or control measure of the incidence of asthma in the catchment population.

If such data were available, it would strengthen the epidemiological validity of these impressive results.

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Quality or inequality in health care?

Sir,

William Fulton's pertinent letter (July *Journal,* p.303) raises a number of important issues about general practice on peripheral council housing estates — the 'forgotten areas of deprivation'.[1] Bosanquet and Leese have shown clearly that the often overwhelming reactive workload facing practices in deprived areas militates against their showing 'innovative' characteristics (practice nurses, trainees, a practice manager and new premises), which are more common in affluent suburban areas where patient demand is less, and is more proactive.[2]

We practise on a large peripheral post-war council housing estate (population 25 000), where high morbidity, unemployment, poor housing and large numbers of pre-school children lead to a heavy workload. Our five full-time partners (plus a trainee) practise from a health centre and in the past year our annual consultation rate has increased from 4.38 per patient (1989/90 with list size 7500) to 4.71 (1990/91 with list size 7400). We offer 10 minute appointments and morning surgery (five doctors working) lasts from 08.30 hours to past noon, with a 20 minute mid-morning 'coffee recovery period'. Our mean consultation length is 9.2 minutes. Sixty five per cent of the babies born in the practice have birthweights below the 50% centile, and 48 pre-school children are on the child protection register. Our night visit rate, at 44.5 per 1000 patients per year, is about two and a half times the national average.

We receive no deprivation payments, because of the anomalies of the UPA8 score, although our practice area is reported to be the second most deprived in Bristol (letters, May *Journal,* p.217). We have only managed to reach the high targets we set for cervical smears and primary immunizations because of our low list size (doctor:patient ratio 1:1500), our committed primary health care team and our past history of screening and preventive work.

In the new contract for general practitioners[3] the population is treated as though there were no demographic difference across the social classes. Deprivation payments, the one exception, are excellent in concept, but inaccurately targeted with regard to need.[4] The increased capitation element has militated against the high ratio of doctors to patients needed to deliver high quality care in areas of deprivation. The Prince of Wales has described the peripheral council estates as 'islands of unemployment and helplessness', saying 'What we need to do is to break the vicious cycle of poverty, hopelessness and depression' (*The Times* 10 March 1989, p.2). Professor Maclennan of Glasgow university has identified the large post-war peripheral council housing estates as the pivotal areas of deprivation of the 1990s, supplanting the inner cities.[5]

It is essential that resources to family doctors, to the whole primary health care team, and to housing, education and social services, should be targeted to where the real needs lie, if Tudor Hart's inverse care law[6] is to be reversed in these 'forgotten areas of deprivation'. In the 10 years since the Black report on health inequalities,[7] the health–wealth gap has widened in the United Kingdom, but has narrowed in most of the rest of Europe.[8] This is the most important issue in health in the UK today, and resources must be targeted to where the morbidity and need are, to give the disadvantaged an 'average chance of health'.[9]

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Hospice care

Sir,

We were interested to read the letter regarding general practitioners' opinions of hospice care (May *Journal,* p.213). All who rely on hospice care are entitled to demand exacting standards. These standards must be judged in relation to what hospices do. They are not 'death houses' which simply receive dying patients for the last 24 or 48 hours of care. A flexible and responsive service depends on accepting that hospice care, whether in the patient's home or elsewhere, is concerned with improvement in quality of life. One important component of this is the development of a relationship based on trust between patient, family and the professional carers. A late first contact with a hospice precludes this humanistic approach and results in fraught situations which stretch the coping skills of all involved.

Thus registering early with a hospice is not a pre-emptive device, but the first step in developing a caring relationship concerned with quality of life and ultimately with a peaceful, dignified death. Hospices do not aim to take over from the primary care team. They offer support when the patient is at home, forging a caring link in preparation for hospice admission if required.

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Factors influencing prescribing habits

Sir,

I read with interest the paper by Taylor and Bond (June *Journal,* p.244) regarding the factors leading to change in the established prescribing habits of general practitioners. The authors are to be congratulated on what is an attempt to examine an important area of therapeutics. However it is a little disappointing that it has taken so long for their results to be published since the major influence on doctors' prescribing habits — the limited list — is now somewhat dated.

They state in the summary that general practitioners were not unduly influenced by commercial sources of information. I would question this since if the effect of the limited list is disregarded the next commonest influence was found to be the pharmaceutical company representative and then the hospital doctor. There is no doubt that hospital doctors are targeted