

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 (casing 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