venient for the patients. Finally, though we have not accurately assessed the costs, for fundholding practices the system would pay for itself within 12 months, given the savings made on hospital attendances.

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Market penetration of new drugs

EDITOR,—Three letters[1] comment on our article on the market penetration of new drugs in Northern Ireland.[2] J P Griffin attacks our article as flawed in its conclusions without revealing the flaws.[1] We did not state that it was "always the first medicine in the field which continues to be... the market leader." We did not advocate that the search for better products in the same therapeutic class should not be pursued. We described not "modest increases" in drug use but twofold and threefold increases over four years. The clinical need for these drugs, apart from angiotensin converting emzyme inhibitors, is unlikely to have increased over the same period. Our generalisations were not "based on too few data." They covered all prescribing for 1·6 million people, every month for four years. Finally, the caution of doctors in the United Kingdom in using new drugs is well documented and probably well justified.

In R C Davis's letter the calculations on the estimated use of angiotensin converting enzyme inhibitors in heart failure are simplistic and unlikely to represent the true picture.[1] The estimated prevalence of heart failure of 0·4% refers to all patients with symptomatic heart failure. Most patients in Northern Ireland who receive angiotensin converting enzyme inhibitors have grade III or IV disease (New York Heart Association classification); patients with this grade of disease make up a relatively small percentage of the total. In addition, most of these patients receive captopril, a short acting agent, and only rarely receive one of the longer acting preparations. The increased prescribing of long acting angiotensin converting emzyme inhibitors is therefore mostly due to these drugs' increased use in hypertension.

With regard to Andrew H Watt's letter, because we work in a drug utilization research unit we are well aware of the difficulties of reaching conclusions from prescription pricing data.[1] Our paper was cautious, with circumspect language. In the case of the three therapeutic groups that we studied we would remind Watt that our argument is simply that "the increase in prescribing of these drugs seems to be greater than can be accounted for by an increase in patients with specific indications for these drugs." We would welcome epidemiological or other evidence from Watt that challenges our conclusions.

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Screening immigrants at risk of tuberculosis

EDITOR,—R M Hardie and J M Watson point to many inadequacies in their survey to determine the methods used to identify and screen immigrants at risk of having tuberculosis.[1] It is not district health authorities, as the authors claim, but mostly local authorities that manage the service. The local authorities do not see themselves as the correct organisation to administer the service, and any appeal for additional resources would be turned down.

If an objective of the service is to familiarise new arrivals with the NHS then why is the service confined to immigrants from the Third World? These immigrants now make up only a small proportion of people migrating to study, work, or settle in Britain; a much larger proportion comes, for example, from the countries in the European Union. If, on the other hand, an objective of the service is to screen immigrants at risk of tuberculosis then the authors do not present convincing evidence for its necessity.

The authors' survey indicated that there was radiological evidence of active tuberculosis in 20 out of 20 000 chest *x* ray examinations—a detection rate of 0·1%. This is hardly an indication for promoting an expensive network of nationwide screening services. Indeed, an audit of 226 chest *x* ray examinations performed on immigrants in Birmingham during 1992 showed no active tuberculosis. No case of sputum positive tuberculosis has been identified in newly arrived immigrants in the past 10 years in Birmingham, the largest local authority in Britain. The natural course of tuberculosis in Britain shows that this is not surprising. Immigrants may arrive with quiescent tuberculosis, but if this becomes active it does so over the next five years.[2]

I accept that all new arrivals need information not only on health but also on other community services and that written information on these can best be provided at the port of entry.

Ethnic minority organisations regard screening services for selected immigrants as discriminatory and without evidence of medical benefit. Hardie and Watson's paper will add to their suspicion and diverts attention from understanding of the underlying causes and management of tuberculosis in people who are at risk of developing the disease.

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Male and female castration

EDITOR,—Aileen Clarke and colleagues suggest that female castration should receive the same attention as surgical castration for sexual offenders.[1,2] I have two comments.

Firstly, though specific and detailed informed consent is clearly required before oophorectomy during a hysterectomy, male and female castration seem to be fundamentally different in this context. Castration of male sexual offenders could be seen largely as a measure to benefit society rather than the person, whereas this is clearly not the case for oophorectomy. This raises quite distinct moral issues.

Secondly, the statement that oophorectomy is a "controversial method of reducing the risk of ovarian cancer"[2] needs to be explained further or it may leave readers confused. Rare cases of primary peritoneal carcinoma (which in all respects resemble ovarian carcinoma) have arisen in women who have had bilateral prophylactic oophorectomy because of a strong family history of ovarian carcinoma.[3] Presumably it is these cases that lead Clarke and colleagues to consider that oophorectomy may not reduce the individual risk of ovarian carcinoma. Probably, however, women with an inherited susceptibility to ovarian carcinoma are at far higher risk of peritoneal carcinoma than the general population. Studies to determine the benefit of prophylactic oophorectomy in those with a family history of ovarian carcinoma are under way.[3]

As Clarke and colleagues suggest, possibly effective conservative methods of reducing deaths from ovarian carcinoma should be investigated. Comparing female castration as prophylaxis against ovarian carcinoma to male castration for a sexual offence, however, is not helpful.

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2 Alexander M, Gunn J, Cook DAG, Taylor PJ, Finch J. Should a sexual offender be allowed surgical castration? *BMJ* 1993;307:790-3. (25 September.)
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Poor children in rich countries

EDITOR,—In his enthusiasm to write a polemic on poor children in rich countries Martin McKee has departed from his usual rigorous standards.[1] In highlighting teenage suicide and expanding to an attack on the socioeconomic systems of much of the Western world he is defying logic in arguing from the smallest of the particular to the largest of the general. With regard to the subtitle of his editorial—"Markets fail children"—I suspect that a brief look at the plight of children in those countries where the wreckage of central command economies is painfully evident (Russia, Tanzania, etc) would quickly lead to an alternative viewpoint.

In contrast, the rapidly improving plight of children in the "tiger" economies of south east Asia, in particular Singapore, suggests that two or three decades of market operation can totally transform the situation of children in Third World economies. This is, in fact, the point. In his comparison between the "Beveridge-type" and "Bismarckian-type" social systems McKee has ignored the vast majority of the world, which would count itself fortunate to fall into either type. I can well believe that the diversity of social cultures in the European Union may ultimately prove more beneficial to the population than the monoculture in the United States, but these arguments are trivial when there is, with the General Agreement on Tariffs and Trade, a single world economy.

We can all prosper if attention is paid to our competitiveness. Arguments about details of social systems will prove irrelevant if we subside into genteel poverty owing to the higher competitiveness of the new trading economies. New Zealand's government recognised this early on, New Zealand being in a particularly vulnerable position in the rapidly growing Pacific region. Even greater adjustments to welfare systems will ultimately be forced on those governments that have not had the foresight to avoid living beyond their means. To invest in our children, as McKee suggests we