to draw up practice guidelines. It is hoped the guidelines will reduce unnecessary and ineffective treatments and serve to protect doctors who follow them from malpractice suits. But it remains to be seen whether the plan can contain Florida's spiralling health costs, which are expected to triple over the decade, from $31·4 billion in 1990 to a projected $90 billion by the year 2000. Currently, 1 in 5 of the state's 13·5 million residents have no health insurance, and adding coverage for them is certain to raise the state's health expenditures over the short term. "This is an experiment", the director of the state's Agency for Health Care Administration Doug Cook told the *New York Times*. "We're going to have to see how it works as we go along. This is a first shot across the bow, and there aren't any guarantees."

Michael McCarthy

USA: Pressure for mifepristone

An abortion rights group in New York has announced that it has begun producing its own version of mifepristone. Lawrence Lader, president of Abortion Rights Mobilization (ARM), said that laboratory analysis shows their drug to be chemically "indistinguishable" from the mifepristone manufactured by Roussel-Uclaf. Lader said that pharmacological tests on primates would soon be completed and that his organisation planned to meet with the US Food and Drug Administration (FDA) later this month to discuss protocols for human testing.

Roussel-Uclaf officials have been reluctant to bring the drug here and risk damaging boycotts of their products and those of their parent company Hoechst AG by anti-abortion activists. Company officials have also expressed concern that the drug will not be as tightly controlled in the United States as it is in France, where its use is limited to designated clinics. Improper use of the drug by untrained US physicians could involve the company in expensive malpractice litigation. Recently, however, Roussel-Uclaf indicated that it intends to market RU-486 in the States, and in February, Edouard Sakiz, the company's president, met with the FDA Commissioner David Kessler to discuss plans to begin testing in the US. But Lader said that abortion rights groups remain suspicious of Roussel-Uclaf's commitment to bring the drug to the US, and he warned that if the company continued to delay "we will attempt to have their patent taken away and assigned to another company". Lader hoped that the threat of patent seizure, which is allowable under US law if it can be shown to be necessary for the public good, "will scare the hell out of Roussel".

The day after the ARM announcement, the 390 000-member American Medical Association, the American College of Obstetricians and Gynecologists, Physicians for RU-486, the National Organization of Women, and several other feminist and abortion rights organisations held a joint press conference to urge Roussel-Uclaf to introduce the drug. The spokesmen for these organisations argue that RU-486 should be made available to women in the US not only for abortions, but also because it was showing promise as a possible treatment for breast cancer, gynaecological cancers, and inoperable meningiomas.

At that press conference, Congressman Ron Wyden, an Oregon Democrat, warned that if the company did not proceed quickly he would initiate Congressional hearings to determine whether the company should be stripped of its US patent for mifepristone.

Michael McCarthy

USA: Vaccine debate

Vaccine manufacturers were quick to denounce the announcement that the Government intends to provide free immunisations to every child under the age of two. Under the plan, the Government would spend up to a $1 billion a year to buy as much vaccine as the nation needed and distribute it to state and federal health clinics. The Government would also provide free vaccine to private physicians, who would be allowed to charge a fee for administering the vaccine, but no more. The plan also calls for the development of a computer tracking system to maintain records of every child's immunisation history, said Department Health and Human Services Secretary Donna Shalala.

Currently, only about 60% of American two-year-olds are completely immunised, and in some inner city areas the vaccination rates run as low as 10%. But vaccine manufacturers were clearly unhappy with the proposal. Company spokesmen said that, as the sole purchaser of vaccines, the Government will be able to drive down vaccine prices, which, in turn, will cut profits and discourage research and development into new vaccines.

A spokesman for Lederle-Praxis Biologicals, Craig Engesser, said that a free vaccine programme was unlikely to succeed, citing the failure of such programmes in 11 states to significantly improve immunisation rates. Immunisation rates fail to rise, argued Engesser, because the public health delivery system is ineffective, public education is inadequate, and many insurance companies do not pay for childhood immunisations. "To us these are the true barriers to vaccinations—not cost", Engesser said. Manufacturers were particularly concerned that the Government will give the contract for a given vaccine to one manufacturer. Such a "winner take all" system would drive manufacturers who lost the bidding out of the business, said Engesser. Until the economic impact of the plan is known, companies are going to be reluctant to invest in more vaccine development.

Michael McCarthy

Australia: Doctors threaten to walk out

Specialists in Australia's largest state, New South Wales, have threatened to resign from the public hospital system following a decision to cut their pay by 15 to 20%. Late last month Justice Barrie Hungerford of the NSW Arbitration Commission, after an 18-month hearing costing about A$7 million, found in favour of the NSW Health Department in its dispute with the NSW branch of the Australian Medical Association, which represents 2700 specialists. While the specialists had sought a 60% increase in their payments, the Health Department had asked for a 40% pay cut and was awarded roughly half of that. The department's arguments over changes to contractual arrangements were also granted. The specialists have decided not to appeal because they say that they no longer trust arbitration.

The current disagreement has its origins in a dispute over the introduction of Medicare, Australia's national health insurance scheme, in 1983–84. As a result of that dispute, an arbitration awarded specialists working in public hospitals payments that were generally thought to have been overgenerous. Leading counsel for the federal Health Department in that case was Barrie Hungerford QC. The AMA tried to have Justice Hungerford opt out of the case on the grounds of conflict of interest (he had vigorously argued

that specialists were paid too much), but he ruled that he was impartial and fit to arbitrate.

It is difficult to assess the impact of this current argument. The 1983–84 dispute took 6 years to resolve fully and spread from NSW to other states, where it was not as strong. This present dispute should stay localised to NSW, although other state governments will be watching the result with interest and may decide to attempt to cut their specialists' pay. However, what of the effect on medical practice? Many specialists built up their private practices after 1983–84 and no longer rely on the public system to the same extent. Many would be able to walk out and be no worse off financially, although they would miss the kudos that comes with the public system and teaching hospital appointments. But others, due to the nature of their work, rely heavily on public funding and would find life difficult in a purely private sphere. The impact on the public is even more difficult to assess. If the contest follows the pattern of the 1983–84 dispute, the most likely outcome is a withdrawal of all except emergency services. But the definition of "emergency" varies enormously. Some specialists will continue their practice as usual under the guise of providing emergency care only, while others will withdraw all services except for patients in extremis. A further meeting of specialists is planned for April 18.

Mark Ragg

India: Family planning project stirs Norplant debate

The Innovations in Family Planning Services (IFPS) Project, to be launched in the northern State of Uttar Pradesh at a cost of US $325 million, with assistance from USAID, is expected to set the tone for reorienting and revitalising India's faltering family planning programme. The project aims to reduce population growth in Uttar Pradesh to levels consistent with its social and economic objectives—ie, to decrease total fertility rate from 5·4 to 4·0, and to increase contraceptive prevalence (measured as Couple Protection Rate) from 35% to 50%, by 2002—by increasing access to and promoting family planning, and by improving quality of family planning services.

Uttar Pradesh (population of 140 million), the largest state, has traditionally been one of the four Bimaru (Hindi slang for sick) states—Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh—where family planning programmes became extremely unpopular because of the forced surgical sterilisations during the National Emergency in 1976–77. Even so, surgical sterilisation remains the mainstay of contraception. The project will be run by an autonomous group, State Innovations in Family Planning Services Agency (SIFPSA), which will, however, receive overall policy directives from a national steering committee chaired by the Union Secretary of Family Welfare. US $225 million of the grant will come to India in the form of local currency, whereas the rest will be used by USAID to provide training and technical assistance and for procurement of supplies not available in India.

The project proposes to involve women in its implementation at all levels. However, womens' groups are up in arms against a USAID proposal to include Norplant and Depo-Provera. The controversy spilled into Parliament last month when Mrs Kamla Sinha created a furore in the Upper House by alleging that women in Uttar Pradesh will be used as guinea pigs for "untested and harmful" drugs. She further alleged that drugs not fit for use by women in the United States had been dumped on third world countries. There was further commotion when another Upper House member, Dr J. K. Jain, a physician by training, corrected Sinha about her "disinformation". John J. Dumm, director of the USAID Office of Population, Health and Nutrition, denies that USAID is trying to push the two contraceptives in any way: "We will not offer any contraceptives that have not been cleared for use by the drug regulatory authorities of India. All we have said is that these contraceptives are available and we are ready to provide them as and when India needs them". Both Norplant and Depo-Provera have yet to be approved by the Drug Controller for widespread use. They have been approved by the US Food and Drug Administration. According to Dr Badri Saxena, senior deputy director general at the Indian Council of Medical Research (ICMR), both agents should be among the choices offered to women. He maintains that there are enough data from the ICMR's Norplant trials to warrant its use here. The ICMR's Norplant trials have had a chequered history. The comparative trials between Norplant (levonorgestrel subdermal implant with six capsules) and Norplant II (levonorgestrel subdermal implant with two covered rods), expected to be chosen for the national family programme because of easier insertion and removal and lower cost, were halted when the Finnish manufacturers abandoned production after the US Environmental Protection Agency asked for additional testing in animals in the light of evidence suggesting that medical grade elastomer 382 used in the rods was carcinogenic in animals. Follow-up studies were, however, continued, and 2 years back, a government technical advisory committee recommended that there was sufficient data for Norplant to be introduced in a phased manner in the country. (The Population Council has reformulated the Norplant II rods and advanced clinical trials are underway.)

Sustained pressure from womens' groups have forced the family welfare ministry to backtrack on its technical committee decision. ICMR will now embark upon a fresh phase III clinical trial with Norplant alone, in ten centres all over India. Although it will be 8 years before the results of this trial are available, the ministry may take an earlier decision to use Norplant on the basis of preliminary data alone. Meanwhile Norplant and Depo-Provera have been dropped from the IFPS project.

Bhupesh Mangla
Vivek Mangla

Germany: Plans for cancer registries

There are hardly any reliable data on the morbidity or mortality from cancer in the west of the country because of the lack of cancer registries. The only exceptions are the small state of Saarland and to a lesser extent Hamburg, but these areas are barely representative of the 60 million West Germans. Neither can their data be compared with those from other international registries. East Germany used to maintain an almost complete register containing 40 years of data, but since reunification, only now is there access to this "treasure", as epidemiologists call it, because the data had first to be made anonymous following the merger. A law to secure the existence of the East German cancer registry in Berlin came into force in January.

Since then the Health Ministry in Bonn has proposed a law that would oblige the remaining West German States to