

Insurers inconsistent over HIV

Some people in Britain who have taken HIV tests have had trouble getting life insurance—even though their test results were negative. Some insurers assume that merely taking a test means that you are at risk of having antibodies to HIV. Here we look at the position in other countries. Most are concerned only if a person has a positive result, but the questions asked about an applicant's lifestyle vary considerably.

Australia

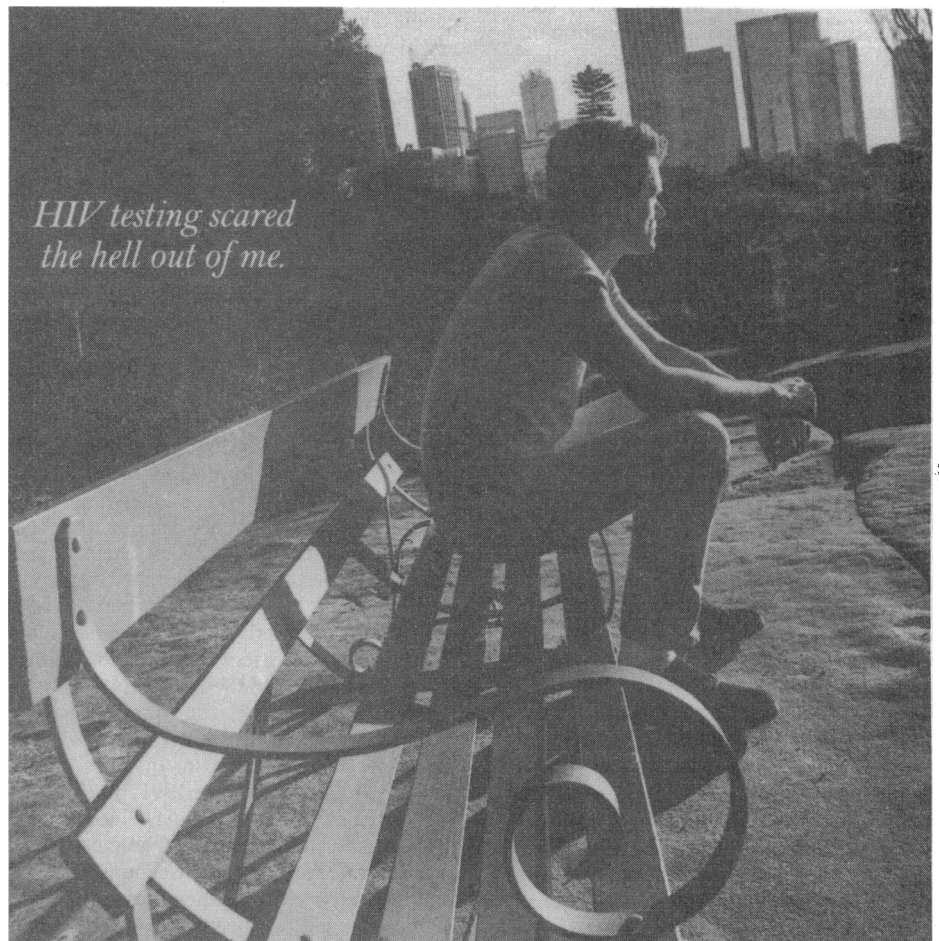
Australian insurers believe that their code of practice for HIV testing is the best and fairest in the world and causes few problems. But AIDS organisations are pushing for reforms. Moreover, access to superannuation, which is now compulsory in Australia, is more important to the gay community than life insurance, and here the position is more contentious.

In 1987 the Commonwealth government set up an inquiry to look at the issues of discrimination and privacy raised by the way that insurance companies dealt with applicants who had taken HIV tests. The report led to insurers uniformly adopting a code of practice in 1988. According to Mr Ken Pike, convener of the Life Insurance Federation of Australia's Committee on Risk Classification "The code ensures that nobody will be rejected from insurance on the basis of sexual orientation."

The wording of questions asked of applicants is the same for all life offices—as specified by the code. When applicants have been tested for HIV or are being treated for AIDS they are presented with a detailed questionnaire which is sealed and filed separately in accord with the confidentiality provisions of the code. Further medical testing is then allowed, either by the company's own doctors or by consultants.

But the code has not made it any easier for gay men to get life cover. Mr Michael Alexander, legal officer for the AIDS Council of New South Wales (the state which contains the majority of Australia's HIV/AIDS population), said that it is almost impossible for men who declare they are gay to buy life insurance.

Insurance companies dominate the private superannuation industry, which demands information on HIV testing and has exclusion clauses for anyone who becomes HIV positive after two to three years of entering a scheme. The new Commonwealth Disability Discrimination Act, introduced this March, makes it unlawful to exclude someone from



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In fact, the evidence indicates that early medical treatment can play a major part in staying healthy longer.

The first step is to telephone the AIDS Council on 008 810 003 to talk in confidence about HIV testing, and recent medical and health-sustaining developments.

Or talk to your doctor.

A joint project of the AIDS Council of NSW, the Victorian AIDS Council and Wellcome Australia Limited. Endorsed by People Living With AIDS (NSW) Inc and the National Venerology Council of Australia.

THE SOONER YOU TAKE CONTROL THE BETTER

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Australian insurers believe that their way of dealing with HIV testing is the fairest in the world

insurance or superannuation where the act of discrimination is not based on actuarial evidence. Mr Alexander says that such evidence has not been found to support exclusion clauses, and if this is tested in court the new act will probably make them illegal.

Mr Lex Watson, an academic at Sydney University who is arguably Australia's best known advocate for people with AIDS, queries the insurance industry's confidence in the code and points to a looming dispute over the life insurance component of superannuation. "We desperately need a redraft-

ing of the code and a proper, independent ombudsperson to mediate when applications are rejected," he said. "We shall be appealing to the government that actuarial evidence does not support clauses excluding HIV positive people. The hysterical predictions of the industry that it would go broke if it covered them have not eventuated."

A comprehensive guide to the minefield of insurance and superannuation for the HIV population was published last month in *The Australian HIV/AIDS Legal Guide*. —PETER POCKLEY, science writer, Sydney

Headlines

London GPs' views of Tomlinson report: Two out of three London GPs who responded to a recent survey by the General Medical Services Committee think that implementing the government's proposals for London in full will be detrimental to health care (p 1547). For most, the priority for the next year is to improve funding for hospitals and increase the number of beds available.

Australian doctors put resignations on hold: A former Chief Justice of New South Wales, Sir Laurence Street, has been appointed to mediate between the state government and the Australian Medical Association in the dispute over pay cuts for 2700 visiting medical officers. The appointment has averted mass resignations from the visiting medical officers, due this week.

Patients die of aluminium poisoning after dialysis in Portugal: Two government reports have found that 72 patients who received dialysis at Evora hospital over the past two years had symptoms of aluminium poisoning. So far 16 patients have died. The health ministry's preliminary investigations suggest that the town's water supply and inadequate filtering by the dialysis machines were both to blame. Two doctors have been suspended.

Netherlands has lowest abortion rate: The Netherlands has the lowest abortion rate in the world—five abortions per 1000 women, says a report from the International Planned Parenthood Federation. Abortion is available on demand in the Netherlands. In Western Europe, where (except in Ireland) abortion is most easily available, the rate is 14 per 1000; in Latin America, where a legal abortion is difficult to obtain, the rate is 30-60 per 1000 women.

Airline allows smokers back: The Scandinavian airline SAS, which banned smoking for flights of up to two and a half hours in March, is to reverse the decision after complaints from passengers. The ban was intended for a trial period of six months. The WHO and the International Civil Aviation Organisation are pushing for a smoking ban on all international flights by 1 July 1996.

Increase in notified drug addicts: The number of notified drug addicts in the United Kingdom rose to 24 700 in 1992, a 19% increase from 1991, the Home Office reports. New addicts increased by 9700, a 21% increase over 1991. The Home Office attributes the rise to more drug addicts seeking help.

Britain

Insurers in Britain are under pressure to stop discriminating against applicants for life insurance who admit to having taken an HIV test. Insurers currently ask about HIV tests—even when the results are negative.

The Department of Health has told the Association of British Insurers that, as more people take up opportunities for HIV testing, negative HIV tests will become a less effective means of identifying those at risk. Baroness Cumberlege, junior health minister, has told the association that it would be more appropriate for insurers to ask only about positive test results or to ask applicants to have HIV tests for policies over a certain amount.

In addition, the AIDS charity, the Terrence Higgins Trust, is campaigning to make it illegal for insurance companies to ask about HIV tests where the results were negative. It believes that the only question asked about AIDS on proposal forms should be whether the applicant has had a positive result in a test for HIV. The trust has suggested that insurers should ask applicants to take HIV tests at much lower levels of cover.

Many people seeking life insurance have to complete questionnaires about their sexual preferences or other factors that could put them at high risk of HIV infection and companies admit that some people may be refused insurance or charged higher premiums because of their answers.

The guidelines on the questionnaires, produced for the insurance industry by the Association of British Insurers, have remained unchanged since 1991. The guidelines suggest that companies should ask applicants for life insurance whether they have ever been personally counselled or medically advised in connection with AIDS or any sexually transmitted disease and whether they have ever had an HIV test. If so, the applicant is asked to give details, dates, and results. Some companies also ask whether the applicant is a haemophiliac,

intravenous drug user, homosexual or bisexual man, and whether the applicant has, to his or her knowledge, at any time been a sexual partner of someone who belongs to one of these groups.

The association says: "Having had a negative HIV test will not, of itself, prevent someone from obtaining life insurance or even affect the cost, providing there are no adverse risk factors present. Consequently, having a test for routine purposes such as giving blood, prenatal screening or employment creates no problem regarding life insurance." But the implication, borne out by what some companies say, is that even tests with negative results, if conducted for non-routine reasons, may make it more difficult or more expensive to obtain life insurance.

In 1991 a study commissioned jointly by the Association of British Insurers and the Department of Health from the British Market Research Bureau concluded that possibly tens of thousands of people were being put off taking an HIV test because of such questions.

Virginia Bottomley, then minister for health, described the results as "worrying." She said that those deterred include some of the people that the Department of Health would most want to encourage to come forward for a test and that such questions could be hindering the government's attempts to halt the spread of HIV.

A spokesman for Commercial Union said there was no automatic bar on providing life assurance for someone who had had an HIV test with a negative result. "But the vast majority of people who are willing to go and have a test would do so because they would feel that they had put themselves at risk in some way. If they are liable to engage in high risk activities, then we believe that must be taken into consideration."

Commercial Union said that it sends a supplementary questionnaire to all single males applying for life assurance, married men applying for cover of £150 000 or more, and married women applying for cover of £250 000 or more.

A spokesman for Eagle Star said that it might send out lifestyle questionnaires if, for example, two men had applied for a joint mortgage linked to a life insurance policy. The spokesman said: "If someone admitted being homosexual, we would ask questions about whether they were in a stable relationship. It would be likely to increase the cost of cover. If there is no evidence of promiscuity we would probably still be able to offer cover."—SHARON KINGMAN, freelance journalist, London

The Terrence Higgins Trust

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British insurers still discriminate

United States

American life insurance companies can insist that an applicant takes an HIV test, but they can't ask questions to find out if the applicant is a member of a high risk group. Nor can they ask about sexual orientation.

"It would be against public health policy to penalise people who have taken an HIV test, because we want to encourage testing," says



TERRENCE HIGGINS TRUST

US insurers accept that people should not be penalised for taking a test

Mark Scherzer, a New York lawyer active in the issues of AIDS and insurance.

In the US insurance companies are regulated by individual states. Facing the AIDS epidemic in 1986, the National Association of Insurance Commissioners (the state regulators) and the American Council of Life Insurance (the leading national trade association of insurance companies) drew up guidelines prohibiting insurance companies from considering a person's sexual orientation when it came to selling life insurance.

"Life insurance is not a condition for getting a mortgage in the US although it is often purchased in connection with a mortgage," says Jeff Levi, director of public policy at the AIDS Action Foundation in Washington. "You can get mortgage insurance with no individual underwriting [evaluation of personal risks]. There's an outrageously high premium, but if the person is buying the home with only a small deposit the mortgage lender may want that insurance," he says.

Mark Scherzer says that when insurance companies ask applicants to take an HIV test they must ask for informed consent and the applicant must designate someone to get the test results—either the applicant or a doctor. "The basic rule is that the insurance company has to underwrite according to risk, to treat people of similar backgrounds equally. The company cannot assess risk based on marital status, sexual orientation, or occupation," Scherzer says.

"There are no industry standards. You can't inquire about another company's practices," says Stephen T Moskey, director of consumer issues at the Aetna insurance firm and a board member of the National Leadership Coalition on AIDS, which helps companies to develop AIDS policies. Most US insurers do require applicants for individual life insurance policies of \$100 000 or more to take an HIV test, Mr Moskey says. "There's virtually no testing of people who get group life insurance coverage through their jobs, their unions, or groups such as university alumni associations. Only if

someone requests coverage for five or 10 times their annual salary may they be asked to take an HIV test," he says.

"No insurance company will write individual life insurance on someone who's HIV positive," Mr Moskey says. — JANICE HOPKINS TANNE, contributing editor, *New York Magazine*

France

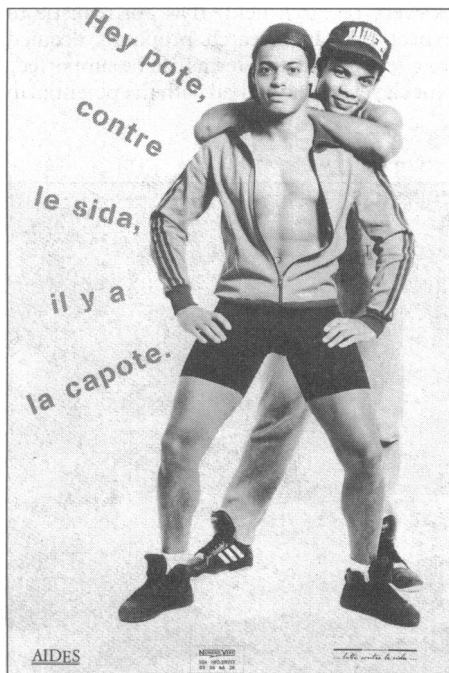
So many French people take HIV tests that simply taking one and having a negative result is not seen as a risk factor. A survey by an association that treats people with AIDS—the Association de Recherche pour le Traitement du SIDA (ARTS)—found that one in four men and women had taken the test. This ratio rises to just over one in two of all people between 25 to 34.

Following the blood scandal in which officials were charged with knowingly distributing blood that was infected with HIV, testing is likely to become even more widespread. Professor Jean-Marie Andrieu of the Laennec Hospital in Paris and founder of ARTS said that over 90% of people would agree to an HIV test if it was free. Most pregnant women and all of France's blood donors are already tested.

According to Pierre Laversanne of the Paris Insurance Union (UAP), even if insurance companies did ask for information on HIV testing merely having a test would not penalise an applicant for life insurance. Testing is usually requested only for people asking for policies over Fr1m.

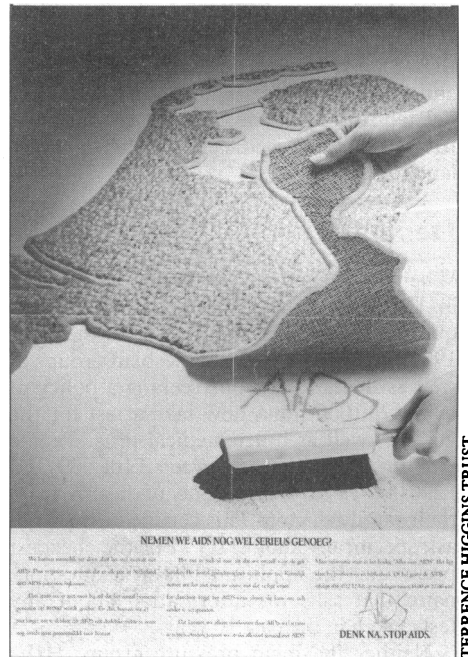
Mme Danielle le Roux of the Conseil National du SIDA, a government organisation, points out that the government and insurance companies have agreed on guidelines for dealing with people who test positive for HIV.

There have been about 26 000 people diagnosed as having AIDS so far, and between 90 000 and 130 000 people have antibodies to HIV. — ALEXANDER DOROZYNSKI, medical journalist, Paris



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France: up front about HIV and AIDS



TERRENCE HIGGINS TRUST

Netherlands: anxious to stop the spread of AIDS

Netherlands

In March Dutch insurers stopped requiring applicants for life insurance to admit to having had HIV tests unless those tests had proved positive. "In past years, problems were sometimes encountered by people applying for life insurance who had been tested for HIV and who were found to be seronegative," says Wiebe van der Woude of the National Committee on AIDS Control, an independent advisory body to the Dutch government. Rob de Waal of the HIV Association also knows of similar difficulties with insurers.

Insurers will still be able to ask applicants wanting life insurance worth more than 200 000 guilders (about £73 000) to have HIV tests. But now the insurers cannot make applicants for smaller amounts or for disability insurance have HIV tests, or ask them open questions about tests. Until this year such applicants were asked, "Have you ever undergone a blood test for sexually transmitted diseases such as syphilis or AIDS? If yes, why, when, for what, and with what result?"

Objections to the wording of this health declaration were raised on all sides. After much discussion in the Dutch parliament a new declaration was agreed at the end of last year and was adopted by the Dutch Association of Life Insurers. In the modified declaration of health, in use since March, applicants are asked "Have you got AIDS?" and "Have HIV antibodies been found in your blood (are you seropositive)?" Questions are also asked about blood transfusions given abroad, misuse of intravenous drugs, and treatment for anal gonorrhoea.

Wim Mooij, general secretary of the insurers' association, says, "If the answer to these questions is 'no' there is no reason why applicants for these lesser amounts should not be accepted by the insurer in the normal way. Lifestyle is of no importance."

The Royal Dutch Medical Association

(KNMG) does not agree. According to Willemien Kastelein of the association, these questions do encroach on the privacy and lifestyle of the applicant and should be deleted from the declaration of health.—HENK HELLEMA, medical journalist, Netherlands

Denmark

When the national insurers' association in Denmark worked out its guidelines for questioning people about HIV in the mid-1980s it consulted gay and lesbian groups as well as doctors. Anyone seeking a policy of over £200 000 must now take a test for the virus as well as other medical tests. People looking for policies between £100 000 and £200 000 need a certificate of health from their family doctor. This certificate does not ask specifically about HIV. For the cheapest premiums the applicant fills in a questionnaire that asks for information about any tests taken in the past 10 years.

Neither the main pressure group, HIV-Denmark, nor the insurers' association, nor gay and lesbian groups have received any complaints about the system. A representative of the Danish Medical Association (DMA) said: "We feel there is fair play. Doctors are only asked to disclose information that is relevant, and this should not include a negative test for HIV. Our policy is that it would be completely unacceptable to disclose this." The DMA would, however, like this to be backed up by a law preventing life insurance companies from demanding access to original documents. It hopes that legislation will go before parliament in the autumn.

The only problem lies in the cheapest bracket of life insurance, where applicants are expected to disclose themselves if they

have taken an HIV test. A spokeswoman for the insurers' association said that it was usual for a company to issue a policy to anyone who had had a recent, negative test result. Companies could not, however, be forced to do this. She added that an applicant who had taken a test some time ago might be asked to repeat it.

Ole Morten Nygaard, of HIV-Denmark, says that the Danish system is among the most liberal in Europe, and as satisfactory as one could expect from the private sector. But he is worried about the possibility of discriminating against people on the grounds of their sexual behaviour, or because they are known to have been tested. About 3300 people in Denmark are infected with HIV, and officials estimate that half as many again are undetected.

Ole Morten points to the first court case in Denmark last year, after a gay man was told that he must show that he was free of HIV infection for 10 years before he could qualify for a local authority pension scheme. The decision was reversed on appeal. The Danish system advises extensive counselling before testing, part of which concentrates on administrative and legal considerations, including insurance.—MARGARET DOLLEY, freelance journalist, Copenhagen

Canada

Applicants for life insurance in Canada cannot be discriminated against either because they are gay or because they have been tested for HIV infection. Any insurance company that did discriminate would contravene the country's laws on human rights.

Guidelines for Canadian insurers were set out in 1987 by the Canadian Life and Health Insurance Association Incorporation—the

trade association for about 102 companies. Charles Black, its vice president for insurance operations, says that these guidelines still hold. They state that "no adverse underwriting decision" should be based on a previous consultation or testing for HIV infection with a negative or unknown result.

Mr Black said that applicants are normally asked if they have ever tested positive for HIV infection or received counselling for that condition. Companies routinely require medical tests for applicants requesting insurance cover of C\$100 000 or more but these are designed to detect a number of risk factors for disease and not just HIV antibodies.

For lower amounts of cover, testing might also be done if there were a medical history of other sexually transmitted disease, but the main concern would be promiscuity and not sexual orientation. If an HIV test ordered by the company was returned negative, no further action would be taken.

The question of HIV testing for insurance has not been a problem in Canada, Mr Black said. "If Canadians were asked whether they had received the test a large number would have to say yes, because every blood donation is tested."

David Garmais, of the Canadian AIDS Society, an umbrella organisation of more than 70 community AIDS groups across Canada, agreed. "I think it's probably not a problem here," he said. "I don't know of any instance where they [insurance companies] have turned people away or discriminated in any way against [applicants] because they have taken a test previously. Nor do I know of any case of their having turned anyone down or discriminated against them on the basis of their being in a high risk group."—DAVID SPURGEON, scientific and medical journalist, Quebec

British government launches science strategy

A process of systematically collecting information on what developments can be expected in science and what industry and other users of research need will be at the centre of the British government's strategy for science, which was launched last week.

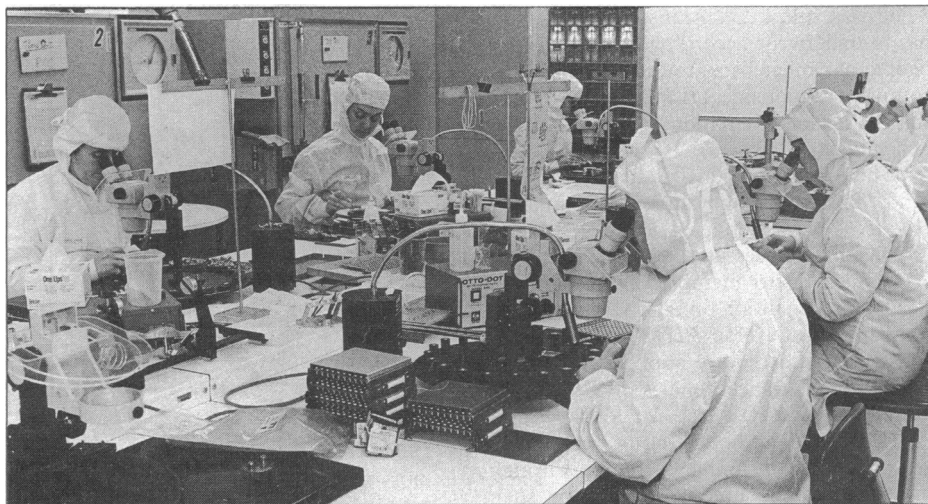
A technology foresight steering group will oversee the process. It will agree a list of technological sectors and then collect information from academics, industrialists, financiers, consumer researchers, and government. The results will be combined into a document that identifies the technologies which will be of most importance to the country's economy. The government will use the information to set the future direction, balance, and content of its own science and technology programmes.

The programme is likely to lead eventually to Britain concentrating on particular areas of science. The white paper says: "The United Kingdom cannot hope to stretch its

intellectual or financial resources in an attempt to support work over the entire area of every research field. It is not realistic to expect that all research proposals deemed excellent in scientific terms can be supported. Nor can every individual with the potential to

contribute good quality research in the field of his or her choosing be supported."

The white paper proposes changes in the central committees that oversee science policy. The Advisory Board for the Research Councils is to be absorbed into the Office of



Government policy is to focus on particular areas of science research

Science and Technology within the government department of William Waldegrave, the cabinet minister with responsibility for science. A new post of director general of research councils will be introduced, and he or she will be responsible for interpreting to the research councils the implications of the results of the foresight exercise.

The research councils themselves will be changed in that the Science and Engineering Council is to be split into two councils, the Engineering and Physical Sciences Research Council and the Particle Physics and Astronomy Research Council, and the Agricultural and Food Research Council is to be changed to the Biotechnology and Biological Sciences Research Council. The research councils are all to be given a mission statement that makes explicit their commitment to wealth creation and quality of life, and they are required to have a part time chairman, a full time chief executive, and a slimmed down council.

The dual support system, whereby funds to support research in universities flow down both from the higher education funding councils and the research councils, will be maintained, and so will the customer-contractor principle used to commission applied research and development within government departments. The government is interested in privatising some of the services currently supplied by government research establishments, but at the same time it is now more willing to support research that leads to producing a marketable product, which until now it has left firmly to the private sector. The strategy also includes plans to develop the career structure of researchers.

The Royal Society said that the white paper offers a "promising framework for the future development of science and technology . . . however, much will depend on the details yet to be filled in." Dai Rees, the secretary of the Medical Research Council, said: "We welcome the white paper and its strong commitment to science. I am pleased to see the bold and realistic approach to the many urgent issues currently facing UK science and technology and the clear resolution to tackle them."—RICHARD SMITH, *BMJ*

Reading Our Potential: A Strategy for Science, Engineering and Technology (Cm 2250) is available from HMSO, price £9.65.

Out of date vaccines given to Indian children

Many thousands of infants in India have received substandard or expired vaccines during India's eight year Universal Immunisation Programme, says a government audit report released this month. The report, from India's comptroller and auditor general, criticises India's ministry of health and family welfare for major lapses in implementing the immunisation programme and



SEAN SPRAGUE/PANOS PICTURES

India spent over 280 million rupees on its much criticised immunisation programme

accuses health authorities of exaggerating their achievements.

The immunisation programme, launched in 1985, aimed to expand immunisation services to protect at least 85% of all newborn babies in India against diphtheria, measles, pertussis, poliomyelitis, tetanus, and tuberculosis. These diseases are estimated to cause a quarter of all infant deaths in India. In 1991 the health ministry reset the immunisation target to cover all newborn babies.

India has spent over 2800 million rupees (£58m) on the programme. Unicef also provided funds for vaccines, cold chain equipment, and training field staff. Infant mortality in India, which stood at 97/1000 live births in 1985, dropped to 80/1000 in 1992. The report, however, says that only eight out of India's 32 states and federal territories have met all the immunisation targets. Under the immunisation programme all pregnant women in India were also to receive two doses of tetanus vaccines. Only six states have achieved this target.

The audit also showed that at least 1.2 million doses of expired or substandard vaccines were given to infants. In one state three batches of tetanus vaccine containing fungus—and previously declared unfit for use by a government research laboratory—were released. In another instance three batches of oral polio vaccine sent for potency testing were declared unsatisfactory, but 197 000 doses had already been given before the test results arrived.

Under the vaccine protocol each infant was to receive, before the age of 1 year, three doses of the diphtheria-pertussis-tetanus vaccine, three doses of the oral polio vaccine, and one dose each of the measles and BCG vaccines. The report said that 3.2 million doses were given to children more than a year after birth. Drop out rates have ranged up to 70% in some states for the diphtheria-pertussis-tetanus vaccine, and up to 50% for the oral polio vaccine.

The audit report accuses rural health centres of presenting unreliable performance reports. Many centres have reported figures for the consumption of vaccines that

exceeded the quantity of vaccines in their stocks. "Either less than the required quantity of vaccine was given in each dose, or the achievements have been overstated," the report says.

The health ministry responded by saying that "steady progress" has been made in expanding immunisation coverage as well as in reducing the drop out rates. Numbers of reported cases of poliomyelitis dropped from 22 000 in 1985 to 6000 in 1992.—GURU NANDAN, science writer, New Delhi

Bogus British professor sentenced to prison

A bogus doctor who claimed to have found a cure for cancer and AIDS was sentenced to six months in prison at Isleworth Crown Court, west London, last week.

Elizabeth Marsh, 49, of Northolt, Middlesex, was prosecuted by the Department of Health under the Medicines Act 1968 for issuing a misleading advertisement. She was found guilty by an 11 to one majority last month, but sentence was postponed until the judge was informed of her activities in Northern Ireland.

Mrs Marsh styled herself as doctor and professor although she has no medical qualifications. In a booklet, *Cancer and AIDS: Is There Any Hope Left for Us*, she claimed her product, CH6 or Canceled, could cure cancer, "Eliminate the HIV virus 100 per cent" and effectively treat Parkinson's disease, myalgic encephalitis, hepatitis, cystic fibrosis, arthritis, sickle cell anaemia, haemophilia, herpes, meningitis, multiple sclerosis, and asthma. Analysis of the substance by chemists showed it had no medicinal properties and contained toxic elements.

Mrs Marsh recruited volunteers for trials of the product at her Bio-Medical Care Centre, run from a house in Greenford, west

London. She made no charge for the drug but demanded a consultation fee of £95.

She also ran two clinics in Cookstown, County Tyrone, under the name Natural Medical Healthcare Clinic from June 1992 to January 1993. She opened a third, the Holistic Health Centre, in Holywood, County Down, last March, while facing charges. The Royal Ulster Constabulary also conducted an investigation into her clinics.

During the trial, prosecuting counsel David Ross described her as "a fraud and a charlatan." He added: "She said she could cure two incurable conditions, and two of the most frightening diseases. It was inevitable that she might attract people desperate enough to try her remedies."—CLARE DYER, legal correspondent, *BMJ*

NHS could work with fewer, better staff says NAHAT

The expanded review into NHS management announced last week (22 May, p 1364) will mean that high quality staff can be used to strengthen local management. This is one of the beliefs of the National Association of Health Authorities and Trusts (NAHAT) in its evidence to the review. It says that the NHS reforms will work properly only if more decisions are made away from the centre by health authorities and trusts. At the same time NAHAT wants to strengthen the accountability to parliament for the overall performance of the NHS.

NAHAT sets out other key outcomes which it hopes the review will aim for. The NHS has to be able to deliver on the targets set by the secretary of state, and the public must have confidence that it can do so.

The increasing role of the NHS Management Executive and the development of corporate contracts has helped to some extent, but the association believes that there is still too much "paper, advice, and guidance" for workers in the NHS to be able to concentrate on priorities. NAHAT puts some of the blame on national pressure groups, including the health professionals, who put too much pressure on the centre for changes in operational management.

Ministers should set the goals and then, on the advice of the Department of Health, set "robust performance targets" for the management executive. NAHAT would like the management executive to become a management agency. It should develop its own identity, with the chief executive accountable to parliament.

In the long term, the association argues, there should be one intermediate tier, and it suggests a number of authorities somewhere between the six management executive outposts and the 14 regional health authorities. The continuation of two tiers—one for purchasing and one for providing—will be illogical once all provider units are trusts. The resulting tier could either be a statutory authority or a regional arm of the management executive.

Its key role will be to regulate the internal market, but NAHAT suggests that it would also be able to ensure that monopolies do not arise in either purchasing or providing, and it could look after long term health issues in the region. NAHAT would like the intermediate tier to operate with a minimum number of staff to carry out core functions.

NAHAT hopes that the review will promote the continued development of effective purchasing and makes the following suggestions: there should be sharing of good practice in purchasing; care should be taken in recruiting suitable chairs and non-executive members of purchasing authorities; purchasers need a higher profile as the organisations responsible for the wellbeing of the public health; and purchasers' performance needs to be assessed rigorously.

NAHAT hopes that the review will suggest ways of enhancing public accountability in the NHS and says that all boards should appoint a company secretary and audit and remuneration subcommittees chaired by non-executives. Boards should be as open as possible and develop procedures for building partnerships with the local community and letting the public know about major decisions.—LINDA BEECHAM, *BMJ*

Home Office pays up for prison suicide

The Home Office has agreed to make a £15 000 ex gratia payment "without any admission of liability" to the family of a young New Zealander who committed suicide in Brixton prison while waiting to be deported for a minor offence. Jeffrey Rofe, 25, who had come to Britain for a working holiday, spent 70 days on Brixton's "F" psychiatric wing—the last 38 after a conditional discharge by magistrates.

The case, which "appalled" the coroner investigating it and filled him with "alarm and disquiet," highlights the inadequacy of the prison system in coping with mentally

disturbed offenders. The settlement was negotiated by MIND, the national association of mental health, which threatened the Home Office with negligence proceedings over the case.

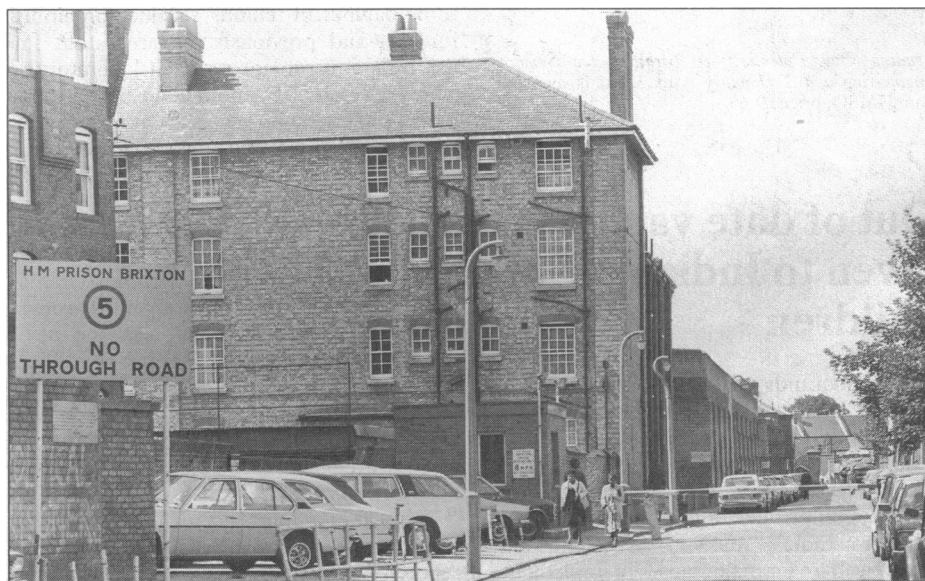
Mr Rofe was arrested in June 1989 after setting fire to pages of his address book and dropping them in a litter bin at Baron's Court tube station in west London. He believed that he was being followed on the tube and was afraid that "spies" would get his friends.

On 19 July the magistrates convicted Mr Rofe of attempted criminal damage by arson and accepted a recommendation by the prison doctor in charge of his care, Manorama Legha, that he should be repatriated to New Zealand. Without consulting psychiatrists or her superiors, she told the magistrates that he wanted to return home and it would be a kindness to send him there. The magistrates gave him a conditional discharge, adding that he should remain in prison until his deportation.

Dr Ham Baxter, a consultant psychiatrist from Charing Cross Hospital, who saw Mr Rofe on 25 July, offered him a bed at the hospital, but Dr Legha refused the offer and Dr Baxter could do nothing because of the deportation order. In a letter to Brixton prison after Mr Rofe's suicide, Dr Baxter wrote that he was concerned because Mr Rofe seemed "heavily over-sedated and was clearly suffering from severe side effects from his medication." In addition, "an acute psychotic illness in a man with no previous history . . . was being dealt with administratively by return to his homeland when he had clearly said he did not want to return."

Dr Legha insisted on accompanying Mr Rofe to New Zealand personally, but staff shortages at Brixton meant there was no cover for her and a flight booking for 14 August had to be cancelled. On 26 August Mr Rofe tied one end of his shirt to a bed post, the other round his neck and rolled over and over until he strangled.

The Home Office took the virtually unprecedented step of reporting Dr Legha to the General Medical Council, following an inquiry into the case by Dr Brian Cooper, principal medical officer at Parkhurst prison.



Brixton prison, described as "the last place you would put a psychotic patient"

Dr Legha, who resigned after the inquiry, was also accused of misconduct in relation to two other prisoners, but the GMC cleared her.

Dr Cooper told the GMC hearing that F wing was "the last place you would put a psychotic patient," describing the wing as "a human warehouse where humans are stored, labelled, and catalogued." He added: "Treatment was largely confined to medication. Staff interrelation with patients were minimal. There are constant background noises interrupted by the screams of the more disturbed patients."

MIND brought the compensation claim on behalf of the trustees of Jeffrey Rofe's estate, who include his brother, Stephen. His mother committed suicide three weeks after her son's death.—CLARE DYER, legal correspondent, *BMJ*

EC ministers take hard look at prices of drugs

The European Commission is investigating whether drugs companies are keeping the prices of new medicines artificially high. The EC social affairs commissioner, Pdraig Flynn, said that some companies were abusing what was effectively a market monopoly for new drugs. Mr Flynn was speaking in Brussels after a meeting of community health ministers on 27 May.

Though ministers widely criticised the current high prices for innovative drugs, they failed to adopt a draft statement asking for more moderate pricing from the drugs companies. Germany in particular opposed the draft text. The Danish health minister, Torben Lund, who drafted the statement, said that all the ministers voiced concerns about high prices in the market. Mr Lund said that the high prices particularly affected pensioners.

EC officials said that some drug firms were refusing to sell new drugs in countries where the government did not approve the prices they wanted to charge. Refusal to sell constitutes the abuse of a dominant market position, which is illegal under the community's fair competition rules.

The EC's scope for acting on drug prices is limited. This is a matter for national governments to settle. But the Danish initiative was destined to put moral pressure on the drug companies. "We have more force when we work together," Mr Lund said. Mr Flynn said that the commission's investigations were being assisted by the Consultative Committee on Drugs Pricing, which was set up under a 1989 EC directive on price transparency for medicines.

During their session, ministers also returned to the question of tobacco advertising. But again they failed to reach agreement. Five countries—Britain, Germany, the Netherlands, Denmark, and Greece—are blocking the adoption of a ban throughout the community.

Brian Mawhinney, minister of state for



The EC's scope for acting on drug prices is limited

health, told the meeting that Britain would, as an alternative, submit later this year a working document to ministers setting out measures that governments could take to discourage smoking and setting targets for the reduction of tobacco consumption. Ministers rejected, however, a Danish proposal to raise excise duties on tobacco products. Ministers did agree to draw up a six year programme to improve the quality of life in the community.—ROBERT TAYLOR, freelance journalist, Brussels

Deep sleep: Australian doctors escape discipline

An eight year investigation into the use of the controversial deep sleep treatment at an Australian private psychiatric hospital has been halted after a High Court ruling that the doctors concerned should not face disciplinary proceedings.

By a three to two majority the court upheld a decision by the New South Wales Court of Appeal that the case against Dr John Herron, Dr Ian Gardiner, and Dr John Gill should be permanently stayed on the grounds that to allow it to go ahead "would be so unfairly and unjustifiably oppressive" that it would constitute an abuse of the state's medical tribunal process.

The three doctors, associates of the late Dr Harry Bailey, the leading exponent of deep sleep treatment in New South Wales, had faced disciplinary charges arising out of a royal commission into the use of the treatment at Chelmsford Hospital in Sydney during the 1970s. The commission had found that the treatment, originally practised by Dr Bailey to treat all manner of psychiatric problems, including depression, schizophrenia, anorexia, and drug and alcohol misuse, was linked to the deaths of 24 patients between 1963 and 1979, when the treatment was ended.

Some patients were kept heavily sedated for several days at a time with tranquillisers and barbiturates. Dr Bailey later faced criminal charges arising out of the use of deep sleep treatment but committed suicide in 1985 after the treatment had been, in the words of one High Court judge, "completely discredited." It later emerged that Dr Bailey had falsified death certificates for 17 of the 24 patients to avoid inquests into their cases.

The original allegations of professional misconduct against his three associates arose out of civil litigation taken out against Dr Herron by a former patient at Chelmsford Hospital. The patient won the case in 1980, which prompted the Department of Health in New South Wales to lay charges against the doctors.

After an investigating committee found that there were cases of misconduct to answer, the complaints were referred to a medical tribunal in 1986. Dr Herron and Dr Gill were granted an order by the New South Wales Court of Appeal to stay those proceedings indefinitely, given the delay in bringing the charges.

But public disquiet and further allegations about the use of deep sleep treatment at the hospital led to the appointment of the royal commission, which, after a 288 day hearing between October 1988 and July 1990, produced a damning 12 volume report. The commission concluded that "deep sleep therapy was an extremely dangerous treatment and was carried out with inadequate facilities, staff, and equipment to deal with the risks. It was therapeutically ineffective."

As a result of the royal commission's findings, fresh charges of professional misconduct were laid against Dr Herron, Dr Gardiner, and Dr Gill relating to the treatment of patients not connected with the original allegations that had been stayed by the Court of Appeal. These alleged that the three had shown a lack of adequate knowledge, experience, skill, judgment, and care and had been guilty of improper or unethical misconduct. Evidence to support these charges, heard in the High Court, had been gathered from 100 patients. The health department appealed to the High Court to have the Court of Appeal's ruling overturned.

While the High Court declared that the occurrences at Chelmsford Hospital had been both "tragic and notorious," three of the five judges ruled that the department had failed to establish any legal grounds to show that the lower court had made the wrong decision and dismissed the appeal. The two dissenting judges, however, said that the laying of the complaints from the royal commission's report were in line with the department's disciplinary procedures and should have been heard by the medical tribunal.

The department was ordered to pay its own costs and those of the three doctors. The total bill is estimated to be more than \$A1m (£450 000).

The High Court's decision means that the three doctors are still able to practise medicine. Dr Herron and Dr Gill are still believed to be working privately, but Dr Gardiner, now over 70, has retired.—DANNY JOHN, Australian correspondent, *Guardian*

Labour blocks GMC bill on performance

The General Medical Council has been thwarted in its plans for early legislation to widen its jurisdiction over the professional performance of doctors. The Cabinet legislative committee has decided not to allocate time in the next parliamentary session for the required bill to amend the 1983 Medical Act. To the regret of the GMC it will not be included in the Queen's speech in November. In this the bill shares the fate of many other hopefuls which end up on the shelf each year. In the Department of Health's priorities it ranked lower than a proposed bill on child adoption. Prospects for the GMC bill would have been better if the department had been able to convince the legislative committee that it would be non-controversial and undemanding of parliamentary time.

Why was it unable to give such an assurance? After all, the GMC's scheme to deal with doctors whose performance is seriously deficient had been in preparation for a laborious three years—or more than a decade if you trace its origins to the Alfie Winn case, which first fuelled the demands for a procedure to deal with incompetent doctors. Moreover, the proposals have the backing of ministers as the basis of legislation.

What in the end frightened the horses was an outburst against the GMC from the Labour party, shattering any hopes of a smooth passage for the bill. It happened about two months ago when Labour's shadow health secretary, David Blunkett, suddenly called for an end to self regulation through the GMC. He said in a press release: "The time has come for a complete overhaul of the disciplinary procedures within the medical profession, with a view to establishing an independent body to investigate and discipline those guilty of professional misconduct. It is no longer good enough for the GMC to have responsibility for these matters given its recent track record."

David Blunkett was responding to the lifting of conditions placed on the registration of Mr Michael Bewick, the consultant involved in the "kidneys for sale" case. Mr Blunkett's statement went on: "If we are to have proper protection for patients then we can no longer have the profession policing itself. Legislation is needed not only to revise the role of the GMC but also to establish a new wholly independent body for the medical profession, with investigatory and disciplinary powers. The present set up is an unacceptable anachronism. Unless change is forthcoming then I fear the public will lose faith in their ability to have misconduct and incompetence investigated and dealt with."

As set out by Mr Blunkett, Labour's new approach is a radical departure. It ends the cross party consensus on the principle of self regulation in the medical profession. David Blunkett has since confirmed that Labour would vote against the second reading of any bill to enact the present GMC scheme. He therefore welcomes the postponement,

saying: "I would rather get it right than get it quickly. The GMC does not have to be destroyed if there is agreement about creating a more independent structure reflecting the needs of the twenty first century."

The omission of a GMC bill from the Queen's speech is not necessarily the last word. It is not unknown for bills to be reinstated during the session. Should that happen, however, Labour has ensured a more wide ranging debate than ministers

bargained for. In the meantime, Nigel Spearing intends to continue his hitherto lonely campaign to simplify the GMC procedures. As MP for Newham South, Mr Spearing is the continuing link with Alfie Winn, the West Ham football club's mascot. On her dead son's birthday Alfie's mother assaulted Dr Oliver Archer, who had failed to diagnose the meningitis which proved fatal. The story is not yet ended.—JOHN WARDEN, parliamentary correspondent, *BMJ*

The Week

More lessons from Oregon on engaging the public

Last week saw more heat than light on the subject of rationing. It started with the possibility, floated by the Treasury, of prescription charges for the young and the old. Next came the idea of charges for staying in hospital and calling out general practitioners. Finally, the Department of Health got embroiled in a row about six babies and an unmarried mother.

The department's response to the news that a mother who delivered sextuplets after in vitro fertilisation was unmarried and living apart from their father was to threaten guidelines. Presumably distracted by the fact that there were six babies, a junior minister questioned whether single mothers should be eligible for fertility treatment.

As it happens Redmayne and Kleine show in this issue (p 0000) that local decisions on in vitro fertilisation are very diverse and raise all sorts of interesting questions. The point is that the issues are intrinsically interesting: their consideration should not have to be prompted by one extreme case. Moreover, the six authorities that Redmayne and Klein discuss were merely those who had made their decisions explicit. As the Association of Community Health Councils also complained last week, many more are making covert decisions.

Health authorities struggling with decision making in the public gaze could do worse than look again to Oregon, not this time to the health care rationing process but to another successful use of public engagement in difficult decisions. In January's *Harvard Business Review* Peter T Johnson, administrator of Bonneville Power Administration (a public electricity company in Oregon, USA) describes how his company, through intensive involvement of community and interest groups, managed to make some very difficult decisions that everyone eventually accepted: "Though some were

disappointed with the choice, they had sufficient respect for the openness, thoroughness, and objectivity of the public involvement process that they did not challenge the decision."

One of these decisions was about whether the power administration should offer cheaper rates to the local aluminium industry to help it out when the market for aluminium collapsed, even though that would raise prices for other customers (the answer was yes, it should, though the price would rise again when the market returned). The public involvement process involved setting up a technical review committee representing all possible interests—local government, consumers, unions, aluminium companies, other customers—which studied the issues and modelled various options; at the same time the power administration sent booklets outlining the issues to 15 000 people and held over 50 public meetings and forums.

Johnson describes the moment they broke through, after a day's symposium packed with elected officials, representatives of public interest groups and utilities, and economists: "The day ended with an unspoken consensus that helping the aluminium industry would help everyone in the room. . . . We had agreed there was a problem, and we were ready to talk solutions." That was not the end of the process: more papers, options, and public meetings followed before the administration decided on a variable rate for the aluminium industry and got it swiftly through the formal public hearings.

One lesson of this article is that involving the public to this extent, and achieving sustainable outcomes, is very hard work: even getting the staff fully on board over being open with the public took over two years. Another is that British health authorities haven't even begun to scratch the surface of this sort of public debate.

HART