Letters to the Editor

Tailoring health services to the needs of individual communities

SIR—Womersley and McCauley’s profile (1987, 41: 190–5) demonstrates a technique for determining areas of relative health need and goes on to argue the importance of standardised mortality ratios (SMRs) in resource allocation. This presupposes that all health expenditure is on services that prevent mortality, but the whole question of resource allocation is in fact far more complex.

To equate the word “resources” with funding is a mistake. Health care resources are personnel, buildings, and equipment; money is simply the means of purchasing them. High disease specific SMRs give clues as to which resources to spend money on and where to deploy them but does not give a reliable basis on which to allocate global sums.

Low SMRs for all causes of death lead to longevity, which in turn leads to greater numbers requiring care at an age when illness and disability are increased and the powers of rapid recovery are diminished. Mortality is in fact a cheap outcome of disease.

In my district, with low SMRs for ischaemic heart disease, cerebrovascular disease, and all causes, we have seen over the last 10 years an increase in the total population of a little under 5% but a 25% increase in the total population over the age of 75. Over the same period the percentage of bed days occupied by patients over 75 in the District General Hospital has risen from 22% to 37%. This indicates the pressures of extreme old age on acute hospital services in an allegedly healthy district. There are, in addition to this of course, the effects on long term care services, both domiciliary and institutional, and psychiatric services which are also likely to be age related.

I believe that in securing equality in health care, a case can be made out for funding to be based simply on population size, leaving the other health indices to determine how the funds are actually spent.

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Health Board (GGHB) population is about 116 (Scotland = 100): in Scotland the standardised mortality ratio (SMR) for the age group 0 to 64 years is used as a ‘proxy indicator of morbidity’ in the SHARE formula for the calculation of revenue resources. The proportion of the GGHB revenue allocation which is attributable to this SMR is 6% for acute (non obstetric, non psychiatric) hospital services, 11.5% for outpatient and day patient services, and 12% for community services (the figure of 7% quoted in the paper for community services was in fact an underestimate). Our suggestion is that the 12% ‘extra’ resources for community (including preventive) services, which are attributable to the relatively high SMR, should be distributed in favour of those communities within GGHB which have the greatest need.

We were not suggesting that these ‘extra’ resources should necessarily be distributed to those communities with the highest SMR values, but rather to individual communities according to their different needs as assessed from measures such as our health profiles. It will however often be the case that those communities with the highest SMRs do have the greatest need according to these measures.

We are not certain that Dr Bush is correct in his assertion that populations with low SMRs have greater proportions of individuals who require care ‘at an age when illness and disability are increased’. The populations would seem to be approaching the biological ideal of maintaining good health to a ripe old age, followed by relatively sudden deterioration and death—the ‘rectangular society’.3 It could well be the high SMR populations that have the longest period of disability and make most use of expensive health service resources.

Again, the 10-year demographic trends described by Dr Bush are not exclusive to areas with low SMRs. The GGHB population has fallen by some 10% over the past 10 years whereas the proportion aged 75 years and over has increased by 16.5%. The percentage of acute bed days occupied by patients aged 75 years and over has increased over the past 10 years from 20% to 29%.

Finally, we would emphasise that our main aim is to try to achieve equality in health—or rather to decrease inequality in health, this being the prime objective of the WHO project ‘Health for All 2000’. It is not to secure equality in health care, which is the basis of Dr Bush’s argument in his final paragraph.

The authors reply as follows:
Perhaps we can give a specific example to illustrate our arguments.
The SMR (0–64 years) for the Greater Glasgow
Tailoring health services to the needs of individual communities.

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