hospitals and district general hospitals, which had occurred in the preceding decade. The calculations, however, were also affected by the arbitrary selection of hospitals: some regions identified only one hospital as a teaching hospital whereas others included all hospitals where a substantial number of medical students received clinical training. Five hospitals were found to have negative excess costs—indeed, St James's Hospital in Leeds seemed to reduce costs to the NHS by over £2000 for every doctor trained there.

For teaching hospitals the service increment for teaching and research is vital to maintain the infrastructure necessary for good quality teaching and research. It is not meant to subsidise inefficient practice in either the clinical or support services. As far as possible the means by which it is calculated and distributed should be seen to be fair and to reflect the purposes for which it was devised. Likewise, the way it is allocated needs to reflect the total purpose of the increment, not just the direct cost of undergraduate teaching. The policy for its allocation between and within units should be consistent so that fair prices can be set by provider units. The regional health authorities now have the responsibility after consultation with medical schools to ensure that this happens; consistency between neighbouring health authorities is also important.[3]

There is no lack of effort or indeed goodwill in trying to devise better methods for resolving these issues. The requirement to prevent the increment being used to subsidise clinical costs unrelated to teaching and research is essential if the new contracting system within the NHS is to work fairly. There is also the need to ensure that money ostensibly allocated to underwrite the costs to the NHS of clinical research is used for this purpose. Finally, as with many other aspects of the health service, there is the "London question." Undoubtedly, part of the extra cost of maintaining teaching hospitals in London is met through the increment, not least because these costs are an important part of the formula that determines its calculation.

Various groups have been considering these questions. A major review mainly concerned with the methods of allocation has been led from the Department of Health by the previous permanent under secretary (the France group).[4] It is hoped that the work of this committee will continue. The Steering Group on Undergraduate Medical and Dental Education and (now) Research, which is a committee jointly sponsored by the Department of Health and the Department for Education, has begun preparing for a formal review of the increment this year. In March last year London University issued a discussion paper recommending that 15% of the total increment should be allocated for the direct costs of teaching clinical undergraduates and that district general hospitals should qualify for this support, pro rata, as long as they took five or more full time equivalent undergraduate students a year.[5] A slightly lower figure for this support was arrived at from a survey in Wessex. A method should be found to ensure that this support is provided even when the students come from different medical schools in different regions if the total commitment exceeds the qualifying standard.

Two papers relating to these questions are published in this week's journal. The paper from King's College School of Medicine and Dentistry is particularly concerned with developing a model for allocating the increment using information that the health service routinely collects and a method that is compatible with that used for calculating the increment (p 95).[6] As the authors state, further refinements should permit the identification of legitimate sums required to support teaching and research—both the total amount and the proportions for individual clinical services. The Southampton study is more concerned with examining the extent to which the increment can be justified for the legitimate extra costs of a teaching hospital and its activities (p 97).[7] Other studies are under way: one at my school is particularly concerned with determining the excess costs of activities in teaching hospitals, while the committee drawn from deans of medical schools is looking at methods of allocating the research component of the increment.

It is too soon to reach definite conclusions. Certainly, the present method used to calculate the increment needs improving, though it is difficult to think of a radical alternative to compare the average costs of a teaching with a non-teaching hospital. Obviously the definition of a teaching hospital is crucial in this respect. As more medical education takes place outside teaching hospitals it is important that an appropriate proportion of the increment goes to these units—not only district general hospitals but also in the future general practice and other primary health care services. An element of case mix probably ought to be removed from the increment and included in the contract price, but there are certainly legitimate extra costs of clinical care in teaching hospitals, which relate to slower throughput of patients and clinical investigations. There are many other factors to consider, such as different staffing levels, excess costs of merit awards, increased use of consumables, part funding of academic posts by the NHS, and the extent to which teaching hospitals subsume the costs of postgraduate and continuing education in the increment.

Particularly important in London and other inner cities is the cost of financing capital and maintaining it. Teaching hospitals have considerably more space per unit of clinical activity than district general hospitals, and costs of maintaining this capital (for example—the costs of heating, lighting, rates, and maintenance) are a legitimate charge against the increment. Identifying the main separate components of the increment and allocating sums specifically for the purpose they are designed to support should eventually be possible. Such a system would ensure proper accountability, thus reducing the controversy that currently surrounds the topic. Separating out the main elements of the increment, if extended to the special health authorities, might also ease these authorities' entry into contracting by providing support for their research and training responsibilities.

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Correction

Reducing home accidents in elderly people

An error occurred in the second paragraph of this editorial by Brian Livesley (4 July, p 2). The estimated annual rate of home accidents in the over 65s is 1002/1000 (770/1000 unreported) and the rate of falls is 677/1000, to accord with the rates reported in the accompanying article by Helen J Graham and Julia Firth.