

## LETTERS

|  |     |  |     |  |     |
|--|-----|--|-----|--|-----|
| Healthcare Resource Group (HRGs): a casemix study<br><i>Hugh Sanderson</i>   | 623 | The incidence and causes of rectal bleeding<br><i>Adrian Edwards and Nigel Stott</i>   | 625 | Doctors' authority<br><i>E Ernst, M Willoughby and TH Weihmayr</i>   | 627 |
| The mental health education fellowship<br><i>Jamie Bahrami</i>   | 623 | Complementary medicine — doing more good than harm?<br><i>DVK Chao</i>   | 625 | Mothers as partners in antenatal care<br><i>Kevan Thorley and Trish Rouse</i>  | 628 |
| Domestic violence: a hidden problem in general practice<br><i>Trevor Stammers</i>  | 623 | Clinical guidelines in primary care: a survey of general practitioners' attitudes and behaviour<br><i>Sima Hay and Pippa Oakeshott</i> | 626 | Health care provision for people with learning disabilities<br><i>Martin Gaba</i>  | 628 |
| Atrial fibrillation in a primary health care district in rural Crete<br><i>Christos Lionis and Giorgos Frantzeskakis</i> | 624 | GPs' views of a new counselling service<br><i>Jane Ogden</i>   | 626 | 'Don't get it right, get it written'<br><i>Mary Seabrook and Virginia Morley</i>   | 629 |
|  |     | What do young people want from their GP?<br><i>Ann McPherson, Aidan Macfarlane and Julia Allen</i>                                     | 627 | <b>Note to authors of letters:</b> Please note that all letters submitted for publication should be typed with <i>double spacing</i> . Failure to comply with this may lead to delay in publication. |     |

### Healthcare Resource Groups (HRGs): a casemix currency for GPs

Sir,  
Julian Tudor Hart comments on the briefing on HRGs printed in the May *Journal*, and makes a number of criticisms of the examples quoted and the concepts of using casemix.

The figures provided were intended to illustrate the sorts of analyses which could be undertaken, rather than to illustrate any actual findings. Hence, the details of time periods, confidence intervals etc. were omitted. As the text makes clear, the comparisons need to be undertaken carefully and do not provide answers, but do provide a convenient way of aggregating information so that data can be used. It isn't intended that this should be the only way in which data is analysed, but with about 6 000 procedure codes, and over 10 000 diagnosis codes, GPs who are not experts in coding systems, or in data manipulation may appreciate some help in summarizing the types of inpatient episodes experienced by their patients, and, because they are nationally defined, results for one area can be compared with another.

HRGs have been developed in this country by clinical working groups, and approved by the relevant professional associations. The basis of their construction is of similarity in resource use. It is therefore legitimate to ask questions of the differences in cost (length of stay) between hospitals for a similar activity, and also to ask questions about apparent differences in the consumption of hospital resources between practices. Dr Tudor Hart rightly criticizes the use of DRG-based reimbursement rates in the US as not being sensitive to socially sensitive factors. They have also been used for many inappropriate purposes such as comparisons of hospital mortality rates. We do not encourage or condone this sort of use. In this country however, prices (HRG-based or otherwise)

are only used as one part of the decision-making process about where to place contracts. Many GP fundholders have used their purchasing ability to change the way in which services are provided. For them, and for health authorities, prices are important (and bench marking information to compare prices with other providers very useful), but at the end of the day they use their professional judgement to strike the right balance between the cost and the quality and acceptability of services.

We have never 'claimed to have solved many extremely difficult problems entailed in using clinical data as evidence for rewards and penalties in a managed market'. We have, and will continue to argue that using HRGs to adjust for casemix makes more sense than using counts of crude finished consultant episodes. We, and the clinicians who have worked with us on the development of HRGs, are always aware that trying to categorize all inpatient care into 528 groups (on the basis of data of variable quality) involves compromises, and we have a continuing programme of development to improve the definitions. The proposals for Version 3 HRGs will be published in September, and the consultation period will run from then until December. We would welcome comments on these proposals from readers of the *Journal*. The consultation document is available from the National Casemix Office.

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### The mental health education fellowship

Sir,  
The study by Singleton and Tylee (June

*Journal* 1996), aimed at an evaluation of the Mental Health Fellowship, has become a rather strange vehicle of criticism of CME and GP tutors. This may partly reflect the misunderstanding of the way that CME has developed since the introduction of PGEA in 1990.

Contrary to the expectations of the authors, in the open market of CME the GP tutors' role could not be, and is not the mere provision of educational activities; they exert a powerful influence in encouraging innovation and shaping continuing professional development in general practice. As a result, there has been a welcome explosion in practice-based learning, practitioner group meetings, audit groups, personal education plans and a variety of other exciting innovations in learning. The authors' perception that all they do is 'manage bureaucracy' is ill-informed and unfair.

Personally, I hope that the fellowship in mental health education will continue, but perhaps in a different shape and different model, taking note of all the progress that has taken place in the field of CME in general practice. This will need a close and continuing dialogue between the architects of the mental health education fellowship, the regional advisers, the GP tutors and others with interest in the field.

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### Domestic violence: a hidden problem in general practice

Sir,  
Richardson and Feder's review of domestic violence as a hidden problem in general practice (April *Journal*), is to be welcomed as a concise and helpful overview