benefits of ophthalmoscopy and retinal photography through dilated pupils with screening being administered by experienced personnel.

BOB RYDER
Consultant physician

Diabetic Unit,
City Hospital,
Birmingham B18 7QH

1 Department of Health and Social Security. *Causes of blindness and partial sight among adults in England in 1976/77 and 1980/81*. London: HMSO, 1988.
2 Kohner EM. Diabetic retinopathy. *BMJ* 1993;307:1195-9.
3 Retinopathy Working Party. A protocol for screening for diabetic retinopathy in Europe. *Diabetic Med* 1991;8:263-7.
4 Buxton MJ, Sculpher MJ, Ferguson BA, Humphreys JE, Altman JFB, Spiegelhalter DJ, *et al.* Screening for treatable diabetic retinopathy: a comparison of different methods. *Diabetic Med* 1991;8:371-7.
5 Finlay R, Griffiths J, Jackson G, Law D. Can general practitioners screen their own patients for diabetic retinopathy? *Health Trends* 1991;23:104-5.
6 Foulds WS, MacCuish AC, Barrie T, Green F, Scobie IN, Ghafour IM, *et al.* Diabetic retinopathy in the west of Scotland: its detection and prevalence, and the cost-effectiveness of a proposed screening programme. *Health Bull* 1983;41:318-26.
7 Smith SE, Smith SA, Brown PM, Fox C, Sonksen PH. Papillary signs in diabetic autonomic neuropathy. *BMJ* 1978;ii:924-7.
8 Smith SA, Smith SE. Reduced pupillary light reflexes in diabetic autonomic neuropathy. *Diabetologia* 1983;24:330-2.
9 Krolewski AS, Barzilay J, Warram JH, Martin BC, Pfeifer M, Rand LI. Risk of early-onset proliferative retinopathy in IDDM is closely related to cardiovascular autonomic neuropathy. *Diabetes* 1992;41:430-7.
10 Ryder REJ, Vora JP, Atica JA, Owens DR, Hayes TM, Young S. A possible new method to improve detection of diabetic retinopathy: Polaroid non-mydriatic retinal photography. *BMJ* 1985;291:1256-7.
11 Jones D, Dolben J, Owens DR, Vors JP, Young S, Creagh FM. Non-mydriatic Polaroid photography in screening for diabetic retinopathy: evaluation in clinical setting. *BMJ* 1988;296:1029-30.
12 Ryder REJ, Griffiths H, Moriarty KT, Kennedy RL, Blumsohn A, Hardisty CA. Superimposing retinal photography with a 4 mm pupil camera on existing retinopathy screening services in the diabetic clinic. *Practical Diabetes* 1991;8:151-3.
13 Barrie R, MacCuish AC. Assessment of non-mydriatic fundus photography in detection of diabetic retinopathy. *BMJ* 1986;293:1304-5.
14 Taylor R, Lovelock L, Tunbridge WMG, Alberti KGMM, Brackenridge RG, Stephenson P, *et al.* Comparison of non-mydriatic retinal photography with funduscopy in 2159 patients: mobile retinal camera study. *BMJ* 1990;301:1243-7.
15 Jacob J, Stead J, Sykes J, Taylor D, Tooke JE. A report on the use of technician ophthalmoscopy, combined with the use of the Canon non-mydriatic camera in screening for diabetic retinopathy in the community. *Diabetic Med* 1995;12:419-25.
16 Ryder REJ, Close CF, Gray MD, Souten H, Gibson JM, Taylor KG. *Fail-safe diabetic retinopathy detection and categorisation by experienced ophthalmic opticians combining dilated retinal photography with ophthalmoscopy. Diabetic Med* 1994;11(suppl 2):S44.
17 Smith SA, Shilling JS, Hull DA, Lowy C, Sonksen PH. Two year audit of primary care eye screening service in diabetes. *Diabetic Med* 1994;11(suppl 1): S23.
18 Brahams D. Medicine and the law: eye monitoring in diabetes. *Lancet* 1992;339:863-4.

The boundary between health care and social care

A positive but insufficient step

The Department of Health's recent guidance *NHS Responsibilities for Meeting Continuing Health Care Needs*[1] merits a cautious welcome. It follows a much criticised draft,[2] which originated in the health service commissioner's upholding of a complaint that Leeds Healthcare had failed to provide long term NHS care for a brain damaged patient.[3] Even so, it does not resolve all the uncertainties about responsibilities at the boundary between health and social care. Still less does it acknowledge the silent, if not surreptitious, shift in the balance between state and individual responsibilities for funding long term care that has taken place over the past 15 years. The profound implications of that shift for the expectations and finances of the current generation of elderly people and their families justify a long overdue public review of the current arrangements and their consequences.[4]

On the more positive side, however, the final guidance can be seen as more substantial, comprehensive, and prescriptive than its draft precursor. In a climate of increasing concern about pressure on resources in the acute sector and emergency medical admissions[5] its overt commitment to continuing care as an "integral part of the NHS" is a welcome and important statement of intent. Especially important is the requirement that district health authorities and fundholders should invest in continuing health care when they are "failing currently to arrange and fund a full range of services." The Department of Health clearly intends NHS responsibilities for continuing care to be fulfilled rather than evaded.

Although falling short of providing national minimum standards, the detailed guidance sets out nine issues that local purchasing policies and criteria for eligibility should cover. The inclusion of rehabilitation and recovery, palliative health care, and respite health care and specialist transport merits particular welcome as clarification of the NHS's responsibilities and extension of the draft guidance.

Although much in the guidance is commendable, much is also deserving of caution. In the striking absence of references to funding, reinvestment in continuing care will imply disinvestment from other areas. The NHS Executive will monitor planned and achieved levels of spending and activity annually, but how it will ensure the commissioning of a full and adequate range of local services is not clear. Hopefully, innovative purchasers will develop new policies and models of continuing care, breaking the long established mould of hospitals and nursing homes. Where such energy and vision are lacking, however, the lack of more specific guidance may result in a return solely to block contracts for long term beds, whether in the NHS or in the independent sector.

Criteria for eligibility will be set locally, resulting inevitably in local variations for people with identical or similar needs, although patients or their carers will have the right to seek review of decisions regarding eligibility before discharge from hospital. Ambiguities and local inconsistencies in criteria for eligibility take on a unique significance at the boundary of health and social care, since care commissioned by the NHS is received free at the point of delivery but that commissioned by local authorities may be subject to charges and means tests of savings and capital, including people's homes. These local criteria will distinguish between patients deemed eligible for care funded by the NHS as inpatients in hospitals or nursing homes (category E) and those identified as requiring "access to specialist or intensive medical and nursing support" while in nursing or residential home care funded by local authorities (category G). The consequences of these crucial but difficult distinctions will be twofold, affecting, firstly, the distribution of costs for residential and nursing home care between the NHS and local authorities and, secondly, the financial costs of continuing care borne directly by individuals and their families.

These locally defined distinctions and boundaries involve three, rather than two, categories: medical, nursing, and social care.[6] Very difficult decisions will be required in respect of both medical and nursing care. For example, what will distinguish between "the need for frequent, not easily predictable interventions" requiring the regular (weekly or less) supervision of a consultant, specialist nurse, or other NHS member of the multidisciplinary team (category E) and the need for "regular access" including "occasional continuing specialist advice or treatment" from medical, nursing, or other community health services (category G)? In addition, the difficult distinction needs to be made between some aspects of domiciliary nursing care and

personal care, for which the local authority or individual patients must pay.[7]

These definitions of categories of care are therefore of equal importance in domiciliary care, particularly as the guidance allows hospitals to discharge patients home if either they or their carers have rejected other options such as nursing homes. Many of the people covered by the guidance already live at home, receiving few statutory services and being cared for principally by relatives and other informal carers. For many carers, domiciliary and day care facilities are crucial in the management of the precarious balance between their caring and other domestic and employment responsibilities.[8,9] Where health and social care resources are tight, however, domiciliary services may be pared down to the absolute minimum.[10] This is particularly the case in intimate personal care, which is so crucial to the core values of dignity and quality of life, which rightly underpinned *Caring for People*.[11]

Long term care has historically been associated with inappropriate institutional arrangements and inadequate provision "in the community." The new priority accorded to the NHS's responsibilities for meeting continuing health care needs is welcome. Those responsibilities, however, will be properly fulfilled only by the investment of adequate resources and commitment in models of services that reverse existing imbalances of provision and promote choice and independence for users and carers.

MAGGIE PEARSON
Professor of health and community care
Health and Community Care Research Unit,
University of Liverpool and North West Regional Health Authority,
Liverpool L3 6AL

GERALD WISTOW
Professor of health and social care
Nuffield Institute for Health,
University of Leeds,
Leeds LS2 9PL

1 Department of Health. *NHS responsibilities for meeting continuing health care needs*. London: Department of Health, 1995. (HSG(95)8.)
2 National Association of Health Authorities and Trusts. *The National Health Service: responsibilities for long-term care. Response by National Association of Health Authorities and Trusts to the draft guidance of the NHS Executive*. Birmingham: NAHAT, 1994.
3 Health Service Commissioner. *Failure to provide long-term NHS care for a brain damaged patient*. London: HMSO, 1994. (HC197.)
4 Wistow G. Charges at the interface. In: Balloch S, Robertson G, eds. *Charging for social care*. London: National Institute for Social Work and Local Government Anti Poverty Unit, 1994.
5 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8.
6 Wistow G. Aspirations and realities: community care at the crossroads. *Health and Social Care in the Community* (in press).
7 Wilson G. Assembling their own care packages: payments for care by men and women in advanced old age. *Health and Social Care in the Community* 1994;2:283-91.
8 Phillips J. The employment consequences of caring for older people. *Health and Social Care in the Community* 1994;2:143-52.
9 Pearson M, Bogg J, Pursey A, Quinney D. *Users' and carers' views of NHS day hospitals for older people*. London: National Audit Office, 1994.
10 Richardson R, Pearson M. *Suffering in silence? Unmet health and social care needs in an inner city area*. Liverpool: Health and Community Care Research Unit, 1994.
11 Department of Health and Social Services Inspectorate. *Care management and assessment—Managers' Guide*. London: HMSO, 1991.

Performance indicators for general practice

Will lead to league tables of performance

Some family health services authorities are now producing performance indicators for the general practices they administer.[1-3] With the move towards a primary care led NHS,[4,5] these indicators will become an important management tool. League tables of practice performance are a possibility: for example, practices could be ranked by rates of uptake of cervical smear tests and the proportion of drugs prescribed generically. Many general practitioners, particularly those who work in deprived communities, will find this development threatening and may think that league tables will unfairly label their practice as performing poorly. Family health services authorities must therefore ensure that performance indicators are interpreted appropriately.[6]

Performance indicators may be used to identify and reward high performing practices with increased allocations for staff and premises. Conversely, if resources are allocated according to health need rather than performance, then less well developed practices (which are often located in areas with high need) may receive more resources. Because such practices may not have the capacity to use additional resources effectively this may lower the morale of the more innovative practices. Performance indicators should not therefore be used uncritically when resources are allocated to practices.[7]

General practitioners can benefit from performance indicators. They can use them to identify how their practice deviates from the norm and where scope for further investigation and audit may exist. For example, a practice with a high proportion of technically unsuitable smears may want to investigate this further. Performance indicators can also help practices to identify priorities for improvement and to monitor how well they address them over time. Finally, performance indicators can be used to carry out descriptive research into variations in medical practice in primary care.[8]

The most important limitation of performance indicators is that they measure only certain aspects of performance. For example, they can tell us what a practice's referral rate is but tell us nothing about the appropriateness of these referrals. Performance indicators also tell us nothing about what most general practitioners would consider to be their most important role: the clinical care of individual patients. Secondly, performance indicators could create perverse incentives, with general practitioners concentrating on improving the indicators rather than improving the quality of their care. Thirdly, performance indicators are constructed from routine

Examples of performance indicators for general practices available to family health services authorities

Patient data	Number of patients per partner
	Demographic breakdown of practice population
	Census derived social variables
Target payments	Cervical smear uptake rate
	Percentage of smears that are technically unsuitable
	Immunisation uptake
Items of service	Night visiting rate
Prescribing	Prescribing cost per patient
	Percentage of items prescribed generically
	Ratio of inhaled steroids and cromoglycate to bronchodilators
Employed staff	Numbers and categories of employed staff
Hospital referral rates	Referral rates for inpatient care
	Referral rates for outpatient care