Authority has tried to make the best use of the data in practice reports and has fed them back to general practitioners. For example, this year and last year we produced a report containing a summary of core data, some of which were obtainable from sources in the authority, and a substantial contribution from practice reports on a locality basis. The "locality profiles" included information on need and practice provision and activity.

We used the information on referrals that was returned to continue a dialogue with one health authority on taking the needs of general practitioners and their patients into account when placing contracts for next year. We are also using this information to feed into a preparatory group looking at the contracts for the wider health agency due to be set up next April.

In the reports for last year and this year we added some optional questions, to which we had a good response (over 80% in the reports returned; 88% of reports were returned). For example, to target resources for the next financial year we asked about local practices' computing needs; a question on appreciable language difficulties during consultations has enabled us to pilot an interpreting service; and we used the report to identify those practices that would be willing to participate in a multiagency project looking at the management of people with minor misuse of tranquillisers.

Next year, recognising that much of the information required by the national contract is actually available within the family health services authority, we are aiming, after consultation with the local medical committee, to send out a much shorter report, which will concentrate on a few key issues (that is, it will target questions specifically at needs assessment and health promotion). We will attempt to tie in the timing of the reports with the planning cycles of the family health services authority and new health agency.

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1 Widgery D, Cembrowicz S. Practice reports. *BMJ* 1992;305: 1173-4. (14 November.)

EDITOR—David Widgery and Stefan Cembrowicz raise several points about the value of the data published in annual practice reports and the need for data to be consistent if they are to be used for planning and mini-epidemiological purposes.¹ The value of the picture of primary care in the late twentieth century built up by a collection of annual reports will indeed be great, but retrieval of the information will be impossible unless the reports are collected, recorded, and indexed for future use.

Health service librarians make great efforts to collect this kind of "grey literature" routinely and will be delighted to add annual practice reports to their collections. A database of such reports already exists within the South West Thames region. At the moment it is available only in the libraries, but within a year or two it will be available to general practitioners through the regional networks.

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1 Widgery D, Cembrowicz S. Practice reports. *BMJ* 1992;305: 1173-4. (14 November.)

Fundholding practices get preference

EDITOR—Hospital staff up and down the country are now facing difficult ethical problems imposed by the virtual blackmail that only by distorting

traditional clinical priorities can their hospitals and units stay solvent.¹ The NHS Consultants' Association has been debating these matters in recent months to provide some guidelines for members and others. These were finalised at the annual general meeting last November, and the following extracts from sections on general practice fundholders and contracts may be of interest.

Firstly, we should avoid giving preferential treatment to patients from fundholding practices except on clinical grounds.

Secondly, we should favour negotiations which enhance the principles of priority according to medical need and oppose those which interfere with this.

Thirdly, we should seek to form alliances with local general practitioners to persuade health authorities to place contracts in line with public demand.

Fourthly, as in the case of general practice fundholders, we should encourage contracts based on priority according to clinical need, avoid those which breach this principle, and decline to operate differential waiting lists based on anything other than clinical need.

Fifthly, when there are management instructions to stop treating local patients because the contract has been fulfilled we should endeavour to continue seeing appropriate referrals, ensuring that both general practitioners and patients are aware of the difficulties by providing factual, non-emotional information. This particularly applies to those cases where patients have been put on a waiting list and later declared non-eligible because of a change of contract.

Finally, in order to maintain clinical control we should try to ensure that letters from general practitioners go direct to the consultant's office and cannot be intercepted without our knowledge.

We can, if we act together, preserve professional standards, but if we fall into the trap of parochialism the losers will be our patients, followed shortly by ourselves.

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1 Samuel O. Fundholding practices get preference. *BMJ* 1992; 305:1497. (12 December.)

EDITOR—Oliver Samuel highlights the major ethical and professional problems facing surgeons working under the purchaser-provider management system that now characterises the NHS.¹ When a surgical department in a hospital has completed its contracted work for a particular purchasing authority that hospital will not receive any payment for the treatment of any subsequent patient from that purchasing authority. If the hospital continued to treat such patients in any numbers a major budget deficit would result and the hospital would face financial ruin.

The surgical department would thus lie idle until the start of the next financial year unless work from other purchasing authorities or general practice fundholders could be attracted. This situation is being experienced by many hospitals throughout England. The purchasing authorities do not have sufficient funds to discharge their responsibility to the communities they serve, and hospitals gear down towards the end of the financial year by reducing lists and closing beds. The government knows that the purchaser-provider system is the most effective method of cash limiting the hospital service and, while cynically claiming that patient choice has been increased, knows that the reverse is true.

This leaves surgeons with the ethical problem of how to discharge their professional responsibility to their patients without the funding to do so. In theory, the purchasing authorities are responsible

for the waiting lists and the provision of hospital care for their communities, but there is still ambiguity here.

Samuel is right to air his concerns, but his letter contains certain inaccuracies relating to the work of my department. Firstly, in common with many departments in many local hospitals we completed our contracted work for patients in Brent for this financial year last November. We are now in a position to treat only urgent and emergency cases for this purchasing authority. Secondly, in this financial year our department does not have a contract with any group of general practice fundholders. Thirdly, during 1991-2 we operated on 26 patients for general practice fundholders in Hertfordshire (less than 1% of our total workload). The patients were seen in a special clinic on Saturday morning and were operated on without affecting the care given to local patients.

In the new style of management of the NHS it is essential to set guidelines to protect the reputations of consultants and clearly establish their professional and medicolegal duties to their patients. The present system should be reassessed by the professional bodies, with the BMA and the royal colleges at the forefront.

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1 Samuel O. Fundholding practices get preference. *BMJ* 1992; 305:1497. (12 December.)

Consultant episodes

EDITOR—Aileen Clarke and Martin McKee suggest that many providers will manipulate the contracting process to their own benefit.¹ Their answer to this is to replace the present method of measuring hospital activity, the consultant episode, with a more elaborate system in which episodes of care would be grouped according to predetermined rules.

As the authors state, "purchasers are negotiating multimillion pound contracts on the basis of totally inadequate information." The conventional purchaser oriented view of this problem is to assume that the key to improved contracting lies in enhancing the quality and quantity of the information provided by current systems. But the authors' coding scheme is unlikely to do this since not only is it substantially more complex than present systems but it would be time consuming and expensive to set up and probably lead to far more coding errors.

The view that providers are out to play the system and maximise income without increasing real workload is derived mainly from the United States.² In the United Kingdom, if providers do engage in such activities it will be less to do with the profit motive and more to do with ensuring survival in the internal market.

The reality is that the budgets of many purchasers are diminishing in real terms, and as a result purchasers are requiring providers to increase activity or decrease the costs of contracts. If providers fail to respond to this pressure they risk being eliminated regardless of the quality or outcomes of the services they provide. The effect of reduced budgets and unrealistic contract costings is closure of wards and theatres and cuts in staffing to generate cost savings. Just as disturbingly, using consultant episodes in combination with other measures of activity (such as length of stay) to construct a "purchaser efficiency index" may result in some high risk patients being denied treatment through implicit rationing. Finally, it is common knowledge that many provider managers and clinicians are favouring private patients and patients from fundholding