are referred to local plastic surgeons who are fully trained and equipped to deal with this type of problem. The type of excision required usually necessitates large areas of skin grafting. Wounds of this size are regularly dealt with by burns and plastic surgery nurses; if small numbers are treated in peripheral district general hospitals the nursing skill required is usually not available. Early referral of these patients is essential for both their survival and their continuing care.

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1 Cox H, Carruth JAS, Rhys Williams S, Brightwell AP. Necrotising fasciitis. *BMJ* 1994;309:341-2. (30 July.)

Author's reply

EDITOR,—The management of necrotising fasciitis that we advocated is intended for use in the head and neck region; all of us have extensive experience in reconstructive surgery in this region (and managed the cases referred to in our letter in consultation with the regional plastic unit). We would not presume to advise on infection in other regions, particularly those referred to by Nigel Mercer, where it is widely recognised that the skin is less vascular. We simply raised the possibility of this method for consideration by surgeons with skill in such areas.

We agree with Mercer that surgeons without adequate experience should not embark on managing these difficult cases without adequate support from colleagues better versed in reconstruction of the region infected. For this reason we advise that head and neck infections are best managed in head and neck units, where such skills are concentrated and frequently exercised.

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Controlling the NHS drugs budget

Recommendations may not help

EDITOR,—Andrew Herxheimer is unstinting in his praise for the recommendations of the House of Commons health committee but does not say why he thinks that they would control drug costs. All his hopes are pinned on the cost effectiveness of prescribable drugs being established.

Some of the drugs listed in the *British National Formulary* are now widely regarded as not efficacious for anything. These may be deemed not cost effective, but they do not make up much of the drugs bill and their deselection would do little to control it. Other drugs are efficacious when used appropriately and would therefore have to be deemed cost effective unless widely overpriced, but they are not cost effective if they are misused or given when a cheaper alternative would serve the purpose equally well.

Unnecessary costs in prescribing in general practice arise in two main ways. The first is through too much prescribing. This is a complex problem that is far from being fully understood, and it will not be solved simply by focusing on doctors. The second way is through the use of unnecessarily expensive drugs. This may be dealt with either by educating doctors better or by imposing tough budgets—both approaches bring their own difficulties; “whitelists” are largely irrelevant.

Herxheimer is incorrect in believing that the current selected list is a whitelist—apart from the section relating to benzodiazepines it is a blacklist.

If the NHS becomes willing to pay for only some of the drugs that meet the three criteria of efficacy,

safety, and quality then the introduction of cost effectiveness as a fourth criterion five years after a drug is launched may have its disadvantages. A company that brings in a mediocre “me too” product may be tempted to price it high and advertise it heavily to recoup development costs or make a profit before it is deselected at the five year review. As for a review of all existing products as a basis for deselection, the cost effectiveness of using an exercise needs careful evaluation itself.

It is possible to welcome many of the health committee's recommendations without believing uncritically that they will bring the NHS drugs bill under control.

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1 Herxheimer A. Controlling the NHS drugs budget. *BMJ* 1994;309:424-5. (13 August.)

Combine old “proplist” with BNF

EDITOR,—Andrew Herxheimer's editorial on controlling the NHS drugs budget reminds me of the activity and purpose of the Standing Joint committee on the Classification of Proprietary Preparations (the Macgregor committee) from the late 1960s. This was a committee of the then Central and Scottish Health Services Councils. It produced a classification of proprietary medicines (the “proplist”) that embodied both the blacklist and “whitelist” of the present day. The categories into which drugs were placed ranged from acceptable to “no proved efficacy,” with subcategories clearly defined. The category code was listed against each medicine reviewed.

My impression is that the committee operated as a national drug and therapeutics committee, evaluating the therapeutic usefulness of individual proprietary preparations more critically than the *British National Formulary* does. Perhaps the ultimate guide for prescribers would be a combination of the old proplist and the current *British National Formulary*. Choice would not be overtly restricted, but rational selection would be encouraged. Are we going full circle yet again?

Now, however, many pharmacists and doctors in the health service accept the joint responsibility for evaluating existing and innovative treatments. The work of the Macgregor committee could be achieved much more easily and responsively with present resources. A mechanism is outlined in the NHS Management Executive's report of the advisory group of health technology assessment, which recommended that research coordination centres should help to “assemble registers of published, unpublished, and ongoing studies, to stimulate, co-ordinate and assist those reviewing evidence on the effects of health technologies.” This includes medicines.

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1 Herxheimer A. Controlling the NHS drugs budget. *BMJ* 1994;309:424-5. (13 August.)

2 NHS Management Executive. *Report of the advisory group on health technology assessment*. Leeds: NHSME, 1993.

Specialised dressings are not available to general practitioners

EDITOR,—The report from the House of Commons Select Committee on the NHS Drugs Budget makes some sensible and important recommendations but has looked at drugs narrowly, ignoring evidence on dressings presented by the National Council for Hospice and Specialist Palliative Care Services. Many patients with large wounds are now cared for in the community. The dressings they need are available free in hospital, and voluntary

hospices buy them for inpatients. A range of large specialised dressings is available for fungating wounds, wounds that will not heal, and wounds resulting from radiotherapy, but they are not available under part IX of the drug tariff, so general practitioners cannot prescribe them and patients at home must pay.

The move from inpatient care to community care will be effective only if the resources saved are made available to patients cared for at home. It is disappointing that the committee did not take this opportunity of correcting a major anomaly.

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1 Warden J. MPs want more people to pay for prescriptions. *BMJ* 1994;309:293. (30 July.)

Low dose thiazide diuretic

Is not available for prescribing

EDITOR,—Because of their proved benefit in reducing cardiovascular morbidity and mortality and their low cost compared with the costs of other antihypertensive agents, thiazide diuretics have been widely recommended for the initial treatment of essential hypertension.^{1,2} Indeed, the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure in the United States recently returned to recommending these agents, or β blockers, as first line treatment in preference to newer drugs.³

Roy Harper and colleagues highlight the benefits of low doses of thiazide diuretic in essential hypertension.⁴ They show that, compared with 5 mg bendrofluzide, a dose of 1.25 mg has substantially less effect on serum potassium concentration and no effect on hepatic insulin action. This complements an earlier paper showing that low doses of bendrofluzide (1.25 mg and 2.5 mg) are effective in lowering blood pressure in patients with mild to moderate hypertension but are substantially less likely than higher doses to cause hypokalaemia, hyperglycaemia, or hyperuricaemia.⁵

Given this information, it might be expected that bendrofluzide 1.25 mg was available for prescription. It is not. The *British National Formulary Number 27 (March 1994)* lists seven companies as manufacturers of bendrofluzide, but none of them produce a 1.25 mg formulation. There are 14 preparations of a 2.5 mg tablet, but only four of these are scored. With a diameter of only about 5.5 mm, these tablets would be difficult for many of the target population to halve. Unfortunately, the low cost of bendrofluzide (a result of the drug's patent having long expired) may have reduced the impetus to develop a new low dose formulation. Nevertheless, given current recommendations and the benefits of low dose treatment, it must be hoped that one of the manufacturers will spot this important gap in the market.

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1 Sever P, Beevers G, Bulpitt C, Lever A, Ramsay L, Reid J, et al. Management guidelines in essential hypertension: report of the second working party of the British Hypertension Society. *BMJ* 1993;306:983-7.

2 Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. The fifth report of the joint national committee on detection, evaluation, and treatment of high blood pressure. *Arch Intern Med* 1993;153:154-83.

3 Guidelines Sub-Committee of the World Health Organisation/International Society of Hypertension Mild Hypertension Liaison Committee. 1993 Guidelines for the management

of mild hypertension: memorandum from a World Health Organisation/International Society of Hypertension meeting. *J Hypertens* 1993;11:905-18.

4 Harper R, Ennis CN, Sheridan B, Atkinson AB, Johnston GJ, Bell PM. Effects of low dose versus conventional dose thiazide diuretic on insulin action in essential hypertension. *BMJ* 1994;309:226-30. (23 July.)

5 Carlsen JE, Kober L, Torp-Pedersen C, Johansen P. Relation between dose of bendrofluazide, antihypertensive effect, and adverse biochemical effects. *BMJ* 1990;300:975-8.

May not lower blood pressure effectively

EDITOR,—We are concerned that the possible misinterpretation of the data presented by Roy Harper and colleagues could have potentially serious adverse consequences if generally applied to the management of hypertensive patients.¹ The clinical implications listed include the statement "evidence now shows that low dose bendrofluazide is as effective as a more conventional dose in reducing blood pressure." The study actually shows a difference in the reduction in blood pressure achieved with a 1.25 mg dose of bendrofluazide (which is not available) and a 5 mg dose (which is not conventional) of 6/3 mm Hg. Though not significant in this small study of 15 patients, these differences cannot be dismissed, particularly in the context of the meta-analyses of hypertension trials, which have shown a reduction of 40% in stroke and 16% in coronary heart disease with an average reduction of 5 or 6 mm Hg in diastolic blood pressure.² Indeed, if a within population standard deviation of 8 mm Hg in systolic blood pressure is assumed³ (this cannot be calculated from the data as shown), it seems that had 19 patients been included in this study the difference in systolic blood pressure observed at 12 weeks would have been statistically as well as biologically significant (as it was at eight weeks).

The clinical implications also include the statement that low dose bendrofluazide "does not have metabolic effects." This study did not have a placebo control group and therefore could not evaluate this issue (only groups given active treatment were compared). Furthermore, even with a control group the study would have been too small to detect potentially important metabolic effects of 1.25 mg bendrofluazide if they exist.

Finally, before recommending the use of "the lowest possible dose of thiazide diuretics" we must be sure that such a dose (even if it was available outside trials) lowers blood pressure as effectively as other doses. This study, while showing an expected dose response in metabolic side effects, does not supply this critical piece of information.

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1 Harper R, Ennis CN, Sheridan B, Atkinson AB, Johnston GD, Bell PM. Effects of low dose versus conventional dose thiazide diuretic on insulin action in essential hypertension. *BMJ* 1994;309:226-30. (23 July.)

2 Collins R, Peto R, MacMahon S, Herbert P, Fiebach NH, Eberlein KA, et al. Blood pressure, stroke, and coronary heart disease. *Lancet* 1990;335:827-38.

3 Bulpitt CJ. *Randomised controlled clinical trials*. Leiden: Martinus Nijhoff, 1983.

Author's reply

EDITOR,—The large placebo controlled study by Carlsen *et al.*¹ quoted in our paper, provided clear evidence that bendrofluazide 1.25 mg lowers blood pressure as effectively as larger doses. At 12 weeks systolic blood pressure had fallen by 12.7 and

13.4 mm Hg and diastolic blood pressure by 9.8 and 10.1 mm Hg with doses of 1.25 mg and 5 mg respectively.

Our study was designed to examine effects of 1.25 mg doses of bendrofluazide (which should be available) and 5 mg doses (which are still widely used) on insulin action. Practical and ethical considerations limit the number of subjects who can be included in a study requiring three hyperinsulinaemic glucose clamps as well as exposure to radioactive isotopes. Clear adverse effects on insulin action were shown with the 5 mg compared with the 1.25 mg dose. Although there was no placebo comparison, bendrofluazide 1.25 mg did not change insulin action from the baseline. Other variables were similarly unchanged, in keeping with the study by Carlsen *et al.*

We therefore believe that the conclusions reached in our paper are justified. We hope that those who apply our results to the management of hypertension will have target blood pressures in mind for individual patients. If these are not reached when a small dose of bendrofluazide is used the doctors must decide whether the clear adverse effects on insulin action and other metabolic variables associated with an increased dose are outweighed by at best a marginal reduction in blood pressure.

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1 Carlsen JE, Kober L, Torp-Pedersen L, Johansen P. Relation between dose of bendrofluazide, antihypertensive effect and adverse biochemical effects. *BMJ* 1990;300:975-8.

NHS reforms

A conspiracy exists

EDITOR,—Chris Ham denies that government policies "are guided by a . . . hidden agenda which, through a series of incremental steps, will result in more private involvement in the financing and delivery of health services. . . . Politicians [are] not that clever [and] for any government to undermine the NHS, however surreptitiously, would be electoral suicide. In practice, health policy is more the result of cock up than conspiracy."¹

The Conservatives gained power in 1979 with a simple agenda: to remove, so far as possible, social decisions from the elected government so that they become byproducts of the pursuit of profit in deregulated markets. The contradiction inherent in running a popular socialised service as a competitive business is obvious. Even the stupidest politician knows that if you want to take people somewhere they don't like you must promise to go somewhere else. Our government therefore proclaims its reverence for the principles of the NHS while it injects the energy, corruption, and ultimate disintegration of the business world throughout the service.

Of course there's a plan. In 1987 a conference brought together Conservative politicians, senior figures in the NHS, and members of "new right" think tanks.² It produced a seven point programme to transform the health service. (1) Establish the NHS as an independent statutory body with decentralised financial accountability. (2) Bring the NHS and private medical care together in an integrated and interrelated market. (3) Extend direct charging in a costed service. (4) Devolve all responsibility for patients' care to directly funded district health authorities, dismantling regional health authorities and their planning function, with individual hospitals encouraged to opt out and compete for patients. (5) End national wage bargaining for NHS staff. (6) Retitle the NHS to reflect the new business era. (7) Jointly with

private insurance companies, create a national health insurance scheme.

All but the last two aims have been achieved. Further progress is probably not possible before the next election, but, with virtually all "experts" now willing to prejudge the real issue by describing marketisation of the NHS as reform, the government might get away with it.

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1 Ham C. Where now for the NHS reforms? *BMJ* 1994;309:331-2. (6 August.)

2 Illiffe S. Trends in Europe health care—implications for Britain's NHS. In: Illiffe S, ed. *Health care and the Common Market. Proceedings of the 8th International Association for Health Policy (Europe) conference 1993*. London: IAHP/Medical World, 1994; 13-5.

Privatisation is a reality

EDITOR,—Chris Ham rejects the idea that the government has a "coherent strategy guiding the development of the NHS" because he dismisses peremptorily the idea of a "master plan, designed to unfreeze (or destabilise) established relationships and to undermine the very principles on which the NHS was established."¹

Ham's evidence for this surprisingly confident conclusion is, firstly, that "politicians are not that clever" and, secondly, that to undermine the NHS, however surreptitiously, would be electoral suicide. To base the argument partly on the alleged lack of cleverness of the relevant politicians—people such as Margaret Thatcher—seems absurd and to conflict with a great deal of evidence. In any case, the relevant quality is not cleverness but enough duplicity laced with ideological zeal. Whether it is electoral suicide for a government to undermine the NHS depends on whether that government is widely held to be responsible for undermining the service. It is relevant that the present government seems to believe that it needs to continue to exhale much air, publish dubious statistics, and spend large sums on public relations activities to try to foster a favourable view of its stewardship.

Whether or not there was a master plan to fragment, destabilise, underfund, demoralise, and privatise the NHS, these things are happening. We are likely to learn whether there was a successful conspiracy at Cabinet level only when a minister's memoirs are written. Until then we should demand something a lot more substantial before Ham deflects us towards relatively minor matters that he himself describes as "ambiguities." The relevant strategies and tactics to tackle a master plan are, of course, different from those required to tackle more ambiguities.

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1 Ham C. Where now for the NHS reforms? *BMJ* 1994;309:331-2. (6 August.)

Deterioration of the NHS

EDITOR,—As a clinical director I increasingly spend my time on reviewing contracts and budgets rather than on treating patients, and as chairman of one of the regional postgraduate education committees I am trying to maintain standards of training against a background of interhospital competition and the Calman reforms. I might therefore be expected to hold a different view of the reforms of the health service from that held by Howard Freeman, the chairman of the National Association of Fundholding Practices.¹ His reply to John Ward and colleagues² does not begin to address the serious and widely felt concerns that their letter raised.