

evidence, but new gaps will continue to appear. In the absence of unambiguous evidence covering all eventualities differences of opinion are inevitable, even among the most reliable sources of guidance.

Furthermore, should respected sources such as the *British National Formulary* (BNF) be expected to provide details about how they reach their advice? Three of the four texts compared in this study provide information relevant to much of the population on the use of several thousand medicines. Vidal et al focused on the prescribing of 100 drugs in circumstances that affect only a small proportion of people. Their call for clarification of the evidence behind the advice that interests them ignores the difficulties of providing similar backing for hundreds of thousands of other similar items of prescribing information. The task would be beyond most editorial groups.

Many items of prescribing information probably cannot yet be matched to primary evidence. Even when such evidence can be found, it is often inconclusive, inconsistent with other studies, irrelevant to clinical realities, or of poor quality. Systematic reviews solve some of these problems, but they too may reach varying recommendations because of differing designs.<sup>8</sup> Most users of the *BNF* probably prefer a text that summarises best practice and does not describe the totality and complexity of evidence that goes into creating it. The *BNF* is probably better “suited for clinical use” because of its relative simplicity.

These caveats should not lessen our appetite for sound, evidence based recommendations for rational prescribing. Vidal et al are right to remind us that, where possible, such recommendations should be referenced and open to scrutiny. However, these ideals have to be seen in context. Most prescribers are probably willing to accept the advice provided by a trusted source in the knowledge that, if they want to see the

existing evidence, they have relatively easy access to it through searches of Medline and other databases and resources such as *Clinical Evidence*.

Prescribing will always be too complex for all the answers to be evidence based and “grey zones”<sup>7</sup> will always be there. Even when the best course of action seems clear, evidence has to be interpreted in the light of variables such as patients’ comorbidities and drug interactions. To cope with these uncertainties, prescribers will still need a combination of clinical experience, common sense, and knowledge based on a firm grounding in the principles of clinical pharmacology.<sup>9, 10</sup>

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## Making prison health care more efficient


*Inmates need more organised and more preventive health care in emptier prisons*

The cost of providing prison health services has been debated since 1774, when the Health of Prisoners Act was passed by the British parliament.<sup>1</sup> That debate continues now, although measuring how much taxpayers spend on prisoners is notoriously difficult. Nevertheless, the annual median cost of incarcerating a prisoner in secure custody in 2003-4 was about \$28 000 (£15 800, €23 400) per state prisoner in the United States,<sup>2</sup> \$45 000 in Australia,<sup>3</sup> and \$53 000 in Britain.<sup>4</sup> <sup>w1</sup> US state prisoners’ annual healthcare costs averaged 12% of total costs (around \$3350). With rising rates of incarceration,<sup>w2</sup> increasing public support for penal policies,<sup>w3</sup> greater needs among inmates for health care,<sup>5</sup> and limited budgets,<sup>w4</sup> prison health care is becoming harder to fund adequately.

In September 2002, the British government announced that it would transfer budgetary responsibility for prison health from the Prison Service to the Department of Health. By April 2006 responsibility for

commissioning prison health care will be devolved to NHS primary care trusts.<sup>w5</sup> Elsewhere, many custodial authorities have implemented strategies such as managed care and copayment schemes to reduce pressure on prison health budgets. In the first three years of the introduction of managed care to Texan prisons, for example, the daily healthcare costs for each prisoner fell from \$5.98 to \$5.11.<sup>w6</sup>

Since prisoners are not generally paying customers, healthcare providers have little incentive to provide good quality care: indeed, they have a perverse incentive to minimise essential services that have high costs. Doctors and nurses generally have to seek approval from managed care organisations to request tests and surgical procedures, but such approval is sometimes so slow in prisons that it arrives after an inmate is released or transferred.<sup>w7</sup> In the US,

 Additional references w1-w13 are on [bmj.com](http://bmj.com)

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where managed care is fairly well established, allegations of poor quality health care and litigation by inmates because of poor care are not uncommon.<sup>6</sup>

All federal prisons and about 70% of state prisons in the US have copayment schemes for prisoners' health care, and part of the money raised is paid into the Victims of Crime fund.<sup>7</sup> Although this has reduced healthcare costs in prisons,<sup>8,9</sup> it has adversely affected most poor prisoners, for whom a sick call fee of \$5 typically represents two days' wages. Chronically ill and elderly prisoners—who generally have greater healthcare needs but are physically unable to work—have the least income and therefore suffer more as a result of such copayment policies. Evidence so far indicates that the cost of administering the programme is greater than its projected savings.<sup>10</sup>

Most surveys in the US, Britain, and Australia indicate that prisoners' health is much worse than that of the general population.<sup>7,10-12</sup> This underlines the need for better initiatives for meeting prisoners' healthcare needs, particularly if it has to be done with the existing (substantial) resources for prisons.

One way to free up resources might be to reduce imprisonment rates, especially for minor crimes.<sup>9</sup> In the UK, Australia, and the US, rates for most major categories of crime are lower than they were 10 years ago, yet prison numbers have risen by about half. In French philosopher Michel Foucault's words, imprisonment has become its own remedy.<sup>10</sup> Greater use of other sentencing options, such as community service for minor offenders, and reserving imprisonment only for offences carrying a sentence of six or more months might reduce imprisonment rates by at least 20% in these countries, given the current average length of imprisonment.

Other ways to reduce the general costs of imprisonment include more mechanised custodial security and fewer staff, although such measures have not yet reduced the costs of staffing. Increased use of live communication via video conferencing between different departments involved with the criminal justice system, however, has allowed the New South Wales (Australia) Corrective Services Department to save \$A2.3m (£1m, €1.4m, \$1.7m).<sup>3</sup> Inmates may now

have their appeals heard by magistrates via such cross-justice videoconferencing, instead of being transported from prison to court.

Reform of prison health services might reduce costs if it brought greater focus on health promotion within the prison population and other preventive services, restructured staffing, obtained discounts through bulk purchases, and maximised resources through better cooperation with other government health agencies.<sup>11,13</sup> Finally, more effective use should be made of data from research, surveys, and clinical practice to reliably determine prisoners' core health needs, current healthcare practices, and cost effective ways to bridge identified gaps in services.<sup>12,14</sup>

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## Pelvic girdle pain in pregnancy

*Exercises may help, and evidence is increasing that acupuncture reduces pain*

Musculoskeletal pain in the pelvic area is common during pregnancy and can cause substantial distress and disruption of function. The lack of any standard definitions of such pain, however, makes it difficult to compare reports of prevalence, treatments, and outcomes. Useful terms for different clinical subgroups include pregnancy related pelvic girdle pain and pregnancy related low back pain.<sup>1</sup> Authors of British review articles and case reports often use the term symphysis pubis dysfunction to describe the pain, but others consider that such dysfunction is more often a secondary problem coexisting with lumbar or sacroiliac pain.

A systematic review of 28 studies that used the two terms pregnancy related pelvic girdle pain and pregnancy related low back pain found that prevalence ranged from 3.9% to 89.9% (mean 45.3%).<sup>1</sup> This wide range illustrates the problems of definition, identification, and classification. The authors found that estimates of prevalence depended on the inclusion or exclusion of patients with coexisting pain higher in the back and the definition(s) of musculoskeletal pelvic pain used to select patients.

Pelvic instability in pregnancy or the puerperium has been widely publicised in the media. This may have led to unnecessary medicalisation of pelvic muscu-