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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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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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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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

Figure 1 Trends in use of NHS services: percentages (three year moving averages) of patients who consulted their general practitioner in past 14 days, attended outpatient clinic or accident and emergency department in past three months, and had inpatient stay in past year

has not altered the rates from those obtained from raw figures.

The figure shows that the proportion of people consulting NHS general practitioners has risen since the mid-1970s—for female patients to a greater extent than for male patients; the proportion of people attending outpatient departments has increased over the same period, but the increase seems to have halted recently; and the proportion of people who were hospital inpatients over the period has changed little, apart from a slight increase in male patients.

During 1992 and 1993, 4% of people were treated as day patients. The general household survey provides other valuable data relevant to the health services, including data on self reported acute sickness, limiting chronic illness, contraceptive use, drinking, and smoking. More use should be made of this valuable source.

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Statistics would make Stalin proud

EDITOR,—The article by the Radical Statistics Health Group on indicators of success in the health service¹ leads us to ask what the NHS stands for today. The answer seems to be No Honest Statistics. The use of flawed statistics is another example of Stalinism in the NHS.² The government has radically transformed the NHS and knows that this has worked because it has the figures to prove it. Likewise, Stalin could prove the success of collective farming by his statistics on crop yield. The truth, however, was evident by the empty shelves in the shops.

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Polymyalgia rheumatica and giant cell arteritis

High dose corticosteroids are recommended

EDITOR,—We disagree with Gillian Pountain and Brian Hazleman's assertion that 20-40 mg of prednisolone is adequate initial treatment for patients with giant cell arteritis who have no ocular symptoms. As the authors state, appreciable visual loss occurs in 30-50% of patients with untreated giant cell arteritis. Anterior ischaemic optic neuropathy accounts for 90% of these cases, the remainder being secondary to retinal artery occlusions or, rarely, an ocular ischaemic syndrome. Although prodromal symptoms such as transient obscuration of vision or photopsia may herald ocular involvement, patients rarely present with these symptoms before the onset of profound visual loss. It is therefore extremely difficult to predict which patients with giant cell arteritis will go on to develop ocular complications, and all patients, even if they do not have visual symptoms, should be considered to be at risk of ocular involvement.

Two studies have advocated low dose steroid treatment in the management of giant cell arteritis. Delecoeuillerie *et al* retrospectively investigated the outcome in 78 cases and found that the 25 patients who were treated with 10-20 mg prednisolone/day had no greater ischaemic or ocular morbidity than the remaining 53 patients, who received initial treatment with 30-90 mg prednisolone/day.² Kyle and Hazleman reported that in their prospective series of 35 patients all but two were successfully treated with 40 mg prednisolone as an initial dose.³ The studies, however, included too few patients receiving low dose treatment to be convincing, especially as the rate of visual complications in untreated cases is as low as 30%.

Ophthalmologists are aware of the potential risks of high dose steroid treatment in elderly patients⁴ and of the disastrous visual consequences of inadequate steroid treatment in giant cell arteritis.⁵ Until larger randomised controlled series show that lower doses really do prevent ischaemic complications we believe that an initial dose of 20-40 mg prednisolone/day is inadequate in all patients in whom the clinical history and results of examination strongly suggest giant cell arteritis (with or without confirmatory results of temporal artery biopsy). We recommend that these patients should receive an initial five to seven day course of 1 mg prednisolone/kg, which may then be rapidly tapered, depending on the erythrocyte sedimentation rate and symptoms. Many ophthalmologists now elect to admit patients with arteritic anterior ischaemic optic neuropathy to give a 1 g intra-

venous infusion of methylprednisolone followed by high dose oral treatment.

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Synovitis and polymyalgia rheumatica can coexist

EDITOR,—Gillian Pountain and Brian Hazleman state that persistent synovitis in polymyalgia rheumatica is uncommon and suggests an alternative diagnosis such as rheumatoid arthritis.¹ This is a common misconception. Studies have shown evidence of extensive synovitis in patients with polymyalgia rheumatica.^{2,3} Evidence suggests that most elderly patients with a diagnosis of seronegative rheumatoid arthritis have a disease process similar to polymyalgia rheumatica except that the synovitis results in more affected joints being clinically detectable.⁴ In these patients the symptoms, lack of erosive changes on radiography, response to treatment, and long term outcome suggest that polymyalgia rheumatica and seronegative rheumatoid arthritis are part of the same disease process or are identical.^{4,5} This has important implications for treatment.

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Consider prophylaxis for steroid induced osteoporosis

EDITOR,—Gillian Pountain and Brian Hazleman consider that elderly women receiving long term corticosteroid treatment should be given disodium etidronate with calcium carbonate as the most effective prophylaxis to prevent osteoporosis.¹ This is of particular importance in patients with giant cell arteritis since it is a disease predominantly of older women and has serious risks if the steroid dose is not adequate. Unfortunately, there is no agreed safe dose, with some authors disputing the claim that low doses carry little risk. Furthermore, bone loss is greatest immediately after the menopause, so how effective prophylaxis for osteoporosis can be in those aged 60-75 is unknown. Finally, the study by Skingle and Crisp referenced in the article showed a significant increase in the bone mineral density of only the L1-L4 vertebrae and not in the neck of femur, which may be a more important clinical site; the vital data—namely, the clinical end point of fractures associated with steroids—are not available.

Our attention has been drawn to recent articles advocating oestrogen replacement therapy for postmenopausal patients receiving long term