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confounders, as these individuals will have increased acid output and may be more prone to gastro-oesophageal reflux and less likely to acquire *H pylori*.[w6]

The trial by Harvey et al is indirect evidence that using "test and treat" in patients with dyspepsia in primary care will not lead to an increase in symptoms of gastro-oesophageal reflux disease.[5] Other evidence to support the effectiveness of the strategy comes from randomised controlled trials comparing *H pylori* eradication versus placebo in *H pylori* positive patients.[3] Whether small benefits in the order of 7% are worthwhile depends on both the persistence of effects of the treatment and its cost effectiveness. On the basis of good data for up to two years of follow up, *H pylori* eradication is likely to provide more lasting benefit than acid suppression alone.[1] Direct evidence of cost effectiveness is awaited from an ongoing randomised controlled trial funded by the Medical Research Council that is comparing *H pylori* "test and treat" with acid suppression in the initial management of dyspepsia in more than 200 general practices in the United Kingdom.

Brendan Delaney *professor of primary care*

Department of Primary Care and General Practice, University of Birmingham, Birmingham B15 2TT
(b.c.delaney@bham.ac.uk)

Paul Moayyedi *Richard Hunt-AstraZeneca professor of gastroenterology*

Department of Medicine, McMaster University, Hamilton, ON, Canada L8N 3Z5

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Choice and equity: lessons from long term care

Government prefers greater equity of finance to equity of access

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On the face of it, recent statements about the equation of choice with equity in the NHS and social care seem to strengthen the government's commitment to care services that are both fair and responsive.[1] Few would oppose increased choice for consumers of public services as a general principle. The United Kingdom, when judged overall, has long had one of the most equitable healthcare systems among developed countries. Inequalities in healthcare provision and the health status of the population have, however, always been marked,[2] and improvement in equity has always been an important policy objective.[3] The government is now arguing that patients should be given more choice about how their own health care is managed and that this managed choice will help to drive up quality in the new, fixed price, internal market.[4] This idea may have some attractions for patients who are unhappy with aspects of their treatment and care, but we do know how far choice will be realised in practice. Lessons from recent history show that more educated, higher socioeconomic groups tend to take advantage, patients outside metropolitan areas find it hard to "shop around" owing to lack of choice of hospitals, and in general patients are unwilling to travel far anyway.[5 6]

In long term care provided by both NHS and local authorities the mix of public and private finance changes the terms of the debate about choice and equity fundamentally. In their 1999 report on long term care the majority of royal commissioners argued for free personal care for all, but the government decided that people on middle and higher incomes should continue to pay for this care, a policy recommended in a report by a minority of the commissioners. The government argued that its approach would be fairer, and in some ways it was right. If payment for services is closely related to individuals' ability to pay for them then that is equitable in terms of the financing of services. People on low incomes in their own homes, with capital of no more than £12 000 ($21 000; €18 000), are now paying a smaller charge or no charge at all (a capital limit of £19 500 applies to care homes). The difficulty comes when one realises that equity of financing can conflict with policies intended to increase equity of access or provision.

Rather worryingly for the government, the level of publicly financed provision has dropped, and the proportion of older people receiving home help from

social services continues to fall—down 40% since 1993.[7] There has been a great deal of policy commentary on this transfer of financial responsibility from the state to older people in the lower to middle income range, who may be struggling to afford to purchase care and are often deterred by payments.[8 9] Asking people to pay for elements of their care assumes that they will exercise choices in ways that maximise their own wellbeing, largely uninfluenced by social and other considerations, but this is often not the case.[10]

Such evidence begs the question: do we want a system that offers greater equity of access to help ensure that care needs are met, as the majority commissioners argued? Or do we continue to leave this to the market as the government decided for those with means? There are different distributional effects, for both finance and provision, in the two positions. The minority commissioners and the government argue that they have maintained a level of private finance, to the tune of £1.1bn, from those individuals with means so they can focus a publicly funded safety net on those without. The main counterargument, from the majority commissioners, is that the current settlement seems to be unfair compared with NHS policy—equal needs are clearly not being treated equally[11]—and in our own research we have found that 60% of the public believe this situation to be unfair.[12]

So, in the ever more complicated policy jungle boundaries between public and private finance and provision of traditional welfare services are becoming increasingly blurred. Within this blurring, though, important trade offs are being made. The lesson from long term care shows that New Labour tends to favour greater equity of finance to equity of access when it is given the choice

Christopher Deeming *research fellow*
Department of Public Health Policy, London School of Hygiene and Tropical Medicine, London, WC1E 7HT
(christopher.deeming@lshtm.ac.uk)

Justin Keen *professor of health politics*
Nuffield Institute for Health, University of Leeds, Leeds LS2 9PL
(j.keen@leeds.ac.uk)

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A firm foundation for senior house officers

Foundation programme will provide a focused educational experience

Modernising Medical Careers highlighted changes that will reform the senior house officer training grade in the United Kingdom.[1] Implementing these long overdue reforms has wide ranging implications for all training posts,[2 3] as outlined in the latest guidance on all training programmes in *The Next Steps*.[4] The main thrust is for doctors to begin their careers with a two year foundation programme. Thereafter they move on to specialist training grades running through to consultant level. This "run through" period would be shorter than the current training period and competency based.

Introducing the foundation programme represents a fundamental change for the senior house officer grade. From August 2005 all medical graduates will undertake an integrated planned programme of general training. The first year will be similar to the current preregistration year and will include full registration. The second year offers doctors further generic skills training in a mixture of specialties. The end point is to have competent doctors who are able to recognise and manage acutely sick patients and are ready to enter specialist training.

Many hospital departments currently rely on the service commitment of 20 000 doctors in the senior house officer grade. Some will be hard pressed to release more service time of junior hospital doctors and their supervisors to create time for education. Thankfully, some helpful resources are available to increase educational value in service, such as the thoughtful *Liberating Learning*, which works along similar principles to the "one minute preceptor model."[5 6]

Uncertainty surrounding the future contribution of overseas doctors, who currently make up a sizeable proportion of the senior house officer workforce, also affects planning for service provision in hospitals and at what point they enter training grades.

In order to enter the "run through" training grade, senior house officers will now have to demonstrate to an educational supervisor that they have achieved the foundation programme competencies. These are similar to those contained in the publication *Good Medical Practice*.[7] They will have a record of in training assessment (RITA) similar to that already in use in specialist training.

Among many challenges to achieve the goals of the foundation programme are the practical issues in creating enough foundation year 1 posts for the foundation year 2 posts and allowing space in foundation year 2 for overseas doctors who already have registration.

Issues about the curriculum and competency framework need addressing. What assessment methods will be used to decide if a doctor has achieved the competency? Who is best placed to make that assessment? It clearly does not always have to be the consultant, but it does

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