them and ensure that it does not make the same mistakes again. The rest of us will either have to pay up or be prepared to push them out as an impossible burden on the community, thereby accepting a harsher, less sophisticated, and more brutal society.

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The hospitals we need

SIR,—The report by Rickard,¹ based on a detailed and authoritative analysis of the cost-effectiveness of two community hospitals, demonstrates clearly how difficult it is to carry out cost-effective studies that allow valid comparisons to be made between two different kinds of hospital such as community hospitals and district general hospitals. As a result of this study Rickard came to the conclusion (p 113) that "the cost of treating medical patients in the Community Hospital . . . exceeded the district general hospital cost" and that "the policy implication of this part of the study is that *the experimental community hospital units, as at present administered, are not cost-effective*" (my italics). The study which led to this conclusion was confined to the experimental community hospital at Wallingford and the Norman White ward at Peppard Hospital, both of which were started in order to evaluate the work of community hospitals.

In your leading article (25 September, p 713) you refer to Rickard's report and state that "the report has killed a myth: that community hospitals offer a cheaper alternative to the facilities offered by a district hospital." Because of the confusion that exists about the term "community hospital" there is a danger that your statement will be interpreted as referring to some (or all) existing general practitioner hospitals.

The accompanying table shows the inpatient and outpatient cost of the nine general practitioner hospitals in Oxfordshire and of the Radcliffe Infirmary, Oxford. The general practitioner hospitals vary in size from nine to 71 beds, but those in the 20- to 40-bed range offer much the same kind of facilities and admit a similar kind of what Rickard refers to as "case-mix" as far as acute beds are concerned. What stands out is the wide variation in costs. Wallingford, which is lavishly built and staffed, is the only purpose-built community hospital; the rest were all in existence before the NHS. There is, however, to my knowledge, a close similarity in admis-

sions policy, case-mix, and facilities available between, for instance, Wantage Hospital and Wallingford Community Hospital; yet the difference in costs is very large and has been consistently so in previous years. Compared with the detailed and meticulous analysis in Rickard's study, the data published in this table are crude indices; but where the differences are so wide it would seem to be unwise to assume that they bear no relationship at all to cost-effectiveness. Supposing, for instance, the inpatient and outpatient costs at Wantage, as set out in the table, were consistently twice as high as in the Radcliffe Infirmary; it would be most surprising if more detailed analysis was later to show that Wantage was, after all, cost-effective compared with the Radcliffe Infirmary. Detailed analysis of costs in general practitioner hospitals may indeed show that many existing general practitioner hospitals, including those that fulfil the criteria of a community hospital, are a cheaper alternative to the district general hospital for certain appropriate groups of patients. In this area, however, the necessary studies have not been carried out. Rickard's report demonstrates the difficulties of cost-effective studies and his conclusions are more guarded than your leading article suggests.

I S L LOUDON

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¹ Rickard, J H, *Cost-effectiveness Analysis of the Oxford Community Hospital Programme*. Oxford, Department of the Regius Professor of Medicine, 1976.

Myocardial infarction—home or hospital care?

SIR,—In studies comparing different types of treatment the subjects in each treatment group should be as nearly identical as possible. I do not think this can be said of the home- and hospital-treated groups of patients with myocardial infarction in the detailed study of Dr Aubrey Colling and others (13 November, p 1169).

The median time for the patient to come under care was about 3 h from the onset of symptoms in each group. This time is significant since by then 70% of deaths had occurred and it therefore approximately separates the periods of high and low mortality risk. Although the median times were similar in the two groups it does not follow that the distribution of the times around the median was the same in each group and does not exclude the possibility that more patients may have been referred for hospital treatment early, when their risk of death was high. The fact that 63 deaths apparently occurred between home and the start of hospital care would support this. The

difference in the percentages of proved infarcts in the two groups implies further dissimilarity. The Peel index which was used to compare the groups is of limited relevance since it is a measure of myocardial damage rather than of vulnerability to the fatal arrhythmias which are responsible for the majority of early deaths. Observer bias in deciding the duration of symptoms would be difficult to exclude, especially in those cases in which the onset was less well defined and in which the patient would perhaps be more likely to be treated at home.

It is of interest that the mortality for care outside the home was 25% if the 63 deaths occurring between home and admission to the ward or coronary care unit are added to the total hospital mortality. In directing attention to improving prehospital management it should not be forgotten that it is also necessary to reduce deaths occurring in hospital during the process of admission (about 33 in this study).

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SIR,—In your issue of 16 October (p 938) you have an interesting "Personal View" by a cardiologist who describes how he was admitted to a coronary care unit five hours after the onset of symptoms of myocardial infarction. Could you ask him to add a note explaining why he went or was sent into hospital, as I understand that the outlook, once the patient survives the first hour, is as good for those who stay at home?

RONALD MAC KEITH

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* * * We sent a copy of this letter to our pseudonymous contributor, whose reply is printed below. Ed, *BMJ*.

SIR,—Thank you for giving me the opportunity to reply to Dr Mac Keith's letter.

The problem in attempting to assess the benefits of coronary care is that with present methods of treatment the outcome in terms of mortality is almost unaffected by treatment for a very large majority of patients. The benefit to the minority of patients who go into primary ventricular fibrillation and are reverted by DC defibrillation is obscured, as these patients are "hidden" among the others in any statistical analysis. I appreciated that at five hours after infarction much of the risk of primary ventricular fibrillation had passed, but I also appreciated that if I did go into that rhythm at home my personal mortality would almost certainly be 100%. It would be of doubtful consolation to know that in a controlled trial one would not be making a statistically significant alteration to the overall mortality of a randomly allocated group.

Any debate regarding the benefit of hospital treatment should not be confined to considerations of mortality. I had the highly uncomfortable experience of an extension of the infarct at 72 h and at that time I was extremely glad of the immediate availability of expert care and analgesia, even though this may not have made any difference to the final outcome.

However, I do take Dr Mac Keith's point that hospital treatment is rarely of dramatic benefit once several hours have elapsed after infarction, and it is my practice if I see a patient at home under these circumstances to

Comparative costs 1975/76: Radcliffe Infirmary, Oxford, and nine general practitioner hospitals in Oxfordshire (Source: Oxfordshire Area Health Authority (Teaching))

Hospital	No of beds	Type of beds	Inpatient costs		Outpatient costs	
			Per inpatient week (£)	Per case (£)	Per OP attendance	Per new OP
Radcliffe Infirmary ..	523		270.83	268.58	10.74	44.38
Abingdon	71	A + M	109.55	185.57	3.43	7.82
Brackley	12	A + M	139.09	147.14	3.10	5.09
Burford	9	A	123.20	360.00	2.01	8.20
Chipping Norton ..	37	A + M	104.37	219.39	6.51	15.26
Didcot	18	A	75.39	178.88	2.17	3.35
Thame	19	A	101.64	239.10	2.92	8.82
Wallingford Community	34	A + M	165.27	267.32	2.12	11.21
Wantage	31	A + M	69.58	149.65	1.72	2.90
Watlington	20	A	84.91	276.28	3.54	12.24

*A = acute M = maternity