Council of Medical Research (ICMR) Bhopal Gas Disaster Research Centre were served termination notices. They went to court for restoration and regularisation of their jobs, and their case is now with the Supreme Court, where hearings started last week. 21 of the 26 ICMR projects pertaining to the disaster were closed down last year. Describing the loss as irreparable, a senior ICMR official says, "The progress of studies completely got arrested and whatever studies were stopped cannot be made up". For more than five years no scientific studies have been given clearance for publication because, ICMR claims, of a ban by the government, but this ban is denied by officials at the Ministry of Petrochemicals, the central ministry dealing with the gas disaster. All the research data and studies of the disaster research centre fall in the confidential category. Says an ICMR official, "It is for the first time that scientific study results are being withheld, even in the case of completed studies". According to Satinath Sarangi of the Bhopal Group for Information and Action, "Earlier the argument given by the government was that these findings could be misused by Carbide against the victims, but four years after the settlement such a ban makes no sense". He adds caustically, "What has the research yielded for the people of Bhopal on whose bodies all this research is being done?"

While hardly any scientific research is being pursued, the results of the studies conducted are denied to the victims and to the scientific community. Judges remain oblivious of the findings, and compensation is totally inadequate or cases are rejected. Victims' organisations allege that claimants' conditions have constantly been underassessed and no records have been kept or given to them. Exposure to methyl isocyanate (MIC) has consistently been kept out of medical records. If the death certificate says that the death was due to cardiac arrest, the judges have refused to accept that the case had any link with MIC exposure. Victims families cannot prove that the deceased had been affected by the gas because they do not have the necessary documents, and those they possess do not mention any history of MIC exposure. Victims' organisations have demanded an international medical commission on the Bhopal gas disaster to chalk out a future course of action.

Sanjay Kumar

Germany: Hitch in medical education reform

Last year the German Science Council recommended that medical education be reformed (see *Lancet* Aug 8, 1992, p 361), and the recommendations then were more drastic than any in the past 20 years. The most important reform was the elimination of the demarcation between the preclinical studies in the first 2 years and the clinical training in the next 6 years. The council also recommended that the medical course be shortened from 8 to 5 years. Although there was praise for these recommendations, medical students will have to wait some time for the reforms—unless they can gain admission to the medical school at the private university in Witten/Herdecke.

Despite the praise, there was some harsh criticism for the recommendations, especially by teaching staff who believed that the new curriculum would increase demands on their time and thus reduce research time. In addition the financial consequences of German reunification mean that the states are tending to abolish rather than create university posts.

The private university was founded 10 years ago in two small towns near Dortmund and offers courses in economics, biology, dentistry, and medicine. It is entirely financed by private donations, mainly from industry. Students do not have to pay fees. Only 30 students are admitted to the medical course each year. They have to cover the same syllabus and do the same examinations as the medical students in the 26 medical faculties at the state universities, but the curriculum is based on problem oriented learning.

At the conference on problem oriented learning to which Prof Johannes Bircher, dean of the medical school in Herdecke, invited deans of other medical schools, much interest was expressed. However, only one school has seriously been trying to implement this form of learning—that at the Free University, based at the Rudolf Virchow Hospital in Berlin. The initiative came from the students, who had gone on strike in 1989 to express their dissatisfaction with the educational system. They formed a committee and were joined by several university teachers. There were plans to start the new curriculum this year for a random 60 of the over 240 students. Now they will have to wait until 1994. "The health ministry in Bonn will have to give special permission", said Dr Eberhard Gbel, a medical historian at the Free University interested in medical education. Permission will depend largely on approval by the Science Council, which will meet in the next few weeks. Approval is likely since nearly all its recommendations have been incorporated into the Rudolf Virchow plans. When these hurdles have been cleared, the state of Berlin will have to provide the money for the additional university posts required before the school can go ahead with its plans.

Annette Tuffs

Australia: National health policy

The first steps towards a national health policy were taken last week at a meeting of all federal, state, and territory health ministers in Sydney. The meeting, called by NSW Health Minister Ron Phillips in a fit of pique in February during tense negotiations over Medicare, proved successful in getting ministers to concentrate on issues broader than health insurance, which usually dominates discussion of health policy in Australia. One of the first steps will be to review areas of funding where there is considerable overlap between state and federal governments, such as primary care and the provision of pharmaceuticals. Coordinated policies will also be developed for disorders such as cancer, asthma, heart disease, lung disease, injury, mental health, and other chronic illnesses. These policies will produce identifiable goals (for example, a goal might be a 20% reduction in mortality from asthma by the year 2000) and will enable bureaucracies, academics, doctors, and public health officials to coordinate approaches and activities. In a statement released after the meeting, the recently appointed federal Health Minister Senator Graham Richardson said: "At the moment, the debate in Australia about health is based on how do we get more money or how do we build more hospitals—that is inadequate. No one is asking the question how do you make the community healthier? Are our prevention and research programs working as well as they can?"

Although the ministers presented a positive front after the meeting, the development of such a policy will require considerable coordination and goodwill. Before the meeting

several state health ministers had expressed doubts on whether such a policy was achievable or even desirable. Their attitudes will have to change if the plan to announce a national health policy in March, 1994, is to be realised.

Mark Ragg

Canada: Ontario's health budget cuts

Bed closures, reductions in services, and new fees for procedures previously covered under the Ontario Health Insurance Plan are being predicted as a result of budget cuts imposed on the health-care system of the country's largest province. Joining the nationwide rush to constrain a spiralling deficit, Ontario finance minister Floyd Laughren has announced a series of budget cuts that will see over Can $1 billion stripped from the $17 billion annual provincial outlay for health care. Foremost among the changes is a requirement that $275 million be slashed from the nearly $4 billion paid annually to the province's 25 000 doctors (a cut of $11 000 on the average $177 000 billed by each doctor in 1990–91). The precise means of achieving the cut is subject to negotiation with the Ontario Medical Association (OMA), but it seems that the province will seek to impose an early retirement plan for doctors; discontinue payments for certain medical procedures; discontinue assistance on malpractice payments; and implement a differential payment system for doctors, depending on where they practise or their specialty. Doctors in heavily populated urban centres will apparently receive less for their services.

In the bid to constrain the budget deficit to $10 billion, Laughren also said that hospital spending will be cut by $160 million. Hospitals will not receive the $50 million they normally do for special programmes such as dialysis, cardiac care, and transplantation; nor will they get $10 million from the Hospital Incentive Fund for emergency response teams. In addition only $49 million of a one-off $149 million payment originally promised to the province's 222 hospitals will be paid this year; when the other $100 million will be paid will depend on availability of funds. The hospitals will also be subject to an unusual proposal (now being negotiated with public employee unions) that will see all government workers take 12 unpaid days off per year. How that will be implemented remains to be seen but provincial health minister Ruth Greer insists that the quality of care will not be compromised.

The list of cuts does not stop there. Laughren also said $195 million (roughly 20%) will be cut from the $1.1 billion Ontario Drug Benefit Plan, which provides free drug coverage for 2.4 million seniors and welfare recipients. Those who can pay will be obligated to shoulder more of the cost but details of the level and type of fee they will have to pay have yet to be determined. The province will also discontinue payments for medical coverage of 80 000 refugee claimants living in Ontario (and thus force the Federal Government to absorb the cost), as well as limit the number of paid tests provided by commercial laboratories.

Predictably, the sweeping changes have prompted accusations that the province has launched itself down the slippery slope towards two-tiered medicine—one system for the wealthy and another for the poor. Both Michael Thoburn, president of the OMA, and Dennis Timbrell, president of the Ontario Hospital Association, have raised concerns that the cuts will result in fewer services and closure of hospital beds.

Wayne Kondro

India: Introduction of sex education

The education authorities are seriously contemplating the inclusion of sex education in the school curriculum, in the light of the growing scare about AIDS. In a society where talking about sex is still taboo, the move is a major step. The National Council of Educational Research and Training (NCERT), which prepares textbooks for all levels of schooling, has initiated a programme to design lessons, relevant to India, in "adolescence education"—the term the council prefers for sex education. Adolescence education will be introduced not as a separate subject but as part of existing population education lessons. Suitable components of sex education will be incorporated in subject areas such as the sciences, social studies, and psychology.

Health and education experts meeting in New Delhi to chalk out the programme for the council recommended that the four modules on sex education—covering the physical and the social aspects, sex roles, and sexually transmitted diseases—prepared by UNESCO should be taken as reference points for preparing teaching material. The emphasis will be on changes occurring during adolescence, the reproduction process, sex-related hygiene, bad effects of teenage pregnancies, HIV infection and AIDS, and drug abuse. To create a favourable public opinion for the introduction of sex education, NCERT will shortly launch an awareness programme among parents, opinion leaders, educationists, and the community.

India has over 100 million subjects in the age group 15–20 years. Experts believe it is necessary to introduce sex education in schools since the gap between the age at which children attain puberty and the age at marriage is widening. A survey conducted by the Family Planning Association last year among schoolchildren revealed that the primary sources of information on sex and related matters were television and magazines, not family, friends, or school.

Annu Anand

Egypt: Combating liver disease

The prevalence of liver disease in the Arab world in general and in Egypt in particular is reaching a "frightening" level, said Dr Yaseen Abdul Ghafaar, a liver specialist, last week. To address this problem, an association of Friends of Liver Disease Sufferers in the Arab World has been formed in Egypt. Abdul Ghafaar disclosed that in the rural districts of El Kaluoba and El Dahkalia, for example, 64% of young people had enlarged livers and that 25% of children in the district of El Manofia have chronic hepatitis. Nearly 50% of deaths in rural Egypt of men aged between 25 and 40 years are caused by bleeding oesophageal varices due to chronic hepatitis, and national figures show that nearly 10% of Egyptians are carriers of hepatitis B virus and nearly 20% of blood donors carry hepatitis C virus. The hepatitis C carrier rate, according to Abdul Ghafaar, is one of the highest in the world.

Similar rises in prevalence of liver disease have been recorded in countries such as Saudia Arabia, Kuwait, and Yemen. However, for a poor country such as Egypt, the cost of setting up screening and treatment facilities is daunting. The trustees of the new association are working towards the establishment of a regional research and treatment centre. There is a pressing concern that the poor should get appropriate care locally, something which is now lacking.

Peter Kandela