in communicable disease control. The control of major outbreaks has many similarities to the control of chemical incidents. There is often a similar sense of urgency and public alarm. Also, consultants in communicable disease control still often act as advisers on environmental health and toxicological issues to local authorities. These consultants should participate in planning for, and controlling, major releases of chemicals. Improving training in this subject for consultants in communicable disease control should be a high priority.

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Economics and the fundamental principles of the NHS

SIR,—In the first of a series of articles addressing questions raised by *Leading for Health: a BMA Agenda for Health*.¹ J B L Howell expresses two fears. The first concerns the reliability of explicit methods of rationing health care resources such as the Oregon experiment and the ranking of treatments according to cost per quality adjusted life year (QALY). Howell argues that the management of waiting lists is “morally and practically the more acceptable.”²

Waiting lists provide a partial view of need. They say little about the urgency, cost, or effectiveness of the treatment required by those waiting or about the relative burdens borne by families, the community, and social services because of any delay in treatment. Nor does everyone in need get on to a waiting list. “The general conclusion to be drawn from published waiting list statistics is that it is very difficult to tell what is going on.”³ Furthermore, the recent scramble, at considerable cost, to remove from waiting lists by 31 March patients who had been waiting over two years was a questionable use of resources aimed at an essentially political target.

Howell’s second fear is that explicit methods of rationing legitimise denying care to some patients. Health economics is concerned not with whether to use resources but with how to use them.⁴ It makes explicit the health benefits that would be gained by increasing or changing patterns of expenditure. By advocating a system that does not attempt to quantify these opportunity costs explicitly Howell does not make the choices between different uses of health care resources any easier. Nor does he manage to assume away the need to make such decisions.

The Oregon experiment highlighted these stark choices. The final cut off below which treatments would not be funded was drawn after an expansion of funds allocated to health care.⁵ The exercise made explicit how much people’s tax liabilities would have to rise to fund most of the treatments defined as being critical to basic health care.⁶ It does not strike me that such an exercise rationalises denying patients care.

I agree with Howell that as yet we cannot have much faith in lists of treatments prioritised on the basis of QALYs. QALYs are in their infancy and are crude. Compiling estimates of costs per QALY, however, provides useful insights into the cost effectiveness of different forms of care.^{7,8}

I do not share Howells’s lack of faith in value judgments made by the public. In the Oregon experiment certain rankings of treatments were overturned because of their unacceptability. This highlights criteria on which society wants to base its decisions to allocate health care resources. If the ranking of treatment in a QALY league table and the cut off below which treatment will not be funded prove unacceptable, our values regarding the correct level and basis of resource allocation in the NHS are forced into the public arena. We are forced to justify them and are made aware of their cost in terms of the health benefits that we lose by pursuing them. These are the goals of health economics. To caricature it as a system for legitimising denying people care is simply to misunderstand it.

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Consultants’ hours

SIR,—We have now sorted out juniors’ hours moderately well. Is it not time that some consideration was given to sorting out the hours and conditions of service of consultants, especially in high profile specialties with low numbers of consultants such as accident and emergency, and often paediatrics, where absence on leave can result in consultants being expected to provide rather more cover than is permissible for juniors? Certainly in accident and emergency the absence of one consultant in a department with two consultants can result in the other being expected to be available on a one in one basis for a considerable time if no locum is provided, as is the case in so many places nowadays.

It is surely time that the BMA addressed this problem, which lasts for 30 years in many people’s careers, as well as juniors’ problems, which last for only a short time during their total career.

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Private insurers not passing the buck

SIR,—Jonathan Boyce’s editorial on private practice, subtitled “Troubled insurers prepared to pass the buck,” is misleading.¹

The reasons for the steeply rising costs of medical insurance claims are well known (more treatments, more sophisticated methods of treatment, the increasing complexity of private sector work, an increasingly elderly population, etc), but private medical insurers are not just sitting back and complacently passing the buck.

Private Patients Plan has been working, in partnership with hospitals and doctors, for several years to find ways of controlling costs of claims

without jeopardising the quality of care. This work, which has already had some success, is continually breaking new ground, to everyone’s benefit.

One example is Private Patients Plan’s pilot study over the past few years of whether the concept of managed care can be successfully introduced in the United Kingdom. Working closely with a large employer, doctors, and a hospital in the north of England, Private Patients Plan has been encouraged by the findings so far and has embarked on the next phase of the study. Another example is Private Patients Plan’s psychiatric benefit protection scheme, which has been developed with the enthusiastic support and participation of virtually all providers of private psychiatric care in Britain. Again, early results are encouraging and the scheme promises to enable Private Patients Plan to maintain cost controlled cover in this important aspect of care.

Additionally, to streamline administration procedures and thereby speed up payment of claims Private Patients Plan has worked with British United Provident Association to develop a common schedule of procedures with standard codings for use by doctors, hospitals, and insurers. We hope that this will soon become a standard for the industry, which will again be of widespread benefit.

Thus, far from complacently passing the buck, Private Patients Plan strongly believes in working in partnership with others to solve common problems and will continue to battle against steeply rising costs.

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Weightings used in distributing NHS resources

SIR,—E S Williams and colleagues observe that the standardised mortality ratio is negatively correlated with the percentage of people aged 65 and over living in English district health authorities and conclude that any distribution of NHS funds based on a positive weighting for the proportion of elderly people is therefore unfair.¹ Two issues should be emphasised.

Firstly, the correlation that they showed is significant. The prime determinant of the significance of any correlation or simple linear regression slope, however, is the number of points contributing to it. The authors did not give the scattergram of the 190 contributing district health authorities or the coefficient of determination (a measure of the strength of the association as opposed to its significance). The figure may explain why. The correlation may be significant but is not strong. The coefficient of determination, r^2 , is low at 0.11. Indeed, a second linear regression excluding the

Simple linear regression of population of district health authorities aged over 65 and standard mortality ratio. $y = -1.2x + 120.5$, $r^2 = 0.11$

top six outlying districts (all with a proportion aged over 65 of >22%) produces a result that is still significant ($p < 0.001$) with the same slope (-1.2) but an r^2 value of only 0.06. This implies that only 6% of the total variation in standardised mortality ratio is associated with a variation in the proportion of the population aged over 65.

The second issue is that a lower standardised mortality ratio and higher proportion of elderly people are good evidence of a higher proportion of "survivors" in need of health care services. It is likely to be elderly people for whom the standardised mortality ratio itself is least useful as a proxy for morbidity because of this "survivorship effect": it is the elderly people who are not dead (of course) who need the resources.

The Northern Regional Health Authority uses a weighted capitation formula for distributing resources, with a positive weight for the proportion of elderly people ($\text{weight} = (1 + \text{population} > 65)^{0.34} \times (1 + \text{SMR})^{0.63} \times (11 + \text{deprivation factor})^{0.08}$), where SMR = standardised mortality ratio. The knowledge that age and standardised mortality ratio are significantly negatively correlated does not mean that this formula is wrong or unfair. In fact, the allocation formula was derived from a multivariate regression analysis that took into account the relation between age and standardised mortality ratio.

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A team future for general practice

SIR,—I agree with Jacky Hayden that primary care is one of the (great) strengths of our system, that patients want round the clock services and easy access to them, but that doctors wish to lead normal lives.¹ The rest of the editorial I find chilling: it is laced with management concepts and fashionable phrases such as "proactive care" but lacks any hint of concern for the caring aspects of our profession.

The ideas set out, particularly in respect of provision of out of hours services, seem to be based on a simplistic view of general practice in which the patient has a scientifically definable problem to which any suitably qualified provider will apply the scientifically prescribable remedy—hence the "obvious conclusion" that what is needed is a multidisciplinary team, appropriately managed, of course, which will pass the "client" on to the correct agency. My long experience of general practice suggests otherwise. People—worried, distressed, even angry—perceiving the nature of their disease to be medical, want to turn to a medically qualified person who will give them ease. Ideally the person doing so will be one with whom they are already familiar, with whom there is already a relationship of mutual trust, and with whom continuity of care can be taken for granted. That to achieve such a utopian state of affairs is impossible should not absolve the doctor from aspiring to it.

I submit that our aim should first be to provide such a high personal service but then to demand adequate financial recompense and, equally, sufficient flexibility—more than our present contract affords—to minimise and to compensate for the disruption of our personal lives that, wittingly or not, we accepted when we chose

our career. To follow the path of a progressive reduction in our responsibilities will inevitably lead to a poor service for our patients, loss of professional status, loss of job satisfaction, and, perhaps worst of all, massive loss of self respect.

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Workload in general practice under the new contract

SIR,—David Hannay and colleagues raise some interesting and controversial issues about the effects of the new contract on general practitioners and their workload.¹ Some of their findings concur with those of my recent survey, but there are also some differences.² Hannay and colleagues found that the doctors had worked an hour a week more since the introduction of the new contract. This was mainly due to more patients being seen in the extra clinics. They also found that time spent in practice administration had fallen slightly.

I studied general practitioners' workload in 1989 and 1991, obtaining response rates of 80% (120 doctors) and 88% (102), respectively; 49 doctors took part in both years. Eighty two of the general practitioners worked more than five hours a week extra and 22 more than 10 hours a week extra after the introduction of the new contract. One hundred and one gave increased paperwork as the reason for this, 49 blamed increased numbers of clinics, and 45 blamed interruptions.

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Costs of day case surgery

SIR,—Nigel C H Stott is correct in stating that I made no allowance for costs transferred to general practice and district nursing when I calculated that day case surgery could reduce costs by 75%.¹ The reason was that "in our experience it is rare for a day surgical patient to have to consult his general practitioner about postoperative problems, and it is uncommon for the community nursing service to be called upon, except perhaps to remove sutures or occasionally change dressings. Such care would need to be provided whether the patient were treated as an inpatient . . . or as a day case."²

For our paediatric patients special home nursing facilities were provided and the total reduction in the cost of day case surgery compared with inpatient care was 55%.³ In the case of adults we initially arranged for community nurses to visit patients routinely within 48 hours after the operation,⁴ which resulted in an average of two or three visits by each community nurse each week. Such visits, however, were often unnecessary, and at the nurses' request the policy was changed to one of visiting only if this was specifically requested by medical staff or the patients themselves; this reduced the load to about one visit by each nurse each month. Only visits made in the first 24 hours postoperatively are relevant, as thereafter the demands on the community nursing service are identical with those made by inpatients discharged the day after surgery.

Thus I had some justification for claiming that "the charge that day surgery merely transfers the

cost and care of the patient to the community medical service is false."² This charge was doubtless made to extract additional funding for the community services and by those wishing to detract from the economic value of day case surgery; but I still contend that the reduction in the cost of day case surgery compared with inpatient surgery is in the order of 70%.

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Ban on home HIV tests is unjustified

SIR,—What data justify the Department of Health's ban on home HIV tests?¹ The relevant data are precise estimates of the false negative and false positive rates associated with the test kits.

Home HIV tests may be used in two ways: repeatedly by people who know that their behaviour puts them at risk of HIV infection but do not choose to confide in their medical practitioner, and infrequently by many people with few (or many) past sexual partners who seek to test themselves in privacy for assurance that they are negative for antibody to HIV-1. Suitable labelling of home HIV test kits to warn the public that a positive result lacks specificity and so needs confirmation (and advice on how to go about getting a confirmatory test) can surely be devised and is a matter for the Medicines Control Agency.

Heterosexual spread of HIV infection is an awful prospect, as the statistics on AIDS in Africa show. Sections of the British press, however, continue to allay public concern instead of promoting public health measures. The Department of Health's ban denies people the freedom to make a preliminary assessment of their HIV status without running the gauntlet of a counsellor or medical practitioner, to whom they have to explain why they are seeking a test. Home testing, as with testing at genitourinary medicine clinics, is not ascertainable by insurers; moreover, those using it would not have to attend a clinic unless further testing was needed to sort out a positive result.

With around 32 million people aged 15-54 in the United Kingdom and only 160 000 voluntary, named HIV tests a year (some of which will be repeat tests on the same person), there is a considerable shortfall of testing with only five in 1000 people seeking a test annually. How many more would do so for assurance that they were negative for the antibody if allowed to do so in the privacy of their own home? How else does the Department of Health plan to increase the uptake of HIV testing in the United Kingdom? Counselling should not block access to HIV testing; it should be available to those who want it but not, I suggest, forced on those who don't.

Epidemiological surveillance of the HIV epidemic would not be undermined by home HIV testing as confirmatory serum tests performed in virus laboratories reporting to the Public Health Laboratory Service would continue to be necessary. The laboratories' workload might well increase though.

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