LETTERS

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,

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

of a much neglected subject. There are several points however, that I should like to raise about it.

Though it was mentioned that women experiencing domestic violence are at increased risk of drug and alcohol abuse, alcohol abuse in the abusing male partner is also a well recognised correlate of domestic violence. One recent review comments that 'half of all batterers coming to intervention will have alcohol abuse problems'.[1] Other substance abuse by men is similarly linked with an increased risk of the perpetration of domestic violence.[2]

Richardson and Feder maintain that younger age, and being divorced or separated are the only associated demographic features for identifying women experiencing domestic violence, yet research shows that cohabitees are also at greater risk of being battered than women who are married to their partners.[3,4]

Finally, the review implies that domestic violence always involves women as the victims. This is not so. Men are sometimes savagely beaten by their female partners. The needs of such male victims should not be dismissed any more than those of battered women. One expert who pours scorn on the idea of an epidemic of battered husbands, nonetheless concedes that 5% of domestic violence victims are men and that this is a 'serious problem'.[5] In one of the few recent UK studies on domestic violence victims presenting to a casualty department, the 300 cases comprised equal numbers of women and men, and surprisingly the study also found that men received more serious injuries and lost consciousness more often.[6]

I would wholly endorse the view that as GPs we should be much more aware of the prevalence of victims of domestic violence presenting covertly in our surgeries. The overwhelming majority of them will be women, and we should do all in our power to help them, but we should do no less for male victims too. I am a member of our local domestic violence forum in Merton, which is one of the most innovative in London in its involvement with not only two refuges and other support services for women, but also a helpline for battered men which currently receives up to 50 calls for help a day.

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Atrial fibrillation in a primary health care district in rural Crete

Sir,

A review article entitled 'Use of warfarin in non-rheumatic atrial fibrillation: a commentary from general practice' was published in the March 95 *Journal.*[1] A similar audit and research project was carried out in Crete, providing brief information about the development of primary health care research in this area.

The prevalence of known chronic atrial fibrillation (CAF) was studied in the area that is the responsibility of the Spili Health Centre (SHC); a mountainous county of rural Crete with 8952 permanent residents. The diagnosis of CAF was documented retrospectively by studying all of the medical records registered in the computerized system of the SHC for the period 01/01/89 to 01/06/94. Diagnoses were made according to the ICHPPC-2-Defined.[2]

We identified 109 subjects diagnosed with CAF. Forty-eight of those (44.04%) were men, sixty were over 80 years old and the median age was 79 (range 57-93). The prevalence of CAF was 2.61% in the age-group 65-79 years and 10.03% in those over 80 years old.

The diseases that were found to coexist more often with CAF in order of frequency were: hypertension, congestive heart failure, ischaemic heart disease, chronic obstructive pulmonary disease and valvular heart disease. These findings are similar to those that Bath *et al*[3] reported. We did not identify any case defined as 'lone atrial fibrillation'.

Eleven patients (10.09%) were taking warfarin and 43 (39.45%) acetylsalicyclic acid alone or with dipyridamole. Thirty-six (33.03%) were not taking any medication and 30 (27.52%) didn't take any medication without having any documented contraindication.

A data list with patients' names, place of residence, individual history and type of treatment is now available and has been distributed to local physicians. Identification of these patients who are at risk, and the subsequent choice of prophylaxis is now a major task for our district medical doctors. A list of recommendations have also been delivered, and the results of these efforts are to be evaluated in the future.

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Table 1. Prevalence of known atrial fibrillation in the Agios Vassilios County, Crete, Greece.

	55-64		65-79		80+	
	M	F	M	F	M	F
Total population*	565	590	769	841	253	345
Number of patients with chronic atrial fibrillation	3	3	21	21	24	36
Prevalence of chronic atrial fibrillation (%)	0.53	0.68	2.73	2.50	9.49	10.43
95% C.I.** of prevalence	0–1.29	0.017–1.34	1.58–3.88	1.44–3.56	5.88–13.10	7.20–13.66

*According to last National Census (1991). **C.I.: Confidence Interval.