

# BRITISH MEDICAL JOURNAL

SATURDAY 23 MAY 1987

## LEADING ARTICLES

Cervical smears: new terminology and new demands	H FOX	1307
Should sympathomimetics be available over the counter?	ANDREW WHITEHOUSE	1308
Special units for acute upper gastrointestinal bleeding	MICHAEL W DRONFIELD	1308
Hospices for children?	T L CHAMBERS	1309
Regional secure units: arriving but under threat	PETER RICHARD SNOWDEN	1310
Why do women live longer and is it worth it?	ALAN J SILMAN	1311
Services for people with epilepsy	P K NEWMAN	1312

## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Colposcopy in a family planning clinic: a future model?	H C KITCHENER, R A BURNETT, E S B WILSON, J W CORDINER	1313
Cigar and pipe smoking and myocardial infarction in young men	DAVID W KAUFMAN, JULIE R PALMER, LYNN ROSENBERG, SAMUEL SHAPIRO	1315
Early respiratory experience and subsequent cough and peak expiratory flow rate in 36 year old men and women	NICKY BRITTEN, J M C DAVIES, J R T COLLEY	1317
Migration of gall stones	T V TAYLOR, C P ARMSTRONG	1320
Probable amniotic fluid embolism precipitated by amniocentesis and treated by exchange transfusion	JULIE DODGSON, J MARTIN, J BOSWELL, H B GOODALL, ROBERT SMITH	1322
Danazol and benign intracranial hypertension	AJAY SHAH, TIM ROBERTS, I N F McQUEEN, J G GRAHAM, KATE WALKER	1323
Clinical evaluation of lysuride in the management of hyperprolactinaemia	P M G BOULOUX, G M BESSER, A GROSSMAN, P J A MOULT	1323
Does atenolol have an effect on calcium metabolism?	C J BUSHE	1324
Successful cadaveric renal transplantation from a donor who died of cyanide poisoning	P W G BROWN, J A C BUCKELS, A B JAIN, P McMASTER	1325
Screening for cervical cancer: a new scope for general practitioners? Results of the first year of colposcopy in general practice	JANE CHOMET	1326

## MEDICAL PRACTICE

Benefits and risks of childhood immunisations in developing countries	JOHN D HOLDEN	1329
Refusal to treat AIDS and HIV positive patients	RAANAN GILLON	1332
ABC of AIDS: AIDS and the lung	ANN MILLAR	1334
Complacency in diagnosis of cervical cancer	M J CAMPION, A SINGER, H S MITCHELL	1337
Remuneration of Soviet medical personnel	MICHAEL RYAN	1340
Effectiveness of publicity campaign encouraging earlier referral of hearing loss in adults	R L KING, BRIGIT BARRY, D N BROOKS	1342
Medicine and the Media—Contribution from TONY DELAMOTHE		1341
Any Questions?		1331, 1333
Medicine and Books		1344
What's new in the new editions?	CLIFFORD HAWKINS	1347
Personal View	SIDNEY CROWN	1349

CORRESPONDENCE—List of Contents	1350
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OBITUARY	1360
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## NEWS AND NOTES

Views	1357
Medical News	1358
BMA Notices	1359

## SUPPLEMENT

The Week	1361
That was the parliament that was	JOHN WARDEN 1362
From the CCHMS: Progress report from management board's finance director	1363
BMA approves guidelines on child abuse case conferences	1365
Funding undergraduate medical education	1366

# CORRESPONDENCE

<b>Inequalities and the new Health Education Authority</b> A M B Golding, FRCM; E J Brunner, MSc ..... 1350	<b>Pinch skin grafting or porcine dermis in venous ulcers</b> L O Simpson, MD; K R Poskitt, FRCS, and C McCollum, FRCS ..... 1352	<b>Better reporting of adverse drug reactions</b> A W Asscher, FRCP ..... 1355
<b>Inequalities in health in Britain: specific explanations in three Lancashire towns</b> P Sleight, FRCP; D J P Barker, FRCP, and C Osmond, PhD ..... 1351	<b>Respiratory health workers visiting patients with chronic respiratory disability</b> A Cockcroft, MRCP, and others ..... 1353	<b>Points</b> Atlantoaxial instability in Down's syndrome (P M Spargo); Overuse of monitoring of blood concentrations of antiepileptic drugs (F J Abajo and others; J H B Scarpello and N Cottrell); Ectopic pregnancy in Finland 1967-83: a massive increase (P E Schlesinger) ..... 1355
<b>Breadth versus depth</b> D Brooks, FRCGP, and E Dunbar, MRCP ..... 1351	<b>Unemployment and mortality</b> K A Moser, MSc, and others ..... 1353	<b>Supersonic jet lag</b> (G Bennett); 75 Deaths in asthmatics prescribed home nebulisers (D J Godden and others; D Murphy); Autologous blood transfusion (A Hedley Brown); Deep vein thrombosis after stroke (P A O'Neill); Erythema migrans borreliosis or Lyme disease? (J Haworth); Preventing AIDS (A Comfort); Portraits from memory (M H P Sayers) ..... 1356
<b>Effect of protein restriction in insulin dependent diabetics at risk of nephropathy</b> A Polak, FRCP, and D Rowe ..... 1351	<b>Fall in intraocular pressure during acute hypoglycaemia in patients with insulin dependent diabetes</b> D F P Larkin, MRCPI, and P Eustace, FRCS; B M Frier, FRCP, and others ..... 1353	
<b>Infection by airborne Chlamydia trachomatis in a dentist cured with rifampicin after failures with tetracycline and doxycycline</b> M Viswalingam, MB, and others; M Midulla, MD, and others ..... 1352	<b>AIDS and the heterosexual epidemic</b> A J Pinching, MRCP; Anne M Johnson, MRCP, and M W Adler, FRCP ..... 1354	
	<b>State of the public health</b> A Smith, FRCGP ..... 1354	

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## Inequalities and the new Health Education Authority

SIR,—It would be unfair to dismiss *The Health Divide*<sup>1</sup> because of its political bias (4 April, p 857; 9 May, p 1230). It has brought together much detailed and important research, and many of the issues it raises would, if presented differently, command wide support.

The main problem is that the report is concerned with inequalities rather than actual standards, so anything that improves the level of health in all social classes but which has mainly benefited the higher social classes can be pilloried as increasing inequality. Thus the figures for cigarette smoking show that in 1972-84 there was a progressive reduction in all socioeconomic groups, but, while the prevalence of cigarette smoking in men over 16 in the professions fell from 33% to 17%, in unskilled manual workers it fell less, from 64% to 49%. If the prevalence of smoking related disease follows that of smoking then the inequality in health between socioeconomic groups attributable to these diseases will have increased. In 1972 the ratio was 1.9 while by 1984 it had become 2.9. By this measure the whole effort to reduce cigarette smoking would appear to have been counterproductive, which is manifest nonsense.

The authors base their approach on the World Health Organisation's strategy Health for All by the Year 2000, which aims at reducing the actual difference in health state between groups. This has the advantage of drawing attention to the needs of those with the worst health, but it is oversimplistic and will alienate many who want to improve the health of the whole community, including especially the poor.

The main divide between the political parties in

Britain is between those who want to distribute the existing cake more evenly and those who want to enlarge the cake so that each portion can be increased. This report will be warmly welcomed by those whose politics are left of centre and severely criticised by the rest.

The authors pay tribute to the health services in the Netherlands and Sweden; but these are rich countries, and richer countries can and usually do spend more on health than poorer nations. In 1983 the expenditure on health per head was £548 in the UK, £988 in the Netherlands, and £1424 in Sweden.<sup>2</sup>

The report is useful in highlighting specific areas for further research and action. For example, the high mortality from hypertension and stroke among people of Afro-Caribbean descent and the high mortality rates for babies of mothers born in Pakistan should stimulate further research and appropriate provision. Success in reducing these problems is likely to reduce the cost to the health service by reducing the levels of hospital provision required, so the injection of modest sums of money may well produce better health for these groups at little cost.

It is not easy to define health, let alone decide how best to allocate resources to improve it, but we should be developing a strategy for spending the increasing amounts of money likely to be available for health as the country becomes more affluent. This strategy should be based on concepts that are less politically divisive than this report, targeted more precisely, and give priority to measures which will help those most in need.

If the report, with all its inadequacies, stimulates

better services, especially for those most in need, then it will have served a useful purpose.

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- 1 Whitehead M. *The health divide: inequalities in health in the 1980s*. London: Health Education Council, 1987.
- 2 Office of Health Economics. *Health expenditure in the UK*. London: Office of Health Economics, 1986.

SIR,—Dr P B S Fowler (9 May, p 1230) deplores "emotive utterances . . . misleading statements" as "worrying propaganda tricks" in the debate surrounding the future of health inequalities in Britain.

He appears to take exception to the view that if the less well off do not have a decent diet this may partly be because of insufficient money. His conviction that the poor have no one to blame but themselves (as far as healthy eating is concerned) is based not on an analysis of the research literature of official statistics but on anecdote: "wives (sic) could tell that a stew made of neck of mutton with onions, carrots, and swedes is more nutritious and cheaper than the packaged convenience foods that are bought in such huge quantities."

Eight million people in Britain depend for all or part of their income on supplementary benefit. A study of goods and services that could be afforded by this section of the population conducted in 1986<sup>1</sup> and based on Family Expenditure Survey figures does indeed show that for a couple with two