full payment of allowances as follows: 1000 patients for rent, rates, staff reimbursement; 1200 for basic practice allowance; 1500 for group practice allowance; 1700 for seniority awards or vocational training allowance. Like the present system, the allowances would be proportionately reduced for smaller lists, that is, a doctor with a list of 1500 would get (1500/1700) x seniority award but full rate basic practice allowance and group practice allowance.

This system would lead to a gradual change in remuneration per extra patient. It would encourage a reasonable list size of 1700 which the British Medical Association has recommended and it would give patients more choice without encouraging giant list sizes.

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Buying and selling practices

Sir,

Dr Robson and colleagues (Letters, September *Journal,* p.431), have highlighted a dilemma facing an increasing number of general practitioners as a result of the present boom in independently owned purpose-built surgeries. Having built two such surgeries ourselves, and being involved in the planning of several others my partners and I have arrived at a formula which, although not ideal, goes a long way to solving the potential problems.

Premises can be valued in three ways. First, rebuilding value; this is obviously unfair to incoming partners. Secondly, market value, either open or closed. Open market valuation is simply what an estate agent would hope to get for you were you to sell your surgery tomorrow. Closed market valuation is what you would get if you sold your premises tomorrow but continued to act as a practice — in other words it takes into account the constraints imposed by the National Health Service on how many doctors can practise in an area. Thirdly, the cost or notional rent valuation, whichever is greater.

The last valuation has three advantages. First, the valuation is free; getting a building worth half a million pounds valued is very expensive. Secondly, it is always possible to borrow money cost effectively against it; in other words the cost rent or notional rent, whichever is higher, will always cover to a large extent money borrowed to either build or buy into premises. Thirdly, it is equitable; there can be no further disputes about who makes the valuation and on what terms — figures obtained from estate agents, even those with theoretical expertise in this field often appear to be little more than arbitrary.

In order to accept this one has to realize that an existing partner will not 'make a killing' out of his premises on retirement, as has often been the case in the past. In order to maintain a reasonable succession of partners who have not had to find vast sums to enable their predecessors to buy *bijou* residences in the sun, one must accept that having an acceptable environment in which to work is in itself an advantage. A gain made over the life of a practitioner will be significant but not vast. It would also equate more accurately to the area in which he practices, once again facilitating succession.

The problem of succession during the lifetime of a loan, be it from the General Practice Finance Corporation or a bank, also needs clarifying. The overall value of the building is known accurately from the rental paid less the total of the outstanding loan on it. At any given moment the exact amount of capital repaid by either an individual or a partnership can be calculated from GPFC or bank figures if direct repayment is used, or surrender value of life insurances if endowment repayment is used. A simple formula can be worked out which summarizes all this. In practice, it is not as complicated as it sounds, and it has removed a significant bone of contention from our practice at least for the foreseeable future.

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Clinical strategies in family practice

Sir,

The paper on clinical strategies in family practice by Dixon (October *Journal,* p.468) emphasizes the importance of concepts of health and illness in providing appropriate care. They are also important in the advancement of the discipline of general practice. To date general practice research has been enormously productive of information, but only now is serious attention being paid to the evolution of models and theories within which this information can be used to test ideas and to better understand 'intellectual processes which may be of significance to all levels of medicine'.

It is interesting that Dixon discusses diagnosis almost entirely in relation to disease, emphasizing the evidence which shows how often in general practice no disease is diagnosable. An alternative to the idea of 'non-disease', which he rightly proposes as an appropriate aim for general practice diagnostic effort, is to consider diagnosis also in relation to illness (patient feeling) and sickness (patient behaviour) as outlined by Barrand.[1] That is, diagnosis is related to patient problems rather than to disease entities.

This is to 'borrow liberally from other conceptual models' but not to 'reformulate the problem in psychological or sociological terms'; rather it is to reformulate the problem in general practice terms. This is perhaps more useful than a 'management diagnosis', because it is more likely to imply ideas about how resolution of the problem can be measured. Delay is only useful as 'a deliberate strategy to change the probability of disease', if the goals of non-intervention and the means of monitoring their achievement are clearly understood by both patient and doctor.

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Reference

1. Barrand J. A model of health. *Aust Fam Phys* 1985; **12:** 1302-1307.

Low immunization rates among students

Sir,

At the beginning of the academic year we interviewed 1800 new students registering with the University health service. We observed that it is quite exceptional for 18-year-old British boys and girls in this intake to have up-to-date polio and tetanus immunizations and many who missed Heaf testing at school had no subsequent follow-up to check tuberculosis immunity.

We feel this should be brought to the attention of school and family doctors so that more use can be made of age–sex registers and computerized recall of patients and the theory of the MRCGP examination actually put into practice. Note also that a fee is payable for such immunizations.

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