# EDITORIAL

# Age-sex registers

*We support the setting up and maintaining of age-sex registers in order to identify those at risk among a general practitioner's patients.*

Expenditure Committee (1977).

THE age-sex register is a feature of British general practice. In many other countries of the world, general practitioners do not have the advantage of working with a precisely known population of patients and may never know the exact number of their patients on any single day. However, once patients register with a general practitioner it immediately becomes possible to classify them, both by sex and age.

## Research use

The early work on developing age-sex registers was carried out mainly by general practitioners who had a special interest in research and the first indexes were often constructed as loose-leaf ledgers. However, the disadvantage of ledgers was that when patients left the practice for any reason their names had to be crossed out and the pages became increasingly untidy. Separate cards are an advantage and furthermore can be tabbed or punched to indicate any facet of health care in which the doctor is interested. Mainly for these reasons the age-sex cards (blue for a boy and pink for a girl), originally designed by the Birmingham Research Unit of the Royal College of General Practitioners, have become increasingly accepted and are now in use all over the UK.

By 1971, when 320 practices had begun to use the Birmingham cards, Goodman wrote to them all and found that about half were using their register for checking on immunization and cytology and about a third for general health checks and research. Very few had stopped using their register. By the summer of 1977 the Birmingham Research Unit estimated that the number of practices with age-sex registers had more than doubled and believe that a minimum of 850 practices now use them.

## Monitoring care

During recent years, then, the use of the age-sex register in British general practices has extended not just because of its research applications, although these have continued, but increasingly because it is now coming to be seen as an essential instrument in monitoring health care in general practice.

How can one begin to carry out surveillance of any age group if the precise population at risk is not known? How can any health worker, health visitor, or doctor ensure that they are looking after all their elderly patients if they cannot identify exactly who and where they are?

A practice which either does not have or does not use an age-sex register is indicating that it is not particularly interested in preventive medicine or the surveillance of age-sex groups among its patients. Nor is it possible to make useful comparison between aspects of practice organization or health care if the age-sex distribution of the lists concerned is not known. Practices with a high proportion of elderly patients may have quite different needs from those in which two thirds of the patients are children.

Articles in this *Journal* have described both the creation and use of age-sex registers (Pinsent, 1968), and their application can be particularly interesting when they are harnessed to other practice record systems such as some form of diagnostic register. They can be invaluable in selecting matched controls for comparisons. What, however, has not previously been published is the cost of setting up an age-sex register from scratch, and this we are now pleased to do in the article by Drs Sloan, Norman and Adams. Their practice costs came to £217, less a proportion for expenses against income tax, which would still leave the doctors paying about £150 themselves.

## Family practitioner committees

There is, however, another way. The benefits to patients are now so well recognized that the NHS is increasingly taking on the responsibility of assisting doctors in the creation of such registers. Already a good number of family practitioner committees in the NHS have agreed to construct age-sex registers provided the general practitioners buy the age-sex cards. In Sheffield, for example, an enterprising family practitioner committee is using the Government's job creation programme to pay extra clerks specifically to make age-sex registers. Why is this not happening elsewhere?

We welcome this development, which is a natural

extension of the role of the family practitioner committees which already keep the master index of all registered patients.

### Training practices

How quickly age-sex registers become routine record systems in everyday general practice remains to be seen. It can hardly be doubted, however, that they will be the standard tools of tomorrow. It follows, therefore, that those responsible for selecting training practices now have a special responsibility. In 1972 Irvine, in *Teaching Practices,* listed the presence and use of an age-sex register as one factor to be considered in selecting trainers. Are not all trainees entitled to become familiar with its use now?

### References


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## Myocardial ischaemia, risk factors, and death from coronary heart disease

Mortality follow-up is now complete for five years in the 18,403 male civil servants aged 40 to 64 who were examined between 1967 and 1969 in the Whitehall Study of British civil servants. During this period 277 of them died of coronary heart disease (CHD); half of these deaths were in subjects in whom the findings at initial screening had suggested early myocardial ischaemia (angina or history of possible infarction according to standard questionnaire, or electrocardiographic evidence of ischaemia). The finding of suspect ischaemia had greater predictive power than the 'primary' coronary risk factors, from which it was generally independent. At each level of the primary risk factors, the risk of death from CHD was much greater in the presence of suspect ischaemia; and, with the possible exceptions of glucose tolerance and physical activity, the main risk factors still operated even at the stage of early ischaemia. These findings have implications for future studies of the effects of intervention.

#### Reference


Rose, G., Hamilton, P. J. S., Keen, H., Reid, D. D., McCartney, P. & Jarrett, R. J. (1977). *Lancet,* **i**, 105-109.