unwarranted. I recently had in my care a patient from eastern Europe sent for investigation of a suspected haemoglobin anomaly.³ It turned out that this patient was taking huge amounts of phenacetin-containing analgesics, which were never found on him but which he stopped taking—as proved by the above urine test—when threatened with being returned to his country with the diagnosis of a grave psychiatric abnormality. Screening large numbers of persons in Switzerland for N-acetyl-*p*-aminophenol in urine has shown that up to 10% of a given population is taking phenacetin-containing analgesics.³ Intake of salicylate on its own is rare in Switzerland. Only two of five leading brands⁴ contain 0.125 g. and 0.37 g.

In addition, it seems important that patients who have regularly abused analgesics containing phenacetin should have their urinary tract searched for tumours at necropsy. Within the last year five of 625 women regularly taking analgesics containing phenacetin died while under close observation, and one developed a carcinoma of the bladder.⁵ This tends to confirm the findings of Bengtsson⁶ and underlines the appeal by Dr. Koutsaimanis and Professor de Wardener that phenacetin should be sold only on prescription, although the evidence for an increased incidence of tumours of the urinary tract after many years' intake of phenacetin-containing analgesics is so far inclusive.—I am, etc.,

U. C. DUBACH.

Medical Polyclinic,
University of Basel,
Switzerland.

REFERENCES

- 1 Spühler, O., and Zollinger, H. U., *Zeitschrift für klinische Medizin*, 1953, 1, 151.
- 2 Kincaid-Smith, P., *Lancet*, 1967, 1, 859.
- 3 Dubach, U. C., *Deutsche medizinische Wochenschrift*, 1967, 92, 211.
- 4 Dubach, U. C., Minder, F., and Gsell, O. R., *Proceedings of the Third International Congress of Nephrology, Washington 1966*, 2, p. 300. New York: Karger, 1967.
- 5 Dubach, U. C., unpublished observations.
- 6 Bengtsson, U., Anérvall, L., Ekman, H., and Lehmann, L., *Scandinavian Journal of Nephrology*, 1968, 2, 145.

Health Services Financing

SIR,—Professor Dennis Lees reviewed (31 October, p. 292) the descriptions of health services in the United Kingdom and 14 other European countries published in Appendices A-Q of the B.M.A. report *Health Services Financing*. While agreeing with him that they are indeed a valuable contribution to our knowledge of health services and deserve further study, it is difficult to accept his interpretation of them to advocate increasing private finance of the N.H.S. Several of Professor Lees's points deserve specific answers beyond the case put elsewhere.¹

In any discussion of health services, it is axiomatic that their first concern must be the patient, not the system or any members of it. The fact that the N.H.S. is unlike health systems in other countries in having relatively few user charges at the point of use is not a case for having them.

The effectiveness of the market mechanism in allocating resources is by no means convincing in the health sector and these studies do little to change that. By definition the market mechanism attracts

resources to those areas and to those people who make an effective demand. (Demand backed by money as opposed to just "demand.") The present inequalities broadly favour the affluent South and the price mechanism might be expected to perpetuate and aggravate this. Likewise it would attract resources to the higher socio-economic groups who are better economically enabled and more socially disposed to make effective demands for health care than the lower socio-economic groups, as is markedly the case in the U.S.A.²

Professor Lees quotes Cooper and Culyer's study as part of his case for more private payment for health. But their demonstration of regional inequalities of health provisions is primarily focused on the hospital service (60% of N.H.S. expenditure), and, as Professor Lees summarizes, in most countries "the bulk of hospital construction is financed from public funds." Likewise, with the exception of the U.S.A., Switzerland, and Australia, "In-patient hospital care is provided virtually free and financed by taxes or compulsory contributions." In short, private finance in the hospital sector has not been a source of salvation in other countries.

The existence of a substantial private sector in other countries has often led to a two-class system—pullman or second class—for example, graded wards and separate waiting rooms of the Austrian system. It has likewise led to severe problems of multiple and non-integrated provision with the more onerous and unprofitable cases (like severe accidents) being left to the public sector, as so often happens—for example, in the U.S.A. and France.

The concept of the potential patient free to choose the type, quality, and amount of care he will consume and freely negotiating the fees with doctor is spurious. Choice on all three criteria may exist for elective treatment, and then often only initially, but moving up the scale of severity choice diminishes to become almost non-existent at the emergency end of the spectrum. Likewise "free" negotiation of fees might well oblige the doctor to behave like a small shopkeeper, simply to maintain his income.

Finally Professor Lees states, "cutting other public expenditures or raising taxes are simply not on." This Government has just cut some areas of public expenditure and is committed to more of the same. Likewise, we are far short of any tax and social security ceiling at around the middle of the range % of G.N.P.—Sweden pays 48.4% of G.N.P. in tax and social security, Austria 43.2%, Norway 42.7%, France 42.5%, Netherlands 42.2%, Denmark 40.8%, and the U.K. in seventh place pays 40.1%.³ In short, others pay more tax and more privately for health services and there is no reason why we should not divert more money to health and/or raise more from taxation, or preferably specific social security contributions.

The most important lesson gained from these national studies is that the means of health service production are entangled in archaic structures, and that the doctors themselves need to come into the twentieth century. Health is now the third largest industry in developed countries; nowhere has management kept pace with its growth. The N.H.S.'s dilemma, and its basic crisis

in common with other health systems, is lack of management and the role of the profession in it, not whether we have fees at the point of consumption.—I am, etc.,

ADRIAN GRIFFITHS.

Medical Care Research Unit,
London School of Hygiene and
Tropical Medicine,
London W.C.1.

REFERENCES

- 1 Logan, R. F. L., Klein, R. E., and Griffiths, D. A. T., *Lancet*, 1970, 2, 647.
- 2 Andersen, R., and Anderson, O. W., *A Decade of health services. Social survey trends in use and expenditure*. Chicago, University of Chicago Press, 1967.
- 3 *Economic Trends*, 1970, No. 202, p. xx.

Length of Gestation

SIR,—Your leading article on the length of gestation (14 November, p. 382) draws attention to the problem of assessing gestational age even where the date of the last menstrual period has been carefully recorded. Estimation of expected date of delivery by Naegele's rule (counting back three months from the first day of the last menstrual period and adding seven days) is based on the premise that menstrual and ovarian cycles are regular. This is not correct.

In order to apply Naegele's rule, menstrual cycles must be regular. While 60 to 80% of all cycles fall within the range of 25 to 31 days, this does not mean that the majority of women are sufficiently regular to be able to apply the rule correctly. There is wide variability in cycle length both between different women and in the same individual from time to time. In bulk statistics so often quoted the cycle length variability is not apparent. For example, only 16% of women have a difference of less than six days between the shortest and longest cycle in the course of a year, and 30% experience a difference of thirteen days or more.

Furthermore, regularity of cycle length, whether long or short, is not accompanied by regularity in the timing of ovulation. While in the majority of cycles ovulation occurs 12 to 16 days before the next menstruation, the timing of ovulation varies between one woman and another and there is considerable scatter within each individual. Prolongation of cycle length adds another variation which should be taken into account. For every nine days increase in cycle length the average increase in the pre-ovulatory phase is seven days and that in the post-ovulatory phase is two days.—I am, etc.,

W. M. O. MOORE.

Department of Obstetrics and Gynaecology,
University of Manchester.

REFERENCE

- Moore, W. M. O., *Practitioner*, 1970, 205, 38.

Bell's Palsy and Surgery

SIR,—Leading articles are very important since they present or should present facts as objectively as possible. The *British Medical Journal* usually follows this rule, but your article on Bell's palsy and surgery (17 October, p. 126) is not at all objective, particularly in its second half. It contains many