believe we are parties to a social contract, not a business contract.'[3]

Already the first wave of enthusiastic fundholding practices have embraced the purchasing and selling of patient care by the creation of services owned by these practices, and have pointed to the resulting improvement of care for their patients. But there are losers. My practice has 6000 patients, too few for fundholding under the current Department of Health guidelines (Oxfordshire Family Health Services Authority, personal communication). My patients now suffer from a two tier system, and do not always receive the best medical care, not for lack of perceived medical needs but for business reasons — lack of fundholding money. This state of affairs was explicitly admitted to by our local medical committee (Oxfordshire local medical committee, minutes of meeting held 22 October 1992). To accept that by managing this market place, we as general practitioners will be able to create a just distribution of good health care seems, therefore, to be without foundation.

Holland, when commenting upon the approach of the Netherlands to their health care crisis, noted that the problems 'cannot be solved by structural change and, least of all, by introducing a market that has no underlying philosophy' and continued that 'The Dutch approach of accepting that in a market situation the losers will be those procedures that are inadequate or inappropriate, rather than the weak and the disabled, is a salutary lesson to us all.'[4]

The drive for change came partly from the growing awareness that at some point rationing has to occur, a process that implicitly results in the practice of non-voluntary euthanasia.[5] The ethical principle that demands to be applied to this social dilemma is justice, not market forces. We as general practitioners are advocates for each of our patients as individuals, not for populations, a responsibility which lies with society. It is as members of our society that we should lend our voices to the debate on rationing.

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Suicide rates

Sir,

David Aldridge's review of suicidal behaviour (November *Journal,* p.482) was timely following the government's white paper *Health of the nation.*[1] Targets for mental health include a reduction in overall suicide rates by at least 15% by the year 2000. It is to be hoped that the development of local and national policies to achieve the targets will lead to an overall improvement in the quality of life of those suffering mental ill health and a reduction in suicide rates. Aldridge addresses the importance of treating individuals who attempt suicide within their social context, however, from the British perspective certain statistics need clarification.

The author highlights the current concern with increasing suicide rates in young people (this is mainly seen in adult males aged less than 45 years[2]). He goes on to state that there is an increase in the number of suicides among older people. However, in England and Wales the rate of suicide among those aged 65 years and over has declined since 1946–50. Charlton and colleagues report that the rate of suicide among adult men aged 65–74 years has fallen from just over 40 per 100 000 (1946–50) to approximately 15 per 100 000 (1986–90).[2] Similar reductions have been seen in those aged 75 years and over. The rate of suicide among women aged 65 years and over has also decreased substantially although the overall rate is considerably lower than that for men. Despite these reductions the rate of suicide in older age groups remains higher than among those aged less than 45 years.[2]

Dr Aldridge goes on to predict a widespread social tragedy resulting from the social upheaval and dislocation currently occurring in continental Europe. Whereas these changes are clearly a cause for concern, the effect on suicide rates is less certain. It is of note that during both the first and second world wars there were marked reductions in suicide rates in England and Wales.[2] The disruption occurring in England and Wales at that time, however, may have been of a different nature to that seen currently in Europe.

The rate of suicide in England and Wales compares favourably with that in many of our European neighbours. The rate of death by suicide and self inflicted injury when standardized by age against the world standard population was 6.0 per 100 000 population for England and Wales in 1989. Comparable rates per 100 000 were: 11.8 in West Germany (1989), 15.9 in France (1989), 14.9 in Sweden (1988), 8.3 in the Netherlands (1989), 10.2 in Poland (1989), 17.6 in Switzerland (1989), 18.9 in Austria (1989), 5.5 in Italy (1988) and 5.7 in Spain (1987).[3] Sainsbury and Jenkins suggest such international comparisons are valid despite differences in reporting procedures.[4] These figures suggest that suicide is less of a problem in this country than elsewhere in Europe. However, this is not to belittle the problem; most deaths from suicide are tragic and the government's focus on this group is to be welcomed. The ability of the health service to reduce rates of suicide must be considered in the wider context of the many factors outside health service control which may also influence these rates.

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Request for information about gout

Sir,

Little is known in detail about the epidemiology of gout, and the information required can come only from general practice. May I ask any general practitioners who keep a register of sufferers from gout if they would be willing to let me know. No details are required in the first instance, but I will send anyone who replies the questions to which I hope to get answers — mainly the number, age, sex and treatment of the patients concerned.

One aspect of the study will be to see the extent to which prescribing data about allopurinol may serve as a guide to the prevalence of the condition in a practice population.

I will be grateful for all replies to the address below (or tel 0532-336770) and subsequent information.

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