care. Furthermore, it suggests that major changes in the organisation of undergraduate medical education in London are necessary.

Some of the report's assumptions should not go unchallenged. My experience in an area of London in which there is not inconsiderable deprivation leads me to challenge the rather optimistic fashionable credo that technological advances will lead to a continuing expansion in the use of day case surgery. I also question the assertion that general medicine as it is currently practised will probably cease to exist and, perhaps more importantly, the notion that hospitals should be smaller and more specialised. It is certainly true that increasing subspecialisation together with the inexorable pressure to reduce the hours of work of junior hospital doctors means that larger groups of specialists are having to work in harmony with each other. In my view, however, the absence of other disciplines from specialist hospitals impoverishes the establishment, to the detriment of patients' care. Perhaps it is the concept of a district that serves no more than 300 000 people that has become outdated.

I also note that, according to the interpretations of the report by the serious press, two of the busiest hospitals in London, North Middlesex Hospital and West Middlesex University Hospital, are suggested for closure. Both of these hospitals cater substantially for ethnic minorities in contrast to their more peripheral sister hospitals closer to the green belt. That such an impression could be created is unfortunate, to say the least.

Let us, by all means, have a task force to study the problems of health care in London, as the commission suggests, but let its terms of reference be unrestricted.

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- 1 King's Fund Commission on the Future of London's Acute Health Services. *London health care 2010: changing the future of services in the capital*. London: King's Fund, 1992.
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EDITOR,—The King's Fund commission on acute health care services in London recommends a 47% reduction in acute medical beds, a conclusion poorly justified by the evidence provided.^{1,2} The estimated reductions depend on achieving rates of admission and throughput in London that are on the 50th and 75th centiles, respectively, for all English health districts. The report outlines numerous developments in investigative and surgical procedures, but these are unlikely to affect bed occupancy or bed requirements in acute medical specialties. The document also fails adequately to analyse the reasons why in acute medical specialties patients stay in hospital some 16% longer in inner London than in comparable districts elsewhere, attributing this to "hidden specialties" (p 108) and to deficits in "community based care" (p 49)—an interpretation justifiably criticised by Margaret Safranek.³

A more thorough analysis of the reasons for the greater use of beds in London would provide a more fruitful basis for future planning. Table 2.2 of the King's Fund's report shows that, despite the population of London representing around 12% of the British population, the capital has only 9.6% of Britain's geriatric and psychogeriatric beds and only 4.2% of the country's voluntary and private nursing home provision. Thus the apparent excess of acute general medical beds in London (0.38/1000 population) only partly makes up for the deficit of geriatric and psychogeriatric beds (1.06/1000 in London v 1.38/1000 in Britain) and of nursing home beds (0.91/1000 v 2.71/1000 respectively). There are, in addition, the dire

effects of capping of the community charge on the ability of local authorities to provide part 3 accommodation in inner London and the problems inherent in the increasing isolation of elderly people in the inner city, which conspire to increase the demands on hospital beds, especially acute medical beds. This makes it fatuous to suggest that increased provision of community health care centres or a new role for inner city general practitioners would permit the 47% reduction in these beds. Providing appropriate care, whether with increased support at home, in long stay hospital beds, or in nursing homes, is bound to entail additional expense for local authorities as well as health authorities, but what is likely to happen instead is that responsibility will be dumped on the patients and their families.

It seems surprising to have to condemn the King's Fund for political naivete, but do we really expect that proposals for investment in primary care to facilitate closure of some 10-15 acute hospitals will be listened to in the midst of a recession bound public spending round? The document will be taken as a justification for further cuts in beds and hospital closures, as has happened with "community care" for the mentally ill.

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Cigarette taxation and single European market

EDITOR,—The target decreases in cigarette smoking are central to the success of *The Health of the Nation* in its main targets to reduce mortality. As John Warden points out, the government's commitment to a tobacco tax policy is an encouraging step towards their achievement.¹ The effects of the recent agreement to harmonise tobacco taxes within the single European market need to be monitored to check that they do not undermine this policy.

Cigarette taxes have three elements: a specific rate per cigarette, an ad valorem rate (a percentage of the retail price), and value added tax. A high specific component, as in Britain, leads to a relatively high price and narrow price range. Where the ad valorem tax predominates, as in southern Europe, producers act to minimise its impact by keeping the non-tax price low, and so prices generally are lower with a wider spread. The European finance ministers agreed a minimum cigarette excise rate of 57% of the retail price, which with a minimum value added tax of 15% (that is, 13% of the retail price) makes a total cigarette tax rate of at least 70%, of which the specific element must be 5-55%. Five countries, including Britain, already conform to the requirements. No country will need to lower taxes, but some will have to raise them; overall cigarette consumption in the European Community is estimated to fall by about 3%.

The agreement theoretically leaves Britain free to increase cigarette taxes as it likes, within the limitation that the specific component is already at the maximum rate. As the minimum tax is given as a percentage with no absolute element, however, there will still be a wide range of tax levels as a high percentage of a low price is still a low tax. Without a minimum specific tax specified in European currency units (ecus) the agreement does little to

equalise cigarette prices, which currently range from about 34p a pack in Spain to £2.04 in Britain and £2.40 in Denmark (£1=1.42 ecus). Although there will be a limit on importing taxed cigarettes for personal use (normally 800 per adult), routine checks will be few and if cross border buying is extensive average prices will effectively fall and smoking will increase. The European Community's tobacco tax policy has potential to reduce the forecast deaths from smoking in Europe, including Britain.² It needs to be carefully reviewed and its effects monitored.

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SIFTR, London, and district general hospitals

EDITOR,—The recent editorial, papers, and correspondence on the service increment for teaching and research (SIFTR) and its allocation draw attention to the changes taking place in medical students' training, particularly in London.^{1,5} Recent dramatic changes in funding for NHS hospitals have made cost effectiveness the criterion for financial support. London teaching hospitals are, it is said, less efficient owing to their teaching commitment. The inefficiency is compensated by SIFTR funds. There is a belief that, regardless of the prestige, London does not always provide good value for money.^{4,5} Numerous reports and recommendations presage further closures and amalgamations among the London medical schools and hospitals.

Faced with the need to educate large numbers of students and a decline in facilities for doing so, London has turned to provincial district general hospitals. With limited exceptions these now provide similar skills and facilities to those provided by London. Many of their consultants were, after all, trained to high standards in London. Medical students are now a regular feature of large district general hospitals in the home counties. There they spend long attachments, are taught free by local consultants, use the facilities of postgraduate centres and especially their libraries (which cost a great deal to fund), and in many cases receive free accommodation. The benefit to the students is obvious, and as SIFTR funds remain in London the teaching hospitals benefit as well by having fewer students to teach. The expense is borne by the district general hospitals.

Now, however, most large provincial district general hospitals are to become trusts. Managers of trusts will consider all the financial implications of these changes, and so will the managers of postgraduate centres. It can no longer be assumed that district general hospitals will continue to receive students without considering the effect on the service and its cost implications.

The existing SIFTR formula is heavily weighted against the district general hospitals. A total of £30 492 is allocated to medical schools for each student for each year.¹ Under present regulations, however, only £3400 of this can be transferred each year to the district general hospital to support the costs of teaching the undergraduates and their impact on services. In reality this transfer of funds rarely takes place.

This problem can only increase. We believe that the SIFTR formula needs to be changed to recognise appropriately the costs borne by