including community homes and day centres run by the social services, Mencap, and other voluntary and private bodies.

The NHS still has an important role and responsibility in dealing with people with learning disabilities, and community care does not mean non-NHS facilities. The NHS provides the best community care for such people who have health care needs. The health districts that ignore, undermine, or marginalise the appropriate NHS facilities for people with learning disabilities will jeopardise the health care needs of a group who are unable to defend themselves and do not understand politics or dogma.

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1 Glover GR, Rohde J, Farmer RDT. Is the money following the clients with learning disabilities? *BMJ* 1993;306:987-90. (10 April.)

Resource allocation

EDITOR,—Trevor A Sheldon and colleagues observe that "The issue of age weighting does . . . highlight a problem with migration of elderly people to retirement areas, which are then given a relatively high level of estimated need for health care resources. . . . This requires further investigation."[1] The current formula for distributing resources to regions, and by them to districts, is based on a capitation payment weighted for age and mortality. The age component uses an age-cost curve, which was calculated by use of age related utilisation at national average rates. We have previously shown that weighting for age and standardised mortality ratios are likely to have opposite effects on the distribution of resources.[2,3] We have now investigated the effect of the age-cost curve alone on district populations.

The Department of Health recently produced data showing the effect of applying the age-cost curve to the populations of all districts in England.[4] The data express the variation between the actual and age weighted populations as a percentage difference. The district that gains most from this adjustment is Worthing (25%), while the greatest loss is suffered by West Lambeth (14%). We have examined those districts that show the greatest variation between their actual and age weighted populations. In 22 districts the actual population was increased by at least 6%, and in 25 districts it was decreased by the same amount.

The 22 gaining districts formed a homogeneous group with many similar features and were designated retirement districts (for example, Eastbourne, Chichester, Harrogate). Nineteen of these 22 districts were coastal. The 25 losing districts were divided into two groups. Fifteen had characteristics of inner cities, with high levels of deprivation (for example, Camberwell, Newham, Tower Hamlets) and the remaining 10 contained some new towns and large business development areas (for example, Milton Keynes, Basingstoke).

Data from the 1992 public health common dataset and health service indicators were analysed to describe commonly used health indicators. To compare the three groups we calculated standardised mortality ratios, the rate of admission to hospital, and the provision of nursing home beds on the aggregated data, thereby allowing for the difference in population sizes. The table shows our findings. The innter city group had the highest level of deprivation, with significantly higher rates of admission to hospital among elderly people and a significantly higher standardised mortality ratio and percentage of low birthweight babies than the two other groups. The retirement group had double the nursing home provision of the other groups (the cost of which is not met out of district health authorities' funds) and significantly lower rates of admission to hospital.

Our findings show that there is a substantially different health need in the three groups. All the indicators presented in the table show that the greatest health need is in the inner cities, while the age-cost curve allocates these areas less money than the retirement districts. Use of the national formula for subregional allocations seems inappropriate. The effect of using the age-cost curve is likely to be a deterioration in health services in inner city areas, leading to an increase in geographical inequalities in health status. As the Department of Health sets about revising its formula we urge that it considers the implications of applying the age-cost curve at a subregional level.

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1 Sheldon TA, Smith GD, Bevan G. Weighting in the dark: resource allocation in the new NHS. *BMJ* 1993;306:835-9. (27 March.)
2 Williams ES, Scott C, Brazil R. NHS distribution of funds unfair. *BMJ* 1992;304:643.
3 Williams ES, Scott C, Brazil R. NHS distribution of funds unfair. *BMJ* 1992;304:1572.
4 Department of Health. *Review of weighted capitation. A discussion document.* London: NHS Management Executive, 1993.

Comparison of health indicators in districts affected most by age weighting (figures in parentheses are 95% confidence intervals)

	Districts gaining more than 6%	Districts losing more than 6%	
	Retirement districts (n=22)	Inner city districts (n=15)	New towns (n=10)
Total population	5 555 000	3 080 000	2 310 000
% Aged over 65	20·7	13·5	12·9
Total No of nursing home beds	18 190	3194	2837
NHS beds/1000 people over 65	15·8 (15·6 to 16·0)	7·7 (7·4 to 8·0)	9·5 (9·2 to 9·9)
Emergency admissions/1000 people over 65	89 (88 to 89)	131 (130 to 132)	106 (104 to 107)
All admissions/1000 people over 65	195 (194 to 196)	246 (245 to 247)	218 (216 to 219)
Jarman index	93·9	124·4	90·6
All age standardised mortality ratio	94 (94 to 95)	102 (101 to 103)	94 (93 to 95)
% Of low birthweight babies	6·2 (6·1 to 6·4)	7·4 (7·2 to 7·6)	6·2 (5·9 to 6·5)
Per capita allocation based on age weighting only (£)*	411	334	334

*Using the national cost curve.

Using Medline for comprehensive searches

EDITOR,—Over the years we have used Medline repeatedly for searches for a wide variety of purposes, ranging from medical students' projects to detailed comparative assessments of institutional research output for a national funding body. Christopher Silagy highlights some of the difficulties in devising a comprehensive retrospective search strategy.[1] He attempted to identify reports of randomised controlled trials relevant to primary care and found it difficult to do so effectively on Medline.

In our experience this difficulty would have been exacerbated by MeSH headings being revised from time to time and the fact that there are various classes (or "levels") of journals indexed, which are treated differently with regard to the depth of indexing and—historically—with regard to details like which index fields are included in the record. But perhaps the greatest difficulty is that of obtaining any printed statement of the detailed policies and practices relating to the selection of journals, the "levels," and matters such as the inclusion of abstracts and the existence or absence of specific fields—and how and when all these things have changed.

Search strategies will be less than optimally effective in the absence of total familiarity with the MeSH headings thesaurus. Indeed, other studies have shown the crucial role fulfilled by expert panels in developing and legitimising search strategies within biomedical science.[2] In this case, "family practice" would, as the standard heading (from 1966), have seemed the appropriate one for a search in general practice. Silagy used "control" (though not actually a MeSH term, as he suggests) in an attempt to enhance capture of papers on randomised controlled trials; this would have produced a variety of irrelevant "hits" including matters such as pest control, communicable disease control, etc. Fortunately, the more recent literature on a "clinical trial" and a "randomised controlled trial" is now identified in the Medline database with these specific headings. They were introduced into the "publications type" field in 1991.

Finally, the choice of journals included in Medline may be seen as idiosyncratic. In the subject of medical education, for instance, an internationally respected research journal, *Teaching and Learning in Medicine*, is excluded, while a professional journal with papers such as "Twelve tips on preparing 35 mm slides" is included.

Medline is in many ways an excellent and sophisticated system. But when bibliometric investigations are based on searches of Medline in order to make summative historical assessments of topics, institutions, or departments we advise use of the maximum of experience, expertise, and caution.

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1 Silagy C. Developing a register of randomised controlled trials in primary care. *BMJ* 1993;306:897-900. (3 April.)
2 Rogers LA, Anderson J. A new approach to defining a multidisciplinary field of science: the case of cardiovascular biology. *Scientometrics* (in press).

Medical messages on television

Grapevine effect

EDITOR,—Simon Collins has suggested that the incidence of overdose with paracetamol among female teenagers had increased in his centre in the weeks following the screening of a particular episode of the BBC series *Casualty*.[1] He suggests that caution is needed to minimise imitative cases among such an impressionable audience. Although we agree with his comments, we report a case in which that episode of *Casualty* was of benefit.

Recently a 19 year old woman was admitted 18 hours after taking an overdose of 48 tablets each containing 500 mg of paracetamol. She was subsequently reviewed by a psychiatrist and considered not to be suicidal but that the overdose had been impulsive. She stated firmly that she would not have come to the accident and emergency