Dutch drop plans for contraceptive pill payments

The Dutch government has dropped its controversial plan to make women pay for the contraceptive pill. The plan would have removed oral contraception for adult women from basic health insurance as part of a £35m savings package. The U turn follows pressure from contraception experts who argued that the move would damage the Netherlands' international reputation for the lowest rates of abortion and unwanted teenage pregnancies in the world.

The plan had also provoked a public campaign by women's groups, immigrant bodies, and political parties who feared that it could lead to an extra 5000 abortions a year. Some women, especially among risk groups such as women from Surinam and Morocco, would stop using the pill, it was argued. A national demonstration was held in the Hague and newspaper advertisements were placed containing signatures of those opposed to the plans.

The proposal, supported by health secretary Professor Els Borst-Eilers in February, was based on the argument that the pill was not a basic health need and therefore the cost should not be refunded for women over 18 through their health insurance. It failed the fourth criterion laid down by the Netherlands' Dunning Committee, which defines what is essential health care and therefore covered by health insurance. This criterion excludes care which should be an individual's responsibility.

The government saw the plan as part of a £35m savings package aimed at weeding out a number of medicines covered by the basic health insurance. The government plans to cap growth in health expenditure at 1.3%, though it currently stands at 2.2% and a £500 000 gap needs to be bridged.

But Professor Borst-Eilers recently announced to the Royal Dutch Association of Pharmacists that the plans for the pill had been dropped because "fundamental and necessary conditions that I clearly underlined" had not been met. These stipulated both that all types of contraceptive pill could be bought from any chemist without a prescription and that the cost would fall.

But she has been advised that under European law (92/26/EEG) for the first five years new versions of any medicine including the pill can be available only on prescription. Neither could she get a guarantee from the pharmaceutical industry that the cost of the pill would not increase.

The pharmacists' association also argued

Protesting about the pill

that the pill should be available only on prescription in order to limit the chances of an adverse reaction with other medication. A spokesman for the association, Gerard Voituren, said that doing so would guarantee its "considerate and proper use."

But Dr Jany Rademakers of the Dutch Institute for Social Sexual Studies believes that there were political reasons too for the government's U turn. She says that there were fears that the Netherlands' international reputation for low abortion rates would be tarnished. In the Netherlands, where 40% (1.5 million) of fertile women use the pill, there are 5.6 abortions per 1000 women aged 15 to 44 each year. This compares with a figure of 13 per 1000 for England and Wales.

Dr Rademakers said: "We are very proud of our record; Dutch family planners travel abroad as ambassadors of their country. I do not think anybody wanted to be responsible for a worsening of the situation." She also felt that the strength of public outcry was important as people realised that the "good contraceptive situation could not be taken for granted."

Meanwhile plans to axe the £2.2m government funding for the family planning advisory body, the Rutgers Stichting, from 1996 have also changed. Funding will now be phased out over a number of years. —TONY SHELDON, freelance journalist, Utrecht

Audit Commission defines NHS management costs

About £900m was spent on senior management in NHS trusts in England and Wales in 1993-4—about 4% of the trusts' revenue. When other administrative and clerical posts are added the percentage rises to 10.5%. These figures, published last week by the Audit Commission, do not show whether management costs in trusts have risen since the NHS reforms.

A Price on their Heads: Measuring Management Costs in NHS Trusts does, however, provide a standard definition of senior management costs. This is based on the work that managers do rather than their grades, and it includes the cost of sessions paid to clinical directors for their management responsibilities. This definition will, claims the report, allow future changes in management costs to be assessed. In the meantime, the Audit Commission has used it to assess variations in costs between trusts and hopes that trusts will use the report to assess their own costs in relation to those of others of a similar size.

Average expenditure on senior management for each trust in 1993-4 was £2.1m. The overall variation was from £0.5m to £6m,

Czech president vetos antismoking law: President Vaclav Havel of the Czech Republic, a heavy smoker, has rejected a law aimed at reducing smoking in public places.

King's Fund will look at London's health care again: The King's Fund, the British health policy think tank, has reconvened its London commission to take a fresh look at the pattern of health care in the city into the 21st century. The recommendations in its first report for shifting care from hospital to primary care were supported in the Tomlinson report, and so far at least 2500 beds have closed.

French doctor in tainted blood scandal freed: Dr Michael Garretta, the former head of the French national blood bank, has been released from prison after serving more than half of a four year sentence imposed for fraud and criminal negligence for giving blood products infected with HIV to haemophilic patients. He may still face a more serious charge of poisoning.

Special adviser on proposals in Calman report appointed: The British chief medical officer, Dr Kenneth Calman, has appointed Professor John Temple as his special adviser on the implementation of the changes to specialist medical training recommended in the Calman report. Professor Temple is postgraduate dean of the West Midlands region.

UK wants amphetamines banned as slimming aids: The Medicines Control Agency is to start consultations on the possible ban of certain amphetamine and amphetamine-type drugs as aids to losing weight.

Fundholders' patients are getting earlier treatment: A report in the Consumers' Association *Which* shows that patients of fundholding general practitioners in Britain are getting hospital treatment more quickly but they have more trouble getting an appointment with their doctor.

French at risk from asbestos: The number of deaths from mesothelioma is rising in France and is expected to peak at 10 000 during 2015-2020. The use of asbestos has been banned in seven European countries but is legal in France. Cancer specialists have asked the government to stop its use.

and most of that was accounted for by the size of the trust. The Audit Commission found no evidence that the type of trust (acute or otherwise) or the use of middle managers to substitute for senior managers explained the variation. The report concludes, however, that whatever the causes of above or below average expenditure "they appear to be manifested through the number of managers rather than their salary levels."

The commission warns politicians that, without more information, reducing management expenditure "is a dangerous game, however popular it might make the player."

The NHS Trust Federation last week endorsed the Audit Commission's method of defining management costs and said that trusts should use it to provide a concise statement on management costs in their annual reports. The federation also wants to see these costs linked to performance measures and recommends research into the costs and performance of other health care systems, especially in western Europe and North America.—JANE SMITH, *BMJ*

A Price on their Heads: Measuring Management Costs in NHS Trusts is available from HMSO bookshops, price £6.

Trust withdraws allegations against consultant

One of the longest running employment disputes in the NHS ended last week when the Royal Cornwall Hospitals Trust unconditionally withdrew "all allegations, criticisms, and charges" against Dr Helena Daly, formerly a consultant haematologist at Treliske Hospital. Both parties agreed, however, that Dr Daly should not return to her former job,

from which she was first suspended nearly three years ago.

The case took a bizarre turn last summer when John Saxby, former chief executive of the trust, publicly admitted that his action in suspending and demoting Dr Daly had been "inappropriate." Dr Daly has always maintained that she and Mr Saxby were lovers and that resentment of the affair among hospital staff was the motive behind many of the complaints made against her. Mr Saxby gave evidence against her before a disciplinary committee in 1993, which later recommended her dismissal. Last year Mr Saxby agreed to testify on Dr Daly's behalf before the professional committee of the secretary of state for health.

On the day the appeal was due to begin a last minute settlement was reached between the parties. In a statement the trust acknowledged that "certain evidence against her was accepted which now appears unreliable. For that reason only, the trust concedes solely for the purposes of the professional committee that the decision to terminate the appointment was unfair." Mr Saxby, now chief executive of the Darlington Hospitals Trust, was present at a press conference called to announce the settlement.

Most of the 23 allegations against Dr Daly related to behaviour towards her subordinates. She argued that her only fault was putting patients' interests before those of staff, and she added that "women consultants who behave as men consultants do are criticised for so doing."

The case has cost the trust at least £300 000, which includes a sum to cover part of Dr Daly's legal costs. She has also retained her £50 000 salary throughout the dispute. In addition, the trust has agreed to pay for a six month clinical refresher course for her and to do all in its power to find her a suitable position as a consultant haematologist elsewhere in the NHS.

Referring to her decision not to seek reinstatement at Treliske Hospital, Dr Daly said:

Mr Saxby and Dr Daly

"It is inevitable that efforts by an employer to justify, or by a doctor to resist, wrongful suspension will force the parties into entrenched positions from which it is difficult to emerge and work satisfactorily. I am deeply saddened that I can no longer care for those patients in Cornwall who have supported me."

Dr Daly criticised the "gender culture" in some hospitals, with its "stereotypic expectations of how women consultants should behave." She said, "I had never experienced such discrimination until I became a consultant. I broke through the 'glass ceiling' in my early 30s. It was the concrete behind it that affected me."—OWEN DYER, freelance journalist, London

14 000 preventable deaths in Australian hospitals

An official report on Australia's hospital system shows that tens of thousands of patients die of, or become permanently disabled as a result of, preventable causes after admission. Preliminary findings of a study commissioned by the federal health department estimate that between 10 000 and 14 000 people died of preventable causes in both public and private hospitals in 1992. In addition, between 25 000 and 30 000 people experienced a preventable adverse event that led to permanent disability of some kind.

The Australian hospital care study found that preventable disabilities occurred in 1% of hospital admissions and deaths in 0.5% of admissions.

The study is based on 14 000 admission records in 28 public and private hospitals in New South Wales and South Australia. The data were extrapolated to achieve a national figure.

Similar studies conducted in California in the 1970s and New York in the 1980s found that one in 25 patients admitted to hospital experienced harm as a result and that about a fifth of hospital deaths were caused by something going wrong.

Carmen Lawrence, the federal health minister, tabled the study in federal parliament as a matter of urgency. "I believe that the evidence is sufficiently stark to warrant immediate action," she said. "What's been identified is not problems with resources but problems in practice, problems in education, problems in communication—and we're getting right on to this immediately."

A national task force to examine the problems has already been established and will consult with the professions and the health industry to report back by December.

Dr Lawrence said that proper quality assurance and peer review procedures were needed. "[The researchers] thought if there had been closer attention by peers to what their colleagues were doing, if there was better quality assurance, monitoring as there is in anaesthetics and in maternal mortality figures, then there would have been a better

ROBERT HARDING

A dying breed: one of Israel's adult smokers

outcome," she said.

The study found that communications problems were responsible for 11% of adverse outcomes, inadequate skill levels of practitioners for 6%, and inadequate resources for 4%.

Dr Lawrence said that the types of systemic problems that led to adverse outcomes included patients' records disappearing or being wrongly filed, patients not being followed up, results not being communicated, inadequate handovers, and incorrectly labelled drugs and wrong drug combinations being prescribed.

Dr David Weedon, federal president of the Australian Medical Association, said that release of the report was premature as its findings were incomplete. He argued that quality assurance was now more advanced than when the study was done in 1992. But he said that hospitals were full of sick people, who were already at risk of death and disability. "If you're in hospital, you're more at risk than you are on the outside," he said.

The study shows no difference between public and private hospitals in the incidence of adverse events.

Dr Bruce Shepherd, chairman of the Australian Doctors' Fund, said that doctors had been warning federal and state governments about declining standards in hospitals for years. "Our calls have fallen on deaf ears," he said.

The study was carried out by a consortium from the University of Adelaide and the University of Newcastle in New South Wales.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

Israeli smoking ban succeeds in 80% of adults at work

A new law banning smoking in Israel's 80 000 workplaces has been hailed as a success, with 80% compliance. An independent survey conducted for the health ministry and the Israel Society for the Prevention of Smoking found that the smoking rate among adults had dropped by 4% to 26% since the ban was introduced.

The law, which bans smoking in any of Israel's 60 000 workplaces except for ventilated smoking areas when permitted by employers, has even curbed the tobacco habits of the chain-smoking prime minister, Yitzhak Rabin. Mr Rabin, having refused to sign the amendment when he was acting health minister last year, has now reportedly stopped lighting up in the cabinet room (although not in his private office) and is urging colleagues to follow his example.

The percentage of adult Israeli smokers fell very slowly during the 1980s, according to the director of the Israel Society for the Prevention of Smoking, Amos Hausner. But between the previous survey in December 1988 and the latest one a few months ago it fell by 13%. "Nothing relevant happened between the surveys except for the law," Hausner maintained. "Cigarettes did not become more expensive; there were no major media campaigns to explain the hazards of smoking."

The law is apparently being observed with little enforcement by the authorities. The health ministry contacted all workplaces in advance to explain the rules and to supply special signs. But municipal inspectors, who were briefed to issue fines of 170 shekels (£35) to anyone caught smoking in restricted areas and twice that to employers for each missing sign, have received few complaints. Most of the enforcement is being carried out by employers under pressure from non-smokers.

Although previous laws barred smoking in lifts, buses, trains, banks, medical clinics, cinemas, wedding halls, taxis, and other public places, smoking is still permitted in restaurants and cafes, which are not defined as workplaces.—JUDY SIEGEL-ITZKOVICH, medical correspondent, *Jerusalem Post*

EU's alcohol subsidies come under attack

The European Union should stop subsidising the production of alcohol and raise taxes to discourage drinking, says Eurocare, an alliance of 23 alcohol misuse agencies in the European Union. In a new report Eurocare argues that the economic burden of alcohol problems may cost Europe more than £60bn a year when social and health costs are taken into account. It calls for taxes that make alcohol "pay its way."

The report says that the £3bn subsidy received from the European Union by drink producers in Scotland, France, and Italy should be withdrawn, that the union should develop a statutory code of practice restricting alcohol advertising, and that the maximum blood alcohol concentration permissible for drivers should be cut to 4.34 mmol/l (20 mg/100 ml) across the union. The current maximum in the United Kingdom is 17.4 mmol/l (80 mg/100 ml).

Mr Andrew McNeill of the Institute of Alcohol Studies, which helped to produce the report, said that its main purpose was practical: "I am happy to concede that the report does not contain anything new from a scientific point of view. This report simply takes the scientific consensus and shows the implications for European Union policy."

Much of the report is a rebuttal of *Alcohol Beverages and European Society*, which was published by the Amsterdam Group in 1993. The approach of the Amsterdam Group, which is funded by the European drinks trade, has been to emphasise the benefits of moderate drinking and to lay the blame for problems caused by alcohol on a small percentage of irresponsible users.

Although the report quotes figures showing that alcohol consumption across Europe has fallen by 7.1% since 1983, Eurocare argues that the current economic recession is masking a slight upward trend.

Mr Ian Winstanley, director of strategy for the Portman Group, the Amsterdam Group's British equivalent, challenged the

ROBERT HARDING

Is harming yourself with alcohol a purely personal problem?

report's recommendations: "All of these statistics are extrapolations from small studies, and alcohol taxation is a blunt instrument to reduce consumption. People should be doing things for themselves if they want to avoid the harmful effects of alcohol."

—DOUGLAS CARNALL, *BMJ*

Counterbalancing the Drinks Industry: A Eurocare Report to the European Union on Alcohol Policy is available from Eurocare, Elmgren House, 1 The Quay, St Ives, Cambridgeshire PE17 4AR, price £5.

Children affected by HIV need more help

More than 3000 children in the United Kingdom have mothers who are HIV positive, says a report for the children's charity Barnardo's. The report, *No Time To Waste*, predicts that there will be 4000 such children by 1997 and calls for more practical help for the families involved.

The report says that these children are affected by HIV even if they are not actually infected with the virus. The director of child care for Barnardo's, Mike Jarman, said: "Most HIV services were set up for adults, but it is the children of parents with AIDS who will also be greatly in need of support and care for many years ahead."

Such children, the report found, are more likely than the general population to live in substandard housing or to be homeless and are more likely to be poor. They are also

often responsible for caring for sick parents and for younger siblings. Most will have to cope with regular upheavals when their parent is ill or in hospital for long periods.

The author of the report, John Imrie, of the London School of Hygiene and Tropical Medicine, says that the true number of children affected by HIV is likely to be higher than the report's estimate: "The figures only include the number of women of childbearing age who have been reported as HIV positive and do not include fathers as these data are not available."

The report recommends that priority be given to giving practical help to affected families: "Respite care, domestic help within the home, maximisation of benefits, breaks for both children and parents, are all likely to decrease immediate stress and create an environment where the future arrangements for the care of children can be discussed with less stress and more confidence. It also criticises the "patchy" nature of current knowledge of these children's situation and calls for more data and research.

The report estimates that two thirds of the children are under the age of 10. It says, "For these children, a parent's HIV infection affects them from birth. Discounting the possibility of mother to child transmission, a significant proportion who experience periods in care, or living with someone else, are effectively orphaned prior to their parent's death."—CLAUDIA COURT, *BMJ*

No Time to Waste is available from Barnardo's Child Care Publications, Tanners Lane, Barkingside, Ilford, Essex IG6 1QG, price £8.50.

GMC approves guidelines on medical practice

The General Medical Council in Britain has approved a booklet, *Good Medical Practice*, which will be sent to all doctors on the medical register later this year. The booklet, together with statements on the duties of doctors and on confidentiality, will replace the guidance set out in the council's "blue book," *Professional Conduct and Discipline: Fitness to Practise*.

The council's standards committee, chaired by Sir Donald Irvine, has been concerned for some time that the guidance was not widely read and not always understood by doctors. Last November the council discussed drafts of the publications (*BMJ* 1994; 309: 251), and the final versions reflect comments by council members. The council took the advice of the Campaign for Plain English, and one major change in the final versions is the use of the second person, "you," rather than "doctors," making it explicit that the primary audience for the guidance is the profession.

The guidance advises doctors to recognise the limits of their professional competence, be willing to consult professional colleagues when necessary, prescribe only those drugs and appliances that genuinely serve patients' needs, and pay "due regard to efficacy and the use of resources." Doctors should respect the right of patients to be fully involved in decisions about their care and ensure that the care or treatment that they provide is not affected by their personal views about a patient's lifestyle, culture, beliefs, race, colour, sex, sexuality, age, social status, or perceived economic worth.

Sections in *Good Medical Practice* cover the duties of doctors when their own or a colleague's health may pose a risk to patients; maintaining professional relationships with patients and colleagues; research; and advertising.—LINDA BEECHAM, *BMJ*

Funding to follow students into the community

Medical undergraduates in Britain should be given more training in general practice to balance the training they receive in hospitals, says the Advisory Group on Service Increment for Teaching. In a new report the group also recommends that general practitioners who teach students be given "fairer support."

The report, *SIFT into the Future*, is the outcome of a review of the service increment for teaching (SIFT), which was set up after the decision to separate funding for NHS research and development (which takes a quarter of the present service increment for teaching and research) from that for educa-

tion. The review also followed the proposed abolition of regional health authorities and concern that the increment (£367m in England) was not always allocated where needed as NHS services and medical school teaching moved away from major teaching hospitals and into primary care. The advisory group represented trusts, health authorities, general practitioners, regions, and universities and was chaired by the NHS Executive's health care director, Dr Graham Winyard.

The report recommends that in future funds to support teaching should be divided into money for clinical placements and money to support teaching. The NHS Executive regional offices will give each medical school a planning budget for placements, based on the same sum per medical student. They will also ask the university to advise on how best to use the available funds and will agree a plan with the university.

The clinical placements budget (a fifth of SIFT) will increase in line with agreed numbers of medical students in clinical training, but the facilities budget will no longer be linked directly to student numbers.

The advisory group recommends that SIFT should replace the present fees paid to general practitioners who teach undergraduates. At present general practitioners who teach medical students receive a sessional fee of £12.15. There will be annual accountability reports to explain how SIFT is used.

The government has welcomed the proposed changes. The health minister Mr Gerald Malone said, "With more health services being provided through general practice and in the community it is important that there should be greater emphasis on this

in training."

Comments on the report are invited by 28 July, and it is proposed to implement the changes from April next year.—LINDA BEECHAM, *BMJ*

SIFT into the Future. Future Arrangements for Allocating Funds and Contracting for NHS Service Support and Facilities for Teaching Undergraduate Medical Students is available from the Health Publications Unit, Manchester Road, Heywood, Lancashire OL10 2PZ.

Report criticises French AIDS "charlatans"

Thousands of French patients with AIDS are treated by unauthorised and probably worthless drugs promoted by self styled researchers, says a new report commissioned by the French government. The report claims that there is a "proliferation of parallel therapeutic practices" sometimes carried out under commercial and moral pressure and often tantamount to "pure charlatanism."

The report was commissioned by Dr Philippe Douste-Blazy, the outgoing minister delegate for health, and produced jointly by the French inspectorates general for social affairs and for national education. It says that the lack of effective treatments and vaccines leads to a feeling of powerlessness in the face of the disease and encourages the

Money will now follow students

ULRIKE PREUSS

proliferation of such "parallel" treatments.

Some so called therapists, says the report, act through bona fide associations, claiming to be pioneers rejected or persecuted by official science and demanding secrecy.

Some companies or individuals are already being prosecuted for the illegal practice of medicine or pharmacy or for deceitful advertising. The report says that many patients and doctors are involved. One group makes claims for "medicine developed by our research team" and has dispensed 15 000 prescriptions made out by 500 doctors for about 8000 patients. Another company, which sells pills for the "treatment of immunity," has a working file of 250 doctors and 4000 patients.

Some may act in good faith. Biologist Mirko Beljansky, a former researcher at the Pasteur Institute, produces his own drug based on extracts from a Brazilian tree and distributes it through French and Swiss pharmacies.

Last year a court found him guilty of illegal practice of medicine but gave him no sentence. A series of tests led French health authorities to declare his drug ineffective, but later Beljansky arranged for samples to be sent for evaluation by Dr Douglas L

Mayers of the Walter Reed Institute in Rockville, Maryland, US. Dr Mayers's report is said to have been sent to French health authorities, but the results have not yet been disclosed.

The government has so far hesitated to tackle complaints; the judicial framework for handling them is complex, and fines tend to be minimal.

One of the last actions of Simone Veil, the outgoing minister of social affairs and health, was to create a unit to suppress such illegal practices.—ALEXANDER DOROZYNSKI, medical journalist, Paris

German doctors fear unemployment

Dr Carsten Vilmar, the president of the German Chamber of Physicians, warned last week that 60 000 doctors in Germany could be unemployed by 2000. He claimed that there were far too many medical students at German universities and warned school leavers not to apply to study medicine. "Stu-

dents have to realise," said Dr Vilmar, "that most of them will not find jobs in hospitals." General practice is also overstuffed.

Dr Vilmar made his statement at the 98th annual meeting of delegates from all medical groups in Germany. The *Ärztetag* (doctor's assembly) is the political mouthpiece of the country's 327 000 doctors. The most important discussion was, again, on abortion laws. Delegates voted to oppose plans by the government to tighten legislation on abortions further.

Under the terms of the new bill doctors would have to counsel women on the legal aspects of getting an abortion and could be prosecuted for not discussing under what aspect of the law women were entitled to terminate their pregnancies. Before they visit a doctor women in Germany currently see someone—not usually a doctor—to discuss whether they are legally entitled to an abortion.

Delegates also expressed concern at euthanasia in the Netherlands. They said that "Although this development may be supported by humanitarian motives, the homicide of terminally ill people threatens to become a regular part of doctors' tasks." —HELMUT L KARCHER, medical writer, Munich

Focus: Washington

Republicans turn health reform into a revolution

American politicians, especially the Republicans who sank last year's health care reform, love to boast that America has the best health care system in the

world. Among patients covered by insurance, they would get little argument. But that will probably change after this session of congress fulfils its promise both to balance the federal budget and to cut taxes.

The very foundations of America's "best health care system" are being scrutinised, and virtually every major health programme will probably be slashed to levels previously undreamed of by doctors, scientists, and even politicians.

Republican leaders in both the house and the senate have promised to cut spending on Medicare, the insurance scheme for elderly people, by up to £200 billion within the next seven years, though they promise not to cut benefits to anyone receiving Medicare subsidies now. The annual budget now stands at about £120 billion.

Already, elderly people must pay for their own drugs (which often run to more than £100 a month), and most congressional leaders say the elderly people of the future will simply have to dig further into their own pockets to contribute a larger share in the

form of "copayments." Most policy experts see little way to avoid such measures in order to save the programme from going broke in 5-10 years time. But these threats to Medicare may be less important to medicine overall than cuts planned for the very foundations that have made America the leader in medical innovation.

The National Institutes of Health (NIH), for decades a place where only the most fearless politicians dared to tread, is now being threatened with huge reductions. Congress is negotiating whether the NIH budget will be cut by 5% or 10%, but both houses agree on a spending freeze up to 2002.

According to NIH director Harold Varmus, non-AIDS research would be cut by as much as 18%. At present the NIH funds about 24% of all grants submitted to it; Varmus has said that the level could fall to as little as 6%. He has pointed out ways in which the NIH has saved Americans money. The recently developed vaccine against *Haemophilus influenzae* type B, for example, is estimated to have saved the country about £267 million for an investment by the NIH of "a few million"

The NIH also has a key role in supporting the 78 000 faculty members at America's 125 medical schools, since 15-16% of their budgets comes from NIH grants. Academic medical centres have been slow to adjust to the changing marketplace

of clinical medicine, so just as the private sector is taking patients away from medical schools congress may worsen the problem.

Finally, even the private sector is threatened by Washington's budget cutting. One agency supported by both liberals and conservatives is the Agency for Health Care Policy and Research (AHCPR). Even President Reagan's health adviser, William Roper, says the AHCPR performs a "critical role" by researching and publishing clinical guidelines for common problems. Roper and others say that guidelines in the private sector might place cost saving ahead of evidence.

Yet the senate is threatening to cut the agency's budget from £108 million to £27 million. House members want to kill the agency altogether. AHCPR has so far produced 15 clinical guidelines that have been shown to cut costs while preserving quality. For example, using the guidelines cut the rate of pressure ulcers in high risk patients in a hospital in Utah from 33% to 9% and saved it about £500 000 annually.

Clearly, health reform in the United States is not dead, although it is now moving in a direction opposite to that proposed by President Clinton. Virtually no health programme will not be cut. The question now is whether President Clinton will use his veto on the budget bill that will arrive on his desk late this year?—JOHN ROBERTS, north American editor, *BMJ*