside the urban centres and in the less lucrative specialties being much more receptive to aspects of the proposed new contract.

Most controversial is the proposal to introduce an entirely new category of "retained" consultant, who would have a full time exclusive commitment to his or her public employing authority. The carrot for this abdication of contractual freedom is an attractive all in salary with no abatements with regard to estimated private income.

More globally, considerable confusion exists at local health board level about the political functions of elected board members and executive functions vested in the board's chief executives. In addition, the Department of Health tightly controls the health services centrally from Dublin without due regard to local circumstances and without any means of identifying and rewarding efficiency. Indeed, the argument runs to the contrary: hospitals or health boards that succeed in controlling expenditure are usually rewarded with a cut in the following year's allocation from the department, while the profligate apply political pressure—usually successfully—to have the tab for overspending picked up centrally.

Where the equation really comes unstuck is in the virtual non-existence of management systems to identify efficiency and encourage thrift, all of which is against a backdrop of painful reductions in overall expenditure in the health sector in Ireland. From a peak of 8·5% in 1980 spending has now dropped to just over 7%, which, although considerably higher than the equivalent British figure, is well in line with the Organisation for Economic Cooperation and Development average.

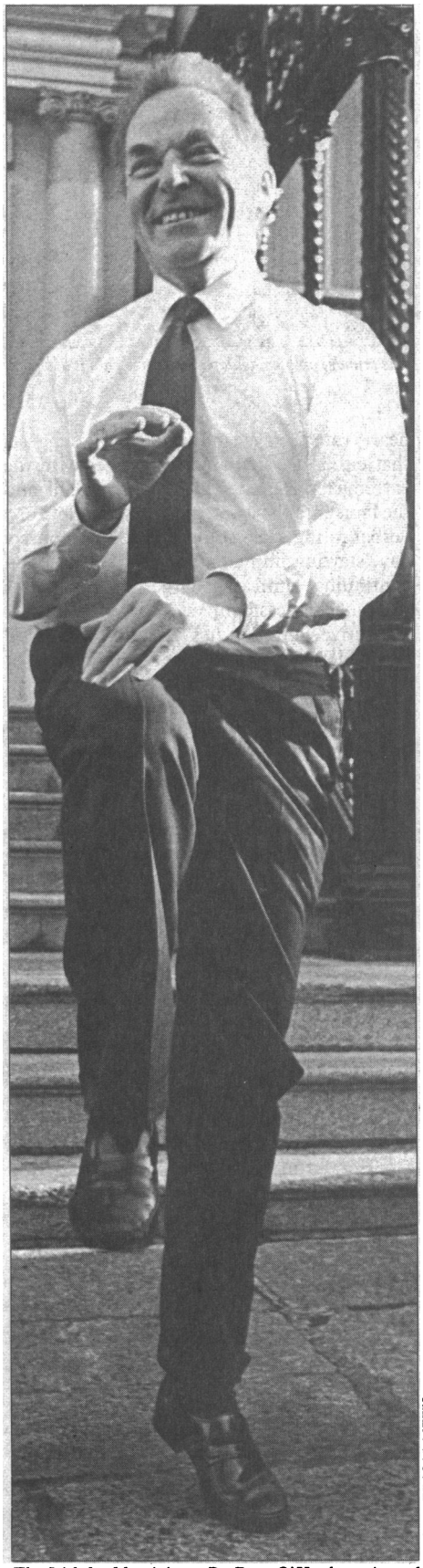
A recently published paper, *Enabling managers to manage: healthcare reforms in Ireland*, by Laraine Joyce of the Institute of Public Administration and Christopher Ham of the King's Fund College, London, concluded that though they did not believe that the Irish health service needed the kind of radical surgery diagnosed by the commission, the line of responsibility, command, and accountability needs to be made clear for all, including doctors, to follow. The Department of Health, they suggest, needs to beef up its policy making functions, but having done that it must allow health boards to decide what best suits the local terrain. To allow the boards to do this "a clear general management function needs to be introduced, supported by an appropriate personnel package and a significant investment in management training and development."

A concluding paragraph from the Commission on Health Funding's report dealing with private health insurance gives a telling glimpse at the scale of the difficulties facing those who wish to untangle the Irish service's Gordian knot. It points out that the cost of treating individual patients for specific conditions is not known, nor is the relative complexity of case mix treated in public and private hospitals. Nor is anything known about the price elasticity of demand for health insurance. Finding answers in this context can hardly be more daunting than assembling all the questions.—JOHN GIBBONS

# Too much pain

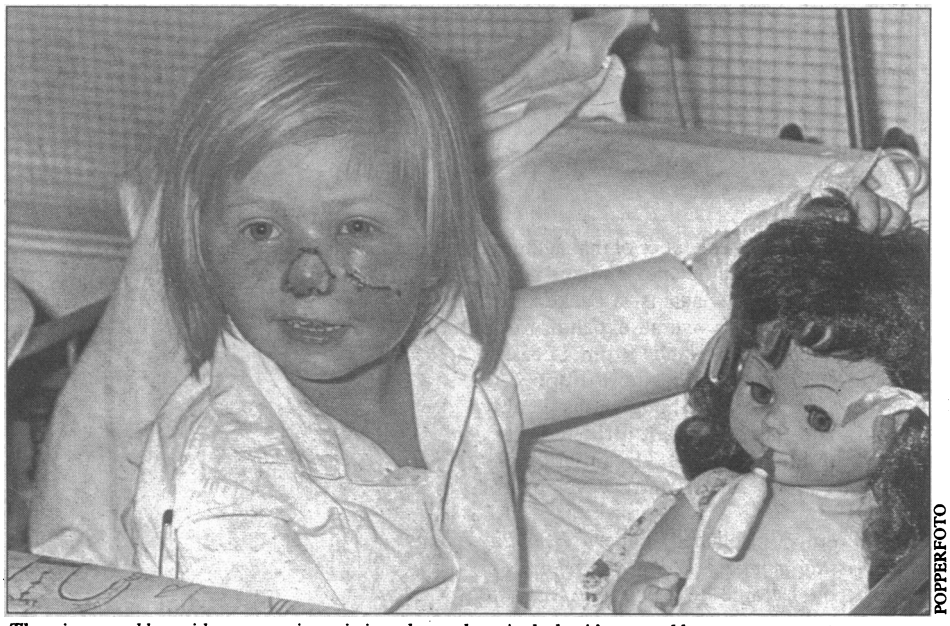
"The treatment of pain after surgery in British hospitals is inadequate and has not advanced significantly for many years." So opens the recent report of the working party on pain after surgery, produced by the Commission on the Provision of Surgical Services in association with the College of Anaesthetists and the Royal College of Surgeons. The report recommends increasing the monitoring of pain by patients and the setting up of acute pain services and high dependency units in all our main hospitals.

"A patient's pain should not be neglected but assessed and recorded along with other observations such as blood pressure and



IRISH MEDICAL NEWS

*The Irish health minister, Dr Rory O'Hanlon, pictured stepping it out at a conference on health and fitness in Dublin earlier this year*



POPPERFOTO

*The primary problem with postoperative pain is to change the attitude that it's acceptable*

heart rate," says the report. It suggests that either a visual analogue scale (with the extreme left representing "no pain at all" and the far right "the worst pain imaginable") or a verbal rating scale could be used 24 hours a day, starting immediately after surgery and continuing until discharge. It recognises that such assessment of patients is wholly subjective, but studies describing nurses' perception of their patients' pain show that nurses' ratings are consistently lower than those of the patients. Indeed, less than half of the patients in one study were even asked about their pain. Such results imply that in some cases patients' pain is being substantially undertreated.

The working party wants to change the public's and health workers' attitudes towards pain. It believes that pain after surgery is not inevitable and urges patients to tell staff, including the consultant surgeon, that they are in pain. It wants to improve the training of all health professionals in pain management, especially nurses, who rather than using analgesia prophylactically tend to delay giving drugs and reduce the dose because of fear of side effects. Pharmacists are well qualified to undertake this educational role. But as well as being undervalued on the wards, pharmacists were also poorly represented on the working party, numbering only one out of the 13 members.

The lack of an identifiable group and a named member of staff with responsibility for managing pain could be improved by developing an acute pain service, the report suggests. This would consist of a consultant and a multidisciplinary team, including pharmacists and psychologists. When asked whether this would necessitate extra staff with an on call commitment, the working party explained that some hospitals had already extended the role of existing staff and that additional resources were not necessary.

Resource problems may arise, however, with implementing high dependency units in all main hospitals. These units, with their high ratio of nursing staff to patients, are intended for the postoperative care of patients at high risk. Currently, only a quarter of hospitals in Britain have such a facility, and therefore the use of techniques such as patient controlled and epidural analgesia has been limited. If resources are made available to provide this level of care on general wards, the report says, such techniques need not be restricted to high dependency units.—SUE CRIMLISK

*Report of the Working Party on Pain After Surgery* is available from the Department of External Affairs, Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PN, price £3.50.

# European meeting on HIV testing

Ideally tests for antibodies to HIV should be reported as positive only after there have been two tests, preferably based on different principles. Most countries in Europe do use primary and confirmatory testing laboratories, although the distinction between the two is not always formally recognised. This finding emerged from a survey of 100 primary and 70 reference laboratories in 16 European countries and was presented to a recent meeting of the AIDS research working party of the Commission of the European Community. The meeting was attended by virologists from the 12 countries of the community and from Norway, Sweden, Finland, and Switzerland.

In the past few years the detection of antibodies to HIV-II has become increasingly important. Even in Britain, where extremely few cases have been detected, all blood donors are now being screened. Previously only those with West African connections were tested specifically for HIV-II. The ELISA used to detect HIV-I before June 1990 could often pick up HIV-II but could not be relied on. European countries vary in their use of ELISA for HIV-I or HIV-II, but more and more are moving to using the combined test. A western blot used as a confirmatory test for HIV-I may not always detect antibodies to HIV-II, and if the latter is suspected a blot specific for HIV-II is best used. Portugal, thanks to its historical connections with West Africa, has a far higher prevalence of HIV-II than most of Europe and now uses a combined ELISA. To confirm positive results it uses both types of western blot.

Although blood tests are unlikely to lose their primacy, tests on saliva or urine would be more convenient and less hazardous. Because of the low concentrations of immunoglobulin in such fluids most tests for antibodies have not been satisfactory. Antibody capture assays work well, however, and there are three class specific capture assays for IgG against HIV that give results as good as those obtained on blood. Though two of these assays need complex and therefore expensive instrumentation, one is simple and inexpensive and could be used in developing countries.

Given the importance, complexity, and novelty of testing for HIV antibodies, assessment of laboratory performance is essential. Both Britain and France have comprehensive quality assurance schemes that grew out of pre-existing laboratory assessment programmes. Their results suggest that the general standard of testing in these countries is high. Several other countries have, or are about to start, assessment schemes, but this will still leave some with none.

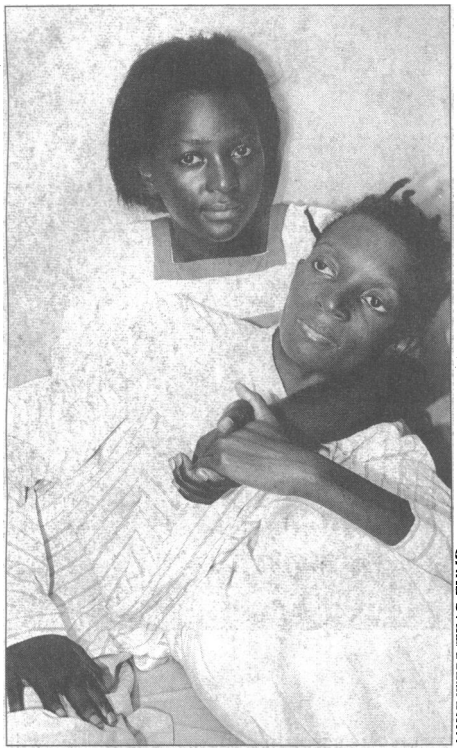
At the end of the meeting the consensus was that given the generally high standard of testing and the rapidity with which new assays are appearing it would be difficult and of little benefit to try to introduce obligatory standards. Participants believed strongly that rapid tests should not be promoted for "do it yourself" home use but were divided as to whether attempts to make such use illegal were either practicable or desirable.—A A GLYNN

# Getting an AIDS vaccine to the developing world

Progress on developing an AIDS vaccine has been so rapid that attention is now turning to the best method of getting it to African and other developing countries that need it most—but cannot afford it.

At a meeting in Washington, DC, sponsored by the National Academy of Sciences' Institute of Medicine, the former head of the World Health Organisation's global programme on AIDS suggested an answer: the developer could give the vaccine's patent to an international organisation, such as WHO, that would make the vaccine available to everyone at cost. In exchange the company would gain a transferable right to prolong the patent for one of its other pharmaceutical products.

Jonathan Mann, now professor of epidemiology and international health at the Harvard University School of Public Health,



MIKE WEBB/TEAR FUND

*AIDS in Africa: a scheme has been proposed to get an AIDS vaccine to the developing world*

said that an important advantage of his proposal was that it would "protect the profit incentive" of pharmaceutical companies to develop the vaccine while allowing the distribution of vaccine for pennies a dose to people who otherwise could not afford to buy it. For industrialised countries, Mann estimated that the AIDS vaccine would cost more than $14 a dose.

He said that the developer of the AIDS vaccine would "not need to be a multifaceted pharmaceutical company to take advantage" of the swap because a transferable right to patent extension would have "a market value which could be considerable." He suggested that it might amount to "hundreds of millions of dollars."

Nevertheless, he added, "these patents that would be prolonged would have to be for drugs that are not perceived to be immediately life saving and are not linked in themselves with major health problems in the developing world." Examples of drugs that would qualify for the patent trade, he said, included "certain ulcer drugs, certain acne drugs."

Mann's idea was discussed by leading AIDS researchers, government officials, and pharmaceutical company executives at the September meeting. Jonas Salk, who invented the first polio vaccine, suggested that profits for manufacturers could be obtained, as usual, through sales of the AIDS vaccine at high prices in developed countries. "But then a special price is provided for the developing countries."

Although the idea "is clearly the most obvious initial way of dealing with this," Mann responded, "the experience [with other drugs sold at divergent prices to developed and developing countries] is dismal." He said that it would lead to black market movement of drugs from places where they are sold cheaply to the regions where they are highly priced. Pharmaceutical companies, he said, found this "not an attractive approach."

Neil Halsey of Johns Hopkins University said Mann's proposal "might possibly even work, but, based upon history, I suggest that it will probably take five to 10 years of political wrangling with multiple countries to get it to be approved." He endorsed Salk's suggestion, noting that manufacturers are providing measles; polio; and diphtheria, pertussis, and tetanus vaccines through Unicef and WHO at "very, very low cost." Mann responded that the costs of developing and supplying an AIDS vaccine will be "considerably higher than the costs of the childhood vaccine system."—REGINALD RHEIN

# Planning for disasters

Both victims and helpers suffer psychological trauma in the aftermath of disasters. Yet, despite the succession of these events in the past few years, organisations offering guidance and counselling have failed to learn from their previous mistakes, says a report by the British Psychological Society. Poorly coordinated support and untrained workers continue to hinder the effective provision of services needed by disaster victims.

The working party that produced the report received evidence from psychologists and other workers closely associated with events at Bradford, Zeebrugge, and King's Cross. It highlighted planning and the coordination of professional groups as two key topics for improvement. "Disasters," as Stephen White, director of information at the British Psychological Society, says, "cannot be predicted, and planning for the event is vital." The main recommendations included:

- establishing a national disaster agency at government level to formulate guidelines for local response
- specialist training for all volunteers and professional workers
- a coordinated policy for all support groups led by a local team prepared to respond in the event of a disaster
- further research into the range of services for helpers as well as victims both immediately and in the long term.

The report describes how jealous rivalries developed between different professional groups. Victims found themselves playing host to many agencies and received an unnecessary number of visits, some from untrained volunteers helping out of "macabre curiosity." The media too came under attack—insensitive reporting, particularly on television, hinders recovery. Representatives of the press, the report recommends, should be included in planning.

Stephen White admitted that psychologists do not have all the answers and recognised that conflict existed even within the profession. Psychologists have, however, conducted most of the research in this field. The report's recommendations are being circulated to government departments, including the Department of Health, which itself is reviewing the psychological and social aspects of disasters.—ALISON WALKER

*Psychological Aspects of Disaster* is available from the British Psychological Society, St Andrews House, 48, Princess Road East, Leicester LE1 7DR, price £5.

POPPERFOTO

*An unidentified woman who lost a relative during the Zeebrugge ferry disaster throws flowers into the sea to pay homage to the victims during a memorial service in front of the capsized "Herald of Free Enterprise"*

# Bloomsbury Hospital: now you see it, now you don't

Despite the announcement by North East Thames Regional Health Authority that several regional schemes are being axed because of the collapse of the property market Bloomsbury District Health Authority remains optimistic that the plans for its new £200m hospital are safe. Unlike some of the projects that have been scrapped, the new Bloomsbury Hospital has not yet received approval from the Department of Health. The plans are currently being re-examined by the department, and both the district and regional health authorities expect that the new hospital will be built as planned.

According to Mr Henry Stanley, the director of estates for the district, the main financial problem is the initial injection of resources. Most of the capital for development is presently tied up in existing old hospitals. But before these sites can be sold their services must be relocated in the new hospital. The health authorities hope that the Treasury or the Department of Health will provide this "bridging money"; otherwise, it will have to be borrowed.

The timing of the scheme is uncertain. The region hopes to clear its deficit of £32m by 1993 and does not expect the Bloomsbury scheme to begin until then. Mr Stanley, on the other hand, hopes to see the construction work starting in two years' time, with completion by 1998.—SUE CRIMLISK

• St Thomas's Hospital in west Lambeth has announced further cost saving measures. Four medical wards are to close with the loss of 81 beds. Seventy six nursing posts will also be lost. A spokesperson for the hospital said that further job losses are to be expected "of all types and all grades, including doctors." The measures are being introduced to reduce spending, currently running over budget by £100 000 a month.

PHOTO CO-OP

*Levels of air pollution are to be reported in the weather forecast*

# The pale green paper

Hopes for firm commitments by the government to improve the environment were dashed last week after the publication of the long awaited white paper. The 350 proposals, printed on recycled paper, were criticised by green pressure groups for simply reiterating existing policies. David Gee, director of Friends of the Earth, described it as "little more than a package of pious posturing."

The far reaching and much hoped for ideas popularised last year by the Department of the Environment's special adviser Professor David Pearce were absent. In particular no mention was made of the carbon tax—a charge for burning coal, oil, and gas—nor were there any firm commitments to reduce urban pollution—for example, by introducing road pricing. The inflationary effects of the Gulf crisis, the approaching privatisation of the electricity industry (which would have been hit by a carbon tax), and the unpopularity of the poll tax were all thought to have contributed to the government's reluctance to introduce any radical changes.

Chris Patten, Secretary of State for the Environment, managed to present the white paper, nevertheless, as a "comprehensive statement" of government policy ranging from the "street corner to the stratosphere." Its proposals include moves to protect the ozone layer, clean up rivers and beaches, combat air and noise pollution, and preserve cathedrals and the countryside. Targets for carbon dioxide emissions, however, the main gas responsible for global warming, fell short of those hoped for. The government settled for a commitment to stabilise them at current concentrations by the year 2005, five years after the proposed target set by the European Commission and short of Germany's commitment to a 25% cut in current concentrations by 2005.

Renewable energy from wind and solar power and other sources will reach 1000 MW by the year 2000, again lower than the hoped for target. Water pollution is to be tackled by imposing fines of up to £20 000 for offences, and concentrations of air pollutants are to be closely monitored with wider publication of the results, including in weather forecasts. Mandatory controls on how long burglar and car alarms can sound will also be introduced to reduce noise levels.

Specific plans to reduce car pollution are proposed—transport, especially road traffic, is responsible for a fifth of Britain's carbon dioxide emissions. Changes to the annual Department of Transport test (MOT) will be introduced to include an emission test for carbon dioxide concentrations. Tougher measures for speeding and a code of practice for car advertising are also proposed. Towns will benefit from better enforcement of parking restrictions, and "red routes" kept free of parked vehicles are to be introduced in London to ease traffic flow. Plans for further subsidies to encourage the use of public transport and a differential rate of purchase tax on cars according to their engine size will not now be implemented.

To ensure that the proposals in the white paper are implemented each government department is to have a minister responsible for its environmental policy. Even if the government has come up with only "a few gestures towards the softer environmental problems," according to David Gee, its proposals do hint at the direction of its possible longer term policies.—ALISON WALKER

# Wellcome to stop vaccine production

Wellcome's recent announcement that it will cease production of vaccines has led to a flurry of activity among other drug companies eager to fill the gap left in the British market. Until now Wellcome has been the only company with a British product licence for vaccines against yellow fever, typhoid, and cholera and for the triple DTP vaccine (diphtheria, tetanus, and pertussis).

Wellcome has decided to rationalise its list of products rather than embark on the substantial investment programme needed to compete with the large international vaccine houses. The French based company Merieux, for example, specialises in biotechnology, producing only serum, blood products, and vaccines. By contrast, Wellcome will now market only two drugs produced by biotechnology. Tissue plasminogen activator (tPA) had already been withdrawn from Wellcome's list after the Italian study GISSI II showed it to be no better than the much cheaper streptokinase.

Merieux, which already markets vaccines against tetanus, measles, mumps, rubella, meningococcal meningitis, and rabies in Britain, and the full "standard range" of vaccines in Europe and North America,

plans to expand its operation greatly to fill the gap created by Wellcome's departure.

Wellcome has decided instead to concentrate its resources on developing its two antiviral agents, acyclovir and retrovir, as well as its range of cardiovascular drugs.—FIONA GODLEE

# Cerebral palsy rarely caused by birth trauma

Many of the representatives of regional health authorities, insurers, and solicitors found their beliefs about the causes of cerebral palsy shaken by experts from three countries at a recent international meeting on quality assurance and risk management held in Oxford.

Cerebral palsy has been widely thought to result from oxygen deprivation during birth, and lawsuits against obstetricians are common in the United States and elsewhere. The awards have often been large and in the United States have resulted in escalating malpractice insurance, the abandoning of gynaecology by some practitioners, and—according to a recent study by the Institute of Medicine—the creation of substantial problems in access to obstetric care. Yet those at the conference agreed that oxygen deprivation at birth is seldom the cause of cerebral palsy.

Dr Fiona Stanley, director of the Research Institute for Child Health in Perth, Western Australia, showed that over the past 20 years in many countries obstetric interventions have increased in variety and number and perinatal death rates have fallen, especially in premature infants. Yet rates of cerebral palsy have remained steady in babies born at term and have risen in premature babies—as more of these high risk infants have survived.

The widespread use of electronic fetal monitoring in labour, undertaken in the hope of identifying asphyxia earlier so that babies in trouble might be rescued, has been associated with an increase in surgical deliveries but no drop in the rate of cerebral palsy. Studies in Western Australia have shown that only about 8% of cases of cerebral palsy are likely to be due to birth asphyxia. Whether the handicap could have been avoided is impossible to assess, Dr Stanley concluded.

Dr Ann Johnson, a paediatrician with the National Perinatal Epidemiology Unit, Oxford, described British studies indicating that neither measures of birth asphyxia nor the quality of intrapartum care were related to cerebral palsy. She described plans to re-examine intrapartum care in a new and larger British study and reviewed a large randomised trial in Dublin that found intrapartum electronic fetal monitoring to be ineffective in preventing cerebral palsy.

The complexities of fetal brain development were discussed by Dr Karen Nelson, a child neurologist from the National Institute of Neurological Disorders and Stroke, Bethesda. She said that the less common adverse events arising during birth are difficult to discern from a background in which maldevelopments of the nervous system are common. Congenital malformations are more common in patients with cerebral palsy than in control populations, and the same is true for patients with mental retardation, epilepsy, and infantile autism. For cerebral palsy and epilepsy errors of nature seem to predominate over errors of medical attendants.—NICK BLACK

## *BMJ* exhibition celebrates 150 years of publishing

As well as publishing its special issue (3 October) the *BMJ* is mounting an exhibition in BMA House to mark its 150 years of continuous publication—maintained through both world wars and the general strike of 1926. The exhibition, "Mirror of Medicine," illustrates the way that the journal has reflected its times from 1840 onwards: the issues it has championed, the science it has published, and the way it works. The photograph here shows the section illustrating the journal's peer review processes.

KEITH MORRIS

"Mirror of Medicine" is in the Hastings Room at BMA House, Tavistock Square, London WC1H 9JR, from 2 October to 2 November, 10 am to 5 pm, Monday to Friday.

**This week's contributors**

**Nick Black** is senior lecturer in public health medicine at the London School of Hygiene and Tropical Medicine

**Sue Crimlisk** is the *BMJ*'s Clegg Scholar

**Clare Dyer** is the *BMJ*'s legal correspondent

**John Gibbons** is managing editor of *Irish Medical News*

**A A Glynn** recently retired as director of the Central Public Health Laboratory, Colindale

**Fiona Godlee** is an editorial registrar at the *BMJ*

**Reginald Rhein Jr** is a medical journalist in Washington, DC

**Alison Walker** is an editorial registrar at the *BMJ*

# Damages for bad housing aggravating asthma

Local councils could face hundreds of damages claims after a ground breaking judgment last week. A 5 year old boy was awarded £12 000 compensation because his asthma was aggravated by mould and penetrating damp in his council flat. The London Borough of Southwark was ordered to pay Solomon Bygraves £4000 for four serious asthma attacks, frequent visits to his general practitioner, and constant treatment and a further £3000 for the discomfort, inconvenience, and distress of living in the flat for three and a half years.

Recorder Barbara Dohmann QC, sitting at Wood Green crown court, also awarded the boy £5000 for future pain, suffering, and psychological problems and for disruption of schooling up to age 18. She said that "No baby or little child should be brought up in premises in the state that they were in this case." Dr Neil Barnes, a consultant physician at the London Chest Hospital, told the court that the boy's condition was materially aggravated by conditions in his flat in Peckham, south London.

The case, believed to be the first in which a child has won compensation for harm caused by defective housing, is expected to alert housing lawyers around the country to the possibility of damages claims. Claims for disrepair are mainly brought to try to force landlords, both council and private, to tackle repairs.

About two million people have asthma in Britain, and 2000 of them die each year. But claims would not be limited to people with asthma and could be mounted when any illness was aggravated by damp or disrepair caused by a landlord's negligence or breach of statutory duty in failing to carry out repairs.—CLARE DYER

# GPs overwhelmingly oppose trusts

The medicopolitical season has opened in an atmosphere of gloomy uncertainty. Let me summarise the week thus.

- A GMSC funded survey (still under way) shows that 85% of general practitioners oppose trusts in a countrywide survey of nearly 3000 practitioners (69% responded)
- Medical schools are facing savage cuts in funding, with Leeds forecast to lose nearly a quarter of its budget and 40 of its teaching posts
- Junior doctors, increasingly frustrated by their overlong hours of work, are to be surveyed by the Hospital Junior Staff Committee to assess support for action to cut hours
- GPs are suffering a squeeze on staff recruitment and improvements to premises
- Family health services authorities are struggling to meet the administrative burden imposed by the new contracts, leaving many GPs uncertain and confused about their new responsibilities.

Now to the detail. For the past two weeks I have written about the government's plans for NHS trusts and, given the damage this could do to the NHS, I make no apology for carrying on again this week. The BMA wanted the views of general practitioners and so far 11 ballots out of 24 completed by the Electoral Reform Society among practitioners have shown: votes dispatched 2981; return rate 69%; against 1725 (85%); for 301 (15%). The remaining results will be reported later. Meanwhile, the BMA reports that

> Next week leaflets will start being delivered to more than half a million households in five areas of the country where strong local campaigns have been organised to fight the government's opt out proposals. In Bradford, Leeds, Bromley, Taunton and north Devon leaflets will encourage the public to write to their regional health authorities about their local hospitals' plans to opt out.
>
> The leaflet, produced by the BMA at the request of doctors in these areas, explains that opting out is likely to increase pressures to concentrate on costs rather than patients' clinical needs; fragment and distort the range of local NHS services; and increase administrative costs, reducing funding for patient care.

The chairman of the General Medical Services Committee, Dr Ian Bogle, commenting on the strength of his constituents' opposition to trusts, urges the Secretary of State for Health not to ignore their views when he decides whether there is sufficient local support for hospitals to become self governing trusts.

From Taunton Dr Martin Elwood, a consultant physician, emphasised the importance of the local community's voice, adding optimistically that "there is reason to hope that it will be heard if we speak loud enough."

The secretary of Leeds Local Medical Committee, Dr Sadiq Ali, warned that none of the proposals in the application documents for the two main hospitals in Leeds had managed to persuade his colleagues that opting out would be better for patients.


"Services continue to be reduced in Leeds," he said, "only last week there was a reduction in district nursing staff."

Dr Ian Jessiman, press secretary for the Bromley Division of the BMA, commented:

> The proponents of our trust are suggesting that we must have a trust in order to get our new district general hospital. While we all agree that a new hospital is required, many of us are concerned that by borrowing money to achieve this the trust will burden itself with an impossible debt to the detriment of services in Bromley. Furthermore if they are successful in acquiring a lot of extra money for Bromley other districts will be correspondingly worse off. This will be harmful to the NHS as a whole.

I trust that Kenneth Clarke takes note of this opposition, which will, I'm sure, be reinforced on Thursday 4 October when the Central Consultants and Specialists Committee holds its first meeting of the session. Members will be told that the BMA is analysing the first wave of 66 trust applicants. I cannot imagine that the results when they are available will reduce the serious anxiety among consultants that the government's proposals to allow units to opt out of the mainstream NHS will divide and damage the service.

### Doom and gloom in academia

I will have more to say on the CCSC's meeting next week. Meanwhile I take no pleasure in reporting the doom and gloom that permeated committee room 1 in BMA House on 28 September when the Medical Academic Staff Committee had its first meeting of the session. Members heard (informally) that a survey by deans of medical schools of the likely effects of the university funding cuts on medical teaching showed that medical schools faced agonising decisions. The worst forecast, it seems, was for the University of Leeds, where the medical school faced a reduction in its funding of over 20% with a possible loss of 40 posts. Beside that figure cuts of a mere 12% forecast for another provincial medical school sounded almost painless. But the position looks pretty desperate, with beleaguered vice chancellors in no mood to protect medical schools from the arctic winds from the Treasury. Some schools are looking at ways of raising money as well as ways of making cuts. Hopes had been raised by the prospect of recruiting more overseas students, but this had run into difficulties on two fronts. Firstly, the cost of expanding facilities would offset extra income, and, secondly, such a change could breach the strict control of medical manpower. Even making academic staff redundant or retiring them early was not an easy—let alone desirable—option to meet tighter budgets because the savings were initially much reduced by the costs of such action.

If the effect of new university funding arrangements on medical schools is even half as bad as members of the MASC were forecasting this would spell catastrophe for the future of medical teaching and therefore of medical care. I left committee room 1 sadder and gloomier than I had entered it.

### GP contract experiences

Finally, the results have come out of the monitoring exercise by the GMSC to see how the general practitioners' contract is operating. This provides much anecdotal evidence of the teething troubles being experienced by doctors. Some of this is inevitable in such a major change, and no doubt many of the problems will be resolved as the months pass and doctors and family health services authorities get used to—even if the doctors don't like—the changed conditions.

Two main messages come through to me from the exercise. Firstly, the severe restraints now apparent on investment in new staff and better premises could endanger standards in practice. This is, unfortunately, a culmination of the government's efforts to put cash limits on general practice, a campaign that started when in 1982 a previous secretary of state, Norman Fowler, and his then minister of health, Kenneth Clarke, initiated an inquiry into practice expenses by the accountants Binder Hamlyn. The GMSC fought a determined rearguard action, but the Treasury seems finally to have won this important financial skirmish. Once again, however, a financial gain is likely to be bought at the cost of lower quality.

The second message of the GMSC's monitoring exercise is that some family health services authorities do not seem up to the task of running their side of the contract. Teething problems aside, I suspect that they are short of staff, particularly of good quality managers, and will be hard put to deliver the government's side of the contract bargain. And that sort of weakness cannot be remedied overnight, even in the unlikely event of the Department of Health providing the necessary money.

As I said at the start, it has been a gloomy week for health care.

SCRUTATOR