CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Enough is enough

SIR,—Over the past few weeks your columns have voiced the increasing concern of the medical profession about the impact of industrial action by the health unions on the care and treatment of patients. This is only right. Less than fair is the suggestion—for example, in the leading article "Enough is enough" (11 September, p 669)—that the failure to resolve the dispute can be put down to inflexibility on the part of Government as well as the unions.

The Government have revised the pay offers to Health Service staff three times since the first announcement of a pay factor of 4% for the public sector as a whole. The first improvement provided a differential in favour of nurses and certain other groups of staff. Then after the settlements of around 6% to civil servants and teachers after arbitration, and to doctors and dentists and the armed Forces after the Review Body reports, the Government offered increases averaging 6% to 7½%. Finally, in a further attempt to break the deadlock last month we made proposals for a two-year settlement to pave the way for the introduction of new arrangements for the determination of Health Service pay by 1 April 1984.

The Royal College of Nursing and other bodies representing professional staff responded to our invitation to talk about these proposals. In contrast, the Health Service unions affiliated to the TUC have refused even to meet ministers to discuss them, even though the proposals were carefully prepared after close consultation with the chairman and secretary of the Health Services Committee. Instead, they decided to continue with industrial action in support of pay increases of 12% and other improvements, making a total claim of 20%. While the Government have moved three times to find a resolution of this dispute they have refused to budge from this claim.

The responsibility for continuing industrial action and consequent risks to patients rests firmly on the trade unions. We made it clear right at the outset of this dispute that industrial action in the Health Service is bound to hurt patients. We want to settle the dispute, discuss better arrangements for determining pay, and take forward our initiatives to improve the management of the resources available to the National Health Service. The way forward is for the unions to call off their action and to respond to the proposals put to them. All those concerned with the impact of their action on patients should urge the unions to accept that this is the honourable course.

KENNETH CLARKE
Minister for Health

Department of Health and Social Security,
London SE1 6BY

Monetarism and health

SIR,—I was delighted to see your leading article on "Monetarism and health" (2 October, p 914) and to see that we are to have 12 articles on the "Essentials of health economics." But can we afford to wait so long before we achieve economic sophistication?

We have been repeatedly told by ministers that spending on the Health Service has been increased by this Government; this is true but is misleading since expenditure has not kept pace with costs and we all know that serious cuts in essential services are occurring all over the country. The Prime Minister said: "The National Health Services is safe with us"; in fact the NHS is rapidly becoming unsafe for the care of patients, and the horrifying exercise drawn up by the regional medical officer of the Oxford Regional Health Authority shows how close we are to disaster.

Governments of both colours have attempted to persuade us that the NHS is not a political issue. This is nonsense: Virchow was right when he said: "Medicine is a social science, and politics is nothing but medicine on a large scale." Politics concerns itself with the allocation of national resources, and I believe that there is now sufficient public and professional concern about the future of the Health Service to make the question of improved funding into an important electoral issue.

The immediate problem, however, is that although the dismantling of the NHS is not (or is no longer?) intended, other methods of downgrading it are still under discussion. Insurance funding is being considered in spite of the fact that other countries with this system have administrative costs (more

paperwork) far greater than those of the NHS, and governments have had even greater difficulty in controlling the total health bill than has been the case in Britain. Your leading article rightly calls attention to declining standards of care for the underprivileged which have occurred under the insurance system in America. Tax rebates for those choosing the private sector have been suggested as a way of "taking the pressure off the NHS," but this scheme would merely absolve the better-off from contributing to the NHS, thus demolishing the basis of the present system in which the rich contribute more than the poor, as one would expect in a civilised society.

At its inception the NHS embodied a number of humanitarian and compassionate ideals; many of these have been discarded or are in danger. The sick were not to be charged, and their contributions from national health insurance and taxation were regarded as a form of insurance. Visitors to this country who became ill were to be treated free. Health service workers were to treat patients to the best of their abilities and resources without any element of direct financial gain; this still survives but the temptations and distractions of the private sector increase as frustration grows. Instead, we are told that health care is subject only to the rules and ethics (if any) of the monetarists' market forces. If standards in the NHS continue to decline there is a real danger of a two-tier system, and, apart from the duplication and diversion of scarce professional and technological resources which this would entail, it is fairly certain that the middle and upper income groups would desert the NHS, thus depriving it of an articulate and influential group capable of objecting loudly to a falling quality of care.

The present industrial action by the health services' unions, though understandable, appears ill-judged as it enables the Government to stand by and watch public confidence in the hospital service ebb away, and it also diverts attention from the real cause of the trouble, which is inadequate funding of the Health Service.

It is time that the financing of the NHS was approached pragmatically and divorced from monetarist and other dogma. The truth is that despite decades of tinkering and economy drives, which have distracted the profession from any forward planning, there is simply not enough money to maintain services at an acceptable level. More money could be found by increased taxation, and I believe that this would be electorally and politically acceptable provided that the additional tax was clearly identified right from the start as being destined for a specific health services budget which would be seen to be used in an appropriate manner. It is time that urgent representations were made by the royal colleges, the British Medical Association, the professional bodies of the other health service workers, and the unions to tell the Government that the NHS is not safe. The alternative is a return to poor-law medicine.

JOHN BLACK

London SE5 8TQ

Medical unemployment

SIR,—Minerva's remarks (9 October, p 1054) concerning unemployment among medical and other university graduates indicate her lack of insight into the current situation. The University Grants Committee gives comparative figures for graduates on 31 December—in the *year of their graduation*. For medical graduates this forms part of their preregistration year, a required part of training, for which the DHSS has long regarded the universities as responsible. What an admission of failure if medical graduates could not finish their basic training.

Comparable medical unemployment can commence only from the following year, with general professional training. In a recent study that I have done and which is currently in the hands of the BMA I found that at least 10% of those graduating from Sheffield in 1980 had experienced an average of two to three months' unemployment in the first five months of general professional training (as at 1 January 1982). I have reason to believe that figures for the 1981 graduates will be even higher.

What comfort can medical graduates glean from contracts of only six months—each time wondering how difficult the next job will be to come by? Other graduates rarely have to play such repetitive musical chairs once employed. The comparison is ill-made.

JOSEPHINE A JONES

Sheffield S10 1LD

Postmenopausal osteoporosis

SIR,—In her criticism of the value and safety of female sex hormone replacement therapy for the prevention of postmenopausal osteoporosis (18 September, p 808) Dr Jean Coope rashly states that: "calcium supplements offer an alternative form of treatment which is probably safe and certainly cheaper" than sex hormone therapy. This matter is of considerable importance in these times of limited financial resources, since any programme of long-term prophylactic treatment against osteoporosis might pose an unacceptable financial burden on the National Health Service.

I would therefore like to challenge Dr Coope to publish the cost of one year's treatment with an adequate calcium supplement (that is, at least 800 mg of elemental calcium daily) and to compare this with the cost of one year's treatment with female sex hormones.

J M AITKEN

Essex County Hospital,
Colchester CO3 3NB

***We sent a copy of this letter to Dr Coope, who replies below.

SIR,—A daily intake of 800 mg of elemental calcium can be achieved by taking two tablets of effervescent calcium lactate gluconate costing £52 a year or £84 if sold directly to the customer at current retail prices. Eight ounces of whole milk or 1½ oz of cheese or one portion of yoghurt each contain 291 mg of calcium, so that a woman who consumes milk or milk products can save much of this cost. Calcium salts may be bought over the counter without a prescription, are self-administered, and need not cost the Department of Health and Social Security a penny.

Hormone therapy would cost between £17 and £44 a year for a patient who has had a hysterectomy and between £23 and £46 for a patient with an intact uterus, who should be prescribed cyclical oestrogen/progestogen. These costs are computed from prices quoted in the current issue of *MIMS* for the six most popular brands prescribed in the United Kingdom. Hormones are prescription-only drugs, and patients would have to collect their prescriptions, involving postage or the cost of travel to the surgery, and would pay prescription charges of about £5·20 a year. Pharmacists' on-cost and dispensing charges might amount to between £4 and £10 a year for each patient.

The true cost of blanket menopausal hormone therapy is far greater than the price of the tablets. Patients would need to be supervised and to have at least one initial pelvic and cardiovascular examination and a follow-up check each year. They should be seen, however briefly, by the nurse or doctor every few months to ensure that they have not developed a condition which contra-indicates therapy and that they have no serious side effects. Some women would require a currettage or endometrial biopsy for the diagnosis of abnormal bleeding. The cost of laboratory tests, of general practitioners' and nurses' time, of endometrial biopsy or curettage (over £100 at current rates in private medical care), and of operations which ensue from positive or doubtful investigations and the overhead costs of running supervisory clinics were assessed at £60m a year in 1975[1] and would make widespread hormone therapy an extremely expensive operation for the DHSS.

Many women are reluctant to embark on long-term treatment, and those who do often stop the tablets because of anxiety about possible health risks; the psychological cost of medicalising life for the entire postmenopausal population would be incalculable.

JEAN K COOPE

Bollington,
Nr Macclesfield SK10 5JL

[1] Dewhurst CJ. In: Campbell S, ed. *The management of the menopause and postmenopausal years*. Lancaster: MTP, 1976:429-30.

SIR,—The authors of the excellent regular review of postmenopausal osteoporosis (28 August, p 585) listed immobilisation among the causes, but it was left to one of your correspondents (2 October, p 970) to mention the potential importance of exercise for prevention.

While it is true that physical exercise is unlikely to be as effective as oestrogen treatment for those people whose bone loss is already severe, the degree of bone loss found in a population of elderly people is probably normally distributed. The situation is therefore similar to that which applies to hypertension. Professor Rose has shown that when planning a prevention strategy for this type of risk factor it is essential to complement attempts to help individuals at high risk—those at the upper tail of the distribution curve—with a "mass strategy" of measures which will shift the whole distribution curve to the left.[2 3]

Those who are at high risk are obviously an important group, but there are many more people at lower degrees of risk. Measures that affect the whole population by shifting the whole curve to the left reduce the risk to those in the hump of the distribution curve.