an important change. It is in the re-evaluation of chemicals, after they have been cleared for commercial use, that the current system is most lacking. In the United States and Canada, both of which were visited by the committee, pesticides must be relicensed every five years, and programmes to reassess "older" compounds are in progress.

The call for more epidemiological research into the long term effects of pesticides may not meet with universal enthusiasm. Because of the difficulties in unravelling complex patterns of past exposure and the rarity of many of the diseases that may be increased by pesticides, studies often fail to produce clear cut results. They do, however, influence regulatory decisions, and scientists must respond to the public demand for information. In the long term the task of the epidemiologist will be made easier if the report's recommendation of a standard record system for pesticide users is adopted.

Much emphasis is placed on the need for more openness in evaluating pesticides. Experience in North America suggests that concern for protecting trade secrets has been exaggerated, at least in relation to health and safety data. The dissemination of information about efficacy must also pose a threat to commercial security, but without it risks cannot be weighed against benefits. The report says little on this important subject. Perhaps with adequate protection of patients a fair arrangement for the release of data could be agreed.

In addition to its main theme the report makes several peripheral recommendations. Some—for example, the suggestion that chemicals with suspected (although not proved) chronic health effects should carry a government warning—are fraught with practical difficulties. Others, such as the proposals for childproof packing of more toxic products, standards for protective clothing, and encouragement of improved methods of pesticide application, seem eminently sensible.

DAVID COGGON

Epidemiologist,
MRC Environmental Epidemiology Unit,
Southampton General Hospital,
Southampton SO9 4XY

1 House of Commons Agriculture Committee. *The effects of pesticides on human health. Vol 1.* London: HMSO, 1987.

Partnership for health: voluntary organisations and the NHS

The government's recent attempts to encourage health authorities to support and cooperate more with voluntary organisations have met with some scepticism. Doctors and others question the role of the voluntary sector, managers are wary of the additional costs, and trades unions fear the spectre of volunteers as alternative cheap labour—a concern shared by the voluntary organisations themselves. All parties have reason to be cautious, but many of their worries arise because one does not know enough about the other's roles. Thus health authorities fail to recognise the diversity of voluntary organisations, whose activities extend from self help and raising funds to providing services and campaigning. In turn the often poor understanding by the voluntary organisations of National Health Service bureaucracy limits their ability to achieve a successful liaison.

Does health care in Britain stand to gain from more cooperation between the statutory and voluntary sectors? A recent report from a group of health authority and voluntary sector representatives believes that it does.[1] In its view the voluntary organisations can complement the NHS by responding to local needs such as those of the minority ethnic groups; they can fill gaps in services by raising extra funds or redirecting public spending from bodies such as the Housing Corporation; they can provide a channel of communication for consumers' views to the health authority; and they can help promote health through activities which improve the environment and lifestyles. Nevertheless, perhaps the greatest asset of the voluntary organisations is their capacity to innovate, a tradition that goes back way before the National Health Service. Recent examples include the hospice movement, respite care, housing for the mentally handicapped, and rural transport schemes—topics in which statutory services and the professions have usually shown little or no interest.

Given these potential advantages, why have most health authorities and voluntary organisations not formed productive partnerships? The lack of understanding of each other's organisation and objectives appears to be the principal reason. The disparate and everchanging nature of the voluntary sector may be bewildering for a health authority seeking cooperation. Conversely, the bureaucracy of the health authority, in which no easily identifiable contact exists for voluntary organisations, contributes to the problem. Clearly many obstacles can be removed, or at least reduced, by simple administrative changes. In addition, to avoid recriminations later, both parties need first to consider the type of partnership they wish to create and to make explicit their expectations.

Broadly speaking there are two types of partnership: consultative and financial. The former provides voluntary organisations with a voice in planning and managing health services and health authorities with access to specialised and local knowledge. Financial partnership may consist either of "arms length" support, in which a voluntary organisation receives a general grant, or contractual agreements, in which a specific service is provided for the health authority on an agency basis. In 1984-5 financial support in England and Wales was about £10m, or less than 0·01% of NHS expenditure—a figure that many voluntary organisations are seeking to increase. Increasing their financial dependence on the statutory sector in this way might, however, threaten a major asset—independence. In addition, any financial support from health authorities will inevitably be subject to the same "value for money" considerations that affect all NHS spending. Voluntary organisations might find themselves having to replace their own criteria with those of the health authority. Hence both partners need to proceed with caution, making their own motives and objectives clear from the outset. But the potential rewards are considerable.

NICK BLACK

Senior Lecturer in Community Medicine,
Department of Community Health,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

1 National Association of Health Authorities/National Council for Voluntary Organisations Joint Working Party. *Partnerships for health.* Birmingham: National Association of Health Authorities, 1987.