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## LEADING ARTICLES



## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED



## MEDICAL PRACTICE



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# CORRESPONDENCE



*Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters.*

*Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.*

*Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.*

## Death or dialysis

SIR,—Mrs Elizabeth Ward's leading article (22-29 December, p 1712) is welcome in that it highlights yet again a national and international disgrace. She deals in some detail with a proposal for helping to cope with the problem but in a fashion far from complete: the true situation is both more complicated and more simple.

Mrs Ward suggests the adoption of contract dialysis to diminish the gross shortfall in facilities for centre dialysis in the United Kingdom for those patients who are unsuitable for transplantation or home peritoneal dialysis or haemodialysis. She has been surprised and saddened to find doctors caring for patients with end stage renal failure less than enthusiastic about these proposals, but the reasons are not difficult to find.

Regular dialysis at the figure of £60 per dialysis that Mrs Ward quotes—that is, £9360 a year for thrice weekly dialysis—is not such an improvement on what is already being achieved in many NHS dialysis units, and may be worse than in some. The real cost of a patient on regular dialysis, whether on haemodialysis or peritoneal dialysis, includes not only the raw cost of performing the dialysis (including staff costs) but also the cost of preparing the patient by creating a fistula or inserting an intraperitoneal catheter, plus any revision of these; the cost of drugs (other than those such as heparin specifically required for the dialysis); the cost of hospital admissions, at £100-£200 a day, and more if intensive care is required; and the cost of a proportion of the salaries of the nurses and doctors who provide the back up and medical supervision of the patient. Costings in the United Kingdom[1] and elsewhere suggest that these extra costs represent an additional £3000-£5000, depending on the type of patient. In 1984 the DHSS quoted figures of £12 300 to £15 500 as average total costs for centre dialysis (A Hurst, personal communication), which cannot include more than about £9000-£10 000 for the dialysis alone.

In fact, an average figure for these extra costs would be a gross underestimate for those patients whom one hopes will benefit from an expansion of centre dialysis in the United Kingdom. Those who do not now receive treatment are, by and large, those aged over 60[2] and those with complicated diseases such as diabetes mellitus. Both groups make greater use of hospital facilities than the average patient on dialysis, and the hospital costs for a single such patient can run into tens of thousands of pounds in a year.

Thus, transfer of funds to a contractor, without allocating extra revenue to prevent depletion of the necessary support services, would result in worse level of care for the needy, since no unit could afford to be responsible for a group of patients in a contracted out, freestanding facility performing only haemodialysis, which would telephone the hospital at the first sign of expensive trouble. Moreover, if North American experience is anything to go by, it would probably increase the total costs.

Almost all renal physicians in the United Kingdom would prefer that the number of NHS dialysis units should be expanded, the new units being placed in those regions with a poor record of treating end stage renal failure. It cannot be an accident that every other country in Western Europe, despite varying patterns of health finance, has opted for 3-4 units per million population, while the United Kingdom lags behind with only 1·1 per million.[2] A poorer, but effective, alternative would be to expand existing units. Renal services in the United Kingdom are all but saturated,[3] with valuable plant lying idle up to half the time[4]—as in our own unit—because there is no money to staff the extra shifts. This money can come only from the regional health authorities, or from central allocation, either from cuts in other services or from an increase in total expenditure on health. In national