role of patients in determining their own care. By concentrating on the relationship between professional 'providers' and lay 'consumers' Professor Campbell ignores the positive aspects of enabling people to make choices about their health. In doing so, patients are in a better position to ensure that the services they receive reflect their needs more closely.

The perspective of consumerism has recently been forcibly introduced into a whole range of public sector services. In the NHS the theme of consumerism was introduced around 1983 when Roy Griffiths produced his first report, *The enquiry into NHS management,* and was sustained and built upon in subsequent green and white papers, notably the consultative document *Primary health care: an agenda for discussion,* the white paper *Promoting better health,* and the NHS review *Working for patients.* All these papers assert that proposed changes are intended to make services more responsive to the consumer and for the consumer to be given wider choice. Given that wider choice, it seems highly improbable that the average patient would wish to be considered as a consumer in matters of health care. In effect, 'consumer' is an accommodating term, imposed on the patient, in order to introduce into the NHS a form of competition, and a market oriented philosophy.

One could argue that the patient is not merely a consumer and, indeed, could more appropriately be described as a partner — a provider of information and case histories, a presenter of illness and disease, a contributor in helping the professional reach a decision, a person actively participating in his or her own health care. Conversely when the new legislation is implemented the real consumers will be those placing contracts with and purchasing services from the hospitals; that is, district health authorities and budget holding practices. The six characteristics of a market relationship summarized by the philosopher Robin Downie,[1] and quoted by Professor Campbell, apply more appropriately to this alternative interpretation, whereby the trading partners are the budget holding general practitioners and the district health authorities on the one hand, and the hospital suppliers on the other.

Despite the repeated assertions that services are to be made more responsive to the patient and that the patient is to be given wider choice, it is difficult at this stage of untested theories and excluded pilot studies to appreciate where these choices lie. Patients will be able to change their doctor and move from one practice to another, but as practices grow larger, even that choice will become limited. It is far from likely that patients will be invited to participate in drawing up contracts which could incorporate specified patient choices and known preferences. Instead patients will be offered the medical treatment they seek where the purchasers have chosen to place their contracts and there is no reason to assume that this will be the patients' choice. This cannot be regarded as a genuine market situation from the patients' point of view. A trading partner would never accept such restricted terms.

It cannot be denied that the market approach implicit in consumerism does potentially enhance the position of the patient, albeit the more confident and articulate patient, but this enhancement can also be found within a participative relationship, where professionals share their decisions with their patients.

Just as there are confident and articulate patients so there are vulnerable patients, some so frightened, confused and emotionally distressed that choices and decisions have to be made on their behalf. It is vitally necessary that protection should be guaranteed to these vulnerable patients. A bill of rights, or patients' charter, such as that already produced by the Association of Community Health Councils in England and Wales, has much to recommend it, not least, as Veatch suggests[2] because it introduces a social dimension so sadly missing in individualized contracts and covenants. In any 'just' society there must be an element of social responsibility for ensuring an equitable sharing of medical provision. In this era of 'cash limiting' there has to be a notion of fair shares; the Patients' Liaison Group is of the opinion that the major flaw associated with consumerism in health care is the ideology of focusing on the individual rather than accepting corporate responsibility for the community.

The unique relationship of trust and understanding between doctor and patient which has evolved over the years will suffer immeasurably if it is seen only in commercial terms. It is being assumed that all patients can converse on equal terms with the doctor; that patients can compete with one another for services; and that patients accept and recognize the full implications of a trading relationship. This is far from the truth. Health care is qualitatively different and should be recognized as such.

DOREEN BUGLER

Patients' Liaison Group
The Royal College of General Practitioners
14 Princes Gate, London SW7 1PU

References

1. Downie RS. Traditional medical ethics and economics in health care. In: Mooney G, McGuire A (eds). *Medical ethics and economics in health care.* Oxford University Press, 1988.
2. Veatch RM. *A theory of medical ethics.* New York: Basic Books, 1981.

Prevalence of iron deficiency anaemia

Sir,

Dr Grant's community based study (March *Journal,* p.112) found 17% of preschool children to have iron deficiency (ferritin level $<10\ \mu g\ l^{-1}$) and 3% to be anaemic (haemoglobin level <10.5 g dl^{-1}). In a community based study in Sligo, north-west Ireland, Armstrong[1] found similar results — 40% of the adolescents tested had iron deficiency (ferritin level $<10\ \mu g\ l^{-1}$) while anaemia was found in 13% of males (haemoglobin level <13.0 g dl^{-1}) and 7% of females (haemoglobin level <12.0 g dl^{-1}). These two studies suggest that iron deficiency is more prevalent than might be expected.

Dr Grant's suggestion of taking blood samples from all pre-school children when they present for the measles, mumps and rubella vaccine may not be practical but perhaps a more sympathetic ear to the request for a 'tonic' or iron supplement would be appropriate.

HELENA MURRAY

General Practice Training Unit
Sligo General Hospital
Sligo, Ireland

Reference

1. Armstrong PL. Iron deficiency in adolescents. *Br Med J* 1989; **298**: 499.

Diabetic care in general practice

Sir,

I was interested to read the paper by Farmer and Coulter on diabetic care (February *Journal,* p.56). This was a stimulating paper and the hypothesis discussed, that organized general practice care reduces the rate of hospital admissions, is important.

However, if the admission rates generated in the paper are applied to the 'average practice' with 7500 patients,[1] then this suggests a difference between 'good' and 'bad' practices of less than one admission a year in total to distinguish their varying standards of diabetic care. This does not appear to be a very sensitive discriminator and it would have been reassuring to see the original total chi-squared value and the deviation to help assess the clinical significance of the trend result.

I would endorse many of their com-