parents who didn't take advantage of early antenatal care, but the problem is different with adults and smoking.

Dr GODBER: The incentives will always have to be positive rather than punitive.

Mr LAING: I wonder. I agree that financial incentives are rather blunt, but what other ways can one think of to make people better citizens, which is what it amounts to?

Professor RAWLINS: Is there good evidence that health education will change people's established ways of life?

Dr ROSENTHAL: It depends what you call health education. The bikini and blue jeans did more to reduce adolescent obesity than any prohibition against bad nutrition.

Dr WILL: Fashion has been very much neglected, hasn't it, though it is very difficult to influence? The problem about selling a good message is that it is somehow very self-conscious in a way that immediately switches people off.

Putting up the price

Dr SMITH: This is exactly the reason why we want to get away from anxiety-provoking health education. The way to reduce the amount that people drink is by doubling the price of whisky.

Professor KLEIN: Studies do seem to suggest that there is a

definite relationship between price and consumption. If people want to improve their standards of living in terms of cars or whatever in a society with very slow economic growth they may have to give up other things.

Dr ROSENTHAL: But there is a problem. If you look at the States, blacks, who as a class are less affluent than whites, disproportionately consume more of the expensive alcohol. That is the result of marketing; it doesn't have anything to do with price elasticity.

Professor KLEIN: I always feel worried when people talk of social engineering. I don't think we know how to do it.

Dr GRAY: But we do do it. The Government is engaged in social engineering at the moment by not putting up the price of alcohol and by taxing high tar cigarettes.

Dr BARLEY: Making seat belt wearing compulsory would be a very simple form of social engineering; we know that it would save a lot of lives, yet we don't do it. Why is it so unpopular?

Dr ROSENTHAL: States in America are repealing mandatory helmet laws as a step for individual freedom: If you want to scramble your own brains, why should anyone else care? And the answer is: because then we are going to have to take care of you.

Dr SMITH: Yes, in simple terms either we have social engineering or we may have to abandon any hope of providing comprehensive health care.

Working papers

Home or hospital?

SIMON BARLEY

Often there is no choice between home and hospital: a 90-year-old with a pathological fracture of the femur must go to hospital. But there are a dozen ways to try to help the same 90-year-old if she is demented and has a breast cancer which is fungating but localised and not metastatic to the femur. She could stay at home with help from neighbours, relations, volunteers, social workers, health visitors, and doctors, or she could go into hospital. Which hospital: the cancer ward, the geriatric ward, the psychiatric ward, the surgical ward, or the psychogeriatric ward? Or might it be something between—a social care home, a terminal care home, a private nursing home, or a sheltered flat?

The choices are not limited to the elderly. A child with acute appendicitis must go to hospital, but should he come home again the next day or stay for a week? The middle-aged man in severe shock from a coronary goes to hospital without argument, but the choice is wider if his attack is a simple uncomplicated one and he has a wife prepared to nurse him at home. In midwifery the arguments are even fiercer. Midwifery has much about it that is simple. All the patients (at least before the birth occurs) are of one sex. The outcome is never delayed longer than nine months. The results are comparatively easy to measure. We ought therefore to have begun our research and to have decided on what grounds we can recommend home or hospital delivery. Yet there has never been a prospective trial of the results of home versus hospital confinement. I suspect that the very lack of such a trial in midwifery and the arguments which still surround the trial of home versus hospital care for uncomplicated myocardial infarction mean that medicine is listening to culture, with its resistance to fast change, and ignoring science. Before we can make firm pronouncements on the merits of home and hospital care we need much more information about the factors that influence outcome—in the patient, in the illness, in the system of medical care, and in society. The combination of these factors is not immutable, and it is in the changing balance that we must seek fresh solutions. The major change that

medicine must make is to stop concentrating on science alone and begin to listen more to the voice of society—our patients.

Sheffield

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COLIN GODBER

A major challenge to our health service over the next 30 years will be the further shift towards the care of chronic illness and disability that will be generated by the dramatic increases in the proportion of the very elderly. Our response to this will depend on the continuing consolidation of primary care, the search for alternative options in community care, and a more selective and efficient use of our costly hospital and specialist services. The range of work carried out by the primary care team will need to extend, with the other professions accepting (and being given) greater responsibility within their fields of expertise. With nurses taking on more screening and surveillance, the social worker should be tackling emotional and social problems that have responded so poorly and at such cost to the FP 10.

As the "general physician" of the future the GP will need a different service from the specialist, more community based and with more opportunity for advice and discussion. Conversely the GP should play more part in the care of his patients in hospital.

We need also to look more closely at the arguments for a much more flexible use of domiciliary nursing to provide for intensive short-term care as an alternative to, or shortener of, hospital stay. Better selection between home, community hospital, and general hospital care in acute illness may well reduce bed occupancy, though admission rates are bound to continue to rise. In general psychiatry and mental handicap we have seen that hospital bed use can be greatly reduced if specialised day care, sheltered employment, and hostels can be developed. We