Community Health Forum. This was a group who represented over 60 voluntary organisations in the locality. The panel has eight members, six being core members nominated from the health forum and two being roving members who represent other groups that are coopted on to the panel when discussions involving their particular interest group are taking place. There is a close relationship with the Community Health Council, which has secured research and development monies to pay for the training of panel members in certain skills.

The patient panel participate in project work and in the purchasing decision making of the steering group. This group will be involved in "rationing" decisions, which are really just part of the purchasing intentions of the group.

Reference has been made to previous work done in this field in Oregon and the Netherlands, and information and support has been obtained from the Worcester Public Health Department. There is also a public health consultant also on the steering group.

With all the hard work that has been put into the formation of the group, the purchasing decisions now reflect the wider view of the population of the Droitwich area, and we believe that this integrated response is a leader in its field. We plan to fully evaluate the process and publish in the future but thought that it would be of benefit to share our developments with readers of the *BMJ*; we also hope that other locality commissioning projects are working as closely in partnership with the patients that they serve as we are.

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- 1 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996;312:1553-4. (22 June.)
- 2 Crisp R, Hope T, Hobbs D. The Asbury draft policy on ethical use of resources. *BMJ* 1996;312:1528-31. (15 June.)

US judicial guidelines on sentencing could show way forward for NHS

EDITOR,—Allocation of scarce medical resources presents problems that have striking similarities to judicial sentencing or the decisions of parole boards. Both the medical and judicial decisions involve ethical and technical constraints. Both must avoid disparity. Both must in principle be accountable to the public, and both must be seen to be fair.

In some states of the United States, notably Minnesota, judicial sentencing guidelines have been developed by the Sentencing Commission to ensure that the punishment allocated both fits the crime and avoids disparity between individual judges. For a crime of a particular degree of seriousness and an offender with a particular record, the judge refers to the guideline sentence. He or she can give any sentence that falls within the limits of the guidelines (such limits being originally defined as a given departure from the mean sentence for the particular combination of seriousness and record). If there are exceptional circumstances and the judge wishes to give a sentence that lies outside these limits, he or she must give reasons for departing from the presumptive disposition. The guidelines are published and reviewed periodically.¹

Initially the guidelines for the fair allocation of prison terms were derived from research projects funded by the US Federal Parole Commissioners, who had been criticised for disparities in their decisions and were under political pressure to curtail their discretion. In much the same way,

the allocation decisions being made by providers of medical care are now under criticism for disparity. Proposals for change have been made, but on the basis only of general principles, not of current best practice.² Before we can move towards a more rational rationing, we need to model rationing decisions as they now exist and attempt to quantify the current practice in probabilistic terms. The mathematical description of decisions could have at least three important benefits: (a) it would be possible to allocate resources more evenly and equitably, (b) the allocation could be more efficient, and (c) the moral principles underlying the decisions would be available for scrutiny. The modelling could facilitate the creation of a codified general policy, formulated as guidelines, which would allow discretion for truly exceptional cases with elements that are not covered by the general policy. Public debate on the principles that underlie the guidelines would draw attention away from the dramatic cases that so often prejudice both the ethics and the effectiveness of decisions.

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- 1 Wilkins LT. *Consumerist criminology*. Heinemann: London, 1984:130-7.
- 2 Smith R, ed. *Rationing in action*. London: BMJ Publishing Group, 1993.

Degree of rationing in Zaire would be unacceptable in Britain

EDITOR,—The paper by the Rationing Agenda Group and the accompanying editorial by Richard Smith are encouraging a serious and more public review of rationing within the NHS.^{1 2} While working as a junior doctor within the NHS I was rarely bothered by the issue, but it is unavoidable here in north east Zaire, and it is occurring at a level of health care that would be unacceptable in Britain. For example, we have decided not to obtain a supply of third generation intravenous cephalosporins to treat meningitis, despite having experienced a number of treatment failures with benzylpenicillin and chloramphenicol. The hospital does not pay for postexposure rabies vaccination, and until recently diabetic patients needing insulin were discharged home if they could not pay for their treatment.³ These decisions have been made on the basis of cost effectiveness; if we subsidised these conditions then other hospital activities would suffer—activities considered to be more important.

"Health for all" is a much used phrase that has an ambiguous meaning. If by it we mean perfect healthcare provision for everybody then we are living in a fantasy world. Reality tells us that many people have little or no access to affordable health care. Rationing is difficult, especially so when it impacts on your daily work, but by admitting the need for rationing we can escape from the fantasy world of perfect healthcare provision and rationing then becomes a useful tool. It can even become a positive experience, albeit a difficult one. Done well and reviewed frequently it may combat the sense of frustration encountered by those working in a situation with grossly inadequate resources, for by wielding this tool effectively and bravely it can help us achieve the best possible healthcare provision for the greatest number of people in any given situation.

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- 1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;312:1593-601. (22 June.)
- 2 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996;312:1553-4. (22 June.)
- 3 Burdon J. Another deadly Zairian disease. *BMJ* 1996;313:58. (6 July.)

Responsibility for social care needs to be considered

EDITOR,—The article by the Rationing Agenda Group was well thought out and comprehensive.¹ I would like to comment on what should be health and what should be "other" forms of care responsibility—that is, social, etc. Although I agree that, ideally, social care should be the responsibility of agencies other than the NHS, in practice this is not the case. Because of funding problems the NHS is often "forced" into paying for social care as a form of insurance against the greater health consequences of not doing so.

I have responsibility for purchasing for mental health, learning disability, and substance misuse locally, and this is a definite and worsening problem. For instance, if we do not spend money on social care in the form of partnership homes or day care or as intensive social support for some ex-users of NHS beds for any of the above three reasons we risk being forced into purchasing far more expensive care—for example, for inpatients, as extracontractual referrals, or privately. We therefore pay for such services knowing that they are predominantly social but being aware that we cannot unilaterally extract the NHS from doing so either on moral or ethical grounds (casting the patients out) or on legal grounds (against government guidance on joint working).

I accept that an ideal position may need to be stated, but to help in reality I think that such practical problems must be faced by any group trying to shed light on the subject. This interface is a huge area of spend (up to 20% of the NHS budget for some of these client groups).

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- 1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;312:1593-601. (22 June.)

Elective waiting lists are becoming explicitly rationed

EDITOR,—The move from implicit to explicit rationing is already under way in the management of elective waiting lists, giving immediacy to the philosophical and practical questions raised by the Rationing Agenda Group.¹

Conflicts have emerged between NHS managerial performance measures and clinical priorities for the management of waiting lists.² The need for the explicit, transparent, and accountable prioritisation of elective waiting lists, perhaps through points schemes, is becoming more evident. Although consultants distinguish between urgent and routine cases on their waiting lists, centralised administrative booking systems in hospitals make further prioritisation within urgency categories difficult. This results in a largely first come first served system. NHS waiting time targets have, until recently, focused debate on achieving waiting times in line with guarantees in the patient's charter. This has served to deflect attention away from the role of waiting lists as a rationing mechanism. Purchasers facing financial constraints are beginning to look at waiting lists as rationing mechanisms.

To avoid further conflicts between clinical and managerial goals for waiting list management, explicit criteria for their prioritisation will be

necessary. A national waiting list policy that guarantees access according to agreed criteria, rather than simply guaranteeing maximum waiting times, could facilitate contracts between purchasers and providers on the basis of agreed criteria for the prioritisation of waiting lists. Points could be assigned to patients by consultants to reflect, for example, current health status, assessed using the EuroQoL or SF36 health status measures; expected gain in quality of adjusted life years (QALY)³ from treatment; or some combination of clinical factors such as rate of deterioration and social factors reflecting dysfunction in usual activities. This is being pursued by New Zealand's Health Commission⁴ and in the United Kingdom is being piloted at Salisbury District Hospital.⁵ Points schemes could help establish thresholds for entry on to elective waiting lists and help standardise general practitioners' referral practice for routine procedures.

If rationing in the NHS is inevitable, waiting list points schemes could help to ensure that patients with similar need, somehow reflected by their points allocation, could be assured of similar access to treatment, regardless of clinical speciality, geographical location, or general practitioner's status. Points schemes could provide a redefinition of the principle on which the NHS was founded within the constraints of resource limitation.

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- 1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;312:1593-601. (22 June.)
- 2 Samuel O. Fundholding practices get preferences. *BMJ* 1992;305:1497.
- 3 Gudex C, Williams A, Jourdan M, Mason B, Maynard J, O'Flynn P, et al. Prioritising health care. *Health Trends* 1990;22:103-8.
- 4 National Advisory Committee on Core Health and Disability Support Services. *Core service for 1994/95*. Wellington, New Zealand: NACCHDSS, 1994.
- 5 Edwards KT. An economic perspective of the Salisbury waiting list points scheme. In: Malek N, ed. *Setting priorities in health care*. Chichester: Wiley, 1994.

Selection of group members needs to be clarified

EDITOR,—I think clinicians would take a little more notice of the Rationing Agenda Group if it included more people who actually had to face sick people and their families day by day over the years. It is difficult to identify any working clinicians in the group.¹

It would be interesting to know the method of selection for members to sit in this group. King's Fund Policy Institute is presumably a registered charity—that is, receives a lot of money from the taxpayer—and its function should be more democratic.

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- 1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;312:1593-601. (22 June.)

Purchasing policies for in vitro fertilisation vary considerably

EDITOR,—The reports from the College of Health^{1,2} continue to confirm a considerable variation between health authorities in their purchasing intentions for in vitro fertilisation. Some have also included sociomedical criteria for allocating these scarce resources. It is unclear as to

whether these policies are subject to review and whether such criteria are explicit.

We have recently completed a cross sectional postal survey of the 106 new health authorities in England and Wales, requesting details of policies on in vitro fertilisation. The response rate was 94% (100/106). Of the 100 responders, 67 fund in vitro fertilisation and 16 do not. The remaining 17 were in the throes of the policy making process and were unable to offer a clear response.

All of the 67 who funded In vitro fertilisation did so on a restricted basis. These restrictions varied in severity, with some constructed so as to effectively deny access except under exceptional circumstances. The restrictions were invariably explicit and were a mixture of medical reasons—for example, woman's age, ranging from 34 to 42 years (where age is used as a marker for clinical effectiveness)—and social factors such as marital status, heterosexuality, and marital stability. In all cases access was also controlled by considering only couples (not individual) presenting themselves for referral.

It is clear that in vitro fertilisation continues to be overtly rationed within the NHS. What is of concern is the use of criteria which are not always related to clinical effectiveness but have a sociological construct that may discriminate against some members of society. It is not clear at present whether such criteria are acceptable to local populations. They seem to reflect the values of purchaser or provider clinicians, or both.

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- 1 College of Health. *Report of the national survey of the funding and provision of infertility services*. London: College of Health, 1993.
- 2 College of Health. *Report of the second national survey of the funding and provision of infertility services*. London: College of Health, 1995.

Don't confuse personal choice with collective choice

EDITOR,—Most of the problems we encounter with rationing decisions¹ arise through collective choice in publicly funded systems. In other words, decisions are taken by a collectivity that binds individuals. In a privately financed system individuals are more able to make personal choices (admittedly constrained by their income). Decisions are less likely to be taken by others on their behalf. Even in most privately funded systems third party decisions are commonplace, but the distinction between personal choice (making your own rationing decisions) and collective choice (making decisions on behalf of others) is an important one.

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- 1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;312:1593-601. (22 June.)

Breast screening has failed older women

EDITOR,—Gary Rubin, service director of the East Sussex Breast Screening Service, said that invitations to breast screening should not be extended to women aged 65 or over until more information is available on the success rate of the

current screening programme and that a lack of staff would limit an immediate expansion.¹

Age Concern England's view is that the fundamental issue of the equity of the NHS breast screening service should not depend on further information. The question that needs to be answered is why the programme of breast screening invitations excludes the age group of women in whom the largest number of cancers might be detected. This reduces the potential effectiveness of the breast screening programme and, more importantly, denies older women an important step towards the early detection of breast cancer.

The inequity of this situation will become increasingly difficult to reconcile as women aged 50-64 move through the breast screening programme and then ask, at age 65, why they cannot continue to receive invitations. The current system, in which women aged 65 or over can request a screening every three years, has proved a resounding failure, with around 97% of eligible women failing to be screened.

Women should be informed that breast cancers do occur in older women and that it is a good precaution to report any breast symptoms promptly. A recent Gallup survey showed that 65% of older women thought that their age group was at little or no risk from breast cancer; 28% thought that there was no risk at all.

Many older women do not seek advice about breast symptoms, believing they cannot develop the disease. In many cases, older women mention that the screening cut off age at 65 encourages this belief.

In view of all these factors, Age Concern England is calling on the government to urgently address the shortage of radiologists, as any further delay in extending the programme would be unacceptable.

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- 1 Rubin G. Wrong comparison quoted for breast screening. *BMJ* 1996;312:1674. (29 June.)

Ratio of waist circumference to height is strong predictor of intra-abdominal fat

EDITOR,—Waist circumference¹ and the ratio of waist circumference to height² have been proposed as better indicators of the need for management of weight than the classic body mass index. The relevance of the different proxy measures is presumed to relate to their prediction of intra-abdominal fat, but a comparison has not yet been reported.

Thirty one women and 16 men presenting for routine computed tomography had their weight, height, and waist circumference measured; all but three men and three women also had their hip circumference measured. The subjects were aged 18-73, and the range of body mass index (kg/m²) was 20.1-48.5. The cross sectional areas of both intra-abdominal and subcutaneous fat were calculated from images taken immediately cranial to the iliac crests, as previously described.³

Pearson product-moment correlations for the logarithms of selected anthropometric variables and ratios with estimates of total fat and the two fat compartments showed that the ratio of waist circumference to height had the highest correlation with intra-abdominal fat ($r = 0.83$, $P < 0.001$). This was higher than the correlations of waist circumference ($r = 0.75$), body mass index ($r = 0.69$), and the ratio of waist to hip circumference ($r = 0.54$) with intra-abdominal fat.