Because blood pressure may fall precipitately early in treatment, starting with a small dose is advisable. The glomerular filtration rate may fall acutely during the first weeks and months of treatment, an effect that is exacerbated by overt nephropathy. Large doses may be needed to affect incipient diabetic nephropathy,¹⁶ which may cause problems in the presence of renal artery stenosis (albeit this is not particularly common in diabetic nephropathy). Antihypertensive treatment does not consistently reduce the fall in glomerular filtration rate, especially in patients with very poorly controlled diabetes who have severe hypertension, obesity, or hyperlipidaemia.

To date, long term intervention studies (with self controlled design) have been reported only in proteinuric patients with insulin dependent diabetes.^{2,5,18,25} Patients with non-insulin dependent diabetes and albuminuria warrant study: they make up a large proportion of those patients who develop end stage renal failure. Short term studies suggest that angiotensin converting enzyme inhibition may also be useful in patients with non-diabetic renal disease: Apperloo and colleagues recently reported that enalapril significantly reduced albuminuria in such patients.²⁶ If longer studies confirm that angiotensin converting enzyme inhibitors have proteinuria lowering effects, independent of their effects on blood pressure, then whether their prophylactic use preserves the glomerular filtration rate in diabetic and non-diabetic patients with nephropathy should be tested.

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Paying for health services

All change

Health care reform is in fashion internationally.¹ Those countries that have relied on a large measure of private finance and the use of market mechanisms, most notably the United States, are searching for ways of achieving more comprehensive coverage and cost control. Equally, those countries that have based their health care systems mainly on public finance and planning mechanisms—for example, the United Kingdom and Sweden—are showing interest in competition as a means of increasing efficiency and enhancing responsiveness to consumers. Even the pluralistic systems of western Europe have not escaped reform, with countries as varied as France, Germany, and the Netherlands all seeking to tackle deep seated problems in financing and delivering health care.

Of all these countries the United States faces the greatest challenges. With expenditure rapidly approaching 12% of its gross domestic product and with over 30 million Americans uninsured, policy makers have long puzzled about how they could introduce reforms to achieve a better balance between equity, access, comprehensiveness, efficiency, and cost containment. Individual states have taken the initiative in

addressing some of these issues—for example, Oregon and its attempt to set more explicit priorities for the use of Medicaid funds for the poor²—but so far there has been no concerted attempt to promote change at the federal level.

Against this background a new study of health insurance in different countries offers a timely analysis of the direction that reform might take.³ As the study seeks to emphasise, those endeavouring to change the American “non-system” do not have to embrace the fully blown national health services that exist in the United Kingdom and several other countries. One alternative would be to move towards the social insurance funding system adopted in western Europe. Using evidence from France, Germany, Belgium, the Netherlands, and Switzerland, the study brings together a huge amount of information to show what this might mean for the United States.

Although the author argues that his book “is not a plea on behalf of statutory health insurance,” there is no disguising his preference for this method of funding compared with the diverse arrangements that currently exist in the United States. As he shows, social insurance systems began in the late

nineteenth century by offering cover to manual workers in certain occupations. They were progressively extended to family members and other groups of workers, eventually including pensioners and the unemployed.

In many countries social insurance is now compulsory for most citizens, with payments usually taking the form of payroll taxes levied on employees and employers. Social solidarity is an important principle in these systems, with those who are better off subsidising the costs of health care for those who are less well off. Despite this, problems of equity arise, as in Germany, where tax rates are set by individual sickness funds and vary according to the membership of funds and their risk structure.

The study shows that social insurance funding does not of itself tackle inefficiencies in the delivery of services, which is why those who are responsible for health care funding have turned their attention towards reforming the arrangement for reimbursement.⁴ For hospitals this has meant greater interest in the use of global budgets; for doctors it has meant attempts to cap fees and closer scrutiny of clinical decision making.

As experience in different countries shows, widely varying admission rates, lengths of stay, costs per case, and other variables, almost regardless of how funding is provided, indicate that reforms that address weaknesses in delivery are at least as important as those that seek to introduce alternative systems of funding. This lesson has clearly not been lost on British governments. Twice in the past decade governments have examined and rejected the arguments for moving away from tax funding and instead focused on changing management and increasing competition.

While Glaser has performed an invaluable service in bringing together a large volume of data from different

sources, he would be the first to acknowledge that information and ideas in themselves are insufficient to produce a change in policy. The United States, forever the land of paradox, "sponsors more research on health care financing than the rest of the world combined, but it has no health care financing system." The real obstacle to reform is the absence of political will. Without this will there is no way forward, and the United States may therefore resort to further research as a substitute for action.

The beneficiaries of this study may therefore be policy makers in other countries where the capacity to promote changes is much greater. Yet even outside the United States health care reform tends to be incremental rather than radical, as the fate of the Dekker reforms in the Netherlands shows.⁵ Given our limited understanding of what works and the inherent difficulties of translating ideas from one political system to another, this may be no bad thing. After an era of activism in health policy a period of caution may well be in order. As Glaser's work shows, there are no quick fix solutions to the problems of paying for health services, and a degree of humility on the part of those charged with running health services would be a welcome antidote to the rush to reform of recent years.

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The management of "psychogenic" orofacial pain

A collaborative attitude and antidepressants may help

Chronic facial pain is an important health problem. It is impossible to measure the extent of distress that it causes patients and those who care for them, but society suffers as a consequence of the disability, loss of employment, litigation, compensation, and costs of treatment. Bonica estimated that five to seven million Americans suffered chronic pain in the face and mouth at a cost to society of over \$4 billion a year.¹

Even when recognised syndromes with well defined causes and treatments, such as trigeminal neuralgia, are excluded there remains a large group of patients who pose major management problems for doctors and dentists. Lack of dialogue between doctors and dentists, and the gaps in dental knowledge among doctors and medical knowledge among dentists contribute to the problem.²

Various poorly categorised descriptions have been used, such as atypical face pain, atypical odontalgia, psychogenic pain, and, more recently, somatoform pain.³ Cohen has repeated the common observation that diagnoses that say what the disorder is not, rather than what it is, are unhelpful and again advocated a problem oriented view that could allow a positive intervention.⁴

Pain is subjective and a complex phenomenon with sensory, emotional, behavioural, and cognitive components. The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms

of such damage."⁵ The understanding of a definition such as this, which emphasises the subjective and avoids any need to show tissue damage, offers an opportunity to offer a problem oriented approach in treatment. Such an approach may well include suggesting that pain relief is not the only goal.

Patients with facial pain have almost universally had negative experiences of treatment. Surgery has often failed, drugs have not worked, and numerous investigations have given normal results. In one study pain had been present for an average of four years before the patient attended a pain clinic.⁶ It does not help patients to be told there is nothing wrong, because in their experience there patently is.

No management can help unless the patient complies with it. In these patients that involves a synthesis between their own experience of, and beliefs about, pain, and those of their doctor, who has an altogether different appreciation of the situation from them. In an elegant view of this necessary synthesis Turk and Rudy advocate an explanatory and exploratory approach. They emphasise the need for information and for attempting to increase the concordance between the beliefs of the patient and the treatment offered.⁷ They also suggest emphasising adherence to treatment, rather than compliance. Adherence implies choice and mutuality in planning treatment with the active voluntary collaboration of the patient. Compliance implies that the patient simply follows the doctor's instructions.⁸