that can be related to perinatal care the controversy to which Hart refers concerning "brain damaged babies" born at Doncaster Royal Infirmary will continue.

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Treating bed wetting

EDITOR,—In response to Harvey Marcovitch's editorial on treating bed wetting¹ I should like to make some points about desmopressin. The lower end of the range of the quoted efficacy figures (12%) comes from an early Czechoslovakian study that used desmopressin delivered by a simple dropper. This form of administration gave a low drug bioavailability and consequently reduced efficacy. The most commonly used form of administration is by a metered dose nasal spray, for which efficacy is generally reported to be 60-80%.¹⁻⁴

Up to 31% of patients remained dry after treatment, a substantially higher proportion than the 15% who spontaneously cease bedwetting each year. The comment that there is no long term advantage of three months' treatment over one month's treatment derives from a paper by Evans *et al.*⁵ If, however, desmopressin's main value is the relief of symptoms then the advantage of treatment for longer than one month is that patients continue to experience dryness for this extended time.

I would like to re-emphasise Marcovitch's point that Desmospray is indicated for primary nocturnal enuresis. The risk of hyponatraemia developing can be minimised by taking a careful history to ensure that each patient is suitable for treatment with an antidiuretic agent such as desmopressin. It should not be used to treat enuresis associated with an excessive fluid intake. The few reported cases of hyponatraemia have generally been associated with either polydipsic or elderly patients with nocturia associated with age related physiological changes.

Only minor adverse reactions have occurred in controlled studies of primary nocturnal enuresis where inclusion criteria have ensured a correct selection of patients before treatment. Long term data accepted by the authorities included 213 patients who were treated for at least three months (range three months to eight years) with only minor adverse events reported.

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Fundholding

EDITOR,—No, let's get this straight: fundholding¹⁻³ is not a good thing for our patients. My partners and I work in Moss-Side (so no need to enlarge on the demographic make up or health needs of the area). We care, and with a team of excellent practice nurses and administrative staff, built up over the past few years, we provide a good "illness service," continuing disease management, and a range of health promotion activities equivalent to the new band three. We are not a fundholding practice.

Our local hospital, underfunded for core and emergency services, can only attempt to balance its books by delaying seeing our outpatient referrals or taking, as a priority, "fundholder" patients. Getting acutely ill patients into hospital has become a nightmare because of "perennial" bed shortages. The only community physiotherapist that we had limited access to can no longer accept our referrals. We would like to computerise to improve our administration, make an assessment of local health needs, audit more effectively, and enable us to keep on with our health promotion activities; but there is probably no reimbursement money. Worst of all, the family health services authority now tells us we have too many staff (we do not). More accurately, they now have less money from the regional health authority to fund provision of primary care in Manchester. They have devised a formula to calculate the estimated total practice budget, which is purely an arithmetical division of the inadequate GMS monies that they have. It is not based on assessment of what is needed to provide a good and adequate service, and it's no doubt a much more stringent allocation than that given to fundholders for their staffing needs.

Why are our patients getting such a raw deal, with a shrinking of our ability to provide the primary care that they now enjoy and expect, and with unequal and inadequate access to the secondary sector? Mrs Bottomley, where is all the money you are putting into the NHS going to? Could it be pouring into the gaping maw of fundholding practices for the benefit of a few and to the detriment of many?

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- McAvoy BR. Heartsink hotel revisited. *BMJ* 1993;306:694-5. (13 March.)
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Deprivation payments

EDITOR,—Our experience supports Richard Hobbs's view that fine tuning of the system of deprivation payments is needed.¹ Neither of the two population bases used—ward and enumerator districts—seems to discriminate sensitively in small towns, villages, and rural communities. There seems to be a distinct bias in favour of heavily urban areas.

We recently examined deprivation payments accorded to practices in three small towns in this county, of similar size, demography, and socio-

economic status. The deprivation revenue per 100 patients on the list varied by a factor of two within one town and by three among the three towns. Moreover, the payment for the highest scoring practice identified did not approach half of the average payment for the health board area.

The anomalies occasioned by the existing formulas translate into unfair inequalities of income, amounting to many thousands of pounds among similar practices. These practices, in turn, are receiving only the crumbs left by their counterparts in larger conurbations, whose payments do not necessitate any effort to improve the quality of patients' care.

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- Hobbs R. Deprivation payments. *BMJ* 1993;306:534-5. (27 February.)

EDITOR,—Richard Hobbs suggests that general practitioners with large lists may take advantage of the system of deprivation payments to increase their income while keeping their ratio of full time equivalent staff to doctors down to "the one to one ratio so often seen."¹ Our ratio of staff to general practitioners is 2.44 compared with Lothian Health Board's average of 1.69, and the number of staff we have per 1000 patients is 1.53 compared with Lothian Health Board's average of 1.06. With a consultation rate of 5.75 consultations per patient a year we in this practice, like others in deprived areas, have been coping for many years with a greater than average workload. The deprivation payments help with this. We should not have to leap through any additional hoops to justify these payments.

There are problems with the Jarman scale. If the entry point for payment was lowered from 30 to 16 more money would have to be made available so that the most hard pressed practices did not lose out. One approach might be to target resources at practices with a disproportionate number of needy patients such as those with HIV infection or psychotic illnesses.

Thirdly, we are disturbed by Hobbs's suggestion that "pressure could also be exerted on practices to adopt 10 minute consultation bookings." Our work is demand led. Increased consultation times would reduce the time available for our many other activities such as immunisation, home visiting, audit, research, and meetings with the practice team and social services.

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Use of Indian ethnic remedies

EDITOR,—John Kew and colleagues' article on arsenic and mercury intoxication due to Indian ethnic remedies¹ and a recent television documentary² publicised an issue that was studied in detail in the late 1970s and early 1980s, particularly by Aslam.³ The lesson proposed by Kew and colleagues is best learnt as part of a broader curriculum.

Health care in India and Pakistan is market led, and patients have great choice: they may obtain remedies from the home, lay healer, religious leader, traditional healer, homoeopath, or practitioner of "Western medicine." Three forms