CHC NEWS

For Community Health Councils November 1983 No 91

Griffiths prescribes— quicker closures

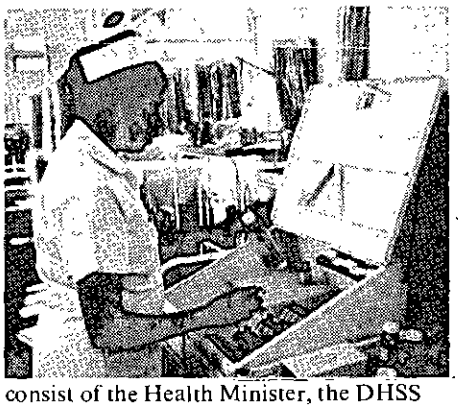
CHCs could be shorn of their consultation rights if recommendations from the NHS management inquiry — see *CHC NEWS* 89 page 1 — are acted upon by health ministers.

The inquiry team of four — led by Sainsbury's managing director Roy Griffiths — has submitted its report in the form of a 24-page letter to the Secretary of State, setting out proposals for radical reform of NHS management.

The emphasis throughout is on speed of implementation — coupled with "major changes in stance and style of management" to enable the NHS to "move much more quickly". Consultation procedure is seen as an impediment to this thrusting new business style.

While aiming at greater devolution of responsibility and routine decision-making, the team wants to see tighter control and leadership from the centre downwards, with a strengthened role for regions. To establish this it proposes:

- a **health services supervisory board** chaired by the Secretary of State, to determine objectives, approve resource allocations, take strategic decisions and receive performance reports. Membership will consist of the Health Minister, the DHSS permanent secretary, the chief medical officer and three or four others, including the chair of
- a small, full-time **NHS management board** answerable to the supervisory board. The chair will be vested with executive authority over the entire NHS, will act on behalf of the Secretary of State, and will "almost certainly" be recruited from outside the NHS. Management responsibilities will cover regional and district health authorities, family practitioner committees, special health authorities — such as the Supply Council — and other centrally financed services. Board membership will include
- a **personnel director** responsible for pay negotiations, training, terms and conditions of service and reviews of staffing — especially nursing — levels. A system of staff incentives and penalties will be instigated for use by health authority chairs — who will themselves "identify" and appoint the
- **general managers** at regional and district levels — and in every unit of management. They will act as "final decision takers" — especially where decisions "cross professional boundaries or cause disagreements and delay" — and will probably be doctors, nurses or administrators. But doctors are seen as "natural managers" at unit level.



The team's desire for speedy action means the new structure is designed to slot into the reorganised NHS without legislation — but all statutory consultation procedures will be reviewed at national and local levels.

At a press conference to launch his initiative Roy Griffiths complained that consultation delays development and managerial action, and made it clear that he wants to see consultation on closures and changes in services cut short — "there are too many vetos and too many rights to refer to higher levels" he said.

Although the management programme will go out for consultation ministers have already set up the core of the supervisory board and health authorities are expected to start implementing the proposals from April 1984.

NEW PILL DOUBTS - Can the clinics cope?

New doubts over the safety of some contraceptive pill brands will mean family planning clinics are likely to face increasing pressure — at a time when services are being cut by districts looking for "easy" financial savings.

And as districts offload birth control costs onto the open-ended family practitioner service budgets by encouraging women to attend GPs' surgeries for contraception, there is growing concern that too few GPs are trained to provide alternatives to the pill.

Two reports published in the *Lancet* last month suggest an increased risk of cervical cancer in long-term contraceptive pill users, and of breast cancer in women taking combined-hormone pills with particular progestogen formulations while under 25 years of age.

The reports have sparked heated controversy — with the Family Planning Association casting doubt on the validity of their findings, while the DHSS has pointed out that neither report claims to have found a *direct* link between pill use and cancer development.

Ministers have accepted recommendations in the *Lancet* from the committee on gynaecological cytology that pill users and ex-users should have cervical smear tests every

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INSIDE.....

A WEEK IN FOCUS

page 5

Your letters

Wait for it

Bob Payne, Secretary, Rotherham CHC

This CHC is concerned about waiting times for *non-urgent* out-patient appointments because it is thought that this additional waiting time is not taken into consideration in discussions on waiting times for hospital treatment. The true situation may be that there are two waiting lists.

We would be interested to hear from other CHCs which are concerned about this.

Featuring fluoride

R V Mummery, Retired Dental Surgeon, St Helier, Jersey

In your article on the dental service — *CHC NEWS* 89 pages 4 and 5 — Michael Silver attributes the decrease in dental decay rates to decreased sugar consumption, and preventive fillings — but mainly to fluoridation and fluoride toothpaste. Yet in a letter to *The health services* — 19 March 1982 — Dr Roger Anderson said "The level of decay in children has dropped between 38% and 50% in groups from 5 to 15, in rural and urban areas, in all social classes, and is *not* related to the occurrence of natural or artificial fluoride in drinking water supplies. The cause for the reduction is not known and may never be known".

The excessive sugar and sweet consumption which fluoridation was implemented to ameliorate did not begin until sweet rationing was ended in 1951. Tooth decay began to fall in the mid-60s, — not in 1943 as implied in the article.

What Michael Silver calls "preventive fillings" were described differently by Jennifer Pinder in the dental journal *Probe* of March 1982. She said she could "give evidence of patients with mesial-occlusal-distal fillings placed in virgin surfaces of teeth, which surely constitutes an assault on that person. I think we all know that this goes on, and has gone on for years." Dental Estimate Board figures over the past ten years would appear to support this allegation.

Writing in the *British dental journal* of 17 February 1976 Professor D Jackson warned that "the arguments used to support claims for fluoride toothpastes are much the same as those used to bolster many other fringe methods of primary prevention. Until we adopt more rigorous criteria for assessing and accepting methods of caries prevention we shall continue to encourage excessively inflated expectations, thereby deluding not only ourselves but the public in general". This could equally well apply to claims for fluoridation itself.

Fluoridation affects only 10% of the population. It is a yardstick of the profession's desperation and reflects an almost complete lack of appreciation of the behaviour of both trace and major elements in living processes.

Can Mr Silver quote any distinguished scientists who have themselves carried out any blind or double-blind tests which prove fluoridation either safe or effective? Dr Ed Groth in *Two issues of science and public policy* — Stanford University 1973 — says "the reported benefits of fluoridation can be seriously challenged on the grounds of poor experimental design, lack of controls over known and unknown variables and potential investigators' bias. An examination of all the fluoridation surveys over the past 30 years reveals that the bias of the dental investigators was explicit and quite strong."

As for dental plaque — there is a film of plaque present in every mouth, healthy or otherwise. Its nature is greatly influenced by the food we eat, and there could be a protective factor in the increased intake of foods containing fibre. In wartime Berlin intakes of both sugar and fibre foods rose and the dental decay position improved — *Lancet* 12 March 1983. It is unlikely that a diet suited to dental health could be produced overnight so until diet improves the most effective oral hygiene measure could be the production of a "fibrous chew" or tablet.

Mr Silver discusses a possible vaccine against dental decay. This would not eliminate the cause of decay — our refined diet. It is likely that microbes at present foreign to the oral environment would take over from those immobilised by the vaccine and the mixed microbic population of the mouth could adapt to increase its attacks on the gums.

Vaccination — like other preventive methods such as fluoridation — reflects what B Cooke calls "a lack of understanding of the basic biological factors underlying causation of dental disease". — *The failure of dentistry* in Vol 4 No 1 of *Healthy living*, January 1976. He says dental disease is associated with a shortage of oxygen in the mouth. Several factors contribute to this, and one is fibre-less diet causing water-logging which favours the proliferation of pathological anaerobic organisms.

It has never been established that an absence or deficiency of fluoride in soil, water or diet has ever caused disease in plants, animals or people. Unfortunately the reputation of the dental profession is bound up with the fate of fluoridation. If it is rejected now it will discredit all those prestigious bodies and individuals who have mistakenly promoted what has been called "the greatest medical fraud of the century."

Franklin Scott, Nunthorpe-in-Cleveland, Middlesborough

To retain an objective overview of Strathclyde's "legal hiccup", so called by the Fluoridation Society Ltd — *CHC NEWS* 88 page 8 — one must remember that there have been adverse verdicts on fluoridation in three similar Court hearings in the US recently. Judges and populations there have been monitoring the delayed, irreversible aftermath of the fluorine syndrome for around 30 years.

Perhaps the Fluoridation Society omitted to mention these because it realises they were considered judgements based on personal experiences and far from being "just legal hiccups".

Figure it out

Tessa Konrath, Administrative Convenor, The Institute of Statisticians, 36 Churchgate Street, Bury St Edmunds, Suffolk, IP33 1RD Tel: 0284-63660

Whilst statistics play an important role in any field, there is perhaps none in which this role is so crucial as in the health field. This Institute is organising an international conference for July 1984 at the University of Kent, under the title *Statistics in health.*

It will aim to cover the widest possible range of topics on the theme. Amongst the sessions already arranged are ones on the lead controversy, the hazardous effects of radiation, the distribution of resources within health services, and clinical trials.

The organising committee is looking for other papers — shorter than those in the main sessions — which may be featured in parallel sessions. One evening will be devoted to a posters session, where delegates can display and discuss aspects and results of their recent work.

Please contact me for further details, including brochure and booking form.

Wanted

Information on provision for chiropody for children at school — as indicated in paragraph 11 of health circular *HRC(74)33.* — Mid-Essex CHC

Information leaflets and suggestions on the format of leaflets explaining the role of GP practice arrangements and how to communicate with your GP.
— Manchester North CHC

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Comment

During this month we will hear the outcome of deliberations by a small group of senior cabinet ministers set the task of deciding whether Mr Fowler or Mr Heseltine — or both — should cut into next year's spending budgets to save the Government the embarrassment of having to ask for more housekeeping money.

Perhaps it is timely to remind ourselves, while awaiting this verdict, of exactly what the Conservative party promised us in its 1983 election manifesto — it may give some clues to what is in store for the beleaguered NHS.

In a manifesto section entitled *Responsibility and the family* there are six paragraphs on the NHS. After the assertion that "the nation is spending substantially more on health, and getting better health care" comes a pledge of sorts:

"We intend to continue to make sure that all patients receive the best possible value for the money that is spent on the health service" (emphasis added).

Oddly enough, a similar definition is used in the Griffiths report. The new management structure, it says, should:

"promote realistic public and professional perceptions of what the NHS can and should provide as the best possible services within the resources available" (our emphasis again).

Let's translate this — they are saying "make the most of what you've got", with the inference that you will not get any more.

It is as well to know this. We can now start adjusting ourselves to the idea that the NHS will no longer cater in full for the health needs of the nation — because with growing demands on resources made by increasing numbers of elderly people and increasingly expensive medical techniques, and with limited resources which will not grow to meet those demands — something has got to give.

What? Let's refer to the manifesto again. After the six NHS paragraphs come another four on "partnership in care". They start: "Conservatives reject Labour's contention that the State can and should do everything" and go on:

"We welcome the growth in private health insurance in recent years. This has both made more health care available, and lightened the load on the NHS, particularly for non-urgent operations" (our emphasis).

We can all stand anything but pain, and if we are told, as were the women of Plymouth recently, that we must wait up to four years for the State to attend to our "minor" but painful ailments then we shall all — irrespective of our political persuasions — follow the Prime Minister's example and go private.

Health News

NAHA cries foul

"Patients will inevitably suffer" if Secretary of State Norman Fowler does not keep 1984-5 resource allocations in line with the original 1983-4 budget announced in January, the National Association of Health Authorities said last month.

And Government-imposed staff cuts run "contrary to the Government's commitment" in the 1979 document *Patients first* by increasing central control of the NHS.

In a survey of its members NAHA found that health authorities have coped with the July "Lawson cuts" in this year's budgets because they were cushioned by money saved on wages during last winter's industrial action and since the pay settlement — which was lower than many had expected.

NAHA is aggrieved that — despite "an unparalleled record in keeping within cash limits" — the NHS is paying for projected overspending in other areas of Government expenditure.

Hospital and community services have lost £80.75 million this year. While absorbing around 15% of the cuts themselves — by transfers from capital to revenue budgets, by drawing on their reserves and by reducing regionally managed services — regional health authorities have passed £65.1 million in cuts to the districts. Many are coping by postponing maintenance work, yet in a recent interview — in *New society*, 27 October 1983 — the Secretary of State admitted that delays in maintenance work have caused a £2 *billion* backlog so far.

In real terms the cuts imposed by the Chancellor of the Exchequer reduced NHS resources by 0.29%. Government claims of a 0.21% "growth rate" for 1983-4 include the yearly 0.5% "efficiency savings" which have accounted for 2% of budgets over the last four years. But NAHA points out that health authorities are coping through short-term measures which cannot be repeated indefinitely. Reserves are "now virtually exhausted" and capital savings will inflict "unacceptable long-term damage".

East Anglia is the only region to receive the 1.2% resource increase necessary to maintain services to patients.

Staff cuts have complicated the picture and will encourage bad management, says NAHA. Health authorities wil be tempted into the uneconomic use of agency staff to reduce levels of directly-employed staff, and cuts may inhibit development of labour-intensive community care.

The figure of 4,837 staff cut from 31 March 1983 baselines is "misleading" says NAHA — "actual staff cuts could be much higher".

NAHA hopes its survey will help Mr Fowler to argue his Department's case in public expenditure negotiations this autumn. Copies of the survey on staff targets and cash limits are available from NAHA at its new address — Garth House, 47 Edgbaston Park Road, Birmingham B15 2RS.

Hospitals for US or them

At least 15 spanking new hospitals are to be built around the country — but no UK citizens will be allowed to use them. The hospitals — costing £300 million — are part of a network of new facilities being built by the US military forces in the UK over the next five years.

They will be kept empty and their equipment stockpiled until needed by US military personnel. They are being built because "the government of Great Britain is not capable of providing medical support for the estimated number of casualties which would be incurred in a European war".

An article in *New statesman* magazine claims "a protracted war in Europe would rapidly exhaust US medical facilities". Each of the new hospitals will provide 500 beds and cost about £20 million. The sites for them are: Cosford, Newton, Upwood, Feltwell, Waterbeach, Bicester, Kemble, Little Rissington, Bordon, Tidworth, Bulford, Locking, Colerne and Nocton Hall.

The first has already been built at Little Rissington and the second is under construction at Upwood. *Bases build-up* by Duncan Campbell, *New statesman*, 21 October 1983, pages 12-13.

Feeding a controversy

The James report on nutritional guidelines — see *CHC NEWS* 88 page 3 — has been published by the Health Education Council in down-graded form as a "discussion paper" with little hope of Government action to encourage take-up of the guidelines in the near future.

The group which produced the report — a sub-committee of the national advisory committee on nutrition education (NACNE) chaired by Professor WPT James — bases its recommendations on a consensus of views from eight major reports by the DHSS, the World Health Organisation and the Royal College of Physicians. A 15-year time-span is envisaged for changes in public attitudes — and in agricultural practices, food manufacturing techniques and Government and EEC regulations. For the 1980s the report proposes the "modest aim" of achieving around one third of the dietary changes shown to be necessary by the expert reports studied.

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Health News

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This means reductions in *average* intake of alcohol, sugar, salt and total fat by 10% of each and an increase in dietary fibre by around 25%. Energy values would remain the same, but with fewer calories from fat and alcohol, more from carbohydrates in bread, potatoes, other vegetables and fruit, and with protein intake levels unchanged. This diet would also increase intake of minerals, vitamins and essential fatty acids.

The report criticises the long-held concept of "balanced diet" — aimed at avoiding deficiency diseases no longer common in the UK — and suggests instead the new approach of a "healthy varied diet". Since upper and lower limits of nutrient intake requirements vary considerably between individuals, the report proposes average intake figures to improve the diet of the population as a whole.

Junior Health Minister John Patten welcomed the report as a "contribution to discussion in the field" but said "the Government does not look to NACNE for scientific advice on matters relating to nutrition and health." The HEC has no plans for formal consultation on the report, but hopes it will "stimulate debate".

A discussion paper on proposals for nutritional guidelines for health education in Britain is free with a large sae from the HEC, 78 Oxford Street, London WC1A 1AH — but distribution is limited to one copy each.

Welshing on the health service

Government claims that more money is being put into health services in Wales have been challenged by the trade union NUPE.

In a detailed report NUPE says that Welsh Office claims of a real growth in health provisions are the opposite of the truth — not enough money has been allocated even to stand still.

The 30-page breakdown of Welsh Office statistics shows that there has been a £1 million reduction in capital spending, a 6.4% increase in revenue expenditure, a 6.6% increase in hospital spending and a 1,350 increase in full time staff — over the past four years since the Tories came to power.

NUPE claims that this has failed to keep pace with medical advances and demographic changes in the same period and so represents a cutback in real terms.

On finance the report says that actual capital expenditure has fallen from £10.519 million in 1978/9 to £9.564 million in 1980/81 which are the last available figures. Health authorities' budgets overall have risen from £512.5 million in 1980/1 to £546.27 million in 1983/4. So the actual rise in hospital spending over the four years since 1980 stands at £33.77 million — a rise of 6.6% in real terms.

On staff NUPE says that a figure of 49,706 full time personnel has risen to 51,056 in 1982 but this fails to take account of the hours lost following the reduction in nurses' working week agreed in the national agreement of 1979.

There is a shortfall on nursing staff alone of 188 between 1979 and 1980 to cover the shorter staff hours. But NUPE claims that increased bonus schemes for ancillary staff and new capital developments have not been considered in Welsh Office claims of growth in health expenditure.

Since 1979 five hospitals have been closed and 684 beds have been discarded leaving a waiting list of out-and in-patients of 100,000.

An analysis of the nine health authorities in Wales shows wards operating with untrained staff in charge of 25 patients. The report is to be issued to all NUPE stewards and CHCs in Wales to be used as ammunition against Welsh Office calls for greater "efficiency savings" and staff cuts.

Indicators of value?

After two years' development — including testing in the 1982 regional reviews — district performance indicators based on 1981 data are available in a heavyweight national summary incorporating a user's guide and data sources, and in regional booklets which rank English district's data in chart and graph form.

PIs have been criticised for measuring service throughput rather than successful outcome — see for instance Mark McCarthy in *CHC NEWS* 85 pages 6 and 7 — and the revised PIs are accompanied by the proviso that "the ranking of the data does not of itself allow judgements as to whether services are good, bad, efficient, inefficient..." A joint NHS/DHSS group on PIs (JGPI) will advise on their future development and use, as well as considering the feasibility of developing indicators of service outcome or quality.

The PIs cover finance, staff, estate management and clinical activity in general medicine and surgery, trauma and orthopaedics, obstetrics and gynaecology. The DHSS has developed computer programmes to help districts analyse clinical and staff indicators. Health authorities are encouraged to report their experience of using the PIs to the JGPI.

Health circular *HN(83)25* accompanies the PIs. Extra copies are available at £14 — for the national summary and £6.50 — each regional booklet, from DHSS leaflets, PO Box 21, Stanmore, Middlesex HA7 1AY.

Drumming out noise

It's your hearing — protect it or lose it. That is the message of the Health and Safety Commission's new public awareness campaign on noise levels. Launched at a House of Commons press conference, it aims to combat the damage done to hearing by excessive noise levels at work.

Last year one million people were exposed to potentially harmful noise from machines such as pneumatic hammers, automatic lathes, woodcutters or power presses. The campaign includes posters, stickers, adverts and a special brochure — *100 practical applications of noise reduction methods* price £7.50 from HMSO.

Illusions of glue

The long-awaited Government film on glue sniffing has finally been released. Titled *Illusions — a film about solvent abuse*, it has been made to show to professional people who have to cope with glue sniffers.

It comes with a warning that it should not be shown to young people and claims to give no simple answers or message about the many problems related to solvent abuse. To hire copies of the film contact CFL Vision, Chalfont Grove, Narcot Lane, Gerrards Cross, Bucks. Tel: 024 07 4111.

Protesting for Innocents

Protests about safety for young people on the Government's Youth Training Schemes have been made to ministers despite assurances of new safety guidelines.

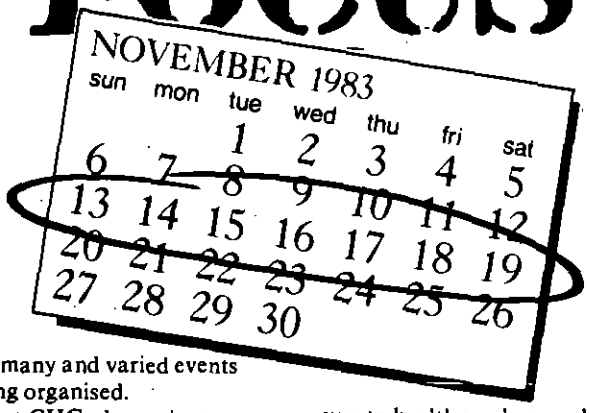
The Health and Safety Commission and the Manpower Services Commission have both initiated moves to improve safety procedures. The HSE has called on the Government to give YTS trainees the same coverage under the *Health and safety at work Act* as other employees. The MSC has appointed regional safety advisers to give specialist advice to their 55 local offices which manage YTS, and have published an on-the-job safety guide.

But independent pressure group Youthaid has claimed that 16 year-olds on YTS are at greater risk of being killed or injured than workers in all but the four most dangerous industries. A delegation, led by Labour MP Dave Nellist, was due to meet Government ministers about safety guidelines as *CHC NEWS* went to press.

News in brief

- Neck injuries in car accidents have doubled since January when wearing seat belts became compulsory. So says an Edinburgh consultant, Dr Keith Little, who claims that neck injuries have increased as the number of serious head injuries has halved. He claims that properly adjusted head restraints could prevent such neck injuries. *Effects of seat-belt legislation* by RJC Steele and K Little, the *Lancet* Vol 2 No. 8345, 6 August 1983 page 341.
- Treatment of drug misusers will come under the microscope of a working group of medical practitioners to be set up by the Government. It will consider the feasibility of extending licensing restrictions which at present cover the prescribing of heroin and cocaine to addicts. Drugs such as methadone, morphine and pethidine may be added to the list.
- Deaths from lung cancer are on the decline partly due to the reductions in cigarette tar. This claim is made by the independent scientific committee on smoking and health in its third report since its inception in 1973. But in its report to health ministers the ISC says rapid reductions in tar may not be possible because smokers would not accept it. Copies of the third report of the ISC are £2.95 from HMSO.

A WEEK IN FOCUS



The watchdogs of the National Health Service — so goes the slogan for CHCs.

Seven days have been put aside to explain just what that means in putting their work and their role in the public eye.

The week is 13-19 November when the Association of Community Health Councils for England and Wales hopes that the public will be bombarded with information about their rights as patients and the representation their CHC can provide. National CHC Week will see a vast range of activities taking place up and down the country. Radio and TV programmes, demonstrations and street stalls, exhibitions and public meetings, seminars and workshops — all have been pencilled in for the week.

The list includes — in Northampton a session with the health education department; in Aylesbury a public meeting; in Guildford "Help yourself stay healthy"; in Stoke "Children in hospital — parents, paediatricians and play"; in Bradford "Children in hospital"; in Brighton "Women's health services"; in Llandudno a daily film show and an "*Any Questions*" session; in Wakefield four meetings on hospital care, health services, mental health good practices and women's health; in Bromley meetings on stress and on women's health; and in Llanelli meetings on community care and plans for a new hospital.

These are just a sample of the many and varied events being organised.

But CHCs do not just operate for one week a year and the Manchester CHCs prove that. IN 1981 the three CHCs in the city initiated "Thank U Month" — see *CHC NEWS* 81 page 8 for last year's awards.

During the month the public were encouraged to say thank you to health workers and this year 12 CHCs in the region are joining in.

ACHCEW has produced a special booklet — *Your community health council in action* — to put across the message of CHCs that they are the "People's Friend" in the health service. It includes a week in the life of a CHC and sections on health education, information, research, complaints and the history of CHCs and their national body ACHCEW — 100 copies for £10 from ACHCEW, 362 Euston Road, London, NW1.

All this comes at a time when the health service and its future has been thrust into the limelight with cutbacks and staff reductions hitting the headlines.

ACHCEW's secretary Tony Smythe has this to say about the role and future for CHCs: "The CHC movement believes that a strong, efficient and developing NHS is essential to the nation's health and the preservation of values in a compassionate society. We believe that the public supports the NHS and will not tolerate the imposition of alternative systems. We believe that a well co-ordinated consumers' voice will be heeded. CHCs provide the main opportunity for public participation in the NHS and although they have been under-funded, patronised and cold-shouldered by the Government, they have achieved much and can play a primary role in the NHS."

With all this in mind, ACHCEW has organised a special conference to discuss the response from CHCs to the Government's staff cuts — see box. Its title is *Patients' needs first* which has always been the principle behind the existence of CHCs. Now it seems it may become the rallying cry in the fight to preserve the NHS.

ACHCEW has called a special meeting for all CHCs and other consumer bodies to discuss the cuts in the NHS.

Entitled *Patients' needs first*, it will take place on Tuesday 15 November at the YWCA building, 16-22 Great Russell Street, London WC1. Running from 10am to 4pm, speakers will include: Jean Davis — National Association for the Welfare of Children in Hospital, Professor Peter Townsend — Bristol University, Brian Rix — Director MENCAP, Dame Elizabeth Ackroyd — Patients Association, and David Hencke — health correspondent of the *Guardian*. The conference will cost £5 per participant payable to ACHCEW in advance. Tony Smythe commented: "We want to provide a forum for consumers. The aim of the conference is an exchange of views and information as well as a positive and constructive debate about what representations can be made to make the NHS a little more secure in the future."

PILL DOUBTS

Continued from front page

five years — but have not yet agreed to extend payments to GPs for smears to cover women under 35 years.

The committee on safety of medicines has advised doctors to prescribe pills with the lowest "suitable" hormone content and has published a table comparing combined hormone pills licensed for use in the UK, although the committee does not endorse the "potency" calculations in the new research.

The DHSS, FPA and CSM are all trying to stagger women's response to the reports by recommending that they should finish their present prescriptions *before* seeking further advice. But over the next few months increasing numbers of women are likely to be seeking alternative contraceptive methods.

Many GPs are not trained to fit caps and diaphragms or insert IUDs, but districts are increasingly adopting the attitude that family planning clinics are a duplication of services offered by GPs — although several CHCs have successfully argued against this.

Vasectomy and sterilisation services, cervical cytology and well women clinics offering breast examination are also coming under pressure in cost-cutting proposals now being put to health authorities, while Bexley CHC is investigating a suggestion that £10,000 could be saved in local clinics by restricting the range of birth control pills, devices and creams available.

•*Breast cancer in young women and use of oral contraceptives — possible modifying effects of formulation and age at use* by MC Pike and others — and *Neoplasia of the cervix uteri and contraception — a possible adverse effect of the pill* by MP Vessey and others, in the *Lancet* Vol 8357, 22 October 1983, pages 926 to 934. See also *Oral contraceptives and neoplasia* an editorial — and letters on page 968 of the same issue.

Helping ourselves...

by Liz Haggard, Secretary, Nottingham CHC

Nottingham CHC shares its offices with a new self help group project.

The self help group of the eighties is not a national fund-raising, public education and information campaigning body, but a local group providing longer-term support and understanding for people who cannot be treated medically in a one-off way. Some groups are set up to share and cope with emotional wounds like bereavement or stillbirth, and the 80 groups in Nottingham include an eczema group, a tinnitus group, a burns group and a Depressives Anonymous.

The Nottingham Self Help Groups Project has the specific task of providing support to these health-related groups. The project is funded by the health authority through joint finance, which pays a part-time project leader, clerical help and modest expenses. It is managed by the Nottingham Council for Voluntary Service and the CHC has supported the project and offered it an office base.

The project acts as a kind of magnifying glass for local groups. It ensures that the goodwill, enthusiasm and work is supported and focused so that groups can reach the Nottingham community.

One of the aims of the project is to encourage the formation of new groups — the right help in the early months can save wasted effort, overwhelming demand which may break the group, and feelings of frustration or failure. Sometimes the best advice for an embryo group is not to start. Although there is a tremendous range of group sizes, structures and patterns which work well, there are some basic criteria which all groups should meet if failure is to be avoided, and it can be individually and socially damaging for groups to start up without a reasonable chance of success.

The project can also guide existing groups over difficult patches and life crises where the advice of an experienced and sympathetic outsider helps the group to see their problems in perspective and to find solutions.

Self help groups cannot help everyone. They are one possible source of help with the advantage that you can refer yourself to them and stop attending at any time.

Groups offer a forum where it is legitimate to discuss your problem at length — in the outside world discussion of your own health is limited by unwritten but powerful social rules. In group discussion you find recognition and feel understanding of difficulties non-sufferers do not share. You tap the group's combined experience and information and through this you may gain confidence to seek new ways of managing your health. Sharing difficulties does not concentrate the misery — an outsider is often surprised by the laughter and humour in self help groups.

Some groups come to identify gaps in the service and press for improvements, and this shared aim can move members out from their own problems to wider issues.

Self help groups have their ups and downs and their dangers. Some may not overcome the stifling effect of endless personal anecdotes while others may be swamped by one powerful member. Some may fossilize into fund-raising groups only and some may be side-tracked into pursuing the holy grail of single miracle solutions. It is naive to oversell the help groups can give — the message should be "try it and see if it helps".

Because the problem a group's members share may be unusual or socially stigmatised, friends, relatives GPs and community nurses are unlikely to know of many other cases, so there is no pool of help and information in the immediate natural community. Most groups' members are regular users of the NHS but will have come to realise that there are limits to the help doctors and nurses can give. The self help group concentrates members' experience and support.

In Nottingham the project has brought such groups together — through regular evening meetings and short courses — to explore what they have in common. Groups have valued this chance to look beyond their own focus and some are beginning to see themselves as part of a wider movement learning from each other.

The project also presents self help groups to professionals and the public, giving them an image and identity through booklets, radio and press features, lectures and seminars where group members can show professionals how groups work and encourage them to see groups as a useful resource for them and their patients.

As the patients' voice CHCs have a special interest in self help groups. Most CHCs use them as a vital source of information on specialist services. We find out as much as we can about local groups so that we can refer members of the public to them. We encourage professionals to tell their patients about them and to invite group members to talk about their experiences as patients. Self help groups which campaign for improved services often contact CHCs.

Most CHC secretaries have become involved in helping at least one self help group to get off the ground. Usually one is enough to teach us how time-consuming and skilled this type of development work is and to make us wary of taking on too much of it. In Nottingham the CHC has always tried to keep in touch with local groups, to interest CHC members in particular groups and to provide a basic information service.

We regularly produce a phone contact card listing local self help groups — but we have had to admit that we have neither the time nor the skills to become involved in development work with individual groups.

So in offering support to the new project the CHC has gained release from guilt at not doing enough about self help groups! We have also gained a much greater awareness of groups and what they offer, and valuable feed-back on patients' views. Patients and the public have gained a central information source for contacting groups, an encouraging sense of active and improved self help effort in Nottingham and support to ensure that voluntary effort is used effectively and rewardingly.

The NHS has gained too. More professionals know about self help groups, their values and limitations. There is a wider range of groups for them to suggest to their patients, and most professionals have learnt something of the skills needed to enable groups to start and flourish.

We have benefited enormously from our close links with the project, while patients and professionals have gained a vital resource which the CHC alone could not have provided. Promoting a local self help groups' project could be an important achievement for patients and CHCs.

Photo: Liz Heron

...and taking the initiative

by Alison Watt, Development Officer, Community Health Initiatives Resource Unit, NCVO

The National Council for Voluntary Organisations recently attracted funding from the DHSS to establish a unit that would promote and support community health initiatives. The NCVO had become increasingly interested in the role that voluntary organisations have to play in the delivery of health care and in the subsequent relationship between the voluntary sector and the NHS.

Interest was generated by the production of two publications (1) and by the research for a publication and conference on voluntary action in ante-natal care (2).

So when I began work in July as the development officer for the new community health initiatives resources unit — CHIRU — there was already within the NCVO a firm commitment to the notion of these initiatives.

But what is a community health initiative? This is a crucial question. CHIRU is staffed by three, and all of us are frequently asked to provide workable definitions. In the early stages of our work we responded to these questions by deliberating about what is or is not a community health initiative, and why.

We now feel that a firm definition is neither necessary nor helpful. Tracing the roots of community health initiatives to the community development movement — see (3) and (4) for instance — shows that attempts at definitions run counter to the whole philosophy of the movement.

Community development can be described as:

"The process by which an open-ended intervention is made in a locality to assist groups of residents to clarify and deal with problems that the local people themselves have identified. Such a process is concerned to assist in achieving social change in the area of social conditions and social institutions" (5).

But we have come up with a loose description which covers very generally what we understand to be the driving force behind community health initiatives — they are groups of people who meet together to work around a health issue that they all have in common, and over which they are attempting to gain greater control.

However, there are some sorts of groups which fall more easily into this description than others. Women's health groups, neighbourhood campaigning groups, ethnic minority health groups all slip more comfortably into the description than, say, a group meeting to raise money for hospital equipment.

For implicit in the philosophy behind community development work is the attempt to redistribute resources more equally, to give local people access to decision-making processes, and to pressure for the allocation of state resources to be more appropriate to people's needs.

This recognition of differences in activities between campaigning groups and groups raising money for their DHA also begs the question of what constitutes "voluntary action".

We have drawn a line between volunteering in its old philanthropic sense — middle class well-wishers doing good to society's unfortunates and committed to relieving the State of its welfare burden — and those people who organise around welfare issues often external to the state and often working in a paid capacity. So "voluntary" need not mean unpaid but usually means non-statutory.

These people typically choose to organise outside the State machinery in order to secure autonomy — often to apply pressure on the State to achieve change.

It must be stressed that these two categories are by no means distinctly separate nor exhaustive, and do not cover those people working within the State to achieve change.

Our decision not to define too closely the components of a community health initiative has meant our estimates of national activity have been pushed higher — there are now perhaps 10,000 groups in England and Wales which fall into our category.

At present we are trying to draw a national picture of all initiatives so we can:

- produce directories of initiatives, organised by issue and geographical region so that people can set up their own networks
- invite people to specify the sorts of resources they would like CHIRU to provide
- identify areas where there is a clear need currently unmet by any initiatives, and then attempt appropriate development.
- enable an essentially invisible and scattered movement to become visible and hence more powerful

We are producing a booklet on attracting district health authority funding and may also produce audio-visual materials. We are working with the London Voluntary Services Council in looking at the training needs of community health workers and are discussing links with other organisations to produce specific directories.

We aim to build a comprehensive and effective information and resource unit which will be responsive to people's needs and will help to place community health initiatives firmly on the health policy map.

If you know of any community health initiatives please pass on the information to us — this is the only way we can attempt to be properly accountable. And if you have any comments or suggestions about our proposed work so far you are welcome to contact us at CHIRU, 26 Bedford Square, London WC1B 3HU Tel: 01-636 4066.

Photo: Raissa Page

Photo: Tony Orhen

References

1. *Community based health initiatives — a handbook for voluntary groups* and *Directory of community health initiatives* both by Caroline Smith and published by NCVO in 1982.
2. see *CHC News* 87 page 1.
3. *Neighbourhood health projects — some new approaches to health and community work in parts of the UK* by Helen Rosenthall in *Community development journal* Vol 18 No 2, 1983.
4. *Community development "outreach" and health* by Alex Scott-Samuel in the Association of Community Workers' *Talking point* No 33, March 1982.
5. *Evaluation of community work* — report of a London Voluntary Services Council working party, 1976.

Book reviews

In labour — women and power in the birthplace

by Barbara Katz Rothman, Junction Books, £5.95

Ms Rothman offers a good, feminist analysis of the history and politics of maternity care. Although written about the US, I found it applied equally to the care available in this country.

She divides this into categories. The most common is the "medical model" — patriarchal, hospital-based control, where the male body is considered the norm and pregnancy is therefore treated as an abnormal condition. She explains how these principles came about and how the new "consumer models" — Leboyer, Lamaze and so on — serve only to reinforce these principles — women are actively discouraged from voicing their opinions and husbands are enlisted as "coaches" to keep their women under control.

In opposition to this is the "midwifery model" — the increasingly popular home birth movement. Midwives offer support and advice when it is requested, and women have control of their own bodies and deliver their babies in their own home.

This is an excellent book covering all aspects of care — from infertility to breastfeeding, with the author's own experiences of home birth included. It will offer support and reassurance to any women unsatisfied with maternity care as it is now.

Sally Wiltshire, CHC NEWS, information service

Understanding mental illness and its nursing

by K L T Trick and S Obcarskas, Pitman Books, £8.50.

Behaviour therapy nursing

by P J Barker, Croom Helm, £7.95.

The first of these is the third edition of an excellent book written in a simple style without unnecessary medical terms. Terms that are used are carefully defined so that anyone without previous knowledge of the subject can read it with ease.

There are two main parts to the text — the first on mental illness is usefully illustrated by case histories and finishes with two chapters on special problems of nursing — physical and managerial. The second part is on the "nature of mental disorder", its recognition and treatment.

The forward to the second book suggests that the chapter revealing the author's outlook on this subject be read first.

An interesting description is given of the technique of behaviour therapy which is designed to help the patient to become more acceptable in the community. Several techniques can be involved and the patient/nurse relationship becomes part of the treatment.

There is a full professional explanation of the different methods of behaviour therapy and theory is examined in some depth. Ethics are also discussed and the text is illustrated by case histories.

Dr U J Avery, Member, East Dorset CHC

The effectiveness of social care for the elderly

by E Matilda Goldberg and Naomi Connelly, Heinemann Educational, £6.50

Dependency with dignity

by Barbara Wade, Lucianne Sawyer and Judith Bell, Bedford Square Press, £6.95

The first book — based on work by the Policy Studies Institute — is sub-titled "an overview of recent and current evaluative research". This formality disguises one of the most readable of books, a mine of information about what is going on in care for the elderly at the moment.

With so much information, so much research of variable quality, and so many experiments in the field it would have been easy to produce an indigestible offering. Instead the authors have ordered the material under sensible headings, pruned and cut the inessentials and enabled us to get to grips with current work. All the way through their own concern shows — the work is written with sympathy.

It fails of course to provide firm answers — we are still searching for many of these — but there is a short chapter at the end called "comments and reflections" and another headed "there are many roads that lead to Rome". This perhaps sums up the book — it points to many of the roads we must follow in the problem years ahead in caring for our ageing population.

I have read many books on this topic but this is one of the better ones.

In contrast the second book seems somewhat thrown together and lacks the sensitive survey of the first. It is a research paper which has been published with little or no editing and so is less accessible to a wider readership. Much of it consists of research findings, analyses, diagrams and so on.

It is a meaty piece of work in true research style with an extensive bibliography. There is a short summary of each chapter, with a final chapter headed "discussion and conclusion". This is quite informative — though still a bit heavy.

Although it is a valuable research document one does wonder whether it merits publication as a book.

Harry Creaser, former Member, York CHC

Housing for the elderly — planning and policy formation in Western Europe and North America

by Leonard Heumann and Duncan Boldy, Croom Helm, £12.95

This is a well-researched and documented book written in an easy style with facts collected in the UK, the US and parts of Europe. Charts and tables with concise summaries give ready information on the need and functional management of sheltered housing in the various countries — chiefly the UK.

The data for the book is based on selected local authorities and voluntary bodies and so reflects only about 30% of the population. It is gratifying to note that housing associations and building firms are moving into this area of work to provide for the higher income groups.

The key to the successful operation of sheltered housing is the warden system, and this is well covered — though a negative comment would be to doubt the advisibility of introducing "professionally trained" wardens rather than the "good neighbour" type.

The book is an excellent one for professionals and students but is not in my opinion likely to have a special appeal for CHC members.

R W Aubrey, former Member, Clwyd South CHC.

Essential community medicine

by R J and L J Donaldson, MTP Press, £6.95.

Father and son collaborated on this guide to community medicine. They have aimed widely — at undergraduate and post-graduate medical students and practitioners as well as nurses, social workers and health educationists. Their approach is traditional, describing the patterns of common diseases and their prevention, services for long-term care groups, environmental health, the NHS and local authority services.

It is an authoritative account with a good index to dip into. I wanted to learn about special education for handicapped children, and the 1981 *Education Act* was well described.

CHCs are given five paragraphs — they "act as the official watchdog for the local community, inevitably receiving adverse comments". But an error in indexing implies — wrongly of course, that CHCs receive 9% of the total NHS budget!

I have two reservations. Firstly the book is too long at 600 pages to hold the attention of many people, especially those *not* studying for exams. Secondly, the authors quote too often from Tyneside and Leicester — their own patches — while ignoring other people's good work. But buy it for reference in your CHC library.

Mark McCarthy, Senior Lecturer in Community Medicine

Fuelling the future

*by Toby Harris**

Every year the onset of winter means tens of thousands more elderly people will die than in the summer months.

The figures make startling reading:

Number of winter deaths in excess of summer deaths for those over 65 (winter — October to March: summer — April to September)

1976	55,100
1977	30,300
1978	36,700
1979	40,900

The figures for other age groups are even more marked. The mild winter of 1980 saw a death rate among men over 85 that was 40% higher from January to March than from July to September. For female infants under one year the excess of winter deaths was 39%.

But this seasonal pattern in infant mortality does not occur in the colder climes of Finland, Netherlands or Sweden. Why should this be so? Our book *Energy and Social Policy* (1) looks at some of the reasons.

The effects of rising fuel prices have not been alleviated by the fitful and incoherent policies of the Government. In fact, Government energy pricing policy actively conflicts with the social ideal of a warm, well-lit home for all.

Poorer households are hardest hit by policies that push up energy prices because they spend a higher proportion of their income on fuel costs. For a significant number of households this means a large slice of their spending. For example one half of single pensioners living in rented accommodation spend more than 12% of their outgoings on heat and light.

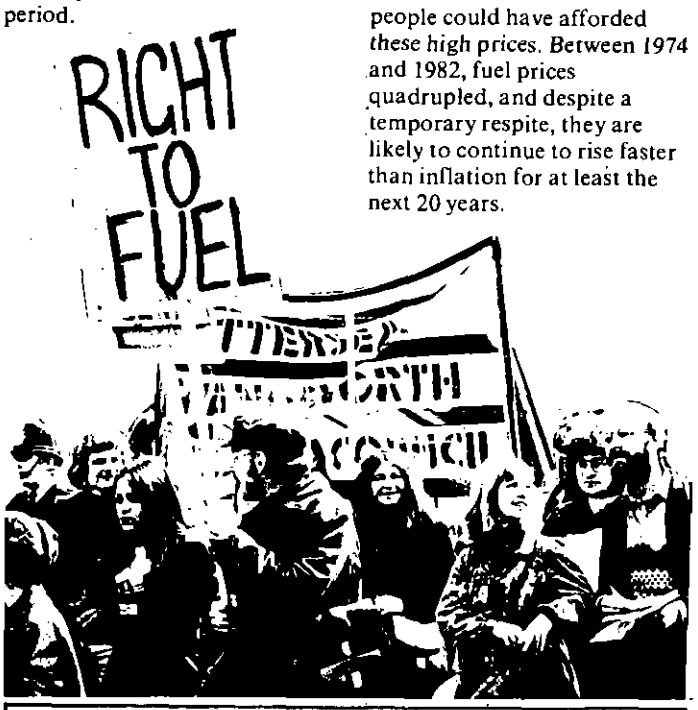
The result — fuel poverty. Many households — particularly the elderly — are so fearful of their next fuel bill that they do not heat their homes to an adequate standard and run the risk of hypothermia and other cold-induced illnesses. While for others the result is high bills and fuel debts. Over the last few years, 115,000 households annually have had their electricity supply cut off for non-payment and 35,000 have lost their gas supply.

More than nine out of ten of these households fell within the hardship categories under the fuel industries' code of practice — designed to avoid disconnection. Financial hardship, debt, disconnection and physical distress will continue to mount up unless a package of measures is brought forward to redress the balance between Government energy policy and its social consequences.

In 1980 for example the Government set financial targets for the electricity and gas industries — and it was the intention of these targets to push up such prices. David Howell MP, who was Secretary of State for Energy at the time, indicated that as a result of these targets he expected gas prices to rise by 10% more than inflation in each of the following three years, and electricity prices to rise by 5% more than the electricity industry's costs over the same period.

In the last year the Government has moderated this policy but the fuel industries are still bound by a network of cash limits. The effect of this is a significant one. The House of Commons treasury and social services committee has found, for example, that price increases have been larger than would otherwise have been the case to enable the industries to meet their cash limits.

Given that such a fundamental part of Government energy and economic policy involved high fuel prices, it is surprising that more effort was not made to produce social policies which would have ensured that people could have afforded these high prices. Between 1974 and 1982, fuel prices quadrupled, and despite a temporary respite, they are likely to continue to rise faster than inflation for at least the next 20 years.



Energy Conservation Areas were first mooted by the National Energy Efficiency Forum (NEEF) a year ago.

Their aim is to co-ordinate much of the ad-hoc, and at times haphazard, work being done on energy conservation. They provide the framework to harness the many varied interests in the energy field in a concentrated way in one particular area.

***A pilot energy conservation area: blueprint for action,* published by the NEEF in April, provides a detailed discussion of the potential of ECAs and their role in a more coherent national energy policy. It covers the need for ECAs and the practical ways of implementing them.**

Copies can be obtained from the Consumers' Association, 14 Buckingham Street, London WC2N 6DS — price £1.50 inc postage and packing.

A major commitment from the Government is required if the fuel poverty that is likely to result from this is to be avoided. An essential element in this must be a comprehensive insulation programme. This might be organised along the same lines as the North Sea Gas conversion programme with improvements being made to all properties on a street-by-street basis.

This would avoid the problems of poor take-up that bedevils the existing Homes Insulation Schemes and often means that low income and other disadvantaged households miss out. Moreover a comprehensive street-by-street scheme would lead to lower costs overall because supplies of insulating material could be ordered in bulk and the work phased.

All in all, the case for an extended conservation programme and above all one that reaches all households is very powerful. It would save money, save fuel, create jobs, improve the housing stock, and — most important of all — reduce the risk of debt, disconnection and discomfort.

Clearly other measures would also be necessary. Direct financial assistance will still be required, either by adjustments in tariffs or more likely by some sort of fuel allowance. Help with budgeting and sensitive fuel board policies in relation to debt will also be required.

The age of cheap fuel is over. We are now beginning to experience the social consequences of future energy shortages. In the absence of the package of policies proposed, the social and health problems caused by higher energy prices will continue. Of course such policies will be expensive. But so too will be the consequences of ignoring the problems that arise when people cannot afford adequate heat and light for their homes.

Energy policy decisions can no longer be taken in isolation. They have already had a major social impact and will continue to do so.

An integrated response is now required — and soon.

Toby Harris is Planning and Liaison Officer for the Electricity Consumers' Council and Chair of Social Services in Haringey. He is co-editor with Jonathan Bradshaw of Energy and social policy — *£6.95, Routledge and Kegan Paul.*

Scanner

Direct your interests

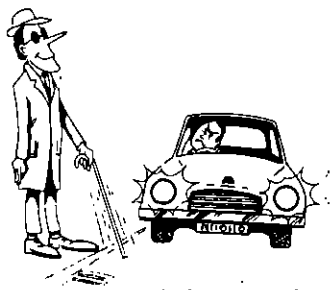
Directories can provide useful reference lists and hospices and medical research charities are listed in two recent documents. St Christopher's Hospice's directory supplies information on in-patient units, home care teams and hospital support teams in the UK and Eire as well as hospice projects. Backed up by an information service it provides contacts for people interested in the development of hospice-type care. Copies from St Christopher's Hospice, 51-53 Lawrie Park Road, Sydenham, SE26 6DZ. The rundown on medical research charities is given in the Association of Medical Research Charities directory. It explains the conditions for applying for one of their grants and the percentage of funds spent on research. Copies from the Association at the Development Trust for the Young Disabled, Royal Hospital and Home for Incurables, West Hill, Putney, London SW15 3SW.

Asbestos again

A comprehensive report from the independent Labour Research Department entitled *Fighting asbestos at work and at home* comes complete with a warning sticker and case studies of the harmful effects of the material in the past. It alleges a lack of government concern at the highest level and predicts 50,000 asbestos-related deaths in the next 30 years. Copies are £1 inc post from the Labour Research Department, 78 Blackfriars Road, London SE1 8HF.

The full proceedings

If you missed the King's Fund Centre's conference *Health promotion: the challenge for CHCs* in June — see *CHC NEWS* 88 page 12 — a report has been published by the centre and is available from the King's Fund Centre, 126 Albert Street, London NW1 7NF or Tel 01-267 6111 — price 50p inc post.



Apparently obvious ways for drivers to help blind pedestrians may be more of a hindrance. So says the Automobile Association's latest *Roadsense* leaflet. Designed as a step-by-step guide for drivers, it warns that 75% of blind people are over 65 and may suffer from other disabilities such as poor hearing. Entitled *About the driver and blind people* it covers the many different circumstances that face the motorist when blind people want to cross the road. The leaflet is free from all AA centres — further information from the Royal Institute for the Blind, 224 Great Portland Street, London W1N 6AA.

Vital statistics

A newsletter on the complicated world of statistics has been published by the Office of Population Censuses and Surveys — simply called OPCS. Intended to keep people at all levels in the NHS up to date with latest news, it will also build to be a useful reference index for regular users of statistics. Birth and death rates, cancer registration surveillance, the 1981 Welsh census, new towns, congenital malformation and fertility have all had the OPCS microscope on them this year and the new quarterly provides a readable index and background. Copies are free from *Newsletter to the NHS*, Vital Statistics Branch, OPCS, Titchfield, Fareham, Hants PO15 5RR.

The point of hygiene

The new law on skin piercing introduced last year comes under scrutiny in consultant Norman Noah's new booklet *A guide to hygienic skin piercing*. Tattoos, ear piercing, acupuncture and hair electrolysis all have new health and safety rules which require them to be registered with the health and local authorities with guarantees of safety from infection — see *CHC NEWS* 90 page 3. Hepatitis can be transmitted during skin piercing and Dr Noah's guide gives detailed instructions on sterilization and disinfection. Copies from the Communicable Disease Surveillance Centre, 61 Colindale Avenue, London NW9 with a £2 donation.

With the growth of new technology, many working people are likely to be using visual display units. The Association of Optical Practitioners has been quick to recognise the need for informed guidance and *VDUs and you* is one of 13 new leaflets giving information on eyecare for the public. Others include *What are contact lenses?, See well, drive safely,* and *Eye care in the pre-school child.* For the leaflets write to the Association at Bridge House, 233 Blackfriars Road, London SE1 enclosing a sae (at least 9 inches x 6½ inches) stamped for 16p.

Counting the costs

The controversial relationship between health services and economic viability are in the limelight at the moment with the Government's efficiency drive. At the centre of the row over the NHS are the administrators so a guide to health economics designed to help them can only be a welcome addition to the debate. *Teaching the essentials*

Parliament

Move on CORAD

The *Chronically sick and disabled persons (amendment) Bill* was introduced in the House of Commons by Labour MP Bob Wareing — Liverpool, West Derby — as a private member's Bill on 20 July and is tabled for its second reading on 18 November. As we go to press the text of the Bill has not yet been published, but its aim is to implement recommendations from the committee on restrictions against disabled people — see *CHC NEWS* 83 pages 4 and 5. Mr Wareing came second in the ballot of MPs wishing to introduce Bills, and the timetabling of his Bill may be affected if the ballot winner's Bill — on video 'nasties' — requires lengthy discussion.

Earlier abortions

Figures for 1981 show that 95% of all abortions were performed below 17 weeks of pregnancy — a rise of 3.9% on 1980 figures which may be accounted for by new notification procedures. But a larger proportion of abortions in 1981 were performed at a very early stage of pregnancy — 31% at less than nine weeks compared to a steady 23% to 24% in the late 1970s. Just over 12½% of abortions were performed between 13 and 16 weeks of gestation from 1976 to 1980 — but this dropped to 10.6% in 1981 (Jo Richardson, Barking, 28 July).

Contra-dictions

From 1977 to 1982 the number of people attending family planning clinics for contraceptive advice fell by around 60,700 — from 1,521,400 to 1,460,700. The number of women whose GPs claimed a fee for providing them with contraceptive advice rose by around 231,600 — from 1,959,000 to 2,190,600. The DHSS keeps no record of how many GPs hold certificates from the Family Planning Association or the joint committee on contraception.

From 1971 to 1978 female sterilisations performed after abortions dropped from 14,193 to 7971 and the estimated number performed after childbirth dropped from 26,650 to 13,940 while the estimate of sterilisations performed independently rose from 20,880

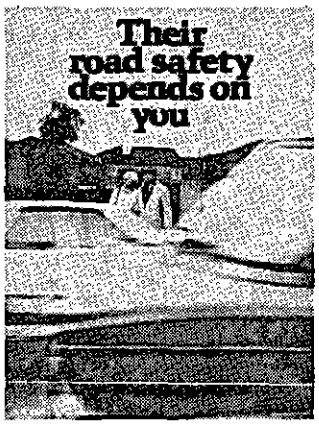
of health economics was jointly written by Gavin Mooney of the health economics research unit at Aberdeen University and Mike Drummond of the health service management centre at the University of Birmingham. Such is the paucity of background training in health economics that the authors only claim to give a skeleton guide to teaching such sums and anlysis. The bulk of their material derives from a World Health Organisation workshop in Copenhagen in 1982 and a series of articles by the authors in the British Medical Journal. The guide is available at £2.50 inc post from Mrs I Tudhope, Health Economics Research Unit, Medical School, Foresterhill, Aberdeen AB9 2ZD. Also available are two discussion papers — *Equity in health care: confronting the confusion* by Gavin Mooney and *A cost-effectiveness analysis of ante-natal care* by J J Artells Herrero, ID Fordyce and Gavin Mooney. Both cost £2 inc post from the same address.

Keep in touch

The effects of hysterectomy have inspired the Hysterectomy Support Group and their blend of personal experiences, listings and useful information will make a valuable reference point. Published three times a year, *HSG newsletter* costs £1 per year from the editor, 11 Henryson Road, London SE4 1HL.

The *British journal of visual impairment* is designed to "provide information and stimulus for all those professionally concerned with children and adults who have a visual impairment". Published three times a year it is available in inkprint, braille and on tape. Single copies £1.50 from the Southern and Western Regional Association for the Blind, 55 Eton Avenue, London NW3 3ET.

Children's and young people's rights are the subject of *Childright* issued by the Children's Legal Centre. Covering proposed law and policy developments from a legal perspective, issue one includes forcible drugging in care. Monthly but missing August and December, a special introductory offer gives you subscription until January 1985 for £15. Available from Children's Legal Centre, 20 Compton Terrace, London N1 2UN.



Eight million elderly people are the target of a joint campaign to protect them from death or injury in their own homes. *Safety in retirement* is the campaign booklet from the Royal Society for the Prevention of Accidents in conjunction with Age Concern. Some 100,000 pensioners succumb to home hazards each year and the booklet provides a comprehensive rundown on the danger spots throughout the home — available at 30p inc post from sales department, RoSPA, Cannon House, Priory Queensway, Birmingham B4 6BS.

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 29p in stamps.

Page 3: South Tyneside CHC Chair: Mrs I Lenderyou
Page 3: Leeds Western CHC Chair: Shelagh Lyons
Page 3: York CHC Chair: Cllr Jack Tate
Page 3: Huddersfield CHC Chair: D Haughey
Page 3: Bradford CHC Chair: J P Gaffney
Page 5: Barnsley CHC Chair: Cllr Gerald Hadfield
Page 6: Hillingdon CHC Secretary: Carolyn Harding
Page 6: Hounslow and Spelthorne CHC 55 Church Road, Ashford, Middlesex Tel: Ashford 59548. Secretary: Ms E A Blanche
Page 7: Basildon and Thurrock CHC Chair: Margaret Robertson
Page 9: Mid-Downs CHC Chair: Dr D M Goodwin
Page 12: Shropshire CHC Chair: Malcolm Soutar
Page 13: South Birmingham CHC Secretary: Janet Upward
Page 14: Lancaster CHC Chair: Mrs B E Alexander
Page 18: Yorkshire Regional Council of the Association of CHCs Chair: Mrs E Mullineaux

Health circulars

HN(FP)(83)24: announces amendments to fees for dental practitioners from 1 April 1983.
HN(FP)(83)27: gives revised prices and discounts for standard drugs and preparations.
HN(FP)(83)31: summarises those provisions of the *Mental health Act 1983* which come into force on 1 September including new regulations on patients' consent to treatment.
HC(83)19: outlines new provisions under the *Mental health Act* for records and access to information for the Mental Health Act Commission.

Statutory instrument

The Mental health review tribunal rules 1983 (No 942) have been published giving the procedure for detaining patients under the *Mental health Act*. They replace the old rules of 1960.

to 53,310.

Vasectomies performed in family planning clinics rose from 11,368 in 1974 to 18,097 in 1978 but dropped back to 14,189 by 1981. Estimates of NHS hospital vasectomies fluctuate between 4340 and 2380 in the period 1974 to 1980 for in-patient cases, but day cases show an increase from 15,080 in 1975 to 36,810 in 1980 (Gwyneth Dunwoody, Crewe and Nantwich, 24 October).

Meritocracy

Merit awards paid to NHS consultants have annual values of — grade C: £4,170, grade B: £9,365, grade A: £15,650 and grade A+: £20,315. Part-time consultants receive *pro rata* payments and the awards form part of salaries for superannuation purposes. Merit payments are awarded by the Secretary of State on advice from a committee drawn from the Royal colleges, the Faculty of Anaesthetists, universities, the Medical Research Council and other consultant representatives, with an independent lay vice-chair. Awards are made for distinguished service to the NHS or — grades B and C — long and meritorious service. Each region's list of award holders is available to all consultants employed in the region but is not otherwise published (Gwyneth Dunwoody, Crewe and Nantwich, 18 July).

Griffiths in Wales

Secretary of State for Wales Nicholas Edwards considers that although the NHS management inquiry examined health services in England, the principles behind its recommendations — particularly on general management — are equally applicable to Wales. He will be studying the inquiry team's report in detail and will draw up proposals appropriate to the organisation of health services in Wales.

Counting our costs

In 1981-2 the total cost of English CHCs was £5.4 million and CHCs in the North West Thames region cost 10% of the overall figure. More recent figures are not yet available centrally (John Wheeler, Westminster North, 27 July).

News from CHCs

□ Norman Fowler's postbag must be bulging judging from the number of CHCs writing in protest at the Government's "manpower" cuts. Indignation and condemnation have emanated from every region with many CHCs going further with their protests by organising meetings and rallies to support health authorities not implementing the cuts.

□ **Brent CHC** sponsored a major rally with their local council and trade unions to support their health authority which has refused Government orders — pointblank.

□ **Sunderland CHC** has held a public meeting on NHS cuts as part of a joint initiative with local trade unions and more meetings are being planned following its success.

□ **East Hertfordshire CHC** has put the case of CHCs most succinctly in writing to the Secretary of State — "Cuts of this magnitude in an already underprovided district may entail major changes in the provision of health services to local people. Indeed the nature of the change is foreshadowed in the health authority's plan which says that unless the district is provided with more resources, it may be reduced to an 'emergencies only' service, a prospect which the CHC finds unacceptable."

□ **Leeds CHC** told the Minister: "The juggling of money within the DHSS budget that deprives hospital and community services of over £100 million does not constitute an adherence to election pledges made in your manifesto."

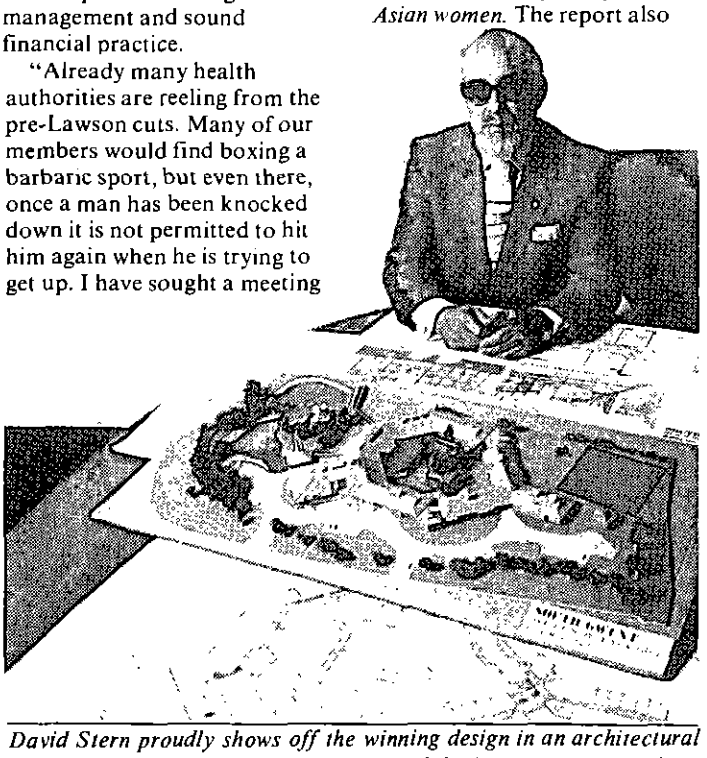
□ **Paddington and North Kensington CHC** has concentrated on pressurising the local DHA — which has decided to refuse to make the staff cuts but is going ahead with the financial savings. "There is no point in having the freedom to decide how many staff are needed to run health services, important though that is, if the DHA does not have enough money to pay staff, build and maintain the premises and buy the equipment needed to provide decent health services for Paddington and North Kensington" says the CHC.

□ In the Yorkshire region **Calderdale CHC** has approached its two local MPs to "discuss the CHC's concern about the future of the NHS in Calderdale."

□ The opposition to the staff cuts is to be co-ordinated by the **Association of CHCs** with a special meeting scheduled for 15 November — see page five.

ACHCEW chair John Austin-Walker commented: "The Government's decisions have nothing to do with 'manpower planning' — indeed they are a negation of that concept. Separation of the control of manpower numbers from planning within financial resources is entirely counterproductive to good management and sound financial practice.

"Already many health authorities are reeling from the pre-Lawson cuts. Many of our members would find boxing a barbaric sport, but even there, once a man has been knocked down it is not permitted to hit him again when he is trying to get up. I have sought a meeting with the Secretary of State to express concern felt by CHCs throughout the country."



David Stern proudly shows off the winning design in an architectural competition run by **South Gwent CHC** *and the* Architect's Journal — *see CHC NEWS 85 page 12. The design has received a tremendous response from health authorities all over the country who were sent details by the CHC. Around 60 replied in the first week to say they would seriously consider using the design for a health service centre for physically handicapped people. David and his colleague Alan Sharp of Opera Omnia Design Centre in London beat competitors from all over the UK. Their prize was £1,500 and an exhibition along with other prize-winning entries in London throughout October. The CHC now has the backing of the local health authority for the design and is pressing the Welsh Office to agree to its construction.*

□ The **Greater London Association of CHCs** has got the green light for launch with 27 of the 31 London CHCs voting to join. The Association, which replaces the London Study Group, will have the immediate task of helping administer a grant of £52,632 made to ACHCEW by the Greater London Council. The grant will fund a research unit to look at the special needs of the health services in London. Correspondence for the new association is being handled by **Hampstead CHC.**

□ Two London CHCs have made determined efforts to broaden their appeal in local Asian communities. **Newham CHC** has prepared a report on the health needs of ethnic groups which has been accepted by the local health authority and a special language training course set up. Also organised is a course entitled *Maternity care for Asian women.* The report also highlights the need for special diets for local groups and the district dietician has promised to take it up. **Ealing CHC** has moved a state further by translating their health authority's booklet — *Bringing your child into hospital* — into Punjabi.

□ Violent threats to staff have encouraged **Wandsworth CHC** to organise self-defence classes. The threatening attentions of unstable passers-by have forced the CHC to end its open-door policy and see the public by appointment only. The South West Thames RHA agreed to look at security measures for the office but a £5,000 bill was considered too high by the CHC and self-defence classes were suggested instead. The classes have received an enthusiastic response with more than 100 people applying to join.

□ Post-operative wound infections are the subject of a special survey being organised in East Anglia. **West Norfolk and Wisbech CHC** has backed a move by a local GP to run a practice survey of post-operative patients. The CHC says complaints are running at almost one a week with some going as far as formal complaints. The results of the survey are expected in a few months and are being collated by the local GP representative on the West Norfolk and Wisbech DHA. The CHC is also hoping that community nurses will report cases on their rounds.

□ **South Manchester CHC** has also initiated an investigation into medical care for patients at Strangeways Prison. Although officially outside its remit, the CHC has written to the Home Office and local MPs expressing concern at press reports of inadequate treatment for mentally ill or physically disabled prisoners. The CHC is particularly concerned at the lack of monitoring of prisoners' health care and problems caused by fire damage to the prison's hospital wing. So far the CHC has received little response from the Home Office but has passed on its correspondence to ACHCEW and is meeting local MPs.

□ A GP has invited **Tower Hamlets CHC** to make informal visits to his surgery — and will ask his colleagues to make the same gesture. The district scene has changed radically since the CHC's inception — from no health centres and many single-handed, elderly GPs to six health centres staffed by younger GPs trained locally at the London hospital medical college. Now Dr James Docherty wants the CHC to see at first hand that the remaining older GPs are still giving a good service.