annually according to an agreed global sum and is not increased with the creation of services such as the one described. Furthermore, there is little in the paper to justify the collection of urine. Although this may be appropriate to a service study, occasional random testing is likely to be as effective and cheaper, especially if counsellors and general practitioners regularly (or routinely) request details of illicit drug use.

Thus the actual cost per patient may be nearer to £1000. Of course, as patients stabilise, costs should reduce further owing to a decrease in the methadone dose and counsellor time. These latter points suggest that cost is not a barrier to managing drug addicts in the primary sector.

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1 Wilson P, Watson R, Ralston GE. Methadone maintenance in general practice: patients, workload, and outcomes. *BMJ* 1994;309:641-4. (10 September.)

NHS funds for fundholders and non-fundholders

Cost calculations are incorrect

EDITOR,—Jennifer Dixon and colleagues' conclusion that fundholding practices have been funded more generously than health agencies may be valid in the former North West Thames region.¹ There are, however, fundamental weaknesses in the authors' methods.

The average cost per hospital day for a specialty, which is used to cost fundholding activity, is the total cost for that specialty divided by the number of days in hospital for that specialty. The average cost for a specialty is unlikely to be an accurate proxy of costs of fundholding activity as it includes the costs of emergency activity, which may be much greater than those of elective activity, to which fundholding practices are limited. Furthermore, day case activity is not captured in counts of bed days, thus the average cost per day for a specialty will be overstated.

This affects comparisons of prices. The authors used their estimates of comparative prices to invalidate the argument that more generous funding of fundholding practices is justified by the higher prices they pay. The methods' weaknesses mean that the authors cannot be confident that fundholders did not pay higher prices. If fundholding practices receive more generous funding they cannot necessarily purchase more activity.

Comparisons of prices are also difficult to interpret because they are based on specialties. Hospitals' different costing mechanisms mean that large variations by specialty may not correspond to large differentials overall. The average price for all the procedures purchased by fundholders needs to be assessed to establish whether fundholders are being charged more than health agencies.

Outpatient attendances were based on regional ratios of inpatient to outpatient activity for each specialty, obtained from Körner returns for 1990-1. Ratios of inpatient to outpatient activity vary by specialty and provider and may have changed since 1990-1 owing to pressures of cost and quality.

The average cost per outpatient attendance was assumed to be one twelfth of an inpatient episode. Costs vary by specialty and procedure. Unless fundholders' activity is a representative subset of total activity and the referral patterns of fundholders and health agencies are similar this assumption could distort the results.

The authors express reservations about their methods while claiming that the results' consistency

supports their validity. But biases can be consistent. The claimed consistency corresponds to large variations in the results, in particular for outpatients, which raise further methodological doubts. We support the authors' aims and share their concerns regarding inconsistencies and inequities in funding for health agencies and fundholders. Analysis that is not robust, even if it agrees with preconceptions or analyses performed elsewhere, does not help to clarify the issues.

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1 Dixon J, Dinwoodie M, Hodson D, Dodd S, Poltorak T, Garrett C, *et al.* Distribution of NHS funds between fundholding and non-fundholding practices. *BMJ* 1994;309:30-4. (2 July.)

Non-fundholders are disadvantaged

EDITOR,—Jennifer Dixon and colleagues' paper highlights the lack of available data for accurate comparisons of funding per capita between fundholding and non-fundholding practices.¹ This is an important finding and an indictment of the government's unpiloted implementation of the fundholding scheme without the rudimentary prerequisite of equitable budget setting within a district being ensured. In an internal market anything short of such equity will lead to patients being treated according to differential purchasing capacity and not on the basis of clinical need. The unacceptable phenomenon of fast tracking of fundholders' patients² is possibly explained by the paper's finding that fundholding practices are more generously funded than their non-fundholding counterparts, in the North West Thames region at least.

Health agencies, as purchasers on behalf of non-fundholders, are clearly disadvantaged in the current budget setting process. Firstly, health agencies are funded according to a capitation formula, while fundholding practices are funded on the basis of historical activity. Inequities are heightened in "capitation losing" districts, where the health agency's allocation can be drastically reduced. Secondly, allocations for fundholders are top sliced from the health agency's budget and not from a separate pool of funds, often further reducing the per capita allocation available for non-fundholders. Thirdly, a health agency's budget is not protected, as is the budget for fundholders. For example, the costs of emergency care, which show a rising trend and are incurred by health agencies and not fundholders, reduce the available budget for non-fundholders. Additionally, fundholders are protected from the costs of expensive treatment, with a maximum expenditure of £6000 a year per patient treatment. Any excess cost is again met by the health agency, with a further diminution of the budget available for non-fundholders.

Given the above, the purported success of the fundholding scheme should be viewed with caution. Furthermore, if the substantial savings made by fundholders in the region studied (£7.7m by 31 March 1994) are a result of overgenerous funding their use solely for these practices clearly constitutes misappropriation of NHS funds in the context of unmet need of non-fundholders' patients in the same district.

The delivery of equitable health care demands that health agencies' budgets for non-fundholders are ring fenced and negotiated on the same basis as those of local fundholding practices. It is incredible that the secretary of state has allowed

patients to suffer differential access to health care on the basis of inequitable funding among general practitioners since the inception of the fundholding scheme three years ago.

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1 Dixon J, Dinwoodie M, Hodson D, Dodd S, Poltorak T, Garrett C, *et al.* Distribution of NHS funds between fundholding and non-fundholding practices. *BMJ* 1994;309:30-4. (2 July.)

2 British Medical Association. Central Consultants and Specialists Committee survey of "fast-tracking" patients for hospital treatment. *BMA annual report 1993-94*. London: BMA, 1994:5.

Equity of access is needed

EDITOR,—I am disappointed that the *BMJ* should have failed to see how flawed Jennifer Dixon and colleagues' paper on capitation funding for fundholders and non-fundholders in North West Thames region was, but perhaps this is because of political pressure to publish the article.¹ I was a member of the capitation steering group acknowledged by the authors, and it was made abundantly clear that prices for operations were vastly different for fundholders and non-fundholders. What fundholders and non-fundholders need is equity of access, not equity of funding, if prices are different. We have repeatedly pleaded with the regional health authority to ensure that directors of finance of trust hospitals charge the same price to fundholders and non-fundholders for equivalent procedures. Until this is done there will always be inequity of funding as fundholders are charged on average 25% more per procedure than non-fundholders. Therefore, to have equity of access fundholders would need more funding.

If the finance directors were forced to reduce the prices that fundholders are charged then equity of funding would be a laudable aim. These views were well known by the members of the steering group but are not mentioned in the article, which reduces its validity.

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**The *BMJ* came under no political pressure to publish this article; nor did we come under any pressure not to publish it.—ED, *BMJ*.

Authors' reply

EDITOR,—Our paper had one main objective: to develop a method of estimating the distribution of NHS funds between non-fundholding and fundholding practices by using the currently available data on costs and activity.

Because the data were poor our approach relied on several assumptions; Carolyn Spenceley and colleagues are right to highlight these. We agree that the average cost per day for a specialty may not be an accurate proxy of the cost of fundholding activity. But if this resulted in an overestimation of the funds available for non-fundholding practices, as suggested, the differences between practices shown in our paper would be even more starkly in favour of fundholding practices. In contrast, in the commentary published with our paper C Bowie and R Spurgeon suggested that we underestimated the funds for non-fundholding practices because the average cost per day for fundholding activity was likely to be higher than the average cost for a specialty. Without strong evidence to the contrary