NHS takeover of prison health service proposed

An urgent need exists for the NHS to take over the provision of medical services in prisons in England and Wales, according to a report published last week by Her Majesty's Chief Inspector of Prisons.

Sir David Ramsbotham's report *Patient or Prisoner?* says that the health care provided by the prison medical service does not match that provided by the NHS. "Specific groups are particularly disadvantaged such as the mentally ill," he said. "Prison can exacerbate mental health problems, with a long term impact on the individual concerned and the community into which he or she is released." The report calls for proper psychiatric services for mentally ill people in prison, which would require new units for day care centres and the ability to provide nursing services 24 hours a day.

Sir David, a former chairman of an NHS hospital, prepared the report after visiting Holloway prison in London and seeing a number of problems with the prison medical service. He said that he hoped his report would stimulate widespread debate of the issues and that the Home Office and the Department of Health would have the will to take this forward within the next two years. Similar proposals have been put forward a number of times before, but Sir David said that he would ensure the debate did not fizzle out this time.

The report says that prison healthcare staff have become isolated, with little training and limited support in the management of their areas. For example, most doctors working in the prison service are not qualified in psychiatry and have received no recognised training in assessing and treating mentally disordered offenders or drug misusers. Very few establishments have trained healthcare managers with a good understanding of how health care should be provided, managed, and linked to the NHS.

Specific groups of prisoners such as juveniles and women, especially those who are pregnant, are also not adequately catered for in prison, the report says.

The report says that it is fundamentally unsound for the prison service, which caters for 57 000 prisoners, to attempt to replicate the high quality, cost effective service provided by the NHS, which caters for 56 million people. And there are serious potential disadvantages from having two parallel systems—for example, when recruiting doctors and nurses from the same limited pool.

NHS trusts and health authorities said

The health care provided by the prison medical service does not match that provided by the NHS

that they were ready and willing to take over the health care of prisoners. But Professor Michael Schofield, chairman of the National Association of Health Authorities and Trusts, added: "Given the current tight financial position in the NHS, there must be a transfer of resources from the prison medical service, and we need to assess as soon as possible what extra funds will be needed to do the job properly and to ensure that the patient's charter standards apply in prison as in the rest of society."

Neither the home secretary, Michael Howard, nor the health secretary, Stephen Dorrell, however, have any political ambition to merge the prison medical service with the NHS. The Department of Health speaks of a need for closer analysis and does not rule out new links "within the framework of current

organisation and funding." But it does not share the enthusiasm of the National Association of Health Authorities and Trusts about being ready and willing to start work straight away, subject to extra funding.

Labour's spokesman, Chris Smith, also has serious reservations about the NHS providing a prison medical service and is concerned that it would alter the nature of the NHS patient relationship and would lead to the isolation of staff. From these initial reactions of the government and its possible successor, the omens for the Ramsbotham report are not promising.—JACQUI WISE, *BMJ*

Patient or prisoner? a new strategy for health care in prisons (ISBN 1 85893 719 1) is published by the Home Office, 59 Queen Anne's Gate, London SW1H 9AT

Benefits of the NHS taking over prison health care

- Continuity of planning between the NHS and prison service
- Examination of public health issues linked to the wider issues local to prisons
- Common standards between the two services
- Continuity of health care between prison and the wider community
- Healthcare staff trained to work in prison or the NHS
- Common system of audit and evaluation
- Common commitment to evidence based practice
- Common commitment to setting and improving standards—for example, the patient's charter

Research trial in babies halted: A pilot study into asphyxia at birth has been stopped after it was discovered that half the babies had been given double the intended dose of magnesium sulphate. The trial, which was taking place in eight countries was stopped when two babies developed complications; one later died. It seems that the babies were given the concentrated form of magnesium sulphate rather than the hydrated form. An independent review is to be carried out.

New York City sues tobacco companies: New York City hopes to recover the millions of dollars spent annually caring for patients with tobacco related illnesses. A recent study by the Columbia University School of Public Health estimated that smoking related illnesses cost the city an estimated \$300m in Medicare, Medicaid, and insurance premiums. Seventeen states and a dozen localities in the US have filed similar lawsuits.

South Africa calls for declaration on medical migration: The deputy president of South Africa, Thabo Mbeki, called on the World Medical Association to develop an international declaration on medical migration. At the association's annual conference in Cape Town he criticised the aggressive recruiting campaigns by organisations in wealthy countries, which has resulted in a number of doctors leaving South Africa.

Cost cutting should avoid quick fixes: An Audit Commission report says that there is scope for NHS organisations to reduce their management costs but that they should avoid quick fixes, which could affect the quality of services. The report, *Form Follows Function*, also gives examples of organisations that have restructured successfully and has a checklist of questions for all organisations to consider when reviewing their management structure.

Smoking may aid concentration: American researchers report that nicotine can enhance the memory by boosting the transmission of nerve impulses in the hippocampus, the area of the brain involved in learning and memory (*Nature* 1996;383:713-6). The research, which was partly funded by a tobacco lobby group, shows that nicotine can induce sufficient calcium influx into the hippocampal neurones to trigger neurotransmitter release.

JOHN EVANS/IMPACT

There is now evidence that BSE can be transmitted to humans

New variant CJD and BSE are linked

The first direct evidence that bovine spongiform encephalopathy (BSE) seems to have been transmitted to humans has been reported. The announcement has increased European pressure on the British government to accelerate the cull of cows.

Professor John Collinge and his colleagues from the Prion Disease Group at the Imperial College School of Medicine in London identified a molecular marker present in cases of new variant Creutzfeldt-Jakob disease (CJD) (*Nature* 1996;383:685-90). New variant CJD has so far been identified in 14 patients in the United Kingdom—two of them still alive—who developed the disease at a comparatively young age.

The characteristic molecular signature seen in the new variant form was not found in other strains of CJD but was seen in BSE in cattle and in BSE transmitted to mice, cats, and macaque monkeys. Professor Collinge said that this was consistent with the idea that this new human disease is caused by transmission of BSE. "However, we can't get direct proof because we cannot inject BSE into humans," he said.

The British government's spongiform encephalopathy advisory committee suggested in March that the new variant of CJD was probably caused by eating beef contaminated with the BSE agent. But it was impossible to be more definitive until the time consuming experiments in mice were complete.

A spokeswoman for the Department of Health said: "This doesn't really change anything as we have been working on the assumption that there is a link since March. The new evidence is not totally conclusive but is persuasive, and it is important to replicate the work."

The discovery of this new molecular marker means that strain typing of CJD can be performed in days rather than the 1-2

years needed for conventional studies in mice. The technique at the moment is possible only using brain tissue, but within 4-6 months the team hopes to be able to use it on lymph node or tonsil tissue and eventually to develop a blood test.

Professor Collinge said that the new technique may help to identify more cases of the new variant CJD. "There appears to be no reason why new variant CJD doesn't affect the elderly. It may be that it just hasn't been spotted because it has different clinical features."

He also called for the test to be used to find out whether scrapie, a similar disease in sheep, originated from BSE in cattle. "There are large public health implications if we find BSE in sheep," he said.

Professor Collinge also hopes that understanding the molecular basis of the infectious agent or prion may help in the development of new treatments. "We cannot predict how many future cases there may be. We need to start talking very seriously about developing therapeutic drugs in case the worst case scenario arises," he said.

The molecular marker was detected by studying modifications of the prion protein thought to be the principal, and perhaps the only, component of the infective agents of the spongiform encephalopathies, which are known as prions. Differences in this protein are thought to correspond to variations in the strains of prions and may be the basis for producing varying patterns of disease.

There are four forms of CJD: a familial form linked to mutations in the PrP gene; an acquired form due to exposure to material contaminated with CJD, notably through use of human growth hormone from cadavers; new variant CJD, which is attributed to eating beef products made from cattle with BSE; and sporadic CJD, which is the most common form and is of unknown aetiology.

The typical age of onset of the disease for the new variant form of CJD is 19-39 years compared with 55-70 years for the sporadic form.—JACQUI WISE, *BMJ*

Mother wins right to refuse treatment for her child

The Court of Appeal last week upheld a mother's refusal to allow her 18 month old son to undergo a lifesaving liver transplantation, although his prognosis is death within a year without it.

The mother, who lives abroad with the boy and his father, had appealed against a High Court judge's order forcing her to return home so that the boy could have the operation. The appeal court's ruling lays greater emphasis on parents' rights than in earlier cases where parents have refused treatment.

The courts have tended largely to follow medical opinion in such cases. But the judgment hinges mainly on the unusual facts of the case and will not open the way for Jehovah's Witness parents to refuse blood transfusions for their children.

The family's identity and the identities of the doctors and hospitals involved with the boy's care are protected by court order. The parents, who are unmarried but in a stable relationship, are both health professionals with experience of seriously ill children. The boy was born with biliary atresia, and his mother's decision not to let him undergo the liver transplantation was influenced by an operation he had when he was aged 3 weeks, which was not a success and caused him pain and distress.

The boy's father has a job in "a distant Commonwealth country," where there are no facilities for carrying out liver transplantations. The boy and his mother visited him between February and April this year and moved there in June. In 1995, while still living in England, the boy and his mother were referred to a paediatrician, one of the few doing paediatric liver transplantations. The mother refused consent after she was given a fact sheet explaining the surgery and post-operative treatment, which stated: "If the family choose not to proceed with the transplantation once they are acquainted with the facts, the decision is respected."

The paediatrician refused to accept her decision and threatened to take legal advice, and so the mother sought a second opinion. The second paediatrician urged the mother to consent to the operation but said that the parents' decision should be respected if they decided not to go ahead.

While the boy and his mother were visiting his father, a suitable liver became available, but doctors were unable to contact the mother and so contacted the local social services department. The police and social services in the country where the family is now living concluded, however, that the boy was well and happy and that no action needed to be taken.

The local authority took proceedings in the High Court under the Children Act. The Official Solicitor, acting as the child's guardian, strongly advocated the operation. The judge, Mr Justice Connell, ruled that the mother was acting unreasonably, that the

transplantation would be in the boy's best interests, and that she should bring him back to Britain to have it.

In the appeal court, Lady Justice Butler-Sloss said that the judge had not taken broader considerations into account. Expecting the mother to provide the necessary commitment to the child after the operation in the face of her opposition was "fraught with danger for the child."

Lord Justices Waite and Roch agreed that in the circumstances it would not be in the child's best interests to order his mother to bring him back to England for the operation.

Doctors now have 14 years' experience of carrying out paediatric liver transplantations, which have a high success rate. Dr Deirdre Kelly, consultant paediatric hepatologist at the liver unit of Birmingham Children's Hospital, said that, of 120 children given liver transplants at the hospital, 90% had survived one year and 80% five years.

The BMA called for a less adversarial system, with an independent person or body acting as advocate for the child, for cases where doctors and parents disagree over whether a treatment was in a child's best interests. In fact, the case was less adversarial than many because the local authority adopted a neutral stance, and the child's case was put by an independent person, the Official Solicitor.

—CLARE DYER, *legal correspondent, BMJ*

Primary care bill is on its way

The Queen's speech at the opening of parliament last week confirmed early legislation to improve and develop primary health care services in Britain. The Primary Health Care Bill will implement the proposals for flexibility in general practice in the recent white paper *Choice and Opportunity* (19 October, p 959).

The bill will enable general practitioners to replace the national contract with local

contracts to pilot new models of care delivery in settings varying from supermarkets to cottage hospitals. The bill will also amend arrangements for appointing general practitioners and employing salaried doctors.

The prime minister, Mr John Major, told the Commons that the bill would make it possible for general practices to provide physiotherapy or chiropody and clinics offering cataract treatment. "The more we can improve the care given by the GP, the more we can relieve the pressure which otherwise would fall on hospitals," Mr Major said. The labour leader, Mr Tony Blair, accused the government of undermining the NHS, which, he said, had 20 000 more senior managers and 50 000 fewer nurses.

In a subsequent debate, the health secretary, Stephen Dorrell, said that no supermarkets had envinced the slightest interest in developing their own primary care sector. He thought it more relevant to contemplate primary care being developed by NHS community trusts.

Opposition health spokesman, Chris Smith, said that Labour would take a severe view of commercial companies establishing primary care services. It would pose a serious threat to the professional relationship with patients if doctors were answerable to a commercial organisation.

The Queen's speech also foreshadowed a draft bill to help people make better provision for their long term care needs in old age. This reflects proposals last spring for state help to enable people to insure their homes and assets against the confiscatory costs of long term residential care (18 May, p 1246). The government aims to produce a draft bill and policy statement in the new year, but it will not be enacted before the general election.

Other legislation this session will reform the procedures of the civil courts in England and Wales. Medical negligence litigation is targeted in order to reduce its costs and facilitate settlements, as proposed in a report by the master of the rolls, Lord Woolf (3 August, p 247).—JOHN WARDEN, *parliamentary correspondent, BMJ*

SAM TANNER

The Court of Appeal placed greater emphasis on parents' rights than has been given in earlier cases

Angioplasty shows no benefit over thrombolysis

Angioplasty is no better than thrombolysis in acute myocardial infarction, according to the results from a major cohort study which look set to fuel the ongoing controversy about optimal management.

US researchers found no difference in mortality during admission or long term follow up between 1050 patients undergoing angioplasty and 2095 patients given thrombolysis (*N Engl J Med* 1996;335:1253-60).

Patients were selected from a cohort of over 12 000 consecutive patients admitted with acute myocardial infarction to 12 hospitals in Seattle between 1988 and 1994. Risk of death during admission was 5.6% in patients given thrombolysis and 5.5% in those undergoing angioplasty.

Dr Nathan Every from the Northwest Health Services research and development field programme at the Seattle Veterans Affairs Medical Center reported: "In a community setting, we observed no benefit in terms of either mortality or the use of resources with a strategy of primary angioplasty rather than thrombolytic therapy." He acknowledged that patients in the study were not randomly assigned to treatment but argued that there were no substantial differences in demographic or clinical characteristics between the two groups.

The primary therapeutic objective in a patient with an evolving Q wave myocardial infarction is prompt restoration of blood flow in the occluded artery. Both immediate coronary angioplasty and thrombolysis can restore flow in most occluded coronary arteries. In an accompanying commentary Cindy Grines from the William Beaumont Hospital, Royal Oak, Michigan, argued that angioplasty continues to have overwhelming advantages over thrombolysis. "Primary angioplasty gives higher short and long term patency rates than those achieved with thrombolysis, with reduced rates of recurrent ischaemia. It is also superior in reducing rates of intracranial bleeding, reinfarction and death," she claimed.

However, in a second commentary, Richard Lange and David Hillis from the University of Texas Southwestern Medical Center in Dallas argued that placebo controlled randomised trials in almost 60 000 patients have shown that thrombolysis limits infarct size, improves left ventricular function, and reduces mortality. Further studies in more than 100 000 subjects have confirmed the efficacy and safety of thrombolytic agents, they said.

So what is the practical way forward for selecting the best management option for each patient with a myocardial infarction? Dr Graham Jackson, consultant cardiologist at London's Guy's Hospital, believes that a case cannot be made for primary angiography in the wider community. "It seems an attractive idea that angioplasty should perhaps be better, and some studies have shown benefits, but these have been in highly spe-

HANK MORGAN/SPL

New research shows that thrombolysis is as effective as angioplasty

cialised units with low risk patients," he said. "In contrast, this latest trial accurately reflects post-myocardial infarction management in the real world."

"Those working in district general hospitals should stop worrying about angiography and get on with thrombolysis," Dr Jackson said. He recommends that angiography should be carried out in departments with appropriate facilities and expertise in selected cases, in line with guidelines issued recently by the European Society of Cardiology. "Patients who are young with a large anterior infarction and cardiogenic shock should get angiography if possible," he added.

Dr Jackson said that as survival rates in the short term seem to be similar for thrombolysis and angioplasty, the preferred treatment is the one that can be applied more quickly, safely, and expertly. "For most patients, this continues to be thrombolytic therapy."—SUSAN MAYOR, *medical journalist, London*

HRT use in high risk women should be reviewed

Doctors should review whether women in high risk groups really need to take hormone replacement therapy, the Committee on Safety of Medicines has announced.

The announcement follows three papers published in the *Lancet* last month that found an increased risk of deep vein thrombosis or pulmonary embolism, or both, in women currently taking hormone replacement therapy (*Lancet* 1996;348:977-87). The relative risk of venous thromboembolism was raised twofold to fourfold in current users, which is greater than that among younger women who use oral contraceptives.

However, the absolute risk still remains

small, with estimates of between 16 and 23 excess cases per 100 000 women per year for all venous thromboembolism and 6 per 100 000 women per year for pulmonary embolism alone. All the studies showed that the risk of venous thromboembolism disappears after stopping hormone replacement therapy, and there seems to be no important differences between types or preparations.

The Committee on Safety of Medicines says that it is looking at these new data carefully to see what amendments are needed to the product information for doctors and patients, and it has also produced some initial guidance.

The committee concludes that the risks of venous thromboembolism with hormone replacement therapy are likely to be greater in women with predisposing factors, such as a personal or family history of deep vein thrombosis or pulmonary embolism, severe varicose veins, obesity, surgery, trauma, or prolonged bed rest. However, as many women with these characteristics have been excluded from trials it is difficult to obtain reliable estimates of the risks for them.

But in the October issue of *Current Problems in Pharmacovigilance* the committee says: "Nevertheless it would be prudent to review the need for HRT treatment in women who have such predisposing factors, as in some cases the risks of HRT may be expected to exceed the benefits."

The committee says that the small risk should be seen in the context of the benefits of treatment in relieving menopausal symptoms and in preventing osteoporosis and possibly protecting against ischaemic heart disease with long term use. There is no need for women who do not have predisposing risk factors for venous thromboembolism to stop hormone replacement therapy.

The committee has produced a leaflet for patients which says that the chances of getting a blood clot while not taking hormone replacement therapy is 1 in 10 000 per year and the risk while taking it is 3 in 10 000 per year.—JACQUI WISE, *BMJ*

Older, cheaper hip implants are best

Older, less expensive hip implants tend to be the most reliable, according to the *Effective Health Care Bulletin*.

The bulletin, which is produced by the NHS Centre for Reviews and Dissemination at the University of York, says that a wide variety of untested prostheses are currently in use in the NHS. Over 60 different types of implants exist, with prices ranging from £250 to £2000, and half of these have been introduced since 1990.

The report reviews the research evidence and says that most of the newer implants have not been properly evaluated and tested so no one knows how long they will last. Around 40 000 hip operations were performed by the NHS last year, and there were over 5000 revision operations for replacements that had failed.

The cheaper, standard, cemented implants, such as the Charnley and the Stanmore, have been the most thoroughly evaluated and have been shown to have the lowest long term failure rates over 10-20 years of follow up, according to the report. It recommends that new prostheses should be used only after they have been thoroughly evaluated or as part of a national coordinated study.

The report also recommends that purchasers might want to consider contracting for the lifetime care of patients having hip replacements, including a premium to cover the risks of future costs due to revision of surgery, to provide an incentive to promote quality.

The report adds that there is some evidence that patients whose operations were done by trainees and surgeons with low volume of activity have poorer outcomes.—JACQUI WISE, *BMJ*

Female genital mutilation outlawed in United States

The US Congress has passed legislation to outlaw the practice of female genital mutilation.

The law requires federal authorities to inform new immigrants from the countries where the rite is still customary that parents who arrange for their daughters to be cut, as well as those who perform the cutting, face prison sentences of up to five years.

The measure, which comes into effect on 29 March 1997, also requires US representatives to the World Bank and other international financial institutions to oppose aid to countries whose governments have not established educational programmes to end the practice.

The most extreme form of female mutilation, infibulation, entails excising the clitoris and labia minora and then sewing together the labia majora, leaving only a small opening

Over 60 different types of hip implants exist, with prices ranging from £250 to £2000

MIKE DEVLIN/SPL

for urine and menstrual blood. Often it is performed by local women who use no anaesthetic or sanitary measures, although sometimes a nurse or midwife will perform the ritual using a local anesthetic.

Side effects of the procedure include infection and bleeding, which may be fatal. It may render childbirth extremely difficult.

The American Academy of Pediatrics has issued a statement declaring that "the Academy is absolutely opposed to this practice in all forms as it is disfiguring and has no medical benefits."

Senator Harry Reid, Democrat of Nevada and one of the sponsors of the legislation, said: "Female genital mutilation has no medical justification and is usually performed with crude, unsterile instruments without anaesthetic. This cultural ritual that takes six adults to hold down a small girl cannot be tolerated. These children cannot speak for themselves."

The custom is most common in Africa, where some people believe that it ensures a woman's chastity and, after she is married, her fidelity by reducing her sexual pleasure. According to some estimates, 99% of women in Somalia and Djibouti, 90% of women in Ethiopia, and 85% of women in Sudan have undergone the procedure. In all, more than 127 million African women have been mutilated, and 2 million girls, usually between the ages of 4 and 12, undergo the ordeal every year.

It has been estimated that 168 000 girls who currently reside in the United States either are at risk of being mutilated or have already had it done. Almost half of them live in urban areas with large immigrant populations, including New York City; Washington, DC; Los Angeles; Houston; Chicago; Philadelphia; Atlanta; Oakland, California; Newark, New Jersey; Dallas; and Boston. Fourteen states already have or are considering bills of their own against the practice.

Several European countries also have banned the procedure. Over the past 10 to 15 years French authorities have prosecuted more than 30 families for subjecting their daughters to it.—NORRA MACREADY, *freelance journalist, Irvine, California*

Health should gain in New Zealand coalition government

It will still be several weeks before the final outcome of the recent New Zealand general election is determined, but it is almost inevitable that the next government will soften the existing commercial approach to the health system and increase funding.

The election was the country's first to be conducted under a form of proportional representation. Both the National party, which won 44 of the 120 seats, and the main opposition party, Labour (37 seats), need coalition partners to attempt to form the next government. Whichever party wins the support of the New Zealand First party will be able to form the government, and it has laid down several policies, including health issues, on which it will not compromise.

These health policies include free general practice consultations for children under 12 and free medical prescriptions for children. The Labour party promises to remove, over time, prescription charges for everyone.

On social issues New Zealand First is more closely aligned with the Labour party than the more right wing National party. New Zealand First is opposed to the privatisation of health and along with Labour has said that it will increase government funding for the public health system.

Both parties promised to remove the commercial focus of the public health system, to return to having elected rather than government appointed health boards, and to stop the crown health enterprises which own public hospitals having to return a "profit."

Health was a much debated issue in the election campaign, with polls showing that it was voters' greatest anxiety. The election result contains a strong message for the National party about health—that its reforms have resulted in longer waiting lists, increased costs, and less accessibility.—CARMEL WILLIAMS, *medical journalist, Auckland*

Dutch efficiency savings are hitting healthcare quality

Signs are emerging in the Netherlands that the most vulnerable sections of society are suffering because of an annual drive towards increased efficiency savings.

The fourth annual report by an influential group of independent economists, led by Professor Arie van der Zwan, warns of a link between increased demands for productivity and poorer quality health care.

The report says that it is the elderly, handicapped, and psychiatric patients requiring nursing and home care who are feeling the brunt of cuts in health spending.

The report, commissioned by the Dutch Federation of Healthcare Organisations, (NZF), which represents all hospitals, nursing homes, and health institutions, has been presented to the health minister, Professor Els Borst-Eilers.

Discussion of the report formed the centrepiece of a national debate of health policy last Monday.

The federation's chairman, Dr Ton Krol,

said: "We must continue to confront the politicians with the consequences of their policy."

The report says that hard pressed staff have less time to talk and physically care for patients. Nursing home staff have to wake and feed patients at unusual hours and do not have the time to give proper information on aftercare and complications of treatment.

In addition there is a high turnover of frequently untrained and therefore cheaper staff, which hinders better care.

Waiting lists have also grown, with 35 000 patients waiting longer than the recommended times for long term care during 1995. The average waiting time for residential care for 8000 handicapped patients was 16-18 months.

In acute care orthopaedic patients wait on average nearly 15 weeks for hospital treatment. Overall the growth in the number of acute patients treated in hospitals slumped from 2.1% to 0.9% for 1995.

The report argues that healthcare institutions have been faced with an increasing demand from patients without a corresponding increase in funds.

Increases in health spending have been capped at 1.35% by the present government.

But the report says this figure is a myth and argues that once the increased cost of treatment and an aging population have been taken into account, real growth has been about 0.7%.

By contrast health spending grew at an annual rate of 2.3% in the decade before the 1994 general election. The report is now calling for an extra 1.6bn guilders (£590m; \$885m) to be spent between now and the year 2000 on top of the 63.3bn guilders annual budget.

Dr Krol said: "We can try to be more and more efficient, but you pay a price for that in quality." He added: "You can do the work with fewer people, but it means fewer people caring for the elderly in nursing homes."

The federation has now called for a national taskforce of government, health service staff, and patients to define a package of health care, including waiting times and quality standards, that would be guaranteed through the Netherlands compulsory health insurance.

Earlier this year Professor Borst-Eilers spoke of the bad example of long waiting lists in Britain's NHS, arguing that governments must ensure that all patients receive necessary care.—TONY SHELDON, *medical journalist, Utrecht*

Focus: Sydney

The paradox of prevention

"Sentimentality is the worst of all motives in the making of social policy." So began one of dozens of vicious attacks recently launched

against the New South Wales government when it amended the law to make it illegal for taxis to carry babies unless they are secured in a car seat.

The restraints have been mandatory in private cars for over a decade. In 1993, 19 unrestrained children were involved in car crashes; five died. Among 228 restrained children only one died.

All week, radio programmes and newspapers threw their lines and letters pages over to angry parents who regaled "government stupidity" with real and predicted stories of taxis refusing to carry babies, consequent long walks with crying, sick children, and the government being out of touch with the needs of people who use taxis because they cannot afford a car. Cab drivers complained that storing the bulky car seats in their boots would not allow them to carry luggage. The plan required taxi companies to provide a cab fitted with a car seat when a parent phoned a booking. No extra charge could be made, and the main problem was expected to be longer waiting times.

Part of the difficulty in selling the new rule lay in the infrequency of injuries and deaths to babies in taxis. Since 1983 only 11 children aged under 1 year have been killed or injured in taxis in New South Wales, compared with 1327 in private cars. Few would therefore have experienced such injuries to their infants or heard of them happening to others. The reason for this difference is that for every taxi there are 451 cars, and babies do not travel far in taxis.

But the parallel observation can, of course, be made about inconvenience. Because transporting babies in taxis is comparatively uncommon, being inconvenienced when waiting for a taxi fitted with a car seat will be correspondingly uncommon. In other words, defenders of the car seats argued: What does it really matter if several times a year parents might have to wait 30 minutes extra for the right taxi when the trade off is immense protection from horrendous injury?

The history of public health is strewn with protests from people complaining that they are inconvenienced by laws imposed for the health, safety, and wellbeing of disadvantaged groups. Seat belts, crash helmets, random breath testing, speed limits, and traffic calming have all met with similar protests. This latest protest comes at a time when Australia's toll of road deaths reflects the benefits of these safety measures in reaching a record low.

Ten years ago kerbs, public buildings, and taxis made no provision for the minority of citizens who use wheelchairs. There were howls of protest about the expense the able bodied community would have to bear when businesses and councils passed on the costs of installing ramps and access facilities.

After all the heart wrenching scenarios of parents stranded in the rain with shivering babies have been paraded, the bottom line of attacks on the new law is the view that people are justified in gambling with a baby's life when they might be merely inconvenienced.

The state transport and health ministers have suffered immense criticism over their decision. Their resolve to act in the interests of babies, who cannot speak up for their own rights, is a rare but welcome example of "unpopular prevention." They deserve the thanks of every parent whose child will be protected. But the chances are that they won't ever get it.

That's the paradox with prevention—it works when nothing happens. People thank doctors for performing a lifesaving operation, but if they grow up without being badly injured or without taking up smoking and developing emphysema they are seldom thankful for the preventive actions of people who bore the brunt of public anger about inconvenience years ago.—SIMON CHAPMAN, *associate professor of public health and community medicine, Sydney*