most doctors were working part-time in public hospitals, with very low salaries, but could have a private practice. This arrangement led to extensive duplication of services between the two sectors. The NHS law forbade private practice for doctors working in the public sector. Many senior doctors left the public service; other doctors remained but ignored the law and continued with their private practice. Public doctors also received gratuities (known locally as "envelopes") from patients, which a paper from the Institute of Economic and Industrial Research (1987) reports can amount to an average increase of 78% of official incomes. A parliamentary committee that was set up to examine the issue stressed the extent of the practice, which they blamed on the attitudes of both doctors and patients. The Ministry of Health has yet to respond to the committee's report, produced in May.

The new law will enable doctors to be employed in the NHS full time or part time or on a per-case basis. The second and third categories will receive low salaries but may practise privately. Full-time doctors will be employed on four-year contracts that can be automatically renewed twice. The post will then be advertised. The Hellenic Medical Association supports these reforms. The opposition of the Association of Public Hospital Doctors to the changes is expected to be softened by the automatic extension of the contracts for two more periods.

The law states that one of its objectives is to improve patients' freedom of choice. The whole population is covered by public health insurance organisations, each of which covers specific occupational groups. The new law entitles patients to visit any physician or hospital, public or private, and the organisations will cover the relevant costs. Previously the patients had access only to providers contracted or employed by the insurance funds. The reform will be piloted in two small districts. Patients will be entitled to four visits per annum to private doctors, and an unlimited number of visits to public providers. The Government expects the pilot projects to cost 12 billion drachma (£33 million) in the first year. If the trends confirm the estimates, the cost of implementing the reform nationwide will exceed the current health-care budget.

Last month also saw a set of measures concerning the financing of hospital services taking effect. The fees paid by the social-insurance funds for the treatment of their members have been kept considerably below costs. Public hospital budgets have been subsidised by the Ministry of Health. In private hospitals patients have had to bear the cost of the deficit. The fees paid by the funds to both public and private hospitals have now been increased by 220% to 300%, depending on type of facilities available. The fees will cover only "hotel" costs. The funds will be expected to pay extra for any diagnostic or therapeutic procedures. These changes mean that the funds will have the main responsibility for financing hospital services, although it is doubtful whether they have the resources to do so. The Ministry of Health has suggested that it will subsidise the funds, which may also have to raise members' contributions. The overall effect of these measures may increase health spending, contrary to the intentions of the Ministry of Health, because there are no policies for controlling the growth of hospital expenditure. Hospital-financing systems remain open ended and hospitals have no incentives to increase efficiency, since the extra charges for diagnostic and therapeutic procedures will mean that they will earn additional income by increasing the quality of services provided. Moreover, there is a levy on funds, of 5000 drachma (£14) for every admission of their members to public hospitals; the money will be distributed to hospital staff as a productivity bonus. User charges have also been introduced. These include a 1000 drachma (£2.8) charge for an outpatient visit.

Elias Mossialos
Anthony Karokis

## **Australia:** Social health atlas

On Wednesday the Minister for Health, Brian Howe, released *A Social Health Atlas of Australia*, which maps, for the first time, disparities in health status within the country and the factors that determine those differences. John Glover and Tony Woollacott of the South Australian Health Commission have broken down the nation into local government areas and shown that the different morbidity and mortality rates are closely matched by socioeconomic status. For example, an upper-middle-class shire on Sydney's north shore has half the morbidity and mortality rates of a suburb in Melbourne's working-class inner city.

The release of this atlas is timely for the Labor Government, which is involved in a malignant debate with the State Governments over funding for public hospitals. The five-yearly Medicare agreement, under which the Federal Government provides funds for the states to administer public hospitals, is due for renewal and early negotiations have broken down. The Federal Government was embarrassed when even its state Labor colleagues threatened to refuse to sign the agreement. Labor health ministers in two states raised the possibility of introducing a means test to limit access to their public hospitals unless the Federal Government offered more money. Government sources say this atlas will provide considerable ammunition for the battle to limit hospital funding. It shows that hospital use is not linked to morbidity or mortality. Use of general practitioners is linked to socioeconomic status, but only in proportion to the amount of illness the poor suffer.

The overall conclusion of the atlas is that health status has little to do with the amount of health care delivered, whether through the hospital system or through private medical practitioners. One approach suggested within government circles is to put more money into transport or housing as a means of improving health status. Such diversion of funds would be incredibly difficult to achieve. Hospitals and other institutions receive almost 60% of the health funding in Australia, and governments are sensitive to charges of a lack of compassion, especially if that charge can be highlighted by media reports of people on waiting lists, or receiving inadequate care. Nevertheless, the Federal Government hopes for the best. The atlas is based on a similar, though less extensive, model released in South Australia two years ago. The State and Federal Governments found that as soon as hospital boards and managers in South Australia realised that there was more to health than additional equipment for health-care facilities, they were willing to accept budget stabilisation, or even cuts, as long as the extra money went into health-related activities.

The political benefits of the atlas may, however, be short lived. The Federal Government is facing an election within a year and a change in government seems possible, if not likely. A Conservative government would not be so concerned about keeping a tight rein on health expenditure, and public hospitals would be more likely to receive the extra

funding they demand. The public-health approach may again be relegated to the sideline.

Mark Ragg

## France: Doctors' strike unsuccessful

The Centre National des Professions de Santé, a federation of unions of doctors, nurses, pharmacists, dentists, and other paramedical professions had called for a strike on June 23 to protest against a law now going through Parliament to control health-care expenditure. The law will allow for an annual increase in medical expenditure to be fixed by the Government and the National Health Insurance Board, which the Board will apply to every individual doctor. Any doctor who costs more than the agreed sum in fees and prescriptions can face financial or fiscal sanctions. Most doctors are opposed to this purely economic control of medical activity but, despite all the furore the law has generated, the strike was not a success, concede the unions. Dentists seemed to have followed the union orders more dutifully than did doctors.

Only 20% of general practitioners in France are unionised; the proportion is greater for specialists. MG France, which represents 6500 general practitioners and was one of the unions that advocated against the strike, is, paradoxically, the group most opposed to the law. Its general secretary Richard Bouton points out that the Government has chosen to negotiate with the Confederation Syndicale Medicale de France, whose members are predominantly specialists and which represents only around 1500 GPs. With the unions vying among each other to be the negotiating body, it is not clear whether the medical profession will be able to mobilise efficiently its troops against the proposed law.

Jean-Michel Bader

## Austria: Struggle to improve clinical researchers' lot

As far back as 1987, the then Minister for Science, Professor Hans Tuppy, drew attention to the sorry state of affairs in university hospitals when he declared in his annual parliamentary report on the universities that "the academic staff is increasingly involved in providing health care, since the provincial health authorities have failed to meet their responsibilities in providing staff and finances to run the service". Yet virtually nothing has been done to improve the situation.

Medical schools are an integral part of the health-care system. The clinical staff of the university hospitals in Graz and Innsbruck consists of those physicians who are affiliated to the university and so funded by the state, and those who are financed by the provincial health authorities. The university hospitals must provide the same level of health care for the local community as do non-university hospitals, which are wholly financed by the provincial authorities. This obligation places an especially heavy workload on the academic clinicians. By law, in addition to their clinical duties, the academic staff must carry out research, teaching, and participate in the administration of the university. However, no clear limitations are put on their patient-care workload and no regular time is allotted to research. Yet these clinicians cannot pursue an academic career unless they fulfil a set publication requirement. Two years ago, the medical faculty of the University of Innsbruck commissioned an independent body to survey their members' professional commitments. The study covered 75% of its academic staff and evoked considerable interest in the national and international press. An important point highlighted by this study is that even a senior physician affiliated to the university hospital has an average workload of 80 hours per week, with clinical work in some specialties being scheduled to be done at night—only about 5 hours can be spared for research. In effect, this means that almost all research has to be done outside of normal working hours.

It is the declared aim of the present Minister of Science, Dr Erhard Busek, to improve the standard of the universities and he has been partly successful in increasing the contribution from the national budget towards the financing of universities. However, since 26% of the country's 8564 academic posts are in the medical faculties, which receive a third of the science budget, Busek is having difficulty in making further improvements. As it is, he faces criticism from other faculties and universities that are concerned about the annual increase of the science budget being swallowed up by the medical schools. The provincial authorities have a legal responsibility for financing their medical schools adequately. The creation of a special department within the Ministry of Science to deal with issues concerning medical schools might be the solution to improving coordination between federal and regional authorities in the financing of these institutions. Meanwhile clinical researchers must wait and see whether plans to enforce legislation on maximum working hours for physicians doing medical research come to fruition.

Kurt Grünewald
Leopold Saltuari

## Germany: Abortion, the woman's choice

After a 14-hour debate and 2 hours of free voting (unshackled, at least in principle, by party whips), the Bundestag (Federal Parliament) approved in the early hours of June 26 a new abortion law, the Fristenregelung. A pregnant woman may choose to have an abortion in the first three months of pregnancy as long as she has undergone obligatory social counselling. The new law, which will provide social benefits such as the right to a place in a kindergarten for every child from 1996 onwards, is aimed at reducing the high number of abortions in Germany (about 120 000 last year). It will apply to the whole of Germany, which has, since unification, been applying separate laws in the East and the West (see *Lancet* 1991; **338:** 1323–24). In West Germany abortion in the first three months of pregnancy is allowed only if a doctor can certify that there is a threat to the mother's life, that the child would be born handicapped, or that there are severe psychosocial problems, whereas in the East abortion is available on demand.

It is unlikely that the new law will be blocked in its passage through the Bundesrat, the federal body of the Länder, where the Social Democrats, almost all of whom supported the new law in the Bundestag, hold the majority. The Federal Constitutional Court, however, may be an obstacle. The Christian Democrat Union (CDU) and their sister party in Bavaria, the Christian Social Union (CSU), intend to mount a juridicial challenge to the new law on the grounds that it is not consistent with the principle, spelt out in the constitution of the Federal Republic, that all life must be protected. 33 CDU/CSU members and their coalition