for better suppression of inflammation by dietary modulation.

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Health needs of the homeless

Homes are cheaper than bed and breakfast

Half a million pounds is spent each week on bed and breakfast accommodation for London's homeless.[1] Most of the families who live in this depressing, dreary way have become homeless because they cannot afford to rent or buy and local authorities cannot provide any alternative. In the past 25 years the number of dwellings available for rent in Britain has dropped by one million. The number of households in temporary accommodation has doubled since 1981 and reached 30 100 in England in December 1988.

Among the many problems of the homeless is getting medical care when they need it, and this issue has now been examined in a joint report by the Health Visitors' Association and the General Medical Services Committee of the BMA.[2] Part III of the Housing Act 1985 requires local authorities in England and Wales to house homeless people with special needs—children, pregnant women, the elderly, the disabled, and the mentally ill.[3] The number of homeless families offered help by local authorities in England has more than doubled since 1979 and reached 116 060 last year. This does not take into account those who applied for but were refused help—more than 400 000 households since 1982.

People living in overcrowded temporary accommodation face many health risks.[4] Children come down repeatedly with diarrhoeal illnesses and chest infections, and homeless women are twice as likely to have problems and three times as likely to be admitted to hospital during pregnancy as other women. Accidents and fires are substantial hazards. Depression and stress among parents may predispose them to abuse their children. Health visitors are concerned about the nutrition of people in bed and breakfast accommodation.[5] Many families have to vacate the premises between 10 am and 4 pm, and when they are allowed back they have to share inadequate cooking facilities with many other families.

Mothers and young children are among the largest consumers of primary health care, and when their health is endangered by their living conditions it becomes even more important that they have easy access to high quality health services. Some general practitioners are reluctant to take homeless people on to their lists. Families in temporary accommodation may hope that it will be for a short time and may fail to register with local general practitioners or do so only as temporary residents, in which case their notes will not be forwarded to their new doctor. Such families may then use accident and emergency departments when they need medical help, but this is not the best way to provide continuing care for families with young children and is a waste of those resources.

The report emphasises the need for more information about homeless families and highlights the problems faced by general practitioners in areas where there are many dwellings in multiple occupation. It suggests that each district health authority should have a liaison officer for homeless persons who has responsibility for informing health visitors about the arrival of a new family, arranging transfer of the relevant notes, and informing the family practitioner committee about the number of families in temporary accommodation. Another possibility is the wider use of client held records to reduce some of the problems caused by the frequent transfer of notes.

The report calls on the government to consult with the BMA about ways of removing financial and organisational barriers that inhibit homeless families from gaining access to primary health care. It suggests that general practitioners should receive a registration fee for new patients and that patients accepted on to a list as temporary residents should count towards the list size. The recommendations in the report are an attempt to improve the provision of primary health care to homeless families, but the real answer to these problems is to provide permanent homes at affordable rents.

Since 1980 the government has encouraged council tenants

to buy their homes, but local authorities are entitled to use only a quarter of the capital receipts from house sales and half of those from land sales for new building. The government also restricts how much local authorities can borrow to pay for renovations and building. These policies are leading to a remorseless reduction of public housing stock and a deterioration in its quality. It costs up to £24 000 a year to place a family of three in bed and breakfast accommodation in London. In 1987 it was twice as expensive to keep a family in bed and breakfast accommodation as to provide a new council flat. As the report says, "Homes are cheaper than homelessness." It must be time to recognise these humanitarian and economic arguments and start investing in public housing.

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Save the general practice record

Or else future historians may not know how the NHS worked

In Britain general practitioners and their predecessors, the surgeon apothecaries, have always treated most episodes of illness for which a doctor is consulted. For anyone interested in the history of sickness and health the records of general practice are at least as important as those of hospitals and other medical institutions.

Few general practice records from before the National Health Service have been preserved. Today, however, records are kept routinely in the National Health Service, and Britain is one of the few countries with a standard form of medical records for primary care, covering most people from birth to death and following them from one area to another. And these are more than the records of primary care: they include hospital consultations, admissions, and investigations. Hospital records are mainly concerned with isolated episodes of illness; records of general practice, for all their imperfections, are the only comprehensive records of all the medical care patients have received throughout their lifetime. Although record keeping in general practice has often been abysmal, some general practitioners have kept excellent records and the standard of record keeping is rapidly improving.

Unfortunately, the same complicated system that ensures the continuity of records of general practice while patients are alive also ensures that these records are systematically destroyed when patients die. Unless deliberate plans are made to preserve some records from general practice few will be available to historians, epidemiologists, or anyone else concerned with research into health care since the beginning of the National Health Service. Some have already been preserved at the Contemporary Medical Archives Centre at the Wellcome Institute in London, and a few at other institutions. Nevertheless, there is a danger of reaching the absurd position that records from general practice in the second half of this century are scarcer than those of the eighteenth and nineteenth centuries.

It may not be generally known that records do not have to be destroyed: general practitioners can, after consulting their family practitioner committees, retain the records of their patients when they die. One of us (JTH) has preserved the records of all his patients who have died over the past 20 years and is supplementing these by microfilming the records of patients now registered with his practice. These records will be deposited at the Contemporary Medical Archives Centre.

In an ideal world representative samples of records from general practice from all parts of Britain would be preserved in the record offices of the relevant counties. But this is unlikely: added to problems of preservation are those of confidentiality. There are no absolute rules, but it is generally agreed that access should be allowed to "bona fide" scholars provided nothing is published that could lead to the identification of patients. The power of deciding who is a bona fide scholar is usually vested in the authority preserving the records and the originators of the records or their successors.

It is worth the trouble. Although a wealth of material on primary care has been published, the original records are not superfluous. Published data are important, but for certain kinds of research there is no substitute for the original records. Senior practitioners who have accumulated records from before or after the start of the National Health Service that urgently need preservation and younger doctors wanting advice on preserving their records should contact their local record office or one of us.

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Correction

Control of meningococcal disease

An editorial error occurred in this editorial by Dr D M Jones (4 March, p 543). The telephone number of the meningococcal reference (Scotland) laboratory is 041 946 7120 and not 041 946 7129 as published.