It is not necessary for Toozs-Hobson and Cardozo to claim that the whole female population is diseased in order to recommend prophylaxis; we recommend supplementation with folic acid for women before conception and in the first trimester without believing that they all have a dietary deficiency. There may well be a very good argument for all postmenopausal women to take hormone replacement therapy, based on evidence of a favourable ratio of benefits to risks. For the women who are being recommended lifelong hormone replacement therapy, convincing arguments of this sort will be more persuasive than labelling a universal life event as a disease.

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1 Toozs-Hobson P, Cardozo L, Jacobs HS. Hormone replacement for all? *BMJ* 1996;313:350-2. (10 August.)

Long term randomised controlled trial is needed

EDITOR,—Karen McKinney disagrees with Elizabeth H Price and Helen Kaye Little's letter about informing women of the risk of hormone replacement therapy, particularly in relation to breast cancer.^{1 2} McKinney cites the nurses' health study as evidence against a link between hormone replacement therapy and the development of breast cancer.³

Unfortunately, the data in the nurses' health study and the authors' conclusions are at variance with McKinney's assertion. In the study past use of hormone replacement therapy was associated with an excess incidence of breast cancer within two years after treatment was stopped, but not for longer. Current use was associated with a significant 32-46% excess of breast cancers. The risks were higher in older women and similar for all hormone replacement therapy preparations. The authors concluded, "The addition of progestin to estrogen therapy does not reduce the risk of breast cancer among postmenopausal women. The substantial increase in the risk of breast cancer among older women who take hormones suggests that the trade-offs between risk and benefits should be carefully assessed."

McKinney also states that the evidence overwhelmingly supports a protective effect of hormone replacement therapy on the cardiovascular system and against osteoporosis. Unfortunately, the cohort studies showing a substantial reduction in heart disease in users of hormone replacement therapy are open to bias, with healthier women being more likely to use the therapy. Barrett-Connor has shown that women who choose to take hormone replacement therapy eat healthier diets, take more exercise, and are more likely to visit their doctor.⁴ Cauley *et al* calculated that women aged over 65 who decided to take hormone replacement therapy had a lower risk of heart disease.⁵ Whether such biases fully explain the apparent protective effect of hormone replacement therapy on heart disease is unknown.

It must be borne in mind that coronary heart disease accounts for around 23% of all deaths among women each year, breast cancer around 5%, and fractured hips about 1%. A small increase in the risk of breast cancer might completely overshadow a larger decrease in the risk of hip fracture.

The only way to determine whether long term hormone replacement therapy is beneficial to women's health is through a randomised controlled trial with long term follow up. Such a trial is long overdue. In the meantime, we should be wary of letting our enthusiasm to prevent illness lead us to make unjustified extrapolations of

results from studies that can suggest hypotheses but not test them.

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Invalidity benefit has been superseded by incapacity benefit

EDITOR,—In an article in the series on caring for older people Charlie Teale presents a clear picture of the bewildering array of benefits that elderly people may be able to claim.¹ Inevitably, with benefit rates changing every year, some of the figures quoted are incorrect. In particular, the article describes invalidity benefit, which was replaced by incapacity benefit in April 1995.

There are three bands of incapacity benefit: the short term lower rate, paid for the first 196 days; the short term higher rate, paid from day 197 to day 364; and the long term rate, paid from day 365 onwards. To qualify for incapacity benefit a claimant must be under pensionable age when the period of incapacity for work begins and must satisfy the conditions regarding national insurance contributions. Women aged 60-65 and men aged 65-70 can continue to receive short term incapacity benefit provided they would be entitled to a retirement pension on the basis of their own contributions. People over retirement age cannot receive incapacity benefit at the long term rate.

Entitlement to benefits is a complex subject for everyone, but especially for elderly people. Citizens' advice bureaux have access to comprehensive information on all benefits. They also have a wealth of experience in helping elderly clients to make the appropriate claims. The service is free and confidential and is based on an understanding of the client's overall situation rather than just the presenting problem. Readers of the *BMJ* should feel free to refer any of their patients with money problems to their local citizens' advice bureau. We will be glad to help.

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1 Teale C. Caring for older people: money problems and financial help. *BMJ* 1996;313:288-90. (3 August.)

Rights and responsibilities in HIV prevention

EDITOR,—Paul Bailey¹ and Stuart MacWilliam² take issue with some of the ideas that I put forward in my article about possible changes in attitudes towards the prevention of HIV infection.³ I should like to make clear that I did not advocate a restriction on the human rights of any individual or group. On the contrary, my article concluded with a clear call for greater protection against discrimination for people who are HIV positive.

My argument is that, while respect for human rights is essential, our concern about protecting

human rights should not cloud our thinking about responsibilities—including the responsibility of individual people, both HIV positive and HIV negative—to prevent the transmission of HIV. Just as governments should not be absolved of their responsibility to people infected with or affected by HIV, so too individual people, whatever their serostatus, cannot be absolved of their responsibilities to themselves and others. Addressing this issue is problematic for all sorts of reasons, but that does not mean that it should not be done.⁴

MacWilliam asks whether AIDS has really been normalised. Sadly, there are innumerable examples of stigmatisation such as that to which he refers. Yet, alongside these, there are also examples indicating the normalisation of AIDS (albeit it is a slow process). This is the result of a combination of factors: epidemiological, medical, and also social and historical.

I am certainly not recommending draconian or Orwellian measures. Far from it. But it is incumbent on us all to consider different approaches to the prevention of HIV infection and to talk openly about what does and does not seem to work.

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Income and mortality in the United States

Incomes should have been adjusted in the two studies

EDITOR,—Whether inequalities in the distribution of income in advanced industrial societies are associated with average levels of population health is a contentious issue.¹ The papers by George A Kaplan and colleagues and Bruce P Kennedy and colleagues seem to support the view that some indicators of income inequality are correlated with mortality, at least in the United States.^{2 3} Given that the United States is the most inequalitarian of the richest industrial nations, such findings are perhaps not so surprising, but whether they are generalisable to other countries remains to be seen. More importantly, however, the significance of these papers is questionable on methodological grounds.

Assessing variations in the distribution of household income is complex. There is general agreement among social scientists, however, that comparative analyses make most sense when primary incomes—from sources such as salaries and wages—are adjusted to take account of taxes, cash benefits, and household composition to yield a measure of "equivalent disposable income." Any failure to make these adjustments is likely to exaggerate the extent of inequality in the distribution of disposable household income.

Unfortunately, the data used by Kaplan and colleagues and Kennedy and colleagues are derived from the United States census, which provides estimates of incomes unadjusted for taxes, benefits, and size of household. The extent of the problem this poses can be illustrated with an example taken from a report prepared for the Organisation for Economic Cooperation and Development, which reproduces estimates produced by the Congressional Budget Office comparing the distribution of income in the United