BRITISH MEDICAL JOURNAL

SATURDAY 28 APRIL 1984

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NEWS AND NOTES

SUPPLEMENT

NO 6426 BRITISH MEDICAL JOURNAL 1984 VOLUME 288 1249-1320
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0007-1447
ASTM CODEN: BMJOAE 288 (6426) 1249-1320 (1984)

CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Treatment of end stage renal disease

SIR,—Once again we read a critique of end stage renal failure services in Britain (31 March, p 998). But before reflex conclusions are pronounced let us remember that the National Health Service has a finite budget decided annually by parliament. If regional health authorities spend more on kidney failure they must spend less on other groups. For an informed debate about priorities we need to raise some further questions.

Firstly, we must consider the international comparisons. We are certainly low in the international league even taking into account the problem that European Dialysis and Treatment Association figures underestimate total treatment rates because some centres do not report. But the deficit is in treatment of older patients. Below age 55 Britain does well. Although selection of patients for treatment can achieve long survival,[1] this average will fall if a wider range of patients is accepted. The boom in treatment in Britain for older people appears to be coming through chronic ambulatory peritoneal dialysis. In other countries it came earlier through hospital dialysis. Yet in the United States (the only country undertaking such social research) there is substantial disquiet about the quality of life of these elderly people.[2,3] Do we wish to repeat their mistakes?

Secondly, let us look at costs and benefits. Cost figures for transplants are distorted by using only the cost for a functioning transplant. It would be better to use the doctor's "intention to treat" cost. Transplants have 20% to 60% failure rates at one year depending on the centre[4]; but these patients whose transplants fail have the highest costs of all because they include both the operation and subsequent redialysis. Chronic ambulatory peritoneal dialysis appears to be more expensive than home dialysis. As for benefits, despite over 100 000 patients treated worldwide we simply do not know: no randomised controlled trial has ever been performed.[5]

Thirdly, although we have the highest absolute number of transplants of European countries several other countries have higher rates. This is a problem of clinical attitudes not of the public.[6] Yet "not one of 30 transplant centres are fully occupied and most work at around half their potential capacity, a dreadful waste."[1] Britain's strength appears to be home dialysis, which is cheaper than hospital dialysis and could, it would seem, be extended to all new patients.[7]

Fourthly, what are the pressures to spend more on treatment of end stage renal disease? Cui bono? Is it the kidney equipment manufacturers who support publications,[4] international comparisons, and regular press releases? Is it renal physicians concerned about career prospects? Surely not, since "dialysis is almost exclusively a nursing procedure. Medical staff play a minor role in the management of chronic dialysis patients."[1] There appears to be some shortage of nurses prepared to work in renal units. But round the country renal units do not complain of inundation with suitable patients who cannot be offered treatment.[8]

The past 15 years have seen a sustained growth in treatment of end stage renal disease at rates far greater than for the NHS overall. There are no accurate, time series costings. But now the government—which proclaims more concern with efficiency than effectiveness—wishes to privatise renal care.[9] Surely this will cost more public money not save it. In the United States, where 40% of dialysis is provided by commericial companies,[10] a renal physician can say: "Centre dialysis in our country has been reimbursed very, very well, and for every patient that we place on centre dialysis we can make quite a profit." In the future perhaps we will also get our national information from a source like *The Kidney Dialysis Industry*.[11]

Treatment of renal failure is surely a fascinating study for health policy analysts. In contrast with most other countries, Britain does not have a reimbursement system of paying doctors, and until now there has been no profit incentive to overtreat elderly patients. Regional health authorities choose to limit treatment of renal failure and spend their marginal new resources on various priorities. We need much better care for long term mentally ill and handicapped people, better services for our growing elderly population, and much more emphasis on prevention in the NHS. These issues may be less glamorous but still to my mind have precedence for what little growth money there is within our closed health budget.

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[1] Taube DH, Winder EA, Ogg CS, *et al.* Successful treatment of middle-aged and elderly patients with end stage renal disease. *Br Med J* 1983;**286**:2018-20.
[2] Bonney S, Finkelstein FO, Lytton B, Schiff M, Steele TE. Treatment of end stage renal failure in