Developing countries need general physicians

Editor – In response to Dr Connor’s article (November/December 1998, pp548–51) developing countries do need general physicians. Many developing countries suffer from relatively low investment in health and low doctor to population ratios. There are few general physicians and even fewer specialists. A poor referral system and a loose network of general practitioners (GPs) encourage patients towards self-referral, so adding to the already heavy burdens of the general physicians.

These observations have several implications:

1. The priority of developing countries should be to train general physicians and general physicians with special interests, rather than pure specialists (or partialists).
2. Developing countries should estimate their own norms for cadre requirements and not follow blindly the proposed numbers of general physicians per population that apply in developed countries.
3. General physicians’ training in developing countries should include more components of skills and knowledge which may be categorised as ‘specialist knowledge’ in developed countries; some of the ‘additional procedures’ learnt by trainees in general (internal) medicine in developed countries would probably be categorised as ‘essential procedures’ in a developing country.

Perhaps it is time for the Royal Colleges to consider having more formal training links with institutions in developing countries, in order to enhance Royal Colleges’ training programmes.

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Sleep apnoea

Editor – The College Working Party on Sleep Apnoea, in agreement with Sackett and colleagues, is concerned that ‘evidence-based medicine may be hijacked by purchasers and managers to cut the cost of health care’ (November/December 1998, pp540–4). Working as I do within a Health Authority (HA) (purchasing/managing) I can say with confidence that I have never come across any purchaser or manager who seeks to cut the cost of health care. Any savings that are made are inevitably spent in some other area of health care. What purchasers and managers attempt to do is question the way in which money is spent in order to be sure that the best value is being obtained from a limited resource. HAs are not permitted by law to save money (they are not allowed to hold cash over at the end of the financial year) and I have never yet come across one which has sought to return money to the Treasury. It is most unfortunate if physicians present purchasers in this light, because they should know better and because this sort of comment is echoed then by the general public in opposition to well meaning and well thought out plans by HAs to reorganise services in order to improve efficiency and cost-effectiveness.

The questionnaire sent by the College to physicians offering an obstructive sleep apnoea service also deserves comment. It is difficult to imagine a similar questionnaire being sent to any group of specialist physicians without the results reflecting the same basic themes: financial problems within the HA, problems with the supply of equipment and provision of support staff, reliance on charitable funding, etc. Further, the finding that six physicians indicated that NHS purchasers had completely rejected applications for funding ‘...’ may well result from the changing nature of purchasing. For example, Wakefield HA no longer purchases this service because the responsibility for doing so (and purchasing almost everything else) has been devolved to GP commissioning groups.

Continuous positive airway pressure (CPAP) relieves symptoms, often dramatically, in patients who have sleep apnoea. The problem we face is one of an excess of demand over supply. The condition varies in severity, and consequently the benefit obtained from treatment is less in patients with less severe symptoms. When there is an excess of demand over available resources, it is sensible to ensure that those patients who will benefit the most — ie the most severely affected — get the treatment. What we need help with from our clinical colleagues is in deciding when to draw the line.

Reference
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In response

We readily acknowledge that purchasers aim to ensure that the resources available are used to the best advantage of patients in a cost-effective manner. We do, however, consider that sleep apnoea represents an example of the concern expressed in the quotation from Sackett. It is self-evident that ‘... the cost of health care’ implies the cost related to the particular problem under discussion, and not the global costs of the NHS.
Evidence-based medicine has been (and is still being) used selectively by some health authorities to avoid funding services for patients with sleep apnoea. Sadly, their 'well meaning and well thought out plans' are frequently not informed by the advice of relevant clinicians.

There are, of course, difficulties in funding services in other specialties, but certainly there is no other branch of respiratory medicine where problems of the magnitude we describe are currently seen. The point Dr Wright makes about devolving purchasing decisions to GP commissioning groups is not relevant as our survey was performed before this developed.

We agree entirely with Dr Wright on the importance of identifying those patients most likely to benefit from CPAP. Clinicians with experience in this area take considerable care to do this by performing individual trials of treatment. Selection is based on the presence of significant daytime symptoms, reduced quality of life, loss of job opportunities, marital discord, road accidents, and above all a favourable response to treatment. However, rational decision making is not helped by purchasing authorities severely and arbitrarily restricting the supply of CPAP units, thus depriving many patients of highly cost-effective treatment.

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Cardiac risk for non-cardiac surgery

Editor – I was interested in the paper of Dr Mark Turner and colleague (November/December 1998, pp545–7), but I think the time has come when patients with adult congenital heart disease should be included in such valuable protocols. During the latter part of the twentieth century, our knowledge and understanding of congenital heart disease haemodynamics, as well as surgical skills, has improved tremendously. As a result a new group of patients has emerged whose pre-operative assessment of cardiac risk for non-cardiac surgery is quite different from that of adults with ischaemic heart disease. This difference is most conspicuous in complex cyanotic heart disease. Further studies and protocols should consider this important issue.

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Setting health priorities

Editor – I read with interest the article 'Setting health priorities' (November/December 1998, p510) and would like to add a few further comments. One area where the confusion is most stark is mental health. Schizophrenia is one of the most disabling and economically destructive of all illnesses and is the second largest economic burden to the country (mental impairment being the first). The major priority over the past 10 years has been to facilitate a hugely expensive care in the community project. At the same time, a parallel advance in pharmacology was evolving, capable of massively improving side effect burden, quality of life and suicide rates (major goals for this and the previous government). However, with every crisis in the community the knee-jerk response has been to reinvest further in community care, whilst funding the entry of new improved antipsychotics has been ignored.

I am sure that National Institute for Clinical Excellence (NICE) is a welcome advance but I believe this will set standards rather than priorities. The chairman of the mental health aspect of this program is a fervent devotee of community care and therefore I hope he will balance his committee with this in mind. I also fear that NICE will be 'evidence-based' and the stringency of evidence set at whatever level is necessary to keep prescribing costs down. In London, funding decisions for new HIV combination therapy are made on a pan London basis with central ring fenced funds. This is an excellent and generous arrangement but one which has come about through a combination of public anxiety and political expediency rather than by sensible prioritisation. The government's new strategy for mental health enhances the funding for new antipsychotics (again, a welcome move, but one whose motives are public anxiety and political need), which arouses some cynicism after years of presenting this evidence to ministers and health authorities to no effect.

I fully support the proposal of a National Council for Health Care Priorities (NCHCP) and would like to help the RCP achieve this. One misgiving I have, however, is that such a bureaucratic body like NCHCP or NICE may lack the technical expertise to look at the emerging role of technology. The day is imminent when predictability tests and drug individualisation by genotyping will allow a considerable degree of targetting of drugs in a cash starved health economic environment. This, along with information technology, will go some way to rationalising tight drug budgets.

Finally, in a Radio 4 broadcast on this