Europe's specific research

Proposals for specific European Union (EU) research work to back up the deadlocked Framework Research Programme (see *Lancet* March 12, p 662) will send a signal to both politicians and researchers that EU-level research can move ahead, European Research Commissioner Antonio Ruberti said on March 11. Ruberti said that the specific programmes that fall under the stalled framework programme must be operational by 1995 to avoid any breakdown in EU action. However, he was confident that talks between the Council of Ministers and the European Parliament on March 21 would lead to a compromise deal over the framework programme, which would allow attention to turn to the specifics.

Ruberti said that in the latest proposals the European Commission had placed a high priority on promoting cooperation between research centres, universities, and businesses in the member states. Another priority carried over from earlier programmes was selectivity about the type of project funded, he said. But in a new departure for EU research, the Commission has added a social and economic research section.

In the medicine and health field, the Commission wants to promote the transfer of research to clinical applications and develop links between small and medium sized companies. Priorities will be research into major diseases—cancer, AIDS, tuberculosis and other infectious diseases; pharmaceutical research; brain research; and human genome research. The last priority is aimed at contributing to genetic mapping, identifying gene function, diagnosing genetic disorders, and developing genetic therapy techniques. The programme will also back current work in the member states into cardiovascular disorders, chronic and age-linked illness, rare diseases, and public health. In parallel with the programme, the Commission says that it will run surveys of European attitudes to questions of medical ethics as well as encouraging research into alternatives to animal testing.

Sara Lewis

Cash for NZ health reforms

Not yet nine months into its health "reforms", the New Zealand government has had to come to the rescue of its financially strapped hospital system. The new Minister of Health, Jenny Shipley, has just announced an injection of NZ$405 million into the budgets of the country's 23 Crown Health Enterprises (CHEs), which are types of public hospitals. The additional funding will be swallowed up by debt.

The crisis had been looming for some time, as CHEs throughout the country reported growing debts and inadequate funding. In June, 1993—before the implementation of the health reforms and the funder-provider split—the accumulated debt of CHEs was between $600 million and $700 million. By March, 1994, they owed $1.25 billion. The government maintains the CHEs' debt problems were inherited from the old health system, but some critics lay the blame on the cost of health reforms, especially extra administration and expensive consultants, new information systems, and the fact that specialists can now charge the public system market rates for their services. The concept of doing your bit for the public good died with the introduction of the free market.

This situation is a far cry from the efficiency gains originally promised. The chief consultant to the reforms predicted gains of 30% and in 1993 the then Minister of Health, Bill Birch, promised the equivalent of between 10000 and 20000 coronary bypass operations. Now the promised efficiency gains have been scaled down to 5%.

The CHEs were established with boards of businessmen and were charged to make a profit. Their affairs are closed to the public on the grounds of commercial sensitivity. Some CHEs have entertained bizarre money-making schemes, such as the Otago CHE's proposal to seek contracts from Saudi Arabia. Less exotic alternatives are to close hospitals, lease wards to the private sector, take fee-paying patients, and cut services.

Contained in the recent financial bail-out announcement was the news that from July 1 CHEs will be able to make cuts to services. For the first year CHEs were instructed to continue the existing level of services. So much for the original promise that the reforms would enhance consumer choice.

The government has yet to touch the area of potential health spending difficulties. Bending to the will of the powerful general practitioner (GP) lobby, the government held back from capping spending on primary health-care services. Instead it carried over the existing fee-for-service system until 1996. Already the regional funders of health are talking of making GPs budget holders, for primary and possibly secondary care. The proposal could well be unpopular with the public because of the requirement to register with a single practitioner and the power it would give GPs to act as gatekeepers to services. The alternative, say the funders, is for consumers to be "more responsible for their own health" and be their own budget holders. This means the kind of voucher system promoted in America by right-wing groups such as the Heritage Foundation.

Sandra Coney

Australian Medicare levy rise proposed

The Minister for Human Services and Health, Senator Graham Richardson, is pushing Cabinet for a rise in the Medicare levy from 1·4% to 2% of taxable income. He says this would pay for an upgrading of the public hospital system and a range of other, as yet unspecified, measures. The levy, which covers only about a fifth of the cost of Australia's national health insurance scheme, has already risen from 1% when it was introduced in 1984.

The proposal has met with considerable opposition from the health industry—the Australian Medical Association and the Australian Health Insurance Association being the most vocal. The Prime Minister, Paul Keating, played down, but did not dismiss, the idea.

Keating's statements should be read against a background of politics. First, the government is contesting four by-elections within the next two months, and is thus keen to avoid a rise in taxes. Second, it would be difficult to justify raising taxes when the government has repeatedly reduced personal and company tax rates, with the latest reductions coming into effect only this year. Third, personalities play a part. Richardson and Keating have been friends for many years, both coming from the right-wing faction of the Labor Party. But there seems to have been a falling out in recent times. Richardson has put up several proposals for changes to the health system, but has failed to win much support from Keating. He has already tried to introduce a two-tiered Medicare levy, whereby people earning more than $50 000 per annum paid a 2% levy while lower income earners paid the 1·4%, but Keating knocked that on the head. Richardson has also suggested publicly that Keating, who earns more than $100 000 per year apart from his income from personal investments, should take out private health insurance. Keating, who likes to keep his private life private, was not impressed.

Richardson also made off-hand comments in a speech last November that seemed to be directed at Keating's wife. Annita Keating had decried the lack of commitment to research into breast cancer, and compared it unfavourably with the amount of money dedicated to AIDS research. Richardson said: "I am getting a little bit disturbed about some contests that are occurring when it comes to medical research. It disturbs me that people feel that we ought to have a list of deserving diseases and that among those deserving diseases we should start to allocate funds, and that AIDS in some way is not deserving . . . We have a duty to fund all [diseases] to the best of our ability".

Mark Ragg