we took the average cost for a specialty as a starting point. Day cases were included in this cost.

Körner data for 1990-1 were used to estimate outpatient activity, but later data were used when available. We agree on the shortcomings of these data, but in North Thames region Körner data are the main source of information on outpatients. The cost of each outpatient attendance was taken from work by the Department of Health.[1] Until outpatient care is contracted for separately, it may not be possible to move far from such gross assumptions. We welcome advice to help improve our methods.

Consistent biases can produce consistent results. But, as shown above, it is not clear in which direction biases may have operated in our study. A working party with representatives from health authorities in North Thames Regional Health Authority is now developing the methodology further. Also under discussion is whether health authorities should contract separately for fundholding-type hospital care.

We agree that estimating and comparing the prices paid by fundholders and health authorities are difficult and that a more detailed analysis is needed. The data illustrated in our paper suggested that prices between fundholders and health authorities were different within specific health agencies but not across the region as a whole. It is therefore difficult to make the case that fundholders were systematically charged more than health authorities. Finally, we believe that our analysis was as robust as was possible with current data and in the time available. While it would be easy to wait for perfect methods and perfect data, decisions about funding for fundholders are being made with little knowledge of the impact on health authorities. We hope that others will see the importance of investigating this issue without delay, especially as fundholding is extended.

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1 Economic Operational Research Division. *The effect of capitation shares of bringing special health authorities into the market.* Leeds: NHS Management Executive, 1993.

Controlling the NHS drugs budget

EDITOR,—The NHS prescribing list suggested by the House of Commons health committee would automatically include all drugs at the time of their launch and for five years thereafter.[1] A review would then take place, at which many drugs being prescribed on the NHS might be removed from the list. One argument for moving towards such a system is that it would discourage irrelevant research and reward clinically useful work.[2]

General practitioners may question whether the practicalities of changing patients to other therapeutic agents will create potentially difficult clinical judgments. Patients have often been prescribed newer drugs by the hospital sector and are also often high risk patients with cardiovascular or respiratory disease. Increasingly, these patients are elderly. Doctors will be forced to prescribe alternative drugs as most of the patients will not purchase drugs privately.

The response of the pharmaceutical industry is unlikely to be passive. International companies are likely to license fewer drugs for British patients if the drugs are threatened with arbitrary removal from the list after five years. Investment in the British research industry may well be affected, but the health committee claims not to be convinced that a selected list has a detrimental effect on research.

Perhaps the greatest concern must surround the bureaucracy created by such an initiative. The most recent publication of a selected list in certain categories has removed few agents from the NHS despite a two year period of judgment. This confirms that even an expert committee finds difficulties in differentiating products that are of no merit to patients.

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1 House of Commons. Health Committee. *Priority setting in the NHS: the NHS drugs budget.* Vol 1. London: HMSO, 1994.
2 Herxheimer A. Controlling the NHS drugs budget. *BMJ* 1994;309:424-5. (13 August.)

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Privatisation of NHS prescribing

EDITOR,—Iona Heath mentions that prescriptions for NHS patients written privately will no longer appear in the practice's prescribing analysis and cost (PACT) data. This is because such items will not be captured on the database of the Prescription Pricing Authority. The effects are, however, more far reaching than that.

Such items will not appear as costs against the practice's prescribing target budget or, in the case of fundholders, against the total fund. The result will be to generate savings, which could be spent elsewhere—for example, on more hospital activity. Such practice gains would not be evenly spread out but would depend on the proportion of patients liable for the prescription charge. Practices in affluent areas stand to gain more, aggravating inequalities in health related to social deprivation.

Many of the management mechanisms used to audit and monitor prescribing, ranging from practices to the NHS Executive, will be distorted. For example, many of the cheaper items on private prescriptions will be generic drugs, creating a spurious fall in the number of prescriptions for generic drugs, which are identified in PACT data.

Such changes should arouse disquiet. Besides short term budgetary distortions, ultimately they will further embarrass scarce resources for the NHS. Despite these concerns hard pressed doctors and managers can hardly decline an opportunity to improve their short term budgetary positions, given the major pressures that are leading to increased expenditure on prescribing.

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1 Heath I. The creeping privatisation of NHS prescribing. *BMJ* 1994;309:623-4. (10 September.)

Infections in sport

EDITOR,—J C M Sharp states that the risk of acquiring hepatitis B during sporting activities is small,[1] but infection acquired from a prick by a contaminated thorn during orienteering events and among barefoot runners has been reported. In a paper on hepatitis B among Swedish track finders Ringertz and Zetterberg considered the possible modes of transmission to be limited: inoculation by a twig that wounded a preceding competitor; water, towels, soap, or brushes used by several people; or person to person contact in steam baths.[2] They believed that transmission occurred mainly in connection with washing after the competitions.

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1 Sharp JCM. Infections in sport. *BMJ* 1994;308:1702-6. (25 June.)
2 Ringertz O, Zetterberg B. Serum hepatitis among Swedish track finders. *N Engl J Med* 1967;276:540-6.

Long term care of elderly people

EDITOR,—I am concerned by the Department of Health's "clarification" of its responsibilities towards elderly people in need of long term care.[1] It classifies such people as requiring medical treatment or requiring only nursing care, with the NHS providing medical treatment (mistakenly referred to as "free") and local authority social services providing nursing care, for which the elderly people will be subject to means testing. Although many people fall into these clear cut categories, a considerable proportion pose a complex interactive matrix of medical, nursing, and social problems. For example, there will be patients whose physical condition cannot be cured but will deteriorate more quickly without medical care. Inevitably, decisions about which category patients are placed in will vary, and this will lead to further erosion of one of the founding principles of the NHS—namely, equity.

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1 Warden J. Government clarifies long term NHS care. *BMJ* 1994;309:498. (20-27 August.)

Discharges from nursing homes

EDITOR,—Clive E Bowman may be correct in stating that there are inadequacies in the medical care for residents of nursing homes. Our survey, however, was designed not to study the care provided in nursing homes but to monitor discharges from nursing homes over three years. Bowman is correct to highlight the importance of inappropriate placement, but, again, our survey was not designed to study this. If people are being placed inappropriately this may be manifested by difficulties in caring for the person or the person being passed to other services. Our survey did not provide any substantial evidence that people were being passed to other services.

Many residents of nursing homes have health problems. Most of these problems are managed by general practitioners. If, as Bowman seems to be suggesting, people are being admitted with medical problems for which they should have been referred to the NHS this would be most worrying. We are unaware, however, of any substantial evidence to support this.

Perhaps research is needed into the impact of cuts in the numbers of acute, medical, and long stay beds on the type of person being admitted to nursing homes and the impact that that may have on a sector whose primary function relates to nursing. What is important is that nursing homes should feel free to consult, and refer as appropriate to, health services without being, as Bowman states, "fearful of acquiring a reputation of not