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Getting more for their dollar: Kaiser v the NHS

Price adjustments falsify comparison

EDITOR—The NHS is little cheaper than health care in the United States, according to Feachem et al.¹ What's next on their agenda? War is peace? Freedom is slavery? The authors purport to show Kaiser's efficiency relative to the NHS. This task is hard, given two undisputed facts: firstly, the United Kingdom's per capita health expenditure is \$1569, the United States's \$4358; and secondly, Kaiser's casemix adjusted costs are about average for the United States. Undeterred, Feachem et al use an outrageous price adjustment, exclude many of Kaiser's costs, and ignore Kaiser's avoidance of the sickest and most expensive patients.

Feachem et al's price adjustment inflates NHS costs by 52%, assuming that the NHS plays no part in constraining drug prices, administrators' or specialists' incomes, etc. Conversely, the adjustment excuses the US system from responsibility for the world's highest drug costs and the billions wasted on healthcare executives and other hangers on. Feachem et al adjust away the price controls that are an important advantage of non-market systems.

Feachem et al trim Kaiser's costs by subtracting profits and high administrative

expenses. Yet both are integral to the competitive market they extol. They falsely equate Kaiser's coverage with the NHS's, although Kaiser covers only minuscule amounts of nursing home care. Finally, many Kaiser patients—more than 12% according to a Kaiser memo—receive care outside Kaiser, costs which the authors exclude. Thus, Feachem et al understate Kaiser's actual costs.

Contrary to Feachem et al's assertions, Kaiser cares for a relatively inexpensive slice of the population. Their claim that Kaiser cannot avoid the expensively ill by booting them out is technically correct; when Kaiser members lose their jobs (for example, because of illness) and hence employer paid coverage, Kaiser must offer them individual policies. But Kaiser may charge whatever it likes—often thousands per month. Hence, few of the unemployed can actually afford coverage. Moreover, because the overwhelming majority join Kaiser through work, severely disabled people rarely get in. Although disabled Medicare patients may join, few do. Hence, Feachem et al's failure to adjust for casemix grossly biases cost comparisons; their adjustments for age and income are inadequate substitutes.

Finally, Kaiser's premiums (and costs) are virtually identical to those of other insurers that serve similarly healthy populations. Hence, Feachem et al's claim for Kaiser is tantamount to a claim that \$1569 = \$4358.

The NHS has grave problems, and Kaiser is far from the worst of US health care. However, Feachem et al's conclusions are pure hogwash.

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Working knowledge would have been needed for comparison

EDITOR—I was very disappointed by the publication of the article by Feachem et al in comparing the California Kaiser system to the NHS.¹ One has to live in California and be a doctor and have some working knowledge of the health maintenance

organisation before passing any judgment about the quality of its care.

Firstly, Kaiser is not a "non-profit" health maintenance organisation. It is for profit, with the profit being divided between shareholder practising Kaiser physicians. The fact was made known by a Kaiser physician.² So the profits shared are labelled as money spent on medical care for their patients, and therefore this justifies their classifying themselves as a non-profit health maintenance organisation.

Secondly, the data presented for their performance were collected and analysed by Kaiser personnel and may involve selection and information bias. I have recently responded to another outcome report by Southern California Kaiser regarding their observation that fewer studies and procedures results in better cardiovascular outcomes.^{3,4} My response and that of others exposed their self serving bias and distortions.⁵

Lastly, the commentary by Enthoven has to be interpreted with the knowledge that he was not only a consultant for Kaiser but also one of the directors of Blue Cross in California (another alleged non-profit organisation) and a leading proponent for the advent and proliferation of the healthcare delivery system that uses health maintenance organisations.¹

I, like many of my colleagues in the United States, was hoping some day to have our country copy the much more humane and cost effective single payer universal healthcare coverage system in place in Europe and Canada for many decades. With the globalisation of the healthcare providers (pharmaceutical companies, insurance companies, health maintenance organisations, etc), acting through the auspices of the powerful World Trade Organization, Europe and Canada run the very real risk of acquiring our very inhumane, wasteful, and diseased healthcare system.

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2 York GK. Executives with white coats—managed care medical directors. *N Engl J Med* 2000;342:130.

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Use of OECD database has led to incorrect conclusions

EDITOR—The serious concerns that the economic analysis supporting the study by Feachem et al is fatally flawed has been well explored by other respondents.^{1,2} There is a further problem, which is that Feachem et al have based their analysis of admissions and bed day use on the database of the Organisation for Economic Cooperation and Development (OECD). Anyone who is even slightly familiar with this dataset would know that it is important to triangulate it with other sources.

- It is not clear that it always uses United Kingdom data—several variables are for England only
- Data on admissions have been submitted in finished consultant episodes, not admissions
- Data are incomplete
- There are major definitional problems about acute care, day cases, long term care, etc. It cannot be assumed that these definitional differences, which have a major effect on numerous key variables in this analysis, have been controlled for by the OECD—Feachem et al make no mention of this.

The OECD database gives the same figure of 1 bed day per capita for each year 1993-8, which should have rung alarm bells. Triangulating these data with other sources further undermines the conclusion. In 1996 in England there were 120 232 beds, which gives a maximum number of bed days available at 100% occupancy of 43 884 680. This means that the maximum number of bed days per capita at 100% occupancy would be 0.897. In fact overall occupancy in the NHS in 1996 was much lower—there were not enough beds in England to give the figure Feachem et al quote. This is confirmed by hospital episode statistics that the bed days per capita were 0.644 for 1996-7.

Kaiser did better than the NHS on hospital use in 1996 and probably still does, but nowhere near as well as the article suggests. The factor that seems to have been ignored relates to the social care of older people—the NHS provides (somewhat against its will) a notable amount of social care in acute inpatient beds, and some adjustment should be made for this.

The lesson that Kaiser much more actively manages clinical processes and invests much more in making sure they work properly, has more specialists, and has invested in clinical leadership—which are the most important conclusions—could be lost by poor quality data analysis, dubious economics, and a tendency for all concerned to see in these data support for their own previously held convictions.

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1 Feachem RGA, Sekhri NK, White KL. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente [with commentaries by J Dixon, DM Berwick, AC Enthoven]. *BMJ* 2002;324:135-43. (19 January.)

2 Electronic responses to Getting more for their dollar. *bmj.com* 2002. (<http://bmj.com/cgi/eletters/324/7330/135> (accessed 21 May 2002).)

Kaiser may be model of American success or aberration

EDITOR—Feachem et al make a strong case for the efficiency and quality of the Kaiser Permanente system.¹ Although comparing health systems is difficult, most health policy experts point to Kaiser as the best model of American health care. It is disingenuous to extend these results to other American managed care policies, as Feachem et al attempt to do. They say that managed care, of which the Kaiser system is one manifestation, is now the norm in the United States, covering 92% of all people with health insurance sponsored by an employer. Despite this, managed care has recently been criticised. Most members of health maintenance organisations, however, report satisfaction with their own health plans.

Their glowing report of Kaiser's success in a competitive market place raises several questions about the benefits of competition.

Firstly, although there is great financial incentive to decrease hospital use, there is almost no benefit for insurance companies to implement prevention programmes. The average US insurance plan has 25% annual turnover, discouraging such long term investments.

Secondly, Kaiser's quality has not resulted in market success. Their plan is not growing, and staff model health maintenance organisations are the exception rather than the rule in the United States. Instead of adopting plans similar to Kaiser most insurance companies are turning away from programmes with "defined benefits" to programmes with "defined contributions."² These programmes will require more out of pocket payments from the sickest people. There will be more financial barriers and disincentives to accessible care. For most Americans, there is no reason to believe that the future of health care in the United States will resemble Kaiser.

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2 Freudenheim M. A new health plan may raise expenses for sickest workers. *New York Times* 2001 Dec 5; section a:1, col 6.

United States is paying more and getting less

EDITOR—Feachem et al present disreputable comparisons.¹ Unadjusted 1988-97 NHS figures for β blockers after myocardial infarction (42%), from one hospital in Britain's most deprived borough, are compared with 1999 Kaiser Permanente data extensively adjusted for contraindications.² A more appropriate comparator (38%) was reported from Kaiser Northern California hospitals 1990-2.³ Similarly NHS retinopathy screening is inappropriately derived from a telephone survey of local estimates in 1996.⁴

Kaiser data exclude 15% of the population, recent entrants who were not members for a full year. In the table the NHS prevention data have been adjusted to exclude this group, which is assumed to have a rate 0.75 that of those full members. Adjusted NHS retinopathy screening for 1999 is 68% and NHS mammography and cervical screening increase to 71% and 91% respectively.⁵

Kaiser comparisons should include the 24% of Californians who are uninsured. The table assumes that the uninsured had 50% uptake for women's screening and 75% for childhood immunisation. Only 58% of Hispanic children in Los Angeles were immunised, and the completed immunisation rate for California as a whole was 75.3%. Not a single NHS health authority had rates as low.

The table does not show that Kaiser's preventive care or hospital productivity is better. NHS specialists do the same number of procedures per doctor as Kaiser, although NHS midwives ensure superior obstetric efficiency. The threefold difference in American heart surgery (or the twofold difference in France) is simply due to numbers of cardiologists. The article does not tell us that Kaiser doctors do not visit their patients at home, in or out of hours, or that Kaiser charges \$10-15 for an office visit, \$50 for casualty, and many other fees and copayments.

In 1997 annual per capita health spending was three times greater in the United States (\$3724) and twice as high in France (\$2125) than in the United Kingdom (\$1193). Kaiser's facilities are more modern, better equipped, and have more support staff than the NHS. That costs more. There is much to learn about efficient use of hospital services, but underinvestment in the NHS remains the major problem.

Comparison between the NHS and Kaiser Permanente*

	NHS (England)	Kaiser Permanente
Prevention (%):		
β Blockers after myocardial infarction ^{2,3}	42 (42)	38 (93)
Mammography†	71 (69)	73 (78)
Cervical screening†	91 (84)	72 (80)
Diabetic retinal examination‡	68 (60)	68 (70)
Three vaccinations with DTP and polio	95 (95)	88 (91)
Productivity (No of procedures):		
Angiograms per cardiologist	47.5	48.3
CABG per cardiologist	58.7	52.9
Caesarean sections per obstetrician	58	27

*Numbers in parentheses are original data. †NHS data exclude people within one year of changing practice; Kaiser data include uninsured people. DTP=diphtheria, tetanus, and pertussis. CABG=coronary artery bypass grafts.

America ranks 37th in performance of health systems, according to the World Health Organization; Britain ranks 18th, and France ranks 1st. The NHS serves all the people without payment at the time of use, without restriction, without exclusion or stigmatisation. Kaiser does not do any of that. When whole populations are assessed, a grossly underfunded NHS outperforms America by a wide margin.

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- 1 Feachem RGA, Sekhri NK, White KL. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente [with commentaries by J Dixon, DM Berwick, AC Enthoven]. *BMJ* 2002;324:135-43. (19 January.)
- 2 Barakat K, Wilkinson P, Suliman A, Ranjadayalan K, Timmis A. Acute myocardial infarction in women: contribution of treatment variables to adverse outcomes. *Am Heart J* 2000;140:740-6.
- 3 Barron HV, Viskin S, Lundstrom RJ, Swain BE, Truman AF, Wong CC, et al. Beta-blocker dosages and mortality after myocardial infarction: data from a large health maintenance organisation. *Arch Intern Med* 1998;158:449-53.
- 4 Bagga P, Verma D, Walton C, Masson EA, Hepburn DA. Survey of diabetic retinopathy screening services in England and Wales. *Diabetic Med* 1998;15:780-2.
- 5 Khunti K, Ganguli S, Baker R, Lowy A. Features of primary care associated with variations in process and outcome of people with diabetes. *Br J Gen Pract* 2001;51:583-4.

Like should be compared with like

EDITOR—As has been commented on, the business of making comparisons between health systems is difficult. In addition to the several issues already cited by respondents, the article by Feachem et al gives an NHS cost of £58.5bn but revenue allocations this year to health authorities in England are £37 157m.^{1 2}

If the £58.5bn cited includes all NHS expenditure (and not just allocations to health authorities) in England then there are some very real comparative problems. Not included in the £37bn figure above, but possibly in the £58.5bn figure, would be central budgets of the Department of Health that fund—among other things—undergraduate nursing tuition and bursaries as well as those for allied health professionals and additional costs associated with teaching hospitals. These alone total nearly £1.5bn. Presumably the Kaiser figures do not include the costs of training and educating the health workforce in California. The £37 157m figure for health authority allocations includes among other things expenditure on public health and ambulance services.

Presumably Kaiser Permanente does not fund the public health departments at state, county, or municipal level in California or ambulance services in the state? The article also refers to the United Kingdom and uses its population. The Department of Health is the health department for England only and not for Scotland, Wales, or Northern Ireland. Nor is it the United Kingdom's department of health, as responsibility is split between the four constituent countries of the United Kingdom. The secretary of state for health is accountable to the British parliament but only for the money voted for use in England. It is not

clear therefore whether the £58.5bn relates to England alone or is an aggregate of the funding in the four countries. Given the central conclusions in the article about the comparability between the NHS in the UK and Kaiser Permanente, it would be important for the NHS funding and population figures to clearly relate to one of the countries alone or the United Kingdom as a whole and for the NHS expenditure figure to be analogous to the services covered by Kaiser Permanente.

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- 2 Electronic responses to Getting more for their dollar. *bmj.com* 2002. (<http://bmj.com/cgi/eletters/324/7330/135> (accessed 21 May 2002).

Length of stay is not the problem

EDITOR—Some readers of the article by Feachem et al have assumed that the NHS has three times Kaiser Permanente's hospital days per head because the average length of stay is that much higher.^{1 2} Explanations have occurred to readers, such as bed blocking because of poor social service care for recuperating patients, weak coordination of services in hospital, weak clinical practices, lack of emphasis on getting patients out quickly, etc.

Some validity to all of these inefficiencies is likely, but let's not jump ahead of the data. Feachem et al's table 3 shows length of stay of five days for NHS and four days for Kaiser. That's 20% more, not 200% more than Kaiser. Before assuming that the NHS must change to emulate Kaiser, let's recall recent American outrage at "drive by delivery" of babies and the legislation it provoked. Reduction of length of stay can be pushed to politically unacceptable extremes, even in the United States. Additionally, the push to limit length of stay can turn out to be an accounting misconception, if either costs of care migrate from inpatient to outpatient or that last day turns out not to cost much to provide, with minimal actual resource savings when it is eliminated.

The big difference between the two systems is not in length of stay but in admissions per head. Although the NHS may be admitting patients that Kaiser would treat on an outpatient basis, this cannot explain the huge gap. Almost certainly, Kaiser's population is much less sick than the NHS's. Indigent and trauma cases in the United States go to the county funded public hospitals, not to Kaiser. One suspects that Kaiser, acting in its own competitive interests, structures its benefit offering to elderly people to attract the healthiest and deter those who are likely to need hospitalisation. This may be true of employees, too, since employers offer them multiple health options with different premiums and copayments, and the Kaiser package may be designed not to appeal to people with known illness. Finally,

given the intensity of health resources devoted to dying people, it would help to have a comparison of death rates in the Kaiser membership to compare with the United Kingdom's death rate.

If the health of the populations is as different as the admission rates suggest, then Feachem et al's conclusion may be invalid. Some of Kaiser's techniques may still be worth adopting in the NHS. But the despondency felt in Britain on hearing that the poor old NHS is not even efficient may be quite unwarranted.

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Summary of responses

The paper comparing the NHS with California's Kaiser Permanente, a not for profit health maintenance organisation, concluded that Kaiser delivered substantially better care to its patients while spending no more per head than the NHS.¹ It and its accompanying commentaries provoked an immediate and emotional response: we received 75 letters, 50 within a week of publication.²

Readers were outraged, puzzled, dismissive, disbelieving, even despairing. The outrage was levelled in equal measure against the investigators, for believing their own data, and the *BMJ* for publishing it. Respondents criticised the methods, the conclusions, and the solutions offered by commentators. They picked up flaws in the analysis, and some took a sledgehammer to the whole exercise. A few offered explanations for the apparent superiority of Kaiser; fewer still offered solutions for the NHS.

Respondents divided roughly into two camps: those who believed the data (27) and those who didn't (48). Comments came in from general practitioners, specialists, nurses, economists, health policy analysts, epidemiologists, government advisers, and even a risk analyst. Sadly, there were none at all from patients. Most worked in the United Kingdom, but a substantial minority were Americans. There were hardly any responses from Europe. Perhaps the *BMJ*'s European readers don't see a fist fight between two failing ideologies as anything to do with them.

Several themes emerged from the paper's critics.

Firstly, adjustments made to the data were misleading, even wrong. The authors compared health care costs per head of population in the two systems and concluded that they were roughly the same. This result emerged only after several adjustments to the crude data.

Most controversial was an adjustment for the higher cost of drugs, staff, and services in the United States. In other words,

the authors compared Kaiser's operating spend with how much the NHS would spend if it were operating in the United States. Which it isn't. So was the adjustment of "purchasing power parity" legitimate? At least 20 respondents thought not, referring to the adjustment as "sleight of hand," "bizarre," "outrageous," "a serious flaw," "a fudge factor," and "a politically motivated abuse of statistics." The same respondents also criticised the currency conversion rate, the fact that Kaiser's profits were excluded from the analysis, and the adjustments made for differences between the two populations. Hardly a single assumption remained unchallenged.

Secondly, respondents were dismayed by the authors' attempts to compare two such different systems serving two such different populations. For example, the NHS treats everyone, Kaiser treats only those that can pay its premiums (or can persuade the government to pay them). The NHS pays for health professionals' training and funds departments of public health, Kaiser does not. The authors made adjustments to account for these differences, and for differences between the Californian and British populations, but responders had no faith in them.

Thirdly, respondents questioned the real world value of the data on quality. The authors studied a range of quality indicators including waiting times, uptake of vaccinations, and cancer screening. But where was the patient's voice in all this? To paraphrase a handful of letters: Kaiser employs vastly more doctors than the NHS, and pays them nearly double what they are paid by the NHS. There's no evidence in this paper that Kaiser's service is proportionately better for patients. It's equally likely that the NHS is simply more efficient, delivering reasonable care at a lower cost.

In the end, 46 letters comprehensively dismantled the authors' analysis, and with it their conclusions. The details of the analysis can surely be defended (and have been) but the message implicit in many of these letters is that the authors and commentators let their ideology cloud their judgment. The same charge, of course, could be made against the paper's critics. The data are not robust enough to resolve the argument either way.

The 27 respondents who believed the data offered a variety of explanations for Kaiser's superiority. About a third mentioned that Kaiser Permanente had more of everything: more beds, more doctors, more nurses, more nurse practitioners, and better information technology than the NHS. About a sixth were also impressed by the integration of primary and secondary care. All these things, they thought, helped explain why Kaiser's patients in California spend so much less time in hospital than do patients in the NHS. Table 3 in the paper shows that Kaiser's patients occupy 270 bed days per 1000 population per year.¹ The average for the NHS is almost four times

higher (1000 bed days per 1000 population per year).

At least three letters complained that the NHS suffered badly from political interference, noting that 30 years of costly reorganisation has achieved little, if anything, for patients.

In general, the letters were more critical of Kaiser than the NHS. Many respondents simply did not believe that Kaiser could have so many more resources at its disposal, pay its specialists more than twice as much as NHS consultants, and still achieve similar per capita costs to the NHS. What about the "indigent poor," they asked. What about the 24% of Californians without insurance? What about people with chronic mental illnesses? What about long term care? They concluded that Kaiser's patients must be richer, younger, and healthier than NHS patients.

The fiercest criticism came from a British nurse working for Kaiser in California. She complained of faceless insurance companies treating private "customers" as a resource and state funded "customers" as second class citizens. Others with first hand experience of insurance based health care included a medical social worker for Kaiser and a resident in emergency medicine from Providence, Rhode Island. Both wrote that Kaiser's results are not typical in a healthcare system that serves so many vulnerable groups so badly. One warned: "If your system serves the underclass, be proud of it."

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¹ Feachem RGA, Sekhri NK, White KL. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente [with commentaries by J Dixon, DM Berwick, AC Enthoven]. *BMJ* 2002;324:135-43. (19 January.)
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"Boutique medicine" in the US

Doctors' groups must rally to preserve the US public's health

EDITOR—In Charatan's news piece on "boutique medicine" in the United States he sketched out a problem that is a symptom of a healthcare system in trouble.¹ As a medical writer and observer of American health care, I would say that the problem is even more worrying than Charatan described. Now we have a system that is faltering not only for the uninsured and underinsured but for the fully insured too. I worry that this problem might go unrecognised unless research and advocacy embarrass Congress to intervene.

Recently, a fully insured friend of mine was referred for a cardiology consultation. When he arrived at the doctor's surgery for a stress test he was told that the practice no longer took his insurance. He had his examination, as one last favour from the doctor, who warned him that he would not see him again. And the phenomenon is worsening: I suspect that an unknown number of insured people are getting referrals only to learn

that there is nowhere to go. Continuity of care and follow up ought to be examined rigorously.

Charatan points out that the rise of boutique medicine means that more doctors can cream from the top, picking those who pay the most. Unsettling questions remain: are American doctors and insurers in their silence building a system that is eroding the public's health? In the past, doctors' leaders and researchers have waged a successful battle in the United States to allow specialty referrals, taking their battle to the press, Capitol Hill, and state legislatures. But they have become eerily quiet on this issue. It is high time for those claiming interest in the public's health to publicise the situation and document the harm.

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¹ Charatan F. US "boutique medicine" could threaten care for the majority. *BMJ* 2002;324:187. (26 January.)

Doctors are more interested in having high incomes than providing better health care

EDITOR—Charatan's news item about the rise in "boutique medicine" in the United States is more amusing than alarming.¹ Like the United Kingdom—but unlike Canada and much of continental Europe—the United States accords its upper income classes economic, legal, and social privileges that are distinct from those accorded the rest of society. Boutique medicine is merely a part of this class based social order.

By the standards of the United States's so called system of justice, or of its system of education, the egalitarian standards observed by its healthcare system are exemplary, with or without boutique medicine. There is not much equality before the American bar. And does any American sincerely believe that a child in low income Trenton, New Jersey, has anywhere near the educational and career opportunities enjoyed by a child in nearby upper income Princeton, New Jersey?

People in Canada or continental Europe would find these class based human services systems appalling on ethical grounds. Alas, for the poor, they are normal in the United States and, it seems to me, in the United Kingdom too. To allow doctors to work in both the NHS and the private sector, and to shift patients between the two sectors, is boutique medicine raised to a higher order. Fortunately, the United Kingdom's health system does at least provide universal health insurance coverage for the lower income classes.

Boutique medicine is not the culprit behind the rising numbers of uninsured Americans. The main culprit is a politically powerful healthcare delivery system that assumes that a relatively unregulated world with millions of uninsured families is more profitable to the supply side than a world with universal coverage but heavier government involvement in controlling health

spending. According to the latest data from the Organisation for Economic Cooperation and Development, in the United States doctors earn an average of 5.5 times the average wage. The comparable ratios for Canada and the United Kingdom are 3.2 and 1.4, respectively. Naturally, these low ratios in government dominated health systems scare American doctors.

Boutique medicine in the United States can be interpreted as a desperate attempt by some doctors to keep the income ratio at 5.5 or above; it is unlikely to be a genuine attempt to provide patients with health care of a higher quality. If quality of care was doctors' main concern there is so much they could do.

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Booked inpatient admissions and hospital capacity

Mathematical model misses the point

EDITOR—Gallivan et al report a mathematical model of variability of length of stay in an intensive care unit after cardiac surgery.¹ The programmes of the NHS modernisation agency use quality improvement methods adapted to health care in England.² The cornerstones of the approach are patient centredness; mapping the whole process; analysis of true demand and capacity; and redesign through innovation, experimentation, and incremental implementation. The methods are underpinned by the science of complex adaptive systems.³ The NHS is the epitome of a complex adaptive system.

Data on the variability of length of stay are valuable but reflect activity, not demand. Activity is limited by capacity throughout the process. Gallivan et al assumed that length of stay was an independent variable, but length of stay in cardiac intensive care will be affected by a patient's clinical condition and the availability of beds for care afterwards. The dependency of other patients may affect the care given and influence length of stay. Gallivan et al assumed that the patient population is homogeneous whereas patients belong to differing groups depending on surgical procedure and comorbidity.

Analysing variables that might help predict length of stay may be helpful—for example, age, comorbidity, or cardiac function. Scoring systems used by cardiac surgeons to predict mortality include Parsonnet, EUROscore, and Bayes's theorem and might also predict length of stay in intensive care so that the booked dates of patients with longer stays can be staggered and variations in demand reduced or anticipated.

Gallivan et al argued that substantial spare capacity is essential. But simply

increasing the number of critical care beds would not resolve the complex issues related to capacity and demand.⁴ Small isolated units require more spare capacity to cope with variability in demand. This can be resolved by creating larger virtual units, a cooperative approach with surrounding intensive care units, flexible use of extended recovery, intensive care, high dependency beds ("critical care without walls").

Booking is one element of a systematic approach to access redesign.⁵ It is essential because for patients, after waiting times, the ability to choose the date or time of their appointments or admissions is very important. Some headroom is required to allow for unexpected variation in demand, but, even in emergency care, there is evidence that profiles of demand are more predictable than was previously assumed. Using analysis to predict demand can enable us to run with much higher levels of occupancy than this study would suggest, especially in the booked elective surgery pathway.

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Variability must be managed to reduce waiting times and improve care

EDITOR—In their article on booked inpatient admissions and hospital capacity Gallivan et al conclude that the greater the variability in cycle time the less efficient the system: either more resources are required or longer queues will develop.¹ They assume that variability is inevitable because it has occurred in the past.

The NHS has learnt much from the experience of NHS Direct. When NHS Direct was first implemented callers experienced long delays and inconsistent service. The system has since greatly improved: both the cycle time at the first point of contact and variability were reduced. This created better "service scripting," which standardised the length of calls. These improvements show that variability in health care can be successfully reduced. In this example, systems were introduced to reduce variability rather than increase resources to deal with the problem. We must identify how variability can be managed in other healthcare settings.

Several factors influence variability. The article assumes that patients and their length of stay are homogeneous. This is not so. Consultant surgeons manage a mix of patients on their list by predicting the time for each operation on the basis of their experience. Thus different operations have different potential for variability. Longer lengths of stay can also be predicted by assessing a range of factors such as comorbidity, smoking habit, and general mobility. Thus patients are grouped according to their predicted potential variability.

Poor standardisation or knowledge of procedures, poor coordination between departments, and even quality failures, such as cross infection, contribute to variability. If these factors are effectively managed variability will be reduced. It is not inevitable; it is caused by the system.

The airline industry is an unfortunate choice of model for booking in advance without problems. Airlines pursue "yield management" practices that guarantee full planes where demand is sufficiently high. They deliberately overbook flights on the assumption that some passengers will not arrive, offering compensation to passengers who are turned away. Consequently, their cancellation rate greatly exceeds that for hospital operations.

Modern operations management techniques are powerful methods to improve performance in health care. The "ideal design of emergency access" (IDEA) programme is testing how these techniques can be applied across emergency care, where variability is high and long waiting times result. New ways of working that will reduce variability and consequently reduce waiting times are being developed.

Variability is unquestionably a problem, but we believe it can be managed effectively to reduce waiting times and improve care for patients in the NHS.

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Education does not explain association between income inequality and health

EDITOR—Muller has shown in an ecological study that lack of high school education accounts for the association of income inequality with mortality at state level in the United States.¹ The implicit inference is that education at the level of the individual is

Odds ratios (95% confidence intervals) fair to poor self rated health by fifth of state income inequality with and without adjustment for income and education

Fifth of inequality	Adjusted for age and income	Adjusted for age, income, and education
White men (n=59 341)		
High	1.22 (1.00 to 1.50)	1.16 (0.97 to 1.39)
Medium high	1.44 (1.18 to 1.76)	1.38 (1.15 to 1.65)
Medium	1.25 (1.02 to 1.54)	1.20 (0.99 to 1.45)
Medium low	0.99 (0.79 to 1.25)	0.98 (0.79 to 1.22)
Low	1.00	1.00
White women (n=62 404)		
High	1.29 (1.01 to 1.64)	1.19 (0.95 to 1.48)
Medium high	1.41 (1.12 to 1.78)	1.34 (1.08 to 1.65)
Medium	1.40 (1.09 to 1.78)	1.33 (1.07 to 1.66)
Medium low	1.11 (0.86 to 1.45)	1.11 (0.87 to 1.41)
Low	1.00	1.00

responsible for the association with inequality of income.

But ecological studies are weak study designs to assess the independent associations of ecological (income inequality) and individual level (education) variables with an individual level outcome (health status). In particular, aggregate data are prone to problems of collinearity, rendering it difficult to tease apart independent effects. Multilevel study designs overcome this limitation by including data at both individual and ecological levels.^{2,3}

We have previously reported results for the association of income inequality at state level with self rated health using data from the current population survey data.^{4,5} We have not previously reported the effect of controlling for education at individual level among adults in the 1995 and 1997 survey as shown in the table. Controlling for education attenuated but did not completely explain the relation between levels of state income inequality and self rated health. Our results do not support the contention that education at the individual level fully confounds or mediates the association of income inequality with health. The remaining portion of the income inequality association may be due to contextual effects (for example, average educational attainment, or historical and political features that vary by state in the United States) or other individual level characteristics such as lifestyle.

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Excess winter mortality

Method of calculating mortality attributed to influenza is disputed

EDITOR—We challenge the method that Donaldson and Keatinge used to calculate mortality due to influenza.¹ Data covering the period 1970-99 were used, but the authors state that the regression analysis started on 1 January 1990. On the basis of the 10 year analysis, they estimate an average of 1265 per million excess winter deaths from all causes, equivalent to 67 000 nationally in England and Wales. They say that 2.4% of this excess (equivalent to a national average of 1620 deaths per year) is attributable to influenza. This estimate contrasts with those obtained by other groups: Tillett et al estimated an annual average of 12 000 deaths (1968-9 to 1977-8)², Nicholson 13 800 (1975-6 to 1989-90)³, and Fleming 12 500 (1989-90 to 1998-9).⁴ The estimate of 12 500 is equivalent to 19% of the 67 000 total excess winter deaths, rather than 2.4%.

Donaldson and Keatinge estimated total deaths attributable to influenza from deaths certified as due to influenza. They presumably used deaths allocated to influenza as the primary cause of death according to the national protocol for allocating deaths by cause. Several points are relevant.

Firstly, the attribution of deaths from influenza varied considerably over the 30 years reported. Furthermore, the coding of mortality by primary cause involved procedural changes in 1984 and 1993, such that the numbers of deaths allocated to respiratory causes between these years were roughly half those before 1984 and after 1993.⁵

Secondly, the data are based on south east England, but this area and population size are not defined. The 10 year average of 5.1 deaths per million equates to 50 deaths a year (distributed over 365 days) in a 10 million population. The authors indicate that 143 deaths per million were registered as due to influenza in 1976, 30 times their estimate of the annual average; a difference so large as to question the credibility of the methods used to estimate the average.

We do not accept that the number of deaths attributed to influenza provides a

reliable indication of the extent of deaths related to influenza. Mortality from influenza needs to be examined in relation to virus circulation, the epidemic periods in which it is circulating, and the impact on all-cause mortality.

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Authors' reply

EDITOR—Influenza epidemics usually occur in particularly cold weather. The key difference between our analysis and the usual assessments of mortality attributable to influenza is that ours makes allowance for the excess deaths that would have been caused, in the absence of an influenza epidemic, by low daily temperatures.

Deaths from influenza were extracted before 1979 as ICD-8 codes 470-474 and thereafter as ICD-9 code 487; allowance was made for changes in coding instructions outside 1984-92 by using the specific conversion factor 0.997 for influenza,¹ not the larger adjustment for the broad category of respiratory deaths mentioned by Fleming et al. Fleming et al ask what we define as south east England. It comprises Greater London, Hertfordshire, Essex, Kent, Sussex, Hampshire, Surrey, Berkshire, Oxfordshire, Buckinghamshire, and Bedfordshire.

Yes, the regression analysis started from 1970, although we focused on results since 1990. We used deaths certified as primarily due to influenza as the explanatory variable in the regression to calculate total deaths related to influenza. A theoretical alternative is to use the prevalence of influenza. Viral sampling is important, but we could find no systematic daily measurement of that in the whole population throughout the last 30 years. It would in any case be difficult to allow for different lethality of different strains of influenza and for different sensitivities and immunities of particular age groups to them. Variation with time in the tendency to certify doubtful deaths as being due to influenza might produce some error in our analysis, but hardly one large enough to affect our conclusion. This was that deaths related to influenza over the past 10 years

accounted for only a small fraction of total mortality related to cold.

A check for any major error can be made by seeing whether our estimated rise in mortality related to influenza in an epidemic year corresponds with the rise in total excess winter mortality that year. Our paper shows that it did, most clearly in the major epidemic year 1976. Both mortalities increased by a similar amount that year, compared with the preceding and following years. This is consistent with deaths related to influenza being at or near the number we calculated and not at the higher figures sometimes suggested previously. It is, we think, common ground that before 1970 epidemics of influenza were more frequent and more lethal than they are now.

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1 Office of Population Censuses and Surveys. *Mortality statistics: cause*. London: OPCS, 1996: table 4. (Series DH2 No 11)

Measures to reduce smoking in films should penalise film and tobacco industries

EDITOR—By looking at adolescents Sargent et al studied the effect that seeing tobacco use in films had on their trying smoking.¹ So many issues are not accounted for in this study that to base sweeping legislative proposals on its findings would be unwise.

For one thing, the correlation that the authors found may operate in reverse (that is, teenage smokers are more likely than non-smokers to favour a variety of passive or thrill seeking behaviours, of which greater patronage of films depicting heavy smoking is only one). In addition, this behaviour is mediated by more important variables (older and poorer youths both smoke more and have attended more of the types of films in which smoking is prevalent).

Evidence for this counter-hypothesis is seen in the study's finding that the odds ratio for smoking in the youths most exposed to films dropped dramatically, from 8.8 to 2.7, when selected sociopersonal variables were controlled for. This suggests that entering additional sociopersonal variables would further reduce or negate the findings.

Importantly, even though an overly broad measure (ever tried smoking) was used, two thirds of youths exposed to even the heaviest depictions of smoking did not try cigarettes once. The authors acknowledge that their findings are preliminary and do not show that films cause smoking by teenagers.

The findings do not justify the proposal by Dr Stanton Glantz and lobby groups such as Action on Smoking and Health for legal restrictions to stop youths watching films depicting smoking. Setting age limits for such films is too severe a curtailment of

young people's basic right to participate in their culture.

Unfortunately, quick fix censorship and schemes setting age limits typically grab American policymakers' attention while proving woefully ineffectual and distracting from effective, politically difficult measures. Most teenagers who smoke come from families and communities in which adults smoke, and the most effective policies to curtail smoking necessitate raising tobacco taxes and restricting smoking by adults.

Dr Glantz has been a rare voice of reason in the otherwise dismal debate on tobacco in the United States, and his concern over the relation between film makers and the promotion of tobacco products is well founded. But I ask that he reconsider the notion of punishing adolescents en masse by restricting them from attending films and, instead, propose measures that directly and exclusively penalise the film and tobacco industries at fault.

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1 Sargent JD, Beach ML, Dalton MA, Mott LA, Tickle JJ, Ahrens MB, et al. Effect of seeing tobacco use in films on trying smoking among adolescents: cross sectional study. *BMJ* 2001;323:1394-7. (15 December)

Medicine compliance aids are partial solution, not panacea

EDITOR—With reference to the news article by MacDonald on prescription charges for elderly people,¹ multicompartiment compliance aids are widely regarded as a panacea for people living at home who have problems with their medicines. Their use is, however, not evidence based, with practice largely based on the needs of professionals and carers, rather than the patients themselves. The response to moves to charge for the supply of such aids has largely been based on the assumption that they are always a good thing.

Our research, based on a survey of practice in Leeds, implies that there may be more than 100 000 people in Britain whose medicines are supplied in such aids.² General practitioners and hospital staff are the most likely to request the use of an aid, which is usually given without an assessment of the individual patient's needs in terms of medicine management. Such needs depend on the patient's motivation, type of medicine regimen, and physical and cognitive ability.

The first step should be to try to simplify the medicine regimen. If that is not sufficient, then a reminder chart may be tried. If a compliance aid is then deemed appropriate, the device chosen should itself match the abilities of the patient - different aids require varying manipulative skills. Such an approach, now endorsed by the national service framework for older people, seems not to be common practice.³ Compliance aids should not be used lightly. They take away a key link between the patient and

their medicines, which become just a jumble of tablets and capsules.

We found that, on a subjective assessment, around 50% of the patients interviewed would be able to manage with their medicines in conventional bottles. The main need that many of these patients expressed was to be able to see if they had taken that day's dose. This could be done with a much simpler daily device which the patient fills each morning.

There is a role for compliance aids for the other 50% of patients who cannot cope with ordinary bottles and community pharmacists could provide a valuable service based around supply of these aids. Reducing by half the number of aids supplied, through proper assessment of need, would make funding more achievable for the NHS, as well as meeting the needs of this vulnerable group of patients better.

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Health policies on drug dependence must be based on scientific evidence

EDITOR—Scientific evidence on the effectiveness of interventions for drug dependence is increasingly available and should be used to inform policies. Differences between the approaches of the Netherlands and Italy lead us to doubt that this is happening.

Dutch investigators have recently recommended the prescription of heroin to addicts on the basis of two randomised controlled trials.¹ The European Monitoring Centre for Drugs and Drug Addiction (the European Union's drug agency) recently stated that "substitution treatment is a key component of a comprehensive approach to drug treatment and can be effective in reducing the risks of HIV infection, overdose, use of legal and illegal drugs and drug-related crime" (policy briefing No 1/2002).

Recently the Italian government announced a major shift in policy on drug dependence, rejecting harm reduction strategies. The resolution approved by one branch of the Italian parliament states that "the use of methadone and other substitution treatments should be confined within the restrictions of the law; it has to be limited to three months, it has to be linked to a rehabilitation project and it has to be used with low dosages."

The Italian government states that "too many" patients of public treatment services receive methadone treatment. The opposite is actually true, as under 50% of the 140 000

people who entered public treatment centres in Italy in 2000 were offered methadone treatment and under 30% on a maintenance basis, the average maximum dose being well below the effective dose.² We believe that the problem is the inappropriate use of methadone treatment rather than its excessive use.

Heroin use in Italy is still a big issue. The estimated prevalence of problem drug use in 1999-2000 and prevalence of HIV infection among drug users are the highest in the European Union³; mortality in heroin addicts is high, particularly among women.⁴

In the United States in July 1998 Mayor Rudolph Giuliani of New York City introduced a programme requiring the 2100 patients in methadone maintenance programmes in selected clinics to stop using methadone within 90 days. Seven months of debate and controversy ensued. In January 1999 the mayor announced that his programme had been inadequately conceptualised, was not realistic, and was being withdrawn.⁵ More recent political declarations have confirmed the intention of banning methadone and harm reduction strategies, but no official steps have yet been taken.

We hope that a proper scientific discussion on this issue will prevent politicians from counteracting scientific evidence and interfering with clinical decisions.

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Competing interests: AL is an employee of the Università di Modena e Reggio Emilia, Modena, Italy. His views do not imply that the Cochrane Collaboration has an official position on the issues discussed in this letter.

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Being a child of donor insemination

Organisations are committed to increasing available information

EDITOR—The anonymous personal view shows how isolating secrecy in donor assisted conception can be and why every step should be taken to stop the practice of donor anonymity, as has already occurred in several countries.¹

My main purpose in writing is to comment on the statement that "the few studies that have looked at us [donor conceived children] have used only parental interpretations of our emotional state." This is largely true if the search for research is confined to the standard sources, such as *Human Reproduction and Fertility and Sterility* (although *Human Reproduction* has published one research paper that has directly sought the views of donor conceived people themselves²).³ A few other studies have sought the experiences of donor conceived people directly but have not been published (G Hewitt, unpublished paper, Sydney, 2001; L W Spencer, unpublished MA thesis, Detroit, 2000).

Interestingly, all of the studies of which I am aware have been undertaken by donor conceived adults. I am currently undertaking some research into the experiences of family members (adults and children) when donor conception has been used.

Montuschi has written a letter [below] on behalf of the support group Donor Conception Network. There are two similar groups, the Infertility Network (in Canada) and the Donor Conception Support Group (in Australia), which are committed to increasing the information available in donor assisted conception and seeking to abolish donor anonymity. DonorsOffspring.com is a website for people who have been conceived with donor assisted conception (email greg@donorsoffspring.com).

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1 How it feels to be a child of donor insemination. *BMJ* 2002;324:797. (30 March.) [Full version at bmj.com/cgi/content/full/324/7340/797/DC1.]

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Donor Conception Network always advises openness

EDITOR—I am the mother of two teenagers who were conceived by donor insemination and who, like the young woman who wrote the personal view, will never know the identity of their fathers or be able to get further information about them.¹ What is different for them, however, is that their father and I started to tell them about their origins when they were very small and they have been able to discuss them with the family ever since. What terrible mixed messages the author of the article has been getting from her family. How could she not have felt guilty and very alone with her secret?

Our own children, by contrast, are comfortable talking with anyone about their origins. One of them would like more information about her donor; the other, a young man of 18, cares only that he was brought up in a family that respected him enough to be truthful.

The Donor Conception Network, of which I am a founder member, exists to promote openness in families created through

donated gametes and to support parents in sharing information with their children in ways appropriate to their age. We recognise that this is a lifelong process, which is best started at an age when children will not be able to remember when they did not know. The network can be contacted on 0208 245 4369, dcnetwork@appleonline.net, or www.dcnetwork.org

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1 How it feels to be a child of donor insemination. *BMJ* 2002;324:797. (30 March.) [Full version at bmj.com/cgi/content/full/324/7340/797/DC1.]

Consultation is in progress about whether to persist with donor anonymity

EDITOR—I found the article on how it feels to be a child of donor insemination extremely moving.¹ I am sad that a person who was raised with the knowledge of her conception should still have so many problems about the fact that she doesn't have information about the donor.

I am a single parent of a 4 year old daughter conceived by donor insemination, and I have told her about her origins in a way that she can understand. Although I am concerned about how she will feel about this when she is older, I believe that because I have provided her with the opportunity to grow up knowing other children conceived in the same way she will not feel so isolated. I am a member of the Donor Conception Network, which exists to provide support to families with children conceived with donated gametes, and those contemplating and undergoing treatment.

Donor anonymity and access to information may change for children in the future, and the Department of Health has opened consultation about access to information on their origins for those conceived with donated gametes. The consultation period runs until 1 July 2002, and details about how members of the public can respond can be found at www.doh.gov.uk/gametedonors.

Many single women seeking donor insemination are now choosing to have sperm imported to their clinic from the United States so that they and the child may have more information about the donor; with an identity release donor the child may have the opportunity to meet him at the age of 18.

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1 How it feels to be a child of donor insemination. *BMJ* 2002;324:797. (30 March.) [Full version at bmj.com/cgi/content/full/324/7340/797/DC1.]



Rapid responses

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