

screening of blood seems to have had a very limited role.

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Effects of fundholding on prescribing habits

Results of similar study in Mersey were different

EDITOR,—In their study into the effects of fundholding on prescribing Sarah Stewart-Brown and colleagues found that although fundholders initially contained prescribing costs more effectively than non-fundholders, this effect was not maintained and was even reversed.¹

Our studies of prescribing in fundholding practices show that similar patterns of cost containment occurred in the first year of fundholding in the first three waves² but that the effect was not maintained.³ Stewart-Brown and colleagues suggest several possible explanations: these include deliberate inflation of prescribing costs in the pre-fundholding year to increase the budget for the next year (on the basis of our data² we thought it unlikely that such an approach was widespread, but it might be a factor in some practices); that all reasonable savings were achieved early on; and that the comparator group of non-fundholders was also trying to contain costs as a result of new prescribing incentive schemes, minimising differences between the groups. We favour this last explanation and in support of this show a dramatic rise in the rate of generic prescribing among all non-fundholders in Mersey region in 1993-4 (fig 1). We believe that this was the result of incentive schemes and a local requirement that the rate of generic prescribing among prospective fourth wave fundholders should be 50%.

Stewart-Brown and colleagues point out an apparent reversal of the pattern of cost containment between fundholders and non-fundholders by the end of the study. We found no such reversal in our study of almost an entire population of fundholders and non-fundholders in Mersey,³ and we suggest that it is the result of the small number of practices studied, as the authors considered. The fact that two of the five non-fundholding practices were

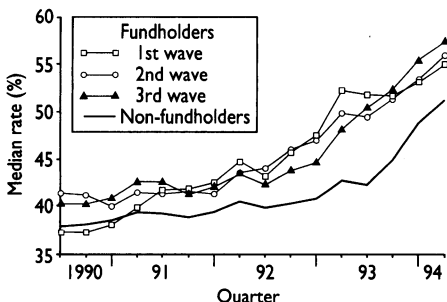


Fig 1—Rates of generic prescribing among fundholding and non-fundholding practices, 1990-4

studied in a year in which they were preparing for fundholding may also be important. We question the authors' assertion that their "results are highly significant" because of the large numbers of prescriptions studied, since their unit of study was the practice, not the prescription. We consider it inappropriate to report the mean difference and parametric 95% confidence interval when n is 3 or 5, as this makes interpretation of the results difficult and even the existence of any (statistically or practically) significant difference between the different types of practice studied uncertain. We agree with the primary conclusion of the authors' paper—that the rate of increase in prescribing costs after the first fundholding year is similar to that among non-fundholding practices—but disagree that a reversal in cost containment patterns occurs later.

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Generic prescriptions are defined differently for dispensing practices

EDITOR,—Sarah Stewart-Brown and colleagues compare the rate of generic prescribing between dispensing and non-dispensing practices in their paper on fundholding and prescribing.¹ Are they aware that the Prescription Pricing Authority (which provided the data for the study) defines a generic prescription differently for dispensing practices? Few doctors are aware of this fact, which is not mentioned in the paper and may well explain the observed differences in the rate of generic prescribing. Any comparison of generic prescribing between dispensing and non-dispensing practices is therefore invalid, as are comparisons between areas with different proportions of dispensing practices.

If this was purely an academic matter it would be of minor importance. However, budget setting for districts and practices, and prescribing incentive schemes, include rates of generic prescribing in their criteria. This discriminates against dispensing practices and hence rural areas.

The fact that even researchers in health economics seem to be unaware of this important peculiarity prompts me to publicise it in the hope of reform.

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Authors' reply

EDITOR,—R Wilson and T Walley present some valuable data on rates of generic prescribing in the Mersey region. Their figures differ from ours only in that, in 1990, the rate of generic prescribing among non-fundholders in Mersey was much lower than that among non-fundholders in Oxford. The trends that we observed in our study mirror those observed throughout the Oxford region (T Jones, medical adviser to Oxfordshire Health,

personal communication), suggesting that our study practices were typical of the region. These data confirm what we already know: that there are some regional differences in prescribing practice. It is possibly more remarkable that data from fundholding practices in the two regions are so similar.

The rate of generic prescribing is only one of several factors that determine prescribing costs. Our argument that trends in prescribing costs had reversed between 1990-1 and 1993-4 was based on data which Wilson and Walley do not present.

We think that it is unhelpful for Wilson and Walley to use spurious statistical arguments and selective quotation from our paper to argue that their findings are more valid than ours. Both of our studies are valid, and instead of arguing about who is "more right" we would surely do better by trying to learn from the differences we observed.

The point that Ted Willis makes is important. He is right that we were unaware of the different ways in which generic rates used to be calculated for dispensing and non-dispensing practices. Changes in the presentation of PACT (prescribing analysis and cost) data in June 1994 enabled medical advisers to learn that earlier data on generic rates had been calculated on the basis of rates of generic prescriptions in non-dispensing practices and rates of generic dispensing in dispensing practices. The difference is of the order of 2-5% for dispensing practices. This means that the generic rate in dispensing practices in our paper is likely to underestimate the true rate by this amount. Adjusting for this difference reduces but does not eliminate the gap that we observed in generic rates between the different types of practice and does not affect the validity of the other prescribing data.

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Prescribing by general practitioner fundholders

Longer study shows that costs rise again after initial savings

EDITOR,—Two interesting papers have examined the effects of general practitioner fundholding on prescribing costs.^{1,2} Robert P H Wilson and colleagues conclude that fundholding affects prescribing costs,¹ but they examined only the first year after practices joined the scheme. Bradlow and Coulter, in their study of general practitioners' prescribing in Oxford, also found that fundholders' costs initially rose less steeply than non-fundholders',³ but further follow up of the practices showed that the fundholders were unable to sustain this advantage two years later.²

We have examined aggregated prescribing budgets for fundholders and non-fundholders in Nottingham and have found a pattern remarkably similar to that reported from Oxford by Sarah Stewart-Brown and colleagues³ (fig 1). Fundholders initially made savings, but their costs are now higher, and rising more rapidly, than those of non-fundholders. In compiling our figures we did not account for possible confounding variables,