

References

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Hospice-at-home

Sir,

The provision of home care services for people who are dying has increased rapidly in the past 10 years, yet in 1990 only 29% of cancer deaths with a terminal period were at home,¹ despite many people wishing to die there.^{2,3} Hospice-at-home differs from traditional services by providing a 24-hour service and 'hands on' care rather than performing a more advisory role. Previously, Koffman *et al*⁴ found that this type of service was able to help HIV/AIDS patients who wished to remain in their homes.

We studied the impact of a hospice-based, hospice-at-home scheme over two years. The service was run by a multi-disciplinary team including four care assistants, 12 bank care assistants, and a part-time occupational therapist, social worker, and nurse. Information was collated on the activity of the service, the place of death, changes in inpatient length of stay, the number of deaths in the local hospital, and home death rates for the district. A cost-minimization analysis was also carried out.

There were 122 admissions to the scheme over the two-year period; 43% were male, 57% female, and 77% were aged over 65 years. Most patients were referred to the scheme from the community and were living alone. The average length of stay was 10 days. Almost 65% of people in the scheme were able to die at home. This percentage was 23% higher than that achieved by the Macmillan service throughout the same time period. The average length of stay shortened from 16.6 to 12.7 days during the period the scheme was operating. Contracting data showed a marked increase in the number of patients admitted to the hospice between 1993 and 1996 for a similar number of occupied bed days. There was no impact on the numbers of people dying in the local hospital or on the rate of home cancer deaths in the district. The total cost of the service was £105 000 and the cost per admission to the scheme was £861. If we take successful outcome as a home death, then the number needed to treat (NNT) to achieve a successful outcome over the two-year period was 2.2. A more conservative estimate is obtained if we look at the extra percentage of home deaths that the scheme facilitated: the NNT becomes 3.0 and the cost becomes £5121 per extra home death.

The study had a number of limitations because of its retrospective nature and short time scale. Home death rates and lengths of stay may have been affected by a number of other factors operating at the time. The scheme was, however, able to enable a high percentage of those referred to it to die at home despite the fact that most of them lived alone. We believe these services need further evaluation as they may contribute greatly to enable dying patients to be at home.

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De-reimbursement of vaccines

Sir,

At a recent 1997 conference of local medical committees, the proposal was adopted that the regulations be amended to enable GPs to charge for all travel immunizations. This will be an attractive proposition to the Government, financially burdened with escalating health care costs, but it needs careful consideration.

Options to the current system for travel vaccines include:

- Transference to NHS prescription of those vaccines currently free to patients in England and Wales, as occurs in Scotland, where the patient collects the prescribed vaccine from the pharmacist and then returns to the surgery for injection
- Payment from those who can afford it
- Cessation of all NHS payments for travel immunizations, provision of this service being left to the open market.

A charge to the patient is a deterrent to seeking appropriate advice and to taking recommended preventive immunizations. There has already been a rise in malaria notifications following the removal of anti-malaria prophylaxis from NHS prescription in 1995, which pre-dates the media publicity about Mefloquine. The costs will be higher for those with large families travelling to visit relatives in areas such as the Indian sub-continent, a group already accounting for 48% of malaria notifications (total >750 in the first five months of 1997; personal communication: Malaria Reference Laboratory, 1997). This raises the concern that those at greatest risk could become the most compromised if limited finances restrict attendances in GP sur-