top six outlying districts (all with a proportion aged over 65 of >22%) produces a result that is still significant ($p<0{\cdot}001$) with the same slope ($-1{\cdot}2$) 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 (weight=$(1+\text{population}>65)^{0{\cdot}34} \times (1 + \text{SMR})^{0{\cdot}63} \times (11 + \text{deprivation factor})^{0{\cdot}08}$), 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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1 Williams ES, Scott C, Brazil R. NHS distribution of funds unfair. *BMJ* 1992;**304**:643. (7 March.)

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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1 Hayden J. A team future for general practice. *BMJ* 1992;**304**: 728-9. (21 March.)

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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1 Hannay D, Usherwood T, Platts M. Workload of general practitioners before and after the new contract. *BMJ* 1992; **304**:615-8. (7 March.)
2 Myerson S. The new contract and relationships in general practice. *Journal of Management in Medicine* 1992;**6**:19-24.

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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1 Stott NCH. Day case surgery generates no increased workload for community based staff. True or false? *BMJ* 1992;**304**:825-6. (28 March.)
2 Burn JM. Responsible use of resources: day surgery. *BMJ* 1983;**286**:492-3.
3 Atwell JD, Burn JMB, Dewar AK, Freeman NV. Paediatric day-case surgery. *Lancet* 1973;ii:895-6.
4 Burn JMB. A blueprint for day surgery. *Anaesthesia* 1979;**34**: 90-805.

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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1 Kingman S. Home HIV tests banned in Britain. *BMJ* 1992;**304**: 864. (4 April.)