

either a nasojejunal tube or (preferably) a feeding jejunostomy.^{33 34}

Most likely to benefit from immediate enteral feeding are patients with a high risk of complications or of needing intensive care postoperatively. Enteral feeding is suitable for patients with acute and chronic pancreatitis provided that the feed enters the gut distal to the duodenum.³⁵ This type of nutritional support is contraindicated in patients with small bowel anastomoses or intrinsic small bowel disease and those receiving an aortic graft.

Few adequate studies have assessed the cost effectiveness of total parenteral nutrition, partly because of the difficulty in estimating the cost of total parenteral nutrition and its complications.^{36 37} Enteral feeding is much cheaper than total parenteral nutrition,³⁸ and with all the evidence that it improves morbidity it is undoubtedly, in our opinion, more cost effective. The time has come for formal comparisons of enteral with parenteral nutrition in severely ill patients.

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Tobacco and the European common agricultural policy

European gold kills

Through its Europe Against Cancer campaign the European Commission aims to reduce cancer by 15% by the year 2000. Smoking kills an estimated 431 000 people in the community each year,¹ and reducing smoking is the only way this target is likely to be achieved. Yet countering the £7.3m* spent on the cancer programme is £900m spent in 1991 to subsidise the production of tobacco.² This subsidy has built up over the past two decades, during which time the European common agricultural policy has operated a complex system of subsidies for growing, processing, and exporting tobacco leaf. In their paper in November's *British Journal of Addiction*, Joossens and Raw describe its main features, effects, and implications—a system of "labyrinthic complexity, uncontrollably expensive and worse than ineffective."²

The tobacco is grown mainly in Italy, Greece, Spain, and France and, to a limited extent, in Portugal, Germany, and Belgium. Support systems were set up to establish a common

policy throughout the region, to expand production in disadvantaged areas, to maintain a reasonable income for farmers, and to adapt production to the varieties of tobacco in greater demand.³ Tobacco is a relatively profitable crop, very labour intensive, and by far the most highly subsidised crop per hectare in the community. Some 26 different varieties are grown by 215 000 growers, mostly on plots of about a hectare, as their main or only source of livelihood.³ The growers cure the tobacco and sell it to processors (about 200 units in the community), who prepare it to the manufacturers' specification and bale it. Traditional production is of dark, mainly air or sun cured, high tar tobaccos, but demand for these is low and falling. Most in demand are the flue cured Virginian tobaccos, which make up only one fifth of the community's production.³ Consequently, the European Community is the world's largest importer of tobacco, buying in over half its requirements.

Subsidies take the form mainly of premiums (£650m in 1989)² set for each variety and paid as rebates to processors as

*A conversion rate of £1 to 1.5 European currency units (ecus) has been used throughout.

an incentive to buy tobacco produced in the community. About £70m was spent in 1989 on directly buying surplus tobacco (intervention) and some £40m in subsidies for exporting.

The policy may have succeeded in supporting farm incomes, but it has led to escalating production and subsidy. The unwanted as well as the desired varieties receive generous premiums and intervention prices. Insufficient differentials in premium between varieties and long lags on price setting have slowed the intended adjustments and led to much of the increased production being of tobacco varieties in low demand.³ Imports of Virginian tobacco remain high, while most of the tobacco grown in the community is surplus to requirements and either is added to mounting stocks or receives export grants to be dumped in developing markets, typically in eastern Europe and north Africa. For example, in 1990 processors in Italy, which accounts for half the exports, exported about 100 000 tonnes of tobacco. The tobacco was sold at less than 23p/kg, having been subsidised by more than £2/kg.² A system of quotas has been introduced to regulate supply by variety and area, but the penalties for exceeding quotas are so low that quotas have been exceeded by as much as 1000%.

The whole system was severely criticised by the European Court of Auditors in 1987³ and again by a special inquiry in 1990 (A Lachaux, unpublished report) both for the policies and for the irregularities. Instances were reported of premiums being set above the recommended price to be paid to growers. In effect, therefore, processors received tobacco free, with a rebate on top, and were paid again when they sold or exported it. The United Nations Food and Agricultural Organisation has described the tobacco surpluses as a constant problem in Europe since the introduction of the common agricultural policy.⁴

Joossens and Raw believe that fine tuning the mechanism is irrelevant.² They recommend that export refunds and intervention buying should be stopped and that the total subsidy should be phased out within 10 years. The money saved (almost £1bn a year) could be spent on direct income support and research and support for reconverting land to alternative

uses. The issues are complex and include economic, political, and legal considerations as well as those of health.

In some aspects of tobacco policy the European Community has been a radical policy maker. It has set maximum tar limits and improved health warnings, and its directive against television advertising of tobacco is now in force. It has proposed minimum tax levels, which should raise average cigarette prices in the community.

The community's policy on raw tobacco does not waste financial resources alone. The main tobacco growers within the community are countries with relatively low cigarette prices and rising cigarette consumption.⁴ The highly subsidised tobacco that is sold within Europe is likely to encourage smoking in direct conflict with targets to reduce cancer and coronary heart disease. Most of the rest is sold to eastern Europe, north Africa, and the Near East—promoting tobacco consumption in these areas and at concentrations of tar unacceptable in the European Community. Medical associations⁵ and cancer societies⁶ in the United States are campaigning against American trade policy on tobacco with its double standards and its prodigious impact on the health of the developing world.⁷ The European Community's policy on tobacco subsidy deserves similar urgent attention.

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Privatisation on parade

Trusts occupy a no man's land that neither "public" nor "private" adequately describes

Is privatisation really part of the government's hidden agenda for the NHS? More subtly, perhaps, will the current reforms lead to increasing interdependence between the NHS and the private sector, making it easier to expand provision within the private sector still further? And will financial constraints on health services through the 1990s lead to a growth in private finance and provision whichever party is in power?

Given the intense political debate on the topic, distinguishing fact from fiction has become increasingly difficult. Nevertheless, an examination of the government's record during the 1980s holds some important pointers to the future. Mrs Thatcher's government twice conducted fundamental reviews of the NHS. Both rejected moving to private insurance or social insurance despite the enthusiasm of some sections of the Conservative party and various right wing think tanks for more radical reform. Instead, the government decided to concentrate on strengthening the management of the NHS and introducing an internal market.

If private finance found little favour under Mrs Thatcher no reason exists for believing that it will hold greater appeal for John Major. He and his senior colleagues have emphasised the importance of delivering high quality public services that are responsive to the needs and demands of the community. For the NHS this means a service so good that people will not want to use the private sector. The announcement at the Conservative party conference that the patient's charter will contain a commitment to the continued provision of health services free at the point of use is a further signal that the government is concerned to show its support for the founding principles of the NHS.

The 1980s nevertheless witnessed a substantial increase in private financing and provision, most evident in the growth in subscribers to private insurance and the increase in the provision of private hospitals, especially those operating for profit. It was also apparent in the policy of competitive tendering, the use of private hospitals to help reduce NHS