but information on mechanisms of mucosal injury.^{9,10} Patients receive a major histocompatibility class incompatible small bowel cadaveric allograft. The distal part of this is left as an enterostomy for at least the first three months, allowing close histological and immunohistochemical follow up by sequential biopsy.

Human allograft rejection is the consequence of a succession of non-specific events, amplifying the immune reaction triggered by allogenic T cells. This is probably due to the abundant lymphoid population within the intestine and explains the main difficulty of controlling the rejection process once it has started. The destructive effect of the cytokines released by this inflammatory cascade emphasises the importance of prevention by active immunosuppression and early detection of rejection with appropriate immunohistochemical monitoring. Other complications of intestinal transplantation include rare cases of graft versus host disease, cases of lymphoproliferative disorders related to small bowel transplantation, and the usual complications of immunosuppression such as viral and fungal infections.

Finally, despite dramatic improvements in clinical outcome, indications for small bowel transplantation will always be rarer than for other solid organ transplants such as kidney, heart, or liver. In Britain an estimated two patients per million population, with an equal number of adults and children, are estimated to require small bowel transplantation each year.¹¹ The procedure should be offered to patients with small intestine insufficiency due to anatomical abnormalities (short bowel syndrome) or functional disorders (intractable diarrhoea of infancy or chronic intestinal pseudo-obstruction

syndrome). In the treatment of intestinal failure, however, small bowel transplantation can only become standard when it can offer greater safety and better quality of life than long term home parenteral nutrition.

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Housing reform: getting tough on poor people

New legislation will further restrict assistance

The British government has announced its intention to repeal legislation that gives some homeless people the right to permanent housing.^{1,2} Its proposed new legislation excludes certain groups from receiving help, such as immigrants admitted on the basis that they would have no recourse to public funds. Furthermore, local authorities will not have to secure accommodation for anyone who "already has suitable accommodation . . . whether within the United Kingdom or elsewhere."³ The proposed changes have implications for public health and also raise the question of how the state may best help to ensure its citizens have decent housing.

A letter of general guidance about the proposed changes sent to local authorities last year states that authorities "will be under no duty to secure accommodation for a household if it is satisfied that there is alternative accommodation available within the authority's area that the household could reasonably be expected to occupy." How "reasonableness" should be interpreted is not clear, but having access to private rented accommodation will probably disqualify applicants from assistance. The central change, however, is in the duration of the duty to help those who do qualify. Currently those entitled to housing are entitled to permanent accommodation. The new legislation provides temporary accommodation for a minimum of 12 months, after which the the authority may continue to provide accommodation but has to review the entitlement every two years. The providers of accommodation have also been extended to include private landlords as well as local authorities and housing associations.

The principal reason for introducing these changes is the

government's concern about abuse of the current arrangements and inequity in entitlements.¹ Consequently the new legislation also proposes the creation of a new unified social housing register from which all permanent placements will be made. Those likely to be given "overriding priority in allocations" will be "that small group of people who are capable of living independently but who could never be expected to secure accommodation for themselves."³ They "may include people with serious medical or social needs, such as people with certain physical or learning disabilities."³ Furthermore, "reasonable preference" in allocations will be given to people occupying insanitary or overcrowded houses; people living under unsatisfactory housing conditions; and people living in conditions of insecure tenure.³

The policy, pursued since 1979, of promoting home ownership as the preferred form of tenure in the United Kingdom has resulted in an expansion of home ownership, the loss of public housing for rent as it has been sold to its more affluent tenants, and the consequent social polarisation of the remaining public housing.⁴ The move from a policy of building affordable homes for rent towards an expansion of individual subsidies through housing benefit has turned out to be costly,⁵ and the amount of housing benefit that new claimants can receive has been limited this year. Add to this the fact that the shortfall in output of public rented housing is 100 000 homes a year^{4,5} and it becomes difficult for many people on low incomes to obtain secure affordable housing. People seeking housing benefit will be expected to negotiate with private landlords to bring rents into line with what local

authority rent officers consider to be reasonable or make up the shortfall themselves.

Given this background local authorities have not welcomed the proposed changes, seeing them as administratively cumbersome and detrimental to a vulnerable section of society.⁶ The Faculty of Public Health Medicine has argued that the proposed legislation will "increase disruption of social networks necessary for relieving social isolation; increase stress within the family, increasing risks of domestic violence, child abuse, maternal depression and child behavioural disturbance; decrease access to primary care and community health services and decrease continuity of care in the community."⁴

May medicalise housing needs

The new legislation has some potential merits. It may allow closer integration of social housing with community care policy, the lack of which is a major problem of the current system.^{4,7,8} It may also allow more efficient allocation of scarce social housing to those with medical conditions caused or aggravated by housing conditions. This outcome, however, rests on the assumption that it is possible to ascribe ill health to specific housing conditions and make some sort of order of priority among them.⁹ Though the current system for medical priority for rehousing may be amenable to improvement,¹⁰ a more likely result is an inappropriate medicalisation of housing need. A second assumption is that the new restricted provision will not itself adversely affect the health of those both given and excluded from assistance. The current shortage of permanent housing will mean that both eligible and ineligible homeless households are likely to spend even longer than at present in temporary accommodation. The mental stress, social dislocation, and poor conditions

associated with such accommodation are not conducive to health.^{4,11,12} The prevalence of poor housing is highest in the private rented sector,¹² yet this sector is expected to play a more prominent part in future.

In trying to make sense of these changes it is impossible to separate their likely effects from an undeclared notion of "eligible" and "less eligible" poverty.¹³ Allocating state help with housing on a basis other than need is inappropriate for a resource which is a prerequisite to health.^{4,11,12} The solution to homelessness in all its forms is to build more affordable homes and do this within a policy which explicitly recognises that homelessness is not acceptable or healthy in a civilised society.^{4,12}

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Near patient testing in primary care

Offers better patient management but needs proper evaluation and quality control

Near patient or point of care testing has been documented at least since Thomas Willis (1621-1675) wrote of tasting urine to test for glycosuria. Today, every doctor uses dry reagent laboratory sticks for simple urine analysis or blood sugar estimation, both in clinics or offices and in patients' homes. In the United States near patient testing now comprises 20% of all testing,¹ and the past decade has seen increasing interest in the use of dedicated single test devices or desk top chemistry analysers among doctors in Europe, particularly in Britain,^{2,3} the Netherlands,⁴ and Scandinavia.⁵ In all countries it is in primary care that the true potential for near patient testing will be realised.

Near patient testing could improve the accuracy of clinical decision making and the reliability of monitoring chronic diseases, assisted if necessary by expert decision support.⁶ Primary care physicians are under multiple pressures to extend and improve their performance in these critical areas. These pressures include patients' increasing intolerance of late diagnosis, growing requirements to ration access to specialist care, sicker patients in the community because of earlier discharge from hospital, and the ever greater demands upon general practitioners to manage the surveillance of chronic diseases. However, if primary care physicians are to manage more patients more reliably and at least as safely, they

will need accurate and efficient tools to assist their decisions (in addition to extra facilities and staff). Near patient testing will contribute to the wider use of appropriate investigation in primary care.

As with new drugs, the efficacy and safety of new diagnostic technologies must be demonstrated both in laboratory and practice settings, including clinical and economic comparisons of different technologies. One major problem is deciding who should fund such research. The most likely sources of funding in Britain will be the NHS central research and development health technology programme (which recently commissioned a systematic review on this subject) and the Medical Research Council through the Realising our Potential Awards (RoPAs) scheme.

Facilities for near patient testing will not be needed for every diagnostic or monitoring procedure in primary care. Electronic links enable rapid transmission of results from a hospital laboratory to a doctor's desk. In Britain this facility will be further enhanced with the advent of the new practice computer systems, which should enable results to be filed electronically and remotely in patients' records, thus reducing the costs and errors of transcription. However, unlike near patient testing, rapid electronic links will not enable clinicians to use test results in immediate management decisions.