King Edward's Hospital Fund for London

King's Fund Centre

PREVENTION IN ACTION

Report of a conference held at the King's Fund Centre on Tuesday, 16 May 1978

The purpose of this one day conference was to demonstrate the opportunities which exist to put preventive health policies into practice The audience, drawn from many sections of the Health Service, was welcomed by David Hands, Assistant Director of the King's Fund Centre, who emphasised that the aim of the day was to look for opportunities for action and to obtain a few glimpses of work already in progress. He introduced the Chairman Professor J.N. Morris, Professor of Community Health at the London School of Hygiene and Tropical Medicine. Professor Morris noted how topical this subject is at present, and said that this conference was just one example of the many meetings about prevention which are taking place throughout the western world. In Great Britain attention has focused on the importance of this subject by the Government discussion document of February 1976, followed one year later by the report of the Select Committee on Expenditure, which made a wide range of recommendations. The key Government document was the white paper published in December last year which laid down a series of principles and committed the Government to action. Professor Morris then introduced the first speaker, Dr. A Yarrow, Principal Medical Officer at the Department of Health and Social Security (DHSS) who spoke on Current Government Policy on Preventive Health Care.

Dr Yarrow pointed out that preventive methods had been in operation for a very long time, but a renewed interest had been taken in the subject during the last few years. The White Paper, however, still places great emphasis on cure as an important factor in maintaining the standard of life. Dr. Yarrow reminded the audience that although many of the infectious diseases of the past had been eliminated, many of the present day common diseases appeared to be self-selected; for example, the high risk of chest infections associated with smoking, and incidents of self poisioning. A concious decision was made

by the Government to turn the attention of the DHSS to the problem of prevention, and to influence and educate the public. Dr. Yarrow was aware that the DHSS had not answered several of the points raised by the Select Committee's report, but the Department is working on these at present, and will issue further booklets in the 'Prevention and Health' series shortly. He regretted however the failure of seat belt legislation in Parliament and hoped this would be reintroduced at a later date. He also acknowledged the political problems associated with implementing both the Blenner-Hassett report on drinking and driving, and the fluoridation programme. Dr. Yarrow listed the three methods available to tackle such problems as smoking and the mis-use of alcohol. Social, fiscal and legal pressures can all be brought to bear. The Government can exert some control over the consumption of alcohol, since increasing taxation and raising the price reduces consumption, but the DHSS acknowledges the difficult political issues involved. When it came to smoking Dr. Yarrow was pleased to note the progress made although he was concerned that the message was not getting through to all sections of society. There had also been success in encouraging the widespread use of contraception, particularly among married people. He noted however the high rate of extra-marital pregnancies, but these figures are now continuing to fall, indicating that the message is at last getting across to a wider section of society. Dr. Yarrow concluded by saying that the Government is still concerned that although the health of the population as a whole has improved over the last twenty to thirty years, there still remain social and geographical discrepencies (for example in the peri-natal statistics) which remain a challenge for the future.

The next speaker was Dr. G. Cust, Chief Medical Officer of the Health Education Council who spoke on The Role of Health Education. He described health education as concerning people and their behaviour particularly the attempt to educate people to change their behaviour and voluntarily to take up healthier habits. He listed three different aspects of this; the first is to encourage individuals to make decisions about good health for themselves, secondly to encourage people to make good use of the preventive services provided and thirdly to be aware of the community responsibility which when backed by health knowledge could create strong public lobbies about such topics as fluoridation. Dr. Cust went on to describe some of the factors which can cause disease. He did not think that health education

could influence host factors such as age and sex of a person, or genetic defects, but it had an important role in influencing human life styles both personal behaviour and the external environment. Action has been taken on the external factors over the last hundred and fifty years, about clean water, clean air and housing etc. Health education seeks to educate and change such personal behaviour as smoking, drinking and wearing seat belts, although the educational standard and way of life of individuals are important factors in trying to get the message across. Although it takes a long time to alter patterns of behaviour, Dr. Cust was pleased to see that health education had been effective in reducing the amount of tobacco products sold in Britain over the last fifteen years. The Health Education Council had recently distributed advertising material on the use of contraception, the value of breast feeding and immunisation and vaccination. They have instigated a mis-use of alcohol campaign in the North, and the nationwide 'Look after Yourself' campaign is just begining to get off the ground. Dr. Cust then outlined some of the health education work which can be done at local level. He emphasised the important role of community physicians and area medical officers in preventive medicine, and the need for trained staff in local health education offices. He said there was a need for planners to gather data about behaviour at local level and he encouraged areas to support national schemes, while at the same time preparing programmes to meet local needs.

The next presentation was on Preventive Mental Health in Primary Care by Dr. D. Craig and Mrs. A. Davey, a Family Doctor and a Community Psychiatric Nurse at Thamesmead Health Centre who described their roles within the primary care team, with particular emphasis on mental health. Dr. Craig described Thamesmead as a new town with a young population mainly drawn from social classes three and four, who have moved out from the inner city and arrive in Thamesmead with an unreal expectation of their new environment. Mrs. Davey said her role placed more emphasis on prevention than was usual for a community psychiatric nurse, who usually spends more time on follow-up and medication of former psychiatric in-patients. At Thamesmead, the team were more concerned with the early recognition of those vulnerable to stress and preventing them from needing the services of a psychiatrist. Dr. Craig saw the main problems that face the team as personalised violence in the home, alcohol, gambling, depression

and family and marital problems which all contribute to a low resistance to stress. When their high expectations of life are not fulfilled the local people then turn to their health centre, which as a result has twice the national utilisation rate. There are few patients with chronic psychiatric illnesses, but many people come to see the nurse only once or twice, for counselling or as a receptive listener. Mrs. Davey finds she can often re-direct them to other community groups who can provide further and more appropriate support. The more intensive work is shared out amongst the team, and overall there is a very low referral rate to psychiatrists. The primary care team also organises a geriatric screening programme in an informal atmosphere. The team are however aware of the potential stress at work within their own group and therefore apply a preventive philosophy to themselves. Mrs. Davey is available for other members of the team to discuss case problems without formal referral, and the whole team also meet regularly on an informal basis away from the health centre. Summing up, Dr. Craig said "Preventive mental health probably needs good modelling in childhood and early marriage. We do believe most of the problems of new towns stem from a deprived and sometimes unhappy childhood in the inner cities. We feel that preventive medicine generally is extremely difficult to put over at any time and it is not very often successful unless it is associated with emotion. We feel that probably, all we can achieve with the present generation we're landed with is through people like community psychiatric nurses and through a more general attitude to encourage amongst the community a bit more tolerance of oddity so that everybody who is odd is not labelled prematurely as having a mental illness. Obviously a wider public understanding of depression is important and perhaps more acceptance of stress and anxiety as a concommitant of being alive. Health education requires emotional involvement; tolerate odd neighbours, be alert to depressed people and put up with some of the stresses and strains everybody has to suffer."

The last speaker of the morning session was Mr. P. Diggory, Consultant Obstetrician and Gynaecologist at Kingston Hospital who spoke on Aspects of Prevention with Obstetrics and Gynaecology. He began by saying that he would include the early detection of disease, as part of the preventive field, and would therefore include

antenatal care in his discussion. He pointed out that ante-natal screening is important not only for the health of the foetus, but as an attempt to detect disease in women who generally have few routine medical examinations. When screening for foetal abnormality harmless procedures such as blood tests and ultrasonics can be employed, but certain techniques such as amniocentesis carry a finite risk of accidental abortion or injury to a possibly healthy foetus, and adequate counselling must be provided. The facility for parents to choose abortion if any abnormality is detected is important. Mr. Diggory felt that not enough attention was paid to measures which could prevent abnormalities of the unborn child. He argued for a nation wide campaign for vaccination of pre-puberty girls against rubella and for greater education of both the medical profession and the public of the drugs which could be potentially dangerous if taken during pregnancy. He reminded the audience of the need for constant vigilance against irradiation in early pregnancy and also of the importance of discussing future contraception in the ante-natal period. Mr. Diggory then highlighted some of the controversy that surrounds peri-natal care today. He felt that although the media is becoming increasingly concerned about the emotional aspects of this subject, the factual presentation tends to be confusing and somewhat illogical. Although the media is pressing for greater parental choice in childbirth the dangers of traumatic and hypoxic deliveries must still be emphasised. However, Mr. Diggory felt that it was as a gynaecologist that he could make the greatest contribution to health education because of the particular rapport he could establish with his patients. He hoped that he could encourage women to return to their doctors on the first suspicion of illness, for a prompt diagnosis and the earliest possible reassurance. He was enthusiastic in his advocacy of wider use of Hormone Replacement Therapy (HRT) which he felt to be one of the more important if rather controversial advances in treatment. There was a case to be made for all women to receive HRT, and it could be used to considerable advantage in cases of endogenous depression, when the prescription of a small amount of oestrogen would dramatically reduce the intake of tranquillisers. He was under the impression that doctors had so far been wary about using HRT partly due to the lack of statistics on the long term use of the drug.

When Mr. Diggory had first taken up his appointment at Kingston Hospital in 1965 he had been appalled at the scale of criminal abortions of 384 hospital admissions as a result of abortion, 234 women admitted that artificial means

had been employed to induce abortion, and it was estimated that for every patient admitted, there were a further ten others still at home. Whilst he felt that the Abortion Act of 1967 was important and satisfactory Mr. Diggory found that to provide a full service overstretched the available gynaecological facilities and at the same time, that gynaecologists were not adequately trained to provide counselling. It was felt that such a simple and repetitive operation could be provided satisfactorily at a part-time GP unit. In 1972, such a unit was set up at Kingston staffed by two GPs and four nurses who carry out both abortions and other simple gynaecological operations, as well as offering contraceptive advice and treatment which is viewed as an integral part of gynaecological work. Six trustees formed a'registered' charity to hire outpatient facilities in the evenings and at weekends, offering out-patient operations. It was decided to charge patients a fee, although services to Kingston residents are funded by the Area Health Authority. Mr. Diggory stated that the clinic was able to offer a wide and total choice to clients wishing to discuss contraception. The clinic was also acting as a screening mechanism by offering immediate hospital facilities to patients in need of them, and often by-passing the waiting list. Mr. Diggory also acknowledged the interest of the local community health council in these facilities, and concluded by offering the Kingston clinic as a model for elsewhere in the country.

Mrs. C. Hampton, an advisory teacher, employed by the Inner London Education Authority opened the afternoon session with her talk on Health Education in Primary Schools. Health education in primary schools she said is in the hands of the individual head teacher, and very often, if they are not particularly interested, there will be very little structured or ongoing health education in that school. Mrs. Hampton was one of the teachers seconded by ILEA and the Schools Council to examine health education in schools and prepare a structured method of teaching it to five to thirteen year olds. This project involved schools in London, Essex, Cardiff and Oxford and consulted medical and paramedical opinion at home and abroad. She emphasised the golden opportunity teachers have for health education in schools as they have a captive audience and can maintain a programme of education.

The Schools Council started by ascertaining what the children ought to know and also what the children themselves want to know. As a result, they adopted a three part rationale:

1. Everybody has a health career; one starts to develop attitudes about health from birth

2. It is important to educate children to make decisions for themselves

3. To investigate the way children see themselves

The 'All About Me' and 'Think Well' books were produced as a result of this project, but teachers were also encouraged to take a second look at books they already had in their classrooms, which could be of use, but were not previously considered to be health education books. Mrs. Hampton felt that in teaching children health education was very much the teachers' responsibility as they had the tools and specialist training in education. She saw the role of the health visitor as a complement to the teaching profession, acting as a link with the pre-school child, and between home, school and parents.

The "Physical Me' chapters of the series looksat a child's behaviour as a direct result of how children see themselves. Instead of comparisons with other children the project aims to look at topics such as colour of hair, and the shape of the face in a wider teaching context. Teachers can set up 'feel boxes' to explore the physical senses or go on 'listening walks' which stimulate discussion, painting and writing on return to the classroom. The 'Feeling Me' can be more controversial looking at not only the child's own emotions, but how they effect other people's feelings. When it comes to the controversial field of sex education, Mrs. Hampton emphasised how important it was to fully involve parents. The books aimed at satisfying a natural curiosity already aroused, rather than overwhelmed children with a great deal of information which they as individuals may not be ready for. The series also seeks to emphasize the responsibility of adulthood. Topics such as 'What Makes Me Grow' include such factors as love, care and food, as well as the physical growth of the body. Chapters on 'Looking After Myself' include the importance of individual decision making about teeth care and road safety for example. The learning about others chapter balances earlier topics and extends the natural interest in one's self to groups and can include such aspects of community living as the family and school. Finally Mrs. Hampton emphasised that health education did not have to be taught as a separate subject, but could and should be integrated into the whole curriculum as a part of everyday school life.

The last speaker of the day was Dr. P. Walker, Regional Medical Officer at the North East Thames Regional Health Authority who spoke about Planning a Preventive Strategy from a regional viewpoint. He admitted there had recently been a crisis of conscience on preventive matters, and now some of the initiative had shifted from the periphery to central co-ordinating bodies. As background, he said that since reorganisation in 1974, North East Thames had been thinking a great deal about prevention. In particular the community physicians had been instrumental in setting up an advisory standing committee to make certain the region did not neglect this topic. Dr. Walker said that North East Thames was one of the first regions to take planning seriously and draw up a draft strategic plan in December 1976, which incorporated a draft policy document on prevention. The region drew up a comprehensive check list of preventive activities that Districts and Areas should be carrying out and by attaching this list to the operational plan, made it a formal document that could not be ignored. The Region asked for details of activities already in operation and details of intended action over the next three years. This check list was to include preventive personnel, the identification of key populations and budgetary forecasts for three years, since the financial aspect was one of the easier ways to monitor progress. Dr. Walker said they also inquired about steps being taken to co-ordinate preventive services with other agencies, such as local and educational authorities. In response to this document new initiatives were being taken and further research carried out. He then talked about some of the suggestions which had emerged from this paper. He pointed out that some routine measures could be discontinued and the money diverted to other projects. For example, he suggested that routine BCG vaccinations could be withdrawn. He proposed a system of confidential inquiries to follow peri-natal death, similar to those already established for maternal deaths. Defaulters from ante-natal care should be encouraged to make early bookings No smoking campaigns on NHS property had also been proposed, along with pre-retirement courses aimed at good health in old age. Dr. Walker pointed out the advantages of including this document in the formal system. As apart of the general feedback process of the planning system a study day on prevention was organised attended by representatives of the community physicians, nurses, administrative and financial staff, which produced a detailed definitive policy statement on prevention. This was then fully incorporated into the strategic and operational planning guidelines instead of being appended as before. This

also ensured that monitoring by region could be built into the system, both formally by written response and more informally through meetings. Regions can also make a positive contribution to preventive methods apart from their planning role. Dr. Walker described some of the ways this is taking place in North East Thames. The region is directly funding the screening process of the 'Computer Vaccination and Immunisation Schedule System'. They have also put aside £100,000 to support new initiatives in research. They can also act as powerful lobbies, for example on fluoridation, and generally ensure that health matters are taken seriously. Dr. Walker concluded by emphasizing that Regions did have a positive interest in the health and health care provided for the 3.7million people in their region.

Professor Morris then opened the discussion to the floor. Several of the points that were raised related to Community Health Councils and the part they can play in preventive medicine. It was suggested that they should have been included in the Regional Planning Study day referred to by Dr. Walker, to put the consumers point of view. It was suggested that they had a role whenever planners got together to see what patients want and need and in this context it was suggested that CHCs could cut through the tiers of administration and provide a link to the grass roots. Several contributors quoted examples of their own local CHCs in action in the preventive field. One council had set up a nutrition and diet campaign in a district which lacked a formal health education unit. North Devon CHC had taken the initiative in setting up a forum with the professionals to formulate a policy and to be seen to be making a positive contribution. St. Thomas's CHC had involved children who wanted to help and they had established a health club once a week for 'latch-key' children, where they learnt about different aspects of health. This had been well attended during its eighteen months in operation and now the children themselves have drawn up plans to teach their peers.

Several speakers drew attention to the role of the health visitor in health education which was one of the many aspects which had not been included in the formal programme. It was felt that the health visitor could do a great deal in the field of health education because of her special links with vulnerable groups, children and the elderly. Their one-to-one relationship with clients was an important factor in influencing and educating people. Discussion was stimulated by the problem of

health education in schools. Some contributors felt that health was a matter to be dealt with by professional health workers, while others could see the value of educationalists having the better teaching methods. It was generally acknowledged that all the various professional groups associated with health education and preventive medicine must be willing to work very closely with their colleauges in other fields often resulting in some overlap to provide the best service for all sections of the community. The difficulty in exactly defining professional ideas was illustrated by Mrs. Davey's description of a community psychiatric nurse. Some members of the audience viewed her work as that previously carried out by social workers, whilst others pointed out how social workers are turning more and more to statutory and group work, which left a vaccum very expertly filled by psychiatric nurses. Another topic which had cropped up several times during the day was the relationship between professionals and lay people. It had been emphasized that we all have responsibilities towards our own health status. Self-help groups went some way to meeting the need, but professional help was still required to give a long-term approach and indentification of problem areas. Greater effort was still needed to reach those people most greatly in need of preventive services.

Professor Morris then drew the conference to a close, saying that it had been an intensely interesting day, which had generated a great deal to think about and he thanked the speakers for their excellent contributions. He said that the role of both the professionals and the public had still not been dealt with adequately, and some of the overlap between professional groups could be thought through more thoroughly. He mentioned the measures we must expect from legal and fiscal responsibilities as well as the responsibility of the individual to behave properly. He said we should be willing to learn new ways of using rescources and trying out new methods. Professor Morris concluded by saying preventive health care was not merely a multi disciplinary field but that it actually involves everybody, professionals, laybodies and every single one of us.

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