last thing the field needs. Meanwhile, there are even more distant issues needing urgent attention. What (if any) accelerator will succeed LHC, and how (and where) would it be built? Now is the time to forge a thorough international enterprise to consider those thorny questions. And what, in 2010 or thereabouts, will happen to the CERN laboratory itself? If Britain and Germany are hoping for an answer to that question by their demand for budget ceilings, they would be better advised to take it up directly. On the timescale of accelerator construction, 2010 is indistinguishable from the year after next. □

US health reform falters

The US Congress is in bitter dispute about health reform and the proposed employer mandates.

THE debate about health-care reform in the United States is at once moving apace and in danger of stumbling to a stalemate as various pieces of legislation emerge from the many congressional committees with jurisdiction of one sort or another. Two main issues divide the Congress, sufficiently to suggest that US President Bill Clinton's plan has little chance of becoming law. Clinton has predicated affordable universal coverage on two ideas: first, that employers should pay 80 per cent of employees' health insurance and, second, that the entire country should be divided into giant regional alliances from which people would purchase insurance, which is an untested notion. Republicans, with the support of some Democrats, are virulent in their opposition to the so-called employer-mandate, which they believe would put small business out of business. And the Rube Goldberg plan for regional alliances has few, if any, real supporters outside the White House.

The indictment for fraud of Representative Dan Rostenkowski (Democrat, Illinois) has been a further setback. When he was ousted last week from the chairmanship of the House of Representatives' Ways and Means Committee, whose vote is crucial to the passage of any bill, Hillary Rodham Clinton, the president's wife, worried aloud that the loss of his political clout will mean that a means of forcing congressmen to support the president's plan has vanished. But the present jumble of bills, voices and warring camps suggests that it will take more than one man to get health-care reform legislation through this Congress before it adjourns for elections in the fall.

Within the past couple of days, several influential participants in the debate have, for the first time, admitted that there may be no bill at all. Representative John Dingell (Democrat, Michigan), who is known for his power to bring his Oversight and Investigations Committee into line, cannot muster the votes for a bill with an employer mandate and has said he would prefer no bill to a bad one. On the other side, Republican leader Robert Dole said last week that he is prepared to turn the fall elections into a *de facto* referendum on the form health-care reform should take.

For those whose chief concern is how health-care reform will affect (and even damage) academic research institutions, delay may well be the best outcome. A provision in some bills to require 50 per cent of US physicians to be trained in general practice by early in the next century is ill thought out and should be dropped.

Other provisions to tax health insurance premiums or to single out other federal resources to support teaching and research hospitals have survived in some bills, but have been knocked out of others, in the usual hurly-burly of political horse-trading. But this is an issue of vital importance to the US research enterprise, even if it is not at the top of the public agenda. (Research seldom is.) A bill whose funding provisions would effectively put research institutions out of business is not in anybody's interest. As things are, no bill at all would be best for now. □

. . . and in Britain also

Britain's internal market in health care has made problems for research.

HISTORIANS will marvel, but will not be surprised, that the difficulties arising in the United States on the financing of medical research are almost exactly mirrored in Britain. After all, there is a close analogy between the 'regional alliances' Clinton advocates as purchasers of health care on behalf of insured people and the regional health authorities that now do that in Britain (with public funds) on behalf of patients of the National Health Service (NHS).

But the British government has manoeuvred itself into an ideological contradiction. The reorganization of the NHS in the past three years has been driven by the belief that the interaction between purchasers of health care and its providers (hospitals, for example) would create an efficient internal market. (The arrangement is to some degree complicated by the encouragement of physicians to function both as providers and purchasers.) Logic then requires that the purchasers should also purchase research. Sadly, the thought seems not to have crossed the minds of the health authorities, nor (it appears) of the government.

The institutions chiefly affected by this neglect are Britain's teaching hospitals, which are financed from two sources — from the NHS (in respect of patient care) and from the Universities' Funding Councils (in respect of the education they provide to physicians). But now the teaching hospitals must compete with others for patients on the internal market, while the traditional use of university funds to support research has been undermined by the doctrine (spreading through the rest of British academic research) that researchers should be accountable to their sponsors project by project. So, inevitably, there has been a committee (see page 514). Not unusually, the government appears to be embarrassed by its conclusions, and is sitting on them. But the issue of British health research is too important to be the victim of the government's wish that a problem it has made for itself would melt away. □