Confederation Negotiating Team (now CEO NHS north west [SHA]) said:

> *PRICCE practices have shown that where effort is targeted they have met with considerable and sometimes unexpected success. This has demonstrated that it is unwise to underestimate what is possible. I commend this project to you as a good working example of how to implement the Quality and Outcome Framework of the GMS2 contract.*

I suggest it is time recognition was given where it is due.

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NHS

Your comments regarding the latest re-structuring and the need instead for a serious consideration of a new approach to funding struck a note of clarity, at long last, in the debate about how best to make the NHS more efficient and effective.[1] I have spent most of my working life under the aegis of the NHS in Northern Ireland, but have many family members in the Republic of Ireland, and while its system of health care has its own problems, the insurance-based funding ensures that both consumers (patients) and providers (health professionals) are made very aware of the actual costs of treatment. The patients may (and often do) obtain reimbursement but the message is clear. I acknowledge that there are significant transactional costs in such schemes but until we can depart from the Holy Grail of a comprehensive 'cradle to grave' service, also 'free at the point of use', no amount of restructuring will address the need for all parties in the NHS to use the service in the most effective way. I hope sincerely that your excellent article is read by those in the medico–political arena, the NHS as it stands is indeed both uncontrollable and now unaffordable.

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Colour vision problems

I read with interest the correspondence from Jayakrishnan and Al-Rawas on the use of universal dots to colour code and identify asthma inhalers.[1]

I appreciate the authors' desire to ensure a universal and consistent system but, unfortunately, the interpretation of colours is fraught with complication. The problem of colour vision deficiency has been known since John Dalton first described the condition in 1798.[2] Some 8% of men and 0.5% of women have some degree of a problem, that is an estimated 2.4 million men in the UK alone. Red–green colour vision deficiency is the most common and brown is a colour where particular difficulty is encountered.

The problems with colour vision deficiency have been documented but continue to be generally under-appreciated in the medical environment, for example, there is good evidence that doctors and patients can struggle to spot red rashes.[3] Those with colour vision deficiency can also fail to recognise blood in bodily fluids[4] and this has translated into evidence that those with colour vision deficiencies are more likely to present with late stage bladder cancer.[5]

I would plead the case on behalf of those of us who are colour blind and I would resist the use of colour in the identification of medicines. In the diagram[1] I was unable to differentiate between the brown, green, or red universal dots. It is particularly challenging to identify small dots or bands of colour, and great care needs to be taken in assigning surface colour codes as those with colour vision deficiencies are prone to error, particularly under lower levels of illumination.[6]

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Competing interest

I have been confirmed as having protanopia and it is clearly not in my personal interest to see the increasing use of colour coding.

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Authors' response

We understand clearly the concern raised by Lawson. Our aim is not to substitute the labelling of the drugs with colour coding, but to suggest uniformity for the existing colour selection of the inhaler's casing.[1] Often the patients are instructed to take the 'blue inhaler' in case of need and to use the 'purple or red inhalers' regularly, rather than identifying them by the drug names. Instead, they could now be asked to take the 'blue dot inhaler' in case of need and to use the