CHC NEWS

For Community Health Councils

November 1982 No 81

The squeeze begins

Health Minister Kenneth Clarke has accused health authorities of "panicking" after a spate of service cut proposals which threaten to revive controversy over the future of the NHS — a controversy which recently came to a head with the leak of the Government's "think tank" report.

Hospital closures and service cuts are in response to 1983-5 resource assumptions — estimates of money the Government is likely to give regional health authorities (RHAs) for running costs and capital spending (see *CHC NEWS 80* pages 6 and 7).

The assumptions show the Government is calling a halt to growth in the NHS, and RHAs are adjusting their plans for the future in the light of these figures.

But Ministers are angered by a discussion paper from Oxford RHA's officers, proposing radical changes to cope with the cash squeeze.

The paper takes its lead from a letter by junior Minister Geoffrey Finsberg, assessing his review meeting with the RHA chairman. He wrote about "hard decisions" for the RHA and said "holding some services at present levels means some reductions in access to services by patients".

The region's officers took him at his word and posed a series of questions for RHA members to consider (see below). The plan is to take £10 to £12 million out of the system "at a stroke", and use £4 million of the money saved to redesign services at a level which could be maintained easily without a yearly, demoralising round of cuts.

Ministers have challenged the paper's pessimistic interpretations of the 1983-5 cash assumptions. After a meeting with Ministers, Oxford's officers produced a new paper stating the figures as the DHSS sees them, but the region's press officer says it is "not fair" for Ministers to suggest that they have backed down on their original paper.

Soon after the Oxford paper was published another row blew up — over a DHSS letter instructing RHAs to cancel plans for new hospitals unless running costs can be met from other parts of the service.

And ministerial letters about the eight regional reviews completed so far show that Ministers want a shift of resources into "Cinderella" sectors — mental handicap and illness, and the elderly — at the expense of the acute sector.

● As we go to press reports suggest that Health Ministers have renewed their battle with the Treasury — this time in an attempt to gain assurances that the contingency fund share of this year's pay award will be repeated in future years. But this may be on condition that pay awards are kept within 4%.

Where the axe is falling

CHCs and GPS could teach patients about their reduced opportunities for health care and encourage a "new pattern of use" suggests the Oxford discussion paper. Plans for a radical re-think on services include:

- Discouraging people from moving into the four counties covered by the RHA, perhaps by residency qualifications for non-urgent treatment.
- Restricting accident and emergency services to one centre per district.
- Abandoning all hospital sites other than district general or psychiatric hospitals.
- Abandoning some services to the private sector (the paper suggests "cold surgery" and family planning.)
- Penalising inefficient districts by reducing their cash allocations.
- Shifting the burden of support functions to families and voluntary bodies.

Many of these proposals would need legislation before they could be legally implemented, but the paper says debating them within the region "will illuminate prospects for the NHS as a whole". Oxfordshire CHC's public meeting on the issue drew strong expressions of support for present standards of service.

Other regions have adopted more conventional cash-saving methods. Hardest hit are the four Thames RHAs, and many of their districts have already issued proposals to close hospitals and phase out services.

But some districts within other regions are also suffering because of inter-regional "levelling-up" allocations.

London's teaching hospitals are feeling the pinch, and some high-technology specialties are threatened. Kidney patients in Birmingham, Manchester and Leeds may be denied life-saving treatment and London's only breast screening clinic faces closure.

A Welsh Office paper promises an "unprecedented squeeze" in 1983-4, and asks districts to cut only in non-priority areas.

But public concern over bed cuts at Great Ormond Street children's hospital may spur Ministers to take action.

INSIDE....

Parliament

Cleaning costs

In 1979-80 total NHS expenditure on contracted-out cleaning services was £7,668,639. This rose in 1980-81 to £9,638,192 (Dennis Skinner, Bolsover, 21 June). In 1980-81 contracts with private companies accounted for 2.54% of total sums spent on cleaning services (Robin Squire, Hornchurch, 15 June).

Computers for GPs

The Government is giving up to £2.5 million for the development and purchase of computer systems for GPs and FPCs. This will fund the major costs of 150 microcomputers for selected GP practices and the computerisation of patient registration in 2 FPCs. It will also help finance the purchase and development of a cervical cytology recall module (Renee Short, Wolverhampton NE, 16 June).

White finger

Recommendations from the Industrial Injuries Advisory Council that vibration white finger should be prescribed as an industrial disease have been accepted in principle, but regulations to implement this will depend on the availability of resources (John Heddle, Lichfield and Tamworth, 26 May).

Help in the home

Some 87 out of 109 local authorities are known to have charged some of their clients for home helps in 1980-81 (Derek Foster, Bishop Auckland,15 June). By September 1980 ten of the 109 had reached a former guideline level of 12 or more home helps per 1000 people over 65. "It is now generally accepted" that this guideline "is no longer helpful because it fails to reflect...different authorities' needs and different patterns of service", said junior Health Minister Geoffrey Finsberg (George Morton, Moss Side, 5 June).

Baby milk code

The aims and principles of the World Health Organisation code of practice on advertising artificial baby milk products will be applied in the UK as soon as possible. Guidelines from infant food manufacturers and health workers will be released for consultation — they will include proposals on advertising and marketing, and on monitoring practice. (Ernie Ross, Dundee W, 27 May).

Your letters

Save our magazine

Mary Merricks, Secretary, Cambridge CHC

My CHC members have asked me to express their concern about the threat to *CHC NEWS* in its present form.

We wonder how many readers are aware that there is a powerful move to discontinue — on grounds of cost — the magazine as we know it and to substitute a publication cheaper in both appearance and content.

This would inevitably involve losing the services of the present editorial staff and losing also the opportunity for CHCs to make some impact in the expanding field of medico-social journalism.

Our CHC appreciates the stimulating blend of information, comment and news from other CHCs which *CHC NEWS* offers and would bitterly regret seeing it become extinct. Members feel very strongly that an expanded version of *Standing committee news* (as has been proposed) would be a totally inadequate substitute for what is at present a highly professional publication — the October issue reaches a particularly high standard.

Everyone appreciates that the annual sum required per CHC of perhaps £400 is high and may be difficult to find from our modest budgets. Nevertheless we believe that most CHCs have sufficient in-built flexibility in their finances for them to find £400 by making other sacrifices.

We urge them to consider doing so before it is too late.

Ed: We are working on proposals to offer CHCs a much cheaper package – but this will be possible only if we can raise money in individual subscriptions from health education departments, social services, voluntary bodies.

Fluoride and Sweden

J T Stewart, Edinburgh 12

Constant research on the effects of fluoridation is the duty laid on those who advocate it — Mr Silver (*CHC NEWS* 80 page 2) is right in this.

Research into the position in Western European democracies shows that every country except Britain and Eire will have nothing to do with this form of compulsory medication without the consent of the recipient.

In 1971 Sweden made water fluoridation illegal. In 1977 the Swedish Government set up a fluoridation commission. In 1981 they upheld the ban on water fluoridation,saying:

1. there is already a steep decline in dental caries and further preventive measures should be voluntary,
2. to many people the measure represents an encroachment on the individual's freedom of choice,
3. the combined and long-term environmental effects are not sufficiently known,
4. there is no adequate survey report on the effects of fluoridation in babies' feeds.

The taking of sucrose, alcohol and tobacco is voluntary — water fluoridation imposes biological changes without consent.

Caring after treatment

H Baker, Honorary Secretary, Northamptonshire County Care Committee, The Shires, Denford, Kettering, Northants. NN14 4EQ

After Care Committees were established many years ago when tuberculosis was prevalent throughout the country. Their members visited patients in hospitals — and more importantly visited discharged patients in their homes, providing where necessary foodstuff such as eggs and milk.

With the decline of the TB scourge the demands on the committees also declined and in recent years members have extended their community caring to the elderly — especially those living alone — and to those who have suffered from a heart condition.

We would like to know if CHCs have After Care Committees in their "patches". If so would they kindly inform me of their secretaries and addresses.

Wexham Park — what really happened?

Brian Rockell, Chairman and Juliet Mattinson, Secretary, East Berkshire CHC.

Our CHC fully appreciates that the issues underlying the extraordinary events at Wexham Park psychiatric unit are of concern and interest to a wide readership (see *CHC NEWS* 80 page 3).

However, there are certain features of this scandalous story which are unique to our local situation — we hope no other CHC has such grave misfortune as this.

We visited the temporary psychiatric ward twice on the day of the transfers and again a few days later and talked to several patients. The overwhelming majority were not voting with their feet as your editorial implies.

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Comment

The Government's new agreement with the tobacco industry slipped quietly in and out of the headlines at the end of last month, along with a startling new concept in health promotion from those nice people who bring you cigarettes.

Yes, the tobacco companies have entered the health field with the Health Promotion Research Trust — funded by the industry's Tobacco Advisory Council with up to £11 million over the next three and a half years.

The period of funding is important because it matches the length of the latest voluntary agreement with the Government on advertising. The grant is unlikely to survive any attempt by a future, health-conscious Health Minister to toughen up on tobacco before the agreement expires.

This restraining function, however, is not the only purpose of the research trust. Its brief is a "balanced programme of research" firstly into persuading us all to "adopt a more responsible attitude" towards

Secondly the trust will look at how that responsible attitude might be affected by "environmental, social and other factors" — anything in fact *"other than .. the use and effects of tobacco products"*.

ASH — action on smoking and health — is "distressed" by this, and with good reason since the use of tobacco is the major avoidable cause of ill health in Britain today. ASH believes the trust will throw a "smokescreen" over this important fact — and a very cheap smokescreen at that.

The annual £3 million for health promotion is a fraction of the £100 million spent on promoting cigarettes.

But what of the new agreement? Well, bigger but no better seems to be the slogan for this campaign.

The health warning on posters and adverts will be larger, taking up 15% of the space instead of the present 9%. It will be more clearly presented and will be included for the first time on point-of-sale advertising in shops — but only on display material of more than forty square inches. Adverts have been banned from video cassettes and the industry will discuss with the DHSS any plans for advertising in new media.

But there will be only one warning. The agreement scraps the experiment of ringing the changes in the wording of warnings. So we return to "smoking can seriously damage your health"— without spelling out the dangers.

Health Minister Kenneth Clarke regards this agreement as "a significant advance". He is "grateful" for the industry's novel new investment. Others are calling it a bribe.

Health News

Asbestos on the YOP job

Young people on a youth opportunities programme (YOP) project were exposed to asbestos while employed to strip out an old brewery, says the Association of Scientific, Technical and Managerial Staffs (ASTMS).

The county council involved stopped the demolition work after asbestos was discovered, but ASTMS general secretary Clive Jenkins says this is too late. He has complained to the Manpower Services Commission about the incident, and is calling for YOP jobs to be certified as asbestos-free *before* work begins.

Recommendations on handling the removal of asbestos from buildings are included in *Asbestos — hazard alert*, health and safety information monitor No 18, free from the ASTMS health and safety office, Whitehall Office, Dane O'Coys Road, Bishops Stortford, Herts, CM23 2JN.

● Action on asbestos in your district — see page 6.

At last the ante-natal report

After much delay the Government's maternity services advisory committee has published its first report (1) — on ante-natal care — for circulation to health authorities and professionals.

Established in response to the 1980 "Short report" on baby deaths at and around the time of birth, the committee reproduces many of the commonsense, low-cost suggestions made in past years for improving ante-natal care, but its helpful layout and checklists for action should ensure that service providers take notice of the advice.

The committee wants every district health authority to set up a local maternity services' liaison committee — led by an "enthusiast for improvements" — which would agree procedures for the district's services and monitor the procedures in use.

The committees should bring together all groups involved in maternity care and — though restricted to the professions for some of its work — should include lay members to help with tasks such as monitoring progress.

Support for the local liaison committees comes in a report (2) from the Royal College of Obstetricians and Gynaecologists which makes recommendations on all stages of maternity care.

1. *Maternity care in action — part 1 ante-natal care. A guide to good practice and a plan for action* price 55p from the DHSS leaflets division, PO Box 21, Stanmore, Middlesex.
2. *Report of the RCOG working party on ante-natal and intrapartum care* from the RCOG, 27 Sussex Place, Regent's Park, London, NW1 4RG.

TV in groups

Channel 4 hopes viewers of its health series *Well being* will form "viewing groups" to discuss the programmes, and suggests that CHCs should participate. Programmes will tackle stress and depression, addictions — of all kinds — food, nutrition and weight, childbirth, ageing and women's health — including a visit to the Manchester well-women clinic.

The book of the series includes chapters on each programme with useful resource lists and a guide to over-the-counter medicines. *Well being — helping yourself to good health* is by the production team with the advice and support of the Royal College of General Practitioners. Price £1.95 in Penguin. Programmes will be shown on Fridays at 10.30pm from November 12. Information and discussion topics for viewing groups from Derek Jones, Educational Liaison Officer, Channel 4 Television, 60 Charlotte Street, London W1.

Developing mental handicap services

"The momentum of change is building up" says the development team for the mentally handicapped in its *Third report — 1979-81* (£2.95 from HMSO). The independent team has now visited most health and local authority areas on invitation at least once to examine and advise on services, for mentally handicapped people.

About half the team's recommendations are now in operation and most others are included in plans for the future, but the report says development is not as fast as the team wished.

An example is lax notification systems — identified in previous reports — which mean parents with young mentally handicapped children do not get social worker support when they most need it. The team is also worried by lack of interest in service provision by regional health authorities (RHAs), despite the need for specialised facilities at regional level.

The team's meetings with parents' associations, voluntary bodies and CHCs are "always of immense value" says the report, and service providers should hold similar meetings every six months.

The independent development council for people with mental handicap (IDC) is also impressed by local efforts to improve services, but is concerned that many authorities are still making future plans based on outmoded principles.

The IDC — set up after the national development group for the mentally handicapped was axed (see *CHC NEWS* 59 pages 8 and 9) — has produced planning guidelines incorporating the principles it wants to see in action. *Elements of a comprehensive local service for people with mental handicap* is £1 inc post from IDC, 126 Albert Street, London, NW1 7NF.

HOW DO WE TREAT OUR KIDNEY PATIENTS?

by Judy Hague, Acting Secretary, Victoria CHC.

This year my CHC work and my personal life have been an echo of each other. Early one bleak Sunday morning last December, as I rode through South West London in an ambulance with my flatmate Nick, I had no idea how much the topic of kidney failure would occupy me in the coming months.

Nick was 28 and had been a diabetic for almost 20 years. He had known for two years that his kidneys would fail, and now the crisis had come.

Nick was to live for six months after that snowy morning and I was privileged to share with him the struggle of coming to terms with the many physical and psychological difficulties he faced. He vested his future hopes in a successful transplant, but alas, his was to fail after five short weeks.

Just as Nick's illness came to a head, so did the situation at Westminster Hospital's five-bedded renal unit. Victoria CHC was consulted over first its temporary and then its permanent closure. Consultation on the temporary closure came "after the event" — the unit had to be closed when the last renal nurse left the district's employment.

CHC members asked me to look into the level of provision in our own and other regions and to test the district's contention that the unit's size made it difficult to staff and therefore not viable.

TABLE 1

REGION	A	B	C
NORTHERN	3.1	104.05	73.87
YORKSHIRE	3.6	66.38	37.78
TRENT	4.6	94.35	36.09
EAST ANGLIA	1.8	90.56	106.67
4 THAMES & WESSEX*	12.7	102.09	94.17
OXFORD	2.2	80.09	76.82
S WESTERN	3.2	85.64	38.44
W MIDLANDS	5.2	61.72	51.73
MERSEY	2.5	91.02	48.00
N WESTERN	4.1	49.03	45.85
WALES	2.8	73.93	52.86

A. Population

B. Patients alive on dialysis per million pop.

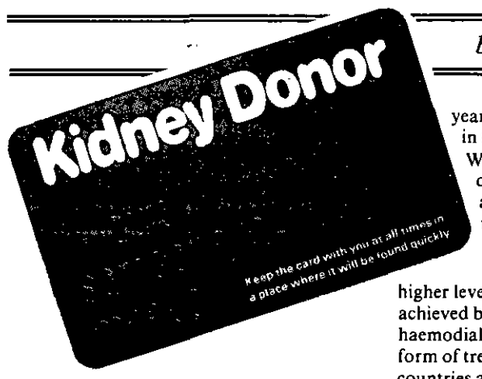
C. Functioning transplants per million pop.

Source: The UK Transplant Annual Report 1981

** These figures are grouped because Wessex and South West Thames have only one unit each. Patients are treated in neighbouring regions.*

I am grateful to the many CHCs — 63.5% of those asked — which responded to my questionnaire. The results have provided useful background to my investigations (1). Renal services are organised on a regional basis, but every CHC and DHA has a contribution to make in overcoming the difficulties they currently face.

Once your kidneys have irretrievably failed you remain dependent on the renal replacement services for life. There are two methods of treatment — dialysis and transplantation. Dialysis may be an interim measure, while waiting for a transplant, or it may be a permanent solution —



particularly for the elderly.

The three dialysis methods are:

Haemodialysis — carried out in hospital or at home using a kidney machine which purifies the blood

Peritoneal dialysis — carried out in hospital, it works by repeatedly passing a fluid through the peritoneal cavity to flush out impurities

Continuous ambulatory peritoneal dialysis (CAPD) — a recently-introduced self dialysis technique for use in the home, it avoids the need for bulky machines.

Being on dialysis of any kind can be a time-consuming, strenuous and demoralising experience. Wherever possible the favoured form of long-term treatment will be transplantation. Currently success rates for cadaveric transplants show 50% of transplanted kidneys still functioning after three years and this may soon reach 70%.

In their recent report (2) the South East and South West Thames RHAs put forward some annual costings calculated over ten years for the different treatments — £9,500 on hospital dialysis, £6,500 on home dialysis, £5,250 on CAPD and £1,450 on a transplant — so cost effectiveness and patient preference tend to coincide.

However, there are several factors which limit the number of transplants. The most obvious is the shortfall in the number of cadaveric kidneys — those donated by recently deceased patients — available for transplant.

Budgeting for renal services can also be a problem, even with a fixed rate for accepting new patients. The movement of patients from dialysis to transplantation, and sometimes back to dialysis, needs to be reflected in the costings.

The number of patients suitable for transplantation within any particular renal programme is limited. There will come a point when new patients will have to be taken on in order to perform more transplants.

Another problem is that doctors who are the source of cadaveric kidneys do not always give donation the priority it merits.

Far fewer new patients are accepted each year by the renal replacement services in the UK than in comparable West European countries. This disparity is particularly noticeable among patients over 45 — see table 2.

European levels of provision reflect a higher level of spending. They have been achieved by a rapid expansion of hospital haemodialysis services, the most expensive form of treatment. Governments in these countries are now reported to be seeking to limit the availability by legislation.

The UK take-on rate for new patients contrasts with the US figure of some 60 patients accepted for treatment per million of the population each year. It is thought that this figure gives a fairly accurate estimate of the incidence of chronic renal failure.

Recent DHSS guidance indicates that renal services should be provided for 40 to 50 new patients per million each year. The realities of current UK provision are somewhat different — an average of 21.13 new patients per million population were accepted for treatment in the UK in 1980. Figures in table 1 contrast the levels of provision by region.

I asked all regional medical officers whether their regions had any plans to vary their current level of provision. Of the eleven regions which replied, five plan to increase provision and two are currently reviewing their service. The main problem facing regions — beyond the obvious one of funding — is ensuring the best possible balance between new patients, transplantation, dialysis — including the development of CAPD and provision for return to dialysis if transplants fail — and mortality.

You may be asking two questions as you read this. Firstly, is there scope for preventive measures? Secondly, should we be asking for priority for an acute service at a time when we are seeking to promote the cause of the "Cinderella services"?

Sadly it seems there is little which can be done to prevent renal failure. But the control of hypertension — which can if unchecked lead to renal failure — would be an important spin-off from a general screening programme aimed at reducing heart attacks and strokes.

Location of Units for Dialysis and Transplantation

1. NORTHERN
Royal Infirmary, Newcastle,
Freeman Hospital, Newcastle
Royal Infirmary, Sunderland
South Cleveland Hospital, Middlesborough

2. YORKSHIRE
Hull Royal Infirmary
Leeds General Infirmary
St James Hospital, Leeds

3. TRENT
Derby City Hospital
Nottingham City Hospital
Leicester General Hospital
Royal Hallamshire, Sheffield
Lodge Moor Hospital, Sheffield

4. EAST ANGLIA
Douglas House, Cambridge
Addenbrookes Hospital, Cambridge
West Norwich Hospital, Norwich

5. NORTH WEST THAMES
Charing Cross, London
St Mary's, London
Hammersmith Hospital, London

6. NORTH EAST THAMES
London Hospital
St Bartholomew's, London
Royal Free, London
St Peter's, London

7. SOUTH EAST THAMES
Guy's Hospital, London
St Thomas's, London
Dulwich Hospital, London
Kent and Canterbury Hospital
Royal Sussex County Hospital, Brighton

8. SOUTH WEST THAMES
St Helier's, Carshalton

9. WESSEX
St Mary's, Portsmouth

10. OXFORDSHIRE
Churchill Hospital, Oxford

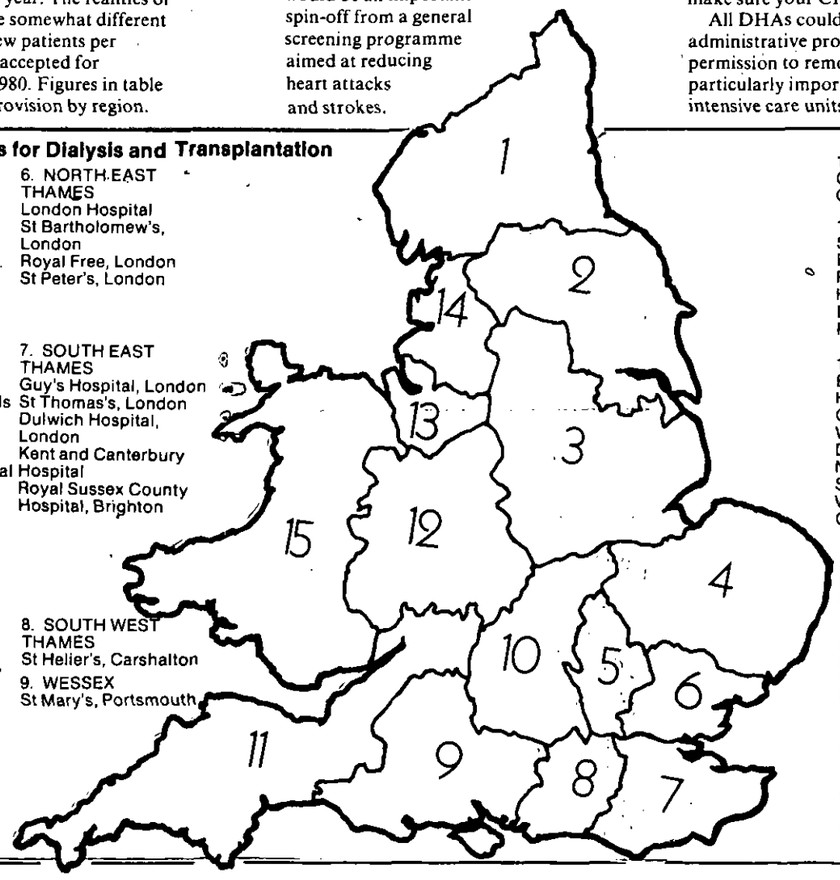
11. SOUTH WESTERN
Southmead Hospital, Bristol
Royal Exeter and Devon Hospital
Derriford Hospital, Plymouth

12. WEST MIDLANDS
East Birmingham Hospital
Queen Elizabeth Hospital
Wordsley Hospital, Dudley
N Staffs Royal Infirmary, Stoke
Walsgrave Hospital, Coventry

13. MERSEY
Sefton General Hospital, Liverpool
Royal Liverpool Hospital

14. NORTH WESTERN
Manchester Royal Infirmary
Withington Hospital, Manchester
Hope Hospital, Salford
N Manchester General Hospital

15. WALES
Cardiff Royal Infirmary
Glanclwyd Hospital, Clwyd



Nick pictured after his kidneys had failed

Photo: King and Hutchings for Westminster Press

Individual CHCs will have to assess the priority they would give to renal services in the context of overall provision in their districts and regions. Having tested the arguments put forward by the Victoria DHA our CHC did *not* oppose the closure of the Westminster unit. We found that even larger London renal units find it difficult to keep nursing staff levels up, and this includes those running renal nursing courses. This may be because the work is repetitive and the emotional strain on nurses is enormous.

CHCs — perhaps in association with your local Kidney Patient Association which most renal units have — could run a campaign to encourage the public to carry donor cards. Since the Panorama programme broadcast early last year on brain death fewer cadaveric kidneys have become available. Research has shown (3) that the public is willing to help if made aware of the need for kidneys and actively encouraged to carry a card — so make sure your CHC office carries stocks!

All DHAs could be asked to review their administrative procedures for obtaining permission to remove organs. This is particularly important in hospitals with intensive care units, where staff need in-service training in the skills required to communicate with relatives on this sensitive issue.

RHAs could be encouraged to appoint a renal transplant co-ordinator. The West Midlands RHA has already taken this step. In the North Western region, where only 60 transplants are performed annually out of the 120 needed to meet the demand, the RHA estimates that 200 potential donors are available annually. The co-ordinator would work with staff and the public to encourage the rate of organ donation.

CHCs can ask if their RHA has a renal advisory committee — some already do. Does the RHA regularly review and monitor the renal service? What is their strategy and priority for developments? There is scope for improvement in the way information on services is collected and the Thames RHA's report (2) makes several helpful suggestions — including a regional computer system covering renal unit activity.

Our CHC is actively encouraging these measures and believes that districts which do not provide renal services have a role to play in improving the overall pattern of care.

A final question which CHCs could ask is whether units provide sufficient emotional and social support for patients and their relatives.

TABLE 2

ACCEPTANCE OF NEW PATIENTS BY COUNTRY: RATE PER MILLION POPULATION IN DIFFERENT AGE GROUPS 1978

Age	W Germany	France	Italy	UK
45-54	58.8	59.8	55.7	43.5
55-64	71.3	69.5	69.5	22.7
65-74	49.9	56.6	52.2	3.5
75+	8.6	17.6	7.3	0

Source: Proceedings of the European Dialysis and Transplant Association Vol 16

The strain of being on dialysis and awaiting a transplant is huge, so psychologists and social workers attached to a unit could help patients and relatives cope with the stress they face.

The particular combination of problems Nick faced proved intractable. The combination of diabetes — with allied complications such as hypertension — and chronic renal failure is apparently difficult to treat successfully. Others with chronic renal failure — if estimates of its incidence are correct — are simply not being referred for treatment. Others, referred for treatment, face an agonisingly long time on dialysis. Their needs could be better met even within current resources if only more kidneys became available.

This would not of itself solve all problems overnight. I have tried to indicate some of the many issues to be tackled — what contribution could you and your CHC be making?

References

1. *Renal services in England and Wales* from Victoria CHC.
2. *Renal services — a report by the South East Thames and South West Thames RHAs* is available from the RHAs.
3. *Public attitudes towards kidney transplantation* by Moores, Clarke, Lewis and Mallick. British Medical Journal 1976 Vol 1 pages 629-31.

ASBESTOS — CHCs can act

*By Jean Robinson**

The only known cause of mesothelioma is exposure to asbestos and it is almost invariably fatal. A recent study (1) on mortality from mesothelioma of the pleura lists areas with raised mortality, so CHCs can now tell if they are in a high risk area (see table).

If deaths from this cancer were evenly spread throughout the country the standardised mortality ratio (SMR) for each area would be 100. Yet Barrow in Furness heads the list with an SMR of 1735 — a tragic heritage of the shipbuilding industry.

Men and women who worked with asbestos will also have a higher risk of contracting cancers of the lung, larynx, gastro-intestinal tract, ovary and possibly cervix. Their families and people who live near asbestos factories may have also been exposed.

Textiles, construction of railway carriages, the building industry and the wartime production of gas masks have all contributed to the high death rates in many areas. But areas where mesothelioma deaths are clustered account for only 40% of the deaths — the remaining 60% are spread around the country and may be caused by environmental or workplace exposure or even hobbies.

Deaths from mesothelioma are continuing to increase as a result of past exposure to asbestos. There is no known successful treatment — this is true of most lung and stomach cancers — but it is important that suffering should be relieved with adequate treatment for pain and good nursing care.

The burden on health services includes the far greater number of cases of cancer of the lung and gastro-intestinal tract which are not identified as industrial disease. Dr Richard Peto of the Cancer Epidemiology Unit in Oxford estimates there will be 50,000 asbestos-related deaths in the next 30 years, although this may be as high as 70,000.

CHCs in high risk areas could discuss the matter with their community physicians and ask about costs and provision for care.

The best possible prevention for the future would be the total banning of asbestos, since mesothelioma can arise from very short exposure — in one recorded case a woman's only known exposure was having made a puppet with asbestos when she was at college. Being a non-smoker is no protection.

Asbestos is safe while sealed or locked into asbestos cement which has not weathered, but demolition of existing buildings can be a public health hazard. It would be helpful for CHCs to press for analysis of house and street dust before and after demolition of blocks of flats and other buildings.

Many people who have worked with asbestos in the past are now worried about their cancer risk. What can we do to help them? The latest medical evidence (2) suggests that beta-carotene in the diet — from carrots, orange-fleshed fruits like apricots, and dark green leaves like kale — may protect against some cancers and particularly lung cancer.

Since this is a health prevention measure which is cheap, harmless and unlikely to be unpopular perhaps CHCs in high risk areas could press for publicity on nutrition — including works canteens and school dinner services.

Not everyone is keen on vegetables but kale makes delicious bubble and squeak and I have never met a child who did not love my carrot cake.

Meanwhile the Society for the Prevention of Asbestosis and Industrial Diseases — underfunded and overworked — is trying to help the victims of asbestos disease with claims for compensation and industrial benefit. Unless tissue is examined with an electron microscope the true level of past exposure to small fibres may be underestimated.

We are also preparing an analysis of cases where victims develop mesothelioma after slight exposure to asbestos.

We would appreciate information or newspaper cuttings from local inquests — send to us at SPAID, 38 Drapers Road, Enfield, Middlesex, EN2 BLU.

Local authority areas of England and Wales with raised mortality from mesothelioma of the pleura during 1968-78

Local authority area	*SMR**		
Men		Rochdale CB	309
Barrow in Furness CB	1735	Gateshead CB	296
Dalton in Furness UD	1282	Thurrrock UD	291
Jarrow MB	1082	Hartlepool CB	279
Plymouth CB	1075	Havant and Waterloo UD	277
Birkenhead CB	1009	Newham LB	274
Kirkby UD	887	South Shields CB	268
Canvey Island UD	772	Bexley LB	240
Hindley UD	646	Teeside CB	235
Hebburn UD	616	Liverpool CB	216
Crosby MB	554	Leeds CB	212
Longbenton UD	536	**Women**	
Portsmouth CB	475	Leyland UD	2153
Bootle CB	460	Spenborough MB	1543
Wallsend MB	459	Carlton UD	1048
Brentwood UD	451	Preston RD	802
Barking LB	445	Preston CB	704
Urmston UD	416	Rochdale CB	582
Morley MB	401	Blackburn CB	568
Gillingham MB	399	Barking CB	565
Crewe MB	390	Leeds CB	480
Malling RD	376	Nottingham CB	473
Southampton CB	362	Newham LB	409
Newcastle upon Tyne CB	353	Bexley LB	364
Wallasey CB	352	Tower Hamlets LB	316
New Forest RD	352	Greenwich LB	291
Watford MB	310	Redbridge LB	288
Havering LB	309	Liverpool CB	207

** Standardized mortality ratio — areas are listed in order of decreasing SMR*

** Jean Robinson is a trustee of the Society for the Prevention of Asbestosis and Industrial Diseases, and a former member of Oxfordshire CHC.*

1. *Mortality from mesothelioma of the pleura from 1968 to 1978 in England and Wales* by MJ Gardner et al. British Journal of Cancer Vol 46 No 1 July 1982 pages 81-88.
2. See for instance a French study in *The Lancet* 27 March 1982 pages 710-12.

Book reviews

The emergency book

by Bradley Smith and Gus Stevens, Penguin, £2.50

Taking a course in first aid is one of those good intentions most of us harbour but never quite get round to. Sooner or later a day comes which prompts bitter regret for such shilly-shallying.

Intelligent, trained responses in the face of emergencies can dramatically save lives. More often they can prevent needless further injury being caused by well-meaning, panicky helpers.

This book is clearly written. It describes what to do for heart attack, drowning, choking, shock, poisoning, drug overdose, accident injuries, burns. It even tells you how to deliver a baby who arrives unexpectedly.

There is no substitute for a first aid course and a chance to practise, but if you had a copy of this book in the house, you might be grateful to it one day.

Janet Hadley
ex-CHC NEWS

Books received

The development of local voluntary action by Hywel Griffiths (The Volunteer Centre, 29 Lower King's Road, Berkhamsted, Herts, £3.25 inc post). **Neighbourhood care —an exploratory bibliography,** by Fred and Suzanne Robinson (The Volunteer Centre, £3.95). **Old age — a register of social research** by Hilary Todd (Centre for Policy on Ageing, Nuffield Lodge, Regent's Park, London NW1, £12.70 inc post).

Scanner

Parkinson problems

A comprehensive survey of patients in contact with the Parkinson's Disease Society shows that this comparatively well-informed group still miss out on services they need — 49% had speech problems but only 3.4% have speech therapy, and 87% needed physiotherapy but only 17% receive it. The Society's own findings are compared throughout with a study of Parkinson's disease patients on a sample of GPs' lists. *Parkinson's disease patients and their social needs* by Marie Oxtoby. Price £3.50 inc post from the Society at 36 Portland Place, London W1.

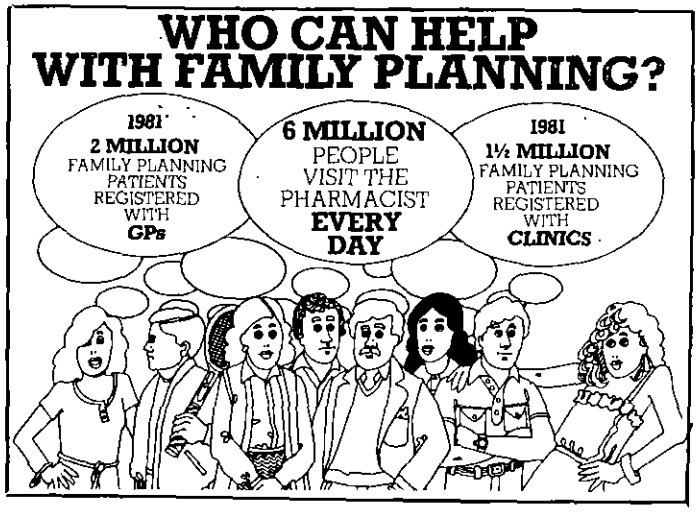
The right to obstruct?

The exercise of conscientious objection has led to problems which make safe, early NHS abortion more difficult to obtain, says a booklet which examines the effect of the Abortion Act's "conscience clause". One result is staggering variations in NHS provision for abortions — less than 10% of abortions in Dudley are on the NHS, yet 12 other districts achieve 90% — and women are dependent on the whims of the senior gynaecologist in their district. GPs are also blamed for delaying referrals without declaring their views. Solutions suggested are day-care units with sympathetic staff, more contracting-out to abortion charities, help for staff in understanding women's problems, and some way for GPs to register their conscientious objection publicly — perhaps on FPCs' medical lists. *Abortion and conscientious objection* price 40p from the Birth Control Campaign, 27-35 Mortimer Street, London, W1N 7RJ.

A voice for all children

is the report of the inquiry team set up by former members of the Children's Committee (see *CHC NEWS* 74 and 68, pages 3), axed in the Government purge on quangos. The new report says there is an urgent need for an independent group to focus attention on children's needs, citing the lack of coordination in services and the low priority given to children when money is being shared out. The booklet traces the lines of inquiry which led the team to conclude that the Children's Committee must be replaced. Published by the NCVO's Bedford Square Press on behalf of the independent inquiry into the need for a children's council, the booklet is £2.75 from bookshops, or £3.09 inc post from Macdonald and Evans Distribution Services, Estover Road, Plymouth.

The Family Service Units have focused on the problem of bedwetting, which they say is a burdensome "fact of family life" for many disadvantaged families, yet is largely unrecognised by professionals. *Enuresis in school children* is £1 inc post from FSU Publications, 207 Old Marylebone Road, London, NW1 5QP.



The Family Planning Association has joined forces with the Pharmaceutical Society to put the case for the corner chemist's role in contraception advice. They feel pharmacists can fulfill the need for a non-threatening and easily accessible source of information. A five-year project to increase the pharmacist's role in primary health care — especially family planning — is outlined in Family planning and the pharmacist — the case for greater involvement. *An expensive 16 pages at £2 inc post from the FPA, 27-35 Mortimer Street, London W1N, 7RJ.*

Training the mind

A loose-leaf pack of facts and discussion notes prepared for schools and colleges encourages students to examine their attitudes to mental illness, and to explore mental health resources in their own communities. Aimed at remedying a lack of understanding of mental illness and its roots, the pack could be used in less formal educational settings by CHCs and community groups. *Mental health and illness* costs £4 plus 62p postage from Christine Wood, Westminster Association for Mental Health, Church House, Newton Road, London W2.

Health circulars

HC(82)16: guidance on powers of the High Court to order disclosure of medical records.

HN(82)34: introduces Treasury booklet *Investment appraisal in the public sector,* with advice on re-appraising capital schemes.

CHC Directory: Changes

Changes to the CHC Directory are published on this page in each issue of *CHC NEWS*. Please let us know if your entry needs updating. Single copies of the directory are available free — send an A4-size self-addressed envelope and 25p in stamps.

Page 3: North East Yorkshire CHC Chair: Cllr Mrs Eva Mullineaux
Page 3: East Yorkshire CHC Chair: Mr J Blyth
Page 3: Harrogate CHC Chair: Miss K M Bradley
Page 3: York CHC Chair: Mrs R Popplewell
Page 3: Leeds Western CHC 61 Great George St, Leeds LS1 3BB. Telephone number remains Leeds 457461
Page 4: Southern Derbyshire CHC Chair: Mrs S M Henry. Secretary: Jean Holden
Page 5: North Bedfordshire CHC Chair: Mrs M T Hamer-Harries
Page 5: Huntingdon CHC has been created in the East Anglia region. Temporary address 4 George St, Huntingdon. Chair: Mrs A M Gibbins. Secretary: John Grigg
Page 5: Bury St Edmunds CHC has changed its name to **West Suffolk CHC**. Chair: Mr H Place. Address and telephone remain the same
Page 6: East Herts CHC Chair: Mrs P R Dickson
Page 6: South Hammersmith and **North Hammersmith CHCs** have merged to form **Hammersmith and Fulham CHC**
Page 6: Barnet and Finchley CHC and **Edgware and Hendon CHC** have merged to form **Barnet CHC**. Details as for **Edgware and Hendon CHC**
Page 8: South East Kent CHC Chair: Mrs M Wigfall
Page 8: Brighton CHC Chair: Miss J D Jolly. Tel: 771186
Page 9: Worthing CHC Chair: Mr E W Popplestone
Page 11: Milton Keynes CHC Tel: Milton Keynes 663800
Page 11: Bristol CHC Chair: C L Hannam
Page 11: East Berkshire CHC Chair: Mr B Rockell
Page 12: Salop CHC has changed its name to **Shropshire CHC**
Page 13: East Birmingham CHC Chair: Mr M Gallagher
Page 13: Solihull CHC Chair: Mrs J P Sinclair
Page 14: Preston CHC Chair: Cllr Mrs M D Scowcroft
Page 14: Chorley and South Ribble CHC has been created in the North Western region. Chair: Cllr S Allison. Address and telephone temporarily as for **Preston CHC**
Page 15: Tameside and Glossop CHC Chair: Mrs A E Corrie
Page 15: Oldham CHC Chair: Mr D Webster
Page 16: Wigan CHC has changed its name to **Wigan and Leigh CHC**. Chair: Mr B P Donaghy
Page 16: Clwyd CHC Chair: Mrs S M Evans

CORRECTION PAGE 5: THE DIRECTORY CHANGE FOR CAMBRIDGE CHC IN CHC NEWS 80 WAS INCORRECT. THE TELEPHONE NUMBER REMAINS AS CAMBRIDGE 62638.

News from CHCs

☐ Health Minister Kenneth Clarke "has no plans to review the future of CHCs in the next year or two". This was his message to the **Association of CHCs** (ACHCEW) last month at a long-awaited meeting between the Minister and ACHCEW representatives. ACHCEW's Secretary Mike Gerrard said after the meeting "I gather reviewing CHCs is not high on the political agenda, but the Minister assured us that when it does happen CHCs will be consulted fully." At the meeting, also attended by ACHCEW's

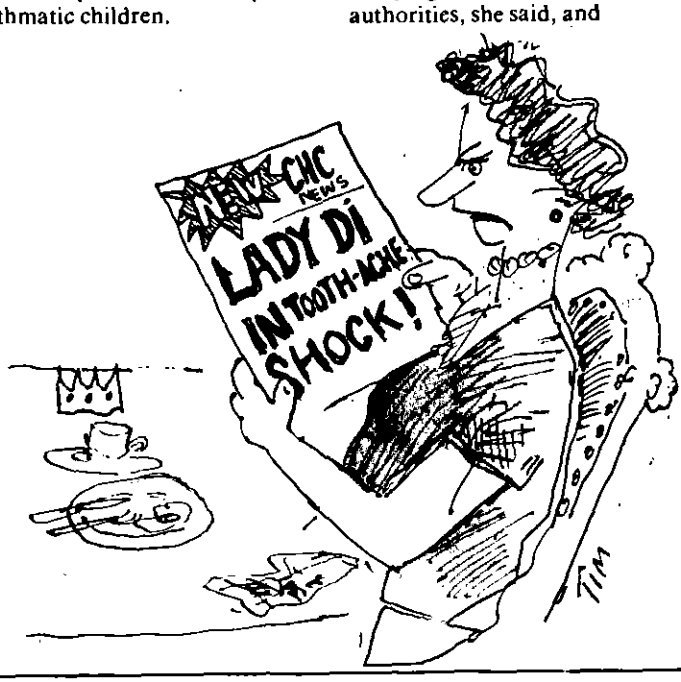
chairman John Austin-Walker and vice-chairwoman Judy Thomas, CHC problems with regional consultation were discussed and the Minister promised to bring up the issue at his next meeting with RHA chairmen. When quizzed on his attitude to *CHC NEWS* Mr Clarke said he supported the decision — taken before he became Minister — to axe the magazine's grant, but he accepted there would be problems in putting *CHC NEWS* onto a commercial footing. Most representations he had seen from CHCs had been about *CHC NEWS*, he said, but where CHCs had comments to make on issues for consultation they had been thoughtful and well-prepared and he valued their contributions.

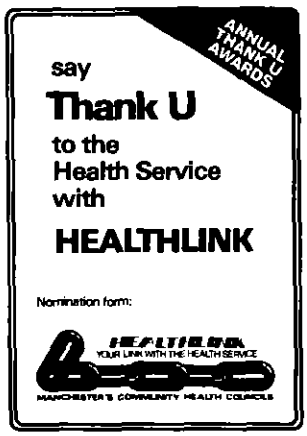
☐ It is not often that the appointment of a CHC member attracts the attention of Paul Foot of the Daily Mirror. But perhaps Mr Michael Turner is an exception. Mr Turner — Director of the AMI-owned Priory Hospital in Edgbaston — has been nominated to **South Birmingham CHC** by Birmingham district council, to the consternation of those who feel he may experience a conflict of interests on the CHC. Paul Foot smelled a story when a local paper reported that the council's Labour group had forced a debate on the nomination, but the CHC itself is still awaiting formal notification of its new member from the RHA.

☐ Meanwhile **Central Birmingham CHC** is discussing a plan to establish closer links with the public by examining conditions in the district's eight electoral wards. The groundwork has already been done (see *CHC NEWS* 77 page 8) in the form of population and service profiles for each ward, and now a working party is looking at the possibility of a two-year round trip of the wards, spending three months in each. The time would be spent getting to know the views of local people and visiting GPs to encourage them to keep CHC literature in their surgeries. A CHC meeting would be held in each ward. The idea is still on the drawing board so the CHC would like to hear from any others which have tried similar schemes.

☐ A series of meetings to assess demand for a local branch of the Asthma Society were so successful that **Wakefield CHC** has decided to go ahead with plans formulated after a showing of a Fisons Ltd film *A breath of fresh air*. The CHC set up a steering committee for the branch and now hopes to help re-educate local teachers about the problems faced by asthmatic children.

☐ Information emerged as the major demand by disabled people at the **Association of CHCs**' seminar on rehabilitation, held in Cambridge last month. Vic Finkelstein — chairman of the British Council of Organisations of Disabled People — asserted the right of disabled people to participate actively in planning and decision-making, while Jim Woodward — development officer of the Disablement Information and Advice Line (DIAL UK) — criticised projects which aim to rehabilitate people "as one would a derelict building". The rise of professionalism has created information deprivation amongst disabled people, he said, yet one third of DIAL's queries came from professionals. Disabled people are at risk when they enter general hospital wards not geared to their special needs, said Pat Saunders — assistant editor of *Handicapped living* and member of Portsmouth CHC. He called for peer counselling in rehabilitation, since those who best understand the problems of living with a disability are disabled people themselves. Raewyn Stone — research assistant to the All-Party Disablement Committee in Parliament — advocated the non-party politicisation of disabled people, who often see their needs as individual problems though they may stem from political decisions. CHCs can take a lead in lobbying MPs and local authorities, she said, and should support advocacy schemes for the mentally handicapped.





☐ The three **Manchester CHCs** had such great success with their first "Thank U month" that they have decided to turn it into an annual event. They hope this month to see a repeat of last year's response, when over 200 nominations were received — some in pictures or poems — from patients who wanted to express their gratitude to health service workers. Each district will present one gold and five silver awards, along with a certificate for each person or unit nominated. As well as boosting NHS staff's morale, the CHCs find the awards create valuable publicity and improve relationships between CHCs and local health services.

CHC surveys and publications

What do you know about your doctor? (**Central Birmingham CHC**). Family doctors — general medical services (**West Birmingham CHC**). Extract a good deal from your dentist (**Brent CHC**). Why are we waiting? — waiting times in outpatients' departments (**City and Hackney CHC**). Mental health services in S Gwent — the present and future (**South Gwent CHC**). Access to hospitals for disabled outpatients and visitors (**Newcastle CHC**). Survey on ante-natal facilities at Freedom Fields hospital (**Plymouth CHC**). Conference report (**Society of LHC Secretaries**). Maternity facilities in Somerset (**E and W Somerset CHC**). Ante-natal care in the Southmead HA (**Southmead CHC**). Clinic access survey (**Victoria CHC**). Birkenhead hospital in-patient opinion survey (**Wirral N CHC**).