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 accepted 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 evaluation 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. We were not fully to evaluate the process and produce 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 Wilkins LT. Comment on terminology: Heinebaum. London. 1994:130-1

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. We were not joined by the issue but learned from it as a basis of the policy. The health care available in Zaire is 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 other treatment failures with benzylpenicillin and chloramphenicol. The hospital does not pay for postoperative rhabdies vaccination, and until recently diabetic patients needing insulin were discharged home if they could not pay for their treatment. 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 groups who feel inadequate in by helping to maintain effort and we can help them achieve the best possible healthcare provision for the greatest number of people in any given situation.

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Responsibility for social care needs to be considered

EDITOR.—The article by the Rationing Agenda Group is a thought-provoking and comprehensive. 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, I believe that the perceived impetus for 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 partner homes or day care or as intensive social support for some ex-users of NHS beds for any of the above reasons we risk having to purchase far more expensive care—for example, for inpatients, as extracutural referrals, or privately. We therefore pay for such services knowing that they are predominantly social but being aware that we cannot unilaterally extract them from doing so either on moral or ethical grounds (causing 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 such practical problems must be faced by any group caring for such cross-cutting problems. 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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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, based on 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.

Similarly, this guideline 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,