the fate of all those in Leicester who defer their admission is not precisely known, though some waiting list forms contain evidence of several deferments.

The practical point arising from the startling proportion of patients who decide not to be admitted is that the clerical staff are put under great pressure to try to arrange substitute admissions to maximise the use of theatre time and beds, and this extra work is not generally recognised. The simple manoeuvre of overbooking admissions by 25% each week is likely to fail since the failure rate varies for any individual surgeon from week to week. Evidently the admission of patients from a waiting list is an active process and if 25% of the patients on the list are eventually not admitted much effort is required to ensure that the average of 25% of patients who do not attend week on week do not delay the admission of those who would.

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Hospital and community health service costs: England and Scotland compared

SIR,—One of the difficulties when seeking a fair comparison of health costs between England and Scotland is to ensure that English economists and managers understand the very different situations and arrangements that exist in Scotland. It was this difficulty which led Dr Stephen Birch and Mr Allan Maynard in their original contribution¹ to equate Scotland's 15 health boards and associated centralised services with a single regional health authority in England. They appeared to be unaware that the English centralised services do not operate in Scotland. Thus since their English "budget" consisted of the sum of the budgets of the regional health authorities, and did not include centralised services, the Scottish budget appeared to be artificially inflated.

There is a further illustration of this problem in their letter of 24 October (p 1067). With regard to local authority rates they suggest that managers should respond to cost variations by adopting the most efficient input mix. While local rates may vary across England and Scotland, the baselines about which they vary are threefold higher in Scotland. Managers may respond to variations in cost only within geographic limits. The paper by Drs Akehurst and Blackburn,² to which Dr Birch and Mr Maynard refer, deals with such variations within a single regional health authority and is not relevant to a comparison between Scotland and England. The wide disparity in the level of rates between England and Scotland is important to Scotland in many economic spheres and not just in medicine.

The claim that private provision has little effect on unmet need, extrapolated from Dr Birch's study of hip replacements, is hard to sustain in the face of the more general findings of Dr Nicholl and colleagues from Sheffield.³ The summary of this paper states, "When assessing the need for, and provision of, acute health care in England and Wales, the contribution of the private sector cannot be ignored."

Our observation about the use of standardised mortality ratio as a correction for morbidity differences, and therefore resource need, is one of scientific principle. If a correction factor is required, and if the accuracy of that correction is in doubt, the greater the magnitude of the correction the greater the liability of error. Because Scottish costs affected by the standardised mortality ratio require very considerable correction the adequacy of that correction can be challenged.

At a time when the Resource Allocation Working Party formula is being thoroughly reassessed in England we are surprised and concerned that it should continue to be considered proper to use it, without refinement, to compare health finance in England and Scotland.

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- 1 Birch S, Maynard A. *The RAWP review: RAWP primary care: RAWP the United Kingdom*. York: University of York Centre for Health Economics, 1986. (Discussion paper 19.)
- 2 Akehurst RL, Blackburn K. Geographic cost variation in the North West Regional Health Authority. *Hospital and Health Services Review* 1979;75:400-5.
- 3 Nicholl JP, Williams BT, Thomas KJ, Knowelden J. Contribution of the private sector to elective surgery in England and Wales. *Lancet* 1984;ii:82-92.

Spending more on turning patients into people

SIR,—The leading article by Sir John Walton (24 October, p 1012) draws attention to the lack of specialist facilities and interest in the rehabilitation of disabled patients. He points to the lack of accredited posts in rehabilitation medicine and suggests that this indicates a lack of interest in rehabilitation among the medical profession. He did not, however, comment on the extensive rehabilitation service provided for elderly patients by geriatricians. Most district health authorities have a geriatric service which in addition to acute and continuing care facilities has both inpatient and outpatient rehabilitation facilities. Even more importantly, geriatric departments will already have developed an appropriate rehabilitation staff, including physiotherapists and occupational and speech therapists, together with a close liaison with the community social and nursing services.

Sir John points out that many of the most severely disabling disorders are caused by neurological disease and cites several examples including stroke, epilepsy, Parkinson's disease, and motor neurone disease. These disorders together with most of the common rheumatic disorders show an appreciable association with age and are commonly treated in departments of geriatric medicine.

There is a need for specialist rehabilitation services particularly for the younger patient and for conditions such as spinal cord lesions and rare disorders such as muscular dystrophy. For most patients, however, rehabilitation within their own district general hospital is likely to be more attractive than travelling long distances by ambulance to regional centres and for health authorities it is likely to be a more cost effective use of limited resources. More integration of younger patients into the well established geriatric rehabilitation service would provide the basis for a comprehensive rehabilitation service,

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Physiotherapists and rehabilitation

SIR,—Although surprised that Sir John Walton omitted any mention of the role of the physiotherapist in his leading article on rehabilitation (24 October, p 1012), I am delighted that he argued such a persuasive case for an increase in effort in this area. I endorse his comments on regional

disability centres and the need to ensure that all are well resourced and properly staffed. Physiotherapists are in the forefront of rehabilitation throughout the health service and, increasingly, in private practice. Like neurologists and occupational therapists, however, they are in short supply. Perhaps we should all be working more closely together in defining an appropriate mix of professionals to undertake this work and campaigning for more resources in the interests of our patients.

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Obstetrics on the labour ward

SIR,—Ms V A Coupland and others (24 October, p 1077) implied that a two tier system demanded more of consultants in terms of work on the labour ward. This is no doubt correct, but we were surprised to learn that the consultants in the two tier hospitals went in on average only 3.5 times a month. We feel that an analysis of the "out of hours" work on the labour ward and the nature of the work carried out is important when determining future staffing levels. We carried out such an analysis for the year 1986, in a three tier district general hospital in Birmingham, which has the lowest perinatal mortality rate in the West Midlands (table). The department had four con-

Timing of emergency workload in 1986

	Time		
	9 am-5 pm	5 pm-10 pm	10 pm-9 am
No of caesarean sections:			
Emergency	94	74	128
Elective	99		
No of instrumental deliveries	158	113	163
Overall % of workload	42	22.5	35.5
% Of emergency work	34.3	25.4	40.3

sultants, four registrars, and four senior house officers. Of the 3766 deliveries in 1986, 392 (10.4%) were by caesarean section and 834 (22.1%) were carried out by doctors.

In this hospital the intervention rate would generally be regarded as low, but almost 66% of the emergency work on the labour ward was carried out in the "out of office hours" period of 5 pm to 9 am.

As the amount of litigation is growing faster in obstetrics¹⁻³ than in any other branch of medicine and to provide the level of care (prompt care) that every pregnant woman deserves, a detailed analysis of the out of hours emergency work that needs to be carried out on the labour wards should be taken into consideration before the three tier system in district general hospitals is dismantled in favour of a consultant based system, as recommended by the Short report.⁴ Consultants, even if they value their skilled practitioner role, get old, and once they are in their 50s they may not appreciate routinely disturbed sleep yet will be expected to offer an excellent "hands on" service the next day. Would a company director put up with such a service commitment until the day he or she retires?

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