against HIV must be defined, and good disinfection protocols must be established. It must not be forgotten, however, that instruments are most reliably and safely sterilised by heat.

E M COOKE

Director,
Division of Hospital Infection,
Central Public Health Laboratory,
London NW9 5HT

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The politics of inadequate registers

Poor registers may undermine the government's plans

The British government has committed itself to screening for both cervical and breast cancer, and yet its programmes may well fail because of the inadequacies of population registers. These inadequacies have been reviewed in two recent editorials in the *BMJ*,[1,2] and today's issue contains further papers exposing serious problems with population registers (pp 98, 101, and 104). In addition to the clinical problems generated by failure of screening programmes for breast cancer and cervical cancer, the inaccuracy of population registers shown in these papers also has a wider political implication. Both the proposed new contract for general practitioners, which is currently the subject of a ballot of all general practitioners, and the NHS review *Working for Patients* contain proposals heavily dependant on accurate population registers.

One of the most contentious issues in the proposed new contract for general practice is that large amounts of income should be derived from meeting specified targets in various preventive health activities. To find patients within the target groups general practitioners will need accurate age-sex registers, and to make the payments health authorities will need to check claims against their population registers. The targets cover cervical cytology and childhood immunisation, and there will be capitation payments for paediatric surveillance and screening of patients over 75. For all of these the amount of work claimed to have been done will form the numerator of a fraction whose denominator is the size of the target population, as defined by the health authority's population register.

The proposed new contract and the terms of the NHS review also make it clear that population registers will be essential not only for checking claims for income but also for calculating sanctions in assessing performance indicators. The accuracy of such figures will be vital when disputes arise over drug costs in indicative drug budgets, over norms for referral patterns, and in real cash terms for actual practice budgets. How can any budget holder be expected to work to a 5% tolerance limit when the population on which the budget is based is inaccurate to the extent shown in the studies published today?

There are also implications for health authorities, which in future will have to know accurately the size and demographic spread of their populations as cash allocations are to move in the next few years to a "weighted capitation basis."[6]

It has been suggested that general practitioners and their staff should be responsible for keeping an accurate track of their practice populations.[1] In future there will probably be financial pressure to do so both from the opportunities and from the penalties implicit in the new system. Patients, however, are entitled to their individual freedom and privacy and should not be required to surrender either as a precondition of NHS treatment. As was emphasised in a resolution passed at the conference of representatives of local medical committees last month registration data are given by patients to their general practitioners and passed on to the family practitioner committee or health board in confidence and solely for the purposes of administrating primary health care services. The government has emphasised both the rights of individual people to freedom and choice and their personal responsibility for health, education, and welfare. It has encouraged patients to change doctors more often to enliven competition, and, using cervical cytology as an example, it insists on several sources of advice being available—including family planning and well woman clinics, private clinics, clinics run by employers, and general practitioner and hospital clinics. At the same time the government is introducing systems of national screening and NHS financing that threaten to penalise financially doctors and health authorities who fail to keep track of individual patients and their health records.

MacEwan and others (p 104) rightly draw attention to the government's duty to educate the public of the necessity of keeping doctors and health authorities advised of basic registration details. In a wider context it is clear that individual practices and health authorities will have to develop accurate population registers for generating income and managing resources. In a country that has so decisively rejected the concept of a national identity card might an NHS card become a surrogate?

ERNEST MACALPINE ARMSTRONG

General Practitioner,
Connel, Argyll

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