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- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Financing health care

SIR,—In October 1982 you published a letter in which I expressed gloom about the future of the NHS¹; unhappily my fears were well founded. Clinical services have had to be reduced and wards have been closed; this makes one wonder whether the government's record of underfunding indicates a plan for partial run down of the hospital services, a considerable expansion of the private sector, and consequently the development of a two tier service.

The alternative strategies for funding the NHS have been elegantly discussed by Professor Rudolf Klein (12 March, p 734), but our present redistributive system of taxation, in which all receive the same quality of service but each pays according to income, does seem to be a proper method for a civilised society.

There has been no lack of ideas for reorganisation,^{2,3} some originating from the American experience with health maintenance organisations (HMOs) and nearly all assuming an increase in private practice. The introduction of competition using variations on the HMO idea is unlikely to be acceptable since the Americans have found that HMOs have not been able to provide an adequate choice for the patient and have failed to control costs. In addition the HMO relies for its financial survival on enrolling the young, the healthy, and the employed, and none of the numerous schemes so far put forward have given adequate consideration to the care of the chronic sick (geriatric patients, the young disabled, the mentally handicapped, and the mentally ill). In 1987 the available beds for these patients constituted about half the total beds in England and Wales.⁴ The exclusion of the chronic sick from any reorganisation would allow their care to sink back into the Dickensian state from which it has only recently emerged.

An expanded private sector would have many drawbacks, but these are rarely discussed openly. The articulate upper income groups, having chosen private care, would no longer have a stake in the quality of the state service and, with tax exemptions for insurance, would leave the NHS to be funded by increased tax contributions from the less well off. Alternatively the NHS would be funded at a lower level as a second class service. Consultants would have less time available for their NHS commitments to patients and hospital committees and for the training and support of their junior staff; they would have little incentive, and perhaps a disincentive, to improve the standard of care for their NHS patients. By its very nature, private practice demands more medical and nursing time per patient than does the state service. The buying and selling of services between hospitals (the "internal market")⁵ has a superficially attractive logic but would do nothing to improve the finances of the less well equipped hospitals; such a scheme could mark the beginning of restrictions on the freedom of the general practitioner to refer his patient to the consultant of his choice, irrespective of administrative boundaries.

I am not saying that there are no good ideas in the present flurry of comment, but much more information is required about what needs to be done, how it should be done, and the possible results. The infinite demand (or "bottomless pit") theory is in vogue, with its corollary of a service limited by inadequate supply, except for the rich. There has been no survey (as far as I know) which has examined the amount of unmet need in a defined area or community. Equally important, we do not know how much of the met and unmet need could be reduced by measures designed to lessen

the amount of avoidable illness and disability (in this context, for example, a planned programme for hip replacements could be regarded as a form of preventive medicine). What is needed is not another management upheaval but planned evolution from where we are at present, with experimental schemes in a few areas. Consumer interests should be better represented at management and clinical levels. All groups working in the NHS should combine to put forward constructive and comprehensive suggestions for improvement, rather than indulging in piecemeal approaches and demonstrations in favour of different sectional interests. If there is no united front each section of workers will be bought off with financial bribes or picked off by political manoeuvres. We must preserve the principles on which the NHS was founded before it is downgraded by the epitaphs of the economists or destroyed by the prejudices of the politicians.

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- 1 Black J. Monetarism and health. *Br Med J* 1982;285:1272-3.
- 2 Butler E, Pirie M. *The health of nations*. London: Adam Smith Institute, 1988.
- 3 Goldsmith M, Willetts D. *Managed health care: a new system for a better health service*. London: Centre for Policy Studies, 1988.
- 4 Chaplin NW, ed. *Hospitals and health services year book 1987*. London: Institute of Health Services Management, 1987: 390-1.
- 5 Timmins N. NHS region may test internal market plan. *Independent* 1988 Mar 14:2.

Private nursing home care

SIR,—Professor W J MacLennan discusses some of the difficulties of quality assurance in private nursing homes (12 March, p 732).

Experience of several types of continuing care services in the NHS has led us to believe that whenever development resources become available there are often more pressing demands than continuing care. Lest there be any doubt of the validity of this statement, we suggest that health authorities should apply the standards for accommodation which they impose on private nursing homes to their own continuing care wards.

In our health district the provision of private nursing home beds has accelerated to the point where over 40 beds are available per 1000 population over the age of 65. At the same time the hospital bed pool for the elderly has dwindled, though its quality in terms of access to diagnostic facilities and input of rehabilitative skill has greatly improved. In such a district, where there is competition for patients by nursing homes with unhealthily large amounts of beds available, the question has to be posed, "Who should receive continuing care in the health service?" The answer is not dependent on physical disability but usually on the financial circumstances of individual patients and, in particular, their eligibility for supplementary benefit payment. The dual standards of care which can and do exist are unacceptable. Most patients are discharged to the care of their general practitioner in private nursing homes, a non-selective (by virtue of medical condition) few remain in hospital care.

Quality assurance for the individual patient can only be guaranteed by regular review and a sense of advocacy by the reviewer. It is quite clear that general practitioners do not have the time to visit their elderly patients in nursing homes and embark on multidisciplinary case conferences, whereas the tradition of geriatric medicine in Britain has established the multidisciplinary conference as the most meaningful way to review an individual's needs comprehensively. For some time in Weston super Mare specialist nurses have followed patients discharged from hospital into private nursing homes to confirm the suitability of the placement and, where necessary, to target paramedical resources so that the care, at least at the outset, has been appropriate for the needs of the patient. The private sector has been receptive to our continued involvement with patients, and some of the skills imparted by this "outreach" activity may have improved the overall standard of care within the private sector.

Major capital investment on chronic care within the health service is unlikely. What is urgently needed is a clear policy on the limits of the NHS's responsibility for providing a service for the elderly and disabled. The burning issue is whether or not the health service should be expected to provide long term inpatient care. Planning for the care of the elderly in particular is at a standstill in many health authorities through lack of clarity on this issue, and, by inference, the service provision to patients is variable and inconsistent between various areas of Britain.

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SIR,—Professor MacLennan reminds us that for many elderly chronically sick patients the reality of community care is quite simply a transfer from one sort of institution to another (12 March, p 732). He says that "proponents of the expansion in private institutional care emphasise that it takes pressure off a hard pressed health service." Such a view fails to take into account the impact which the concentration of large numbers of these highly dependent patients has on local general medical services,

which in certain parts of Britain are being stretched to breaking point.

The General Medical Services Committee believes that the present arrangements for the planning and registration of nursing and residential homes are inadequate and fail to take account of the ability of local general practitioners to provide the services required. We have made it clear in our discussions with the Department of Health and Social Security and in our evidence to Sir Roy Griffiths's review of community care and the review of residential care by Lady Wagner that these patients have medical needs which are no different from those of patients in long stay hospitals. We have proposed that such homes should be required to appoint medical advisers and that such appointments should be a condition of registration. We have also recommended the establishment of a national inspectorate, similar to the health advisory service, to inspect and license nursing and residential homes, whether private, voluntary, or statutory.

In its white paper *Promoting Better Health* the government refers to the special needs of the elderly and to those doctors practising in areas where there is a growing number of nursing homes. Let us hope that this recognition leads to an improved and more appropriate service for these patients, who are among the most disadvantaged and deserving in our society.

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SIR,—Professor W J MacLennan's leading article (12 March, p 732) does much to put things into perspective in a subject which has been debated hotly for some years.

The article fails to highlight, however, the use of "contractual beds" in private nursing homes by local authorities. This has proved to be beneficial in alleviating the strain on hospital long stay systems as well as retaining the role of geriatricians in selecting the type of patient who would be admitted to such beds. Until quite recently this scheme has been operational in Brighton Health District and has contributed appreciably to "through put" in the local geriatric unit. (Alas, this too has fallen to the axe of cut backs.)

The current DHSS supplements which are available to patients with low incomes could be used more resourcefully if a tiered structure were introduced. This would take into account the geographical location of the nursing home. It is cheaper to set up a nursing home in the north and the DHSS supplements provided there should therefore reflect the lower weekly nursing home rates that ought to be charged in these areas. "Means testing" of even the low income groups and providing differential DHSS supplements rather than a "blanket" rate of £170 or whatever per week would be another example where costs could be cut. The extent of disability and the actual amount of nursing care required could form yet another basis where the tiered system would operate.

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SIR,—Professor W J MacLennan interpreted Day's and Klein's excellent review of institutional care of the elderly¹ as being particularly concerned about the difficulty of ensuring standards of care in the flourishing private nursing home sector. Our interpretation was that they emphasised that the

problem of ensuring standards of care applied equally to other sectors providing institutional care for the elderly. We agree with the opinion expressed in both articles that there is a need to shift attention from the regulation of structure and process of care towards outcome in terms of quality of life.

Unfortunately, many pay lip service to quality of life but make little attempt objectively to measure quality of life. An instrument for measuring the quality of life of old people in residential care is available.² We have developed this instrument for use in continuing hospital care and nursing homes, allowing comparisons to be made between these sectors. Quality of life outcomes include patient autonomy, choice, engagement, satisfaction with life, satisfaction with the home or ward, staff morale, staff v patient oriented policy, homely environment, and patient characteristics (physical, cognitive, and behavioural dependency). We have found that the questionnaires have clarity and are well accepted by staff and patients and that good interobserver correlation is obtained for questionnaires with subjective components.

Professor MacLennan rightly draws attention to the need to improve regulation in the private nursing home sector, particularly in preadmission assessment. Nevertheless, valid measurement and comparison of quality of life outcomes in all sectors providing institutional care for the elderly are necessary to inform policy makers and prevent "emotional and political prejudice."

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- 1 Day P, Klein R. Quality of institutional care and the elderly: policy issues and options. *Br Med J* 1987;294:384-7.
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Treatment of prostatic cancer

SIR,—Mr D A Gillatt and colleagues (27 February, p 644) favour the relative merits of surgical orchidectomy over medical orchidectomy even though they admit that most patients, given the choice, select medical orchidectomy. They further argue that the psychological effects of both procedures have not been studied. We conducted a randomised clinical trial comparing medical and surgical orchidectomy in advanced prostatic cancer,^{1,2} during which we conducted a psychological study using a standard cross validated psychological questionnaire, which was administered before and after treatment at three monthly intervals.^{3,4}

Fifty five patients who could be evaluated were randomised to medical orchidectomy using decapeptyl and 49 to surgical orchidectomy. No psychological difference was noted before treatment between the groups for anxiety, depression, cheerfulness, fatigue, energy, anger, composure, or thoughtfulness. By six months the decapeptyl group showed less fatigue, anger, composure, depression, and anxiety and more cheerfulness and energy than the surgical orchidectomy group. These results did not reach statistical significance, but there was a clear trend in favour of medical orchidectomy. A larger group of patients may give a statistically significant result. Since all our patients were fully aware of their diagnosis the psychological impact of the cancer seemed to override the immediate impact of surgical orchidectomy. When the patients were subsequently told about the clinical results of surgical and medical orchidectomy about 70% of those from the surgical group said that they would select