of standard systems to which general practitioners can usefully contribute all the more difficult.

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- 1 Haste FM. Value of data provided for health promotion programmes. *BMJ* 1994;309:959-60. (8 October.)
- 2 Record MC, Spencer JA, Jones RH, Jones KP. General practitioners' views about the statutory annual practice report. *BMJ* 1994;309:849-52. (1 October.)

Culyer report

EDITOR,—It is unfortunate that the Culyer report, *Supporting Research and Development in the NHS*, omits the needs of public health and operational research^{1,2}; the House of Lords Select Committee on Science and Technology highlighted this in 1988 as being particularly neglected.³ With the current emphasis on the *Health of the Nation* as guiding NHS policies,⁴ it is unfortunate that the programme of research in the NHS has been hijacked by clinical research in hospitals and the community.

As the House of Lords select committee commented, the term "health services research" can too easily be perverted, and this is why care in labelling is required. The committee emphasised the neglect of public health research, which it defined as including "research into health education and health promotion as well as the provision of services. It embraces epidemiological and sociological studies of populations, as a means both of aiding prevention of disease and of establishing health needs. Drawing on a range of disciplines, including epidemiology, the behavioural sciences, statistics and economics, it seeks to establish strategies to promote health and provide optimal health services." This neglect—and misapprehension of words—was evident in the government's response to the select committee's report.⁵

Although there are problems in both recruiting and funding clinical researchers within the NHS, the difficulties facing public health and operational researchers are greater, and it is a pity that once again they have not been addressed.

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- 1 Research and Development Task Force. *Supporting research and development in the NHS*. London: HMSO, 1994. (Culyer report.)
- 2 Peters K, Himsworth R. Welcoming the Culyer report. *BMJ* 1994;309:751-2. (24 September.)
- 3 House of Lords Select Committee on Science and Technology. *Priorities in medical research*. London: HMSO, 1988; paragraphs 1.8, 4.12, 4.13, 4.14. (Session 1987-8, third report.)
- 4 Department of Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992.
- 5 Department of Health. *Priorities in medical research: government response to the third report of the House of Lords Select Committee on Science and Technology: 1987-88 session*. London: HMSO, 1989.

Health care reform in the US

EDITOR,—It must strike some people as a curious and regrettable paradox that the United States, which is arguably the world's wealthiest nation, is probably alone among the industrialised nations in failing to provide universal health coverage for its citizens. John Roberts's article on health reform identifies some of the salient factors that have driven nails into the coffin of health reform in the United States.¹

For one thing, the president's plan, all 1342 pages of it, was far too complicated for either

Congress or the public generally to grasp fully. The complexity of the plan was a major weakness because it hindered understanding.

Cost was also a major relevant factor. The United States has a health care system that costs roughly a trillion dollars a year. Even though medical inflation may have tapered off last year to 4.3%,¹ it remains considerably above the general inflation rate of 2.6%.² Many small businesses claimed that they simply could not afford the payment of workers' insurance premiums mandated by the Clinton plan. Many larger corporations also sought to knock down the key pillar—an employer mandate for insurance—upholding the Clinton plan. An unexpected blow emanated from a relatively obscure appendage of Congress, the Congressional Budget Office, which issued financial forecasts for major proposed reforms that were considerably higher than the projections of sponsors.³ Moreover, many Americans, or at least those with adequate insurance, seemed increasingly concerned with problems such as crime and reform of the welfare system and less concerned about providing health coverage to the 17% of the citizenry that presently lacks it.³ Indeed, one national poll showed 61% favouring waiting until next year for health reform.²

In the search for scapegoats ostensibly responsible for the demise of health care reform fingers can be pointed at predictable self centred lobbying on behalf of deep pocketed interests in the health industry. Partisan political obstructionism can also be cited. Yet there is considerable genuine uncertainty regarding health reform. Even though managed care has taken up to 85% of the market,¹ much remains to be learnt about it. Braveman *et al* recently showed that rupture of the appendix was more likely with a fee for service system than with private coverage paid for in advance.⁴ Still, a regulated fee for service system and a single payer system have many supporters.⁵ The battle between a fee for service system and managed care will probably last for years.

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- 1 Roberts J. Health reform is dead: long live health reform. *BMJ* 1994;309:630. (10 September.)
- 2 Greenberg DS. Saving remnants of health-care reform. *Lancet* 1994;344:657.
- 3 Greenberg DS. Health reform no longer a hot issue. *Lancet* 1994;344:807.
- 4 Braveman P, Schaaf VM, Egerton S, Bennett T, Schecter W. Insurance-related differences in the risk of ruptured appendix. *N Engl J Med* 1994;331:444-9.
- 5 Schiff GD, Bindman AB, Brennan TA. A better-quality alternative single-payer national health system reform. *JAMA* 1994; 272:803-8.

Local pay negotiation

EDITOR,—In Linda Beecham's news article on local pay negotiation Sir Anthony Grabham is quoted as saying that doctors should withdraw from management in trust hospitals in protest at the proposals.¹ I hope that this will not be acted on as I believe that such a move would be against the interests of the medical profession. Those trusts that see performance related pay as a way to "meet political and managerial targets" would in all likelihood be delighted with such a move, which would allow them a free rein to set their own agenda without interference from doctors.

The harsh fact of life is that if the government is set on introducing local pay negotiation then it will probably succeed. The BMA's objections to other health service reforms have had limited effect in changing the government's plans. If we are to make the best of the situation we need to move closer to the management of trust hospitals, not further away. It is only by means of such close

working relationships that we as a profession will be able to set the standards by which we think we should be judged.

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- 1 Beecham L. Local pay will harm care, warns BMA. *BMJ* 1994;309:625-6. (10 September.)

Genocide in Rwanda

EDITOR,—In his apologia on the genocide in Rwanda R Hugh James is selective to the point of misleading readers.¹ For a comprehensive analysis, beyond the limits of this letter, I commend the lucid (horrific) 440 page report by African Rights.² The specific points that James raises should, however, be answered before they become received wisdom.

Firstly, he advances the now discredited simplistic view that ethnic antagonism explains the genocide. In fact, the first people to die were the Hutu leaders of opposition parties.

Secondly, he fails to explain why "hundreds of thousands of Tutsis fled to . . . Uganda" 30 years ago. It was because Hutu leaders incited the population against them to the extent that tens of thousands were killed in a series of pogroms lasting seven years. And the reason the children of these "refugees . . . formed the Patriotic Front [and] invaded Rwanda" was because they were stateless Rwandan citizens persecuted in Uganda yet denied the right to return to their homeland.

Thirdly, and incomprehensibly, James asks, "Given the presence of a war, is it surprising that there were then massacres?" He ignores the fact that the Arusha Peace Accord formally ended the war eight months previously. By November 1993 it had delivered a broad based transitional government and guaranteed early multiparty elections for next year, when it was expected that the then ruling extremist government would lose power to Hutu opposition parties. The arrangements were seen as a model for the future and offered the prospect of peace and democracy.

Sydney Brandon and Kenneth Craig's snapshot of the situation in Rwanda paints a relatively positive picture, yet the future remains precarious.⁴ The new government inherited a country with no money, no civil administration, no infrastructure, and 14% of its population dead and 70% displaced. The international donor community remains reluctant to contribute critically essential funds: most aid has been channelled into refugee camps in bordering countries, where nearly two million people remain incarcerated, misinformed and terrorised by their leaders and by killer militias who remain politically and homicidally active.

There is now an overwhelming need to promote methods of mediation and reconciliation between the two groups in a society polarised by the carnage. Physicians for Human Rights (UK) has been meeting various groups in Britain, such as Responding to Conflict, which has experience in Uganda and the former Yugoslavia, in the hope of promoting an initiative in the future. Anyone with skill in this or a desire to help might like to contact me.

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- 1 James RH. Reflections on a genocide. *BMJ* 1994;309:875. (1 October.)
- 2 Dillner L. Human rights group condemns UN in Rwanda. *BMJ* 1994;309:895. (8 October.)
- 3 African Rights. *Rwanda: death, despair and defiance*. London: AR, 1994.
- 4 Brandon S, Craig K. Rwanda after the Holocaust. *BMJ* 1994; 309:963. (8 October.)