choose not to spend their money on private dentistry, with others not being able to afford to do so. The fact that most dentists are no longer prepared to take on new NHS patients will have the most impact on those with limited incomes, who will now have to wait many weeks and travel considerable distances to be seen.

Is it appropriate to target the least well off in society, who anyway have little political influence? If dentists are concerned about their income and wish to protest, surely an alternative would be to increase charges to private patients. Certainly this would have commanded greater respect than their present action has done.

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1 Minerva. *BMJ* 1992;305:996. (17 October.)

People without health insurance in New York State

EDITOR,—I wish to correct one piece of misinformation in what was otherwise an accurate and comprehensive article resulting from an interview I gave to Fred B Charatan.¹ The misinformation is the observation attributed to me that “In some areas 80% of the population who are working don’t have access to health insurance.” The figure is erroneous.

The New York State Department of Health recently published a report on the problem of lack of health insurance in New York State. In all, 11.8% of New York’s population is without health insurance. The proportion of people lacking insurance is highest among privately employed household workers, at 53%. In no geographic region or sector of the economy is the proportion lacking insurance as high as 80%. Even among the unemployed, 59% have health insurance, often through the public health insurance programme for the poor (Medicaid).

I believe that the mistake occurred in the translation of a different observation also contained in this report. Of the 2.1 million people in New York State who lack health insurance, 81% are employed or are dependants of those who work.

Our inability to achieve universal access to health care in the United States should be (and is) emphasised as a major national failure. Unfortunately, the error that occurred in this article portrays the problem as larger than it is.

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1 Charatan FB. Conversation with New York’s health commissioner. 1992;305:753-7. (26 September.)

Charging for exchanges of information

EDITOR,—A short report that a colleague and I had published in the *BMJ* last year¹ led to several patients from outside our catchment area being referred to our clinic for second opinions. As part of our assessment procedure we requested copies of recent hospital discharge summaries for all the patients. One such request resulted in the prompt return of 30 sheets of photocopied case notes, including barely relevant material, such as casualty notes and handwritten medical notes; nevertheless, I was pleased to receive such

comprehensive information. One month later I received a letter from my hospital’s finance department asking me to pay the £15 bill for photocopies that it had received from the patient’s original hospital. My hospital has made clear that funds are not available to cover these expenses and has suggested that I should pay for the photocopies from a research fund or departmental funds.

It seems remarkable that hospitals are now beginning to charge other hospitals for the exchange of important clinical information on patients. Will failure to pay these bills result in hospitals refusing to release information to bad debtors? Don’t administrators have enough foresight to realise that the costs of exchanging information will balance out and that billing each other for these services succeeds only in diverting money away from patient care? Are there limits to the costs that hospitals can charge for the sale of clinical information? Surely £15 for 30 photocopied sheets is extortionate. If hospitals refuse to pay for these data should clinicians also refuse to pay, or should they pay from departmental, research, or private funds?

The topsyturvy world of trusts and budgets is giving rise to extraordinary complexities in the formerly friendly relationships between hospitals. The retailing of essential clinical information for profit must strengthen the fears of those who believe that the NHS is no longer a unified body working in the interests of patients.

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1 McGuire P, Fahy T. Chronic paranoid psychosis after misuse of MDMA “ecstasy”. *BMJ* 1991;302:697.

Forced family planning in Tibet

EDITOR,—As a Tibetan woman I was greatly encouraged to read Robbie Barnett’s coverage of the forced abortions and sterilisations that have been imposed on the women of my country.¹ Despite the impression given in the article there is nothing new in China’s claim that Tibetans in towns are officially allowed only two children or that Tibetans in more remote areas should have three children. This propaganda has been promoted since at least the early 1980s in an attempt to create the illusion that Tibetans are given greater freedom to bear children than the occupying Chinese, who, we are informed regularly, are restricted to one child. For example, an article by Zhang Tianlu in the *Beijing Review* of 17 August 1987 states that provisional regulations in 1986 restricted Tibetan cadres and workers to two children, and three in special cases.

An aspect of the policy that is not so widely broadcast is the practice of forcible sterilisation, as evidenced by the substantial detailed testimony by eyewitnesses that has increasingly emerged from across Tibet and has been featured in a recent report published by Campaign Free Tibet, *Children of Despair*, which is the only detailed analysis on the subject. What is the point of claiming that Tibetans can have two or three children if the population of entire regions or villages has already been sterilised, unless it is an exercise in deflecting growing international concern at China’s birth control policies in Tibet?

Tibet’s population should not be misunderstood to be a component of China’s population, with its demographic problems. We did not ask China to invade our nation or impose any form of birth control on us. Why is it that with an estimated population of six million (calculated to be less than 1% of that of China in an area as large as the European Community), Tibet is singled out for any form of birth control? Furthermore, if China

has nothing to hide why has it consistently refused any impartial or independent investigation into these brutal methods of birth control that have traumatised so many women in Tibet?

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1 Barnett R. Family planning methods in Tibet. *BMJ* 1992;305:911. (17 October.)

Pathology of power

EDITOR,—John Warden implies that the stress of being prime minister leads in most cases to an appreciable deterioration in health.¹ He states that there is historical evidence that men who become prime minister in their 60s and serve a full term or more are almost invariably forced into retirement by ill health. This is not supported by the evidence.

Of the 19 prime ministers this century, only three—Churchill, Attlee, and Macmillan—fulfil these criteria, a full term being taken as five years. Churchill was 65 when he became prime minister. It was not ill health but electoral defeat that forced his resignation five years later. He formed a second administration at the age of 77 and died aged 90. Attlee was 62 when he became prime minister. He served for six years, continued as party leader for four years after losing office, and died aged 84. Macmillan was 62 when he became prime minister. It is true that after serving nearly seven years he retired on the grounds of ill health, but this was largely due to an overpessimistic prognosis by doctors for he lived to 92 with his mental faculties unimpaired.

John Warden further states that prime ministers who are forced into an economic somersault are seen to age, and he cites Wilson and Heath as examples. Wilson became prime minister at the age of 48 and Heath at 53. Both are now 76, and Heath is still active in politics.

Of the 19 prime ministers this century, 13 are now dead, the average age at death being 78. Only one, Bonar Law, failed to reach 70, and he was already sick when he took office. Five former prime ministers are still alive: Home (89), Callaghan (80), Wilson (76), Heath (76), and Thatcher (67). Five prime ministers—Balfour, Baldwin, MacDonald, Chamberlain, and Home—served in high office under their successors, and three—Asquith, Attlee, and Heath—remained in the House of Commons as leader of the opposition after their parliamentary or electoral defeat.

Thus, far from suffering poor health as a consequence of their tenure of office, most prime ministers this century have been long lived and active to the end.

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1 Warden J. Pathology of power. *BMJ* 1992;305:1050. (31 October.)

Doctors and libraries

EDITOR,—James Owen Drife’s tongue in cheek article about medical libraries raises some of the issues currently facing those of us responsible for such services.¹ I welcome the chance to reply.

Out of hours service? A great idea, but in a graduate entry profession whose staff are considered to be “admin and clerical” by the NHS and marooned at the bottom of the pay scales, finding and keeping able staff to cover the hours of 9 am to 5 pm is a more pressing problem.

CD-ROM and *Index Medicus*? Wonderful tools but apt to produce a wealth of only half useful material unless searched by discerning users, be they doctors or librarians. Also apt to throw up