polio—must be set against its failings in developing health infrastructure in individual countries. Other players in international health—Unicef, the World Bank, and non-governmental organisations—have too often been seen as threats rather than partners, so that countries are confused by an array of competing and sometimes inappropriate interventions. As programmes have been cut despite growing numbers of senior managers, staff morale has fallen. Gradually the scientists, clinicians, and administrators who gave their lives to furthering the good of mankind have found themselves mired in bureaucracy, political infighting, and petty corruption.

The new director general faces a daunting challenge: to restore the WHO's finances, reform its constitution, modernise its management structure, recast its priorities, build creative alliances with other agencies, and rebuild staff morale. Faced with these challenges, what sort of person does the WHO need? Above all, it needs a leader—someone who can create a clear vision of where the organisation is headed, communicate that vision throughout the organisation and

beyond, and motivate others so that they want to achieve that vision too.

Beyond this fundamental attribute, the new director general should have certain specific skills and experience. She or he should be politically independent, command respect from the major donors, be able to relate to both developed and developing countries, be well versed in the problems of poverty and the links between development and health, and have a real interest in the empowerment of women. She or he should have proved abilities to cooperate in a complex global environment and to engender a culture of openness, accountability, and advancement on merit. She or he should be committed to reform.

Not everyone will agree with this prescription. It is based on the premise that the WHO must change or die. The good news is that, for once, the field of applicants is strong; the bad news is that many of those who will choose the next director general may prefer the status quo to an uncertain future.

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The effect of speed cameras on injuries from road accidents

The technology exists to ensure all road traffic is regulated to safe speeds

When motor cars first appeared on British roads they had to be preceded by a man waving a red flag to warn the public of the approaching danger. As the number of vehicles has grown, many ways of ensuring the orderly management of traffic and public safety have been tried. Despite improvements in vehicle and road design, traffic regulation, and driver behaviour and despite reductions in accident rates, road traffic accidents remain a major cause of premature death or serious injury.¹ Can anything further be done to reduce this toll?

The epidemiology of road traffic accidents is well known. For prevention the most important measures are separation—of streams of traffic from each other and of vehicles from people—and control of speed. Limited separation has proved practicable only on motorways: the complete separation of heavy goods vehicles from cars, bicycles, and pedestrians is unrealistic. The role of speed in accidents and in seriousness of injury is incontrovertible, but the issue for prevention is how to apply and enforce speed limits. Abundant data have accumulated from observational studies on the effects of introducing speed limits (in urban areas, on motorways, for war time black out, for fuel economy in the petrol crisis) and also on the effects of relaxing speed limits.^{2 3}

The Highways Agency recently reported the findings of a six year experiment in the use of speed cameras on west London trunk roads. The design was a before and after comparison of deaths and injuries in the three years before the installation of cameras and the three years afterwards. The numbers of deaths

reduced threefold, from 68 to 20, and the numbers of serious injuries by over a quarter, from 813 to 596. Lesser injuries also fell significantly, from 4983 to 4375. The study considered the spillover effects of traffic seeking side roads to avoid cameras and found no compensating increases in neighbouring roads. Acknowledging the difficulties of ascribing causality from a before and after comparison, the study also included a control: comparable trunk roads in other areas of London with no cameras over the same period. A small reduction in accidents was observed on control roads, and all rate reductions in the study area were adjusted accordingly: even so, all reductions on the study roads remained highly significant.

American studies have also suggested an 8% reduction of fatal accidents for each reduction in average speed of 1 mile per hour (1.6 kilometre per hour).³ Another trial of area wide traffic calming schemes, based on speed bumps, road narrowings, and road markings, has shown a comparable reduction in overall accidents.⁵ The gradient in risk reduction by severity of injury in the speed camera project may be interpreted as a sort of dose response.

The next question for road safety and public health is whether the improvements in this study are sustainable and repeatable elsewhere. The risk compensation theory suggests that motorists will find other ways of injuring themselves and other road users. However, the technology to measure and record vehicle identification, time, place, and speed has been with us for many years and the automation of this technology makes enforcing speed limits more practicable. In the interest of safety we should expect all road traffic to be regulated

to safe speeds, and in the near future to variably set safe speeds depending on prevailing conditions.

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1948: a turbulent gestation for the NHS

Some things don't change

This year is the 50th anniversary of Britain's National Health Service. On 5 July 1948 Aneurin Bevan, minister of health in the postwar Labour government, launched "a unique experiment in social engineering."¹ The experiment continues, but the public has long since judged it a success, even though that success has become tarnished in the 1990s.

The NHS's gestation, however, was described by Bevan—in a classic understatement—as "not ... altogether trouble-free."² Certainly, the months between December 1945, when the health minister made his first major policy statement to parliament, and the "appointed day" in 1948 were a turbulent period in medicopolitics. The unfolding dramas were faithfully chronicled by the *BMJ*, and in this opening issue of the anniversary year the journal publishes its first "filler" on the NHS selected from the issues of 50 years ago (p 20). Others will appear during the year, but not necessarily in chronological order because the selections have to be fitted into available spaces. Nevertheless, readers will receive a flavour of the events of a momentous year.

In 1948 most doctors probably supported the principle of a comprehensive, state funded health service. After all, the preceding two decades had seen the BMA publish reports advocating a form of national medical service, the wartime Emergency Medical Service had shown the effectiveness of nationally organised hospital care, and William Beveridge's famous 1942 report proposing a "cradle to grave" welfare state had received wide public and political support.³ The profession was, however, unhappy with the details as they affected doctors as defined in the NHS Act passed in November 1946.⁴ So much so that the BMA warned that the independence of medicine was at stake.

As a result the BMA and the government spent many months in acrimonious and public confrontation. The differences were most acute over general practice. Hospital doctors, too, were worried: about the nationalisation of voluntary hospitals; the loss of influence by the teaching hospitals; a fair distribution of consultant skills; and private practice. But the presidents of the royal colleges, particularly the physicians' president, Lord Moran, worked behind the scenes to persuade Bevan to make enough concessions to defuse opposition among hospital doctors.⁵

General practitioners depended on the political skills of the BMA to achieve their objectives. They feared that the new service would convert them to salaried employees and compromise their clinical independence. General practitioners also saw the NHS as devaluing the financial worth of the goodwill that was

bought and sold when they entered or left practices. Plebiscites were held, special representative meetings called, and threats made that doctors would not sign on in the new service. Negotiations dragged on to a stalemate in December 1947.

As 1948 dawned, an angry government tried to split the profession, with Bevan savagely attacking the BMA's leaders and accusing them of misleading "a great profession." The profession's answer came soon after in the result of a plebiscite of all doctors by the BMA. Asked whether they would accept service in the NHS, almost 90% of respondents—75% of the whole profession—opposed joining under the government's terms. This riposte so alarmed the cabinet that Bevan (aided by Lord Moran's informal conciliation⁶) promised an amending act.^{6,7} He conceded sufficient ground to the BMA (including specific exclusion of a salaried service for general practitioners) to ensure—after more heated debates and another plebiscite—that doctors would join the NHS on 5 July 1948.

The profession's arrival at the starting line may have been at the 11th hour, but Nicholas Timmins, in his admirable biography of the welfare state, described 5 July as "by any standards one of the great days of British history."⁸ Events in the remaining months of 1948 showed how much that day meant to the British public. The *BMJ* of 13 November, for example, noted "the eagerness with which the public has sought to take advantage of a service which, in effect, guarantees the supply, free of direct charge, of everything from wigs to iron lungs.... Doctors' surgeries are crowded out, and the doctors themselves deplore that this heavy pressure of work has made it at times impossible for them to give their patients adequate care and attention."⁹ That observation remains pertinent 50 years on. But the important principle was that people could visit the doctor without fear of the financial consequences and when necessary be referred for specialist care. Even in today's cash strapped NHS such access to medical care is cherished by the public. Long may it remain.

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See p 20

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