

Rationing in action

EDITOR,—The *BMJ* recently sent me a copy of *Rationing in Action*.¹ At the conference that gave rise to the book I said that the health service is having to address the problems outlined in the book every day, as indeed it has had to since it was founded. We at the centre are helping to inform and when necessary steer the debate, and we welcome the continued input of academics, the medical profession, managers, and the public.

As everyone is covered by a universal and freely available health service the problem is one of setting priorities rather than sharing out resources. The pressures on health care will bring many of the issues further to the fore in the next few years: demographic pressures, improved medical technology, new types of treatment, and recognition of the rights of patients will all lead to greater pressure on resources and mean that the health service will need to be more flexible.

In my speech at the conference I emphasised that the government has a legitimate role in setting a strategy for health care. This inevitably leads to priority setting, to ensure a fair distribution of what is available. However, we can set only the framework in which local decisions are made: clinicians and managers must determine the health needs of local populations and how they are best met. These decisions are given legitimacy only when the views of patients and local needs are taken into account. Health professionals determine jointly with each patient his or her health needs and, in doing so, must make clinical decisions on the relative priority to be accorded to each patient. Thus it is essential that purchasers consult the public about planning and priorities, as well as general practitioners discussing treatment options with patients.

The government's role in this is to set the strategic and regulatory framework for providing health care, monitor the provision of care, provide information on clinical effectiveness, and ensure that decisions are made properly and fairly and take into account the needs and views of the population served. It is not the government's role to lay down local priorities or make local decisions; local purchasers and local providers of health care are best placed to do that.

The centre plays an important part in setting priorities. It must ensure that information about effectiveness is widely disseminated among purchasers and providers of health care. We have been carrying forward the important work, mentioned in my speech, on outcomes and effectiveness, and the information that emerges from this will enable health professions and those responsible for purchasing health care to order priorities on the basis of properly researched and validated evidence.

We have moved a long way towards ensuring that priorities are set on the basis of sound evidence about the effectiveness of interventions. In the book Ham discusses a range of approaches being taken in six districts.¹ All purchasers are having to consider how they determine local priorities. The fact that different approaches are used suggests that there is no place for national setting of local priorities when the determination of local needs is elusive, even to people living in the district.

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Setting priorities at almost any level is never straightforward. Klein points out that there is no "set of principles or techniques that will make our decisions for us" and that the best we can do in a changing environment is to make the process of setting priorities more rational.¹ Through our analyses of purchasing plans and the activity of purchasers we continue to monitor the way that this process is being developed at local level.

This is an important debate and is being held at all levels of the health service. *Rationing in Action* shows the wide range of opinion on setting priorities and rationing; by doing so it makes a valuable contribution.

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1 *Rationing in action*. London: BMJ Publishing Group, 1993.

Long term management after splenectomy

A national problem

EDITOR,—We wish to respond to the correspondence on our paper on the increased risk of sepsis after splenectomy.¹ We were saddened by Helena M Daly's letter.² We did not set out to audit individual clinicians but to identify why asplenic patients are still admitted to hospital and die with overwhelming pneumococcal sepsis. Since we submitted our data a further patient who had not received prophylaxis has died in Cornwall of pneumococcal sepsis. The data from Paul Kinnersley and colleagues³ and Sheena Reilly and colleagues⁴ confirm that this is a national problem. Our statement that "we do not know what advice—if any—they had been given" clearly referred to the six patients who died of pneumococcal sepsis. None of these patients were under Daly's care.

The initiative taken by Peter Baddeley and colleagues⁴ is welcome. Reilly and colleagues,⁴ R P D Cooke and colleagues,³ Peter J Flegg,⁴ and M Makris and colleagues⁴ all highlight important issues. In particular, Makris and colleagues draw attention to the uncertainty surrounding the use of prophylactic antibiotics. We acknowledged this in our paper but have elected to use prophylactic antibiotics until evidence from trials indicates that we should not. We think that the approach adopted by Makris and colleagues is equally valid. Our own policy, therefore, is to offer patients vaccination against pneumococcal, meningococcal, and *Haemophilus influenzae* infections. We believe that children should receive continuing antibiotic prophylaxis with penicillin, erythro-

mycin, or amoxycillin, while adults should receive the same for at least two years postoperatively. Selected "immunocompromised" groups of adults should also continue antibiotics for the rest of their lives. Educating patients about the risks that they face is the most important issue of all, and patients should have antibiotics at home to take in the event of infection.

We reiterate the need to establish protocols that clearly identify responsibilities for ensuring that all patients receive appropriate management. All patients already at risk who have not yet been identified need to be actively sought.

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- 1 Deodhar HA, Marshall RJ, Barnes JN. Increased risk of sepsis after splenectomy. *BMJ* 1993;307:1408-9. (27 November.)
- 2 Daly HM. Pneumococcal vaccine and splenectomy. *BMJ* 1993; 307:1561. (11 December.)
- 3 Kinnersley P, Wilkinson CE, Srinivasin J. Pneumococcal vaccination after splenectomy: survey of hospital and primary care records. *BMJ* 1993;307:1378-9. (27 November.)
- 4 Correspondence. Long term management after splenectomy. *BMJ* 1994;308:131. (8 January.)

Monitor antibody levels after vaccination

EDITOR,—The role of the spleen in protecting against overwhelming sepsis due to encapsulated bacteria has long been established, and animal studies have shown the importance of the spleen in clearing organisms that have been opsonised by complement.¹ In animals that have undergone splenectomy the fixed macrophages of the liver take over this function, but high levels of specific capsular antibodies are required to facilitate hepatic clearance.² Vaccination in patients who have undergone splenectomy aims to maintain high specific antibody levels.

Mary McMullin and George Johnston emphasised the importance of vaccination against pneumococcus and possibly haemophilus and meningococcus in patients after splenectomy.³ They failed, however, to mention measurement of specific antibody levels after vaccination, which would show whether the patients have responded to immunisation. Since pneumococcal antibody levels may decline rapidly in some high risk groups it seems prudent to continue to monitor these antibody responses. We believe that some patients may need reimmunisation earlier than the recommended five years.

In our experience revaccination with pneumococcal vaccine may be associated with adverse effects: immunisation of 16 healthy adult volunteers resulted in erythema and pain at the site of the vaccination in three and an illness similar to serum sickness which lasted three days in one. Subsequently it was shown that the latter volunteer had had high pneumococcal antibody levels before vaccination. Measurement of specific antibody levels at least once a year would help to determine the most appropriate time for vaccination or revaccination.⁴

Measurement of specific antibody concentrations, though useful, does not give a true indication of the functional capacity of these