Missing: a strategy for the health of the nation

Radical Statistics Health Group
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In 1978, the World Health Organisation (WHO) took the lead in emphasising the need for a clearly defined quantifiable strategy for the promotion of health worldwide.[1-3] Through `Health For All by the Year 2000', WHO called on each of its regions to identify appropriate targets for health to be achieved by the year 2000.[4,5] The UK Government was a formal signatory but has consistently failed to endorse the 38 targets for health identified by WHO's European region[6] despite the fact that over 70 local authorities and health authorities in England have independently adopted the European strategy[7].

Now, after a decade of resistance, does the publication of the Green Paper, *The Health of the Nation*, mark a change in policy?[8] We have serious reservations. Although the government has monitored its progress towards WHO's targets[9], it seems to have rejected many of them and is now setting its own. The targets proposed seem to be restricted by two concerns: to maximise the efficiency or output of the NHS and to change the behaviour of individuals. Absent from the paper are three principles that are central to the WHO strategy. These are the philosophy that all government policies should take into account their impact on the health of the population, the need to redress social inequalities and the importance of community participation. The WHO considers that these principles are essential for any strategy to have a successful impact on the health of the nation.

Why now?

The renewed political interest in targets dates back to October 1990 when Kenneth Clarke, then Secretary of State for Health, announced the intention of developing a portfolio of targets for health care. His view was that " ..."*targets give those in the NHS a tangible objective to aim for. Second, they provide a way of measuring success and evaluating what we are getting for our investment in the NHS. The new NHS structures are in place; we are determined that what they provide leads to major improvements in health*". (Department of Health press

release, October 1990 (90/1487) The impression given is of targets which had less to do with health than with the business management ethos of *Working for Patients*.[10]

The Government's embarrassment over the difficulties caused by the changes to the NHS must have made the idea of announcing a national strategy for health distinctly attractive. In the event, a curious and muddled collection of targets has emerged. Some targets relate to efficiency in the NHS, some to disease prevention, some to health promotion, and others to quality of service. The lack of a unifying framework reflects the absence of overall strategy and of relevant data to implement and monitor it. In view of the way the green paper has emerged, great care is needed to look beneath the superficial gloss of this unreferenced document and to question its likely impact on the health of the nation. Several areas of concern emerge.

A strategy for health?

The first problem is that the document confuses a strategy for health with a strategy for the health service. Furthermore, most of the initiatives are not even new. For example, projects cited include Look After Your Heart, the smoking programme, the joint breast feeding initiative, the workplace scheme and cervical and breast cancer screening.[11,12]

All these programmes over-emphasise individual responsibility without sufficiently considering the barriers which make it difficult for some people to change their lifestyle. For example, the strategy for dealing with alcohol-related diseases is confined to exhortations to keep *"within the sensible drinking limits"*. The document states that *"smoking during pregnancy is associated with low birth weight babies and also a 28% increase in perinatal mortality in babies"*. The proposed strategy is to *"provide information and support to women to enable them to stop smoking during pregnancy"* with a grant of £1 million to the Health Education Authority (HEA). This ignores the evidence that socio-economic factors not only contribute to the likelihood of women smoking but operate independently to increase the risk of having a low birth weight baby.[13] Socio-economic factors also influence smoking among adults more generally: members of the manual classes are more likely to smoke than those in non-manual classes but no

attempt is made to target this disparity. Though the prevention of alcohol-related disease is sensitive to both legislation and pricing, the document contains no specific proposals for legal and fiscal measures.[14]

Although road traffic accidents caused 4938 deaths in England and Wales in 1989[15] and there are significant social class differences[16], the approach is to increase public awareness rather than to enforce measures related to safety. Other types of accidents are mentioned but no preventative measures are proposed.

A further limitation of the green paper is its focus on particular diseases and habits instead of on the groups within the population and their problems. As a result, many of the targets relate to the treatment of disease rather than the promotion of health. Though targets are set for reducing mortality from ischaemic heart disease and stroke, there is also a health care performance target for ischaemic heart disease, based on the number of coronary artery bypass graft operations per million population.

In the discussion of asthma, a disease in which the incidence may be rising, there is no mention of the aetiology of asthma or its association with bad housing conditions and damp.[17] Instead of setting targets for reducing the incidence of asthma, indicators of clinical practice are chosen with a recommendation that outcome measures should reflect "*adherence to published clinical management guidelines*".

Where groups within the population are considered, the emphasis is on setting narrow 'medical' targets. Disability is an example of an area where multisectoral influences are more important than medical services alone. The barriers to integration with the rest of society include poverty, legislation, segregated education, lack of accessible buildings, transport, employment prospects and personal assistance.[18-20]

The green paper not only seems to ignore the vast amount of work on person-based outcome measures relating to disability[21-25] but fails to give prominence to the third WHO target: By the year 2000, disabled people should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life. Instead, the stated objective is to enable people

with physical disabilities to reach an optimal level of functioning and suggested targets are confined to reducing contractures and incontinence and pressure sores by 5-10%. Policies and targets recognising the need for multisectoral change across departments and coordinated legislation are completely absent.

Health promotion activities pursued solely within the NHS are unlikely to improve the nation's health. Concerted action is needed from many areas of government with policies to reduce homelessness, increase income support, protect the environment including reduction of air and water pollution, improve public transport, and promote health and safety at work. Fiscal and legal measures are needed to discourage consumption of alcohol and tobacco and to make food safe. Above all, policies are needed to reverse the growing inequalities in health in our society. All these are vital components for a national programme aimed at enhancing the nation's health and all are absent from *The Health of the Nation*. Only 6 of its 151 pages are explicitly devoted to action outside the NHS and these merely contain lists of central Government departments and their activities. Thus, while citing a century of achievements in housing and describing improvements since the 1960s, it contains little indication of the new policies and initiatives required to combat the adverse impact on health of a decade of escalating homelessness and substandard housing.[26-28]

Measurement problems

As measurability is a criterion, the choice of targets is constrained by the availability of relevant information. It is surprising that lack of information itself is not considered worth targeting. The lack of morbidity data needed to measure and monitor the health of the population and the subsections within it is a well known and longstanding problem.[29-31] As usual, the authors of the document are left dependent on mortality and activity statistics. For example, there are few routine data on the prevalence of ill-health and disability among elderly people, children, people with disabilities and mental illness and those in need of terminal care or rehabilitation. This makes it difficult to set reductions in morbidity through targets and instead targets have been chosen that relate to performance such as reducing bed occupancy and closing psychiatric hospitals. In the absence of morbidity data, alternative targets could have related to

aspects of care such as implementing care in the community[32] by improving the availability and range of domiciliary services.

Food poisoning and HIV have been excluded from target setting because the document states that information on cause and incidence is inadequate. This is clearly not the case. The Government appears reluctant to develop strategies to address these problems although a great deal is known about their aetiology and their mode of transmission.

Methodological problems are also ignored. There is no systematic analysis of past and projected trends in the indicators chosen. Such an analysis would need to consider whether these trends reflect changes in clinical practice, health promotion, lifestyles, the age structure of the population or the many socio-economic factors that can affect health. For example, no attempt is made to interpret the fall in smoking prevalence, the decline in mortality from ischaemic heart disease and stroke, or changes in asthma incidence.

Other statistical questions are those associated with random variation. For example regional and district health authorities are asked to set targets for stillbirth rates and infant mortality but the small number of deaths in each district means that rates are subject to wide random variations from year to year.[33]

Inequalities in health

The first of WHO's targets for the European region is: *"By the year 2000, the actual difference in health status between countries and between groups within countries should be reduced by at least 25% by improving the levels of health of disadvantaged nations and groups"*. This is dismissed as being *"unlikely on the present evidence to be achieved"*. In doing so, the green paper ignores a wealth of detailed evidence on inequalities,[34-36] thereby sidestepping the need for action. This rejection is in line with the philosophy of *Working for Patients* which turns its back on the original aim of the NHS - equality in both health and access to health care.[37]

Countries that have developed strategies for achieving targets for health have equity as a main criterion for selecting priorities in line with the first WHO target.[38] Although there are methodological

problems in comparing inequalities in health in different countries, it is apparent that inequalities in health, as measured by morbidity and mortality, are wider in England and Wales than in Sweden.[39,40] In addition, the gap is not widening as it is in England and Wales.[41,42] Thus inequalities in health are not inevitable even though no society is free of them.

Widening differentials in wealth in the United Kingdom might be expected to be followed by corresponding inequalities in health. Internationally, there is a crude relationship between the magnitude of inequalities in income and magnitude of inequalities in health.[42] Overall, life expectancy is lower in countries with wide income differentials independent of gross national product.[43] It is clear that inequalities in health are not inevitable. There is no evidence that simply relying on an increase in the overall wealth will reduce the numbers of people in poverty or diminish the gap in health.[44,45]

In the absence of both a criterion stipulating equity and the necessary data to monitor it, the needs of people who are not well placed to respond to health education and health care initiatives may be neglected in favour of those who are better able to do so. Thus, health promotion initiatives may target those in the population who can make a larger contribution to *"health gain"* as measured by health statistics. This could result in the emergence of an inverse health law to parallel Julian Tudor Hart's inverse care law which stated that the availability of good medical care tends to vary inversely with the need for it in the population served.[46]

The views of the public

Where does the public fit into all this? The views of the public are mentioned only once in the entire document and only then in the context of family health services authorities. Surveys of people's attitudes to smoking restrictions in public and increasing taxes on tobacco show that a majority would support such measures.[47,48] An HEA survey, showing that pollution and the environment were viewed by the public as the major threat to health[49], was cited in an earlier draft of the green paper as an indication of how badly the public were informed. These are just two examples of Government disregard for public opinion.

Implementing the strategy

The document states that the Government will not only set up the strategy but take an active role in its implementation through the English National Strategy Steering Group, supported by three expert working panels. The constitution of these groups and, more importantly, the power they will have in reaching the targets are not mentioned. Will other departments be represented and forced to follow decisions made by these groups? How will districts and people at the grassroots be represented? Though some have praised the document for making Government accountable, an alternative scenario, not dissimilar to that of local authority expenditure, is that ineffective management will be used as a scapegoat in poor districts that fail to achieve the necessary reductions.

It must not be forgotten that the changes in the NHS were introduced in part to distract attention from underfunding. The strategy proposes that as much emphasis should be placed on the promotion of health as on the treatment of ill health but gives no commitment to extra resources. Under such conditions, will the strategy have a detrimental effect on access to health care for those who are already ill? In a cost-contained NHS, how will health authorities choose between health promotion and health care? Will they be forced to invest in ineffectual health promotion policies, in the mistaken belief that these will promote health? Which sections of the community will benefit from this shift in resources? Will resources be shifted away from health care for the elderly, poor and disabled to fund health education campaigns for the younger, healthier and more affluent people who are able to respond to campaigns to change their behaviour? Or will little more be done in health promotion because no funds are being made available and the targets identified will probably be achieved through existing programmes?

Conclusion

On the whole, the scope for improving health lies outside the NHS but its key role as a treatment, care and rehabilitation service must be safeguarded in a revised strategy. If the NHS persists in trying to tackle health single-handed it will be held accountable for making promises it cannot keep. Worse still, it will be distracted from the

groups in the population whose needs are being ignored in the arguments about efficiency, health gains, and benefits.

An effective strategy for the nation's health must therefore distinguish what the health service can achieve in both providing health care and promoting health and then set out clearly the responsibility of other Government departments and agencies for promoting health in a wider sense. It needs to collect the data required to implement and monitor strategies rather than opportunistically to shape strategy to the restrictions of existing data. Above all, there must be a commitment to reducing inequalities in health and to providing the resources and mechanisms needed for implementing strategies successfully.

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"Well, Mr. Thomson, you can either die, or have private treatment."