respondents were home owners and 61% car owners, was recruitment principally from the upper social class? Furthermore, it would have been beneficial if the authors had described the sociodemographic characteristics of the non-respondents, thereby allowing comparison with those of the respondents.

Secondly, respondents were asked whether particular services would currently be of some help, great help, or no help to them personally. It was therefore no surprise that the "healthy" group gave higher rankings to health promotion activities than to symptomatic treatments compared with the "unhealthy group." Ill individuals may be best placed to put a utility value on their own state of health. Sick people, however, would not be able to give "informed" opinions about health states that they have not experienced, and their judgment may be consciously or subconsciously biased. It would have been more useful for prioritisation purposes to have invited respondents to be more altruistic, by asking them to value primary care services for society as a whole. This would be similar to Rawls's "original position," when subjects are asked to make judgments from behind a "veil of ignorance."²

Thirdly, it was disappointing that Hopton and Dlugolecka dealt very superficially with ethical issues such as equality and equity and then only at the end of their paper. Equity is similar to Aristotle's concept of justice, whereby equals are treated equally and unequals unequally, in proportion to their relevant differences.³ While the respondents in this study are different in terms of health state, there may be other factors of moral worth that we wish to consider. In any case, Hopton and Dlugolecka do not indicate how the views of unhealthy people may be given more weight. We would prefer to appeal to the ethical principle of equal consideration of interests. Since we are all potential users of health care, we should all have a right to participate in decisions on prioritisation, even if this is biased towards conditions that we would be least likely to experience rather than actual experience of a reduction in quality of life associated with different health states.

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1 Hopton JL, Dlugolecka M. Patients' perceptions of need for primary health care services: useful for priority setting? *BMJ* 1995;310:1237-40. (13 May.)

2 Rawls JA. *Theory of justice*. Oxford: Oxford University Press, 1971.

3 Aristotle. *Politics*. Oxford: Oxford University Press, 1995. (Translated by E Barker.)

Authors' reply

EDITOR,—An important deficiency in the burgeoning research literature on health needs assessment and priority setting, particularly in attempts to incorporate users' views, is a preoccupation with methodological debate in isolation from debate about principles of social justice and morality. We attempted in our paper to deconstruct our own methodology to raise this debate rather than to summarise it. We are pleased that others are eager to take up the debate, and the issues raised by Quentin D Sandifer and colleagues are valuable in moving forward from our necessarily superficial coverage.

In the context of our concern with the nature of the debate, the key issue raised by Sandifer and colleagues is that of framing participation in the

process of priority setting or needs assessment in terms of Rawls's "original position" and asking participants to make judgments from behind a "veil of ignorance." With this approach important challenges remain. A method needs to be developed that can critically assess the extent to which a veil of ignorance has been established. At a conceptual level health services and local needs (as opposed to needs of society as a whole) have to be placed within an original position. We agree that there may be factors other than health state that may be of moral worth. Again this is a matter for debate, along with consideration of their place within health services needs assessment and priority setting.

Sandifer and colleagues also raise the issue of comprehensiveness of participation, both in methodological terms, by considering the characteristics of non-respondents and in conceptual terms, by appealing to the ethical principle of equal consideration of interests. The issue of non-respondents or non-participants is common to all methods, and we acknowledge the limited representativeness of our sample. With regard to equal consideration of interests, only if our analysis is interpreted as a substitute, rather than a stimulus, for negotiation does considering the preferences of different groups conflict with this principle. In other words, everyone has the right to negotiate how or whether the preferences of different groups are given more weight.

Habermas's approach of rational communication that is comprehensive, understandable and truthful as the basis of a model of democratic reason has also been suggested as a basis for social negotiation of needs.¹ A weakness of this model is that professional knowledge is often disempowering. It seems to us that the greater challenge is to ensure that this debate moves from the professional arena into everyday negotiations.

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1 Doyal L, Gough A. *A theory of human need*. London: Macmillan, 1992.

measures of activity: finished consultant episodes, admissions, and patients. Finally, we derived the ratio of finished consultant episodes to admissions and patients treated (table).

The number of admissions (day cases and ordinary admissions) increased 98% between 1989 and 1993 (table). The number of patients admitted, however, rose by only 14%. Most of the increase in finished consultant episodes and admissions was therefore due to repeat admissions and readmissions of the same patients. In 1989 the ratio of all admissions and finished consultant episodes to individual patients was 1.23 and 1.33 respectively, but by 1993 these ratios had risen to 2.13 and 2.24 respectively. Thus in 1993 there were 2.24 finished consultant episodes and 2.13 admissions per patient treated.

The implications of this for contracting are threefold. Firstly, admission rates are often used as a proxy measure for the population's access to treatment and care, but the paradox is that an area with high admission rates may admit few patients (with numerous readmissions) while, conversely, areas with low admission rates may admit many patients but with fewer readmissions and repeat admissions. Secondly, because the admission or finished consultant episode includes day cases it may give a spurious picture of the use of resources and patterns of care. Thus an area with low admission rates may have higher costs because more patients are admitted as inpatients; conversely, an area with high admission rates where many day case procedures are undertaken may have low costs. We are undertaking further analysis to ascertain how admissions relate to actual treatment of colorectal cancer. Thirdly, our findings support the Radical Statistics Health Group's conclusion that the increase in the number of finished consultant episodes in recent years cannot be used to support ministers' claims that more patients are being treated.¹

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1 Radical Statistics Health Group. NHS "indicators of success": what do they tell us? *BMJ* 1995;310:1045-50. (22 April.)

General household survey provides valuable data

EDITOR,—The authors of the article on NHS "indicators of success"¹ make only passing reference to the general household survey.² This continuous survey throws light on some of the questions regarding trends in use of the NHS by people resident in private (that is, non-institutional) households. Since 1972 the survey has provided data on the percentages of people who consult an NHS general practitioner in a 14 day period and who attend an outpatient or casualty department in a three month period. Since 1982 information has also been collected on the proportions of people who had an inpatient stay in hospital in the previous year (figure), and since 1992 similar data have been collected for day patients. The rates presented in the figure have been age standardised to the "old" European population³ and are shown as three year rolling averages. The standardisation

Measuring NHS activity

Admission rates are misleading

EDITOR,—We recently analysed five years of statistics on hospital episodes for all residents in the South Thames region admitted with a diagnosis of colorectal cancer between 1989 and 1993. Using date of birth, age, sex, and postcode as patient identifiers, we were able to link finished consultant episodes to admissions to calculate both the total number of admissions and the total number of patients treated. Data on 35 230 finished consultant episodes were obtained; these related to 20 434 patients, who had 32 364 admissions for colorectal cancer. We then examined trends in hospital activity over time, using three different

Trends in finished consultant episodes and admissions for colorectal cancer between 1988 and 1993 in South Thames

Year	Finished consultant episodes	Inpatient and day case admissions	Patients with at least one inpatient or day case admission during year	Finished consultant episodes/patient	Admissions/patient	Finished consultant episodes/admission
1989	5105	4737	3851	1.33	1.23	1.08
1990	5809	5385	3781	1.54	1.42	1.08
1991	6642	5830	4109	1.62	1.42	1.14
1992	7839	7050	4306	1.82	1.64	1.11
1993	9835	9362	4387	2.24	2.13	1.05