Home visiting by general practitioners in England and Wales

Home visits are a feature of primary care in many western European countries

EDITOR,—Paul Aylin and colleagues' paper on home visiting in general practice perpetuates one of the many myths concerning the NHS.[1] It is not true that home visiting "is one of the factors that distinguish primary care in Britain from primary care in many other Western countries." Home visits are a feature of primary care in many Western countries, and also in the former socialist countries of central and eastern Europe. In 1994 they accounted for about 3% of face to face consultations in general practice in Denmark, under 1% in Finland, 19% in France, 9% in Germany, 5% in Greece, 3% in Israel, 11% in Italy, 9% in the Netherlands, 2% in Portugal, 3% in Spain, 2% in Sweden, and 7% in the United Kingdom.[2] This makes the United Kingdom about average for western Europe. Among central and eastern European countries, home visits are a feature of the soviet model of health care provision and of those countries where primary care doctors have moved to an independent contractor model of provision (the Czech Republic and Slovakia).[3] Only in the countries of the former Yugoslavia are home visits rare.

Unfortunately, the feature that truly distinguishes the NHS from other health systems is the persistent belief in the United Kingdom that the NHS is fundamentally different from health care systems elsewhere.

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1 Aylin P, Majeed A, Cook DG. Home visiting by general practitioners in England and Wales. *BMJ* 1996;313:207-10. (27 July.)
2 World Health Organisation. *General practice country profiles (draft)*. Copenhagen: WHO, 1995.
3 World Health Organisation. *Health care systems in transition. (Preliminary versions on Slovakia and the Czech Republic)*. Copenhagen: WHO, 1996.

Phenomena that underpin frequent attendance need clarification

EDITOR,—Paul Aylin and colleagues' found that 1.3% of patients accounted for almost 40% of all home visits in their study.[1] We performed a similar analysis using data from a validated dataset consisting of a date record of all contacts with four practices in and around Leeds in 1992, 1993, and 1994.[2] While in general we found a correlation between consultations in the surgery and home visits—for example, patients who seldom attended the surgery were visited infrequently—this was not true among the 1 in 50 patients who received frequent home visits. Combined data from the four practices showed a visiting rate of 428 visits/1000 patient years. In 1992, 1993, and 1994, 13.1%, 13.8%, and 13.0% of all contacts, respectively, were visits and 2.2%, 2.3%, and 2.3% of patients (those with five or more visits in the year) accounted for 49.3%, 47.6%, and 48.6% of all visits. These figures are higher than those quoted by Aylin and colleagues but are in keeping with national trends.

We found that the number of home visits and the number of consultations in the surgery per individual was positively and significantly correlated for each of the three years, and when the sample was limited to the high users of home visits the two variables were negatively and significantly correlated for each of the three years (table 1). While overall there was a relation between the number of home visits and consultations in the surgery, high users of home visits were not frequent attenders at the surgery.

Table 1—*Correlation of number of visits with number of surgery consultations and of number of visits in one year with number of visits in subsequent years*

	Sample size	Spearman's correlation coefficient r (95% confidence interval)
Correlation of No of visits with No of consultations in surgery		
All patients in:		
1992	57 508	0.225 (0.217 to 0.233)
1993	55 731	0.211 (0.203 to 0.219)
1994	53 361	0.182 (0.174 to 0.190)
Patients with five or more visits in:		
1992	1245	−0.169 (−0.222 to −0.114)
1993	1299	−0.247 (−0.297 to −0.195)
1994	1227	−0.147 (−0.202 to −0.092)
Correlation of No of visits in one year with No of visits in another year		
All patients:		
Visits in 1992 and in 1993	59 923	0.339 (0.332 to 0.346)
Visits in 1993 and in 1994	59 923	0.343 (0.336 to 0.350)
Visits in 1992 and in 1994	59 923	0.263 (0.256 to 0.270)
Patients with five or more visits in 1992:		
Visits in 1992 and in 1993	1247	0.215 (0.161 to 0.267)
Visits in 1993 and in 1994	1247	0.579 (0.541 to 0.614)
Visits in 1992 and in 1994	1247	0.082 (0.026 to 0.136)

The number of home visits per person was stable from year to year. A positive correlation was found for the annual number of home visits between years for high users of home visits in 1992. The correlation was stronger when all patients were included (for example, infrequent users of home visits in one year were likely to be infrequent users of visits in subsequent years) (table 1).

While the high workload of home visits is important, it should be considered in the context of the overall disproportionate workload, whether at the surgery or at home, that is generated by the minority of patients who consult frequently. The phenomena that underpin high use of services and frequent attendance are not yet understood—for example, our data suggest that this behaviour is not constant, as the correlation of the number of visits was weaker between 1992 and 1994 than between 1992 and 1993. Until these phenomena are understood, it is premature to suggest that the appropriate response will lie with "allocation of budgets for prescribing and fundholding."

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1 Aylin P, Majeed FA, Cook DG. Home visiting by general practitioners in England and Wales. *BMJ* 1996;313:207-10. (27 July.)
2 Neal RD, Heywood PL, Morley S. Real world data—retrieval and validation of consultation data from four general practices. *Fam Pract* (in press).

Colleges should have a special membership for doctors practising in another specialty

EDITOR,—As it becomes more common for doctors to make several career moves, many will become members of several colleges or faculties. The unpalatable choice is either to pay multiple subscriptions or reluctantly to resign from all but the most recent.

We suggest that the colleges should institute a special membership at reduced rates for doctors who are currently practising in another specialty. This would allow doctors to have continuing contact with areas of medicine in which they have more than a passing interest and would surely foster interspecialty understanding and cooperation.

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WHO's decision not to recommend use of artemether in Africa is unethical

EDITOR,—Jacqui Wise reports that artemether, the active ingredient of a traditional Chinese remedy for fever, has been found to be as effective as quinine in severe malaria.[1] She states that most deaths from malaria occur in Africa and then quotes Dr Peter Trigg, a scientist with the World Health Organisation's malaria unit, as saying that the WHO appreciates the operational advantages of the new drug in the field but will not "recommend its introduction into Africa because of fears that ... resistance would spread."

This decision by the WHO is unethical and unprofessional. The organisation is condemning African patients with malaria to the possibility of death even while it is announcing that a new drug has shown better outcomes than occur with quinine. It is incredible that an organisation that is part of the United Nations and that is charged with implementing health for all in the world by 2000 should decide to abandon patients to possible death from malaria on the basis of the lame excuse that resistant strains might develop if a new drug was introduced. Would this kind of trial be approved by an ethics committee?

Rather than deprive African patients of the benefits of a new drug, the WHO should use its influence and resources to educate the governments and people in Africa about the dangers of misuse of drugs and the emergence of resistant strains of malaria.

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1 Wise J. Back up drug found for severe malaria. *BMJ* 1996;313:134. (20 July.)