Heaf test		Chest radiography		Outcome	
Grade	No (%)	Result	No (%)	Intervention	No (%)
0	8 (5)	Abnormal	2 (1)	Chemoprophylaxis	7 (4)
1	28 (17)	Child (no radiography)	8 (5)	Offered BCG	1 (1)
2	105 (62)	Old tuberculosis	1 (1)	Followed up	11 (7)
3	12 (7)	Refused	10 (6)	Discharged	151 :89)
4	8 (5)	Normal	149 (88)		
Refused test	9 (5)				

positive. Seven required chemoprophylaxis. There were 19 refusals of one or both tests (table).

In replies from 20 of 22 other universities we contacted, only 13 (65%) were able to enumerate overseas students registered for the 1992-3 academic year. Ten had no tuberculosis screening programmes; two had no student health service. Eight of the remaining 10 had arranged screening with the local consultant in communicable disease control. Twelve universities had medical schools, 10 of which screened students for tuberculosis. Only a few universities had any data on abnormalities detected currently or in previous years. This, together with the absence of denominators, made estimates of the prevalence of tuberculosis impossible and served only to reveal the extent of failure to comply with the national guidelines and purpose of screening. Since admissions of overseas students from high prevalence areas are increasing, there is clearly a need for a multicentric rationalisation of screening procedures and preventive policy.

Students from these regions qualifying for study in Britain are usually advantageously placed in comparison with their home populations in terms of education, health, and standard of living. The occurrence of seven cases (4%) requiring chemoprophylaxis in the 44% minority who attended for screening in Bristol, the fact that 92% are not screened at the port of entry, and the lack of compliance with minimal preventive measures all point to a situation which, in the generality of immigrants, must already be creating foci for further spread of tuberculosis in the United Kingdom.

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GPs accept patients' vote on fundholding

EDITOR,—We were interested to read of the ballot of patients in Leicestershire over fundholding.¹ We carried out a similar consultation process, which ended with a different result.

We are a small inner city practice, with 70% of our patients attracting a medium deprivation payment. Fundholding seemed to be the natural progression of the services we were already providing, and we believed that it would provide more choice for patients and a wider range of services in the community. In 1991-2, however, fundholding was a politically contentious issue, and we therefore decided to discuss the matter with our patients.

The practice as a team produced a document indicating some of the advantages and disadvantages of fundholding, which was circulated to patients. We then held a public meeting to discuss it with them and gained approval for six months of negotiation. In the winter of 1992 we held another public meeting; on this occasion we had television

and newspaper coverage. After discussing our plans we split into smaller groups to answer questions.

The attendance at both meetings was over 100, which for a practice of our size—2500 at the time—was remarkable. We sent out a questionnaire to determine whether those who attended our public meetings were representative of the population we serve. This proved to be the case. Patients voted four to one for the practice to become a fundholding practice. In the three years since then we have made fundholding work in our patients' interests and have benefited this community without disadvantage anyone else. We regularly report on fundholding in our quarterly newsletter for patients.

One of the biggest fears expressed by patients in inner city Nottingham and other general practitioners was that we would turn our backs on the NHS and seek private care. Over the past years of fundholding, less than 5% of our budget has been spent outside the NHS.

We continue to believe as a team and a practice that fundholding gives patients more choice, enables services to be provided closer to patients' homes and with their active participation, and improves the range of services available in the community.

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1 Mulka O. GPs accept patients' vote on fundholding. *BMJ* 1995;310:664. (11 March.)

A global health disaster network is needed

EDITOR,—Kobe, Chechnya, Bosnia, Rwanda... all these disasters have been characterised by difficulties in communication. How many people are injured? Homeless? Buried? Need food? Most of these pressing questions are answered by word of mouth. The lack of accurate and timely information is compounded by our inability to establish immediate, real time communications among international health agencies, non-government disaster and relief organisations, affected governments and local authorities, and the people themselves, which leads to needless morbidity, mortality, and waste in both manmade and natural disasters. It is only now that we are beginning to apply new technologies to improve communication during disasters.

We are in the middle of a telecommunications revolution. Telecommunications systems such as the internet are reaching millions of people world wide and are growing rapidly, even in developing countries. The growing global health network should begin to establish a global health disaster network directed at preventing disasters and planning responses to disasters.^{1,2} The global health network could also provide an improved means of transferring information into and out of a disaster area and among the "shareholders" in a

disaster. Such a system has already been established to a limited extent in Central America, South America, and the Caribbean by the Pan American Health Organisation, regional office of the World Health Organisation (C DeVill, personal communication).

In a pilot project the Pan American Health Organisation, with the support of the National Aeronautics and Space Administration, is linking through the internet the major coordinators of disaster management in Central America (health disaster coordinators, civil defence, health commissions, etc). This project—part of the global health network initiative—establishes the foundation of the regional "information highway." Much more needs to be done to ensure that sufficient portable units could in some cases be backpacked to the affected area to allow more rapid assessment and transfer of information about the disaster.

Training of health care professionals in monitoring international disasters and in telecommunications is important. These "cyberdocs" would be essential for establishing and coordinating information during disasters. Experts in epidemiology and preventive medicine and those in disaster planning and response and in telecommunications must continue to work closely to coordinate responses for the disasters in the 21st century and beyond.

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- 1 LaPorte RE, Akazawa S, Hellmonds P, Boostrom E, Gamboa C, Gooch T, et al. Global public health and the information superhighway. *BMJ* 1994;308:1651-2.
- 2 Sauer F, LaPorte RE, Akazawa S, Boostrom E, Ferguson E, Gamboa C, et al. Towards a global health network. *Current Issues in Public Health* (in press).
- 3 Ferguson EW, Sarkisian A, Young F, DeVille de Goyet C. Telemedicine for national and international disaster response. *J Med Syst* (in press).

Rationing intensive care

Intensive care provision varies widely in Britain

EDITOR,—D W Ryan believes that high dependency units will solve some of the problem of insufficient beds in intensive care units in Britain and suggests that some elective admissions to intensive care units could be diverted to such a