Tensions grow over health research proposals

London. A fierce struggle is developing between Britain's teaching hospitals, its medical research establishment and the Conservative government over the control of funds allocated for the support of research by the National Health Service (NHS).

At stake is the question of how health-related research should be funded in a political environment where the government is demanding market-style thinking in all NHS activities. Many research-based institutions that have relied on the NHS for support in the past are worried about the consequences for their own survival.

Medical schools are, in particular, concerned about the conclusions of an unpublished report, commissioned last year by the Department of Health and delivered to the government at the end of April. This is expected to suggest that the NHS funds they receive to cover the indirect costs of research should be allocated separately from those provided for teaching, and subjected to far greater scrutiny than at present.

Both teaching and research funds are provided currently through the so-called Special Increments for Teaching and Research (SIFTR), which provides up to 20 per cent of the funding of teaching hospitals through regional health authorities.

SIFTR money is distributed according to a formula based primarily on clinical student numbers. "The system works, and it works well," says Peter Richards of St Mary's Hospital Medical School in London, chairman of the council of the Deans of UK Medical Schools.

Reforms that made it more difficult to obtain NHS support for research could mean that some university teaching hospitals "could go broke", he warns. Similarly, redirecting research funds to other institutions considered more 'productive' by the government would amount to little more than "robbing Peter to pay Paul".

Both proposals, however, are believed to figure in the report on NHS research prepared by a task force chaired by Anthony Culyer, professor of economics and provice-chancellor of the University of York.

At the same time, the government itself is believed to be unhappy about another conclusion of the report, namely that bodies such as hospital trusts, which it wants to turn into the main decision-makers for allocating NHS funds as the 'purchasers' of health care, are not well placed to make decisions about what research they should be supporting.

Publication of the detailed proposals made by Culyer on how to separate out the research element of SIFTR funding, and how to organize the 'top-slicing' of money allocated to local bodies for health service research, is still awaiting a decision by the health minister, Brian Mawhinney.

But, speaking at a meeting in London organized by the British Postgraduate Medical Federation, Culyer said he was able to reveal some of the basic principles the drafting group had agreed on, and which underpin its main conclusions.

On the current arrangement for funding teaching hospitals, for example, Culyer said that most of the 200 individuals and institutions who provided evidence to the task force "wanted to see the teaching and research components of SIFTR separated".

Culyer added that it was "widely felt" that the research infrastructure in general practice and health care "generally needed core funding based on university departments and networks of research-oriented community-based practice".

Similarly, there were a number of reasons, he said, why giving health-care purchasers responsibility for commissioning research on top of all their other responsibilities "seemed to us not only completely unrealistic under present circumstances, but probably inappropriate".

He listed four reasons for this conclusion: that the fruits of research and development (R&D) are a 'public good'; that the various skills required to commission research properly are 'very scarce'; that giving a single organization responsibility for both health care and R&D purchasing "would pose a terrible dilemma for local decision makers"; and that local purchasers were rarely on international research networks.

Health-care purchasers needed to be given a significant voice in decisions about the allocation of R&D resources, said Culyer, "but without wrecking the system of rocks and whirlpools I have just described".

Such a conclusion, if it survives in the published version of Culyer's report, is likely to be welcomed by the Medical Research Council. Many MRC scientists have recently been complaining that the reorganization of the health service — and in particular the greater discretionary powers being given to local purchasers — threatens to undermine Britain's traditional strengths in clinical research.

But it is a direct challenge to the thinking of government ministers who have been arguing in favour of raising these powers to a maximum. How far they are prepared to retreat from this position to meet the requirements of research is now being hotly debated in Whitehall. **David Dickson**

Biomedical levy gathers pace in US

Washington. A one per cent levy on health insurance premiums, which would plough an extra $5 billion annually into biomedical research, is included in the first health-care reform bill to clear a congressional committee. Officials say it stands a good chance of inclusion in a final bill.

Although the proposal for a levy was widely seen as improbable when launched three months ago (see *Nature* **368**, 3; 1994), it has since been gathering momentum in the Senate. It has less support in the House, where key committees — especially that chaired by John Dingell (Democrat, Michigan) — are having great difficulty agreeing any bill at all.

But biomedical research bodies and medical schools backing the levy know that, despite its present chaos over health care, Congress is almost certain to come up with a bill for President Clinton to sign in the autumn, and are increasingly confident that the research levy will be in it.

As Senator Edward Kennedy's labor and human resources committee passed its health-care bill last week, his research levy co-sponsors Tom Harkin (Democrat, Iowa) and Mark Hatfield (Republican, Oregon) called on supporters to mount a final push for the votes of Congressmen on key House committees.

The research levy would take one per cent of all health insurance premiums, and place it in a fund which would release the money directly to the National Institutes of Health (NIH) — on condition that the institutes' existing appropriations continue to grow (in order to ensure that the new money is genuinely additional). Most of the money would be divided between NIH institutes in proportion to the amount they already receive.

The proposal benefits from simplicity, from a splendid isolation from the rest of the complex, interlocking proposals for health-care reform, and from a strong feeling on Capitol Hill that the health-care package needs to contain some benefits for medical schools. But it suffers from the fact that it smells like a tax.

Hatfield, who describes the measure as "not a new tax *per se*, but a fee in the contract people have with their insurance company", says it has only one real opponent in the Senate, namely finance committee member Dave Durenberger (Republican, Minnesota).

Harkin says he is "very optimistic" that the measure will figure in any final bill. He has resisted calls to scale down the proposal, and claims he has "good support around the country. I don't think any compromises need to be made". Compromises seem certain; but come the autumn, biomedical research may get a pleasant surprise. **Colin Macilwain**