that their skills are unimpaired by their current levels of drinking unless they thought that there was a high risk of getting caught.^{11 12} Many serious offenders (those with multiple convictions or very high blood alcohol concentrations) are dependent on alcohol, and changing the limit is unlikely to affect their behaviour.¹² A lower limit operating alongside random breath testing might, however, affect these hard core drink-drivers.¹³

The combined results of these studies show clear support emerges for changing the legal drink-driving limit from 17.4 mmol/l to 10.9 mmol/l. While Britain and other countries debate this issue, clearly the higher limits such as those found in some states of the United States and in the Republic of Ireland should be lowered. The researchers have done their job; it is now in the hands of the elected representatives.

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Healthcare resource groups

A more sensitive and less costly approach to contracting

Doctors in Britain may not have a burning interest in contracting, but their future depends on it. Contracting is now impinging on doctors' training and employment and may lead to departments or even whole units closing. Doctors can either allow serendipity to determine mechanisms for contracting or act to improve the process for the benefit of patients.

In the everyday world of commerce customers buy products with clearly labelled prices and know exactly what they are getting for their money. But the health service is different. Until recently there has been no way of assigning costs to health care and prices have varied widely among hospitals. Purchasers hardly know what they want to buy and have no description of what they are buying. The block contract is a blunt instrument that counts cases on the basis of finished consultant episodes. These defy definition: for low back pain an extensive laminectomy and an epidural anaesthesia may be counted the same.

Systems for costing health care and defining its products are urgently needed. This is not just an academic exercise: whether providers survive depends on their contracts with purchasers. To facilitate this process the national steering group on costing has already produced an executive letter laying down the rules for costing.¹ The remaining problem is how to define these packages of care. Fundholding general practitioners can purchase distinct operations from a list issued by the NHS Executive, but this contracting, on a cost per case basis, is very expensive to run.

There is now a more precise and cheaper method of assigning health care costs. Healthcare resource groups, developed by doctors with the help of the National Casemix Office, were originally designed to improve on the unsatisfactory system of American diagnosis related groups. Healthcare resource groups are based on ICD diagnostic codes, with codes for procedures from the Office of Population Censuses and Surveys; they also take account of data on age, complications, and comorbidity. They allow patients to be allocated to groups that both are clinically similar and use similar amounts of resources. The groups have been developed by clinical working groups led by a clinical leader nominated by

the relevant royal college or professional association. They have also been evaluated statistically to ensure that they are both clinically homogeneous and homogeneous in terms of resources (as indicated by length of stay). Although length of stay is not a perfect indicator of cost, it is readily available and correlates closely with costs when such data are available.

Proposals for the second version of healthcare resource groups were widely distributed for consultation last November.² This latest version has an additional process whereby an independent assessor nominated by each college or association provides quality assurance on behalf of each specialty. But these are still only steps towards better contracting—the second version is not the final product. The consultation process has ended, and details of the final groups have now been delivered to the software developers and will be available this August.

How will healthcare resource groups be used? Firstly, they will be used to produce comparative costs within specialties. In 1994-5 hospitals will be asked to cost two out of three specialties using healthcare resource groups and by 1997-8 all specialties will be costed to inform the contracting process. The use of these costs will enable purchasers to compare prices on a fairer basis than currently, but contracts will not have to be specified in terms of healthcare resource groups. For example, for a particular specialty future contracts might be specified in terms of healthcare resource groups covering 80% of the workload, the number of cases in each resource group, and the price per case. Purchasers and providers can then be clearer about their responsibilities and liabilities in relation to the contract that they have agreed.

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