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- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

## Interpretation and management of PACT (prescribing analysis and cost) data on formularies

SIR,—A recent comparison of PACT (prescribing analysis and cost) data for one practice with hospital prescribing data showed the adverse effects on NHS costs of two widely used marketing strategies—the “loss leader” and “price confusion-market expansion.”

A loss leader is a product that is heavily discounted into one market segment in the expectation that the improved uptake in this segment will influence other (bigger) segments. Cash limited health authorities have been happy to take advantage of the discounts offered to hospitals on such loss leading drugs but have not considered the effects that may be generated in the community (where such discounts do not apply) when patients continue treatment after discharge. The strategy of price confusion-market expansion aims to confuse the prescriber by providing such a wide choice that it is difficult to conclude objectively which is the best product. Such a strategy aims to increase overall expenditure rather than allow costs to be reduced through competition.

During the past decade many new drugs have had only minor advantages over their established competitors. In response to this fact and in the face of limited budgets many health authorities, and now some general practitioners, have reduced the range of medicines available by introducing formularies. A recent analysis of PACT data for a local general practice led us to realise that in drawing up formularies authorities need to be aware of the effects of marketing strategies. Two examples illustrate this.

The potassium sparing combination diuretics recommended by hospital formularies are often heavily discounted. PACT data showed that one local practice prescribed almost as much of the recommended drug as all the hospital units together. Unfortunately, this particular drug is one of the most expensive of its type to the NHS. If the hospital recommended an identical combination (from another manufacturer) the costs for the practice (if it followed suit) would fall by £500 a year—14%. If the hospital recommended a slightly different combination altogether the practice's costs would fall by £1325 a year (37%), and if this practice is typical then the savings to the family health service authority could be £53 000 a year. Similar savings are possible with oral nitrate preparations; the practice could save about £1960 a year if a slightly different preparation were recommended by the hospital formulary.

The *Monthly Index of Medical Specialties* (MIMS) lists 14 potassium sparing diuretics in 16 strengths and 28 pack sizes, with an NHS price (excluding hospital discounts) ranging from 6p to 36p for the defined daily dose. Twenty two oral nitrates are

available in 45 strengths and 60 pack sizes at prices of 4p to 43p per dose. This staggering array of sizes and products does not enhance consumer choice but simply confuses the market.

It is well known that drug prices are often discounted to hospitals. What is less clearly understood is the influence that this practice has on formulary decisions—and on prescribing costs outside hospital. Hospital drug and therapeutic committees need to work collaboratively with local general practitioners and family health service authorities to ensure that hospital policies do not financially burden the NHS as a whole and that effective and economic continuity of care can be achieved when patients enter and leave hospital.

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## Bedding and sleeping position in the sudden infant death syndrome

SIR,—The careful study by Dr Peter J Fleming and colleagues has a problem that besets so many retrospective studies of the sudden infant death syndrome.<sup>1</sup> Case-control investigations with questionnaires cannot hope to match adequately the history of a living baby with that of an infant who has died.

The inevitable guilt that follows a sudden infant death and the parents' consequent need to seem to have done everything possible to care optimally for their baby before his or her death could bias the results. The parents of living infants are not subjected to the awful circumstances that surround the death of a baby, including inquiries by the police and coroner; hence the validity of prospective rather than retrospective data in this subject.

It is widely acknowledged that young infants must not be allowed to become cold and that the prone position is better than the supine. For example, one widely read book on child care states that “The ideal and safest sleeping position for a new baby is on his tummy, with his head turned to one side. Then, if he is sick, there is much less risk of milk running back down his throat to choke him.”<sup>2</sup> With this information in the back of their minds some parents might report incorrectly their baby's sleeping position.

We would also like a detailed description of how the authors defined the side, prone, and supine positions. Could the interviewer have been biased in his or her decisions concerning the degree of trunk rotation that indicated a side or prone position?

Since this article was published several parents whose babies have died of the sudden infant death syndrome and who had adopted a prone position for their babies have told us how upset they have been by the media activity surrounding the report. How certain are the authors that their data should persuade parents to disregard traditional teaching about the posture and bedding requirements of newborn infants?

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- 1 Fleming PJ, Gilbert R, Azaz Y, *et al*. Interaction between bedding and sleeping position in the sudden infant death syndrome: a population based case-control study. *Br Med J* 1990;301:85-9. (14 July.)
- 2 Brudenell M, Chiswick M, Nash B, Gilbert P, Smy J, eds. *The complete book of baby care from conception to three years*. London: Octopus Books, 1985.

SIR,—We are concerned that the results of Dr Peter J Fleming and colleagues have been over-interpreted so that the inevitable media attention has caused confusion and distress among parents.<sup>1</sup> There are several questions we would like to ask before accepting the results.

Firstly, information about sleeping position, clothing, and wrapping was collected retrospectively from parents of infants who had died when the parents would have been distressed and may have been subject to confusion and selective recall. How certain are the authors that their data are accurate? How was it ensured that sleeping position was accurately determined? The definition of prone, supine, and lateral is not straightforward, and if the babies were not actually observed by a trained individual how were the questions asked of the parents?

Secondly, are the authors certain of the importance of the significant interaction between sleeping position and thermal insulation or tog value? Given the small difference in the tog value between the infant who died and control infants and that few infants died in the supine or lateral position what might have happened to the statistics if just one or two of this group had, say, been covered with a little more insulation? Though it may be normal epidemiological practice to quote risk ratios, we wonder if it is wise here given the wide confidence intervals and the certainty that the press would latch on to the figures without qualification.

Thirdly, the authors report tog values for bedding scaled by the proportion of body surface area covered (80%) to yield an “effective total insulation.” Such scaling may be appropriate for studies of adult clothing, but in sleeping infants, who lose up to 85% of their heat through the head, it is quite inappropriate. As it was applied to both control infants and those who died it will not affect the