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Health Promotion: The challenge for CHCs

A REPORT OF A CONFERENCE HELD AT THE KING'S FUND CENTRE ON

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KING EDWARD'S HOSPITAL FUND FOR LONDON

HEALTH PROMOTION: THE CHALLENGE FOR CHCs

Chairman: Dr Rod Griffiths

District Medical Officer, Central Birmingham Health Authority
(formerly Chairman of the Association of CHCs for England and Wales)

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The conference was organised by Mr David Hands, Regional General Administrator, West Midlands RHA (formerly Assistant Director, King's Fund Centre) and Marcia Saunders, Secretary, Islington CHC.

PURPOSE OF THE CONFERENCE

The conference was sponsored by King Edward's Hospital Fund for London, the Association of Community Health Councils for England and Wales, the Unit for the Study of Health Policy and the Health Education Council.

Background

A number of recent developments in health policy in the UK have highlighted the importance of the positive promotion of health and the prevention of disease and disability. For example, recent publications such as the Black Report on "Inequalities in Health" have emphasised the need to plan imaginatively for the health of future populations. The activities of the Health Education Council have drawn attention to the importance of individual and collective responsibility for maintaining and promoting healthiness. The World Health Organisation sees "education for health" as a vital component of its programme of Primary Health Care within its global programme to achieve "health for all by the year 2000".

Some recent developments (for example, the compulsory wearing of car seat belts) seem to support the move towards a more preventive strategy, but perhaps the lack of equivalent action against smoking and alcohol consumption is a move in the opposite direction. There has also been strong criticism that a positive health promotion policy is unlikely while such social objectives are subordinated to economic policy.

Objectives

CHCs have a responsibility to articulate the views of local communities about the policies of, and services provided by, health authorities. The purpose of this conference is specifically to examine the role of the Community Health Council in relation to health promotion and health education. How far should and can CHCs influence the development of preventive strategies by health authorities and how far should CHCs become directly involved in such activities themselves?

WELCOME

Mr Graham Cannon, Director of the Centre, extended a welcome to the Chairman, the speakers and participants. He noted that the conference had been vastly oversubscribed and that two hundred applicants had had to be turned away. He said that some plan of action would be formulated with a possible repeat of the proceedings.

INTRODUCTION

Dr Rod Griffiths, District Medical Officer, Central Birmingham HA, Chairman of the Conference, thanked the King's Fund for holding the event and encouraged the participants to share their ideas stressing the importance of the local level.

He regretted the absence of Mr David Hands, Regional General Administrator, West Midlands RHA, who, because of the demands of his new job was unable to give a review of recent developments in health promotion and prevention.

THE SOCIAL, ECONOMIC AND POLITICAL CONTEXT OF HEALTH PROMOTION - A LATERAL THINKER'S VIEW

Dr Peter Draper, Director, Unit for the Study of Health Policy, Guy's Hospital Medical School*

Introduction

After making acknowledgements to the Health Education Council, the Joseph Rowntree Memorial Trust and the Leverhulme Trust for financial support to the Unit and to colleagues at the Unit, Dr Draper began by defining the term Health Promotion. It includes both prevention - of accidents, disease, disability - and promotion in a positive sense. It involves a range of activities from health education and personal services to policy development which might lead to legislation and district policy.

In the political context

The two main traps for CHCs and their involvement in health promotion are that health education can be used to distract CHCs from challenging the health establishment and that CHCs can be led into taking up too much time on administration rather than on key issues of policy.

The answer to this is for each CHC to press for health promotion to be taken seriously in its district but not for the CHC itself to fill in the gaps.

The most crucial issue for CHCs is the future of their existence because of the serious threat from Mrs Thatcher and the "CHC death squad". There are various defensive measures such as

1. showing the difference in role between the District Health Authorities (DHAs) involved in cuts and concentrating on services, and the CHCs being well-informed and able to focus on unmet needs

2. boosting morale by stressing the value of CHCs e.g. publishing a Good Practices in CHCs Report

3. killing the myth that the administrative overheads of the NHS (which include the cost of running CHCs) are high. They are in fact much lower than Europe and the USA (5% versus 12-15% and 21% respectively).

The wrong context

It seems a better balance is needed between health promotion and treatment and rehabilitation and care. The first should not be a rival to the others. In the short term, extra resources for health promotion have to come from treatment and care services but in the long run the UK <u>can</u> afford health promotion. It is a question of how resources are used.

Contrasting approaches to health promotion

Similarly, a better balance is needed between contrasting approaches to health promotion. The Unit for the Study of Health Policy sees three types of health education concerning:

Type 1 - personal responsibility as shown by the Health Education Council approach - a widespread and safe approach

Type 2 - information about services

Type 3 - tackling the environment, social and physical, to make it a healthier one e.g. understanding the causes of accidents - an approach which is rare and risky but essential for headway.

This Type 3 approach involves intervening in the economy, not a new approach when one considers the huge finance and manpower committed by the Victorians to building sewers and developing the water supply. The involvement is political in the sense not of party politics but to do with public policy. Any advance involves social change and this demands strong and subtle handling. Much of Fleet Street, the recession and market ideology form strong anti-health forces.

Here are two examples of careful handling:

- keeping a low profile but seeing that others take the lead e.g. when school meals are being attacked asking a paediatrician in to highlight health risks

- drawing attention to prestigious documents e.g. the Black Report as a reminder that poverty is on the health agenda.

A safe aspect of the political context for CHCs to touch on is the EEC which has funds and personnel that can be mobilised to help to make the local environment healthier.

The socio-economic context

There are five aspects:

1. Continuing high unemployment. Firstly, this adversely affects wider issues of employment such as low pay, health and safety at work, women's employment and the employment of mentally-ill or handicapped people, and the physically disabled. It also affects the health of the families of the unemployed as well as the unemployed themselves because of social dislocation (causing anxiety, stress etc.) and poverty with effects on nutrition and heating, for example.

Secondly, there is the waste of human skills. It would be more logical to take people off the dole and fill some of the staff shortages, in the caring sector of the NHS, for instance. Unemployment (with lost income tax, VAT etc.) costs as much as employment at an average wage.

2. The poor are getting poorer. CHCs should put poverty on the local health agenda e.g. by highlighting the Black Report.

3. There will be continuing pressure on public expenditure. Public services have up to now provided a healthier and safer environment (water and sewage, environmental health, transport).

4. The pressure on public expenditure will get worse. North Sea oil will run out and tax revenues will fall. Health Service funding will therefore suffer and the environment will become more hostile to health.

5. Ecological factors. Resources (e.g. oil and copper) will become scarcer, pollution will increase and the fertility of the land will decrease. Human ecology is synonymous with public health.

Polluting the thinking water

There exist bogus economic concepts e.g. productive versus unproductive. Bacon and Eltis suggest Britain has too many unproductive workers and too few of the opposite. They see productive as equalling "products or services sold". Thus one has the empty classification that sweet manufacturers are productive and dentists unproductive.

Another example is the bogus concept of "real jobs". Similarly, the notion of added value applied to food industry means "the more processing, the better"!

The constructive approach to these conflicts is to challenge the damaging concepts and promote the idea of alternatives in order to develop a health-promoting economy.

Conclusion

Information for health promotion needs to be improved using all available means such as postal questionnaires, students and unemployed people.

We must remember the increasing nuclear hazard and the waste of resources on armaments neither of which we can afford. The World Health Organisation drew attention to these problems in the Declaration of Alma Ata.

* An edited version of this speech can be seen in CHC News, July/August 1983.

INNOVATIONS IN PREVENTION AND HEALTH EDUCATION

i) BY HEALTH AUTHORITIES

Dr June Crown, District Medical Officer, Bloomsbury Health Authority

Dr Crown felt that innovation was not the most pressing need, but that it is of more importance to ensure that action is taken on familiar issues. She shares many ideas with Dr Draper about the importance of the wide spectrum in relationship to health promotion as well as the narrower and more local one that she would now talk about.

Both CHCs and DHAs should have a primary and shared interest in the health of the community and there is much potential for collaboration between them. They can, for example, work together to combat the lack of clear communication about the ways of achieving health, such as the butter/margarine debate, which can lead to the public being confused, and then disregarding health advice altogether. They can also combine resources to produce a wide spread of health promotion activity which is necessary today, when we are dealing with complex human behavioural problems. One hundred years ago it was possible to make major improvements through traditional public health measures. Much can still be done by general environmental control and by fiscal measures such as taxes on alcohol and tobacco. But the real plagues of today - coronary artery disease, hypertension, arthritis - depend on behavioural change. This involves a lifelong approach and people find it difficult to appreciate today what will benefit them years hence.

DHAs generally consider health promotion to be a community service, provided largely through the Health Education Department. The size and structure of such a Department, however, is often questioned. There is a "norm" for the number of Health Education Officers in a District based on resident population. In urban areas, however, it is important to take account of the non-residents such as all the shoppers in Oxford Street, and commuting workers. In addition, the big teaching hospitals not only serve large numbers of patients from a wide locality, but also are major employers whose staff can benefit from health education. The staff, especially those in uniform, are an important reference group. Patients and visitors are often influenced by both the advice they are given by these groups and by the example they set. To avoid confusion there should be consistency in the information passed to and from them. This applies across the board from receptionists to health visitors, who are probably the largest group of health educators and clinical consultants. CHC members are also a reference group with a big potential for health education.

Specific examples of health promotional activities

1. Nutrition. This involves providing basic and clear dietary information about matters such as infant feeding, salt, butter/margarine, animal fats and fibre.

The difficulty lies in the enormity of the framework involved. People's decisions about food relate not only to the actual foods which are eaten but are affected by commercial interests (advertising), employment (how much you can spend on food) and the role of women (working women have less time to cook and may be tempted to rely on "fast food").

Each Health Authority can develop a district dietary policy. DHAs and CHCs can then work together to support the implementation of the policy in

- general hospitals
- long stay hospitals
- hospital staff canteens
- local authority services
  (e.g. meals on wheels, school meals).

It is also possible to take this outside the public sector to canteens on industrial sites. CHCs can be particularly helpful with this because they can take action which is sometimes not possible from within the NHS.

2. Compliance. Many doctors were trained before health education services were widely available, and do not always appreciate the contribution they can make in clinical care. For example, the communication skills of health educationists can be used to help explain to patients about their disease and its treatment. When doctors are shown that health education can benefit them in clinical activities, they are likely to support more strongly other health education work. One example of this is by helping patients to understand and keep to the treatment advised by the doctor for high blood pressure. This prevents strokes and is an example of a positive health promotional activity.

Evaluation of health promotion activities

Because health promotion and health education are easy targets in the face of cuts it is important to justify their activities. In such times money tends to be allocated to acute and long-stay care services.

The evaluation of health promotion activities is difficult methodologically, because you are trying to measure things which have not happened. For instance, the reduction in death rate achieved by stopping people smoking may take a long time to show in the statistics. In the DHA the time scale of resource allocation is much shorter.

It is hoped that academic colleagues in University Departments will help in developing methodologies in this field.

In the meantime you should at least be looking at proxy measures. Changes in knowledge, attitudes and behaviour can be measured and can be related to subsequent changes in risk factors and disease. They can demonstrate to clinicians the effect of health education, and show that health education is being subjected to much more critical appraisal than is often the case for clinical services, on which much more money is being spent.

Summarising the range of the role of CHCs in health promotion

There are two main roles:

1. The questioning role. CHCs must ask the DHA about the allocation of resources for health promotion and ask the clinicians about the advice on prevention which they give to patients.

They must question the government about health, as opposed to health service policy. Issues such as the relationship between fiscal policies and health should be considered.

They must question commercial organisations about their attitudes to health in their products and advertising and about the contribution they would be willing to make to support local health promotion initiatives. Provoking the conscience and continual pressure are very important.

They must question the local community and help the DHAs to identify local needs.

2. The role of collaborator. The CHCs should
   - work with the DHA in establishing policies
   - share publicity
   - be a bridge between local authorities and DHAs
   - put pressure on external forces
   - support local health education departments.

INNOVATIONS IN PREVENTION AND HEALTH EDUCATION

ii) BY COMMUNITY HEALTH COUNCILS

Mr Mike Gerrard, Secretary, Association of CHCs for England and Wales

The role of CHCs - a closer review of the scene

As both Dr Draper and Dr Crown have said, CHCs are not the only bodies equipped to stimulate innovation. DHAs, Social Services, voluntary organisations and the DHSS also have a part to play in health promotion and the development of a new approach.

CHCs are particularly well-placed because of their statutory status, their relationship with DHAs, public representatives and the press, and because they are outside the NHS bureaucracy. These characteristics enable them to feed in good ideas at the point of maximum effectiveness.

The CHCs role is one of advancing the interests of the community, spotlighting issues and raising levels of awareness all round rather than heatlh education as such. Within that role, one important function is not just to promote but to impress the philosophy of health promotion on DHAs, using its own reports, deliberations and recommendations, and the influence its observers can exert at health authority and FPC meetings.

Pressure can draw attention, spark off developments and facilitate innovations.

CHC activities

1. Innovations sponsored or supported by CHCs have included:

   - new methods of providing care for mentally handicapped children in the community
   - mental health teams involving patients and non-professionals
   - "Good Practices in Mental Health" projects (extended now to "Good Practices in Maternity" and perhaps "Good Practices in Solvent Abuse" as well)
   - the Well Women movement.

At first, many CHCs saw the "Good Practices" approach mainly as a consciousness-raising exercise but it has become apparent that the identification and good practice and consequent publicity for it can lead to propagation and adoption elsewhere.

2. Some examples of other CHC projects with a health promotional impact are:

   - CHC Guides to Services
   - the Manchester CHCs' "Thank-U Month", nominating an individual, a unit or a service and leading to the "Health Service Unit of the Year" award
   - public opinion surveys
   - West Essex CHCs "Prevention and Health Days" (a strongly interventionist approach)

- the former St Thomas's CHCs Children Club
- Dewsbury CHCs Multi-coloured Weeks for Children (during the school summer holidays).

3. Areas where CHCs have taken a position on health promotion include

   - opposition to Health Service charges seen as an obstacle to the use of the NHS
   - demands for attention to the isssues raised by the Black Report
   - challenges to some of the "low cost - low service" strategies suggested by DHAs and the notion of community care as a cheap alternative
   - rejecting privatisation where it offers no benefit to the public, but is rather a means of shuffling wage costs (and union problems) on to someone else.

Interestingly, these areas are all obviously political. This emphasises the fact that health promotion is a political subject, and it is short-sighted not to recognise this.

4. At a lower level on the scale of controversy are issues such as

   - the needs of ethnic minorities, women, elderly and disabled people and children
   - pressure for enhanced primary and community services
   - better access to NHS dentistry and opthalmic services
   - smoking, alcohol and dietary campaigns.

These too are political, because the choices made are about the use of resources; because they have an impact on the entire community, and because they have far-reaching, long-term implications.

Health education and the media

CHCs have a part to play in making sure the media put the correct emphasis on the presentation of health issues. They must also encourage the popular press to improve the style of coverage. Media coverage of health questions tends to be superficial, and of a sensational type. There is much media education still to be done.

Summary

CHCs are actively involved in prevention, health education and promotion already. But much that is done is seen as part of their routine activity, and not undertaken at a very sophisticated level. There are many areas not yet touched. Obviously this is a result of the wide brief given to CHCs and the minimal resources at their disposal.

I should like to offer you four health promotional issues of the moment in which I believe CHCs should now become involved:

1. Preparation for pregnancy and parenthood (with all the implications this study has both for education and the health services).

2. The prevention of accidents to children. Most accidents occur in the home, in early childhood and at school. This activity has implications for housing and schools, and will demand a great deal of research effort.

3. Drug safety and iatrogenic disorders (with all the research, ethical, commercial and public protection considerations which that area of investigation entails).

4. Health promotion for elderly people (especially relevant in an ageing society). This comprises the whole process of keeping people healthy, self reliant and active longer as part of a national response to longer life expectancy.

The political backdrop can be regarded as one of stability during the next five years, and the CHCs must use this opportunity to set the agenda before the politicians do. This is part of the challenge to which CHCs must now rise if they are to achieve their potential and make an impact in establishing positive health and its promotion in the national consciousness during the decade to come.

FUTURE STRATEGY FOR HEALTH PROMOTION AND EDUCATION IN ENGLAND AND WALES

Dr David Player, Director, Health Education Council

Introduction

At present there is no strategy as such but the Health Education Council (HEC) are using the framework proposed by the World Health Organisation (WHO) in their call for "Health for all by the year 2000" and share much of the philosophy.

The WHO strategy

The target is to help all people "attain a level of health that will permit them to lead a socially and economically productive life." The question is how this ought to be achieved. They suggest not by bigger hospitals and the high technology approach or by more specialisation but by a strategy based on belief in people. Care is most often provided by lay people. Resources should be going into the primary health care level.

The proposed strategy for WHO has three main components:

1. the promotion of individual and community life-styles conducive to health
2. the reduction of preventable conditions
3. a fundamental change in the health care system so that the whole population is covered.

They say health services should be equitable, adequate, accessible, and acceptable to the people they serve.

These processes are not really happening because health is not being promoted, prevention is being ignored, there is inequality in the provision of services and some services are inadequate. This is a fair assessment in the light of what Dr Draper and Dr Crown said this morning.

Education of the general public is only one component of health promotion and by itself is ineffective. It must be part of a package. This means being allied to legal, fiscal and political measures.

England and Wales and the background

Any policy for health promotion should acknowledge the background of ill-health from which it starts. We have high rates of coronary heart disease, lung cancer, accidents and alcohol abuse. There are the problems of a growing elderly population and high levels of mental illness. The Black Report illustrated the inequalities in the NHS and drew attention to the "pockets of poverty". Clearly there is plenty of scope for improvement.

Educational strategy

Health education demands new educational approaches. It is a marketable product. It should

- boost the value people put on good health
- help people regain confidence in their own ability to cope with health matters
- teach people to become full partners in the health services, not just passive consumers.

At the HEC programmes aimed at the general public have fallen into two main categories:

1. Image-making campaigns. These try to influence the prevalent values and beliefs held by society, for example, boosting the image of the non-smoker, making non-smoking appear attractive and, in contrast, making smoking seem unattractive. In Scotland a deliberate link was made between non-smoking and football because of it being popular with the younger age groups. Through sponsorship the Scottish team for the World Cup were presented as popular non-smokers. On the other hand advertisements were adopted which made a joke of the way smokers smell of stale tobacco.

The methods may be gimmicky but if health education is a marketable product then we should be rivalling our opponents with devices as subtle.

Another example, the Welsh Good Health (Cycle) Race, highlighted the conscious link between health and enjoyable activities.

2. Encouraging active participation by the general public.

Here are three examples:

- the HEC "Look after yourself" campaign encouraging more exercise, healthy eating, non-smoking and relaxation
- the teaching of "lay" skills like how to relax, keep fit and stop smoking (involving 1300 adult education tutors)
- The Great Britain Fun Run in August 1984 round the coast of Great Britain.

Encouraging the public to make better use of existing health services constitutes a big challenge to CHCs. The strategy for attracting people to the preventive services must be much more imaginative. The whole structure of a service may have to change to suit the customer more closely, e.g. the imaginative idea of the Woman's Health Shop in Edinburgh using the shopfront approach.

Also we must educate the public to take part in the planning and running of primary health care services. There is a call for education for a new kind of service which would

- promote higher levels of self care
- encourage mutual aid groups for health problems e.g. MIND
- transfer some medical and technical skills to lay people (like the "barefoot doctor" schemes)
- give more support to people who cope with chronic disease and disability in the home.

Making the healthier choice easier

Health promotion inevitably comes into the role of politics because individuals can only do so much to change their own health for the better.

1. The role of politics. The HEC plans to ask politicians to give more commitment to a health promotion policy

- to increase the price of "unhealthy" products and reduce the price of "healthy" ones
- to restrict advertising and sponsorship by anti-health firms
- to bring in incentives for the agricultural industry to switch to production of more healthy foods
- to give priority to the creation of a healthier, safer environment e.g. by building more recreation facilities and by restricting lead and other environmental hazards.

2. The role of the community. Health agencies need to exert pressure on local policy makers to bring about changes e.g. by creating non-smoking zones, supplying nutritious food in canteens and creating cycle routes.

3. Within the health professions. If there is to be emphasis on primary health care with consumer participation, there will have to be full consultation with and retraining of staff in the health professions to change present attitudes so the service will work.

The challenge for CHCs

Ideas for action include:

- identifying areas for improvement in the community
- advising health services on the consumer's point of view
- helping stage events for the local community
- helping form future health promotion strategy
- pushing for consumer participation.

POINTS ARISING FROM QUESTIONS TO SPEAKERS

1. Big stores have shown a good response to displaying health promotion materials in Darlington especially the Co-op.

2. There was disappointment that so little could be done in the way of major parliamentary legislation today with the resulting emphasis on individual behaviour change. Dr Draper reminded us of the huge costs of an accident - and illness-promoting economy and said that CHCs must increase their pressure. Dr Player said that it was the responsibility of the government to introduce health legislation. Government resources would be better spent in achieving a healthy society by introducing laws to restrict tar, lead, etc. than in maintaining an unhealthy one. Health is too low on the government agenda.

3. Some CHCs are dealing with DHAs who do very little about health promotion; one CHC at least has no Health Education Officer in its District.

4. There is a need to capitalise on fun runs and marathons, the "health is fun" aspect, as there is a feeling that health education condemns everything we enjoy.

5. The role of CHCs and Family Practitioner Committees in relation to particular services was queried. In answer to a suggestion that FPCs could do more, Dr Crown commented that health visitors are often in a better position to promote health education than general practitioners. With regard to the role of health visitors and the promotion of health amongst the younger generation, Dr Draper said that health visitors are skilled but very frustrated because the anti-health environment is not being tackled.

6. In Newcastle, in response to three CHC projects, a health information worker has been appointed funded by Inner City Partnership. The worker liaises with the Health Education Department and the community. It is a three-year post.

7. Local community development workers are showing a growing interest in health and perhaps CHCs should collaborate more. In some cases they need to correct the image of health education as some of its messages are actually offensive and inappropriate to certain target groups. For instance, people living in high-rise flats are often antagonistic to messages from the bureaucracy which is responsible for putting them there in the first place.

8. About NHS services

- DHAs should be responsible for information about services (type 2 education). At present there is from the top an attitude of "these are the services - comply". CHCs need to point out alternative ways of publicising services
- CHCs should invite comments on services
- the NHS needs to develop a welcoming attitude to patients. GPs need to be taught to communicate and hospitals need to extend their provision of immediate care to thinking in terms of the patients' future health.
- CHCs should encourage patients to be more involved rather than passive.

9. For the prevention of illness in Coventry there has been very successful use of a computer to analyse figures for illness in children. Using figures from the DMO on vaccination against killer-diseases, the study showed fewer city children being immunised than middle-class children. Every GP now has a computer pack and with the help of health visitors the rate of vaccination has increased by 9%. This could be extended. Item of service payments could be used as these already give us information on family planning and cervical smears and this could then be mapped and analysed.

10. The persistence of Dover CHC has been rewarded because they now have a real possibility of an Asian liaison officer for health.

11. On a question about the diversification of the tobacco industry, Dr Draper suggested that the HEC could help promote this e.g. by offering an award for the best retraining scheme by industry for healthy, socially useful jobs. The HEC is effective in selling the personal responsibility approach to health promotion (type 1) but it needs to use the same approach for tackling the environment to make it healthier (type 3). Dr Player suggested the participants might send in ideas for an award for type 3 health education.

12. The HEC has urged the government to cooperate on WHOs guidelines on babyfood.

13. The HEC has said it would try to do more on drugs - advice to doctors and patients, drug safety and the promotion of alternatives.

PLENARY DISCUSSION

This consisted of reports from the small discussion groups. A general comment was that many more ideas could have been shared both in the groups and in the plenary discussion had there been more time available. Four questions were posed:

Question 1. Should CHCs be involved in health promotion?

All the groups agreed that involvement was necessary.

Question 2. What approach should CHCs be adopting?

There was a range of answers, many confirming what had been mentioned by the main speakers. To summarise:

CHCs should

- be complementary and not act on their own
- not be directly responsible for health education but support the DHEO and involve GPs
- facilitate a) involvement by local people in health promotion activities and b) dialogue between groups of service users
- identify issues and needs, especially of ethnic minorities
- transmit information about local issues through the local press and radio
- apply pressure where needed
- raise awareness of environmental hazards in the district
- set up structures and self-help groups.

Question 3. What ideas for CHC activities?

CHCs should

- become involved in preconceptual care and preparation for parenthood
- set up well-person clinics
- run campaigns on nutrition and smoking (in particular, the post-operative effects of smoking)
- promote communication between hospitals and GPs. This is urgently needed especially when elderly people are discharged and they do not receive help to achieve and maintain positive health
- ask DHAs to introduce health education into the training of all health professionals and encourage all to use the same language
- produce more guides to local medical services
- use surveys and monitoring techniques to provide information on preventive measures.

Examples of CHC activities included the Positive Health Group in Brighton which gives grants, and in Stockport the plan to award prizes to supermarkets for good practices in relation to health.

Question 4. What ideas for the Health Education Council?

It should

- run a campaign on the care of feet
- develop health-promotional literature that could be used on a local level
- publish a greater number of informative leaflets like those of the Scottish Health Council Education Group
- give an award to cafes and restaurants in an area for healthy food.

CONCLUDING COMMENTS

In closing the conference, Dr Rod Griffiths stressed how important it was to take stock and ask where our community would be in ten years' time.

You can employ the sociological method of force field analysis and draw up a list of all that is against the health of the community and all that is for it. One can then subtract from the "cons" and add to the "pros" and produce a coherent plan. It is essential to press the authorities to have such a plan for the next ten years and to present it as soon as possible. This analysis can be done for each care group, finding out, for example, what exactly is being done about accidents in the case of children or hypothermia in the case of the elderly. CHCs are in an excellent position to increase awareness and involve the general public.

The immediate outcome of the conference will be a report, a press statement and a letter to CHCs about the HEC funds available for them to initiate pump-priming projects. There will be another conference in response to the demand.

LIST OF PARTICIPANTS

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BALDWIN, Mr A	Secretary	West Hants CHC
BATES, Mrs S H L	Secretary	City of Aberdeen LHC
BAYNHAM, Mrs M	Member	Cheltenham & District CHC
BEATTY, Mrs S	Secretary	Hammersmith & Fulham CHC
BENNETT, Mr H A	Member	Merton & Sutton CHC
BERESFORD, Mr M	Member	Cheltenham & District CHC
BIRD, Mr D	Chairman	Walsall CHC
BLAY, Mr J	Member	Waltham Forest District CHC
BOLTER, Mrs V	Member	Newcastle CHC
BORLEY, Ms R	Secretary	Richmond, Twickenham & Roehampton CHC
BOWDEN, Mrs J S	Secretary	West Cumbria CHC
BRADFORD, Mr A J	Secretary	Northallerton District CHC
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