Several disease coding systems exist, including the ninth and tenth revisions of the International Classification of Diseases and the Read classification.² The ICD classification is most widely used, but the Read classification is potentially more versatile. Unfortunately, commercialisation of the Read classification by the NHS may limit its use internationally. For national and international comparison of data the coding system used must be widely accepted and freely available. It is possible, however, for a computer program for medical audit to use different coding systems but be linked to an agreed standard.

I suggest that the Centers for Disease Control and the World Health Organisation (which developed EPIINFO, which is software in the public domain for use in epidemiological research) should collaborate with other interested organisations in developing a computer program for medical audit to be in the public domain. It should consist of a core database linked to an agreed standard disease coding system. It would need to be easily customised by the end user. The problems of diagnostic certainty and coding hierarchy would need to be addressed, and decisions on coding hierarchy could be incorporated into the routine for checking for errors of data entry. Other goals should include user friendliness, robust routines to check for errors, and safeguards to protect the data. Worldwide many hospitals and health services already have audit programs of variable complexity. A coordinated approach now would prevent unnecessary effort being expended on developing additional unique systems.

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1 Leung DTY, Tseng RYM, Davies DP. Setting up a clinical audit of paediatric morbidity in Hong Kong: some early experiences. *Aust Paediatr* 1987;23:111-3.

2 Chisholm J. The Read classification. *BMJ* 1990;300:1092.

Discharges from nursing homes

EDITOR,—In suggesting that their survey of discharges from nursing homes refutes the view that the NHS has become a dumping ground for increasingly dependent residents of such homes Jennifer M Henry and colleagues, perhaps accidentally, encourage policymakers and health commissioners to be complacent.¹ The inadequacies of medical care for residents of nursing homes, with proved opportunities for treatment being missed, have been documented.²

The authors found that a quarter of residents were discharged to the community but do not state whether admission to a nursing home was appropriate. Planned respite care and intervention for domestic crises are justified, but how many residents were admitted because of medical problems instead of being referred to health services? A high death rate is to be expected among elderly people in nursing homes, but some uncertainty regarding the timeliness and nature of death must exist, especially when about a quarter of discharges are to the community and half are because of death.

My interpretation of the survey is that it supports the view that residents of nursing homes constitute a dynamic population in which much change, currently not supervised, occurs. A preliminary audit of admissions to my hospital from nursing homes suggests that people with an acute illness such as infection are referred to hospital, where treatment is frequently straightforward (and within the capability of many nursing homes), with medical advice and supervision. Admissions from nursing homes of people with remediable chronic conditions are uncommon; I

presume that this is because the conditions are dismissed as acceptable deterioration related to age. I am concerned that some homes, fearful of acquiring a reputation of not coping or of "dumping" their problems, increase care rather than seek help, promoting dependency and morbidity.

The issue of high dependency care in the community and the appropriate use of health services is inadequately defined. A confidential inquiry into deaths in nursing homes similar to those into perinatal and postoperative deaths could initiate a greater understanding. This sounds ominous but is probably preferable to an increasing spiral of litigation and scandal. The individuality of residents in long term care makes audit of care difficult, while a review of care after death offers at least an indisputable outcome.

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1 Henry JM, MacPherson IA, Donald SC. Survey of private nursing homes in seven English counties. *BMJ* 1994;309:314. (30 July.)

2 Pearson J, Challis L, Bowman CE. Problems of care in a private nursing home. *BMJ* 1990;301:371.

Human rights in Kurdistan

EDITOR,—C M Milroy's personal view about his recent mission to south east Turkey will help to raise awareness among the British medical profession of the terrible situation of the Kurdish people in Turkey.¹ The Kurdistan Human Rights Project is an independent, non-political project that was founded and is based in Britain. It is committed to the protection of the human rights of all people in Kurdistan, irrespective of race, religion, sex, political persuasion, or other belief or opinion. Its supporters include both Kurdish and non-Kurdish people. Its aims are to promote awareness of the situation of the Kurds in Turkey, Iraq, Iran, and Syria; to bring an end to the violation of the rights of Kurds in those countries; and to promote the protection of the human rights of the Kurdish people everywhere.

The project's work includes helping people to bring cases to international human rights bodies; sending people on fact finding missions and to observe trials in all areas of Kurdistan and producing reports on these; and promoting awareness of the plight of the Kurds at both European and international levels. The project's dramatic achievement has been in calling Turkey to account in international law for its unconscionable policy of repression in south east Turkey. Over 100 individual complaints of violations of human rights have been filed before the European Commission of Human Rights in Strasbourg by the project.

Milroy's article clearly shows the effects of widespread and systematic violations of human rights on innocent civilians. The fact that this occurs in a country that is both a signatory to the European Convention on Human Rights and being considered for membership of the European Union makes the situation even more disturbing. As Milroy states, however, the Kurdistan Human Rights Project is using international standards and mechanisms to help people bring human rights cases against their governments. If any readers wish to receive further information about the project and how they can support its vital work it can be contacted at Room 201, Linen Hall, 162-168 Regent Street, London W1R 5TA.

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1 Milroy CM. A secret and dirty war. *BMJ* 1994;309:135. (9 July.)

Equity in health care

EDITOR,—E S Williams and C M Scott comment on our review of some of the weaknesses of the current methods of allocating resources to NHS regions.¹ They argue that the age-cost weights in the current formula assume, in their view wrongly, that all elderly people have the same health needs² and that we should have made this point in our paper. While they present their argument in terms of the age-cost weights in the formula, their quibble seems to be with the subsequent needs weightings.

They seem to be arguing that the additional needs weighting in the formula over and above the age-cost weightings, in the form of the standardised mortality ratio, is inadequately sensitive to relative needs between city districts and retirement areas. They argue that selective migration is the main factor causing a district to have a high proportion of elderly people, that the people who migrate to retire tend to be the more affluent, and that the current formula fails to recognise this. Yet they state that these retirement areas have low mortality standardised for age and low levels of deprivation. Surely, this indicates that elderly people in, say, coastal retirement areas will be given relatively fewer resources than those in conurbations or inner cities with higher death rates, even on the basis of the current formula, when age structure and mortality are multiplied together.

To support their criticism of the current capitation formula they present a scatterplot of the proportion of the population aged over 65 against the percentage of people aged over 75 living alone and show a highly significant inverse relation. They use this to argue that areas with higher proportions of people aged over 65 tend to have lower needs. This assumes that the percentage of those aged over 75 living alone is a relevant indicator of need. It may be, but the authors make no attempt to justify their assertion.

The current capitation formula does not assume that all elderly people (or people in any age group) have the same needs, as Williams and Scott suggest. It simply uses a two stage approach to population needs weighting once the size of the population has been entered into the formula. Firstly, each age group is weighted empirically for need in relation to the national average cost of use in each group. Secondly, after standardisation for age, remaining differences in population need are accounted for by the all cause standardised mortality ratio for the area. This ratio may or may not adequately measure the relative needs of more and less affluent communities, but it attempts to do so.

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1 Judge K, Mays N. Equity in the NHS: allocating resources for health and social care in England. *BMJ* 1994;308:1363-6. (21 May.)

2 Williams ES, Scott CM. Equity in health care. *BMJ* 1994;309:198. (16 July.)

Drug users and sick notes

EDITOR,—Clive L Morrison and Sue M Ruben recommend that general practitioners should not issue sick notes to drug users unless they have a coexisting medical or psychiatric condition.¹ Twenty four of my patients are receiving maintenance treatment with methadone, and all but one receives invalidity benefit. The immediate effect of my refusing to issue further sick notes would be to reduce their weekly income from £69.10 to £45.70, assuming that they then received income support. Understandably, my patients are reluctant to accept this and I am reluctant to impose it on them.