From Principles to Practice: Policies for health promotion and public health

Virginia Beardshaw, Sarah Harvey and Linda Marks

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King's Fund Institute

FROM PRINCIPLES TO PRACTICE: POLICIES FOR HEALTH PROMOTION AND PUBLIC HEALTH

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SECTION 1

HEALTH PROMOTION IN BRITAIN: AN APPROACH TO POLICY ANALYSIS

Defining Health Promotion

The World Health Organisation defines health promotion as 'the process of enabling people to increase control over, and to improve, their health' (WHO,1987) - a definition as broad as it is vague. More specifically, but no less broadly, the US Office of Health Promotion uses the definition 'any combination of health education and related organisational, political and economic intervention designed to facilitate behavioural and environmental adaptations that will improve or protect health' (US Office of Health Promotion, 1980).

Most discussions of health promotion policy or practice begin with a tortuous analysis of the meaning of the term, and the extent to which it overlaps with, encompasses or transcends the related fields of health education, preventive medicine and public health (Anderson, 1983). This process is symptomatic of the difficulties of coming to terms with a new and ill-defined policy area which has the promotion of positive health, rather than the cure of disease, as its goal. It also indicates significant disagreement both about what health is, and the means available for promoting it.

Tannahill (1985) has usefully defined health promotion as "comprising three overlapping spheres of activity - *health education, prevention,* and *health protection.*" He goes on to articulate seven domains for this activity, which are highly inter-related. They are, in summary: straightforward educational,

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Most discussions of health promotion policy begin with some attempt at analysis of the meaning of the term, and the extent to which it encompasses or transcends the related fields of health education, preventive medicine and public health (Anderson, 1983). This preoccupation reflects the difficulties of coming to terms with a new way of thinking about health which has the promotion of positive health, rather than the prevention of disease, as its goal. It also indicates significant disagreement about what health is, and the means available for promoting it.

Tannahill (1985) has usefully defined health promotion as "encompassing three overlapping spheres of activity - health education, prevention and protection." He goes on to articulate seven domains for action which, he argues, are highly inter-related. They are, in summary: strategies to promote positive

preventive and protective measures which promote or enhance health; policies at local, national and international level which promote health; education to encourage take-up of preventive health care such as immunisation and screening; legislation or other significant policy measures to protect health, for example seatbelt legislation; and campaigning and lobbying for protective and preventive health measures, such as smoking control.

Even according to this definition, the scope of health promotion activity is enormous. At its widest, it amounts to a new approach to the field of public health (Milio, 1986). Practice in the field has not kept pace with theory, however, and health promotion planning often betrays contradictions and inconsistencies. In particular, it is proving difficult to stimulate public participation and to move policy-making outside the formal health care sector, despite widespread recognition that this is an essential part of 'the new public health' (Jones, 1987). Conceptually, too, it appears difficult to approach specific policy areas in health promotion in terms of positive health, rather than in relation to disease (Faculty of Community Medicine, 1986).

Most critically of all, health promotion is inescapably bound up with the full range of social and economic determinants of health. WHO lists these determinants as 'peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity' (WHO, 1987) - a list which, by implication at least, touches on the entire range of human economic, social and political activity. The problem for health policy analysis as it relates to health promotion is of limiting and defining the field in a way that provides a useful basis for policy making.

Concepts of Health

The idea of enhancing or supporting health is central to health promotion. But what is health? The voluminous academic literature on concepts of health (Stacey, 1977) indicates considerable disagreement both on what health is, and its meaning for individual people. The debate is not simply a philosophical one, since clear ideas about what constitutes health are necessary for formulating an approach to policy.

The widest definition of health is probably WHO's: "Health is a state of complete physical, mental and social well-being: not simply the absence of infirmity." This stands in conscious contrast to traditional, narrowly medical definitions of health which see it as the absence of disease, and which equate health improvement with medical intervention and responsibility (Anderson, 1983). There are difficulties with the breadth of the WHO definition, however. In it, health is indissoluably fused with human happiness and quality of life. While this may in fact be an accurate reflection of its relationship to individual existence, in policy terms it is very difficult to disentangle the particular health-related elements needed for enhancing 'total well-being' from the vast universe of social, economic, cultural, political and spiritual components which influence it. More helpful is the notion of health as a means to an end: something that enables individuals to function within different environments and fulfill their potential (Berg, 1975). This theme relates closely to the idea of health as an active process, which is the result of the continuous interaction of mind, body and environment (Anderson, 1983).

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as "a resource for everyday life, not the objective of living (WHO, 1987)." This definition goes on to stress that "health is a positive concept emphasizing social and personal resources, as well as physical capacities." While this may verge on the platitudinous, it is important to realise that the concept of positive health is far from deeply embedded in national health policy, which - while paying lip-service to the need for active health promotion and preventive medicine - generally equates health with health care and disease treatment.

Approaches to Health Promotion Policy

Simply speaking, two main schools of thought underlie current thinking on health promotion policy. Both have their roots in an appreciation that curative medicine alone does not provide an adequate response to the modern epidemics of cancers and ischaemic heart disease which began before the second world war and which are currently responsible for a third of premature deaths in England and Wales (Doll, 1985), and to the related perception that 'high-technology' medicine involves ever-increasing costs which are associated with sharply diminishing returns in terms of health gains and quality of life.

The degenerative diseases typical of developed countries in the late twentieth century - heart disease, many forms of cancer, diabetes - are not curable in the same sense as the infectious diseases which were the source of most nineteenth and early twentieth century illness and death. Neither do they have a single, easily isolated 'cause' which can be tackled by traditional preventive measures like immunisation. Instead, their causes are directly bound up with human behaviours like eating habits, obesity, sedentary living,

work, drinking alcohol, and smoking, as well as with 'environmental' factors such as atmospheric pollution, hazards at work, and housing quality.

The main thrust of health promotion policy at national level concentrates on an effort to alter individual behaviour by substituting 'healthy' living - exercise, a low-fat diet, drinking - for undesirable behaviours such as smoking, substance abuse and drinking large quantities of Newcastle Brown Ale (see, for example, DHSS, 1984, 1985). The result is the 'life-styles' approach to health promotion, an approach which relies heavily on health education and other information material to alter individual behaviour in order to produce healthier ways of living (DHSS and HEC,1986). This thinking relates to the intrinsically appealing - but unproven - notion that, as well as avoiding a good deal of human suffering, health policies based on positive health and preventive medicine are likely to be cheaper than continuing to rely on curative services: "an ounce of prevention is worth a pound of cure." In fact, the small amount of research that has been done to test this commonsense hypothesis suggests that it is unlikely to be true (Hiatt & Weinstein, 1985), even if it were politically feasible to expand preventive measures at the expense of clinical medicine.

In its naive form, the life-styles approach is analogous to the traditional 'medical model' of disease management. Health education and other information materials on healthy living devised by experts equate with medical 'treatments', which are applied to individuals. The approach is top-down and exhortatory, and relies on the notion both that individuals are effectively responsible for their own health and that the supply of information is, of

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itself, a sufficient stimulus for behaviour change. Almost inevitably, individuals or groups who succumb to disease are overtly or covertly 'blamed' for failing to respond appropriately to the message (Anderson, 1983). Typically, life-styles approaches place great emphasis on communication methods like mass-media advertising and on simple, 'lowest common denominator' health information (Farrant, 1987).

Any recognition of the importance of exposure to risk factors unrelated to individual behaviours is generally omitted from life-style approaches to health promotion (Blane, 1987). Occupational hazards, housing quality, exposure to environmental pollution, and the effects of income on diet are typically conspicuous by their absence from 'life-styles' analysis, as is any systematic recognition of the relationship between poverty, class and health.

A second, contrasting, approach to health promotion is rooted in the public health tradition and rests on a recognition that the health of the population as a whole has always owed more to the quality of nutrition, living and working conditions, sanitation and income levels than to medical care (McKeown 1976, 1979; Wildavsky 1977). This approach sees health as determined in the social, economic and physical environments in which people live and work, and, by extension, sees health promotion activity as effective only when it is directed at making those environments more conducive to health. This 'ecological' model of health promotion (Lalonde, 1978; WHO, 1985) shifts the focus of activity from information and health education to policy changes and other structural measures that will, in WHO's words, "create environments supportive to health" (WHO, 1987). Essential to the approach is the notion that individuals' circumstances heavily constrain their ability to choose, and

that social and economic policy must be devised in a way that "makes healthy choices the easy choices" (WHO, 1986).

In practice, this involves looking at policy areas well outside the formal health sphere, notably those of housing, incomes, employment, water quality, working conditions, environment and food supply in order to consider structural changes, including legislation, that will promote health. While doing so, it is important to consider how best to promote individual behavioural change within the context of healthy public policy, bearing in mind the real life constraints created by individual circumstances (see for example Graham, 1987). In addition, the contribution of primary health care and preventive medicine must be carefully considered (see Marks, 1987 and Brown and Hughes, 1987).

There is no doubt that the 'ecological' model of health promotion provides a more powerful, all-embracing approach to the problem of promoting positive health than one based on life-styles alone. Its concentration on the determinants of health provide more realistic, multi-dimensional fields for action than the life-styles model. In theory at least it embraces many of the elements of nineteenth and early twentieth-century public health - planning across traditional policy boundaries in housing and sanitation, immunisation, screening, improvements in primary health care - and adds to them tentative late-twentieth century approaches such as community development (SHECC, 1987). An additional strength of the ecological approach is that one of its central tenets concerns the need to tackle regional and social health inequalities - one of the most persistent challenges to British health policy (Marmot and McDowall, 1987; Balarajan et al, 1987; Pocock et al, 1987).

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The 'ecological' model has limitations of its own, however. Chief among them is a kind of political myopia. While insisting on the need to concentrate on the socio-economic determinants of health, it ignores their profoundly political implications. Its emphasis on making health an objective of policy outside of health care proper, while valid, often seems based on the idea that reversing a given policy's adverse effects on health will be a straightforward matter. This is unlikely to be the case, especially when to do so means opposing important commercial interests (Taylor, 1985). Further, while stressing the need for participation and community involvement, 'ecological' theory has not made notable progress in accommodating lay health beliefs and perceptions in its notions of behaviour change (see, for example, Hunt, 1987). Neither has it considered fully how to integrate health promotion and primary health care. In its own way, 'ecological' health promotion is top-down and exhortatory, and relies on 'experts' to determine the new public health agenda. Finally, theories of 'ecological' health promotion tend to play down the difficulties of building the alliances necessary for creating the new public health. In Britain, this means close collaboration between health authorities and local government - bodies with distinctly different traditions of accountability and styles of working. Joint working has not been easy in the field of community care; there is no reason to suppose that collaboration on public health will be any simpler (Hunter and Wistow, 1987).

Currently, WHO is the principal source of the ecological approach to health promotion, and the effort to link it to a revitalised public health movement (WHO, 1987; Ashton, 1986). WHO-style health promotion has developed from the Organisation's 'Health For All by the Year 2000' Strategy, which is closely linked to the Alma Ata charter for primary health care (WHO, 1978). WHO's

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approach has been heavily influenced by North American thinking on public health and health promotion, in particular by Marc Lalonde's historic *A New Perspective on the Health of Canadians* (1974) and Nancy Milio's work on public health, health promotion and its relationship to public policy (Robbins, 1987).

'Health for All' has four main aims: to ensure equity in health; to improve the quality of life; to increase the number of years that people live free of major diseases and disabilities; and to increase life-expectancy by reducing premature deaths. Key elements of the strategy for health promotion policy include the development of coherent policies which support health by all sectors and levels of government; addressing inequalities in health; giving local communities a voice in health matters; and reorienting health services by moving resources from cure to care, prevention and health promotion. All this depends on fostering a general recognition by people at all levels in society that health is "one of the most positive and productive resources society can have" (Mahler, 1987).

Health Promotion Policy in Britain

'Health for All' is grand strategy indeed. It, and WHO's related health promotion and 'new public health' policies provide a potent mix of ideas and rhetoric which can be used for developing a new approach to fostering positive health. But there is no denying that, in Britain at least, rhetoric has far outstripped reality: we are only just beginning to consider how to develop health promotion policies in line with 'Health for All'.

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health promotion. *Prevention and Health: everybody's business* (DHSS, 1976) stressed the responsibility of the individual for his or her health and emphasised the importance of public and environmental health measures. *Care in Action* (DHSS, 1981) continued this theme by underlining the need for 'an unequivocal change in policy' leading to coordinated action by health, education, local government and the voluntary sector in order to discourage smoking, reduce the incidence of heart disease and stroke, and improve preventive medical services like immunisation and screening. More recently, the government has endorsed the 'Health for All' strategy, and the European targets set for achieving it (WHO, 1985).

But these broad statements of principle from the centre have not been matched by the development of coordinated approaches to health promotion within the health service, or concerted action between formal health care services and local government, and other organisations on any but the most limited scale. There is, in fact, no clear and unambiguous statement of what national health promotion policy consists of in practical terms (KFI, 1987). Recent activity at the centre has concentrated on what Tannahill (1985) has aptly termed 'razzmatazz' - 'AIDS: don't die of ignorance' and 'Look After Your Heart' - while recommendations for structural measures - for example, on talks with the food and catering industries on altering the composition of foodstuffs (COMA, 1984) - have been quietly dropped. Although health promotion activity within the NHS has undoubtedly increased during the last five years (DHSS, 1987), a 1985 survey of Regional Health Authority health promotion strategies revealed wide differences of content, approach and emphasis between regions, as well as very limited funding: only six RHAs earmark funds for health promotion and of

these only two allocate £150,000 or more to it (Castle and Jacobson, forthcoming).

The establishment of the Health Education Council as a special health authority and its new location within the health service has given the new Health Education Authority a clearer relationship with the formal health care sector. This may help to give health promotion a sharper focus in national policy terms. However, without a clear health advocacy brief and genuine independence it is hard to see the new Authority playing a a central coordinating role for national health promotion policy within and outside the NHS (KFI, 1987). Furthermore, placing the new authority within the health service may jeopardise its links with local government and the voluntary sector.

Outside the NHS, certain local authorities are attempting to reassert influence over the public health function that they largely handed over to the health service in the reorganisation of 1974. More than a third of urban councils now have health committees. These are new and fragile bodies which are still in the process of defining their role, but they share an approach to health which centres on its social and economic determinants - housing, nutrition, environmental factors, and income (Moran, 1986).

In practice, however, many of the current initiatives in both health and local authorities suffer from the undeniable practical difficulties of moving beyond life-style centred approaches to health promotion to address the social and economic determinants of health (see Fryer, 1987; Ingledew, 1986). This is hardly surprising: redressing health inequalities through housing, employment

and incomes policy, and ensuring a concerted approach to healthy public policy from all sectors of government are more than ambitious targets - they present a challenge to current political beliefs, organisational structures and vested commercial interests that health and local authorities are ill-equipped to tackle on their own. Furthermore, reorienting health care and fostering community participation directly threaten key professional interests within the formal health sector (Jones, 1987). Unsurprisingly, then, many health and local authorities make genuflections in the direction of "the social and economic environments of health" and "intersectoral working", and then concentrate on health education to encourage smoking cessation and healthier eating in the hospital canteen. Indeed, such a course of action may frequently be the only realistic one available in a national policy climate keen to support mass-media approaches to health education and indifferent to anything more than token endorsement of WHO's 'Health for All' strategy, with its key themes of equity and participation (Farrant, 1986).

Nevertheless, a handful of new approaches to health promotion are beginning to emerge at local and regional level (see for example Bloomsbury HA, 1986). Most make direct use of 'Health for All' rhetoric, and attempt to develop some sort of collaboration between health and local government. Currently, WHO's "Healthy Cities 2000" initiative is throwing up some enterprising collaborative ventures aimed at a reorientation of health care and a genuine 'new public health' approach (Ashton, 1986). Outstanding among them is Sheffield's programme to meet 38 'Health for All' targets, which is jointly sponsored by the City Council, the Health Authority and the Family Practitioner Committee. This strategy is firmly based on plans for improvements in housing, environmental and occupational health, addressing

health inequalities and a restructuring of primary health care towards health promotion. Achieving a measure of community participation in health is central to the plan (Sheffield Health Planning Team, 1987). The question of how to reorient primary health care towards health promotion is also beginning to be considered for areas such as accident prevention and school health (see Brown and Hughes, 1987, and Constantinides, 1987).

The Welsh Heart Programme 'Heartbeat Wales' is pioneering a regional approach to the problem of heart disease, based on structural measures which include work with the food and farming industries to develop healthier food products, as well as an emphasis on proving preventive measures in primary health care (Directorate of the Welsh Heart Programme, 1985). This approach stands in decided contrast to 'Look After Your Heart', the joint Department of Health/HEA heart health campaign for England, which uses mass media advertising to promulgate simple life-styles messages.

Elsewhere, there are a number of efforts to address the problems of multiple deprivation and ill-health through experimental community development projects (Davies, 1986 and Farrant, 1986). These depend critically on fostering community participation and involvement, and a number aim at increasing job opportunities and improving housing standards in their neighbourhoods. Community development initiatives in health promotion are, however, new and fragile: the approach is in its infancy in terms of method and evaluation.

Towards an Approach to Health Promotion Policy

To sum up, the field of health promotion policy throws up more questions than answers at this stage in its evolution. Its most striking feature is the

current imbalance between theory and practice. In theory, there is general agreement at national and international level about the need to rethink our approach to health care along preventive and health promoting public health lines. WHO's 'Health for All' strategy and its current strong emphasis on health promotion provides both the philosophy and a powerful rhetoric for such a reorientation. Our government has endorsed both the strategy itself and the European targets set for its achievement.

In practice, however, we are very far from even engaging in a meaningful debate about such a shift of priorities, and have only the vaguest understanding of what it would involve.

The King's Fund Institute proposes adopting WHO's broadly based, 'ecological' approach to health promotion, and to interpret the subject as one important facet in an emerging 'new public health' movement (Beardshaw, 1987). The Institute will use WHO's 'Health for All' strategy, the European targets set for achieving it and the related 'Charter for Health Promotion' as a basis for its approach to the subject. Our proposed initial programme of work will centre on four main subject areas, each of which relates to a number of important 'Health for All' themes. The subject areas are: occupational health, local health profiles, national strategies for coronary heart disease prevention, and implementation of the new national breast cancer screening programme. In addition, the health promotion working group will work closely with priority services on developing a strategy for health promotion and ageing.

Throughout its work on these topics, the Institute's overall aim will be to

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heighten awareness of major policy themes which lie behind the promotion of positive health. In this sense, the subject areas chosen will be exemplary case studies of important issues in health promotion policy , as well as policy topics in their own right. The themes are: healthy public policy, equity, participation and reorienting health services from cure to care, prevention and health promotion.

The Institute will do its best to avoid adding to the present rather sterile debate on the meaning of health promotion. Instead, our work will centre on trying to establish and develop practical approaches to health promotion and public health in Britain. In doing so, we will attempt to address some of the deficiencies in the ecological model of health promotion which we have identified above.

We will concentrate on working with key organisations from the health field and the voluntary sector in order to foster a clearer understanding of what health promotion policy should amount to in practice. Key questions for the group will include a consideration of how desirable behaviour change can best be fostered within the context of healthy public policy, taking account of lay health beliefs; the role of preventive medicine within health promotion; and the relationship between primary health care and health promotion. The project descriptions which follow are designed to illustrate the way in which we propose to approach these themes and questions.

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SECTION 2

Introduction

The second section of this paper describes four separate streams of activity which the Institute's health promotion working group proposes to undertake over the next eighteen months. In doing so, we hope to make a distinctive contribution to discussion of health promotion policy in the UK.

The first project - occupational health - concerns an area of health policy which has remained outside mainstream health care provision in Britain, despite the fact that it is a key element of WHO's 'Health for All' strategy. In undertaking work on this area we hope to increase awareness among policy makers of occupational health and its potential contribution to health promotion. The second area of work - local health profiles - involves consideration of the information base needed for health promotion work at local level, and will also consider the information necessary to encourage user participation. The third project outlines a research proposal which we intend to submit to an outside body for funds to monitor the implementation of the national breast cancer screening service - the single most important innovation in the field of preventive medicine this decade. The final project outlines our plans to collaborate with the Coronary Prevention Group on a major conference on coronary heart disease prevention policy for the 1990s. A timetable for this work programme follows the project descriptions.

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Project 1

HEALTH PROMOTION AND OCCUPATIONAL HEALTH

Introduction

The last decade has witnessed renewed concern about inequalities in the health experiences of different occupational classes (DHSS, 1980; Whitehead, 1987). These differences in health status exist at every stage of life and for some conditions the social gap in morbidity and mortality rates has widened (Marmot and McDowall, 1986). The first of the European targets for achieving Health for All by the year 2000 is to reduce inequalities in health status by 25 per cent. Most of the current differences in health are determined by living and working conditions. Up to 30 per cent of the variation in health experiences may be explained by work related factors (Fox and Adelstein, 1978), yet the relationship between work and health has received little acknowledgment in health policy. Government initiatives to improve the health status of the population have typically relied on the provision of health services. Industrial, environmental and social factors, however, which lie outside the control of the Department of Health and Social Security (DHSS), have a more significant impact on health than DHSS policies (Graham, 1984).

Policy targets are relatively easy to formulate; the formulation of practical strategies for achieving them are more difficult. The reduction of inequalities in health will require much greater emphasis on prevention and health promotion, but much of the action needed lies outside the traditional scope of medical practice (Faculty of Community Medicine, 1986). Current activity in the field of occupational health has a medical orientation towards the identification and treatment of conditions. Estimates of the extent of

occupationally related ill-health, including multiply determined conditions where occupation is just one of several factors, however, suggest that there is considerable scope for health promotion and disease and injury prevention in the workplace, whether the factors causing illness originate within or outside the work environment (Webb, Schilling and Babb, 1986). Occupational health, as a health promotion and public health issue, needs to be given a higher profile in current health policy, but this raises a number of questions. Why has the relationship between work and health been underplayed in health policy? How do occupational health services interface with the National Health Service ? What should occupational health services do and who is to be involved in health promotion strategies in the workplace? This paper does not provide answers to these questions: instead it outlines the King's Fund Institute's perspective on occupational health and a programme of work designed to raise the level of debate on health promotion and occupational health. Fundamental to the Institute's work on occupational health is a concern to develop practical proposals which reflect the themes of healthy public policy, equity, participation and reorienting health services from cure to prevention and health promotion.

Perspectives on Work and Health

The distinction between disease and ill-health arising from the workplace and that arising from other causes is increasingly difficult (EMAS, 1985), yet the differentiation between occupational and non-occupational diseases has persisted in the organisation and delivery of health services. Underlying this issue are different conceptualisations of the relationship between work and health and of the responsibility for prevention and health promotion activities.

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Perspectives on Work and Health

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The Black report on inequalities in health argued that occupational class differences in health are primarily due to differences in material factors which include working and living conditions (DHSS, 1980). The report also noted that the relationship between work and health has been underplayed.

"..we have been particularly struck by the ill developed nature of conceptions of and deprivation at work." (DHSS, 1980)

Employers have traditionally thought about safety issues, but health has been seen as the domain of the medical profession. The emphasis has tended to be on specific identifiable risks of accidents or toxic contamination at work, rather than on health in relation to general working conditions. The policy responses have therefore focussed on reducing the frequency or intensity of exposure to recognised hazardous agents, or providing monetary compensation for damages to health. There are a number of reasons for this limited conception of the relationship between work and health. One possible explanation is that the available national statistics relating to occupational diseases underestimate the extent of work related illness and disease. Unlike other countries such as the United States and Sweden which have insurance based systems of health care, there is little incentive for employers in the UK to provide occupational health services, when their employees have access to services provided within the National Health Service (NHS).

In the health field, individuals are typically perceived and defined as consumers rather than workers (Navarro, 1986). Where the relationship between work and health has been recognised, work has been seen either as an environmental problem or as a source of income. Health promotion policies have concentrated on individual lifestyles, education and the accessibility of

health care services. The cumulative effects of work and environmental factors in explaining the aetiology and natural history of physical and psychological ill health have often been underplayed (Blane, 1987).

Health Promotion and Occupational Health

Occupational health services have traditionally been oriented towards the identification of occupationally related ill-health through routine or episodic medical examinations, and the limited treatment of work-related disease and injury. Although the organisation of employer provided occupational health services varies, most employ a very limited number of staff on a full, part-time or ad hoc basis. The services may be staffed by occupational physicians, state registered nurses with an occupational health certificate, or by generic medical and nursing staff with no formal qualifications in occupational health. The identification of health risks and the control of acceptable standards of physical, chemical and biological factors which might affect the health of those at work is a separate activity which is the responsibility of industrial hygienists. Thus, there has been a traditional separation of disease identification and prevention functions in the workplace.

There are signs, however, that the prevention and health promotion function of occupational health services is being increasingly accepted by both the government and by employers. The Black report, for example, in its recommendations for reducing inequalities in health proposed that:

"government departments, employers and unions should devote more time to preventive health through work organisation, conditions and amenities."

The Health and Safety Executive have recommended that accident and illness prevention and the promotion, maintenance and restoration of health should be the major functions of an occupational health service (Health and Safety Executive, 1982) and a recent survey has shown that some of the country's major public and private sector employers and several trade unions have begun to develop comprehensive health promotion programmes (Webb, Schilling and Babb, 1986). These programmes have included topics such as alcohol, smoking, cervical screening, stress and welfare advice, but issues such as maternity, ante-natal and child care and sexually transmitted diseases, have received very little attention in workplace health promotion programmes. The majority of occupational health services that have been established, however, continue to have a medical bias towards the identification and treatment of conditions.

The implications of the links between the health of the population and the work environment for policy, and for the development of specific health promotion strategies need to be spelled out. There is a danger that health promotion in the workplace will be narrowly defined and that the current "victim blaming" approach to health promotion issues such as smoking, alcohol abuse and stress will be adopted, deflecting attention from the identification and elimination of hazardous agents and working conditions. The relationships between occupational health services, primary health care and other sectors of the NHS also need careful working out. Recognition of the preventive and health promotion function of occupational health and the multi-causal nature of many illnesses led the House of Lords Select Committee on Science and Technology to comment that:

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"Occupational health should be considered as an integral part of the primary care of patients and General Practitioners should take full account of the effects of occupation on health." (House of Lords, 1983).

Recent policy developments will mean that the linkages between occupational health and general practice will be increasingly important. Since 1986, general practitioners (GPs) have had a legal duty to notify employers if they consider a patient is suffering from certain work related illnesses: the employer in turn must notify the employee of the GP's assessment. GPs, however, are unaccustomed to recording the occupational histories of their patients or to thinking about work related hazards. New regulations for the control of substances hazardous to health (COSHH), to be introduced in the next two years, will require more doctors with occupational health expertise. It is envisaged that GPs as well as fully qualified occupational health physicians will be involved in performing the increased number of medical inspections which the COSHH regulations will demand (Taylor, 1985).

The need to integrate health promotion programmes with strategies directed towards the identification and prevention of occupationally related ill-health, identified in various reports, raises a number of issues for both policy and practice which need critical examination. Key issues are the health determinants which can and should be tackled in the workplace and who should be involved in such strategies. Fundamental to raising the profile of occupational health in health policy, however, is recognition of the scale and nature of work related morbidity and mortality.

Work and Health

Accidents at work, stress and occupationally related ill-health are major causes of premature death and illness and contribute to the inequalities in

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morbidity and mortality rates between occupational classes. Evidence from the Registrar General's decennial supplement on causes of mortality by occupation and from longitudinal surveys shows that for the major causes of death people in occupational classes IV and V have higher mortality rates than those in classes I and II (Fox and Adelstein, 1978; OPCS, 1987). Even in old age, men in occupational class V may have up to 50 per cent higher death rates than those in class I (Fox and Goldblatt, 1982). Manual workers are also more likely to experience spells of ill-health and sickness. In 1984, males in unskilled occupations were one and a half times as likely as those in professional jobs to report a long-standing illness. The occupational class gradient in long-standing illness is even more marked for women, the proportion rising from 29 per cent for those in skilled manual work to 47 per cent in unskilled manual occupations (OPCS, 1986). A substantial proportion of the differences in health experiences between occupational classes is related to work. Analysis of the decennial supplement on occupational mortality for 1970-72 revealed that overall, eighteen per cent of the variation in mortality rates between occupational classes is occupationally related and for circulatory and respiratory diseases the proportion explained by work is nearer to 30 per cent (Fox and Adelstein, 1978). If we are to reduce inequalities in health by the year 2000, we need to direct action at the major causes of such disparities. Improvements in occupational health should be part of that strategy.

The official records of occupational injury and disease underestimate the extent of work related disorders due to factors such as non-identification and reporting of work-related illness and injury, the exclusion of self-employed people from industrial injury notification prior to 1986 and variable quality

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of the recording of cause of death and occupation on death certificates (Schilling, 1986). The Royal Commission on Civil Liability and Compensation for Personal Injury (Cmnd, 7054, 1978) identified that many illnesses which are not officially recognised as prescribed occupational diseases could be attributed to working conditions and that these illnesses could be up to five times as numerous as prescribed conditions. Other countries have more reliable systems of recording occupational imorbidity and mortality. In Finland, for example, a register of occupational diseases and injuries has been kept since 1926. The data is collected from three sources: occupational disease reports from physicians which are reported to provincial medical officers, accident reports and physician diagnoses recorded by insurance companies, and cases diagnosed by the Institute of Occupational Health. In 1984, the register contained 58,000 cases of occupational disease and 6000 new cases are added each year. The most common occupational diseases reported in that year were repetitive strain injuries, noise induced hearing loss and skin disorders (Institute of Occupational Health, 1985). The size of the economically active population in Finland, however, is considerably smaller than that of the UK. If we assume that the UK has a broadly similar pattern of employment and illness to that in Finland, there would be 72,000 new cases of occupational disease in the UK each year.

Estimates of the real scale of occupational ill health are largely conjectural. Work related diseases are often indistinguishable from diseases with other aetiologies and there may be long delays between cause and effect for conditions such as cancer. Some conditions, such as dermatoses and stress, are widespread, accounting for a large number of lost working days, but may not be entirely due to work conditions. Deaths from occupational

diseases in Britain, however are roughly ten times higher than the number of deaths from work related accidents (HSE, 1984).

Much is now known about the effects of specific agents and the risks to health, but little is known of the total impact and relative significance of occupation on the major causes of disease. This is illustrated in the variability of estimates of the proportion of cancers which are related to occupational factors. Cancer is a major cause of death in Britain and currently accounts for a quarter of all deaths (OPCS, 1985). It has been estimated that between 2 and 8 per cent of cancer deaths, claiming the lives between 2,800 and 11,200 people in Britain each year, could be prevented if occupational hazards were removed (Doyal and Epstein, 1983). Other sources have estimated that occupational factors contribute to as many as 20 per cent or more of all cancers (Bridboard, DeCoufle and Fraumeni, 1978). The carcinogenicity of some products has been firmly established. For example, there have been extensive epidemiological studies of the relationship between hazardous substances such as asbestos, rubber, benzene and vinyl chloride and their effects on workers (Infante, et al, 1977; Fox and White, 1976; Rinsky, Smith and Hornung, 1987; Baxter, 1980). Many of these occupationally related cancers and premature deaths are preventable and some commentators have suggested that the causative factors may be more amenable to change than those which are related to individual lifestyles.

"Measures to prevent industrial cancer have a greater chance of success than those dependent on changes in individual behaviour and despite the limited scope they should be given a high priority." (Davis, 1983)

The association between specific occupational hazards and disease can be difficult to prove. In the case of fatal and major accidents in the

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workplace, however, the direct effects of occupation on health are clearly implicated. The 1980s have seen a reversal of the long term decline of fatal and major occupational accidents. There were over 700 deaths from accidents at work in 1985 and nearly 20,000 major accidents (Hansard, 1987). In the manufacturing and construction industries the increase in accidents is particularly striking. The numbers of major and fatal injuries in these sectors have increased by 15 and 26 per cent respectively since 1981. There was a marked decline in the number of people employed in manufacturing over this period so in fact the data on incidence rates presents an even bleaker picture (Nichols, 1986). Target 11 of the the European strategy for Health for All is to reduce deaths from accidents by 25 per cent by the year 2000. The WHO suggest that the attainment of this target would require a reduction in occupational accident mortality by at least 50 per cent, as well as significant reductions in traffic and home accidents (WHO, 1985).

The costs of accidents and injuries at work are considerable and entail losses for the individual, the employer and the economy as a whole. The Robens Committee Report on Safety and Health at Work (House of Commons, Cmnd 5034, 1972) estimated that the resource costs of occupational accidents and prescribed industrial diseases in Great Britain in 1969 were in the order of 0.87 per cent of the Gross National Product. A more recent estimate put the resource costs as high as 1.2 per cent of the GNP in 1979 (Morgan and Davies, 1981). Both estimates were calculated on the basis of the officially recorded accidents and prescribed industrial diseases which are acknowledged to understate the scale of the problem. Minor accidents also have resource implications and may account for between one eighth and one half of the total resource costs of all occupational accidents (Morgan and Davies, 1981). Most

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of the costs of ill-health and disablement fall on the individual or are met by state welfare benefits and services. The costs to employers may also be significant. A survey of over 100 accidents in one organisation, which resulted in 3 or more days absence from work (excluding fatalities), estimated an average cost to the company of £1240 per accident (Accident Prevention Advisory Unit, 1985).

In view of trends in the rates of occupational accidents and diseases, occupational class differences in morbidity and mortality and the costs of largely preventable ill-health to the individual, the community and the economy, there is now a clear case for rethinking our approach to occupational health and safety. The challenge of occupational health should be at the heart of strategies for shifting the balance from "Health for Some" towards "Health for All" by the year 2000.

Occupational Health Policy

It is important at the outset to make the distinction between occupational health policy developed at the national level and policies developed at the organisational level. The government's role in matters concerning the health of the workforce has been mainly regulatory and supervisory and includes limited medical examinations, inspection of industrial premises and the provision of medical advice on occupational health issues. No treatment services are provided: responsibility for providing occupational health services rests with the employers, but there is no statutory duty for them to do so. This means that some occupational illnesses are treated by occupational health services, but the rest are likely to be seen by a general practitioner or treated in hospital based services. A survey by the

Employment Medical Advisory Service found that almost half the workforce in Great Britain works in firms with little or no regular access to occupational health advice (Health and Safety Commission, 1978). The survey excluded many small businesses, the NHS, local government and the agricultural sector. Occupational accidents and diseases, therefore, have demand implications for the NHS and particularly for primary health care.

The relationship between occupational health services and the NHS has been the subject of a number of government reports, but for the most part their recommendations have received little response. The Dale Committee of Inquiry on Industrial Health Services (Cmnd 8170, 1951) identified that reliance on a voluntary system of occupational health service provision was inadequate and that such services were often beyond the means of small firms. The Committee concurred with the recommendations of the Gowers Committee of Inquiry into Health, Safety and Welfare in Non-Industrial Employment (Cmnd 7664, 1949) that the government should ensure some kind of comprehensive provision for occupational health in both industrial and non-industrial sectors. The Porritt Committee's report, commissioned by the British Medical Association, also called for a comprehensive occupational health service (Medical Services Review Committee, 1962). These recommendations have been largely ignored by the government. The Robens Committee in 1972 carried out the most comprehensive review of work and health and their recommendations formed the basis of the 1974 Health and Safety at Work Act. The Robens Committee took a different view to previous inquiries and did not recommend further government involvement in the provision of occupational health service as they saw this duplicating services already provided by the NHS (Cmnd 5034, 1972).

Underlying the two viewpoints expressed in these various reports is a tension between recognition of the problem of occupational ill-health and the need to provide services to meet those needs, and a recognition of the burden which regulations impose upon employers. The Robens Committee took the latter view and recommended a system of self-regulation of occupational health and safety by employers. Current policy developments in the field of occupational health also exhibit this tension. The Green Paper "Building Businesses not Barriers" (Department of Employment, 1986), for example, outlined a number of proposals for reducing the burden of regulations on employers. One suggestion was to introduce self-auditing of health and safety procedures which would reduce the number of visits by local authority environmental health inspectors or the factory inspectorate. The government have also been hesitant to ratify the International Labour Organisation's (ILO) Convention 161 which requires member countries to undertake the development of occupational health services for all workers. There is also evidence to suggest that the government has been reducing supervision of health and safety in the workplace. The Chief Inspector of Factories (manufacturing and service industries) in his 1983 report commented that many companies under financial pressure had cut back on maintenance activities and the services of safety specialists. Despite the potentially greater demand for ensuring that safety standards were enforced, the number of health and safety inspectors fell by 10 per cent between 1981 and 1985 from 1380 to 1259 (Hansard, 1985), whilst the number of sites that the inspectors were expected to cover increased by 27 per cent (Chief Inspector of Factories, 1985; Health and Safety Advice Centre, 1986). In the face of these trends, regulations and controls dealing with the safety of the workforce have continued to be developed. Regulations controlling the handling of lead, for example, were

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introduced in 1980, new procedures for the notification of new substances in 1982, and tighter controls on substances hazardous to health are to be introduced in 1988/1989.

The conflicting trends in occupational health policy warrant detailed, critical examination. The tension between regulation and deregulation, the reorientation of occupational health services to prevention and health promotion, and the relationships between these services and the NHS are key areas for analysis. The King's Fund Institute should take a leading role in expanding the debate in this policy area.

KFI Project on Occupational Health and Health Promotion

The aim of the project is to open up the debate on the future development of occupational health services and their relationship with NHS and general practitioner services. The project will consist of three parts.

A critical analysis of the development of occupational health policy in Britain will form the first part of the project. This paper would examine the structure of occupational health, trends in occupational health policy, both nationally and in relation to developments within the European Community, and would identify the key actors and assumptions in policy development. The central issues highlighted in the paper will serve as basis for consideration of the implications of recent policy developments and future policy options: this will form the second part of the project.

Several trade unions and researchers have produced recommendations and suggestions for the development of a more comprehensive occupational health

service (GMBATU, 1987; Webb, Schilling and Babb, 1986) which will be examined in more detail. The topics of health promotion in the workplace, participation of the workforce in occupational health programmes, information needs in occupational health, options for providing occupational health services to small firms and relationships between occupational health services, primary health care and other NHS services will receive particular attention. These issues will be discussed in one or more papers, at least one of which will be used as a background paper for a conference on health promotion and occupational health.

The conference on health promotion and occupational health will form the third part of the project and it is hoped that we might collaborate with Health Education Authority, or another suitable partner, in the organisation of this event. It is intended that the conference should attract an audience with wide ranging interests and expertise, such as occupational health doctors, trade union representatives and officers, health promotion workers, policy makers and academic researchers.

The conference would aim to heighten awareness of the extent and nature of occupational ill-health, and to consider the implications of health promotion strategies in the workplace. At this stage the format of the conference is flexible, but it would probably be based on a number of core papers discussing the extent of occupational ill health, the linkages between occupational health and health promotion, and some specific programmes which have been established and evaluated. It is envisaged that the survey of health promotion in the workplace carried out for the HEC (Webb, Schilling and Babb, 1986) would form one of the core papers. The Institute would be take the lead in producing some of these background papers.

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Project 2

LOCAL HEALTH PROFILES: THE NEXT STEP?

Introduction

The philosophy of "Health for All 2000" is now widely supported and its key themes of health promotion, equity, community participation and multi-sectoral collaboration are largely accepted in principle - if not translated into practice.

The International Conference on Primary Health Care, held at Alma Ata in 1978, made it clear that primary health care was the key to achieving the goals set by the World Health Assembly in 1977. The definition of primary care adopted at Alma Ata goes far beyond traditional notions of primary care as first contact care provided by health professionals to incorporate all sectors which have an impact on health. Thus, it includes "in addition to the health sector, all related sectors and aspects of national and community development in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors; and demands the coordinated efforts of all those sectors" (WHO, 1978,para VII (4)). Equally fundamental as this public health and ecological approach is a commitment to community participation given that primary health care "requires and promotes maximum self-reliance and participation in its planning, operation and control" (WHO, 1978, para VII (5)).

Increasingly, WHO goals and targets are being used as a framework for planning public health activities. At a local level, however, the challenge of operationalising this broad public health approach remains. How are targets

to be made relevant by and for local people and professionals so that a truly participatory approach to primary care and public health may emerge? Generating information which is locally relevant and useful forms a crucial part of this endeavour.

Throughout the late 1970s and the 1980s numerous health profiles have been created, the community health movement and the inequalities debate providing inspiration for many of these. In addition, it has been argued (Knox, 1987), that "regular reporting of the state of the public health" as represented by the Medical Officer of Health Reports pre 1974, should be restored.

This paper briefly reviews these initiatives and suggests that, in order to create local "minimum data sets" for primary care, additional sources of information are needed. In particular, the public health potential of information held within general practice needs to be explored and opportunities offered by the creation of 'localities' as a result of decentralisation of health and local authority services, need to be exploited.

The final section outlines a number of options for building up a minimum data set for public health at local level.

Local Health Profiles: The Information Explosion

Identifying the health service needs of defined populations is one of the tasks of district health authorities - and no less than 80 districts have carried out surveys in this area within the last three years (Head, 1987). The majority attempt to gauge user satisfaction with services; the needs of

specific groups (such as older people) or factors influencing uptake of preventive services.

The 1980s have also witnessed an upsurge in local health related information which is not solely geared towards the sphere of activity of district health authorities. While these "local health profiles" differ in both content and orientation, they all present a challenge to centralised and management related information systems which can too easily ignore public health concerns, levels of morbidity in local populations and the "consumer voice".

Typically, these profiles adopt a public health approach, drawing on some combination of environmental data, unemployment statistics, deprivation indicators and, in some cases, the views of professional and local communities on factors influencing health. Health authorities and local authorities (sometimes jointly), academic departments and numerous community health groups have contributed to this debate.

For example, Liverpool, Sheffield and Coventry health authorities are among those who have carried out "community diagnoses" of their populations (Ashton, 1985; Sheffield Health Authority, 1986; Binysh et al, 1986). A number of the twenty or so local authorities with active health committees have produced (or coordinated) borough-wide reports (Sheffield City Council, 1987); Tower Hamlets Health Inquiry took evidence over a 2 year period from local professionals, community and voluntary groups covering all aspects of health and health services in order to get a full picture of the extent of social deprivation and ill-health in the borough (Tower Hamlets Health Inquiry, 1987). North Manchester Joint Care Planning Team has developed a

participative consumer-based approach to service planning, enabling elderly people to say what kinds of support they need (North Manchester JCPT). Numerous community health projects have carried out surveys in which local people have identified their views of health and social services, and their own health priorities. (These are currently being reviewed by the National Community Health Resource.) Extensive local morbidity studies have been carried out by a number of academic departments (Curtis, 1983).

The field has extended to the point where surveys of surveys and profiles of profiles are now being carried out in order to gain an overview of progress.

Local health reports are not immune from the well-known hazards of information gathering. More effort may be expended on data collection than on the much more daunting task of ensuring that the data are relevant to, and inform policy; the temptation to exploit existing data sources may override careful analysis of how information is to be used and the ability to manipulate data may outstrip the organisational wherewithal to act upon it. Finally, although a number of profiles have been closely tied to subsequent community development work and local action (Betts, 1985), galvanising local participation is rarely a major priority.

Though the generation of local health data is now high on the agenda, confusion still obtains at local level over implications for action by health authorities, local authorities, local groups and local people. This is particularly the case when agencies with different agendas, timescales and funding priorities have to work together to devise public health strategies. In addition, if the voice of WHO is to be heeded, local user participation

must be the bedrock of effective strategies for both primary health care and health promotion. It is often not clear how community participation is to be achieved at local level.

Getting the Measure of Local Health Profiles

Health profiles typically serve a number of different purposes. In terms of primary objectives however, most fit into the following categories:

* **Demonstrating links between social deprivation and inequalities in health status**

  The publication of the Black report (1980), has spurred the production of "local Black reports" which serve to demonstrate correlations between social deprivation and health status at a local level. These have been extensively reviewed elsewhere (Betts, 1987; Whitehead, 1987). Data from the census, local surveys and available mortality and morbidity data form the major information sources. The new local authority health movement, which dates from the early 80s, has provided a major input into these Black reports. A large number of small area studies have confirmed the relationship between various indicators of deprivation and health indicators (Whitehead, 1987).

* **Planning services**

  Health profiles may be constructed at district or neighbourhood level in order to determine 'pockets' of multiply deprived areas; areas with large numbers of older people and children, or areas of high avoidable morbidity and mortality. Such information may influence health education activities, deployment of local staff and resource allocation.

More generally, surveys may examine the relationship between community-defined need and the use of health services. This has often been undertaken by departments of community medicine as part of their remit to identify health needs and plan and evaluate services. CHCs have also been active in this area.

* **Epidemiological studies**

Some profiles are specifically designed to contribute to an understanding of the role of social factors in health. Such studies typically require a larger population base than that of a district.

* **Community health profiles**

Community health groups, active since the 1970s, have organised their activities around neighbourhoods, interest groups (such as pensioners, mothers and toddlers) or particular issues. The process of producing community health profiles has often enabled people to become more aware of the relationship between their health and their environment and this has often proved to be as important as the actual survey results. There are few channels, however, through which such reports may fuel management action.

* **Health for All 2000**

Increasingly, health profiles are being developed within a HFA framework (Tsouros, 1985; Sheffield, 1987). The 38 European targets for HFA 2000 (WHO, 1985) may be used as a means of for assessing the progress of a health or local authority towards HFA 2000. As part of this, profiles may attempt to identify local effects of national social and economic

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policies using indicators from health, education and local authorities.

The results of these studies may often remain unintegrated, even where they refer to the same local area.

When the purpose is to provide information for managing and planning health or local authority services the route from information to management action is clear - albeit often untrodden. Profiles with the more complex aims of revitalising public health awareness and action face particular problems. Difficulties arise partly as a result of the kinds of data used; partly due to the lack of local collaborative and participatory effort for public health and prevention, and partly due to data being available at levels of aggregation which are not directly useful to local professionals, local people and local managers.

Census Data

Census data figure prominently in studies exploring the links between health and social deprivation. They may be used to indicate priority areas for positive action (in the tradition of urban or rural planning); for identifying areas of increased morbidity or for targeting activities for certain groups such as older people or children. Their use in local health reports forms part of the increased use of census variables in health service planning more generally and is one consequence of increased interest in using indices of social deprivation as proxies for morbidity. Indices derived from census variables have been developed for use in health service planning (Irving and Rice, 1984); to indicate professional workloads (Jarman, 1984)

and as a more sensitive indicator of need for resources than SMRs (SETRHA, 1985). Each of these activities has been separately criticised on methodological grounds (Thunhurst, 1985; Scott-Samuel, 1984; Mays, 1987) and the subject continues to be a focus for debate.

A major strand of criticism is that census variables are used as proxies - for example of morbidity or poverty - when direct measures of each could be made available. This criticism equally applies to some of the data used in local health reports.

In addition, in an analysis of local reports Thunhurst (1987) argues that "to the extent that the prime purposes of such analyses is to demonstrate social and geographical inequalities....the battle is well and truly won". The publication in 1987 of the Health Divide (Whitehead, 1987), the report of the British Medical Association Board of Science and Education discussion paper on Deprivation and Health (BMA, 1987) and a myriad of local reports throughout the 80s, lend weight to this assertion.

A further difficulty is that policy recommendations and specific service initiatives do not flow smoothly from the various clusters, indices and scores. Demonstrating that health is inextricably linked with physical, social and economic factors does not always clarify action locally. Strategies which emerge from local reports often require action at national policy level. Few local authorities are unaware of the gradual deterioration of their housing stock or of the deleterious effects of this on the health and happiness of borough residents. In many cases, they simply lack the resources to alter the situation.

The temptation to use easily available census data or hospital morbidity data - combined with the attraction of computerised mapping techniques - has overshadowed the need to generate different kinds of data and new local organisational and management structures. The difficulties that health and local authorities have experienced in trying to work together in the field of community care are well documented. Joint action for public health and prevention is unlikely to prove any easier. In addition, the challenge of generating information for local people which they can use to further public health and prevention, remains.

Fostering New Approaches

Local neighbourhoods, boroughs and district health authorities have been the focus of most health profile activity. If profiles are to be built on community participation, and linked with action, it seems important that local people and professionals can easily identify with the populations or geographical areas concerned; that information relevant to this population is (or could be) routinely collected, and that there is some feasible organisational arrangement to take action forward.

This section outlines possible ways forward in this area.

* **Healthy Cities**

  In the European targets for HFA, the importance of local coordination of health related services was highlighted as was the need to incorporate both the broad ranging approach to primary health care and local participation. For example, Target 30 reads "By 1990, all member states should have mechanisms by which the services provided by all sectors

relating to health are coordinated at the community level in the primary health care system" (WHO, 1985). This implies that local information, accessible to local people, will be necessary if community participation is to be enabled and effective local decision-making enhanced.

One of the WHO initiatives which attempts to develop this approach is the "Healthy Cities" initiative, established in 1986. To date, over 60 cities have expressed an interest in establishing local projects. This initiative reflects the philosophy of HFA 2000 in its emphasis on local action. Participating cities are committed to establishing a city health plan; to create health impact statements and to establish a minimum data set (Ashton, 1986). Information will be required from various different departments such as town planning and housing, education, transport, environmental health and recreation.

* **Going Local**

In recent years a number of local authorities have decentralised their services. In the wake of the Griffiths reorganisation, in 1983, health authorities too have begun to implement patch management and locally-based information systems. The publication of the Cumberlege report (1986) with its recommendation for "Neighbourhood Nursing Teams" has provided an added boost for a patch approach.

The philosophy of decentralisation has been summed up as "accountability, responsiveness, participation and coordination" (Dalley, 1987). While problems related to interprofessional and interagency collaboration and professional accountability remain,

coterminosity of local and health authority patches provides increased opportunities for "intersectoral collaboration". However the public health potential of a shared information base has yet to be tapped.

There is a long tradition of targeting preventive and community development work on a 'patch' basis. In 1981, the Acheson report commented that "the identification of the needs of particular communities is essentially a local activity. For each neighbourhood - which may comprise a housing estate, a group of streets, a complex of flats - those responsible for providing health and related social services should meet together on a regular basis. In collaboration with neighbourhood groups and associations, voluntary organisations and representatives of the local community, the professional teams should identify the needs of the population they serve..." (para 8.13). Likewise the Black report recommended health and social development programmes for selected deprived areas in order to reduce inequalities. Community health projects and the community development movement have traditionally concentrated their activities on particular neighbourhoods.

Attempts have been made to involve professionals and managers as well as local people in a neighbourhood approach. The Speke Neighbourhood Health Group, for example, was jointly established by Liverpool Health Authority and the City Council; membership included participants from health and local authority services, the police and probation departments. The group successfully combined the activities of a multidisciplinary health promotion team with a community development

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approach (Scott-Samuel, forthcoming). 'Patches' provide a more accessible focus for local people than district health authorities; they can also offer an opportunity to develop a locally integrated data base.

Putting general practice into the picture

In recent years there has been a renewed emphasis on the potential of general practice data, and on the public health role of the general practitioners (Hart, 1984; Bussey, 1984; Ashton, 1983). Following in the footsteps of Julian Tudor Hart, Mant and Anderson (1985) call for the creation of a "community general practitioner" trained in population medicine and delineate the public health tasks of primary health care. These include the publication of a 'Practice Report' which includes the effect on health of local social and environmental factors; monitoring of environmental hazards; planning of local community services based on need and monitoring preventive programmes. They argue for increased cooperation between general practice and community medicine and better use of FPC population registers as one route to achieving this public health role.

The potential of the FPC data base is also being explored - partly as a consequence of the new planning functions of FPCs since their independence. For example, Barnsley FPC, in conjunction with the Centre for Health Economics at York has produced an information profile as well as charting the various possibilities of the FPC data base (a far more up to date register than the census) (Carr-Hill et al, 1986).

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Collaboration between general practice and community medicine has been hampered by the fragmented nature of primary health care as well as by issues of confidentiality. Nevertheless, some general practices are beginning to adopt a public health approach. One Bristol based practice, for example, is charting the geographical incidence and prevalence of morbidity of its practice population (Difford, 1985).

While the potential exists for integrating FPC and GP data into patch-based information systems, this does not seem a likely development in the short term.

* **Local information exchange**

It is a truism to state that information at a local level is important. However, sharing information at a local level on public health issues is particularly poorly developed. Links have to be created between professionals and their managers, users and providers of services, professionals working in different statutory agencies, and between statutory, commercial and voluntary sectors. The problems involved in such information sharing should not be underestimated. Professional boundaries may be transgressed; information may refer to different populations (FPC, practice population, health authority, local authority, care group, occupational groups and so on); it may be held at different levels of aggregation and laws relating to confidentiality may prevent easy transfer. Finally there is no one focus for the collection and dissemination of a "public health profile" which needs to incorporate information from each of the above.

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Public Health Profiles: Some Policy Options

With a profusion of local health profiles already in existence, it is important to justify further investment of work in this area. This paper has argued that most profiles are prepared on a DHA, borough, or "neighbourhood" basis; that local environmental data are poorly represented; that accessibility and relevance to local populations is limited; and that the organisation to follow proposals through is often non existent. Initiatives in WHO, general practice and "patch" planning open up new areas for information-gathering and for the participation of both professionals and users.

While some work has already been done in this area, questions still remain. Which information can usefully be made available by 'patch', GP practices, boroughs or cities - and by whom? How can problems of confidentiality and information transfer be resolved? Which groups of people should be involved? How can information be meaningfully presented for professionals and users of services and clearly related to local action? Most important, how can people's priorities and views on health and health services be <u>systematically</u> incorporated into information systems and planning priorities?

In an effort to answer some of these questions, the following proposals are suggested.

KFI Project on Local Public Health Profiles

Information for primary health care and a commitment to local participation are areas of interest and concern for both the King's Fund Centre for Health

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This project consists of three parts.

First, a critical analysis of local health profiles will be prepared, drawing on reviews currently being undertaken within the local authority and community health fields. Particular emphasis will be placed on answering some of the questions raised earlier in this part of the overview paper.

Second, small multi-disciplinary working groups will be established in each of the three following areas:

* Public health and general practice
* Patch profiles and prevention
* Healthy cities: creating a minimum data set.

In each case emphasis will be placed on generating information which can be used locally. Barriers to information collection and joint action will also be identified. Each working group will produce a short 'minimum data set' which will serve as a focus for wider discussion.

A final conference will be held on "creating a new Medical Officer of Health report", which will draw on the experience of the three working groups. A final report will then be published.

This work will be coordinated by the Institute, which will draft reports,

Services Development and the King's Fund Institute. This creates further opportunities for joint working.

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A final conference will be held on 'creating a new Medical Officer's [illegible] report', which will draw on the experience of the three working groups. A final report will then be published.

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organise conferences and arrange for the publication of the final report. Preliminary discussion with those active in the field suggest that such an initiative would be welcome.

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Project 3

PROPOSAL FOR A JOINT CORONARY PREVENTION GROUP/KING'S FUND INSTITUTE CONFERENCE ON A NATIONAL CHD PREVENTION STRATEGY FOR THE 1990S

Introduction

Through this conference the Institute will work with the Coronary Prevention Group to stimulate awareness among policy makers and the public about the need to develop healthy public policies across a number of key sectors of national and local government and the health service in order to address our national epidemic of coronary heart disease (CHD). Developing strategies for addressing the important social and regional gradients in CHD rates and reorienting health services towards health promotion and CHD prevention will be important sub-themes of the conference.

Conference Aims and Outcome

The conference will aim to put forward ideas on how an integrated policy for coronary heart disease prevention could be developed in Britain. Part of this process will involve an examination of progress on the recommendations of the Canterbury Report *'Coronary Heart Disease Prevention: Plans for Action'* (1984), and an assessment of what has been achieved, what remains to be done, and what new elements should be added to the strategy. The conference will, however, be futures-oriented in its use of the Canterbury Report: the document will be used as a yardstick for assessing how far we have come (and how far we need to go) in developing a strategy rather than as a blueprint for national CHD prevention policy. There will be careful consideration of the different elements needed for such a policy: addressing current social and

Introduction

Through this conference the Institute will [illegible]
Group to stimulate awareness among [illegible]
to develop healthy public policies [illegible]
and local government and the health [illegible]
epidemic of coronary heart disease [illegible]
addressing the important social and [illegible]
prioritising health services towards [illegible]
be important sub-themes of the [illegible]

Conference Aims and Outcomes

The conference will aim to put forward [illegible]
coronary heart disease prevention [illegible]
process will involve an examination of [illegible]
Canterbury Report 'Coronary Heart Disease' [illegible]
(1984), and an assessment of what has [illegible]
and what new elements should be added [illegible]
however, be future-oriented in its approach [illegible]
document will be used as a yardstick for [illegible]
how far we need to go) in developing a [illegible]
national CHD prevention policy. There will be [illegible]
different elements needed for each of policies [illegible]

regional inequalities in CHD rates, diet, and prevention and health promotion in primary health care are three key areas.

The conference's overall outcome will be the production of a document outlining proposals for a national CHD prevention strategy for the 1990s. This document would concentrate on the need to develop structural approaches to the social and economic determinants of CHD.

Documentation

The conference will have as its starting point an Institute publication analysing UK CHD prevention policy. In addition, the National Forum for Coronary Heart Disease Prevention will be producing a document on progress on CHD prevention in the first half of 1988, which the Coronary Prevention Group (CPG) has contributed to. These two documents will provide a useful initial focus for conference discussions.

The 'outcome' document of CHD prevention strategies for the 1990s will, however, need careful advanced planning prior to the conference. It will be most important to think in the long-term instead of, as usually happens, over a two or three year period. The Institute will take the lead in producing the 'outcome' document, which - as well as outlining key elements of national policy for the prevention of CHD - would aim to provide health authorities and local government with practical points which they could use when planning their own health promotion and primary health care strategies on heart disease.

regional inequalities in CHD rates, diet, and prevention and health
in primary health care are three key areas.

The conference's overall outcome will be the production of a document
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This document would concentrate on the need to develop strategies
to the social and economic determinants of CHD.

Documentation

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analysing UK CHD prevention policy. In addition, the National Forum for
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(CPO) has contributed to. These two documents will provide a useful
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The 'outcome' document of CHD prevention strategies for the 1990s will,
however, need careful advanced planning. Prior to the conference it will
most important to think in the medium term of, as realistically
a two or three year period. The Institute will have the task to produce
'outcome' document, which as well as containing a statement of policies
policy for the prevention of CHD - would also be a working document with authority
local government with practical points which they could
their own health promotion and primary health care strategies - first
disease.

Target Audience

Ideas on this would need to be refined during detailed conference planning with CPG, but initially we would - like the Canterbury conference - be aiming for a multidsciplinary audience of health authority members, doctors, journalists, environmental and other public health officers, cardiologists, community physicians, epidemiologists and campaigners.

Timing

The conference will take place in autumn 1988, or five years after the Canterbury conference upon which the Canterbury report was based. It will probably be necessary to hold a two day conference to cover all the necessary ground.

Project 4

MONITORING THE INTRODUCTION OF THE NATIONAL BREAST CANCER SCREENING SERVICE: A STUDY OF POLICY IN ACTION

Introduction

The introduction of the new national breast cancer screening service is the most significant addition to British preventive health services for over a decade. Through a detailed 'process' analysis of its implementation and early operation, the Institute will be in a position to make an assessment of the effectiveness of this major health policy initiative. The Institute's proposed study - for which we are seeking outside support - will examine the organisational arrangements developed for the new service, concentrating on the relationship between primary and community services. A key aspect of the study will be its focus on the quality of information supplied to its users.

Problem Statement

Breast cancer is the leading cause of cancer death in British women. Every year some 24,000 new cases are reported in the UK, and there are 15,000 deaths from the disease. The British mortality rate is the highest in Europe and North America.

Evidence from clinical trials suggests that deaths from breast cancer in women aged between 50 and 64 can be reduced by a third or more if they are offered breast screening by mammography. The Forrest Committee, which was established to suggest a range of policy options for breast cancer screening, concluded that screening by mammography could significantly reduce the number of deaths from breast cancer (1). On 25 February the Secretary of State for Health and

Project 4

MONITORING THE INTERNET

A STUDY OF POLICY IN ACTION

Introduction

The introduction

most significant

decades. There

controlling the

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Evidence from

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broad acceptance

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Social Services announced the establishment of the world's first national breast cancer screening service. When fully implemented, the new service will offer women between 50 and 64 mammographic screening every three years. The Secretary of State stressed his commitment to introduce the service "as efficiently, as effectively and as quickly as possible."

There are formidable organisational problems involved in managing an effective mass screening service, and these are different in degree and in kind from the problems experienced in experimental trials. The seemingly intractable problems of the cervical cytology service clearly illustrate this point in a way which suggests that once a service has been operating for a number of years it is extremely difficult to make any significant change to it.

Plans for the New Service

There is no international experience of a mass population breast screening service to draw on when designing the new service for the UK: in fact, the British breast screening service will be the first of its kind in the world. Accordingly, the Forrest Committee have specified the essential elements of an effective service in considerable detail (2). The government has accepted the Forrest proposals in full, and has recommended that health authorities refer to them when establishing their own services.

The Forrest Report outlines a system whereby whereby all women aged between 50 and 64 will be invited to attend for screening by a personal letter from their General Practitioner. Fail safe mechanisms for recording and acting upon positive results at the basic screen, which would be by single medio-lateral oblique view mammography. Each screening unit would have access to a

Social Services recommend [illegible]

breast cancer screening [illegible]

offer women between 50 and 70 [illegible]

Secretary of State [illegible]

efficiently, as efficiently [illegible]

There are [illegible] an alternative

mass screening [illegible] in kind from the

problems either [illegible] Immunotoxin

[illegible] of the [illegible] via point in a

way which [illegible] number of

years it is [illegible] it.

Plans for [illegible]

There is no [illegible] screening

service [illegible] fact, the

British [illegible] in the world.

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The Government [illegible] between 50

and 64 [illegible] from their

General Practitioner [illegible] upon

positive results of the [illegible]-lateral

oblique view [illegible]

specialist team for the assessment of screen-detected abnormalities. The specialist team would be multi-disciplinary, consisting of a specially trained clinician, radiologist and pathologist supported by a radiographer, nurse and receptionist. The Forrest Committee recommends that biopsies undertaken as a result of screening should, wherever possible, be performed and assessed by a specialist breast team, and the report envisages that breast cancer surgery and other treatments will also increasingly be concentrated in specialist clinical teams. At the administrative level, a screening record system will be needed to identify, invite and recall women eligible for screening - initially at three year intervals. This system will also need to record attendance for screening and results and monitor the screening process and its effectiveness.

The Secretary of State has asked regions to produce plans by the end of 1987 for the establishment of a screening service for all women aged 50-64 within the next three years. By March next year each region will be expected to have set up at last one screening centre. Four of those centres will be used to train staff, with the aim of establishing 120 centres nationwide over the next three years - approximately one centre per population of 41,500 women aged 50-64. A total of £41 million has been made available over three years for the establishment of the new service. The equipment costs of each screening unit have been estimated at £115,000, with annual revenue costs put at £135,000. The new screening units will require a total of 930 whole-time equivalent staff, including 40 radiologists and 200 radiographers. In addition, Family Practitioner Committees will need 360 additional staff to operate the call and recall systems for screening centres. Additional pathology and nursing staff will also be needed.

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Potential Problems for the New Service

The organisational, administrative, manpower and training implications of the new service will clearly pose a formidable challenge to the NHS. With this in mind, the Forrest report has made detailed suggestions on staffing levels, quality control and training requirements. It also recommends that each local screening service should have a designated person responsible for its management. Nevertheless, the potential difficulties for the service are very real. They include the following problem areas:

* Unless the quality of screening is very carefully controlled at all centres there is a danger that some cancers will go undetected, and impair the overall effectiveness of the programme in reducing deaths from breast cancer. Alternatively, if screening is too sensitive, a high number of 'false positive' results will cause needless distress to women and greatly increase the costs of the service because of unnecessary further tests and biopsies. Stringent quality control both within and between screening units is therefore essential to the success of the new service.

* The new service requires recruitment of a very significant number of new staff if implementation is to proceed according to schedule. There are already indications of possible shortfalls (3).

* The success of the new service depends on a high proportion of women taking up their invitations to present for screening. The Forrest Committee has based its proposals on the assumption that a 70% take-up rate can be achieved overall. Take-up will depend on the accuracy of

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the computerised FPC age/sex registers\and the efficiency of the call and recall system which FPCs will operate. Doubts about the accuracy of the FPC lists have been expressed, and there are also significant delays to the computerisation programme (4). Take-up rates will also be influenced by the information available to women and to their general practitioners about the aims and process of breast cancer screening. The Forrest Report largely omitted to make recommendations about this important area, and it is as yet unclear what approach will be taken to the question of information and counselling for users of the service, and their general practitioners.

* The national breast cancer screening service outlined in the Forrest Report is predicated on the assumption that women between 50 and 64 will form the screening group. In practice, it seems likely that women from outside the age-range may request screening - thus posing a dilemma for the organisers of the new service.

* There may also be problems at a technical level. There are indications that a significant number of the X-ray machines available in the NHS are not of a sufficiently high calibre to produce mammograms of the standard required for screening (5). There has also been some discussion about whether the single-image mammogram recommended by Forrest is in fact the most appropriate technique for the new service (6).

Aims of the Research Study

The inauguration of the national breast cancer screening service is

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Aims of the Research Study

The inauguration of the national breast cancer screening service is

unquestionably the most important initiative of the decade in the field of preventive medicine. If it proves to have a significant impact on UK death rates from breast cancer the new service will represent an important landmark for women's health generally.

However, successful implementation of the new service is distinctly problematic, depending as it does on the successful resolution and 'mesh' of a range of manpower, organisational, administrative, technical and information issues.

Accordingly, the King's Fund Institute is proposing to conduct an independent study to monitor and evaluate the implementation of the breast screening programme. The Institute's research would be interactive, in that information collected as part of the study would be fed back to those involved in the phased implementation of the service on the ground and to the National Advisory Committee, which will have overall responsibility for the new service, in a way that would allow problems to be addressed quickly as the service develops.

The specific objectives of the study are to:

(i) measure the outcomes of the adoption of a particular organisational system and see if these outcomes match the criteria for success outlined by the Forrest committee.

(ii) if these outcomes are not up to expectation to identify the weakness in the system and seek explanations for the problem, and to present these

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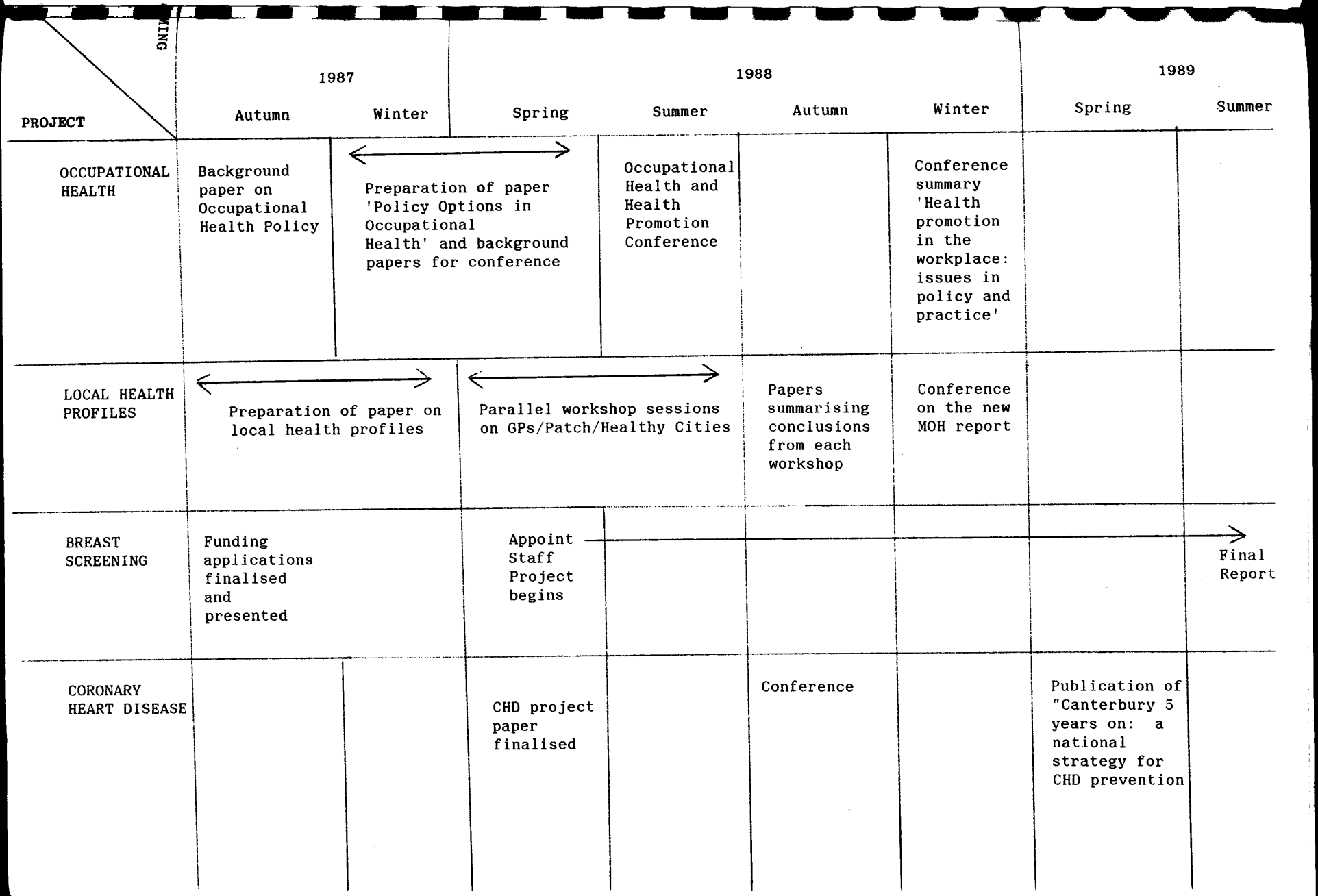
PROJECT
1987
1988
1989
Autumn
Winter
Spring
Summer
Autumn
Winter
Spring
Summer
OCCUPATIONAL HEALTH
Background paper on Occupational Health Policy
Preparation of paper 'Policy Options in Occupational Health' and background papers for conference
Occupational Health and Health Promotion Conference
Conference summary 'Health promotion in the workplace: issues in policy and practice'
LOCAL HEALTH PROFILES
Preparation of paper on local health profiles
Parallel workshop sessions on GPs/Patch/Healthy Cities
Papers summarising conclusions from each workshop
Conference on the new MOH report
BREAST SCREENING
Funding applications finalised and presented
Appoint Staff Project begins
Final Report
CORONARY HEART DISEASE
CHD project paper finalised
Conference
Publication of "Canterbury 5 years on: a national strategy for CHD prevention

1989

TOPICS	Winter	Spring	Summer	Autumn	Winter
HEALTH	Communicable diseases		Occupational health	Respiratory problems	
OCCUPATIONS	Mental health problems in the workplace		Occupational health, safety and personnel issues	Basic principles of occupational health	
TRANSPORT					
ENVIRONMENT					
SOCIAL TRENDS					
LOCAL STUDY