fectiveness." Perhaps not, but it certainly aimed to ensure those features on the basis of need, which market forces patently never had, and never will have, any intention of doing.

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- 1 Johansson AC. Fundholding general practice. *BMJ* 1991;302:1405. (8 June.)
- 2 Greatorex IF. Changes to the NHS. *BMJ* 1991;302:1406. (8 June.)

Homeless people and psychiatric care

SIR,—The last paragraph of Dr S L George and colleagues' paper on their census of single homeless people in Sheffield gives the impression that large numbers of long stay patients in psychiatric hospitals have been discharged to live in "reception centres, in substandard rented accommodation, or on the street."¹ By contrast, we did not find that any of the long stay patients in hospital in the same city in 1982 were homeless at follow up eight years later.²

Evidence is accumulating that the outcome of resettling long stay psychiatric patients is perhaps not as bad as some campaigning organisations feared. For example, in New South Wales not one of 208 long stay patients discharged into supported accommodation had drifted to a refuge for the homeless at follow up at 21 months.³ In a companion study, similar in design to the census in Sheffield, hospital records for a cohort of homeless men in a refuge showed that only three of the 22 residents with schizophrenia had had a prolonged admission to a psychiatric hospital.⁴ Admissions for the remaining 19 had been brief and frequent, but the duration of stay in hospital had not altered appreciably over the years. It would be interesting if psychiatric records for the people studied in the Sheffield census were available for comparison. They may show that the population in the census did not generally come from long stay wards.

In evaluating evidence about homelessness and the fate of discharged psychiatric patients it is important to distinguish between the needs of long stay patients who have been discharged and the needs of people who may no longer be able to get psychiatric care. My concern is that the results of surveys of homeless people are being interpreted as showing that traditional psychiatric hospitals should be preserved.⁵ Government policy recognises the need for "asylum," but this can be arranged in smaller, well staffed units.

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- 1 George SL, Shanks NJ, Westlake L. Census of single homeless people in Sheffield. *BMJ* 1991;302:1387-9. (8 June.)
- 2 Double DB, Wong TI. What's happened to patients from long-stay psychiatric wards? *Psychiatric Bulletin* (in press).
- 3 Andrews G, Teesson M, Stewart G, Hoult J. Community placement of the chronic mentally ill. *Hosp Community Psychiatry* 1990;41:184-8.
- 4 Teesson M, Buhrich N. Prevalence of schizophrenia in a refuge for homeless men: a five year follow-up. *Psychiatric Bulletin* 1990;14:597-600.
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Need for pain relief services

SIR,—The study by Dr Iain K Crombie and Mr Huw T O Davies on outpatient pain relief clinics shows that there is no clear consensus about the requirement for this type of service.¹ A similar variation occurs across our region (from Hospital Activity Analysis statistics). Our clinic has a higher throughput (of new and old patients) than any in

Dr Crombie and Mr Davies's study, yet our waiting lists are steadily growing.

What is clear is that no one really knows how many people in the community have chronic pain. Hence the new purchasers have few (if any) guidelines on the level of service required. The need for pain relief services must be realistically assessed urgently; then pain relief will start to be placed on a sound financial footing.

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- 1 Crombie IK, Davies HTO. Audit of outpatients: entering the loop. *BMJ* 1991;302:1437-9. (15 June.)

Compulsory immunisation

SIR,—In common with most general practitioners I still bitterly resent the manner in which the new contract was imposed last April by an administration that preferred to confront rather than consult. The government's present difficulties with the health reforms are clearly the price to be paid for failing to win the support of health professionals, who generally continue to try to do the best for patients despite the worst that politicians can throw at them. In my opinion one of the worst aspects of the contract is the inherent philosophy that responsibility for a person's health rests primarily with the doctor rather than with that person. Does this not run counter to all Tory doctrine?

This perverse principle is epitomised in the concept of targets for smear testing and immunisation. In our practice we have sweated blood to increase uptake of immunisation, but our main hurdles remain apathy and fear among a subgroup of patients, many of whom believe the vaccines to be intrinsically unsafe. We have done our utmost to persuade them otherwise. Paradoxically, I now find that the harder we try the less they trust us—after all, they have read that we receive a "bonus" for reaching our targets. Did anyone in the Department of Health anticipate this erosion of confidence?

I believe that a sea change in the opinions of these patients will be achieved only by vigorous publicity campaigns combined with an element of compulsion as now exists in many countries—for example, France, the US, and Sweden. Under such a system a child cannot attend school without a certificate of full immunisation (or valid exemption).

The merits of this approach seem so obvious that I cannot believe we are still waiting for its introduction here. Indeed, I have not even heard it debated at high level. At a stroke the public would see that full immunisation should be the norm—indeed, that to allow an unimmunised child to mingle with other children is socially irresponsible. It would also release literally millions of doctor and nurse hours per week to be spent on other tasks (I spend five hours a week persuading patients on this topic). Most importantly of all, it would save much cost (in human suffering, time, and money) currently incurred by these diseases and their treatment.

With the planned introduction of the influenza vaccine to the schedule in 1992 and hepatitis B vaccine possibly close behind the overall schedule is soon to become much more complex. Without adequate public education and an element of compulsion there is a danger that the whole programme could disintegrate in confusion.

The recent health reforms threaten to introduce to our shores some of the worse aspects of the American health care system. Why not instead adopt one of its best?

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Consultants, contracts, and fundholders

SIR,—I notice that in his editorial on the impact of general practice fundholding on hospital practice Mr A P J Ross carefully avoided the one thing that prevents the consultants mounting an effective (and much needed) campaign against the new NHS arrangements.¹ That is, of course, the fact that so many consultants already operate a two tier system of private and NHS practice in which clinical need seems not to get the priority accorded to it in the editorial. This means that the consultants as a group have little or no moral authority on the issue.

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- 1 Ross APJ. Consultants, contracts, and fundholders. *BMJ* 1991;302:1479-80. (22 June.)

Assessing protective effect of sunscreen products

SIR,—Drs Robin Russell Jones and Ian R White discuss methods of assessing the protection that sunscreen products afford against ultraviolet A radiation and ways of labelling products.¹ It is true that Boots will introduce early next year a system of labelling to attempt to standardise the increasingly confusing claims made on packs regarding protection against ultraviolet A radiation. The system is intended to aid customers' selection of sunscreen products without diminishing the importance of the sun protection factor, which is generally regarded by the photobiological community and regulatory bodies as the major descriptor of protection against the sun.

As Drs Russell Jones and White point out, international groups are discussing different methods of assessing the protection of sunscreens against ultraviolet A radiation, including the Boots method. The recent meeting in San Antonio on ultraviolet A radiation did not favour or reject any one method, and further discussion and investigation will be needed before a common position is reached internationally. It is therefore likely to be 1993-4 before consumers could benefit from such agreement by seeing consistent information on packs. Boots is participating in many of the current discussions on sun protection, both nationally and internationally, and will continue to do so; the aim is to define a common international method for testing and labelling.

Meanwhile, in an effort to prevent the proliferation of a variety of protection factors relating to ultraviolet A radiation and claims based on different methodologies appearing on packs in our stores, in April 1992 we propose to introduce a consistent labelling system, which we believe will provide the following benefits to our customers: firstly, it will give a single standard by which they can compare the protection offered by each product; secondly, it will retain the sun protection factor as the primary factor in the selection of products; and, thirdly, it will avoid further confusion among customers which could result if more than one method of measuring ultraviolet A was used on packs.

As a company we are committed to providing our customers with the best possible choice of sun protection products and a high quality of information to support these. Our intention is to improve their ability to make an informed purchase.

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- 1 Russell Jones R, White IR. Assessing protective effect of sunscreen products. *BMJ* 1991;302:52. (6 July.)