man of the college's continuing medical education committee, I wish to clarify some points.

The college supports a programme of continuing medical education for its consultants, associate specialists, staff grades, and accredited senior registrars; it recommends this, but there can be no compulsion. Provided that subscriptions are paid, fellows and members of the college will remain on its register, and there can be no question of preventing them from remaining in practice. The sanction for those who do not take part in the programme is that their names will not appear on the roll of specialists, which is simply a list of those who have achieved 200 credits (200 hours of postgraduate work) in five years.

The preparation for the college's programme of continuing medical education has spanned almost two years. There has been much dialogue with, and constructive criticism of the programme by, the college's fellows and members, particularly since the "road shows" to introduce the programme last October, November, and December. Virtually all the fellows and members accept the principle of what is being set up because they realise that it is in the interests of best practice and best care.

There has also been considerable discussion about possible sequelae for those who do not achieve their 200 credits in five years. Regarding this, Kale was too definite and has made some assumptions. How other institutions and bodies such as the Department of Health, the General Medical Council, the conference of colleges, the National Association of Health Authorities and Trusts, the defence unions, chief executives of trusts, and administrators in the private sector will react to the programme of continuing medical education and the idea that names may not appear on the roll remains to be seen. It is thus wrong for Kale to state as fact that those whose names are not on the role will not be considered for merit awards, as college examiners, or to act in any official capacity on behalf of the college. This does, though, remain possible, depending on the reactions and responses of the bodies that decide merit awards and these other activities.

Kale's article was too hawkish. The college intends its programme to be fair and merciful, we are confident that it will be successful.

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Funding international family planning

EDITOR,—Last October Senator Brian Harradine from Tasmania blocked part of the Australian government's funding to international family planning. He defends his action by three arguments: that the "empirical evidence documenting the supposed negative net impact of population growth on economic development in general is either fragile or non-existent"; that family planning is a "diversion of Australia's precious aid money from development cooperation and poverty alleviation programmes to population control"; and that family planning programmes are not wanted by the recipient countries.[1]

In reality, among countries in the Organisation for Economic Cooperation and Development a mere 1% of foreign aid goes to international family planning (Australia gave 0·5% of its foreign aid to international family planning in 1991). Moreover, statistics on support for family planning—as, for example, in the case of Sweden—are often based on a broad interpretation and include many aspects of reproductive health or even general development projects.

Certainly, economists have recognised that the interaction between moderate population growth and economic growth is complex and not always negative (50-80% of women want to space or limit future births).[2] But there is also a strong consensus that rapid population growth (for example, that in Pakistan, at 3% a year) is detrimental and more than justifies the small sums spent on international family planning. Those people who work in international family planning do not claim that unintended pregnancies are the only or even the main problem facing the world, but they do assert that population growth is more than 1% of the development equation.

We agree with Harradine in condemning coercion in family planning. Surveys confirm that the success of many family planning services (for example, in Thailand, Mexico, Colombia, and Korea) is due to the strong desire for family planning. Anyone who has visited hospital wards dealing with the results of botched abortions, where women may have to share a bed, can see the unmet demand for family planning turned into a painful reality.

Criticisms of the type set out by Harradine are not limited to Australia; they are false yet interfere with the setting of policies and implementation of programmes among both the donors and recipients of foreign aid for family planning.

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Focusing social policy

EDITOR,—Bruce G Charlton's assertion that "redistribution [of wealth] removes advantage at the same time as it addresses deprivation" should not go unchallenged.[1] Evidence suggests that countries that have a gross national product above $4000 per capita and more equitable distributions of wealth have better health status indices for their whole population (not just the more deprived).[2-4]

Rather than become engrossed with statistics on wealth distribution, however, it is more salient to look at the reality of people's lives and what lies behind inequalities in income. After all, it is not income itself that is responsible for ill health but living conditions. Social policy could be much better focused on improving working and housing conditions as well as enabling people to change their lifestyle without having any direct impact on income distribution. Far from creating "health losers," such policies would go hand in hand with the "enlightened self interest" involved in policies of better education and child care referred to by Martin McKee to create a healthier, happier workforce, on which the health and wealth of all of us rely.[5]

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Regional information systems

EDITOR,—The only surprising thing about the woeful attempts to introduce a regional information system is that anyone should be surprised at the outcome.[1] As long ago as 1977 an editorial in the *BMJ* entitled "Experiments with computers and our money" referred scathingly to unsuccessful attempts to introduce information systems and commented on poor management[2]—as did the committee of public accounts even more forcefully.[3] The earlier editorial concluded that unless the Department of Health and Social Security concentrated on simple systems and supported those systems that seemed to offer practical clinical benefit we were (in the 1980s) "likely to see a repeat of the grandiose shambles of the past few years."

The journal has been proved right. Massive wastage of money on failed projects has meant that other information systems have been starved of resources. As the journal commented, wastage of resources on grandiose projects "will make particularly galling reading to other computer scientists... either not funded or whose projects are due to close."[2]

Little has changed since 1977. One simple, clinical system that dealt with 16737 patients with acute abdominal pain delivered substantial evidence in eight hospitals of massive savings in resources (over 8000 bed nights in two years) coupled with improvement in performance.[4] The trial, which used methods devised by the Department of Health and Social Security itself, took 10 years to set up and execute and seemed clearly to benefit patients, doctors, and the public purse.[4] Far from being allocated £20 milion to develop the system further, the team of users and developers was recommended to form a user group and talk about it.

Fortunately for the system in question, several overseas organisations provided the necessary support. The original study's findings and benefits have recently been replicated in a dozen or so further studies involving around 50000 patients—the latest a concerted action of the European Union in 64 hospitals in 19 countries.[5] Fine for the system, but not for British taxpayers or British patients.

It would be nice to think that lessons have been learnt. The evidence suggests that they have not. Having failed in the 1970s to integrate a single hospital, the Department of Health decided in the 1980s to integrate a whole region. Having failed (at 10 times the cost) to integrate a single region in the 1980s, the department is now busily engaged in reorganising the whole of medical terminology.

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Correction

Murder in the NHS

The names of two authors—Josephine Francis and Ian Ross—were inadvertently omitted from this letter by C R Birch and colleagues (12 February, p 477).