feasible to record breastfeeding rates in the community, and indeed this already occurs in the five-yearly Office of Population Censuses and Surveys infant feeding surveys,[2] in the annual surveys of Scottish maternity hospitals by the Scottish Joint Breastfeeding Initiative, and through the data collected routinely on all infants at the time of the Guthrie test.[5] I believe that setting a target based on the fall in the level of breastfeeding from birth to a set period postpartum would be more appropriate. This should be expressed as a specific proportion of the current level of breastfeeding at birth at that time. This would mean that absolute target levels would vary across the country but would ensure that challenging yet achievable targets could be set in all areas.

In summary, the Baby Friendly Initiative in the United Kingdom deserves the full support of the public health medicine profession. The 'Ten Steps' standards provide an excellent basis for either external evaluation or internal audit of hospital support for breastfeeding mothers. To link these processes to breastfeeding outcomes, a challenging but achievable target level which is directly linked to the support practices being evaluated should be retained. However, these should be expressed as a maximum 'attrition rate' in breastfeeding levels which is acceptable over the period from birth to some fixed point postpartum for which data can be collected routinely. In Scotland, the data collected at the time of the Guthrie test might provide a suitable endpoint.

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Clinical and economic consequences of patients as producers

Sirs,

Julian Tudor-Hart cries out for collaboration between health economists and clinicians. I respond as one of a few trained as both.

A number of interesting and under-appreciated observations are made about the nature of medical care and the therapeutic relationship. His analysis of the relevance of this to the purchaser–provider split, however, is impoverished by a reliance on the paradigms of a very anglocentric political dichotomy between left and right. This may explain some of his distaste for (and misunderstanding of) economic terminology.

The industrial view of health (in which patients are passive recipients of health care) describes a traditional biomedical view of health care. This was a view predominant in medical thinking until recently and which may yet be true of much hospital care. Patients are rendered passive by their illness and by the dislocating effect of admission to hospital itself. However, hospital care is peripheral to most health care, being only a small proportion of professional health care, which is in turn a small proportion of all health care. Passive patients validate biomedicine, its adherents and its institutions. This reinforces a view that professional and institutional care is always best and enhances professional and institutional authority.

Whatever kind of public health care system is in operation, providers must always either compete for public resources, or not survive as providers. Resources (an economist might call then 'profits') accrue to whoever fulfils the appropriate criteria. The reality of combining the functions of purchasing and provision is that the criteria for resource allocation are rendered opaque and are not necessarily related to any public view of the purpose of health care. This confers advantage on historically well-placed providers. Large university hospitals located near a seat of power come before small, primary care providers serving relatively disenfranchised communities. Professional care wins out over informal care. A good example of the latter is the hugh disparity between what we are prepared to pay in allowances to people who care for elderly relatives and what we are prepared to pay when the same care is professionally led (in a nursing home, for example). The separation of purchaser from provider renders resource competition (which is in fact a kind of profit motive) explicit. The criteria for resource allocation can potentially be debated.

The notion that in market interactions the aims of

purchaser and provider 'are never congruent' needs to be challenged. The congruence or divergence of aims depends on the nature of the incentives in the contract. Aligning these aims is precisely what purchasers should strive towards. Profit (which in this case means claims for social resources) can and should go hand in hand with meeting social ends. Within organizations, the contract is psychological and the rewards are more often satisfaction more than money. Congruence of aims beomes a task of management.

It is odd to read that Adam Smith's 'successors now see the mass of the people only as objects, useful only as disposable parts of the production machine or as consumers'. I heard the opposite view expressed by a former Minister of Health from one of the Baltic states. She saw the non-market philosophy prevailing in her country until 1990 as responsible for seeing people only as instruments for achieving social ends. Those with least productive potential (the elderly, long-term ill and handicapped) were afforded lowest priority in health care. Markets, on the other hand, she saw as a means for people's real concern for the disadvantaged to be articulated in resource terms.

It may be more important that we do reflect the values underlying health care provision than whether we choose to reflect them through market or non-market mechanisms. What is conspicuously absent from the United Kingdom's quasi-market is a means for the public's values to influence or inform purchasers' decisions. Markets can be a powerful engine, but they do not obviate the need for a driver. Perhaps that is where we should clamour loudest for participative democracy.

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