be very time consuming. In our practice once these regular audits have been set up (not a particularly long task in itself) they take only a few minutes.

With audit becoming compulsory and with the acknowledgement of many doctors that continuous regular audit in essential our practice is glad that it has bought a car rather than continuing to rely on a bicycle.

Ammonite EX13 5AG

Robert McEwan

AIDS Education for Young People Research Programme, Division of Epidemiology and Public Health.
School of Health Care Sciences, University of Newcastle upon Tyne Medical School, Newcastle upon Tyne NE2 4HH

MARTIN WHITE

Division of Epidemiology and Public Health


Advertising infant formulas in hospitals

Sir, — The promotion of infant formula in hospitals as described by Charles Price and Kate Jackson1 and observed in other NHS hospitals illustrates again how reluctant companies that manufacture baby food are to abide by the spirit and letter of the code of marketing of breast milk substitutes drawn up by the World Health Organisation and Unicef.2 These companies contributed to the drafting of the code and have repeatedly promised to comply with it. The code was strongly supported and promoted by the United Kingdom’s Department of Health. It was drawn up to remedy the commercial pressures from infant feeding and to protect parents, babies, and health workers from such pressures, to which we are all vulnerable.

Companies that manufacture infant formulas would not have launched advertising space such as posters on hospital walls if it was not effective. One company has spent £3m promoting two brands of infant formula in the United Kingdom so far this year. In the United Kingdom that is 22% of the baby milk grew in value by 21% in the 12 months to October 1990.3 The Department of Health currently spends £50000 annually on the joint breast feeding initiative.

One way to address the problem is for purchasing authorities to include initiatives to protect and promote breast feeding in the contracts that they make with provider units. In the division of public health at the Institute of Child Health we have our own policy for implementing WHO and Unicef’s code, outlining what we should do in respect of the various articles of the code. This policy includes an agreement not to accept funding for research from manufacturers of infant formulas. Any health care workers in developing countries look to institutions in the United Kingdom to set ethical standards. All new staff in our centre are given copies of WHO and Unicef’s code and of our divisional policy, and implementation of the policy is monitored.

We suggest that all hospitals should develop their own policies for implementing the code effectively and monitoring compliance with it. The code was designed to protect all infants, including those who are bottle fed. The choice of a substitute for breast milk should be based on clinical criteria and not be influenced by commercial pressures. Paediatricians, who treat many sick and premature babies, and other health workers have a responsibility to take a lead in this.

JENNY AMERY ANDREW TOMKINS

Centre for International Child Health, Division of Public Health, Institute of Child Health, London WC1N 1EH


Privatisation on parade

Sir, — Chris Ham writes that growth in private medicine is likely over the next decade owing to the strict controls on public expenditure that is likely to occur.1 The view that public spending on health is heavily constrained rests essentially on two implicit assumptions: firstly, that public spending is not to grow as a proportion of gross domestic product and, secondly, that spending on health will not rise as a proportion of government spending. Growth in public health expenditure is therefore at best limited to growth in the gross domestic product.

No doubt unintentionally, Ham gives the false impression that private spending on health care is free from the same restrictions. If, as he suggests, the private sector will grow faster than the public sector it must escape one or both of the above constraints. Consequently, either private spending must rise as a proportion of the gross domestic product, or private spending on goods other than health must fall. But long as the government maintains public spending as a proportion of the gross domestic product and gives health the same priority as does the private sector, the public sector will not suffer a relative decline.

There is, however, one other means for private spending to grow faster than public spending; if the government took the so-called missed opportunities to take a larger share of the national income. In other words, a rise in inequality occurs. This has taken place to a substantial degree over the past decade, as Tony Delamothe’s article on social inequalities in health illustrates.4 I suggest that rising inequality, which Ham does not consider, is an important reason for the recent increase in private health care.

It is fashionable to suggest that the future growth of private health care is somehow an external phenomenon that governments are powerless to prevent. This is untrue, often for reasons not directly related to health expenditure. I have suggested above that total public expenditure— irrespective of actual health expenditure— and inequality of income will have appreciable effects on the growth of private medicine. Even if Labour and Conservative governments were to face the same direct constraints on health spending they offer widely differing policies on public expenditure and inequality.

IAN TOLSTIN

University College, Oxford OX1 4BH

1 Ham C. Privatisation on parade. BMJ 1991; 303:1099-10. (26 November.)


Education on AIDS during biology classes

Sir,— In response to pressure to include teaching on HIV and AIDS in the national curriculum the Secretary of State for Education, Kenneth Clark, announced in the House of Commons on 24 October that in future school biology classes would include teaching about AIDS. Though this is a welcome step, Mr Clarke misses the key point. Clearly, it is important that young people have accurate information about what HIV is and how it spreads. Young school leavers and young people know how HIV is transmitted.4 What they need is time to reflect on their knowledge and its implications for their future sexual and recreational lifestyles. They also need the skills to adopt and sustain behaviours that will protect them from infection in future.

Health educators, including specialists in HIV and AIDS, have argued that HIV infection needs to be addressed in the context of teaching on sexually transmitted diseases, sexual health, and relationships.3 These are subjects that should be covered in classes on personal and social education by specially trained and, where appropriate, specialist school health educators. Teaching about the mechanics of infection in biology, though interesting and educational, cannot provide the opportunity school pupils need to discuss the complex and sensitive issues surrounding HIV infection. The outcome that health educators seek, and will continue to lobby for, is the allocation of core curriculum time to personal and social education.

ROBERT McEWAN

AIDS Education for Young People Research Programme, Division of Epidemiology and Public Health.
School of Health Care Sciences, University of Newcastle upon Tyne Medical School, Newcastle upon Tyne NE2 4HH

MARTIN WHITE

Division of Epidemiology and Public Health

