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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Healthcare resource groups (HRGs): a casemix currency for GPs

Sir,
A single page on this topic appeared on p.298 of the May *Journal,* without authors or references, unlisted on the contents page, indeed with no way of knowing whether it was an editorial statement, anonymous opinion piece, or announcement from the NHS Executive.

We are given two histograms, both without numbers, confidence intervals, time periods, or any way of finding where they come from. The first compares orthopaedic acute myocardial infarction rates per 1000 list size, apparently between six general practices. Both would provide a good teaching example of how *never* to present data to a serious, informed and critical audience.

It is difficult from this evidence to gain more than a first impression of what is evidently destined to become a new currency for trading across the purchaser-provider split. There are close parallels with the similar tool used in the USA. Diagnosis-related groups (DRGs), which also claimed to have solved the many extremely difficult problems entailed in using clinical data as evidence for rewards and penalties in a managed market.

DRGs became the units used both to evaluate physician performance through Medicare peer review, and to reimburse hospitals for patient care through the prospective payment system.[1] Like all clinical data used to calculate either rewards or penalties, they have been manipulated to maximise hospital incomes, emphasizing cost-sensitive factors like length of stay, and minimizing or ignoring socially sensitive factors like continuity, accessibility and community loyalties to and from local units.[2]

Readers should look carefully at Figure 2 in this 'paper', with two- to sixfold differences in infarction rates over unspecified periods, calculated from unstated case numbers and list sizes, and ask themselves whether they can accept that their own work should be measured in this slipshod way. The aim is clear: to devise league tables which compare apparent health outputs by different hospitals and practices serving different catchments, just as schools are now being ranked in league tables of achieved literacy without knowledge of underlying economic and cultural factors. In both cases, the real complexity of case mix, and the difficulties of professional work in poorly resourced and sometimes demoralized populations, can be seriously addressed only by professionals with long personal experience of doing it.

It the purchaser-provider split generates such worthless currency, why not return to our original cash-free economy, based on co-operation between local units at primary, secondary and tertiary levels, serving defined local populations rather than customers from an unlimited marketplace? If the existing political parties find this too difficult we must help them. Finally, how did this paper come to be published in a serious, independent, peer-reviewed journal?

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References

1. Steele K. Market forces and USA health care: success or failure? *Br J Gen Pract* 1990; **40:** 484-486.
2. Luft HS. Modifying managed competition to address cost and quality. *Health Aff* 1996; **15:** 23-38.

NOTE: The editor regrets the inclusion of this advertising feature in the May *Journal,* without any indication of its provenance. This was due to an administrative oversight and not to a change in editorial policy. Further information about the advertisement is given on p.348 of the June *Journal.*

Examining the value of eradication therapy for *H. pylori*

Sir,
Rosengren and Polson's paper[1] reinforces existing evidence on the value of eradication therapy for *H. pylori* in patients with known peptic ulcer disease (PUD) in general practice.[2,3,4] However, areas of uncertainty are evident in Rosengren and Polson's data.

Firstly, 13 (33%) out of 40 patients declined treatment. In a similar study in six practices,[5] only 27 out of 54 (59%) patients with PUD were given eradication therapy by their GPs. Practitioner feedback suggested that the use of eradication was reduced by a lack of confidence in the benefits of eradication and concerns over tolerability of regimes on the part of the GPs, and not patient refusal. Comparable results were seen in a recent audit of *H. pylori* eradication in other practices (personal communication, Solihull MAAG).

Eradication therapy is very effective in preventing ulcer relapse, with a number needed to treat (NNT) of, at most, 1.5.[6] Studies showing the effectiveness of *H. pylori* eradication in general practice[1,2,3] and the availability of shorter, more tolerable eradication regimes, should offer GPs the confidence to recommend this treatment to patients. Media attention towards this subject in the 2 years since this study was performed would be expected to have raised expectations, making eradication therapy more acceptable to patients.

Secondly, only 69% of the patients tested positive for *H. pylori* on a serum ELISA test. The prevalence of *H. pylori* in this group would be expected to be between 85 and 90%. The prevalence of long-term antisecretory therapy (3.9%) and of peptic ulceration (0.7%) were higher than in previous studies,[7] suggesting that a significant proportion of the peptic ulcer patients may not have actually had an ulcer (we are not told the diagnostic criteria).

In addition, the predictive value of a