occurs on different days of the disease. How would the model fare if it rested (as perhaps it ought, and this should be discussed) on dates of onset? Furthermore, dates of onset are sometimes difficult to assign, for example: "J.S. Coryza 8 days, cough 3 days, headache began yesterday. Was febrile last night. Today T. 101·2° (3.0pm) . . .". What date do I assign? The method would seem to be vulnerable to different interpretations of the nature of the disease and one should ask if it is as soundly based on the realities of the host-parasite interaction as it at first sight appears to be.

2. "The susceptible population for this practice is taken of those who become infectious or require medical treatment." I find this statement incomprehensible. "Hence, the initial state of the population in order to estimate R to fit the model C = RIS is I = 10, S = 280." Whence?

The present model does not explain why the Hong Kong influenza A epidemic of 1968/69, having got under way successfully, terminated having attacked perhaps only five per cent of susceptibles, nor why the 1969/70 epidemic only eight months later attacked more than twice as many in less than half the time and again terminated in the presence of abundant susceptibles. A model must be accounting for the realities of the host-parasite situation if it is to be useful in controlling influenza. At present there are such large gaps in our understanding of influenzal epidemiology that we need to take a long hard fresh look at our underlying concepts of epidemic mechanisms to make sure we have not got our thinking all wrong.

If Dr Damms and his colleagues continue their observations, as I hope they will, may I suggest that they base some models on different assumptions about how (and whether and when) influenza is spreading?

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## THE COST OF CARE

Sir,

Dr Richards's article (November *Journal*) was of no interest to me until I was horrified to see it reported in the *Daily Telegraph.* I subsequently heard many doctors talking about it and on reading the article was astonished to find it was written by a relatively inexperienced doctor, who had carried out a survey covering *two weeks.* None of this was mentioned in the newspaper.

Despite the College's elation at the number of young doctors sitting the membership examination, it still remains true that two-thirds of general practitioners are not members of our College, and we ought to ask ourselves why this is so, and not feel satisfied that 750 general practitioners are sitting the examination this year.

The article, of course, is utter nonsense. I refuse to accept responsibility for the cost of the nation's health. If irresponsible governments make a free-for-all health service, without any disincentives or deterrents when the country is at its lowest ebb and tottering on the brink of bankruptcy, the blame cannot be put on general practice. Nor can the onus for redressing the balance of irresponsible government be expected to be put right by general practitioners. This would be similar to saying that police officers were responsible for the enormous costs involved in the apprehension, trial, and incarceration of the great train robbers. This comparison is not ridiculous, as the public appetite both for medicine and for crime is increasing and insatiable.

The College should not appear to be an organization with its head in the clouds, or part of the establishment, but similar to other medical Royal Colleges, not one of which would publish a letter suggesting that more surgeons and physicians would increase the nation's health bill, but would regard the increase as a natural corollary of a national health service. Despite the protests that articles in the *Journal* do not reflect the official views of the College, that is the general impression.

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