from a drug will immediately preclude its use, evidence that affects our social behaviour has to be overwhelmingly obvious before it is acted on.

The authors make four recommendations for preventing marital breakdown and promoting good health. These are undertaking more research into the factors that cause strain in family relationships and what can be done to help; educating teenagers in personal relationships; making early intervention available for people with problems with relationships, giving them greater access to counselling, including that from trained general practitioners; and integrating health and family policy within a single government department. The first three points merit strong support; so would the fourth if it would truly provide a better service to those in need.

It should also be remembered that, although *The Health of the Nation* was presented to parliament by the Secretary of State for Health, most of the other government departments had made explicit or implicit contributions to its content. Shouldn't some of these departments be enlisted to improve the health of the nation through dealing more effectively with the antecedents and consequences of the breakdown in relationships? Fiscal measures, the law, housing, and employment are all relevant.

Doctors would do well to recommend that the government should consider carefully the link between marital breakdown and the ill health of the nation. The evidence for an association is irrefutable even though identifying causative factors is more difficult.

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Private practice

Troubled insurers prepare to pass the buck

All health insurers are receiving more frequent and more expensive claims from their subscribers. This has reduced their surpluses and in some cases led to record underwriting losses that have had to be met from reserves.¹ For the moment the haemorrhage has been staunched by increases in premiums substantially above the rate of inflation.² But what will be the consequences of these increases? Can the insurers weather the storm, and what will happen in the long run?

The key questions are whether the current price increases will lead to reduced demand and, if so, by how much? (In the language of economics: "What is the price elasticity of demand for private health insurance?") Estimation is difficult because of background changes in people's disposable income and in the perceived availability of alternatives, chiefly NHS treatment. The influence of these two factors over the past 35 years has ensured that despite a twofold increase in the real price of health insurance there has been a ninefold increase in the number of people covered.³ The picture is also confused by a steady shift away from personal insurance towards large companies insuring their employees. A benefit that has been given to employees is hard to withdraw, and overall demand from this sector of the market is unlikely to be very sensitive to price rises (although, of course, demand for an individual insurer's products is highly sensitive to price, with corporate customers and their brokers regularly seeking fresh quotations).

In the personal sector, where the decision to lapse would affect only the person making it, we might expect greater elasticity. But the evidence does not support this: even when personal insurance made up almost the entire market there was a sustained growth in numbers insured despite real price rises. For example, between 1955 and 1962, although the real price rose by half, the number of people insured doubled.³ If the market has proved so inelastic in the past are the current increases in premiums irrelevant?

Several factors suggest that this time they could be more significant. Firstly, superimposed on the steady increase in both price and demand over the past 35 years it is possible to show some short run elasticity in the market. For example, from 1974 to 1977 the price of private medical insurance increased by 35% above inflation and the number of subscribers fell slightly.³ Many personal subscribers to the larger companies have experienced a price rise of similar size in the past 12 months alone. If they do not wish to lapse entirely they have the option of trading down to an insurance plan with more restricted benefits, reducing income to insurers, hospitals, and doctors alike.

Secondly, personal subscribers who lapse or trade down will tend to be the healthier ones. Anyone with chronic illness or early symptoms of disease is less likely to reduce insurance cover. This will increase the claims made on the insurers yet further—leading to still greater rises in premiums. Another reason for concern about the insurers' present situation is that although most corporate clients are unlikely to stop buying cover for their employees, the recession is forcing many to reduce their workforces or is putting them out of business entirely. Either way, the number of subscribers will fall. Finally, if the government's health service reforms are successful in reducing waiting lists and improving the quality of service, or are successful in creating the perception that they are doing so, any economically induced fall in the level of private health insurance may become a permanent one.

What would be the consequence for consultants with private practices of a fall in the number of subscribers? In most industries a drop in demand results in increased competition and falling prices. This will not happen spontaneously in private health care, mainly because price is not a major influence on those who choose the consultant—patients or, more usually, their general practitioner. Moreover, prices are to some extent maintained by the BMA's scale of charges. So

there will be no price war—simply a general famine in which most consultants will see fewer private referrals. Faced with this, they can maintain their income by a mixture of raising their prices and generating extra work by such measures as booking extra follow up appointments. The insurance companies will then experience further rises in the frequency and size of claims. How will they respond?

Insurers already challenge hospitals and doctors who charge high prices,⁴ and many have reduced the conditions for which subscribers are covered. But neither measure is easy to implement effectively, and both carry political risks. Insurers are therefore exploring other options.⁵ In an oversupplied market selected hospitals and doctors may be persuaded to contain prices and practise efficiently in return for a guaranteed volume of referrals. The insurers can then steer their subscribers to these “preferred providers” by using various methods, including financial incentives. These may well be linked to other attempts to control the size of specialists’ fees by encouraging developments such as package priced surgery.⁶ Alternatively, rather than risk constraining their subscribers’ choice many insurers may prefer to review the appropriateness of more episodes of care than the few very expensive cases that they already look at. Experience from the

United States over the past 10 years suggests that two changes can be expected to such review. Firstly, it will become prospective, with insurers requiring certification or second opinions before admission, and, secondly, it will become participatory, with insurers’ agents interacting with providers to ensure that care is focused and efficient as it occurs.

Many of these changes will occur regardless of the outcome of the insurers’ present economic woes. The recent appointment to the top job in one of the biggest insurers of someone who previously ran a large sugar company serves to underline that the private health market has come of commercial age. How sweetly the profession takes to the prospect remains to be seen.

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Motor neurone disease

Treating the untreated

Progressive loss of the α motor neurones in adult life (motor neurone disease) was well described nearly 150 years ago,¹ yet the cause and a specific treatment or preventive measure continue to elude us. Many doctors and especially neurologists (90% in our experience) continue to offer no care to patients suffering from this fatal paralysis, as though the lack of a cure is somehow equated with the absence of any treatment. This is curious because patients with many other fatal diseases receive supportive care or palliation from their doctors (including neurologists). Yet a paralysed patient with motor neurone disease is often neglected despite the availability of many symptomatic treatments.^{2,3}

Painful muscle cramps often make life even more miserable for patients, as does the constant drooling some experience, and such manifestations can nearly always be reduced to a tolerable level, if not eliminated altogether.^{2,3} Severe fatiguability,^{2,4,5} sleep problems,² incipient contractures, subluxation of the shoulder joint, dysphagia,² and neuralgia⁶ can all be ameliorated. Drugs may control the extreme emotional lability that is often an early feature of amyotrophic lateral sclerosis.^{2,3,7} This results in uncontrollable swings of emotion, usually towards prolonged weeping, which demoralises not only the patient but all those around. These measures can be applied whenever needed in the course of the illness.

A paper in this week's journal by Dr Tony O'Brien, Sister Moira Kelly, and Dame Cicely Saunders describes their experience with patients in the terminal stages of motor neurone disease, immediately before and during respiratory failure (p 471).⁸ Perhaps their most important point is confirmation that giving generous doses of narcotic drugs at this time is safe, non-addictive, and effective.⁹ Transient improvement may even occur in some patients, over and above the expected analgesic and euphoric effects; both morphine and pethidine seem equally effective.

As most patients terminally ill with motor neurone disease suffer from dysphagia, narcotic drugs should be given subcutaneously (in the same way as insulin is given) unless intravenous access exists. The subcutaneous route seems effective and is readily taught to patients' families for use at home.

The management of motor neurone disease in the United States differs in several respects from that in Britain. American patients are more likely to be offered respiratory support; with help from family and friends some of these patients can be very successfully managed at home,^{10,11} thereby avoiding prolonged stays in hospital. Also, in the United States considerably more than the 8% of terminally ill patients reported by O'Brien and colleagues⁸ undergo catheter gastrostomy. Gastrostomy, which has been revolutionised by the catheter procedure,¹² spares patients the pain of aspirating food and drink as well as the distress of dehydration and starvation.

Another major difference in our experiences is that the American hospice movement lags behind that initiated so successfully in Britain by Dame Cicely and her colleagues.^{8,13} Perhaps on this account, we have encouraged our patients with terminal disease to remain at home if possible, though house calls then become a heavy burden for medical staff. A gradually increasing number of our patients are being admitted to hospices for terminal care, and hospice nurses are actively collaborating in our home care programme.

It was not so many years ago that good doctors regarded the care of the dying and the support of their families as an essential part of their practice—a role not easily delegated to others. Today in the United States bureaucrats and accountants have in effect decreed otherwise. Fortunately research is being done into motor neurone disease, from which we may dare hope for a successful primary treatment and eventual