to reimburse the cost of an intervention when resources are limited is laudable for many reasons. This policy as applied in Australia can be praised particularly for its theoretical objectives. However, use of this policy as a rationale for requiring often unrealistic proof of economic benefit must be challenged.

The experience of Australian manufacturers has not been as uncomplicated as the authors portray. The dominant theme common to most complaints received from manufacturers has been that, while the policy espoused is one of cost effectiveness, the policy applied becomes one of cost containment.

The cost containment part of the process in Australia arises from the need for negotiation over price after acceptance of the "proof" of cost effectiveness. This approach has several fundamental flaws. Firstly, no validated method is applied to determine the price premium that should be paid for increased relative effectiveness. Secondly, the price is usually negotiated down from the price that was accepted as cost effective previously. Thirdly—and this denigrates the policy of evaluating cost effectiveness—the operating margins of the manufacturer are considered in the pricing process.

Furthermore, and possibly as a tool of cost containment, not only does the onus of proof of cost effectiveness lie with the industry but the requirements for such proof can be onerous. These requirements may be a consequence of the dynamics of decision making by funders of health care (and probably more so with governments), where uncertainty is anathema. The result can be an impractical expectation of proof of cost effectiveness from applications for reimbursement. Examples include the desire by some evaluators for long term clinical trials to prove incremental cost effectiveness for diseases that require interventions today.²

As a caveat to the above, the process is still evolving. We believe that the success of the process is largely due to the continuing contribution of the industry to the practical modification of the guidelines.³

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1 Freemantle N, Henry D, Maynard A, Torrance G. Promoting cost effective prescribing. *BMJ* 1995;310:995-6. (15 April.)

2 Glasziou PP. Support for trials of promising medications through the pharmaceutical benefits scheme. A proposal for a new authority category. *Med J Aust* 1995;162:33-6.

3 Commonwealth of Australia. *Guidelines for the pharmaceutical industry on preparation of submissions to the Pharmaceutical Benefits Advisory Committee: including submissions involving economic analysis*. Canberra: Department of Health, Housing and Community Services, 1992.

Fundholding and prescribing

Fundholders with more modest prescribing history receive less recognition

EDITOR,—Jon S Dowell and colleagues report having achieved a saving in their drug budget of £137 712, much of which has been used to benefit their patients and their premises.¹ Their experience contrasts sharply with our experience of fundholding in the same health board area.

I work in a semirural practice that has five principals and 7800 patients. We embarked on fundholding in December 1991 as part of a pilot project among small practices. As the rules on list size for fundholding changed we became "live" fundholders on 1 April 1993. The proportion of patients on our list who are aged over 65 is higher than average; we treat around 650 temporary residents each year; and there has been a consider-

able increase in homes for frail ambulant people and nursing homes, one of which has 50 patients. Despite this, since before fundholding was announced the amount we spend per fully registered patient has consistently been below the averages in both Scotland and Tayside. The underspend has ranged from 20% to 11%, with a slow drift towards the mean. This may reflect increased awareness among colleagues in a need to review critically all prescribing and local factors such as our growing population in nursing homes, with its heavy demand for drugs, dressings, and appliances.

Constant review of patients plus regular debate about prescribing issues within the partnership, including our trainees and students, has achieved these efficiencies. Over the past four years we have moved steadily towards more generic prescribing when appropriate and after full discussion with our patients.

Despite all this our drug fund has been consistently overspent. Our allocation for 1992-3 was £52 per patient per year and our actual spend was £56.80. In 1993-4 the allocation was £58.36 (in Dowell and colleagues' study the figure was £88.96) and our actual spend was £62.14. Our fund for 1994-5 was set at £67, which included an abatement by the health board for poor performance in attaining its target for generic prescribing. The fund for 1994-5 is heading for an overspend of £13 000 even though the rate of generic prescribing has risen from 40% to just over 60% in the past year (in Dowell and colleagues' study the figure was 57.6%).

We believe that a historically modest prescribing practice is being denied recognition for its efforts. The winners in fundholding seem to be those practices that make sudden lurches towards our pattern of prescribing. As we prepare to negotiate next year's budget our patients will be looking forward to receiving some of those benefits provided by the windfall reported in the authors' study. After all, our patients have helped finance it.

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1 Dowell JS, Snadden D, Dunbar JA. Changing to generic formulary: how one fundholding practice reduced prescribing costs. *BMJ* 1995;310:505-8. (25 February.)

Similar savings in non-fundholding practices are not similarly rewarded

EDITOR,—As Jon S Dowell and colleagues observe, prescribing in general practice consumes vast quantities of NHS funds,¹ and any initiative that reduces this expenditure without adversely affecting patients' care is to be welcomed. Unfortunately, in their enthusiasm to publicise their efforts as a positive benefit stemming from their adoption of fundholding the authors seem to have a poor knowledge and understanding of the standards that many of their contemporaries accept as the norm.

The figure details the prescribing costs incurred by our partnership over the past six full financial years, derived from prescribing analysis and cost (PACT) returns. Our partnership has consistently saved over 25% each year when our costs are compared with the national average, resulting in a total saving of more than £1 000 000 over six years. Adjustment on the basis of the averages for the local family health services authority shows a marginally less rosy picture, with the sum saved dipping to £840 000. Our rate of generic prescribing has risen consistently and currently approaches 70% (Dowell and colleagues claim a one off figure of 58%). This level of performance is achieved without special effort or initiatives and simply reflects the standard that we have expected of ourselves for at least 15 years.

Comparative prescribing costs for Derby Road Surgery, 1989-94

Unlike the partners in the practice studied by Dowell and colleagues, we are not fundholders. For many reasons we remain principled non-fundholders, and despite a sustained performance, which by any yardstick must be of the highest standard, we have yet to see a penny of the saving reinvested in services to our patients.

Those of us who have striven to improve standards in general practice since long before the advent of fundholding continue to do so despite the financial disadvantages of remaining principled non-fundholders. We are not impressed by apparent attempts to promote fundholding as the main driving force for quality and cost effectiveness in primary care.

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Capitation payments would be fairer

EDITOR,—Jon S Dowell and colleagues' paper shows that generic substitution can be acceptable to patients but also shows the inequity of the budgeting process.¹ The practice budget shown of £573 802, or £89 per head, for 1993-4 seems astronomical. This compares with a projected spend in our fundholding practice of approximately £48.25 per head in 1994-5, with a budget allowance of approximately £50 per head. The fact that this huge difference is probably not due to practice demography is underlined by the savings of 24% in one year, which works out at £67 a head after the changes described. To me, this looks like a year of very expensive prescribing followed by a year of expensive prescribing.

The large sum of money released is then invested in the primary health care team; this does not resolve the inequity of funding in comparison with funding of other local practices. We do not know whose agenda is followed when decisions are made on how the savings are spent. We are told that £94 000 is invested in extra equipment and services, which may be a useful investment for local health gain, but we are not told who now owns the equity of the investment. If it is the general practitioners should they become the main beneficiaries of this process, as many seem to have done?

The practice in which I work has always been a low prescribing practice, so fundholding has not put us "on the winning side" in terms of generous budgets. What is needed is a nationally agreed budget based on capitation, which could be weighted to allow for local variations in deprivation, rates of disease, and the detection and follow up of chronic disease such as asthma. General