CHC NEWS
For Community Health Councils
March 1977 No. 17

June AGM for Association of CHCs

Letters have gone out inviting each CHC to join the **Association of CHCs for England and Wales**. The closing date for replies is 30 April, 1977, and all those CHCs taking up membership will then be invited to the inaugural Annual General Meeting of the Association, to be held in London on 15 June, 1977.

These decisions were taken at the February meeting of the Provisional Standing Committee of the Association. This body was set up by a resolution passed at the national conference of CHCs last November and consists of representatives from CHCs in each English region and Wales, and of CHC secretaries. In fact, only West Midlands region was not able to elect a representative in time for the meeting. Mr Leslie Rosen, Chairman of Leeds East CHC and Yorkshire region's representative was elected chairman of the committee, and Mr John Pater is its acting secretary.

LESLIE ROSEN the new committee's chairman

The committee considered the question of finding staff and offices for the new Association. It was agreed that the selection of the Secretary of the Association should not be made until after the AGM in June, but that the post should be open to people with or without experience of CHCs or NHS administration, and that there should be no special age restriction.

The committee agreed unanimously that a London base was preferable for the Association, and Mr Pater was able to provide evidence that suitable offices could be found in inner London for as little as £2 per square foot. It was reported that the Secretary of State is willing to meet the cost of information services for CHCs, including *CHC NEWS*, on a continuing basis, but expects these services to be available free of charge to **all** CHCs, whether members of the Association or not. The Provisional Standing Committee will therefore be recommending to the Association that the decision taken at the November conference to charge non-members for all information services be reversed.

The other costs of the Association will be met from subscriptions of members and this will be worked out as soon as it is known how many CHCs are going to join. Of course, CHCs will have no element in their 1977/78 budgets to cover the cost of the subscription (which could be between £60 and £120) so the DHSS is willing to underwrite the total cost of the Association including *CHC NEWS* and the information service until 31 March, 1978.

The Provisional Standing Committee next meets in May when it will be making the detailed arrangements for the inaugural AGM, and for the formation of a substantive Standing Committee elected by member CHCs.

The AGM will elect a Chairman and Vice-chairman of the Association and finalise the constitution. The Standing Committee can then proceed to recruit the staff and arrange the move into new offices.

PRIVATE BEDS

ONE THOUSAND private beds will have disappeared from NHS hospitals by 21 May 1977. This follows the passing of the Health Services Act last November, and the legislation sets in motion the government's policy of separating private and NHS health care. Another important aspect of the Act is the creation of common waiting lists between private and NHS patients — which is sought in order to enable patients to be admitted to hospital on the basis of medical priority alone.

In a letter dated 2 February from the Secretary of the Health Services Board (the body set up to work out the detailed requirements of the Act) CHCs are asked for evidence on hospital waiting lists. This can draw attention to factors affecting NHS waiting lists and can raise practical suggestions for setting up common waiting lists. The time available is very short because evidence received after March 16th may not be considered.

The Board is charged with making recommendations to the Secretary of State by 21 May about the best way of introducing a system of common waiting lists.

YOUR LETTERS

MEMBERSHIP

J. P. Moyses, Chairman Liverpool Eastern CHC

It would be interesting to learn if any other CHCs are having difficulties in obtaining a fair measure of support from all its membership or does the work get done by the willing minority, who have the distinction on occasions of being the vital quorum at Council meetings. One can sincerely appreciate how much work local councillors must become involved in, as, too, are the members drawn from the voluntary organisations. As an ex-councillor in Liverpool with ten years' experience, I fully appreciate how much time is taken up with Council affairs. The hard pressed voluntary organisations find it very hard indeed to obtain relief help while their representative is engaged on work for the CHC.

More should be done to make the nominating bodies aware of what it means to be an active member of a CHC so that when nominations are being considered, some idea can be given of what is involved to the people they wish to nominate. Personally, I feel that if ever a National Association of CHCs is established, it would be very appropriate to make one of its first tasks to look at the present format of CHC membership and advise the Secretary of State on how it must be improved.

CONVULSIONS

Colin Hobbs, Secretary Rhymney Valley CHC

A recent observation alleging a high incidence of convulsions amongst children in the Rhymney Valley has been received by my Council and they are now attempting to secure statistical evidence from clinical records, and those doing research into child neurology. It would assist me if other CHC secretaries could advise me as to whether they are in receipt of any records in their respective areas of any evidence of high incidence of convulsions amongst young children.

RISKS OF TREATMENT

Michael Silver, Dental Surgeon, Hemel Hempstead

The articles about medical protection societies and FPC committees (*CHC NEWS 15*) are all very useful. NHS medical and dental service committees are all too formal and "secret" as far as the public are concerned, and too frequently represent the professional interest and defend clinical freedom. The CHC should be present.

The protection societies have large financial reserves and a back-up of medical and legal support. This often makes it impossible for patients who feel aggrieved to sustain a case through the courts to claim damages unless they obtain legal aid.

In order to obtain damages patients have to prove negligence — very difficult against the protection societies — and because of this many new wonder "treatments" continue to be carried out because the professionals feel protected and it is not "their" money being risked. The society pays the damages.

Many patients do however suffer often prolonged and nasty after effects of well thought out, regular treatments, e.g. a nerve damaged after an injection or after wisdom tooth removal.

The damage may even be lifelong and without any thought of negligence. The patient should be able to obtain some compensation for the disfigurement or disability and an enquiry as to why the trouble occurred so that it can be published in order to put the professionals on their guard by learning from the occurrence.

I think a *Medical Treatments Injuries Compensation Board* should be investigated and set up.

MYSTIFYING REMARKS

Anita Sutton, Secretary, Centre of Environment for the Handicapped

I am slightly puzzled by an article that appeared in the December issue of *CHC NEWS*, about the function of the Health Education Council in the "promotion and development of health education". I am wondering quite what Mr Mackie means by his rather mystifying remarks about tomcats and internal machinery. You tell us he wishes to present information in a straightforward way without making judgements, but juxtaposed to this is a direct quote from Mr Mackie which seems to advocate a rather more elaborate version of the "if you masturbate you'll go blind" form of sex education based on the engendering of fear and guilt. Promiscuity, it seems, will not make you blind but according to Mr Mackie it is likely to make you impotent, unstable, and permanently damaged. "Even more so", he says, "in the case of women, whose internal machinery, if they are promiscuous, will be damaged".

I can only assume that by the "epidemiological grounds" which are supposed to make sense of this startling piece of information Mr Mackie is referring us to various forms of venereal disease, in which case I think it might be less harmful were he to specify that it is the disease that is damaging in this way and not, of itself, the promiscuity.

NHS ABORTIONS

Vera Bolter, Secretary Newcastle CHC

Complaints about waiting lists have figured largely amongst matters causing concern to this and other CHCs. One area where there are now no delays in Newcastle is in obtaining abortions within the NHS, and the reason why is explained in an article in *The Lancet* of 11 December, 1976.

Consultant gynaecologists devised and monitored a central referral system which has resulted in 99 per cent of appointments being met within a week, with increased proportion of terminations before the twelfth week by simpler methods. The greater use of vaginal evacuation has reduced pressure on hospital beds and the gynaecological waiting lists have dropped. The abortion rate has remained below the national average but 95 per cent are performed under the NHS.

This is an interesting example of co-operation ensuring a better use of existing resources and at the same time giving an improved service to patients. Views of CHC members about abortion vary of course, but I should like to draw attention to this system for the benefit of CHCs in areas where there are complaints about access to NHS care.

A reprint of the article can be obtained from Mr. J. B. Lawson, Dept. of Obstetrics and Gynaecology, Newcastle General Hospital, Westgate Road, Newcastle-upon-Tyne, NE4 6BE.

MEDICAL EXPERIMENTS

Alan Saint, Chairman, Patients Protection Law Committee, 59 Hackworth Point, London E3.

We are appealing to your readers to help us in our efforts to establish legislation to protect patients from unethical or objectionable medical experimentation.

For some time we have been campaigning to stop experiments which are unnecessarily dangerous and which carry great risks for patients. It is imperative that anyone who submits to an experiment is fully informed of the procedure and of all the possible risks and side effects. The only way to be certain that this is done is by a law stating that it must be done. We have drafted such a law and need to collect supporting evidence.

Could readers please let us know of any instances of medical experimentation done without prior consent or without proper explanation, or of cases where dangerous procedures are carried out which have no relevance to the condition for which the patient is being treated.

HOSPITAL FOOD

G. W. Bell, Member Gateshead CHC

The excellent report entitled *The Organisation of the In-patients Day* stated "Despite illness and often a disinclination to eat, the quality and quantity of food, whether it has been well cooked and how it is presented, are matters of considerable importance in a patient's day."

I am therefore much concerned about a suggestion being made in high places that there should be a change in the present type of breakfast being served to hospital patients. I wonder if other CHCs would consider this matter to prevent any adverse changes.

We welcome all letters from our readers but request that they be kept short so that as many as possible can be included. We reserve the right to cut any contributions for reasons of space, and particularly those over 150 words.

CHOOSING THE RIGHT GROUP STRUCTURE

This analysis of various working group structures that CHCs are adopting has been written by Charlotte Williamson, who was formerly a member of Northallerton CHC. It follows the "briefing for new members" (which appeared in last month's issue) and should help both new and existing members to assess the working style and methods of their own CHC.

SIZE OF GROUPS

This can vary from three members to half the total membership. Small groups involve all the members in the work of the CHC and permit study in depth of topics because small groups can meet often (up to twice a month) and come to a shared viewpoint quickly. Co-options are easier when a group is small. Their disadvantage is the heavy workload for members and for the secretary co-ordinating the groups. Small ad hoc working parties set up within larger groups can give the advantages without the disadvantages of small semi-permanent groups.

SPREAD

Broad-based topics allow a range of relevant factors to be considered but may lead to large gaps or to overlap in a CHC's work. A schedule of narrower topics, each worked on in turn until a set of recommendations is formulated, can help prevent the leisurely approach that broad-basedness may encourage.

TOPICS

The topics chosen for the working groups probably determine the outcome of a CHC's work more decisively than appears at first.

1. **Special Problem Groups** examine factors likely to cause idiosyncratic difficulties in the district e.g. rural transport in a large country district; problems of ethics and priorities of treatment in a district with a medical school; problems of tourism in a seaside district.
2. ***Client-Group Groups*** *e.g. children, the* elderly, must have access to specialised insights about the needs of their client-group. This can be got from liaison with the clients or their relatives; from an organisation "for" them; or from an appropriate CHC member. Members with the requisite knowledge are often appointees of voluntary organisations pursuing their own policies in the district, and this is welcomed by some CHCs, resented by a few. The member himself has to help his CHC colleagues distinguish between up-to-date aspects of client care generally, and his organisation's local priorities.
3. **Geographical Groups** will visit all the health service premises in the sector or part of the district they live in and meet together regularly. They are suited to large rural or rural/urban mixed districts and can give a CHC a thorough and systematic grasp of gaps in provision and inconvenience in siting. The local knowledge of members, particularly of the GP services and health centres, comes into its own, which is why a link with the

Continued on next page

LEARNING TO USE ONE'S TIME BETTER

Research has shown how people in different kinds of jobs can learn to improve their effectiveness. Dr Rosemary Stewart of the Oxford Centre for Management Studies, describes these findings under three main headings: first, understand your job; second, analyse what you do and third, analyse how you do it.

UNDERSTANDING YOUR JOB

There are three factors to consider here: demands, constraints and choices. "Demands" are the core of the job — what anybody doing it would have to do. "Constraints" are the factors that limit what the job-holder can do and "choices" are the opportunities for one job-holder to do things differently from another in the same job.

The first thing to do is list the demands and assess how much of your time they take up. Then try to define the constraints which limit what you do — which can also include the attitudes of people you have to deal with. The third step is to identify the choices that exist in your job. This last can be very difficult and it is easier if you can compare your perception of your job with other people's perception of it. One common choice is the relative emphasis that people give to different aspects of a job.

ANALYSE WHAT YOU DO

The best way of doing this is to keep a diary for a week or two of everything that you do noting the different tasks and how long you spend on each one.

ANALYSE HOW YOU DO IT

This stage can be the most difficult. You need to compare what you have done with your view of what you think you should have done and should be doing — there is often quite a gap between them. Look at the different tasks and identify them as "demands" or "choices" and where they are "choices" you should analyse, as truthfully as you can, why you did it and what priority it had. Look at the methods you use to undertake certain tasks which will help you to understand how you are going about your job — for example, how you obtain information or how you seek to influence others.

The commonest discovery people make when they keep a record of what they are doing is that they fragment their day more than is necessary and that they should consider who they need to be available to and when. Some people have found that they actually waste time and that keeping a record can help them to get through more work.

There are of course many other ways in which people can work inefficiently: prolonging conversations unnecessarily, taking a long time to make a point, not listening to other people, not having any sense of priorities for the day or the week's work, spending too long reading material that is unimportant and so on. Keeping a record can help to pick up some of the ways in which you could work more efficiently, getting someone to observe what you are doing can be even more helpful. (Discussions with other CHC secretaries could be helpful, and if readers are interested in a meeting to explore possibilities, please let the Editor know.)

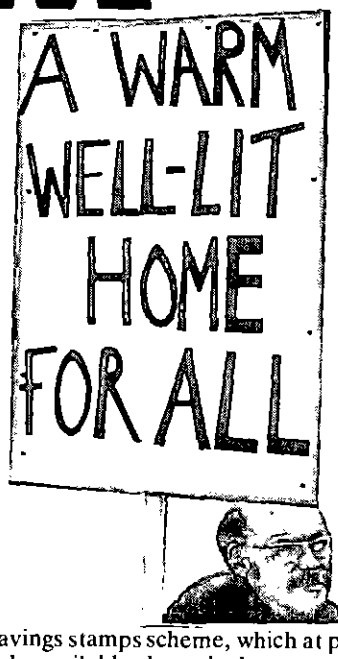
BOOKS TO READ

- *The Effective Executive* by Peter Drucker and *Managers and their Jobs* by Rosemary Stewart (especially the last chapter), both published as Pan paperbacks.

KEEPING WARM

This bitter winter has seen a growth in local projects aimed at helping old people to keep warm and avoid hypothermia. In Scarborough the local Age Concern group has organised a 13-week project, backed by £9,500 from the government's Job Creation Programme, to talk to every old person in the town and establish their needs. Scarborough is popular with retired people and 26 per cent of its residents are of pensionable age. The JCP team began work in January and in its first week it visited 250 homes and interviewed 80 old people. Twelve of these said they needed extra heating, and several others needed advice on budgeting and state benefits. The project is being organised by Eric McKie, the local Age Concern chairman who is also vice-chairman of Scarborough CHC. The 18 project workers — aged between 25 and 50 — trained by visiting similar Age Concern schemes at Doncaster, St. Helens and Preston, and by attending a one-week conference at York University on social work and the responsibilities of statutory bodies.

People found to be in need are being referred to the statutory agencies, or put in touch with various forms of community care — for instance, with one of the nine Age Concern over-60s clubs in the town. Mr. McKie expects the project to produce much useful feedback for the CHC's elderly committee, which he also chairs. He hopes the team will have time to cover at least some of the villages in the Scarborough health district. The CHC itself has tackled the North Eastern Electricity Board about its savings stamps scheme, which at present is only available through showrooms in large towns. The board has agreed to consider the sale of stamps through its local cash agents, many of whom also run village post offices. It also emerged that discussions are in progress about the possibility of issuing National Fuel Stamps, which would be applicable to all fuel boards and sold in post offices.



In Portsmouth, Age Concern liaising with the Red Cross, WRVS and statutory bodies, has prepared a leaflet entitled "Keeping Out the Cold", which the Portsmouth and SE Hampshire CHC is using as publicity material. Ten thousand copies of this leaflet have been printed and distributed particularly through a scheme organised by the local Student Community Action group. Over 150 polytechnic students are getting the leaflet displayed in pubs and corner shops, and are also calling door-to-door with it.

The students are delivering coal, blankets and heaters to people found to be in need. The district's department of community health has arranged with the gas and electricity boards for fires to be installed within 24 hours in urgent cases, and with the local DHSS office for discretionary heating, bedding and clothing grants to be paid to all people in need, not just to those on supplementary benefit.

One result of all these efforts in Portsmouth is that during the period October to January this winter, 46 per cent more people were brought to the attention of the community health department than in the same period last winter.

The London-based Right to Fuel Campaign (see *CHC NEWS 11*) has over 180 local Fuel Action Groups at work around the country, and it is now preparing to monitor the operation of the new code of practice for payment of domestic electricity and gas bills, issued last December. The campaign believes this code is inadequate because there is no right of appeal against a fuel board's decision, because particular groups such as the handicapped, the mentally ill and the already disconnected are not mentioned in the code.

Fundamentally, it feels that fuel boards are not the right agencies to be entrusted with welfare judgements. The campaign is pressing for implementation of the Oakes report which last June recommended a complete end to disconnections.

A number of CHCs — including Greenwich and Haringey in London — have passed motions of support for the Right to Fuel Campaign's policies. Haringey has also arranged some local press publicity, informing people of their rights under the new code and advising anyone threatened with disconnection to contact the borough's community lawyer.

HOW CAN CHCs WORK EFFECTIVELY?

Choosing the right group structure

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FPC is so desirable. Local authority councillors are likely to have a sound appreciation of the problems of their own part of the district, and it is to be hoped that LAs will rotate the councillors they appoint to give advantage of this to the CHC, just as voluntary appointees are rotated for their special knowledge. Some CHCs have geographical panels of 2-4 members who visit premises near them independently of the main groupings of the CHC.

4. **Institutional Groups** visit all the health service units of a particular kind and are suited to urban districts with a multiplicity of specialities. They can become expert in comparing standards of care and pick up deficiencies and problems quickly. They run a risk of becoming managerially oriented and satisfied with slow progress in institutions whose staff they get to know well.

5. **Service Groups** e.g. ambulance, family planning, are particularly useful for studying a service as it would be experienced by patients and their relatives. Inconveniences in timing, waiting periods and poor co-ordination with other services are likely to be picked up. Provided members draw freely on the experience of patients and can imagine themselves in their position it is perhaps the single most fruitful approach for a CHC.

6. **Territorial Groups** are geographical groups on to which are co-opted members of the public chosen specifically for their backgrounds and circumstances which help make a council more typical of the population in general than appointed members tend to be. They provide an "intelligence network" for the views of the public in each territory.

Each of these topic-groups can uncover situations that require further study, either by a new group of a different category e.g. a geographical group can lead to the setting up of a client-group group, or by co-option a joint study group with non-CHC members. Many combinations of groups and systems of liaison with other people in the district are possible. The resources of members' knowledge and time can be matched to the "needs" of the district in various ways; but experience suggests this should be done deliberately and fairly often in order to maximise the effectiveness of CHCs.

PERSONAL VIEW

Complaints and the CHC secretary

by Brian Thomas, Secretary of Bromsgrove & Redditch CHC

Over the centuries the medical mafia has developed a position so impregnable, and wields an influence so great, that even the most militant trade union must envy them. Many patients are still too afraid to complain about any aspect of their NHS treatment because they fear subsequent reprisals and because they do not believe that their complaints will be investigated fairly and without bias. This basic lack of faith in the impartiality of complaints investigation extends both to the hospital services and to the family practitioner services.

I accept that consultants are in positions of great influence in their hospitals and that their junior medical and nursing colleagues are invariably going to defer to the opinions of a senior consultant. Thus on the (doubtless infrequent) occasions when that eminence drops a brick I expect his minions to cover his tracks. It disturbs me however when hospital secretaries also see their role as one of papering over the cracks. I accept that the pressures on administrators not to rock the boat are — at times — immense, but I do not accept the contention that it is more important to remain on good terms with medical colleagues than to be seen to be divorced from them in an impartial investigation.

If this sounds gloomy then the position with family practitioner services is even gloomier. CHC secretaries are required to "advise and assist" patients who wish to make complaints. I have advised and assisted a patient who is making a complaint about her GP. That GP happens to be in the same practice as my former GP. I say "former" for when my assistance to this patient became known my doctors asked me to look elsewhere for treatment. My former GP has also stated that he accepts that I was acting properly in advising this patient and that the only solution to the problem which he can see is for CHC secretaries and their families to be treated by GPs based outside the health district in which the secretary works.

The second part of this "advise and assist" dilemma concerns representing patients at service committee hearings. Despite a clear statement by the Minister of Health that CHC secretaries are not regarded as paid advocates and that they can therefore assist complainants at FPC hearings, some family practitioner committees are seeking to deny this right. In my own case, solicitors for one of the medical protection societies are currently attempting to persuade my local FPC that I should not be allowed to assist a complainant at a forthcoming hearing. The burden of Messrs. Sue, Grabbit and Runne's song appears to be that the legal advice which the Department of Health has been given is incorrect. Messrs. Sue, Grabbit and Runne's interpretation of the regulations would naturally exclude CHC secretaries from the hearings.

But do not worry. All this aggro is part of the process of growing up. CHCs by their nature are seen as a threat to the medical profession. Ergo the medical mafia will seek to curb them. They must not be allowed to succeed but rather brought to an understanding of the value of having such a candid partner.

News from CHCs

- East Leeds CHC's part in uncovering the consultants' squabble at Chapel Allerton hospital has been praised by Chancellor Denis Healey, who is also a Leeds MP. In January an inquiry set up by Leeds AHA reported that friction between two consultants had led to anaesthetic services being withdrawn from a neurosurgical team for nine weeks, disrupting hospital organisation. Said Mr Healey: "The report has stressed the immense value of having a lay body of consumers who can bring the officials under scrutiny if something appears to be going wrong. It is a triumph for Leeds CHC and for that whole system".
- The West Midlands Regional Association of CHCs has suspended its quarterly meetings and appointed a working party to review its role and constitution. In its first year the association has encountered poor attendance and a feeling amongst some members that meetings concentrate too much on urban problems.
- North Camden, South Camden, Islington and Haringey CHCs have set up a CHC desk at Friern psychiatric hospital, to make contact with patients and their families. The desk will open each Sunday afternoon. In Sheffield a branch of the Citizens' Advice Bureau has operated for a year at Middlewood psychiatric hospital. It is manned by CAB volunteers and a mental health worker appointed through the Job Creation Programme.
- Yorkshire RHA has agreed to insure CHC members against accidents while on CHC business. The cover will provide £10,000 on death and £50 per week for temporary total disablement.
- Oldham CHC has had its hopes raised and dashed by the DHSS, in its attempts to win the right to raise general complaints with the town's FPC. The CHC approached the FPC last year on behalf of a neighbourhood council, which was unhappy with the emergency doctor service. The FPC said only relatives and friends could make complaints on behalf of patients, and this was taken up with Roland Moyle by local MP Joel Barnett. He was told that the council's complaint was "entirely appropriate". But now the DHSS has apparently changed its mind, and is supporting the FPC.
- The care received by elderly patients following hospital discharge is being investigated by East Roding CHC. Researcher Mr Nicholas Valdez is spending four months interviewing up to 100 people aged over 60, following their discharge from King George Hospital, Ilford, East London.
- Cardiff and the Vale of Glamorgan CHCs have proposed a community-based alternative to their AHA's plans to upgrade Cardiff's Ely Hospital. The CHC alternative, based on 80 neighbourhood houses, would allow the phasing out of the hospital in 10-12 years.
- Better publicity for chemists' opening hours is urgently needed in Edinburgh, according to the city's Local Health Council. In evidence to the Working Party on General Practice Pharmacy in Scotland, the LHC suggests subsidies for chemists willing to set up in areas which are not commercially viable.
- North Nottingham CHC has designed a poster in collaboration with its Local Medical Committee, which is allowing the council to write to every GP in the district asking them to display the poster in their surgeries.
- For details of new chairmen and secretaries, see back page.

EDITORIAL

If you go into a chemists shop and buy 100 aspirin tablets, it will cost you about 15p. But if you get a prescription for the same tablets it will cost you nothing if yours is one of the 60 per cent of prescriptions exempt from the 20p charge, but it will cost the NHS about 44p. In 1975 there were 19,700 prescriptions for aspirin (BP, 30mg) of which 12,700 were for patients exempt from paying charges.

There are many other drugs available over the counter which doctors continue to prescribe, thus preventing savings being made both by the NHS and by patients who are not exempt from charges. In an excellent report on the role of the Prescription Pricing Authority* the author, Mr Bob Tricker, comments on this state of affairs and suggests that if doctors were given more ongoing feedback on the cost-effectiveness of their prescribing, they would improve their prescribing ability. In evidence to Mr Tricker, the Royal College of General Practitioners also pointed out that it was in doctors' own best interests to prescribe sensibly since their public credibility would be lessened by reports of irresponsible practice.

Mr Tricker's belief that "the very large majority of the profession will recognise the need to improve their prescribing and seize the opportunity" may be over-optimistic until doctors realise that some measure of public accountability for their "exercise of clinical judgement" is both necessary and desirable.

**Report of the Inquiry into the Prescription Pricing Authority, R. I. Tricker, HMSO, £3.00.*

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FOCUS ON CHINA

by Stephen Lancashire
a member of the Society for Anglo-Chinese Understanding, and a youth and community worker in central London.

Chinese health care is said to "walk on two legs" using traditional Chinese techniques alongside Western methods. Perhaps the most distinctive aspect of our visit was to huddle into three barely-furnished operating theatres and watch tumours about the size of golf-balls being removed from the brains of patients who were fully conscious yet quite comfortable with the use of acupuncture anaesthesia. This technique is used in about half the cases of this type.

During three weeks in China it was difficult to go on an arranged visit — be it to a production brigade, workers residential area, kindergarten, old people's home, factory — and not come across a clinic. A recent experience of a friend whose appendix has just been removed has at last clarified what it was that was so striking about those Chinese clinics. The fact is they are so ordinary and familiar. They are in rooms which have been converted rather than function-built. Particularly from the outside the clinic in a residents' area, factory workshop, production brigade, looks like any other room.

Inside the atmosphere between the staff and patients seemed very relaxed. This is no doubt in large part facilitated by the fact that the staff are treating their peers, who have selected them to do the appropriate training to become health care workers.

Clinics in China are staffed by barefoot doctors (countryside), worker doctors (factories), neighbourhood health workers (residential areas, usually former housewives). These labels are used because these workers don't spend all their time doing health care work in clinics, and particularly the former two types do manual work with other peasants and workers. They have their leather satchel with them and are available to give basic medical aid but, more importantly, to advise the others about preventing disease.

The medical bag contains medication including traditional herbs, aspirin, antacids, penicillin, chlorpromazine, and items like gentian violet, alcohol, bandages, forceps, clinical thermometers, surgical and acupuncture needles and syringes. Generally the staff have a 3-6 month period of formal training followed by a variable period of on-the-job training under supervision. The emphasis during training is on the skills that the trained can demonstrate rather than a specific type or duration of training. The basic textbook for barefoot doctors is 560 pages long and costs about 60 pence. A glimpse of the contents of this book gives an idea of the range of knowledge expected of such doctors. On the other hand, talking to a number of them, they clearly recognised the importance of being aware of the limits of their capabilities.

A brief "tour" of some of the clinics the group visited during November should give a further idea of the situation.

Firstly, the Nanchang municipality kindergarten has 360 children aged 3-7 years, and 67 staff. The children are resident there from Monday morning to Saturday afternoon and spend the rest of the week with their families. Of the monthly fee of 12.50 yuan, one yuan is to cover medicines. The sick bay of the kindergarten was a small classroom with three beds.

Secondly, the Szuping Workers Residential Area in Shanghai has been built up since 1953 on what was formerly a stretch of wasteland where a few people lived in "sheds" of cardboard and mud huts. In 1976 there were 834,000 square metres of dwelling space in 3- and 5-storey blocks inhabited by 56,500 people (13,200 households). The area has one hospital and ten co-operative medical centres. One of these was a large two-storey building with a bright naturally lit foyer crammed full of posters criticising the "Gang of Four".

Thirdly, the Nan-Yuang (South Garden) Commune is situated in the suburbs of Peking, about 10 kilometres from Tien An Men Square. It has 41,000 people (10,000 households) organised in 16 brigades and 134 teams. Each brigade has one or two barefoot doctors. Each commune member pays two yuan a year and receives free medical care. Also if a member needs to be sent to the "big" hospital the commune pays the costs. The Happiness House for old people on this commune has 80 residents aged 48-94 (the youngest one was a disabled man) the average age being 73. The clinic in the complex was a room about 30 feet by 15 feet. Like other clinics it had a couch and two large chests of about equal size full of medicines and dressings.

One contained Western medicines, the other Chinese. The clinic was staffed by a woman barefoot doctor aged 25 who had been doing this kind of work for 8½ years and been at this particular place for two years. She explained how she used acupuncture techniques to treat headaches and arthritis.

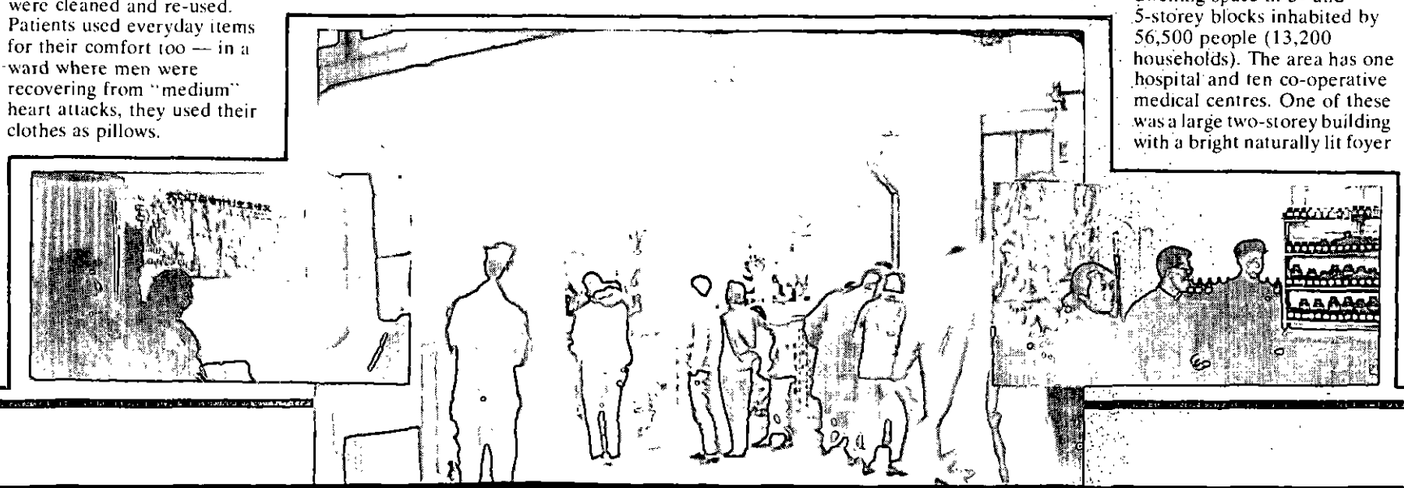
A brigade health clinic covered 11 teams (4,300 people). It had several barefoot doctors at the centre and was open 24 hours a day. On average, barefoot doctors here spend 100 days each year working in the fields.

It is difficult to imagine the extent to which the health care picture in China has been transformed in under 30 years. Pre-liberation China was viewed as the "sick man of Asia". Nutritional illness and starvation were common. Infectious diseases — including cholera, leprosy, TB, typhus, smallpox, malaria and venereal diseases — remained unchecked. Drug addiction was high and infant mortality in the first year was 20 per cent. Today, nobody starves in China, all the diseases listed above are completely eliminated or under control. There is no drug addiction, except perhaps amongst the very old, and infant mortality rates have put China towards the top of health league tables. One cannot escape the feeling that the way the Chinese deliver health care as well as it being such a high priority, has contributed to the transformation.

Hsan-Wu hospital was built in 1958 and concentrates on neurological surgery. Besides this speciality it also has departments for internal and external medicine, gynaecology, obstetrics, massage and acupuncture. It is a teaching and research hospital with 500 beds and 2-3,000 outpatients daily. It has about 700 staff, one hundred of whom are primarily administrative staff. The internal medicine department has a staff of 90 workers — 47 doctors, 29 nurses, 3 people in charge of cleaning. The outpatients department and ward are responsible for prevention and treatment of diseases and serves two districts and one county (comprising 4-500,000 people) of Peking municipality. Each day this department has over 4,000 out-patients and about 100 emergency cases. It has 100 beds. The hospital is one of two "central" hospitals and serves its catchment area with two Chinese traditional hospitals and local clinics in factories, neighbourhoods and communes. The department has four mobile medical teams — teams created throughout China in the late sixties and seventies in response to Mao's call for medical and health work to put stress on the rural areas — and at the time of our visit, 39 per cent of doctors were in the countryside or factories. The department staff also visited about 100 people in their houses — this was referred to as the "family ward" programme.

The organisation of the hospital involves a wide range of groups meeting, discussing, reflecting on their practice and politics and planning. These groups organise their activities to "serve the people" and involve all kinds of workers in the hospital and find ways of involving patients. Like other agencies of this kind of size, the hospital had a party committee and revolutionary committee. Briefly, the party committee's responsibility is to "exercise leadership over" the workings of the hospital. It is a key link between the organs of central and local government and everybody involved in the running of the hospital. In particular, this committee ensures that the lines (positions) of central government are discussed and their implications implemented in the hospital. It must ensure that lines are discussed and understood in as open a way as possible. The hospital party committee has 18 members (four women) — seven are doctors and nurses, two are workers (i.e. carpenters, electricians, etc.), eight are cadres (administrators).

The revolutionary committee is generally responsible for the running of the hospital according to the agreed political principles. It consists of 14 people (five women) — five cadres, six doctors and nurses and three workers. Both committees have overlapping roles in that they facilitate two-way communication and, with other groups, create an atmosphere in which everybody feels their opinions and ideas matter. They also bring together the various types of worker on an equal basis. Neither doctors nor leading administrators are completely full-time in the primary jobs. They regularly do manual labour and participate in the mobile medical teams. Generally speaking, doctors and nurses work six days a week, with weekly periods of political study and vocational study. Most of them live in dormitories in the hospital grounds. Wage differentials are still quite wide, but are constantly being narrowed as younger workers replace retiring doctors. Another striking feature of the hospital was that hardly anything was thrown away. Unless absolutely beyond redemption, linen, dressings and syringes were cleaned and re-used. Patients used everyday items for their comfort too — in a ward where men were recovering from "medium" heart attacks, they used their clothes as pillows.



BOOK REVIEWS

MEANS TESTED BENEFITS

Published by the National Consumer Council and available from HMSO or bookshops, price 75p.

In just 80 pages the National Consumer Council has managed to provide a comprehensive review of our system of means-tested benefits including the political and economic background and European comparisons. They identify 45 separate means-tested benefits of which 18 can be considered directly related to health, while most of the remainder might well be claimed by people suffering disability or incapacity due to health reasons. When local variations are taken into consideration, the numbers run into thousands. The report shows the various ways in which the means-testing system is not doing what was originally intended, and points to low take-up rates, insufficient and/or ineffective publicity, the "poverty trap", over-complexity of forms and high administrative costs.

One of the most worrying aspects of the health-related benefits (e.g. milk, vitamins, prescriptions, dental and optical charges, etc.), is that they have a very low take-up rate when not included in a "passport" of benefits available for people already claiming Supplementary Benefits or Family Income Supplement.

A number of suggestions for improvements and simplifications are made — for instance, the setting up of User Consultative Committees to monitor operations and sometimes to act as review bodies. The major recommendation is for a Beveridge-type review to "outline a plan to reconstruct our tax and social security systems to work in such harmony that according to need, they give as well as receive". Until that happens, this book is a helpful guide to understanding some of the complexities of our welfare jungle.

MASTECTOMY

By Nancy Robertson and Ian Swash Thorson Pub Ltd. £2.50 paperback/£3.95 hardback (publication date 17 March).

Subtitled 'a patient's guide to coping with breast surgery' this readable book goes through, in a matter-of-fact way, the various physical and emotional stages of breast cancer. It quotes examples from case histories and gives some extraordinarily useful hints which have not been gathered together before in this way in this country. One chapter is aimed specifically at husbands and families and the book is to be recommended to anyone who is undergoing or who has had a mastectomy or anyone close to them — including medical and paramedical staff.

PAPER DOCTORS

A critical assessment of medical research, by Vernon Coleman. Temple Smith, £4.50.

Medical research all too often has more to do with advancing the careers and status of medical researchers than it does with improving people's health. That is the message from Dr Vernon Coleman, GP and medical journalist. "Research workers . . . search for answers we do not need to problems which do not matter, while answers we have to problems which do matter remain gathering dust in the libraries". In Britain the £100m.-plus being spent annually on medical research is producing little or no improvement in the length or quality of people's lives, claims Dr Coleman.

He reminds us that instead of searching for "the cure" for cancer we could simply expose ourselves less to cancer-causing substances — in our environment, at work and in cigarette smoke. We could also indulge much less in the spectacular type of medicine typified by transplants, and get better value for money by switching resources into environmental health and preventive medicine.

This is not an elegantly written or exciting book. It reads as though it was jigsawed together from a box-full of press cuttings and reprints from learned journals. In places it is inaccurate and over-stated. But its value for lay people lies in its power to dispel the magical aura which still surrounds the abstract but costly virtues of "progress" and "the quest for truth".

Aneurin Bevan 1897-1960

by J. E. Pater

The Labour landslide in the election of July 1945 brought to the Ministry of Health a politician who had 16 years of frequently stormy opposition behind him but no experience of office. Aneurin Bevan had earned a left-wing reputation before the war and during it, when he was one of the few with the temerity to criticise Winston Churchill in the House of Commons and in return was called by Churchill a "squalid nuisance". What would someone like this contribute to the birth of the National Health Service?

Bevan grew up in the South Wales mining community, and knew only too well the health care problems of the working class in those days. As the son of a miner who died of chest disease, and a miner himself from the age of 13, he probably favoured the principles of the Socialist Medical Association — free services for everyone, whole-time salaried service by all doctors, general practice by groups of doctors from health centres, and so on. But he was essentially a pragmatist, ready to compromise on minor issues if necessary to gain the larger victory, as his negotiations with the medical profession were to reveal.

The White Paper of 1944 and the revised proposals based on it by the then Minister of Health, Henry Willink, showed pretty general agreement about some principles — the service to cover all forms of treatment and care, available to every member of the community, free at the time of need — and about some of the methods — administration of general practitioner services by a body like the Insurance Committee representing the professions and lay consumers, payment of GPs by capitation fee in some form, encouragement of group practice from health centres, provision of community health services by the major local authorities — but there was a major unsolved problem. This was how to provide a unified hospital service. The war had laid the foundations by bringing all suitable hospitals into the Emergency Hospital Service and co-ordinating them from

Photo: Universal

the centre by the use of the carrot and the stick, that is by control based on financial support, but leaving them under their existing administrations. Not unnaturally, both the voluntary hospitals and the local authorities wanted to go on in the future in the same way, but with less control. Accordingly, the Willink plans included elaborate systems of representative councils to co-ordinate the hospitals in each locality by consent, which did not really satisfy anybody and which were likely to prove quite unworkable in practice.

Bevan's main contribution was to cut this Gordian knot. He went for the simple but sweeping solution of transferring ownership of all hospitals to the central Department, and appointing new regional and local bodies to administer them. The outcry was loud, and comparisons with another Welshman's dissolution of the monasteries were common; but Bevan stuck to his guns, and even defeated Herbert Morrison, the champion of the London County Council hospitals, in the Cabinet. The result was an administration which functioned unchanged for 25 years, and a hospital service with a level of availability and professional care unequalled elsewhere in the world. That, it is fair to say, was Bevan's work.

A case study in consultation

Many CHCs are concerned that their statutory right to be properly consulted may be ignored when AHAs propose to close or change the use of existing facilities.

We present a summary of one such case occurring in Brent which, according to official sources, contains some of the most socially deprived parts of London. The result of the Brent case is that the AHA have been forced to reopen consultations and the local authority is taking legal action against the health authorities. Lack of space prevents a full discussion, particularly in terms of the effect on patient care, but we nevertheless hope that the points set out below will be informative for those CHCs which are also determined to protect their right to be consulted.

1973
NHS Reorganisation Act provided for the establishment of community health councils (Section 9). In December, statutory regulations (S.I. 2217) spelt out in further detail the function of CHCs. Para 20(1) begins: "It shall be the duty of each relevant Area Authority to consult a Council on any proposals which the authority may have under consideration for any substantial development of the health service in the Council's district and on any such proposals to make any substantial variation in the provision of such service". CHCs have a right of appeal to the RHA if they are dissatisfied with the consultation process.

MAY 1975
In Brent, first proposals were made concerning the changes in services at Willesden General Hospital (reductions in accident and emergency services).

OCTOBER 1975
Circular HSC(IS)207 issued on closure or change of use of health buildings (covered in *CHC NEWS 5*) set out guidance on the exact procedures and timings to be followed when closure or change of use is proposed. It emphasised the obligation of AHAs to consult fully with a range of consultative and advisory bodies and stressed the need for agreement of the CHC before decisions are taken. An exception was made for temporary closure or change of use but the CHC must still be informed and if the temporary change is likely to become permanent the detailed procedures should apply.

MAY 1976
Brent CHC received from Brent and Harrow AHA informal consultation documents on proposed closures and changes of use of health buildings which aimed to achieve "long-term financial stability" in Brent district.

These presented five alternative options, but each one included the running down of services at Willesden General Hospital. Also proposed was the closure of St. Monica's (a 35-bed geriatric unit).

JULY 1976
The CHC submitted a paper on the 19th agreeing one proposal (a change of management districts) but protesting vigorously at the way in which the plans under consultation were being pushed through. On the 28th the AHA wrote to the CHC opening the formal 3-month consultation period. At an AHA meeting on the 29th the CHC observer was excluded from a session discussing finance.

(In May it had been estimated that Brent district would overspend by £300,000 in 1976-77 but that the DMT could balance its books without making short-term changes).

AUGUST 1976
On the 4th the CHC wrote to all AHA members personally saying that it felt the closures were unconstitutional. On the 12th a special meeting of the AHA was called to discuss again the financial situation.

SEPTEMBER 1976
On the 16th the AHA endorsed a paper which included recommendations that the acute services at Willesden General Hospital be stopped by the end of the month and that St. Monica's should close by the end of the year. On the 27th the District Administrator issued a circular giving information on the decisions made at the AHA meeting on the 16th and saying that "the Authority plans for most of these changes to be permanent". On the same day, by coincidence, the CHC contacted Brent Community Law Centre for advice. The CHC wrote to the Area Administrator on 29th and 30th reiterating its views and pointing out that proposals were apparently being implemented one month *before* the consultation period was due to end. On the 30th the accident and emergency unit at Willesden General closed and the last in-patients left the hospital.

OCTOBER 1976
Builders moved into Willesden General and began renovating wards to convert it into a geriatric hospital. The Regional Administrator wrote to the CHC on the 6th accepting that the consultation procedures recommended by the DHSS had not been fully complied with and that the AHA was being asked to prepare a consultation document on the proposed (sic) decisions and that consultation procedures should be carried out as required by circular HSC(IS)207. He added that it was also "essential that expenditure by the AHA be contained within the cash limit and the action taken by the AHA to implement the programme on a temporary (sic) basis for this purpose is accepted as being within the provision of para. 2 of Appendix B of the circular" (relating to temporary closures or changes of use).

On the 11th the CHC received a letter from the DHSS which ended: "as you say, there would be difficulty in reinstating these services which for practical purposes have now ceased at certain hospitals. I am told, however, that developments are not absolutely irreversible should reinstatement prove to be appropriate".

On 19th the CHC received Counsel's opinion which concluded that the AHA clearly did not intend the steps in question to be temporary. "Further, the same step cannot be both temporary and permanent . . . obviously the implementation of alleged 'temporary' changes of the kind in this case, intended from the beginning to be permanent, pre-empt proper consideration of the proposals." In Counsel's opinion the AHA had acted ultra vires (i.e. beyond its powers) in prematurely implementing the closures and the RHA had "misdirected itself in law" in its letter of 6th October. Brent Law Centre, on behalf of the CHC, wrote to the Chief Executive of the local authority (London Borough of Brent) on the 22nd asking the borough to use its powers under Section 222 of the Local Government Act 1972 to take legal action in the interests of the local community, should the need arise. (This was done because the CHC might have difficulty in taking legal action itself, and anyway lacked the funds — a minimum of £1,000 would be required and much more if the case was protracted.)

NOVEMBER 1976
The Finance and Co-ordination Committee of the borough decided to recommend legal action if the AHA did not promise to consult openly, to stop further closures in the meantime and to re-open the units already closed.

Continued on page 10

SOCIAL CLASS & HEALTH

by Ivan Waddington, Member of East Leicestershire CHC and Lecturer in Sociology at Leicester University.

In the past 20 years a considerable body of evidence has been accumulated to show that despite the availability of universal free-on-demand medical services under the NHS, the use of certain kinds of medical services continues to show a high positive correlation with social class, i.e. the higher the social class, the more intensive use is made of health services.

Although the development of the NHS does appear to have eliminated some of the more gross social class differentials in use of hospital and general practitioner services, it is quite clear that very large social class differentials continue to exist for a whole range of preventive medical services. These differentials in usage are well established, and in what follows I confine my remarks to this particular problem.

For some time it has been known that the incidence of cervical cancer is related to a number of social variables, one of which is social class. This relationship is an inverse one, i.e. the lower the social class, the higher the incidence of cervical cancer. We also know that women from social classes IV and V (i.e. wives of semi-skilled and unskilled manual workers) are massively underrepresented amongst women who use the existing facilities for cervical smear screening. A similar picture emerges with a variety of other services. For example, a study of the use of dental services indicated that the lower a person's social class, the less likely he was to use dental services, especially for conservative dentistry. And we know that wide differences exist in the stage of pregnancy at which women report for ante-natal care: use of ante-natal care facilities is least adequate precisely amongst those women most at risk, i.e. the unmarried, the lower social classes and those with several children already.

It was the accumulation of evidence of this kind which led Dr Julian Tudor Hart to formulate what he called the "inverse care law", i.e. "that the availability of good medical care tends to vary inversely with the need of the population served".

It is paradoxical that while a directly analogous problem — the under-achievement by working class children in schools — has been the subject of several government reports the problem of under-utilisation of health services, though the subject of much research, has never to my knowledge been the subject of official enquiries in the same way. Of course one cannot compel people to use health services; but equally one cannot compel working class children to develop their full potential within the schools. What successive governments have tried to do in relation to the latter problem is to change the organisation/structure/facilities of schools in such a way as to make them more conducive to the development of the talents working class children have. Similarly a number of writers have suggested various changes (often quite inexpensive ones) in the way in which health services are organised which could reduce what is often a hiatus between the very formal bureaucratic organisation of services, and the life style and expectations of working class people. For example, a recent study of cervical cytology included evidence which suggested that more working class women would have had a smear test done had it not been necessary to make an appointment. There have also been some interesting and apparently successful experiments in the organisation of health care. The use of a mobile clinic able to perform a wide variety of diagnostic checks in the London Borough of Southwark proved remarkably successful on attracting semi-skilled and unskilled workers and their families. All this indicates that working class people will use preventive medical services if these are organised in the right way.

A case study in consultation

Continued from page 9

DECEMBER 1976

The AHA refused to give the undertakings asked for by the borough on the grounds of cost and because it had been advised that it was within the law. The borough wrote to the RHA demanding that it used its powers of intervention. The RHA's solicitor replied that the period from May to July amounted to a satisfactory consultation period. On the 19th St. Monica's was closed and boarded up.

JANUARY 1977

The AHA reopened consultations in accordance with the RHA decision made in October. The CHC has to submit alternative proposals by 23rd March, 1977. On the 11th the London Borough of Brent served writs on the AHA and RHA to enforce Regulation 20 of Statutory Instrument No. 2217. On the 16th two of the renovated wards were opened at Willesden General Hospital to geriatric patients.

District Committees in Northern Ireland

by G. H. Reid, Secretary of the Association of District Committees.

There are 17 District Committees in Northern Ireland which were set up during 1974 with the general function of representing the interests of the public in the Health and Personal Social Services in their districts. A memorandum issued in 1973 by the Department of Health & Social Services sets out advice and guidance to the four Health and Social Service Boards on the constitution and functions of District Committees and, following a series of seminars arranged by the Boards in 1974, a booklet on the role of District Committees was issued.

Average membership of the Committees is 20 with one-third district council nominees, up to one-half voluntary and community organisations and the remainder from churches, trade unions and employers representatives. An officer nominated by the District Administrative Officer acts as Secretary of the District Committee and helps to maintain close liaison between it and the District Executive Team. The consensus view is against duality of membership of Boards and Committees, although this still applies in the case of one Board. Committees usually meet once monthly at a district facility to discuss submissions by the Board or District Team on new policy developments or replying to Committee queries and to discuss points raised by members or arising from visits to district units which include hospital and social service facilities and health centres. Complaints from patients or the general public or staff may also be discussed. No executive powers are vested in the Committees but the scope of their advisory activities is wide-ranging covering all aspects of the service relating to patients' and clients' treatment, whether projected or actually in operation.

In some instances, Committees hanker for executive powers similar to those held by the former Hospital Management Committees and feel that their views do not have much influence with the Boards. The consultation process too has been criticised as not operating early enough to allow for the incorporation of Committee ideas into new schemes or proposals. The Committees themselves have been attacked for being out of touch with local people and community groups.

In January 1975 the Association of District Committees for the Health and Personal Social Services was established to act collectively and effectively in the interests of all the Committees. Amongst its objects are exchange of views and information, assistance to District Committees, acting for Committees in matters of common interest and organising conferences. It meets bi-monthly and consists of two representatives from each district committee. The General Purposes Committee deals with any urgent matters coming up between Association meetings. The Association's conference held last June on the care of the mentally handicapped was generally considered very successful in terms of representative attendance and useful discussion.

In the short period of its existence it is felt that the Association has helped to strengthen the impact of District Committees vis-a-vis Boards and Department; dealt with a wide range of subjects; represented District Committees at health service conferences and has not hesitated to expose shortcomings, including its own, when necessary in the interests of the service.

Family Planning and the NHS

Responsibility for family planning services has been handed over gradually to the NHS over the past 2½ years and was completed in England and Wales by October 1976. *Some of the background to this was given in CHC NEWS 5* and here we summarise the current situation.

Training

Before 1976 training was carried out under the auspices of the Family Planning Association (FPA) and since March 1976 it is the responsibility of AHAs. Courses for doctors have to be approved by the Joint Committee on Contraception. Training is particularly necessary for intra-uterine devices (IUDs) where success of the method depends on insertion techniques and constant practice rather than the IUD itself. For GPs prescribing the contraceptive pill no special training is required. The Joint Board of Clinical Nursing Studies has a course for nurses.

Research

The FPA used to carry out its own research and clinical trials into methods, types and brands and only FPA-approved products were available from FPA clinics. The FPA no longer does research into birth control methods but does still have a Medical Advisory Panel. Research is now undertaken by the World Health Organisation, some of it in this country by doctors and researchers who are also on the FPA Medical Advisory Panel.

General Practitioners

Before July 1975 GPs gave family planning advice and treatment on the NHS for "medical" reasons only and some gave it privately for "social" needs. In July 1975 a schedule of fees was agreed by the parties concerned (£3.50 pa per patient or £10 for patients fitted with an IUD). Many of the problems of negotiating fees have been concerned with the difficulties of defining "medical" need and "social" need for family planning advice and/or supplies. There were 23,000 GPs registered in 1975 *of whom 20,591 were on the 'contraceptive* register', 4,972 were registered as prepared to insert IUDs. There are no figures on how many of these GPs have received specific training. The DHSS estimated in February 1976 that the annual cost of GP family planning services for a full year at present levels in England and Wales would be about £4½ million.

Hospitals

Since July 1975 doctors performing *sterilisations (male or female) are being* paid fees at an agreed rate. Over the past year a number of AHAs have expressed fears that the number of sterilisation operations would have to be curtailed due to lack of funds to pay the agreed rates. In February 1976 the DHSS estimated the *annual cost of these fees in England and* Wales at about £3 million. Before the handover sterilisations under the NHS were only carried out in hospitals for "medical" reasons and doctors received no special fees.

Chemists

Prescriptions for contraceptive pills and devices (other than condoms) which are dispensed by chemists attract the usual 40p dispensing fee although the patient does not pay anything. No dispensing fees are payable when pills and devices are supplied at clinics.

Clinics

Family planning clinics are now the responsibility of AHAs. Many people prefer the specialist knowledge and treatment available only at clinics and not all GPs can provide a full service. Services *provided at clinics are usually less costly* than services provided in other ways. In some parts of the country, clinics have been threatened with closure over the past year and numbers of sessions have been cut.

Domiciliary Services

While these services could be valuable they *are also very expensive to run and provision* was very limited before the handover. The situation is probably unchanged now.

Publicity and Education

An additional £200,000 pa has been given to the Health Education Council which now has overall responsibility for publicising the country's family planning services. £90,000 of this is being used by the FPA to run the Family Planning Information Service which is now able to provide a wide range of free leaflets (including 4 simple explanatory leaflets in 4 Indian dialects) and various other publications.

Methods

In 1975 there were 10.5 million women in the UK aged 15-45 of whom 8 million were estimated to be sexually active. The *following are figures for different forms of* contraception in use in 1975: contraceptive pill 3.1m, condom 2.5m, coitus interruptus 1.4m, rhythm method 0.4m, IUD 0.35m, cap + spermicide 0.25m, spermicides only 0.15m.

NB: condoms are not generally available *through the NHS.*

Summary

Well over half the women 'at risk' are not being provided with a family planning service by the NHS — while a proportion of these women will not wish to avail themselves of services anyway there is *obviously a large number who would wish* to do so if they knew about the services and if these were easily available. Any proposals for curtailment of clinic services should be examined very closely. Particular attention should be paid to opening times, ease of access and publicity, as well as the relative costs of providing the same services through clinics and through GPs and hospitals.

Parliamentary Questions

COMMUNITY HEALTH COUNCILS

David Ennals stated, in answer to a *question from Patrick Jenkin MP, that a* National Association of CHCs would be set up. He said that he respected the views of the minority of CHCs which is opposed to a National Association being set up without delay but had decided that the wishes of the majority should be met. He was satisfied that the extra cost of the National Association would be relatively small as much of the expenses will relate to the continued provision of the news magazine and other information services for CHCs.

In reply to a question from Keith Speed MP Roland Moyle gave the estimated annual cost of CHCs in England as about £3m for the current financial year.

In response to Robert Banks MP's suggestion that employer organisations *should have an equal right with trade* unionists to be represented on CHCs Roland Moyle stated that as trades councils have affiliated to them organisations representing larger numbers of the community than any other voluntary organisations one can think of they should be represented on CHCs. Apart from this trade unionists have the same right as anyone else to be appointed to a CHC.

HELP FOR THE DISABLED

Local Authorities which have provided equipment for disabled persons requiring the use of electricity are empowered to make payments direct to electricity boards where they are satisfied that the need exists, whether or not the disabled person is in need of supplementary benefits, was the reply given by Alfred Morris to John Hannam MP.

JOINT FINANCING

The balance of allocations for jointly financed projects not used in 1976/77 (about one-third) is expected to be carried forward to 1977/78 said Roland Moyle in response to a question from David Price MP.

SMOKING-RELATED DISEASES

An estimate of £36m was made in 1970/71 (the last year for which figures are available) of the total annual health care costs for the treatment of smoking related diseases. At 1976 prices this would be £85m said Roland Moyle in reply to a question from Renee Short MP.

CLINICAL TESTS

It is normal practice for the results of all tests relevant to a patient's medical care to be recorded in his case history and for the patient's consent to undergo the test also to be recorded. This information was given by Roland Moyle following a question from *Peter Emery MP.*

NOTES.....

APPEALS AGAINST TRIBUNALS

Several improvements are to be made in the supplementary benefit appeal tribunal system, following a DHSS review. The proportion of tribunal chairmen with legal qualifications will be increased, and a right of appeal from a tribunal to the High Court on a point of law will be created. Training for tribunal chairmen will be introduced as soon as possible, and an appeal tribunal procedural guide will be prepared. Other improvements will include "measures to overcome the difficulties in attending hearings of elderly or handicapped appellants".

DHSS MANAGEMENT REVIEW

A review of management in the DHSS has begun, as the latest in a series of reviews of major government departments. It will look at the working of top management and at relationships between the department and the NHS. It should be completed by autumn this year.

NEW ABORTION GROUP

Doctors for a Woman's Choice on Abortion is a new medical group which wants the law changed so that decisions about whether or not to have an abortion can be taken by the women concerned, not by their doctors. In the short-term the group suggests several changes within existing law. These include "an end to the enormous regional variation in abortion facilities", more widespread day-care facilities for early abortions, and better publicity and information. The group opposes the new Abortion (Amendment) Bill on the grounds that more women would be forced to seek illegal abortions. DWCA, c/o 8 Magdala Crescent, Edinburgh 12.

RICKETS AND VITAMIN D

The resurgence of rickets amongst Asian children in major British cities has prompted a DHSS booklet for doctors and nurses, describing the disease, its treatment and its prevention. Rickets and osteomalacia (the disease in adults) are disorders of bone growth caused by vitamin D deficiency, and dietary changes and supplements can be used to correct this. School medical officers and nurses can help to detect the disease amongst children and adolescents, and young pregnant women, chronic housebound sick and the elderly housebound are also at risk.

Vitamin D deficiency and osteomalacia, by S. J. Darke and J. M. L. Stephen, 75p from HMSO.

ADVICE ON PUBLIC HEALTH

The Public Health Advisory Service, a charity providing information and advice on public health and housing matters, has published a 92-page interim report on its work since it was set up as a three-year experimental project in 1974. The service includes a fortnightly newsletter, a series of public health practice notes and a reference library. There is also a PHAS directory, listing environmental health officers in Britain who are prepared to undertake inspections and surveys voluntarily in their own time.

PHAS Interim Report 1976, £1.30 inc. post from Care House, Bigland Street, London E1.

HC (77) 1: MAJOR ACCIDENTS

This circular outlines the local major accident plans which should be drawn up by each AHA, in consultation with other bodies, and by ambulance authorities. It recommends testing of the communications and ambulance parts of the plans at six-monthly intervals. Existing major accident plans should be revised as appropriate at the next normal review.

HDC (77)1: HEALTH SERVICE IN WARTIME

First in a series of circulars outlining new arrangements for running the NHS in wartime. One consequence of nuclear attack would be that CHCs would be suspended and their staff would be "redeployed at the discretion of the Health Authority".

HN(77)1: HAEMOLYTIC DISEASE

The Standing Medical Advisory Committee has revised its first memorandum on Haemolytic Disease of the Newborn, issued to GPs in 1962. The disease occurs because of incompatibility between the blood groups of mother and baby, and in rhesus-negative women this can cause severe illness or death of the baby, or stillbirth. The disease can now be treated by giving anti-D immunoglobulin to the mother, and GPs have a key role in identifying women who might be at risk.

HN(FP)(77)1: EXPERIMENT TO IMPROVE DENTAL SERVICES

An experimental scheme to encourage the provision of dental services in areas where such facilities are inadequate is being introduced. The scheme will run for a two-year trial period in four selected areas of England only. Participating dentists may work in publicly provided premises, and will be paid a basic salary plus a bonus related to output above a certain level.

HN(FP)(76)66: PRICE INCREASES ON SPECTACLE FRAMES AND CASES

Gives details of price increases on orders for metal frames and spectacle cases, which opticians should have implemented on January 17.

HN(77)3: NEW EQUIPMENT FOR THE DISABLED

Requests AHAs and Boards of Governors to give details of research and development work during 1976 on "equipment that might increase the range of activities and independence of disabled persons". Returns should have been made by March 1, and will be included in the annual report for 1976 required by the Chronically Sick and Disabled Persons Act 1970.

DIRECTORY OF CHCs

A directory of the names, addresses and telephone numbers of all community health councils in England and Wales is now available, priced 60p. Corrections are published monthly in CHC NEWS. Please notify the Editor of any changes.

Cheques and postal orders should be made payable to "King Edward's Hospital Fund for London" and sent with orders to: CHC NEWS, 126 Albert Street, London NW1. Please note the following changes:

Page 4: Sunderland CHC
Chairman: Cllr Rev J Caden
Page 8: Central Derbyshire CHC
Chairman: Norman Lonsdale
Page 10: Barnsley CHC
Secretary: Alan Hicks
Page 11: Sheffield Northern CHC
Chairman: Cllr C Betts
Page 15: Brent CHC
Chairman: Miss Z Mason
Page 21: Eastbourne CHC
Chairman: J A A S Logan
Page 21: West Riding CHC
Chairman: David Shepherd
Page 22: Dartford & Gravesham CHC
Chairman: Cllr J F Little
Page 22: Hastings CHC
Chairman: Mrs J G Yates
Page 25: Mid Surrey CHC
Address: 73 The Street,
Ashtead, Surrey KT21 1AA
Telephone: Ashtead 76805
Page 33: Torbay CHC
Address: 1 East Street,
Newton Abbot, Devon
Telephone: Newton Abbot 67929
Page 34: Cheltenham CHC
Chairman: Allen Field
Page 35: Kidderminster CHC
Address: Burgage Lodge, 184 Franche Road, Kidderminster, Worcs DY11 5AE
Page 38: Dudley CHC
Chairman: B A Meredith
Page 42: Preston CHC
Chairman: Cllr J Lund JP
Page 42: Blackpool CHC
Chairman: Cllr J D Grime
Page 45: Stockport CHC
Chairman: J L Warrington
Page 49: Merthyr & Cynon Valley CHC
Chairman: T J Handley
Page 59: Oxford Region
Chairman & Secretary: Mrs-Pat Keep
Telephone: High Wycombe 445910

EXHIBITION STANDS

A set of exhibitions stands is now available on free loan to CHCs.

The kit has 10 poster-sized panels and when assembled, the overall dimensions are 2.3 metres high x 3.0 metres wide (7ft 8in x 10ft).

CHCs wishing to borrow the stands should contact CHC NEWS to make a booking.