MT.

PART 4

CONFIDENTIAL FILING

Seminars on Health and Social Security Matters

NATIONAL HEALTH

PT1 : August 1983

PT4 : June 1988

~~Attached folder~~ Incorporated in file

The Health of the Nation - Consultative Document

PREM 19/3859

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~15.7.88~~							
~~5.10.88~~							
~~6.6.90~~							
~~15.6.90~~							
~~7.10.88~~							
~~25.3.91~~							
~~3.4.91~~							
~~24.4.91~~							
~~26.4.91~~							
5.6.91							

Dd 8398366 2M 11/83 JET

Faxed to
Edinburgh 10·12

Prime Minister

I am writing to let you know about the success of the recent European Drug Prevention Week, a Europe-wide initiative in which the UK can justifiably claim to have played a leading role.

You may recall that European Drug Prevention Week was a UK proposal and it was encouraging to see that all Member States made the most of this opportunity to raise the profile of prevention as a vital element of tackling drug misuse. In the UK alone over 200 events were organised at local and national level. Typically these involved young people, their parents, teachers, drugs professionals, the police and other key members of the community.

The highlight of the Week was a two day flagship event in London, which attracted a capacity audience of over 1,000 representatives from the media and other professional groups, including some 400 participants from outside the UK. With an emphasis on broadening horizons, the event provided a forum for delegates from across Europe to exchange ideas and information.

At the official launch of the Week at EC Health Council on 13 November, it was clear that other Member States were very impressed by the energy and imagination that we had injected into the Week. I believe that it has been a good practical example of how the UK can make a creative and effective contribution to a community initiative.

If you were looking for an example of active UK involvement in a European initiative to mention during the Edinburgh Council this might be very suitable.

I am copying this to Douglas Hurd, Tony Newton as Chairman of EDH(D) and to Sir Robin Butler.

Virginia Bottomley

10 December 1992

V.B.

mrh
cc DSH
Carolyn Sinclair

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

21 June 1991

Dear Paddy,

Thank you for your letter of 28 April. I am glad that you found the Seminar at Chequers valuable. So did I; and I am sorry to have taken so long to reply.

I appreciate your writing at length about funding in the NHS. I agree with you that demand for health care will always exceed the finance available for a service free at the point of delivery. This is a basic problem which all industrialised countries are facing in one guise or another, whatever their system of financing health care. (You may have seen the recent 'Economist' article on this point.)

But I cannot accept that activity has increased exponentially while funding for health care has increased only a little after allowing for NHS inflation. Activity in the Hospital and Community Health Services has grown at roughly the same rate as real expenditure - by some 50 per cent since 1979. Unit costs have fallen in real terms throughout the 1980s, reflecting the reduced length of stay you mention. This is to the credit of the NHS. But there is much room for improvement. We need to bring the standards of the worst up to the level of the best.

The reforms will not at a stroke resolve the issue of meeting demand for a 'free good' within finite resources. But

2

they will ensure that demand and supply are more effectively balanced, with money going to those Units which can deliver a good service at reasonable cost. This will prevent the situation described in your letter where operations are cancelled to save only a little money.

Due to pressures on my diary I do not think I will be able to meet you in the near future to discuss these issues further. But if you would find it helpful, I know that Carolyn Sinclair in my Policy Unit in Downing Street would be very happy to go through them with you and your colleagues. If you would like to do this, may I suggest that you contact Carolyn direct?

Yours Ever,

John

I / I would be helpful if you could talk to Carolyn. She's very able - you'll like her. I'm sorry my diary is so impossible.

J.

Alexander P. Ross, Ms, FRCS

Alexander P. Ross, M.S., F.R.C.S.,
25 Canon Street, Winchester SO23 9JJ
Telephone: 0962 869757

APJR/SH

Sixteenth
June
1991

File
- no further action.

21/6

The Rt. Hon. John Major,
Prime Minister,
House of Commons,
London SW1A 2AA

PRIVATE AND CONFIDENTIAL

Dear Prime minister,

I am writing to you further to my letter of the 28th April, which I wrote following my visit to Chequers to participate in the discussions on the draft Health Strategy document.

You kindly gave to me the opportunity on that occasion to discuss very briefly in private the problems that are facing the health service now. My subsequent letter to you was intended to precede what I understood was to be a further meeting with you to enable myself and colleagues to enlarge on the matter at greater length on a strictly confidential basis.

I spoke with Mr. Barry Potter shortly after my letter had been received in Downing Street and he outlined the possible sequence of events.

I regret that to date I have received only a postcard which acknowledged receipt of my letter and that a telephone call to your office last week, in which I sought information as to when I might anticipate a response to my letter, has yet to be returned despite my request for such action.

With best wishes,

Yours sincerely,

Paddy Ross

Barry

Sorry I couldn't tie this up completely for you before I left. Treasury & I cooked up the reply between us. I attach a copy of the 'Economist' article.

10 DOWNING STREET
LONDON SW1A 2AA

7th June 1991

Stephen Alcock Esq
Private Secretary
Secretary of State's Office
Department of Health
Richmond House
79 Whitehall
LONDON SW1

Dear Stephen,

LETTER FROM PADDY ROSS

I enclose a fuller version of a draft reply to Paddy Ross's letter of 28th April to the Prime Minister. As I shall be away next week, could you please let Barry Potter have any comments direct?

Yours ever,

CAROLYN SINCLAIR

150.cs

DRAFT LETTER TO ALEXANDER P ROSS MS FRCS

25 Cannon Street
WINCHESTER
SO23 9JJ

Thank you for your letter of 28th April. I am glad that you found the Seminar at Chequers valuable. So did I; and I am sorry to have taken so long to reply.

I appreciate your writing at length about funding in the NHS. I agree with you that demand for health care will always exceed the finance available for a service free at the point of delivery. This is a basic problem which all industrialised countries are facing in one guise or another, whatever their system of financing health care. (You may have seen the recent 'Economist' article on this point).

But I cannot accept that activity has increased exponentially ~~financially~~ while funding for health care has increased only a little after allowing for NHS inflation. Activity in the Hospital and Community Health Services has grown at roughly the same rate as real expenditure - by some 50 per cent since 1979. Unit costs have fallen in real terms throughout the 1980s, reflecting the reduced length of stay you mention. This is to the credit of the NHS. But there is much room for improvement. We need to bring the standards of the worst up to the level of the best.

The Reforms will not at a stroke resolve the issue of meeting demand for a 'free good' within finite resources. But they will ensure that demand and supply are more effectively balanced, with money going to those Units which can deliver a good service at reasonable cost. This will prevent the situation described in your letter where operations are cancelled to save only a little money.

Due to pressures on my diary I do not think I will be able to meet you in the near future to discuss these issues further. But if you would find it helpful, I know that Carolyn Sinclair in my Policy Unit in Downing Street would be very happy to go through them with you and your colleagues. If you would like to do this, may I suggest that you contact Carolyn direct?

150.CS

CF

FILE PG.

cc DoH
P.U.

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

5 June 1991

Dear Dame Margaret,

Thank you for your letter of 8 May following our meeting at Chequers. I, too, found it a helpful meeting, and welcome the constructive suggestions as to how the Colleges and their Faculties can assist with taking forward work on Health Strategies.

I agree that it is unfortunate that misrepresentation of the position of Trust hospitals has clouded the air. But the need for change in the pattern of service provision is far from new; this is particularly evident in the situation in London and other major cities. Successive governments have pursued a policy of distributing health service resources more fairly across the country, and, as a result, we have seen much-needed new hospital developments in areas of growing population. The need for change in health service provision in London and other major cities is simply another facet of this evolution of the health service to meet changing needs.

We can, as you say, expect a change of case mix in individual hospitals as a result of the reforms. But the great strength of the new arrangements is that changes will now reflect what local DHA purchasers and GP fundholders want to buy by way of services. I do not believe there is a real risk that the unattractive areas of medicine will be neglected as long as purchasers want such services. If necessary, District Health Authorities will be able to call on reserve powers which will

oblige NHS Trusts to provide local services if they are the only hospitals able to do so. I can assure you that the Department of Health are monitoring the position to make sure that Health Authorities continue to secure a comprehensive range of health services to meet the needs of their local populations.

We appreciate, however, that changes of the magnitude which may well be necessary in London will need to be managed with care. The Secretary of State for Health has been discussing how best to do this - within the context of managing the contracting process - with the Chairmen of the four Thames Regions. If you and your colleagues from the Royal Colleges would find it helpful to discuss the future pattern of hospital provision in London with the Secretary of State for Health, I know he would be happy to do this.

Yours sincerely,

Tessa M.

Dr. Margaret Turner-Warwick

10 DOWNING STREET

Prime Minister,

With Carolyn's help, the third para of the DH reply to Dame Margaret Turner-Warwick has been rewritten to meet your concerns.

If you are content to sign the revised version, I think you should address it to 'Dame Margaret' not 'Dr Turner-Warwick'.

PHP

4/6

GO/4837p+/2

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of State for Health

B H Potter
10 Downing Street
LONDON
SW1A 2AA

4/4

Dear Barry

04 JUN 1991

Thank you for your letter of 30 April enclosing one from Paddy Ross. I enclose a draft reply and apologise for the delay in doing so.

I believe that officials here have cleared the line about a possible meeting with a member of the Policy Unit. But if you want to firm that up it might be worth checking with Carolyn to see if she wants to actively seek a meeting.

Yours

PAUL AHEARN
Private Secretary

KK/4782p+

SCANNED

Mr A P Ross
25 Canon Street
Winchester
SO23 9JJ

Thank you for your letter of 28 April. I am glad that you found the seminar at Chequers valuable. So did I.

I am aware of the surveys you refer to. I know that William Waldegrave and you have already had a meeting to discuss them and that your discussion is being followed up in detail. Due to pressures on my diary I do not think I will be able to meet you in the near future but I have asked Mr Waldegrave to keep me fully informed of progress in that work.

If you would find it useful perhaps you would like to meet someone from my Policy Unit to run through the issues you raise. If that idea appeals to you perhaps you could contact Barry Potter here to make the arrangements.

John Major

SD/4747+/3

G.R.
✓
as amended
BTP
30/5

R246

Barry Potter Esq
Private Secretary
10 Downing Street

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071 210 3000
From the Secretary of
State for Health

Dear Barry,

29 May 1991

You wrote to me on 14 May enclosing a letter from Dame Margaret Turner-Warwick to the Prime Minister.

You suggested that the reply to Dame Margaret might hold out the prospect of discussions between Mr Waldegrave and the Royal Colleges on the future pattern of hospital provision in London. Carolyn Sinclair since wrote to me with a similar suggestion following a meeting she had had with Dame Margaret.

The Secretary of State is content to go along with these suggestions and I attach a draft reply accordingly. Inter alia, it makes the point that teaching should follow service needs and not the other way around - something that at least some of the Royal Colleges have difficulty in accepting.

Mr Waldegrave also has it in mind that this initiative might be kicked off by an informal dinner hosted by Sir Arnold Elton of the Conservative Medical Society. But that is not something we would want to refer to in a letter from the Prime Minister.

I am copying this letter and enclosures to Carolyn Sinclair.

Yours,

STEPHEN ALCOCK
Principal Private Secretary

SD/4747p+

SCANNED

c:\Economic\warwick (DOT)

Draft reply from the Prime Minister to
Dame Margaret Turner Warwick

Thank you for your letter of 8 May following our meeting at Chequers. I, too, found it a helpful meeting, and welcome the constructive suggestions ~~as to~~ on how the Colleges and their Faculties can assist with taking forward work on Health Strategies.

I agree that it is unfortunate that misrepresentation of the position of Trust hospitals has clouded the air. But the need for change in the pattern of service provision is far from new; this is particularly evident in the situation in London and other major cities. Successive governments have pursued a policy of distributing health service resources more fairly across the country; and, as a result, we have seen much-needed new hospital developments in areas of growing population. The need for change in health service provision in London and other major cities is ~~simply~~ another facet of this evolution of the health service to meet changing needs.

The great strength of our reforms is that, by devolving decisions on use of services to local DHA purchasers and GP fundholders, we have provided a more effective way of signalling where and how these changes should be made. Providers - whether or not they have become Trusts - will need to adapt and respond to purchasers wishes. This will not eliminate the need for difficult decisions, especially in London, and the Secretary of State for Health has made it clear that we will not shirk these. But the reforms will provide a much better basis for making these decisions.

I accept that changes in the pattern of service provision in London are likely to have consequences for the organisation of undergraduate medical education and postgraduate medical training. I fully recognise the importance of maintaining the quality of medical teaching and research although I am sure you will agree that this organisation must be shaped around service needs. Changing arrangements for teaching are of course not new; the welcome developments in recent years, for example of increasing medical teaching in the community, demonstrate how teaching is responding flexibly to changes in service provision.

We appreciate, however, that changes of the magnitude which may well be necessary in London will need to be managed with care. The Secretary of State for Health has been discussing how best to do this - within the context of managing the contracting process-with the Chairmen of the four Thames Regions. If you and your colleagues from the Royal Colleges would find it helpful to discuss the future pattern of hospital provision in London with the Secretary of State for Health, I know he would be happy to do this.

We can, as you say, expect a change of ~~casemix~~ case mix in individual hospitals as a result of the reforms. But the great strength of the new arrangements is that changes will now reflect what local DHA purchasers and GP fundholders want to buy by way of services. I do not believe ~~that~~ there is a real risk that the unattractive areas of medicine will be neglected as long as purchasers want such services. If necessary, District Health Authorities will be able to call on reserve powers which will oblige NHS Trusts to provide local services if they are the only hospitals able to do so. I can assure you ~~The~~ Department of Health ~~will be~~ are monitoring ~~what is happening~~ the position to make sure that Health Authorities continue to secure a comprehensive range of health services to meet the needs of their local populations.

(letter in for sig.) GR? R 31/5

Barry

I got 2 copies of this letter, which makes me wonder if you got the top copy!

I would be reluctant to omit para 3, unless Dold feel strongly. It will annoy MTW, & will not persuade her. For the purpose of this diplomatic exercise, I would write as amended.

Lady

With the Compliments
of the Principal Private Secretary to
the Secretary of State for Health

G.R.
Amend given
as CS
suggests.
BHP 31/5.

Richmond House
79 Whitehall
London SW1A 2NS
Telephone 01 210 5157

DEPARTMENT OF HEALTH

Barry Potter

PA

10 DOWNING STREET

LONDON SW1A 2AA

PERSONAL AND CONFIDENTIAL

Stephen Alcock Esq
PS/William Waldegrave
Department of Health
Richmond House
LONDON
SW1

16 May 1991

Dear Stephen,

I saw Margaret Turner-Warwick today - the invitation arose at the Chequers Seminar.

We touched on the points in the latter paragraphs of her letter to the Prime Minister (Barry Potter's letter of 14 May to you). I said that as long as purchasers wanted to buy some of the unattractive areas of medical care for their population, I was not clear that gaps in coverage would arise overall, though some hospitals might chose not to provide them. Dame Margaret was not convinced; but nor was I convinced by her that matters were going to be worse than in the past, as opposed to different.

Overall, however, the discussion was very positive. Dame Margaret was at pains to stress the difference in attitude between the Conference of Royal Colleges, and the BMA. Although there are great delicacies here involving the role of the JCC, it is clear that the colleges would like more of their own dialogue with the Government. I know your Secretary of State is building on this - and indeed I am sure there is nothing new in what I am reporting to you. But it is mildly encouraging that the willingness to have more dialogue seems unimpaired by recent events.

PERSONAL AND CONFIDENTIAL

Dame Margaret raised a specific idea which links in with the point in Barry's letter to you. Would the Government find it helpful if the Royal Colleges were to set up their own Working Party to look at certain aspects of the need for rationalisation in London (clearly we cannot stop them from doing this if they want to)?

Given that:

- there are advantages in keeping some kind of dialogue going with the Royal Colleges;

- it is presentationally better to talk about London (which everyone knows is a problem) as opposed to the reforms per se;

- any practical discussion of planned rationalisation in London must involve the Royal Colleges as well as the medical Deans (I assume).

I do wonder if we can respond positively; and if we could signal this in some way in the Prime Minister's reply to Dame Margaret?

I am copying this letter to Barry Potter.

Yours ever,

CAROLYN SINCLAIR

068.CS

Turner-Warwick 28/5

Where is letter?

FILE KK

c/Economic/Alcock

cc Carolyn Sinclair
Sarah Hogg

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

(1) 29/5

14 May 1991

I enclose a copy of a letter the Prime Minister has received from Dame Margaret Turner-Warwick.

I would be grateful for advice as to how we should reply. I suspect the problem Dame Margaret refers to - the risk that unplanned rationalisation of services by Trusts will lead to gaps in medical provision - is largely a London problem. If this is right, would there be advantage in your Secretary of State engaging the Royal Colleges in discussing the future pattern of hospital provision in London?

This is known to be a long-standing problem. And it is one where the Government could look to the profession to come up with proposals. Such an approach is more attractive politically than appearing to agree that the reforms have thrown up problems.

If your Secretary of State agrees, this would enable us to send a reasonably forthcoming reply. Any discussions with the Royal Colleges would be taken forward by your Secretary of State, and not by the Prime Minister. I think this would fit in with what he is planning to do anyway.

(BARRY H. POTTER)

Stephen Alcock, Esq.,
Department of Health.

QAS.

MR POTTER

14 May 1991

cc Mrs Hogg

LETTER FROM MARGARET TURNER-WARWICK

This is tricky. I think you will need advice on a reply from William Waldegrave's office. But I also think we could put forward on idea of our own.

I believe the problem she refers to - the risk of unplanned rationalisation of services by Trusts leading to gaps in medical provision - is largely a London problem And it raises an old, old problem-the need to rationalise hospital provision in London. As I told you, both David Willetts and Sir Arnold Elton (Conservative Medical Society) have separately suggested to me that the one area where the Government could fruitfully have discussions with the Royal Colleges is on the future of London. More and more of the medical leaders now accept that something needs to be done. The Government could ask the Royal Colleges to make proposals.

Because everyone knows that the London problem predates the NHS reforms, this is a better basis for discussion than "problems caused by the reforms". Sir Arnold Elton is floating the proposal over Sir Terence English (President of the Royal College of Physicians) on 21 May.

You might like to write to Stephen Alcock on the lines attached.

CAROLYN SINCLAIR

055.CS

GR, Pls type.

KK

DRAFT LETTER TO PS/WILLIAM WALDEGRAVE

I enclose a copy of a letter the Prime Minister has received from Dame Margaret Turner-Warwick.

I would be grateful for advice as to how we should reply. I ~~believe~~ suspect the problem Dame Margaret refers to - the risk that unplanned rationalisation of services by Trusts will lead to gaps in medical provision - is largely a London problem. If this is right, ~~the Prime Minister wonders if there~~ would there be advantage in your Secretary of State engaging the Royal Colleges in discussing the future pattern of hospital provision in London? This is known to be a long-standing problem, and it is one where the Government could look to the profession to come up with proposals. Such an approach is more attractive politically than appearing to agree that the reforms have thrown up problems.

If your Secretary of State agrees, this would enable us to send a reasonably forthcoming reply. Any discussions with the Royal Colleges would be taken forward by your Secretary of State, and not by the Prime Minister. I think this would fit in with what he is planning to do anyway.

056.CS

cc GS
cc DJH

Royal College of Physicians

11 St Andrews Place Regents Park London NW1 4LE

Telephone 071-935 1174 FAX 071-487 5218
Telegrams Medicorum London NW1

From The President
Dr. Margaret Turner-Warwick
DM PhD DSc(Hon) FRCP(Edin) FRACP FACP FFOM PRCP

The Rt Hon John Major MP
Prime Minister
10 Downing Street
London
SW1

PRCP/AR/PP/38 R10/5 PPS
May 8, 1991

Dear Mr Major

Preventive Medicine Meeting Held at Chequers 27th April, 1991

Thank you for a constructive and most worthwhile meeting on Health Strategies at Chequers on Saturday.

As you know, The Royal College of Physicians will be publishing its report on Preventive Medicine very shortly. The Department of Health had an observer on the working party and the CMO and the Secretary of State for Health have had advance preprints which I hope are helpful. I have also commissioned and received some additional short papers on Asthma, Cancer and Diabetes (I hope to add one on Coronary Artery Disease) and I am forwarding copies of the these to the CMO because these were priority targets mentioned by the former Secretary of State. The reductions of morbidity and mortality inevitably link with setting improved targets of clinical care, and this usually has financial implications.

I believe there are a great many ways in which the Colleges and their Faculties can help - this includes setting standards, monitoring their implementation and assessing their effectiveness in changing and improving practices. They also have a major role in educating both the health professions and the public. I will certainly report an outline of the Chequers meeting to The Conference of Medical Royal Colleges so that they can all consider ways in which they can make a contribution.

It was very sad that this important initiative was almost totally eclipsed in the media by the matter of the Trust hospitals, which was neither part of the agenda for your meeting, nor part of the group discussion. I regret that the purpose of the meeting was misrepresented and used as a platform to air the Trust hospitals controversy.

cont/

The Rt Hon John Major, MP
Prime Minister

PRCP/AR/38
30th April, 1991

2/

The threat of loss of departments linked with professional jobs at Trust hospitals is, of course, of great concern because of the effects of changes in casemix on comprehensive patient care, training and research which follows, particularly when this is driven by immediate financial pressures. Financially-led selectivity of casemix in one hospital has a reciprocal effect on others (whether they be Trust or otherwise) - someone must care for the unattractive areas of medicine. Previously I had the opportunity of sharing this very problem with Sir Christopher France, Kenneth Clarke and Mrs Thatcher. All denied it would happen and that reserved powers would be used, supposing it did. Now we are told, as we also anticipated, that it must be resolved at a local level. You might be interested to see the original diagram which at first looks slightly complicated but is actually very simple - it seems to be requiring a certain historic validity!

With this early experience, we would urge government, once again, to draw back from the 'free for all' approach and proceed using sensibly planned and coordinated rationalization of services so that those with financially unattractive disorders are cared for equally well as those perceived to provide financial opportunities.

Thank you again for a most worthwhile occasion and I look forward to our next meeting.

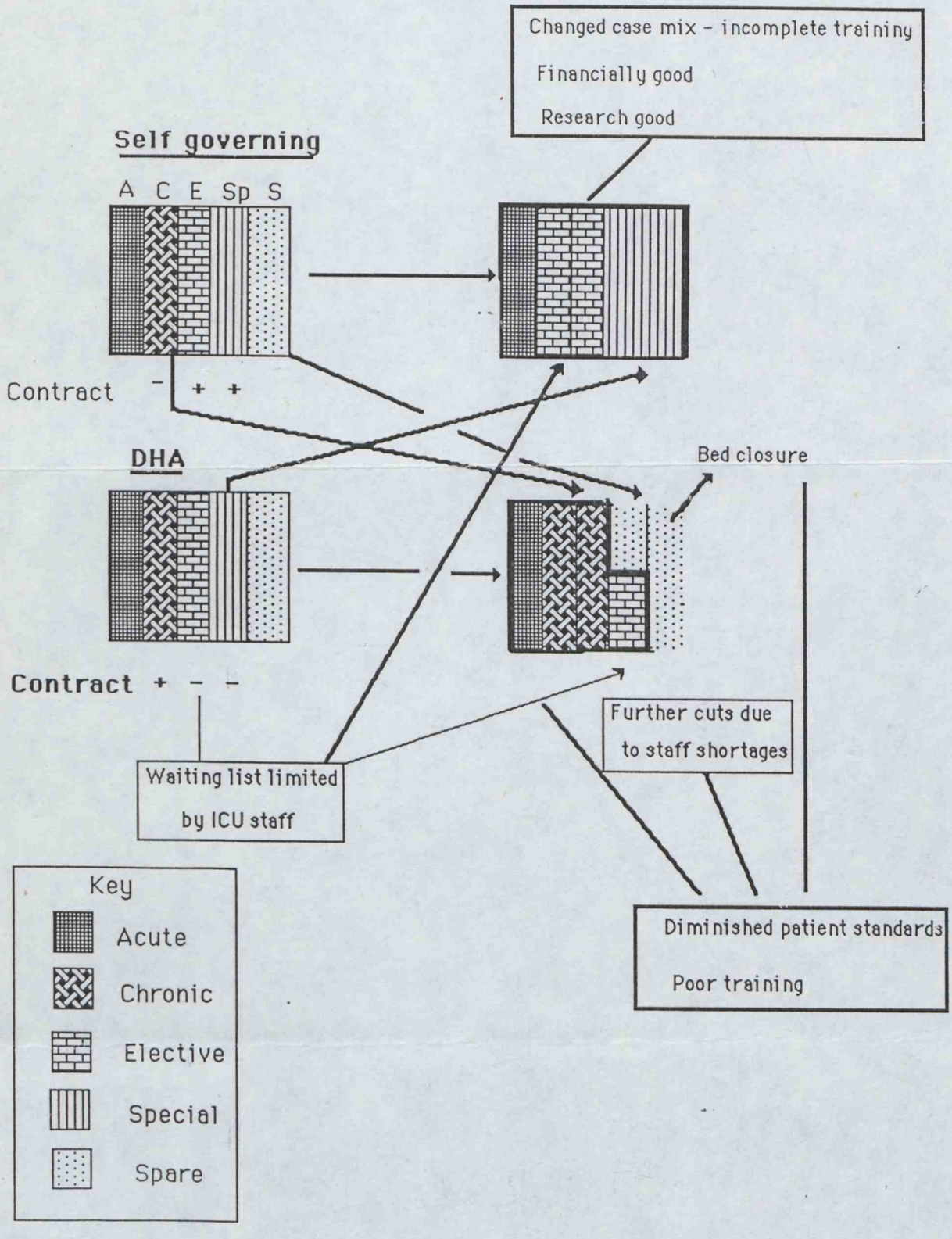
Yours sincerely

Margaret

Margaret Turner-Warwick

enc

The effects on patient care and training of Self governing and DHA hospitals in competition



Ross
14/5

1) 21/5
2) 29/5

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

30 April 1991

I attach a copy of a letter the Prime Minister has received from Alexander Ross.

I should be grateful if you could provide a draft reply for Prime Ministerial signature. It would be helpful if this could reach me by Tuesday 14 May.

B. H. POTTER

Paul Ahearn, Esq.,
Department of Health.

CONFIDENTIAL

SUBJECT cc MASTER

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

29 April 1991

Dear Stephen,

HEALTH SEMINAR

The Prime Minister chaired a seminar on health at Chequers on Saturday 27 April. The seminar was attended by your Secretary of State, the other Health Ministers, representatives of health professional bodies and senior Department of Health officials (list attached).

Health Strategy

The Secretary of State for Health explained the thinking behind the Government's proposed health strategy on which a consultation document would be published shortly. Participants in the seminar had seen an earlier version of the document. The fact that everyone agreed with the principle of a health strategy was very gratifying. The task now was to agree on some priority areas where targets should be set for improvement. But progress in the priority areas must not be at the expense of care in other areas.

In discussion, support for the concept of a health strategy was reaffirmed, with the proviso that it must not become a replacement for the acute services. There was general agreement that more effort must be put into measuring the output of the NHS. In the past this had been something of a Cinderella area, but there were signs that more researchers were now interested in measuring the effectiveness of the health service.

There was some debate as to whether it would be best to concentrate on reducing illness and death from three main causes - cancer, stroke, coronary heart disease - or whether there should be a longer initial list of target areas, including maternal and child health, and mental health. The wider approach was generally endorsed. Several speakers emphasised the enormous importance of reducing smoking. There were strong arguments for the Government grasping the nettle now and banning tobacco advertising.

Other points made included the importance of research and development, where the new commitment to target funding was warmly welcomed. It was pointed out that surgeons and physicians were increasingly working together, and there was greater readiness than in the past for the medical profession

to disseminate information about the effectiveness of various kinds of treatment.

It was agreed that it would be important, when focusing on the target areas for further improvement, not to lose ground in areas where we had made striking achievements in the past eg tuberculosis, cholera and diphtheria. A successful strategy would depend on close liaison between the medical profession and health service managers, and with the public. Managers would have a crucial role to play in turning medical and public aspirations for better health into reality. The whole purpose behind contracting was to deliver better health as well as better health care.

Summing up this part of the discussion, the Prime Minister said that he welcomed the large measure of agreement on the objectives underlying the Government's proposed health strategy. He noted that there was considerable support for the view that the NHS was now better placed to assess health needs and thus implement a strategy for health. It would not be sufficient just to pick target areas where progress was easy to measure. The concept of targets was a dynamic one: the initial targets would be rolled forward and new ones would be added in due course. The Government would need to consider its position on tobacco advertising in the context of deciding how to implement the strategy.

Health Care to the year 2000

The Prime Minister said that during the rest of the morning he wanted to hear the views of participants on likely developments in health care to the year 2000, and the implications which this would have for the NHS.

In discussion it was noted that demographic change had considerable implications for the health service. A larger proportion of elderly in the population would mean more demands on the NHS as the elderly suffer more sickness. It was agreed that a balance needed to be struck between developing exciting new treatments which would be of help to relatively few people and focusing effort on improving the treatment of more widespread ailments.

Another point made by several speakers was the increasing need for different parts of the medical profession - GPs, hospital doctors, nurses - to work in partnership to tackle the health problems of the next decade. There was broad agreement that in future GPs would have an increasingly important role to play in primary health care. There was a need for them to work closely together with general physicians in hospitals. The next decade should see a switch away from attendance at out-patient departments. The proportion of people seeing consultants as outpatients in the UK was unusually high by international standards. This whole area was ripe for re-examination.

It was also agreed that the divisions between different types of nurses - community nurses, practice nurses, district nurses - looked increasingly artificial. It was a cause of some concern that the best nurses seemed increasingly to want to work as practice nurses. This partly reflected poor working conditions in hospitals. This point could not be ignored. Most people judged hospitals on the basis of the quality of the nursing which they received in them.

In discussion of medical advances, it was noted that it was now possible to pick up 70% of cases of congenital heart defects through screening in pregnancy. This raised ethical issues. Most mothers opted for termination when told they were carrying a child with a congenital heart defect. Another difficult issue concerned the apparent refusal to prescribe a specific course of treatment. Sometimes this was blamed on lack of funds. Yet often the doctors themselves were not agreed on the clinical effectiveness of the treatment in question. Health authorities, as the purchasers of health care, would need to be given advice on the treatments which they should purchase for their populations. But any guidelines should leave some scope for exceptions to be made by doctors on clinical grounds.

Moving on from discussion of medical advances, it was pointed out that people were keenly interested in matters such as waiting systems, the quality of service received and the extent to which the service appeared to be responding to what people wanted. Another point made was the need to think now about the implications of developments in health care for the capital programme of the NHS. Capital projects had a long lead time. It was important not to embark on building the wrong kind of capital infrastructure for the year 2000. Managers in the NHS would increasingly find themselves having to pay to motivate and retain staff, as outside employers offered attractive alternatives. This made it essential to have effective manpower planning which avoided unnecessary waste.

Summing up this part of the discussion, the Prime Minister confirmed that the Government remained wholly committed to a publicly funded health service which was free at the point of delivery. He also confirmed that there were no plans to reduce the level of spending on health in real terms. The objective was to get more health care for every pound spent. Cash savings generated through efficiency measures would be spent elsewhere on improving the NHS. He noted the points which had been made by several speakers about the increasing need for consensus and partnership both among the different branches of the medical profession, and between the medical profession, health service managers, the Government and the public at large. An increasingly ageing population and increasingly successful techniques for prolonging life would pose big challenges for the health service over the next decade. But he was heartened by the positive approach shown by those

participating in the seminar. It was agreed that the exchange of views had been helpful, and that the dialogue should continue.

Yours,

Barry

BARRY H POTTER

Stephen Alcock Esq
Department of Health

THOSE ATTENDING A SEMINAR ON HEALTH AT CHEQUERS ON SATURDAY 27 APRIL 1991

Prime Minister
Secretary of State for Health
Minister of State for Health (Mrs. Bottomley)
Parliamentary Under-Secretary of State (Lady Hooper)

Dame Margaret Turner-Warwick
Dr. Colin Waine
Dame Rosemary Rue
Dr. Stephen Hunter
Dr. M. McNichol
Professor Cyril Chantler
Miss Christine Hancock
Mr. Brian Edwards
Mr. A.P.J. Ross

Mr. D.K. Nichol
Mr. C. Sinclair
Mr. T.S. Heppell
Sir Christopher France

Alexander P. Ross, M.S., F.R.C.S.,
25 Canon Street, Winchester SO23 9JJ
Telephone: 0962 869757

APJR/SH

Twenty-eighth
April
1991

STRICTLY CONFIDENTIAL

R30

The Rt. Hon. John Major,
The Prime Minister,
10 Downing Street,
London SW1A 2AA

Dear Prime Minister,

First, may I thank you for the kind invitation to the Chequers Seminar on the NHS and for the very pleasant associated hospitality. I am sure that the sensible way forward is to set strategic objectives for the health of the nation arising from discussions of all the parties involved. I know that the Joint Consultants Committee would wish to be involved in any further such meetings.

Second, I appreciated especially you giving to me the opportunity to discuss other matters in private with you and I would like to expand on the "message" that I was trying to give to you.

My present concern is based on the evidence of four separate surveys of the effect of financial restrictions on the hospital service that have been carried out independently recently. Two, those carried out by the Royal Colleges of Surgeons and of Physicians, were restricted to academic departments and looked specifically at the effects on teaching and research. The other two, those of the Royal College of Obstetricians and of the BMA's Central Consultants and Specialists Committee covered the UK and each health district in England respectively. I enclose the brief summaries of these latter two. However, all four showed that the restrictions on clinical services are severe and are not just confined to certain metropolitan areas.

I was struck particularly in our meeting yesterday by your comment "But where is the money going?". I feel somewhat diffident in trying to explain to someone with your background the economic explanation of this apparent conundrum!

Cash limits were placed on the acute hospital sector in the late 1970's and if one uses the appropriate NHS deflator (which I believe is the correct term) there has been only a minimal increase in real terms in the funding of this sector of the NHS since that time. However, the amount of clinical activity i.e. patients treated in this sector, has increased exponentially year after year until the most recent figures were published.

This increase in activity has been achieved by reduced lengths of stay and faster throughput of patients. But most of the expenditure incurred when treating patients across the surgical specialties arises in the first forty eight hours because of the administrative costs of admitting the patient, of pre-operative investigations, and of, particularly, the high costs associated with operating on the patient especially when such items as hip replacements are used. Thus, in rough figures, by halving the length of stay of a patient one reduces the in-patient costs not by 50% but only by about 20%. As soon as that patient is discharged then another patient is admitted and therefore although one has reduced the unit cost per patient one is increasing the hospital's overall expenditure as one increases the throughput of patients.

The result is that as long as one has eliminated other inefficiencies as effectively as is possible in any human organisation the only way to reduce projected expenditure in excess of available resources is to stop admitting non-emergency patients. Hence, the extensive number of cancelled operating sessions shown in the surveys that I have enclosed. Unfortunately, as approximately 75% of hospital expenditure is on staff salaries, one is only reducing the normal expenditure of an operating session by about 25% yet no patients are being operated upon during that time. This is a terrible waste of scarce resources.

What we are seeing at Guys, Bradford etc. is that NHS Trusts are not prepared to pay staff "to do nothing". This might appear to make sound economic sense but it will mean greater unmet demand and inevitably rising waiting lists. The purchaser-provider split will <u>not</u> resolve this problem as it is in reality the purchasing authorities i.e. DHA's that do not have the available resources to fund the activity that could be carried out in hospitals during these cancelled operating sessions and by using the beds that are currently closed for financial reasons.

I hope that you will not regard me as being presumptious if I say that I believe that the Government may well soon regret the so-called 'transparency' of the new system!

You kindly said that you would be prepared to discuss this matter further with me and that I should liaise with Mr. Barry Potter with this in mind. I would like to be accompanied by Mr. Stanley Simmons, President of the Royal College of Obstetricians and Gynaecologists, and by Mr. John Chawner, Chairman of the Central Consultants and Specialists Committee as they could explain in detail the results of their surveys. None of us would be representing the organisations that we lead but would be three individual senior hospital doctors with both the experience and background information to expand further on the contents of this letter.

I can assure you that we would regard the meeting as private and strictly confidential.

With best wishes,

Yours sincerely,

Paddy Ross

enclosures

CCSC SURVEY OF ACUTE SECTOR RESOURCES - 1991

FINAL REPORT

The response to date is 165 districts or 74% of total. The results grossed up* to represent all districts are as follows:

Beds closed in year to 2/1/91	4,680
Of which:	
Planned	1,460
Financial reasons	3,220
Temporary closures	4,330
Out-patient sessions cancelled	430
Of which due to staff shortages	75
Operating sessions cancelled	1,130
Of which due to staff shortages	290
District reporting:	
(a) Restricted admissions	66
(b) Day surgery increases	29
Consultant vacancies	106

* By acute bed numbers within region.

25 April 1991

ENQUIRY INTO HOSPITAL SERVICES (RCOG DATA)

These figures are for the UK, based on information at the beginning of November 1990.

284 Hospitals were surveyed - 197 replied to date
70% return rate

RESULTS

OBSTETRICS

Reduction in Beds

64% have no bed reductions
36% have had reductions, of which 52% was in the past 3 months

Restriction of Services

56% have had no restriction
44% have had some restriction, of which 56% was in the past 3 months

Prevention of Development of New Services

65% no prevention
35% yes eg prenatal counselling, of which 57% was in the past 3 months

Shortage of Midwives

70% have a shortage of midwives (mainly due to financial constraints)
30% have no shortage

GYNAECOLOGY

Reduction in Beds

38% have had no bed reduction
62% have had reductions, of which 56% was in the past 3 months

Increase in Waiting Lists

10% have had no increase
90% have had an increase, of which 50% has been in the past 3 months

Cut in Operating Services

5% have had no cut in services
95% have had a cut in services, 64% in the past 3 months.

Admissions Regularly Cancelled

69% do not have to cancel admissions
31% regularly have to cancel admissions

Cut in Special Services

88% have had no cut in special services
12% have had a cut in special services, of which 88% has been in the past 3 months

MEDICAL SCHOOLS

18 replies to date

Limitations in Services Affecting Teaching

3 medical schools say yes
15 medical schools say no

Insufficient Clinical Material for Teaching

14 medical schools say no
4 medical schools say yes

Loss of Teachers

14 medical schools say no
4 medical schools say yes

25/1/91

Prof. Peckham/.

I will ask you to comment

near the end of this discussion.

Content?

yes.

My mother died of Asthma

Br-in-law of lung cancer!

Asthma is getting significantly worse

Who shd. accompany @ the

end:-

(1) Chas Frame

(2) William

?

I think W W.

But you might ask C Frame.

to say something just before end

Many Hewer.

- V. Useful.,
- too little time.,

- all worthy of a week.

(3) ~~Plan~~ Plan for Future

(4) - not re-acting to present.

Powell says other countries not generally better - US exception

(1) Ref. reference to Sbst. treatment

(2) Sbst. is over or Future.

(5) Media. - Important. Tell Durbrow to pay,
- discretion -,
- radio-remarks private -.
can the record more accurate

Dr Ross on right wants to speak.

Prof. ~~Chantler~~ spoke –

that

So far, so good.

- We still have more $ per patient than the US per patient.

yes. Will you summarize @ the end?

I Shd. I invite Chris F. to speak?

I What of Virginia / Shirley / Glorie?
I think you should say, Only, that we welcome to join in

I think you should ask him to say how the relationship between ~~ete~~ DH r manager has changed.

Rosemary Rue
r Cyril are prepared ~~ready~~ to speak of course.

~~Would you like to~~

pol. script.

area of turbulence

No. of points
about me forcibly
that I will wish to acquire about-

Press.

Media cat.

(radio-commercials are private)

- impossible to be censored
(on the record) - less chance
of misreported.

Risk.

Do you want to comment
towards the end or Donald?

Me, I think. Mike Peckham should comment too.

Miss Hancock.

1,500 – 18,000.

Dame Rosemary.

Wave of modern trainees.,
Control of inflation.,
Man-power., (skills shortage).,
N. " shortage now.,
Community Care.,
Primary Care in Cities.,

Virginia.

PM/wskip.,

Stephen H.

involving Junior Dr's.,
Senile dementia will
increase.,

Stephen H.
PROF. CHANTLER
Chris. F.

(Football).

Mr. Edwards.

Gloria.

Mr. Peckham.
Stephen D.

G.P.F.H.

– must improvements
in quality in 3 not
than in 5 yrs.

Peckham.

1975.

Prof. Chantler. (W

Education., Colleges RNR + RCN.,

Dr. McNichol.

Better now than then. What is best?

Dr. Ross.

Dr. Waine.

opp. to delegation to N. Staff.

Higher prof. training.,

Miss Hancock

A lot of them.,

N. power-house for change.,

Staff to 'own' a change of direction.,

Back injuries.,

Duncan.

Ronald.

Is it safe to say :-

(a) we have an intention of privatising health care + moving away from comprehensive NHS ✓

(b) an ambition for savings in over-all expenditure — only better use of funds

(1) 'Consultation' can be a term of abuse.

Dame Rosemary

PH doctor., most welcome move; o/due;

'Comprehensive H. Care'., R+D Forgetting (delighted).,

Only make a start on measuring.,

'Ownership' of targets vital., Freedom of Indiv.

Dr. Waine

Welcome. Res. Suite.

Rptg III'., { Coronary H. disease
LC
Cancer of Lung

Pop-based approach.

Personal :: — His Dr. Care.

Mr. Ross.

Role of Govt., HIV infection.,

Forrest Report on Pr. Screening.,

Tobacco related.

Dame Margaret

Smoking., Focus on that., What do you mean 'Chronic illnesses'

Adv. practices., [Asthma., Cancer].

Outcome Measurements.

Miss Hancock

Tobacco.,

Targets diff.

Nat. + Ch. Health.

(2.) To 2,000.

'rounded'.

With prof. not > ;t-

'Work together'.

Dame Margaret

Patterns of disease.,
Changes of treatment.,
Development of Tech.,
– How we train Dr's., Prim. Care Services.,

Need to recog. multi-plicity of disease.,

New Systems

May be tempt to focus on financially viable.,
If so – cut down breadth of care.,

Change of Care.

Nurses., Doctors., – as a team. (Endorse partnership).

Better as a team., – 10 yrs. ago

Interesting themes there.,

Huge opp.
Won't lead to fewer Doctors.,

(1) Prev. h. care.

(2) Savings in o/all expenditure.
Keyhole surgery., technology.,

(1)

PRIME MINISTER

HEALTH SEMINAR

You asked me to let you have some briefing for the Health Seminar as soon as possible.

I attach first a very early draft of the popular version of the health strategy document. Reading this is the quickest way to assimilate broadly what is in the health strategy document. ✓

Second, I attach the health strategy itself. Though it is getting better it is still far too long. The Department of Health accept this and are working on a shorter version. For tomorrow you need do no more than dip into some of the key sections.

Thirdly, I attach brief biographical notes on the participants at the seminar; and particular points they are planning to make. Also attached are their comments on the draft health strategy paper and some notes on issues they may raise.

Finally I attach a background factual note.

I will provide a full briefing pack as soon as possible - but it is unlikely to be ready before this evening.

BHP

BARRY H. POTTER
26 April 1991
c:\economic\seminar (kk)

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(1) Health St. Document

(2) Budget in Health + Health Care.

PRIME MINISTER

HEALTH SEMINAR

I attach Carolyn Sinclair's steering brief for tomorrow's seminar.

I have also arranged with Mr. Waldegrave's office that he will arrive at 0945 for a pre-meeting chat.

Can I add just two points to your brief?

i) Dame Margaret Turner-Warwick is a strong opponent of the reforms and will give you a hard time. So will Paddy Ross. Moreover, you should presume that anything you say to Dame Margaret Turner-Warwick is likely to be leaked to the press immediately after the seminar.

Why did we invite her then?

ii) Second, you will be pressed strongly on resources.

I therefore attach a short Treasury briefing note on NHS expenditure. It is not ideal - I have marked one set of figures you simply must not use.

The general line to take is:

- health has always done well under this Government (quote the figures);

- governments in all countries recognise that the demand for resources for health care is infinite: more resources can only be provided as the economy grows;

- but health is a priority within available public expenditure resources and will remain so;

- however it is not just a question of cash inputs - it is about the output of health care; achieving more and improving value for money is what the health reforms and the new health strategy are all about.

BHP

BARRY H. POTTER 26 APRIL 1991 c:\wpdocs\Economic\Health.MRM

CONFIDENTIAL

CONFIDENTIAL

PRIME MINISTER

26 April 1991

CHEQUERS' SEMINAR ON THE NHS

The purpose of this seminar is:

- to demonstrate your interest in the NHS;

- to consolidate William Waldegrave's success in achieving better relations with the medical profession.

In pursuing these diplomatic aims it will be important to underline the Government's commitment to the NHS reforms; and to make it clear to those working in the NHS that they will have to learn to live within their means.

A list of participants, with biographical details, is at Flag A. They include Dame Margaret Turner-Warwick, President of the Royal College of Physicians (she is formidable and not a friend of the reforms), Dame Rosemary Rue, President of the BMA (who seem to be relaunching their campaign against the reforms) and Christine Hancock of the Royal College of Nursing (she is good value and positive about change). The seating plan for the morning session is at Flag B.

Some suggested opening remarks are at Flag C. The first part of the morning will discuss the Government's proposed health strategy document. After about 40 minutes you will want to switch to more general discussion of developments in health and health care over the next 10 years. William Waldegrave will introduce the health strategy discussion. For the second part of the morning five speakers (sitting more or less opposite you) have been invited to speak for a few minutes each on selected themes.

Health Strategy

You will want to ask William Waldegrave to explain the thinking behind the Government's proposal to develop a health strategy involving targets for improvement in specific areas. Participants in the seminar will have had an earlier version of the consultation document (the version which Robin Cook seems to have). It has since moved on and they will not have seen the latest version.

Discussion must not be allowed to turn into a drafting session. What you want to hear are the views of health professionals on:

- the concept of setting targets for improvement in selected areas;

- the criteria for selecting some areas and not others (medical specialists tend to argue that their speciality must be a priority).

Targets as such are not new in the NHS - there have been targets for types of operations eg hip replacements. But setting priorities for achieving improvements in health is the first step in a debate about the choices to be made in a health care system financed with finite resources.

There has always been rationing in the NHS but it used to be covert and largely dictated by individual consultants. The reforms will make rationing more explicit (eg your Health Authority has decided to purchase appendix operations on your behalf but not, perhaps, fertility treatment).

The views of participants who have commented on the consultation paper are summarised at Flag D. They are generally favourable:

the need for a health strategy and targets is accepted but most commentators (predictably) want to add topics to the list of target areas.

There is a tension in the medical profession between practising doctors (many of those round the table) and the public health doctors who inhabit the Department of Health. The consultation document, with its emphasis on disease prevention, reflects the latter's preoccupations. Some of this tension may surface in the discussion - though few would want to argue openly against effort on disease prevention.

After about 40 minutes you will want to wind this part of the morning up and switch to the more general discussion of health care in the next decade.

(II) **Health care in the year 2000** : how it will develop : what we shd. prepare for.

You could open this second part of the discussion by asking Dame Margaret Turner-Warwick to say a few words on:

- new patterns and practices in health care between now and 2000.

The four other speakers and themes are:

Dr. Colin Waine	-	changing face of primary health care
Dame Rosemary Rue	-	priorities in public health
Miss Christine Hancock	-	future role of nursing
Professor Cyril Chantler	-	medical advance and setting priorities (Dean of Medical School @ Guy's).

You will want to bring in each of these speakers at roughly 15 minute intervals - the order does not matter. This may involve conducting skills - some, particularly the ladies - will be

inclined to make the most of their platform.

This will be the trickier part of the morning. You are bound to be told that the key problem is lack of money. There may be reference to today's announcement of 600 job losses at Guy's Hospital on which there is a note at Flag E. If so, you could invite Cyril Chantler - Dean of the Medical School at Guy's - to comment. He will defend the management decision robustly. But unfortunately he is not typical. Many senior doctors still have great difficulty with the idea that they should work within a budget as opposed to working to the limit of their own professional capacity.

Doctors are also concerned about the way the reforms may work:

- will they lead to a two tier system, with patients referred by GP fund-holders getting quicker and better treatment than others?

- will patient and GP choice be restricted because Health Authorities have not kept back enough money to cover referrals which are not covered by a GP or Health Authority contract?

Notes on these points are at Flag F. You will want to look to William Waldegrave or others in the Department of Health to field detailed questions. Background facts on the NHS are at Flag G.

You will want to wind up the morning around 12.45 pm. Luncheon will be served at 1.00pm, after which the guests will leave.

CAROLYN SINCLAIR

383.CS

GOVERNMENT'S RECORD ON NHS EXPENDITURE

- Since 1978-79, spending on NHS up 51 per cent in real terms

- This year spending up nearly 5 per cent in real terms

- Spending more than 5 per cent of GDP, up from 4.5 per cent in 1978-79

- Over 30 per cent more acute in patients and day cases treated compared to 1978-79.

- Past record shows:

	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92
Cash(bn)	15.3	16.8	18.5	20.0	22.5	25.0
Real(%)	3.5	4.1	2.5	1.8	4.6	3.7

- Published plans show:

		1991-92	1992-93	1993-94
Cash(bn)	*	25.0	26.5	27.7

Don't use: implies a real terms fall

* Taking account of announced Reserve claims, 1991-92 will come to £25.4 billion and take real growth to 5.3 per cent.

Spend more on health?

- Government record already very good:

  NHS net spending grown from around 10 per cent of general government expenditure in 1978-79 to around 13 per cent this year

  Health second largest central government programme

  Now spend more on health than defence (1991-92 : £25.0 bn against £22.8 bn, respectively)

- Increasing expenditure would not satisfy the unlimited demand for health care evident since NHS formed

- NHS reforms and health strategy recognise that resources are always limited and priorities must be set - as in any public service

- What matters to people is volume of healthcare output, not just cash inputs. Can only be achieved by improving efficiency and choice which is what NHS reforms are about.

BRIEFING FOR SEMINAR

CHEQUERS SEMINAR ON NHS: 27 APRIL 1991

TOPICS FOR DISCUSSION

Five of the guests have been asked to be ready to say a few words on particular topics. They are:

i. Dame Margaret Turner-Warwick.
She will be ready to speak about new patterns and practices in health care, including how resources can be used more effectively by different methods of health care.

ii. Dr Colin Waine
Dr Waine will give his view of the changing face of primary health care, including how the GP reforms are bedding down and the changing nature of the relationship between primary and secondary health care:

iii. Dr Rosemary Rue
Dr Rue will speak about priorities in public health, the developing role of health authorities as purchasers of health care and the relationship between this and the public health function.

iv. Miss Christine Hancock
Miss Hancock will give her views on the future role of nursing and the key issues facing nurses in the next decade.

v. Professor Chantler
Professor Chantler will speak briefly about his experience at the "sharp end" of medicine advance, decision-taking about choices and priorities and how the reforms affect this process.

Pen pictures

Sir Christopher France

Sir Christopher gained a First Class Honnours degree at New College, Oxford in PPE before joining HM Treasury in 1959. His range of jobs included spells as Prinipal private Secretary to the Chancellor of the Exchequer (73-76) and Principal establishments Officer (77-80). After spells with the Electricity Council and Ministry of Defence, he was transferred to DHSS and in 1989 was appointed First Permanent Secretary at the Department of Health.

Sir Donald Acheson

Appointed Chief Medical officer on 1 January 1984.
A graduate of Oxford University (1951), his interest has been in the epidemiology of disease and the organisation of health services. He has been Director of MRC's Environmental Epidemiology Unit and Chairman of Southampton District Health Authority. He was Foundation Dean at Southampton University Medical School (68-78) and is currently the UK member of the Executive Board at WHO.
Sir Donald chaired the recent Public Health Enquiry, the report of which "Public Health in England"(January 1988) presents the first major review of the public health function since the Royal Commission in 1871.

Duncan Nichol

As General Manager of Mersey Regional Health Authority (84-89), he served (from 85) as a member of the NHS Management Board before he was appointed Chief Executive (of NHS Management Executive) in December 1989. Having held health posts in London, Manchester, Chicago and Salford, he was appointed Regional Administrator for Mersey in 1981.

Prof. Michael Peckham

Appointed Director of R&D in January 1991, he was previously with the Institute of Cancer research, Director of the British Postgraduate Medical Federation and Civilian Consultant to the Royal Navy. He is President of the

	Federation of Cancer Societies, Editor in Chief of the European journal of Cancer and Fellow of the royal Colleges of Physicians of London and Glasgow and the Royal College of Radiologists.
Sir Roy Griffiths	Sir Roy has been associated with the NHS since his 1983 report on its management and was Deputy Chairman of the NHS Management Board from 1986. Currently a non-Executive member of the Board of Sainsbury's PLC (Previously Deputy Chairman) and Deputy Chairman of the NHS Policy Board.
Strachan Heppell	Currently Deputy Secretary heading the Health and Social Services Policy Group having held a number of posts in DHSS and been Social security adviser to the Hong Kong Government.
Dame Margaret Turner-Warwick	Currently President of the Royal College of Physicians (since 1989) and Chairman of the UK Standing Conference of Medical Royal Colleges. A consultant Physician (gen Med) at Elizabeth Garrett Anderson Hospital and London Chest Hospitals since 1965, she is a member of CMO's Expert Advisory Group on Postgraduate Medical Education and a member of the Working Part on Junior Doctors Hours.
Dr Colin Waine	By background a north country GP and community unit general manager (SW Durham). A past member of the Northern RHA, he has extensive experience in postgraduate education and has significant research work to his credit. He is currently seeking to take his Unit into a Trust and has recently been appointed Chairman of the Council of the Royal college of General Practitioners.
Dame Rosemary Rue	Currently President of the British Medical Association, Dr Rue was regional Medical Officer for Oxford Region before being appointed the first Regional General Manager with a medical background(again at Oxford) in 1984. She retired in August 1988.

Dr Stephen Hunter	Currently Chairman of the Hospital Junior Staff Committee (from 1 October 1990), he is a lecturer in psychological medicine, University of Wales College of Medicine, Cardiff(honourary Senior Registrar). He has been a member of HJSC five years and Deputy Chairman 89/90.
Dr Martin McNicol	Currently Chairman of Central Middlesex Hospital trust (based at Park Royal). Before that He ~~has~~ worked at the hospital for 25 years as a cardiothoracic Consultant. He was formerly Chairman of Brent HA before it merged with Paddington and North Kensington to form Parkside HA.
Prof. Cyril Chantler	His medical career began at Guy's in 1963 where he is currently Professor of Paediatric Nephrology and dean of the medical school. From 1985 to 1988, he was General Manager of the hospital and is currently a member of the NHS Policy Board.
Christine Hancock	Appointed General Secretary to the Royal College of Nursing in succession to Trevor Clay, Miss Hancock was previously General Manager of Waltham Forest HA (85-89) and District Nursing Officer for Bloomsbury HA.
Brian Edwards	Began his health service career in 1958 before joining the National Administrative training scheme 6 years later. He has held a number of administrative posts and lectureships in health service management before being appointed Regional Administrator at Trent RHA in 1981 and Regional General Manager in 1984. He is an advisor to WHO and an Associate Fellow of the Nuffield Institute, University of Leeds.
A.P(Paddy).J Ross	Currently Chairman of the Joint Consultants Committee and Consultant Surgeon based in the Royal Hampshire County Hospital in Winchester. Previously he was a Senior Registrar at St Bart's Hospital and Surgical Fellow in Boston,USA.

RESPONSES TO DRAFT CONSULTATIVE DOCUMENT

Note

The following comments are based on an earlier and longer draft. Since then, the document has been shortened and sharpened up.

Introduction

1. This note summarises responses received from :

   Professor Chantler
   Dr Martin McNicol
   Mr Paddy Ross
   Dame Rosemary Rue
   Professor Sir David Weatherall (Not attending on 27 April).

Points

2. There was clear acceptance by all of the value and need for a health strategy and setting targets.

3. Main points made (aside from drafting points and concerns about length):-

   Cyril Chantler

   i. "like paper... balance about right... The whole document in an important sense provides the intellectual basis for the NHS reforms".

   ii. Suggested additional issues: resource; the cost of handicapped children and prevention of handicap (target low birthweight babies and genetic services); and research.

   Martin McNicol

   i. Concerned at lack of stance on tobacco and alcohol fiscal policies, social deprivation and cultural problems ("poorly motivated population").

   ii. Unlike Professor Chantler, though document not clear on how reforms free NHS Authorities to address wider health issues.

   iii. Mental illness and rehabilitation not supported for inclusion. Need limited number of issues.

   iv. Number of concerns about length and style.

Paddy Ross

i. Should mention effect on NHS of reducing premature death ie more elderly people and thence greater costs.

Rosemary Rue

i. "Brave attempt" but danger of implying new emphasis on "health" is at expense of "health services". Reassurances needed.

ii. Omissions : elderly people and community care; family planning and abortion; resources.

iii. Audience - tries to address too many different audiences at once.

David Weatherall

i. Concept excellent. Agree areas chosen. Need to be careful about dietary advice. Important to be able to monitor progress.

ii. Child health - need emphasis on potential of genetic services.

iii. Needs to address problem of increasingly ageing population (made more acute if strategy successful).

iv. Key is education - of professions as much as public.

Notes on issues surrounding GP Fund Holders expected to be raised by guests

Waiting Times

Issue Dame Margaret Turner-Warwick has expressed concern that GP Fund Holders (GPFHs) could influence waiting times and ensure their patients have priority.

Response GPFHs, in the same way as District Health Authorities(DHAs), cannot oblige a provider unit to accept conditions of contracts but rather agree those with the hospital concerned.

All purchasers (whether GPFAs or DHAs) will increasingly look to stipulate waiting times in their contracts and provider units must ensure that waiting times are not agreed in contracts which cannot be realistically delivered.

The NHS Management Executive has already issued guidance on the need for consultants to be fully involved in the contractual process and waiting time stipulations are a key area for their contribution.

GPFHs are not being preferentially funded for the purchase of hospital services and they and their patients are, therefore, not given unfair priority.

Equally there is no reason why there should not be different waiting time stipulations in different contracts at the same hospital. Having a plurality of purchasers will make hospitals more sensitive to the need to have and maintain standards on waiting times, which is to the advantage of all patients.

H0417/1

Extra-contractual referrals

OVERALL APPROACH

Recent newspaper reports (based on a Labour Party survey) have suggested that DHAs are not holding back sufficient resources to fund extra-contractual referrals by GPs (those referrals not covered by contracts agreed at the start of the year). It is claimed that this will restrict patient choice.

However there is no reason to be surprised that the vast majority of GP referrals will be covered by contracts in advance. Health authorities have undertaken extensive consultation with GPs to ensure that their contracts do meet GPs' and patients' wishes.

Every DHA has been instructed to hold sufficient funds to cover the likely level of referrals outside contracts this year, based on existing information about patient flows. It has long been expected that these would not usually be more than 1 to 4% of their budgets.

DHAs REFUSING TO FUND EXTRA-CONTRACTUAL REFERRALS

There have also been reports of DHAs refusing to fund extra-contractual referrals made by GPs. This would only be justified if a GP was making a referral which was so clearly perverse that no special individual circumstances could justify it.

For valid clinical referrals (and indeed for cases like sterilisation for social reasons), a DHA would be expected to agree to pay. However there would be a need to judge the relative priority of individual referrals against other demands on resources, leading in some cases to a longer wait for treatment. This happens all too often now.

HO417/2

Allegations that the NHS reforms will lead to a two-tier service

There have been claims that implementation of the reforms will lead to the development of a two-tier service in the NHS. Supposed examples would be the residents of one DHA 'queue-jumping' over those of another, or the patients of GP fundholders getting a better service than patients of GPs not in the scheme.

Points to make:

- it is a myth to pretend that the service in the NHS is of equal standard everywhere now. This was one of the reasons for the reforms, to change the system so everyone would have incentives to improve performance;

- the reforms are based on the principle that delegating responsibility as closely as possible to where health care is delivered is the way to improve services. This involves releasing local initiative and enthusiasm, and encouraging the local setting of priorities. The corollary of this is that the pace of improvements across the country will vary;

- we will look for Trusts and GP fundholders to lead the drive for improvements, which others will then be able to learn from. There are already signs that this is happening;

QUALITY STANDARDS

Issue The profession has expressed concern that the introduction of the GP Fund Holders(GPFHs) could lead to variations in quality of treatments offered.

Response GPFHs' patients receive the same basic standards of clinical care as DHA funded patients. GPFHs have been anxious to secure through the contracting process improvements to "hotel services" (ie catering, domestics etc.) for their patients, improved communications between consultants and GPFHs (ie prompt issue of discharge letters) and to changes in treatment pattern agreed with the consultants concerned (ie GPs taking on aftercare of hospital patients at an earlier point than hitherto).

The contracting process involving GPFHs has also led to the identification of waste (ie elimination of unnecessary out-patient appointments).

It is open to DHAs to seek similar improvements in respect of patients covered by DHA contracts.

Having a range of purchasers - all contracts are open to public scrutiny - encourages innovation and critical consideration of the manner in which services are provided by hospitals. Encouragement of this process can only be of benefit to <u>all</u> patients.

'POP' VERSION OF HEALTH STRATEGY

THE HEALTH OF THE NATION: POPULAR A5 VERSION

PAGE 1

The Government has decided that the time is now right to launch a health strategy for England.

This is an important initiative and everyone will have a part to play. The Government wants as many people as possible to be involved from the very start. This is why, before finalising the strategy, it is inviting the views of everyone who works the field of health and the general public.

The aim of this leaflet to give a brief flavour of the Government's proposals and to show how *you* can contribute to the discussion.

PAGES 2–5

THE HEALTH OF THE NATION

There has been a revolution in the nation's health over the last century. Better sanitation, improved diet, better health care and greater prosperity have all contributed to an immense improvement. People today live longer, healthier lives. And still we are making progress.

In the last ten years, average life expectancy in Britain has increased by 2 years - to 72 for men and 78 for women. In the same period, the number of deaths at birth has halved. The NHS treats more patients than ever before. But broad figures like these can only tell part of the story, which involves achievements in many different areas.

Preventing Disease

In the last two years, we have been able to hit rigorous targets for immunisation - over 90% of children will have been vaccinated by the time they are five. We are now well on the way to make that figure 95% by 1995.

Screening

The NHS led the world when it launched its national programme to screen for breast cancer in 1987 and we were the first in Europe to launch a programme to screen for cancer of the cervix. By 1993, all women in the ages at most risk will have been invited for a smear test or breast scan.

Healthier Living

Travel by bus, train or plane and the chances are it will be mostly non-smoking. Over the last fifteen years, the proportion of people smoking has dropped by a quarter. This is just one aspect of the general trend towards a healthier lifestyle - reflected by a vast increase in information available.

On top of greater interest in health shown by the press and TV, national health education campaigns have addressed major health issues, from AIDS and drug-misuse to tooth decay and heart disease.

A stronger NHS

In the last decade, equal effort has been spent on getting to grips with how the health service is organised and managed. There are over 16,000 more doctors and dentists and 60,000 more nurses and midwives. The number of patients treated in hospital has risen by almost a quarter in the last ten years. Recent reforms will enable the NHS to provide even better service.

PAGE 5

THE RIGHT TIME

Based on these successes, the Government has decided the time is now right to pull the various strands together, and spell out where we want to go in future.

The strategy for health will set targets for improvement in important areas. It will enable everyone involved in health to work together more effectively with a clearer sense of direction and a stronger sense of purpose.

Meeting these targets will bring tangible results - results that will give many thousands of people the chance to live happier, healthier and longer lives.

PAGES 6-7

AGREEING THE TARGETS

To begin with, the strategy will focus on areas of major ill-health where there is the opportunity for real and immediate improvement. More and more areas will be added as it develops.

The initial challenege is to choose the areas to be targeted. Many people are likely to have many different suggestions.

Some areas spring immediately to mind. **Coronary Heart Disease** for example is the biggest single killer of people under 65 - and yet in many cases, it is preventable. **Stroke** is another. That death rates for both have been falling since the early Seventies shows we can achieve change.

THE HEALTH OF THE NATION: POPULAR A5 VERSION

TARGET * A 30% drop in the rate of premature deaths from Coronary Heart Disease by the year 2000 ?

Smoking is another clear example where a great deal can and should be done. It is the biggest preventable cause of death, and causes a vast range of ill-health, from lung and other cancers to stroke and heart disease.

TARGET * To reduce the proportion of people who smoke by up to a third by the year 2000 ?

In areas, like **Immunisation** and **Dental Health**, great improvements have already been achieved, but there is always scope for more.

TARGET * by 2003 the average twelve year old should have no more than 1.5 decayed, missing or filled teeth.

The Government has drawn up a list of areas from which the final choice might be made - and it invites suggestions for more.

Graphic block:

Key health areas include:

Asthma;
Coronary Heart Disease;
Stroke;
Cancers;
Smoking;
Eating & Drinking;
Pregnant Women & Children;
Diabetes;
Mental Health;
Rehabilitation.

PAGE 8

WHAT DO YOU THINK?

The Government's full plans are published in a Green Paper, "The Health of the Nation", obtainable from HMSO bookshops and good booksellers (price £x) or through main libraries.

In the next few months, the Government will be inviting the views of as many people as possible.

The most important questions are:

What areas of health should we tackle first?
What targets should we set?

To put forward your own views, please write by 31st October 1991 to:
The Health Strategy Unit,
Department of Health,
Room B1208,
Alexander Fleming House,
Elephant and Castle,
London SE1 6BY

Word Count 919

A

A

Pen pictures

Sir Christopher France	Sir Christopher gained a First Class Honnours degree at New College, Oxford in PPE before joining HM Treasury in 1959. His range of jobs included spells as Prinipal private Secretary to the Chancellor of the Exchequer (73-76) and Principal establishments Officer (77-80). After spells with the Electricity Council and Ministry of Defence, he was transferred to DHSS and in 1989 was appointed First Permanent Secretary at the Department of Health.
Sir Donald Acheson	Appointed Chief Medical officer on 1 January 1984. A graduate of Oxford University (1951), his interest has been in the epidemiology of disease and the organisation of health services. He has been Director of MRC's Environmental Epidemiology Unit and Chairman of Southampton District Health Authority. He was Foundation Dean at Southampton University Medical School (68-78) and is currently the UK member of the Executive Board at WHO. Sir Donald chaired the recent Public Health Enquiry, the report of which "Public Health in England"(January 1988) presents the first major review of the public health function since the Royal Commission in 1871.
Duncan Nichol	As General Manager of Mersey Regional Health Authority (84-89), he served (from 85) as a member of the NHS Management Board before he was appointed Chief Executive (of NHS Management Executive) in December 1989. Having held health posts in London, Manchester, Chicago and Salford, he was appointed Regional Administrator for Mersey in 1981.
Prof. Michael Peckham	Appointed Director of R&D in January 1991, he was previously with the Institute of Cancer research, Director of the British Postgraduate Medical Federation and Civilian Consultant to the Royal Navy. He is President of the

	Federation of Cancer Societies, Editor in Chief of the European journal of Cancer and Fellow of the royal Colleges of Physicians of London and Glasgow and the Royal College of Radiologists.
Sir Roy Griffiths	Sir Roy has been associated with the NHS since his 1983 report on its management and was Deputy Chairman of the NHS Management Board from 1986. Currently a non-Executive member of the Board of Sainsbury's PLC (Previously Deputy Chairman) and Deputy Chairman of the NHS Policy Board.
Strachan Heppell	Currently Deputy Secretary heading the Health and Social Services Policy Group having held a number of posts in DHSS and been Social security adviser to the Hong Kong Government.
Dame Margaret Turner-Warwick	Currently President of the Royal College of Physicians (since 1989) and Chairman of the UK Standing Conference of Medical Royal Colleges. A consultant Physician (gen Med) at Elizabeth Garrett Anderson Hospital and London Chest Hospitals since 1965, she is a member of CMO's Expert Advisory Group on Postgraduate Medical Education and a member of the Working Part on Junior Doctors Hours.
Dr Colin Waine	By background a north country GP and community unit general manager (SW Durham). A past member of the Northern RHA, he has extensive experience in postgraduate education and has significant research work to his credit. He is currently seeking to take his Unit into a Trust and has recently been appointed Chairman of the Council of the Royal college of General Practitioners.
Dame Rosemary Rue	Currently President of the British Medical Association, Dr Rue was regional Medical Officer for Oxford Region before being appointed the first Regional General Manager with a medical background(again at Oxford) in 1984. She retired in August 1988.

Dr Stephen Hunter	Currently Chairman of the Hospital Junior Staff Committee (from 1 October 1990), he is a lecturer in psychological medicine, University of Wales College of Medicine, Cardiff(honourary Senior Registrar). He has been a member of HJSC five years and Deputy Chairman 89/90.
Dr Martin McNicol	Currently Chairman of Central Middlesex Hospital trust (based at Park Royal). Before that He ~~has~~ worked at the hospital for 25 years as a cardiothoracic Consultant. He was formerly Chairman of Brent HA before it merged with Paddington and North Kensington to form Parkside HA.
Prof. Cyril Chantler	His medical career began at Guy's in 1963 where he is currently Professor of Paediatric Nephrology and dean of the medical school. From 1985 to 1988, he was General Manager of the hospital and is currently a member of the NHS Policy Board.
Christine Hancock	Appointed General Secretary to the Royal College of Nursing in succession to Trevor Clay, Miss Hancock was previously General Manager of Waltham Forest HA (85-89) and District Nursing Officer for Bloomsbury HA.
Brian Edwards	Began his health service career in 1958 before joining the National Administrative training scheme 6 years later. He has held a number of administrative posts and lectureships in health service management before being appointed Regional Administrator at Trent RHA in 1981 and Regional General Manager in 1984. He is an advisor to WHO and an Associate Fellow of the Nuffield Institute, University of Leeds.
A.P(Paddy).J Ross	Currently Chairman of the Joint Consultants Committee and Consultant Surgeon based in the Royal Hampshire County Hospital in Winchester. Previously he was a Senior Registrar at St Bart's Hospital and Surgical Fellow in Boston,USA.

Carolyn - Revised Seating Plan B
SC 25/4

DRAFT SEATING FOR SEMINAR ON 27 APRIL

Mr Strachan Heppell	Dr Stephen Hunter
Mrs Virginia Bottomley	Sir Roy Griffiths
The Baroness Hooper	Dr. Martin McNichol
Mr Duncan Nichol	Dame Rosemary Rue
Rt Hon William Waldegrave	Professor Cyril Chantler
PRIME MINISTER	Dr Colin Waine
Miss Carolyn Sinclair	Dame Margaret Turner-Warwick
Sir Donald Acheson	Sir Christopher France
Professor Michael Peckham	Miss Christine Hancock
Mr Stephen Dorrell	Mr Brian Edwards

Mr Barry Potter Mr AP.J. Ross

ENTRANCE

C

OPENING REMARKS

I am very grateful to all of you for giving up a Saturday to come here. This is a distinguished gathering of medical and managerial experts. You have a wealth of experience between you and I look forward very much to hearing your views.

I propose that the first part of our discussion should focus on the proposed health strategy for England. I will ask William to introduce this. I understand you have all seen the consultation paper in draft, though work is of course continuing on it, not least in the light of today's discussion.

The concept of a health strategy is exciting. I see it as a logical product of the managerial reforms which are now in place. Increasingly we shall know how we are spending money in the NHS, and what we are getting for it. This will enable us to plan priorities - to have a strategy - in a way that would not have been possible before.

And I believe it is right that we should begin by focussing on health promotion. Ill health is costly in personal and financial terms. The more we can do to prevent it, the better.

But since ill health will sadly remain with us, I would like to spend the second half of the morning hearing your views how you see health and health care developing between now and the year 2000. Demographic change, advances in medical science and changes in clinical practice will all be important factors. Some of the possibilities look very attractive - a more effective role for nurses, whom I believe are an under-used source of talent, and for GPs, who could become the main focus for health care. I think many people would welcome this: they would find it more convenient and less daunting than having to visit impersonal out-patient departments for relatively minor procedures. I would have thought that the professions would welcome these

developments as well - no doubt you will be quick to tell me if I am wrong!

I am hear today mainly to listen. But I would like to make three points:

- every industrialised country seems to be grappling with the problems of soaring medical costs and soaring public expectation of more and better treatment;

- all countries engage in some form of health care rationing. Some do it by shutting out those not covered by national insurance from all but a limited number of treatments. I am glad that we do not do this;

- there are no objective yardsticks to show how much money should be spent on health care. Besides, the amount <u>spent</u> is not the point. What do we get for what we spend? Could we get more?

Now I would like to ask William to introduce discussion of our proposed health strategy.

367.CS

D

RESPONSES TO DRAFT CONSULTATIVE DOCUMENT

Note

The following comments are based on an earlier and longer draft. Since then, the document has been shortened and sharpened up.

Introduction

1. This note summarises responses received from :

   Professor Chantler
   Dr Martin McNicol
   Mr Paddy Ross
   Dame Rosemary Rue
   Professor Sir David Weatherall (Not attending on 27 April).

Points

2. There was clear acceptance by all of the value and need for a health strategy and setting targets.

3. Main points made (aside from drafting points and concerns about length):-

   Cyril Chantler

   i. "like paper... balance about right... The whole document in an important sense provides the intellectual basis for the NHS reforms".

   ii. Suggested additional issues: resource; the cost of handicapped children and prevention of handicap (target low birthweight babies and genetic services); and research.

   Martin McNicol

   i. Concerned at lack of stance on tobacco and alcohol fiscal policies, social deprivation and cultural problems ("poorly motivated population").

   ii. Unlike Professor Chantler, though document not clear on how reforms free NHS Authorities to address wider health issues.

   iii. Mental illness and rehabilitation not supported for inclusion. Need limited number of issues.

   iv. Number of concerns about length and style.

Paddy Ross

i. Should mention effect on NHS of reducing premature death ie more elderly people and thence greater costs.

Rosemary Rue

i. "Brave attempt" but danger of implying new emphasis on "health" is at expense of "health services". Reassurances needed.

ii. Omissions : elderly people and community care; family planning and abortion; resources.

iii. Audience - tries to address too many different audiences at once.

David Weatherall

i. Concept excellent. Agree areas chosen. Need to be careful about dietary advice. Important to be able to monitor progress.

ii. Child health - need emphasis on potential of genetic services.

iii. Needs to address problem of increasingly ageing population (made more acute if strategy successful).

iv. Key is education - of professions as much as public.

E

GUY's AND LEWISHAM TRUST

The Trust provides acute care from Guy's Hospital, Lewisham Hospital, Dunoran House, Hither Green Hospital, Sydenham Hospital and mental health services in the community.

Income for 1991/92 is expected to be £128 million. The Trust employs 8,000 people - 6,000 whole time equivalent staff.

The management at the Trust are taking steps to clear debts of £6.8 million from previous years.

At the same time they are making further savings of £6 million which will be re-invested in high priority services and improving staff conditions. The re-investment will be done by reviewing services in conjunction with purchasers and local GPs.

The Trust is responsible for its own day to day management. It is for the Trust's Board to determine the way forward and to manage their affairs sensibly.

In taking steps to clear debts of £6.8 million from previous years the Trust is actively managing its financial situation.

The Trust has undertaken to attempt to avoid compulsory redundancies. The reductions in staff will be made at all levels, where possible by early retirement, redeployment and leaving vacancies unfilled. The Trust has a natural turnover of staff of some 800 per annum.

The Trust hope not to reduce services provided.

GUY'S AND LEWISHAM NHS TRUST: BULL POINTS

1. The issues that Guy's are trying to address have been around for some time. They certainly pre-date the NHS Reforms. They are not really Trust issues at all.

2. Management is taking sensible decisions to address those issues. They are making their actions explicit. They are actions which do not impinge on patient care and which will largely be achieved without recourse to compulsory redundancy.

3. Arguably, the freedoms and responsibilities of Trust status mean that management is better equipped to handle these difficult matters.

4. It will be for purchasing Health Authorities to determine the volume of patient care and the numbers of people being treated year on year, via their contracts with providers such as Guy's.

F

A[redacted]gations that the NHS reforms will lead to a two-tier service

There have been claims that implementation of the reforms will lead to the development of a two-tier service in the NHS. Supposed examples would be the residents of one DHA 'queue-jumping' over those of another, or the patients of GP fundholders getting a better service than patients of GPs not in the scheme.

Points to make:

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OVERALL APPROACH

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G

COMPARATIVE RECORD

(England unless otherwise stated)

	1978/79 - 1990/91	1974/75 - 1978/79
Real increase in spending	Average annual INCREASE 3.1%	Average annual INCREASE 1.5%
Proportion of GDP spent on health (UK)	Up from 4.78% to 5.19% (1989) Average annual INCREASE 5.16%	Up from 4.63% to 4.78% Average annual INCREASE 4.84%
NHS capital spending	Up from £0.4bn to £1.7bn in cash Annual real terms INCREASE 4.2%	Up from £0.2bn to £0.4bn in cash Annual real terms REDUCTION -4.7%
Hospital Doctors pay	Real terms INCREASE 37.4%	Real terms REDUCTION -6.4%
Nurses pay	Real terms INCREASE 45%	Real terms REDUCTION -21%
Increase in numbers of in-patients treated per year	Average annual INCREASE OF 2.2% (to 1989)	Average annual INCREASE 0.9%
Infant mortality rates per 1,000 live births (England and Wales)	Down from 13.1 to 8.4	Down from 16.25 to 13.1
Number of GPs*	Up from 21,040 to 25,608 Average annual INCREASE of 415	Up from 20,219 to 21,040 Average annual INCREASE of 205
Increase in numbers of nurses and Midwives*	Up from 351,000 to 405,300 Average annual INCREASE 4900 (wte)	Up from 314,100 to 351,000 Average annual INCREASE 9200 (wte)
#Increase in numbers of Dentists*	Up from 11,919 to over 16,000 Average annual INCREASE 367	Up from 11,023 to 11,919 Average annual INCREASE 351

Figures include permanent paid and honorary staff (including Hospital Practioners, but excludes locum staff.
* Figures not yet available for 1990.

ACTIVITY

In ten years to 1989/90 :

Number of inpatients treated has risen by nearly 25% to 5.8 million.

Number of day cases treated doubled to 1.1 million.

Acute out-patient attendances rose by 8% to 31 million

Geriatric in-patients treated rose by almost 90% to 450,000

New Surgical Techniques

In past 2-3 years, considerable increase in "keyhole surgery", where operations such as the removal of a gall bladder are carried out through a small incision using a laparoscope.

Since 1982, possible to restore some hearing to totally deaf people through cochlear implants - Government funding of £1 million pa.

Annual number of liver transplants increased from 21 in 1982 to 295 in 1989.

Bed Closures

NHS treats patients not beds. Number of patients treated continues to rise - 24% increase since 1979 - but because of new methods of treatment, shorter stays, more use of day surgery etc. Fewer beds needed to treat more patients.

Bed numbers have been falling steadily for some years because:

faster turnover: 28 in-patient cases per available bed in 1989/90 compared to 17 in 1979.

day surgery - increased almost 100% nationally since 1979.

Bed numbers are reducing in many countries not just UK.

Improvements in Health

Perinatal, infant and maternal mortality rates have declined significantly over the past 10 years as effectiveness of maternity and neo-natal services has continued to improve;

infant mortality rates down from 13.1(per 1,000 births) in 1978 to 8.4 in 1989

Life expectancy increased by around 2 years during the life time of this Government - to 72 for men and 78 for women.

NHS EXPENDITURE

Spending at an all time high. Expenditure plans for 1991-92 will mean an increase of 52% in real terms since 1978-79.

About £511 a head of population is being spent on health in 1990/91 compared with £365 in 1978/79 (updated to 90/91 costs) - a real term's increase of 40%.

For every £1 spent on health in 1979, nearly £4 will be spent in 1991-92.

UK spends higher proportion of GDP on publicly funded health care than USA, Japan, Spain, Australia or Denmark. Proportion of public GDP up from 4.8% to 5.3% (1979-1989) - under Labour it fell.

More now spent on patient care because of increased efficiency. Cumulative savings from cost improvements programme now over £1 billion.

Capital

NHS Capital spending is £1.5 billion (1990/91), just over 4% in real terms and 62% in real terms higher than 1978/79. By comparison, from 1974 to 1979 capital spending fell be 16%.

Throughout England, over 450 capital schemes, each costing over £1 million are at various stages of planning, design and construction.

Between 1979/80 and 1989/90, a total of £1.1 billion has been realised from the sale of surplus land and property - the health service has kept all the money.

NHS REFORMS

Aim

To give patients more choice and better quality care and staff more freedom and responsibility. Not a "back door" to privatisation.

Government fully committed to NHS.

GP Fund-Holding

Scheme entirely **Voluntary** - it utilises expertise and experience of GPs to obtain best use of NHS resources for the benefit of patients. First wave (306 practices- 1720 family doctors) with effect from 1 April- 350 expressions of interest for second wave) Fund-holders already negotiating with hospitals on improvements in quality of service and value for money.

No patient will be denied treatment because of practice funds.

GPs will not run out of money - hospital treatment costs above £5,000 for any individual in any year will be met by the patient's district health authority.

NHS Trusts

Trusts will remain fully part of NHS.

Health authorities not Trusts will be responsible for securing comprehensive health services for their residents.

57 Trusts are being established from 1 April 1991.

Trusts will be better able to respond to patients needs through greater freedoms and flexibility and greater local involvement.

Dental Contract

12 million patients in England and Wales have "signed on" with a dentist under the new contract since October 1990 - steady build-up at the rate of over 2 million a month.

GPs' New Contract

Over 80% of GPs have received payment for reaching immunisation and cervical screening targets.

In first nine months of contract (April 1990 to December 1990) GPs performed almost 500,000 individual surgical procedures. Over the same period over 450,000 individual health promotion clinics held (eg anti-smoking, diabetes, well person).

Massive increase in expenditure on GPs' staff and premises, 1991 allocation of £564 million is 87% more than spent in 1989/90 (£302 million).

Number of nurses working with GPs increased by 65% since 1989/90.

Indicative Prescribing Scheme

NHS expenditure on drugs prescribed by GPs is currently £1.9 billion per year. Some GPs currently spend twice as much as others.

There will be no cash limit at any level on GPs' prescribing - GPs' clinical freedom will not be infringed in any way.

Manpower

There are now more than 16,000 more doctors and dentists than in 1979(GB figure).

In England, the number of GPs has risen from 22,651 in 1978 to 27,420.

There are now 60,000 more nurses and midwives than in 1979.

Since 1978, the number of dentists has risen from 11,919 to more than 15,000.

Junior Doctors' Hours

Commitment to reduce hours to 72 per week agreed on 17 December.

Government's immediate response was to fund 200 new consultant and 50 new staff grade posts in England.

Health Promotion - Disease Prevention

AIDS

Since 1985/86 the Government has allocated :

over **£31 million** to the development of the national AIDS public education campaign;
over **£350 million** to health and local authorities for the development of AIDS related services; and
over **£6 million** to agencies in the voluntary sector.

The UK strategy is highly regarded internationally, for example by the World Health Organisation.

Smoking

£2 million teenage smoking programme now in its second year. Advertising element of the programme has achieved remarkably high levels of awareness.

Now funding £1 million over two years for a new Health Education Authority programme to reduce smoking during pregnancy.

Alcohol and Drugs

New specific grant of £1.4m for voluntary services.Bids accepted so far :

25 for drugs services	£453,612 (32.4%)
32 for alcohol services	£750,429 (53.6%)

This grant has greatly encouraged local dialogue between statutory and voluntary sectors which bodes well for the implementation of Community Care.

Strategy For Health

First stage is Consultation Document - due to be published in May. It will include targets for health and health care improvements.

Th. you for coming -
Distinguished gathering medical / managerial expertise.
V. much want to hear yr. views — to listen.

Focus discussion in two parts

(1) Proposed Health Strategy (ww to i/duce).

I know you have seen an early draft - work continuing
- yr. comments material to that.

Concept of Health Strategy is exciting.
with current reforms - increasingly we will know - here we are spending - NHS
what " " getting for it.

This makes it poss. to have a strategy - to plan priorities in a way
we could not previously have done.

In doing that, .. how we should focus on health promotion.
Ill health is costly, distressing.
We shd. prevent it where we can. (better health costs not cure
[Beveridge J. - on (1), not (2).

BUT
Since, whatever we do, ill-health will always be with us
I want to spend much of the morning seeking yr. views
on how you see health + health care developing up to 2000.

NHS Pay

Greater flexibility in NHS pay to help recruitment and retention.

From 1 April, Trusts will have freedom to make their own arrangements.

Hospital Doctors' Pay

During this government, pay of hospital doctors and dentists has increased by 36% in real terms - compared to 6.4% drop between 1974 and 1979.

Nurses' Pay

Nurses' pay has gone up by 43.5% on average in real terms since 1979 - compared to real terms fall of 21% between 1974 and 1979.

TRANSPLANT

For this p/o discussion ww has asked a number of you to introduce topics — gp. to you.

Clearly there will be changes: —

demographic changes

(no doubt) changes in medical practice / treatments

(certainly) advances in science

Some poss. changes look attractive.

- How will the role of Nurses change?
  Can we use their skills to better effect?
- How will role of GP's develop?
  Can they become a larger focus for Health Care?

I want mainly to listen. But, @ the background to our discussion are 3 evident truths: —

(1) Every industrial country is facing the same medical challenges we are — > expectations, > costs, + ↓ in the end, finite resources.

(2) Everywhere there is some form of health rationing. often hidden, it exists. [Some do it by shutting out people from such treatments if not covered by N.I. Glad that not our way].

(3) Have responsibility to get MAXIMUM health care we can for resources available. ww — 1/piece STRATEGY DOCUMENT

CONFIDENTIAL

PRIME MINISTER

HEALTH SEMINAR

You are holding a health seminar for Ministers and senior health professionals on Saturday morning at Chequers.

I will provide detailed briefing, in consultation with Policy Unit, on Friday evening.

In the meantime you might like to see the attached letter and note from Carolyn Sinclair. The short point is that one main purpose of Saturday's seminar was to discuss the health strategy document. But the draft has run into trouble. It is too long; it is too boring; it is too much geared to NHS professionals; and it is too little suited to the general public.

As the attached letter from Mr. Waldegrave indicates, he accepts these criticisms. The practical difficulty is that publication of the health strategy document will be delayed at least until mid May.

The idea of a separate popular version as a White Paper is only just getting off the ground. It looks sensible: but you may want to discuss with Mr. Waldegrave.

There is a silver lining. It does mean that at Saturday's seminar it should be possible to pick up ideas which might be reflected in the final document.

There is also a black cloud. I understand an early version of the document has been leaked to Robin Cook M.P. That could be potentially damaging. Some of the graphs in that earlier version showed Britain in a relatively poor light. And the whole draft was confusing.

Moreover both the Telegraph and The Times are running more positive stories about the seminar tomorrow. Mr. Cook's planned press conference will cause us difficulties.

I have warned Gus and Press Office.

BARRY H. POTTER

24 April 1991

c:\wpdocs\economic\health.dca

CONFIDENTIAL

CONFIDENTIAL

PRIME MINISTER

24 April 1991

HEALTH STRATEGY DOCUMENT

This is the main topic for discussion at your health seminar at Chequers on Saturday. You may like to know where things stand on the drafting.

The original idea, trailed by Kenneth Clarke at the last Party Conference, was for a document highlighting the achievements of the NHS and proposing a number of areas where we would set targets to improve health - for example, by reducing deaths from coronary heart disease. The political aim was to switch debate away from the aridities of managing the NHS to something of interest to ordinary people.

But the purpose of the document changed in the drafting. William Waldegrave has been convinced by Donald Acheson that if he is to carry the leaders of the medical profession along with the idea of setting targets for better health, he must admit the weaknesses in British health. The upshot was a long document addressed to health professionals full of graphics which presented England in a poor light internationally.

Some of your colleagues on HS were taken aback by this. They had been expecting an altogether more upbeat paper. At David Waddington's suggestion it has been agreed that publication should be put back a little from the proposed date of 30 April to allow the draft to be improved.

Work is now in hand on this. Most of the negative tables have already been replaced by more positive ones which are actually more relevant to the text. A small drafting group chaired by the Cabinet Office and including the Treasury (I am also on it) will start work on Friday.

But while this group should be able to produce a shorter and better paper, there is a more fundamental issue to resolve. William Waldegrave's desire to carry the health professional is important. If this requires the consultative document on a health strategy to be written in a certain way, you may want to press him to produce a snappier and more politically useful "white paper" on health targets in September/October. You will be best placed to decide this after the Chequers' seminar when you will hear the views of professionals who have already seen a draft of the paper.

CAROLYN SINCLAIR

366.CS

24.04.
P1191

THE HEALTH OF THE NATION

A CONSULTATIVE

DOCUMENT FOR

HEALTH IN ENGLAND

THE HEALTH OF THE NATION

A CONSULTATIVE DOCUMENT FOR

HEALTH IN ENGLAND

Presented to Parliament

by Command of Her Majesty April 1991

CmXXX

LONDON: HMSO

PRICE £00.00 net

FOREWORD BY WILLIAM WALDEGRAVE, SECRETARY OF STATE FOR HEALTH

As we approach the next millenium it is timely to look forward to what we in England want to achieve by way of further improvements to our health.

In the last few years attention has concentrated on improving the organisation and management of the National Health Service. Significant changes have been made to the way family health, community and hospital services are organised. The purpose of the reforms was to give the Health Service a much greater capacity explicitly to address the health needs of the country. This consultative document shows how the reformed NHS can, with the Department of Health and others, play its part in identifying those needs and developing policies which will help to meet them.

A key feature of the reforms has been the establishment of a clear strategic role for health authorities – Regional and District Health Authorities, the new Family Health Services Authorities and non-geographical bodies such as the Health Education Authority. For too long health authorities have been preoccupied with the – very real – problems of day-to-day management of services. This has been to the detriment of their strategic role of maintaining and improving the health of their local people. Paradoxically, it has also been argued to have been to the detriment of the services themselves, where local managers and clinicians have not felt they have been left free enough to manage.

The reforms have established that the prime role of health authorities is an explicit responsibility for the health of their residents. Their job, as "champions of the people", is threefold:

First, to assess the state of health of the people they serve

Second, to obtain the services needed to ensure effective action is taken to maintain good health, prevent and treat ill health, rehabilitate people to good health, and provide support and care for those who are disabled, chronically ill or dying

Third, to ensure the quality and effectiveness – including cost effectiveness – of the services their residents use.

These changes at local level have been matched by complementary changes at national level. Not least of these is the establishment, within the Department of Health, of the NHS Management Executive whose task is to improve the 'head office' function of the NHS and ensure that responsibilities delegated to local level are effectively discharged and performance properly monitored and reviewed.

However, the reforms also refocus the Department's attention on the broader public health issues which often go beyond the remit and responsibilities of the NHS. It is often forgotten that the Department of Health's predecessor Ministry was established in 1919, long before the creation of the NHS. Its origins lay in the great public health reforms of the second half of the

FOREWORD BY WILLIAM WALDEGRAVE,

SECRETARY OF STATE FOR HEALTH

CONTINUED

19th century and the need to consolidate responsibilities for health within a single Ministry. The 1919 Act required my predecessor the Minister of Health to "take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people". Only later came my NHS responsibilities for the prevention, diagnosis and treatment of ill health. The exercise of these central Government responsibilities has not been in abeyance, but their importance and the attention we pay to them need now to be brought into a better balance with the attention we rightly pay to the National Health Service. The changes allow this to happen. The strategic role of the Department of Health is clear. Its task is to monitor and assess the health of the nation and take the action necessary, or ensure that the action is taken, whether through the NHS or otherwise to improve and protect health.

This document describes how we might best go about developing this new health programme. It sets in train the generation, effectively for the first time in England, of national and local health objectives and targets within a strategic framework. Parallel steps have already been taken by my colleagues in Scotland and Wales and are under consideration in Northern Ireland.

A variety of public authorities have a role to play. Historically, the nineteenth century reforms involved many Departments and institutions of Government. We now accept as the norm the availability of clean water, effective sewerage systems, the absence of vermin, clean air, safe food, regular waste collection and disposal, and street cleansing. We also now accept that part of the justification for income support for certain groups of the population and the need for a decent standard of affordable housing to be available to all is related to health. Today, therefore, not only Government Departments, but also local authorities, public water and sewerage companies, HM Inspectorate of Pollution, the Health and Safety Executive, and many other bodies have a continuing role in maintaining and improving our health. Their contributions to this health strategy, therefore, should be acknowledged and, where practicable, co-ordinated.

But the national health objectives and targets and associated initiatives which this document proposes are not for the authorities alone. Government cannot by itself secure the health of the population: that can only be secured by persuading ordinary citizens that it is worth doing and securing their commitment, co-operation and concerted action. Likewise, objectives and targets have to be broadly accepted if they are to be of value – not just by professionals but more widely. That is why we are publishing at the same time as this fuller document a summary version which I hope will have wide circulation.

The discussion and ideas in this document speak, I hope, for themselves. However, there are three points I wish to emphasise:

First, a major theme of this document is the prevention of ill health and promotion of good health. It must be right to redouble our efforts to prevent avoidable disease and premature death. This must not, however, be at the expense of caring for ill people and treating illness, of effective rehabilitation after accident or illness, or of looking after the infirm and dying. We need simply to find the right balance between what Beveridge identified as the three key areas: prevention, treatment and rehabilitation.

Second, there is considerable emphasis in this document on the need for people to change their behaviour – whether on smoking, alcohol consumption, exercise, diet, avoidance of accidents and, with AIDS, sexual behaviour. The reason is simple. We live in an age where many of these main causes of premature death and unnecessary disease are related to how we live our lives. For too long, however, the health debate has been bedevilled by the two extreme claims of, on the one hand, "It's all up to individuals" and, on the other, "It's all up to Government". We need a proper balance between individual responsibility and Government action. Government must ensure that individuals have the necessary information with which they can exercise informed free choice. Education both of children and adults is the key here. Government also takes a variety of actions to try to see that people live in physical and social circumstances where the exercise of free choice is possible. Nonetheless, where law or regulation is concerned, it is Government which must take effective action on behalf of individuals and their families. In between Government and individual stands a range of organisations – statutory authorities, voluntary bodies, health professionals and others – whose activities will be more effective if their partnership is exercised within a broad agreement about their goals. You cannot in the end coerce people into good health. That is why we need mutual agreement on priorities and on how best to work together to improve our health.

Third, I am convinced that setting objectives and targets for improvements in health is an essential discipline. Much of this document is based on that conviction. But we must get the targets right. They must be sufficiently challenging, yet not so daunting that they become a disincentive to achievement. A key purpose of this consultative document is to focus debate on a number of alternative objectives and targets which are specified in the text. Others may wish to propose additional targets. It is important to state clearly, however, that priorities are meaningless if they include everything. Not every deserving objective can be a priority. Further, if targets are to be of any use, they must be defined, and there must be a clear understanding of how the setting of targets can be carried forward into effective action to meet them. The converse of this is, that by raising the priority of certain areas where a concerted effort can bring major rewards, we are not lessening our commitment to steady progress

FOREWORD BY WILLIAM WALDEGRAVE.

SECRETARY OF STATE FOR HEALTH

CONTINUED

across the board by means of comprehensive health provision policies.

The development of a health strategy is a new concept for England. The NHS management reforms give us for the first time a firm foundation on which to build our approach. We can now think strategically about the future direction of health. We are clear about one thing: a strategy imposed by Government which takes no heed of the views of those who will have to implement it, including the people themselves, is valueless. Implementation depends, in the current jargon, on shared 'ownership'. Health is determined by a wide range of influences. Responsibilities for action are similarly widely spread from individuals to Government. Commitment – shared commitment – to a health strategy for England is essential. Hence this document initiates the active consultative process which is described in the final chapter.

The consultation will be positive and comprehensive. As well as seeking comments during the consultation period to the end of October 1991 on what is in this document, the Department of Health and the NHS will jointly be establishing a number of groups to look in more detail at specific issues raised. The results of consultation and the work of these groups will influence a second **Health of the Nation** document to be published later and which will set out the way forward proposed in the light of the consultation. Complete agreement may be unattainable. But it is right to seek as much common ground as possible.

I look forward to your responses and the discussions I am confident this document will stimulate.

William Waldegrave

WILLIAM WALDEGRAVE April 1991

Secretary of State for Health

Whitehall

LONDON

THE HEALTH OF THE NATION

The Health of the Nation is a discussion document which sets out for consultation the Government's proposals for the development of a health strategy for England.

THE VALUE OF A STRATEGY

1 The Government believes the time is now right to develop a health strategy for England. The recent series of reforms affecting health and health care provide significant new opportunities for improving the health of the country. In addition, since the process of reform has inevitably concentrated attention on mechanisms and means rather than ends, the Government believes attention must now be focused on the **improvements in health** which were the aim of the reforms.

2 The value of a strategy is that it clarifies aims and responsibilities, focuses action and sets a framework against which progress can be measured. Its ultimate purpose is to improve further the span of healthy life of the people of England.

THE POLICY OBJECTIVES

3 The key policy objectives and guiding principles which underpin the proposals are the need:

- to identify the **main health problems** and focus on them:
- to focus as much on the **promotion of good health and the prevention of disease** as on the treatment, care and rehabilitation of those who fall ill or who need continual support, **whilst ensuring that work on either is not at the expense of the other** – there must be no lessening of the NHS's role to provide high quality services to meet changing or increasing demands:
- to recognise that as health is determined by a whole range of influences – from genetic inheritance, through personal behaviour, family and social circumstances to the physical and social environment – so **opportunities and responsibilities** for action to improve health are widely spread from individuals to Government as a whole:
- to recognise that the concerted action needed calls for **greater co-operation** between those involved, at national and local level, within and outside the NHS:
- to secure a proper balance between central strategic direction and **local and individual discretion, flexibility and initiative**: and ensure that where responsibilities are devolved there is fair, but rigorous, scrutiny of performance and outcomes:
- to secure the best possible use of available **resources** – resources will always be finite and there are competing demands in society.

4 The Government recognises that the achievement of these objectives in turn means:

- improving the ability both to **monitor** the state of the people's health and to **evaluate** the health benefits of policies and programmes, and the ability to **assess the effectiveness** – in terms of 'health gains' – of particular services and practices:

• ensuring everyone has the best possible **information** they need to understand the influences on their health, especially the influence of their own behaviour, and the necessary **support** to improve their health;

• **involving people more**– individually and through local and voluntary organisations – at both strategic and operational levels in discussion and decisions about options and priorities, and through that involvement generating a shared commitment.

KEY OBJECTIVES AND TARGETS

5 Central to the Government's suggested approach is the need to identify and **agree clear objectives and specific targets for improvements in health.**

THE HEALTH OF THE NATION: THE CHALLENGES

6 The last 100 years have seen a transformation in the health of the people of England. Continued vigilance is needed to sustain the improvements. And there are still formidable challenges:

• many people still die prematurely from conditions – diseases, accidents – which are to a large extent preventable.

• many people still suffer from preventable illnesses which significantly impair the quality of their, and their families', lives.

• many of these causes of death and illness are known to be preventable both in principle and from comparison with performance in other countries, and within England. Moreover, in practice many of them can be prevented if effective action is taken.

• there are significant variations in health – geographical, ethnic, social and occupational – within England as in other countries. This is a cause for concern and a challenge: concern, because there is often no known intrinsic reason for their existence: a challenge, because, like comparisons with other countries, they indicate the possibility for improvement.

• despite significant progress – and what the NHS has achieved is formidable – there are still variations in the quantity and quality of health care in different parts of the country.

7 What needs to be done? Key are the need

• to increase understanding of the state of the population's health and what influences it

• to reduce exposure to risks from people's own behaviour or the environment which damage health

• to take action to ensure that people are properly informed and have the freedom to exercise choice. People cannot be forced to behave sensibly in terms of their smoking, eating, exercise, alcohol or sexual habits

• to continue to improve the efficiency, effectiveness and quality of NHS care, and

• for Government or others, to take effective action on behalf of the community as a whole, to monitor and, when necessary, to eliminate or minimise the threats to

individuals from the external world which they cannot themselves control.

FACING THE CHALLENGES: OPPORTUNITIES AND CONSTRAINTS

8 There are new opportunities as well as existing strengths on which to build. The reforms to the NHS – "Working for Patients", "Promoting Better Health" and "Caring for People" – have made profound changes:

- The more strategic – "health" – role of health authorities. The emphasis is first on assessing the state of health of the people they serve, second taking action and, third, assessing what improvements to health have been made.
- The new emphasis on health promotion in primary care.
- The renewed emphasis on the strategic responsibility of the Department of Health to monitor and assess the health of the nation and take the action necessary, or ensure the action is taken – whether through the NHS or otherwise – to improve and protect health.
- Renewed emphasis at all levels on developing better ways of monitoring and assessing health, and measuring the effectiveness of interventions and monitoring their achievement.
- The full integration of the Health Education Authority within the NHS.

9 These changes enable the NHS and DH better to play a leading role in addressing health issues. They reinforce the already well-developed mechanisms at both national and local level, in Government and outside, whereby key environmental and other health issues are addressed. The document sets out the responsibilities for health of Government Departments and local authorities and acknowledges the vital contribution of the voluntary sector and the increasingly important role of employers' and employees' organisations.

10 Constraints are twofold: knowledge and resources.

- There is a need both to concentrate on what is known to be likely to be effective and recognise there are no simple, single solutions.
- The resources needed to take forward a health strategy and re-order priorities are finite in terms of money, time, skills and enthusiasm.

11 A strategy is about developing a continuing process which provides opportunity for decisions to be taken about what matters most, and allows attention to be concentrated on securing improvements in these areas.

A HEALTH STRATEGY FOR ENGLAND: FORM AND CONTENT

12 The proposed approach is:

First, to identify for attention key areas where improvements can be made.

Second, within those areas, to place the emphasis on

securing genuine improvements in health for which targets can be set at either national or local level and progress monitored.

Third, to seek to improve knowledge and understanding in order to review and re-appraise priorities over time and bring further areas within the scope of national priorities and targets.

13 The document proposes three criteria for the selection of these key areas:

***First*, the area should be a major cause of premature death or avoidable ill health (sickness and/or disability) either in the population as a whole or amongst specific groups of people**

and

***Second*, the area should be one where effective interventions are possible, offering significant scope for improvement in health**

and

***Third*, it should be possible to set objectives and targets in the chosen area and monitor progress towards their achievement through indicators.**

OBJECTIVES AND TARGETS

14 Rigorous analysis of the possible interventions in each area and the setting of objectives and targets are essential disciplines for achieving a strategy. Targets should:

- provide an overall goal and sense of purpose
- be explicit, quantified and monitorable over time through accurate indicators
- be achievable over a specified time, given what is known of scope for improvements within resource and other limitations, and within the wider context
- be challenging, if they are to help gain the maximum benefit from a strategic approach.

15 Ideally, these targets should be expressed as improvements in health or changes to risk factors (such as smoking) or the precursors of ill health (such as raised blood pressure), though in some cases it may be appropriate to relate targets to interventions or processes which are known to improve health.

SUGGESTED KEY AREAS AND TARGETS

16 The document looks in turn at each of the three criteria for selecting key areas. The areas which emerge reflect a diversity of possible candidates:

causes of substantial mortality

- coronary heart disease
- stroke
- cancers
- accidents

causes of substantial ill health

- mental health
- diabetes
- asthma

factors which contribute to mortality, ill-health and healthy living

- smoking
- diet and alcohol
- physical exercise

areas where there is clear scope for improvement

- health of pregnant women, infants and children
- rehabilitation services for people with a physical disability

areas where there is a great potential for harm

- HIV/AIDS
- other communicable diseases
- food safety.

17 Annexes discuss each of these areas, together with possible targets (if any) which might be set. In some cases it concludes that target setting at this stage is neither possible nor helpful. Subject to the results of consultation the intention is to agree a limited portfolio of initial key areas and targets. Chapter 7 suggests the candidates for inclusion.

18 Other areas would be identified over time. The document recognises the importance of continued developments in each individual subject area and also in the general ability to monitor and assess the health of the population, develop and assess effective interventions and increase understanding of the measurement of health outcomes. Initiatives in all these areas are outlined, including the recently announced research and development strategy designed to provide a sound scientific basis on which to improve health.

MAKING PROGRESS – MAIN RESPONSIBILITIES

19 The achievement of improvements in health requires a shared commitment of all those with responsibilities for health. At the heart of a strategic approach will be the need to identify in each key area responsibilities and individual and collective roles for, amongst others

- individuals
- health care services
- the health professions
- voluntary sector
- the education service
- industry and commerce
- the media
- Government, local and national.

20 The need for concerted action calls for Government involvement in ensuring progress is made – it needs to lead, facilitate and monitor to ensure progress is made.

THE PARTICULAR ROLE OF THE NHS

21 The document considers the particular role of the NHS in achieving national targets. It stresses the need to make the link between national priorities and local action which must be determined in the light of local circumstances and other local priorities.

22 The document sets out for discussion the ways in which national targets could be built into NHS planning mechanisms at local level, and sketches the individual

roles of Regional Health Authorities, Family Health Services Authorities, District Health Authorities, and provider units and independent contractors. It also looks at the special role of the Health Education Authority.

QUALITY

23 The proposals focus primarily on improving health in terms of the incidence, prevalence and effects of disease. The document emphasises that this necessary refocusing of activity on the prevention of disease and the promotion of good health must *not* be at the expense of NHS treatment and care services. A better balance is needed, not a bias in one or other direction. To help ensure this balance is sustained in this health strategy, the document proposes that in addition to the objectives and targets proposed, each Health Authority set itself stringent "quality of service" targets. The Government believes the areas where targets should be set and the targets themselves are generally best decided at local level (with Government ensuring they are both rigorous and met) – with the exception that *appointment times* is an area where all health authorities *must* set targets. The NHS Policy Board will keep a close watch as these are developed.

CONSULTATION

24 The Government wishes to encourage full and widespread discussion of the idea of a health strategy for England. The main questions for consultation are identified in chapter 12.

25 During consultation two expert working groups will be established to look at issues raised in the document. One will consider the role of the NHS in implementing the strategy. The other will look at the wider public dimensions. In addition, a number of working parties will be established to examine the specific options for objectives and targets. The whole exercise will be overseen by an English Health Strategy Steering Group chaired by the Secretary of State for Health and supported by a task force. There will also be a series of conferences.

THE HEALTH OF THE NATION

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Notes:

i It has not been considered appropriate to provide detailed references to the various statistics quoted in this document (although where graphs or charts are used, sources are quoted). Most of the statistics for England have, however, been obtained from OPCS, and WHO for international comparisons. References to research findings, and other references, are treated similarly.

ii Where possible England-only statistics have been used. In some cases, however, information is available only for England and Wales, Great Britain, or the UK as a whole.

INTRODUCTION

The achievements of the last 100 years – The scope for improvement – A strategic approach needed.

1.1 "Nasty. brutish and short". It is salutary to remember that it is only relatively recently – a matter of a few generations – that Thomas Hobbes' words ceased to be the common experience of life for the majority of people in England. Infectious diseases were rife. The toll exacted by the ravages of disease. squalor. ignorance and undernourishment speaks for itself. Sir John Simon estimated that at least nine-tenths of all deaths in the 1850s were premature. A century ago four out of ten babies did not survive to adulthood. Life expectancy at birth was only 44 years for boys and 47 for girls. As recently as the early 1930s. 2500 women a year died during pregnancy or childbirth.

1.2 The transformation has been profound. as is illustrated in *figures 1 and 2*. Life expectancy at birth is now 72 years for boys and 78 for girls. Infant mortality – a basic indicator of any nation's health – now stands at 8.4 deaths for every 1000 live births. The greatest period of change was during the second half of the 19th and the first half of the 20th centuries when death rates from diseases such as tuberculosis. enteric fever. diphtheria. scarlet fever. whooping cough and measles fell to one per cent of their previous levels. Immunisation and the development of effective drug treatments played their part. but the achievement was essentially due to various social and public health changes. Safe water and sewerage. better housing. less overcrowding and better working conditions. greater economic prosperity. better nutrition and better education lay at the heart of the transformation.

1.3 The challenges faced by our predecessors were formidable. as were their achievements. But society cannot rest on these achievements. There are still major health problems to address. They are just as challenging. People may be living longer but many still die prematurely or have the quality of their lives – especially in their later years – impaired by avoidable ill-health. There is enormous scope for further improvement.

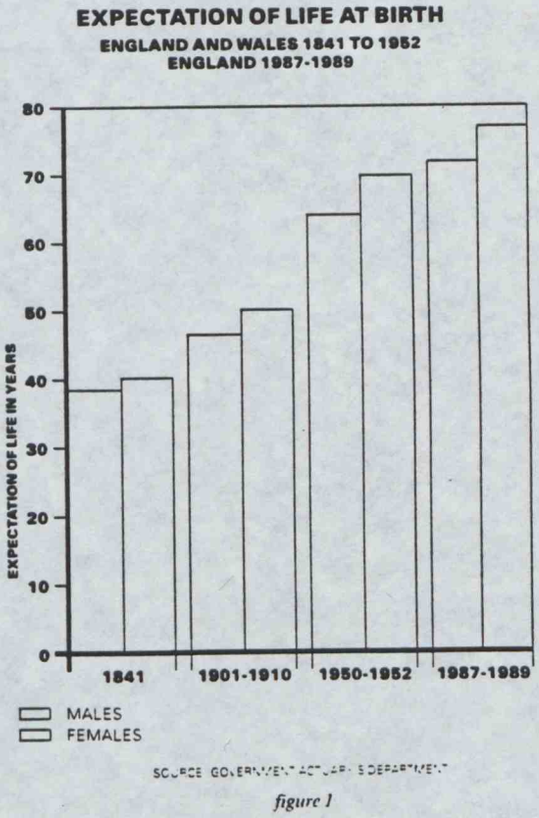
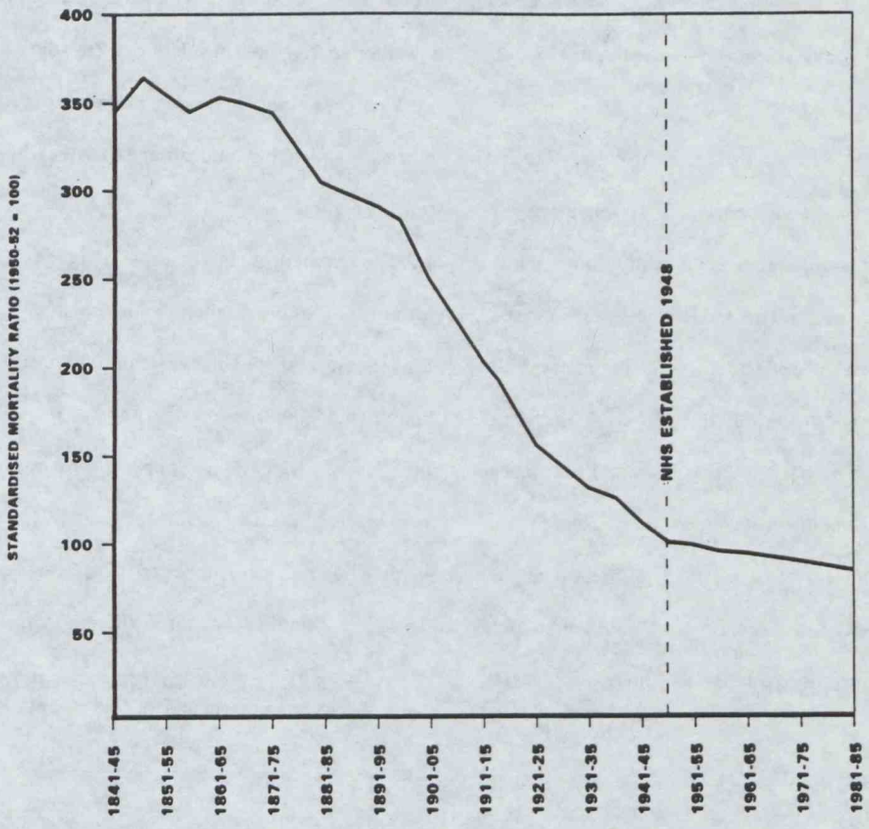


figure 1

MORTALITY TRENDS 1841-1985

ENGLAND AND WALES ALL PERSONS



THE STANDARDISED MORTALITY RATIO (SMR) IS AN INDEX WHICH ALLOWS FOR DIFFERENCE IN AGE STRUCTURE. VALUES ABOVE 100 INDICATE HIGHER MORTALITY THAN IN 1950-2 AND VALUES BELOW 100 INDICATE LOWER MORTALITY

SOURCE OPCS

figure 2

1.4 Much has been achieved, and much is being done. But as tends to happen in England, the emphasis has generally been to pursue separate initiatives rather than develop a more strategic approach. The Government believes that the time is now right for such an approach; what needs to be done can best be secured by concerted action within a common strategic framework. The NHS reforms have created significant opportunities – particularly in the change of emphasis in the role of health authorities[1] – on which a strategy can draw to achieve significant improvements to the health of the population.

1.5 This consultation document sets out for discussion and comment what the Government hopes to achieve through the development of such a health strategy for England. "What form will it take?", "Who will be involved?", and above all "What is it hoped that it will achieve?" are the main questions. The overriding aim is that the strategy should genuinely contribute to improvements in people's health by focusing attention and action on the major health problems to be tackled for the rest of this decade and beyond into the 21st century.

1.6 This document deals only with England. A separate approach has been taken in Wales and in Scotland, and is under consideration in Northern Ireland.

[1]Unless otherwise stated, the term 'health authorities' used in this document refers to Regional Health Authorities, District Health Authorities, Family Health Services Authorities and, where appropriate, Special Health Authorities.

WHY A STRATEGY FOR HEALTH?

Why a strategy is needed – Rectifying the balance between health care and health – Turning aspirations on health promotion and disease prevention into reality –The pioneering work of the World Health Organisation's "Health for All" – An English Strategy – Common ownership – The broad principles and objectives – The importance of objectives and targets for health.

HEALTH

2.1 It is commonplace to say of health services, in other countries as much as England, that they are not **health** services but rather treatment and care services. The major preoccupation is with treating illness and looking after infirm, chronically sick and elderly people who need continuing care and support.

2.2 It is not difficult to understand the reasons for this. People fall ill and need to be treated and cared for. Their illnesses and needs exist here and now. On the other hand the promotion of good health may not appear so immediately demanding. Moreover, understanding of what to **do** effectively to promote health is not as advanced as understanding of how to treat illness. And often the results of health promotion take time to emerge and are difficult to measure.

2.3 Even within the treatment and care services themselves the emphasis in measuring achievement has tended to be on the volume of resources put into the service and the numbers of patients treated rather than what improvements to health and quality of life have been achieved. The reliance until only very recently on hospital 'death and discharge rates' as a key indicator of health service performance aptly demonstrates the point.

2.4 However, if full advantage is to be taken of the opportunities to improve the nation's health, then health must be seen not simply as the treatment and cure of illness, but as something in its own right at which to aim.

2.5 The need for countries to re-orient their policies and programmes towards health rather than simply health care was the motive behind the World Health Organisation's "Health for All by the Year 2000" programme. The HFA approach has been adopted by some countries as the basis for developing their own health strategies. It has similarly been used by many health authorities in England. The Government acknowledges its debt to WHO – and the extent of that debt will be clear from this document – but as WHO is the first to acknowledge, HFA cannot in itself provide any country with a strategy tailored to its specific needs. Valuable lessons can be learned from WHO and other countries' experience, but England is no exception to the rule that every country needs its own approach – one which is accepted by the general population. Such ownership and commitment can only come through discussion and consultation to develop a strategy suitable to society as a whole.

A STRATEGY FOR HEALTH

2.6 The aim of a strategy is simply expressed: it is to improve further the span of healthy life of the people of England. The value of a strategy lies in identifying broad aims, clarifying objectives and responsibilities, focusing concerted action and setting a framework against which such improvement can be measured.

2.7 Some key strategic policy objectives and guiding principles can be stated at the outset. They underpin the entire approach. They are the need:

- to identify the **main health problems** and focus on them;
- to focus as much on the **promotion of good health and the prevention of disease** as on the treatment, care and rehabilitation of those who fall ill or who need continual support, **whilst ensuring that work on either is not at the expense of the other**;
- to recognise that as health is determined by a whole range of influences – from genetic inheritance, through personal behaviour, family and social circumstances to the physical and social environment - so **opportunities and responsibilities** for action to improve health are widely spread from individuals to Government as a whole;
- to recognise that the concerted action needed calls for **greater co-operation** between those involved, at national and local level, within and outside the NHS;
- to secure a proper balance between central strategic direction and **local and individual discretion, flexibility and initiative**; and ensure that where responsibilities are devolved there is fair, but rigorous, scrutiny of performance and outcomes;
- to secure the best possible use of available **resources** – resources will always be finite and there are competing demands in society.

2.8 The Government recognises that the achievement of these strategic policy objectives in turn means:

- improving the ability both to **monitor** the state of the people's health and to **evaluate** the health benefits of policies and programmes, and the ability to **assess the effectiveness** – in terms of 'health gains' – of particular services and practices;
- ensuring everyone has the best possible **information** they need to understand the influences on their health, especially the influence of their own behaviour, and the necessary **support** to improve their health;
- **involving people more** – individually and through local and voluntary organisations – at both strategic and operational levels in discussion and decisions about options and priorities, and through that involvement generating a shared commitment.

2.9 To achieve these ends the Government believes that clear objectives and specific targets for improvements in health in key areas are central to a health strategy. These alone can

- give a common sense of direction and purpose, and a tangible result at which to aim;
- stimulate the development of the ability to assess,

compare and contrast performance;

- provide a measure by which to decide action and use of resources;
- provide a measure by which to judge success.

2.10 They lie at the heart of what this document proposes. The next chapter looks at the health challenges facing the country, and then at opportunities and constraints. Out of that analysis a strategic way forward is proposed.

THE CHALLENGES

The challenges – Longevity increased, but quality of extra years uncertain – Large remaining burden of preventable death and illness – Quality of health care uneven – Addressing the causes – NHS alone cannot solve the problems – Individual behaviour: informed choice, education and opportunity – External threats to health – Continued development of NHS services – The challenge of medical advance and demographic change.

FUTURE IMPROVEMENTS IN HEALTH – THE NEW CHALLENGES

3.1 Chapter 1 highlighted the transformation for the better of the health of the people of England over the past century. The successes have been hard won: vigilance is needed to maintain them. Safe water and effective disposal of waste, the supply of wholesome food, safety at work, controls on pollution and good housing remain as important as ever. More specifically any marked reduction in the take-up rate of immunisations could mean a return to widespread epidemics of infectious diseases.

3.2 But challenges remain. If the ideal is for each person to lead a physically and mentally healthy life well into old age then, although in many respects the health of the people of England is very good:

- many people still die prematurely from conditions – diseases, accidents – which are to a large extent preventable;
- many people still suffer from preventable illnesses which significantly impair the quality of their, and their families', lives;
- many of these causes of death and illness are known to be preventable both in principle and from comparison with performance in other countries. Many of them can be prevented if effective action is taken;
- there are significant variations in health – geographical, by ethnic and social and occupational groups – within England as in other countries;
- despite significant progress – and what the NHS has achieved is formidable – there are still marked variations in the quantity and quality of health care in different parts of the country.

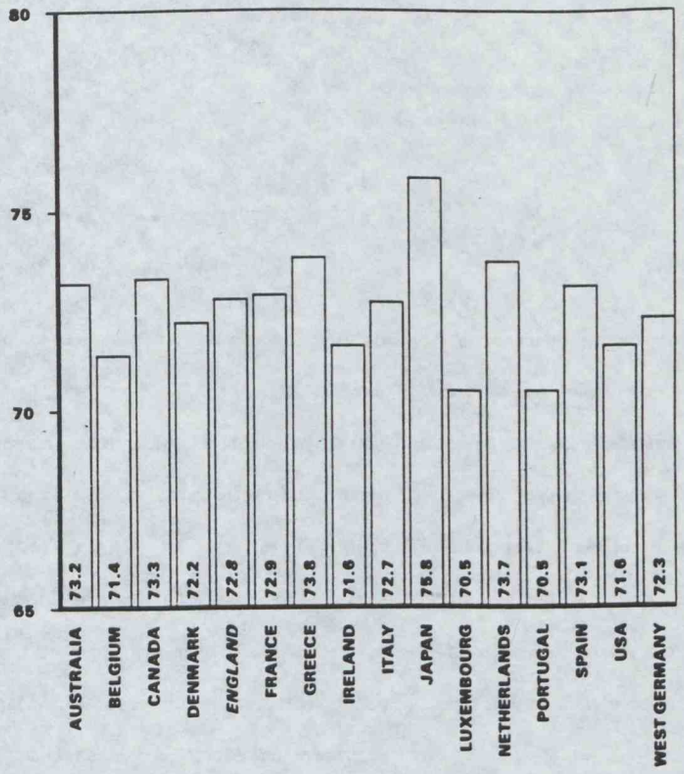
THE FACTS

3.3 These points are well illustrated:

Figures 3 and 4 show life expectancy at birth for men and women in various European Community and other westernised countries. At first sight the difference between them, especially between England and the best, seems small. With the exception of Japan, the difference for men amounts to only one year. But a shift of one year in the total population represents a lot of life gained or lost in the population as a whole. This is more so for women where the difference is larger.

Figure 5 shows the infant mortality rate and the

MALE EXPECTATION OF LIFE AT BIRTH 1988*

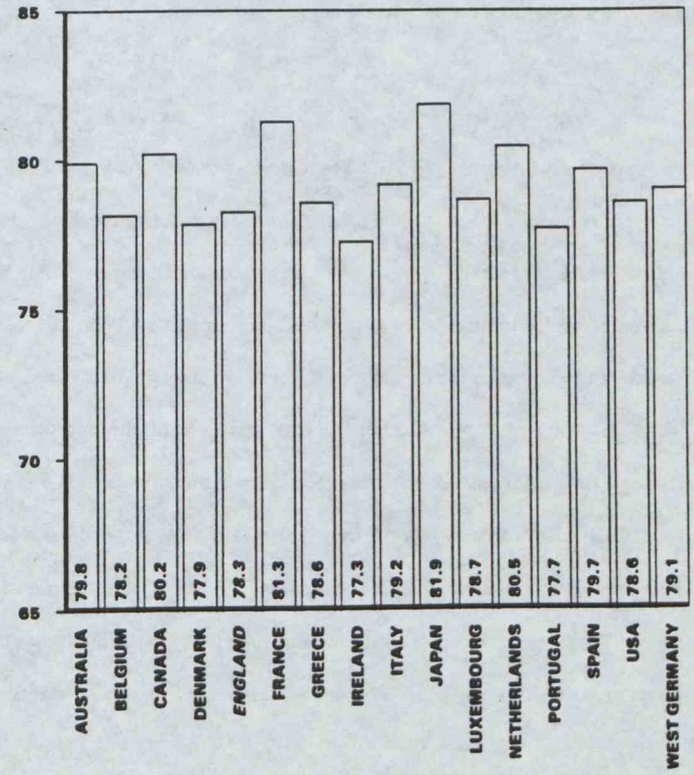


*DATA FOR 1988 EXCEPT FOR GREECE, IRELAND, USA, CANADA AND AUSTRALIA 1987
BELGIUM AND ITALY 1986, AND SPAIN 1985

SOURCE: OECD, WHO ANNUAL HEALTH INDICATORS

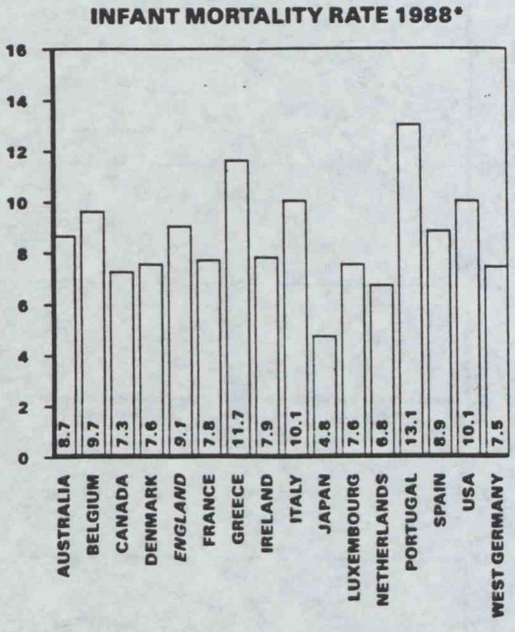
figure 3

FEMALE EXPECTATION OF LIFE AT BIRTH 1988*



*DATA FOR 1988 EXCEPT FOR GREECE, IRELAND, USA, CANADA AND AUSTRALIA 1987
BELGIUM AND ITALY 1986, AND SPAIN 1985

SOURCE: OECD, WHO ANNUAL HEALTH INDICATORS



*DATA FOR 1988 EXCEPT FOR GREECE IRELAND USA CANADA JAPAN AND AUSTRALIA 1987 BELGIUM AND ITALY 1986 AND SPAIN 1985

SOURCE OPCS WHO ANNUAL HEALTH INDICATORS

figure 5

variations between countries.

Figure 6 shows the distribution of total deaths by cause in 1931 and 1988. A marked change in the pattern of disease is evident. The proportion of deaths due to infective, genito-urinary and respiratory disease has declined. The proportion of deaths due to tumours, cardiovascular diseases and, at younger ages, accidents and violence has increased. That there are fewer early deaths – that life expectancy has increased – should not hide the fact that in terms of cause, preventable diseases which have been significantly reduced have been replaced by other preventable diseases which have not. Between them coronary heart disease, cerebrovascular disease (stroke) and lung cancer account for about 36% of all premature deaths (in death before age 65[1]) – some 37,000 deaths each year. Each is to a significant extent preventable.

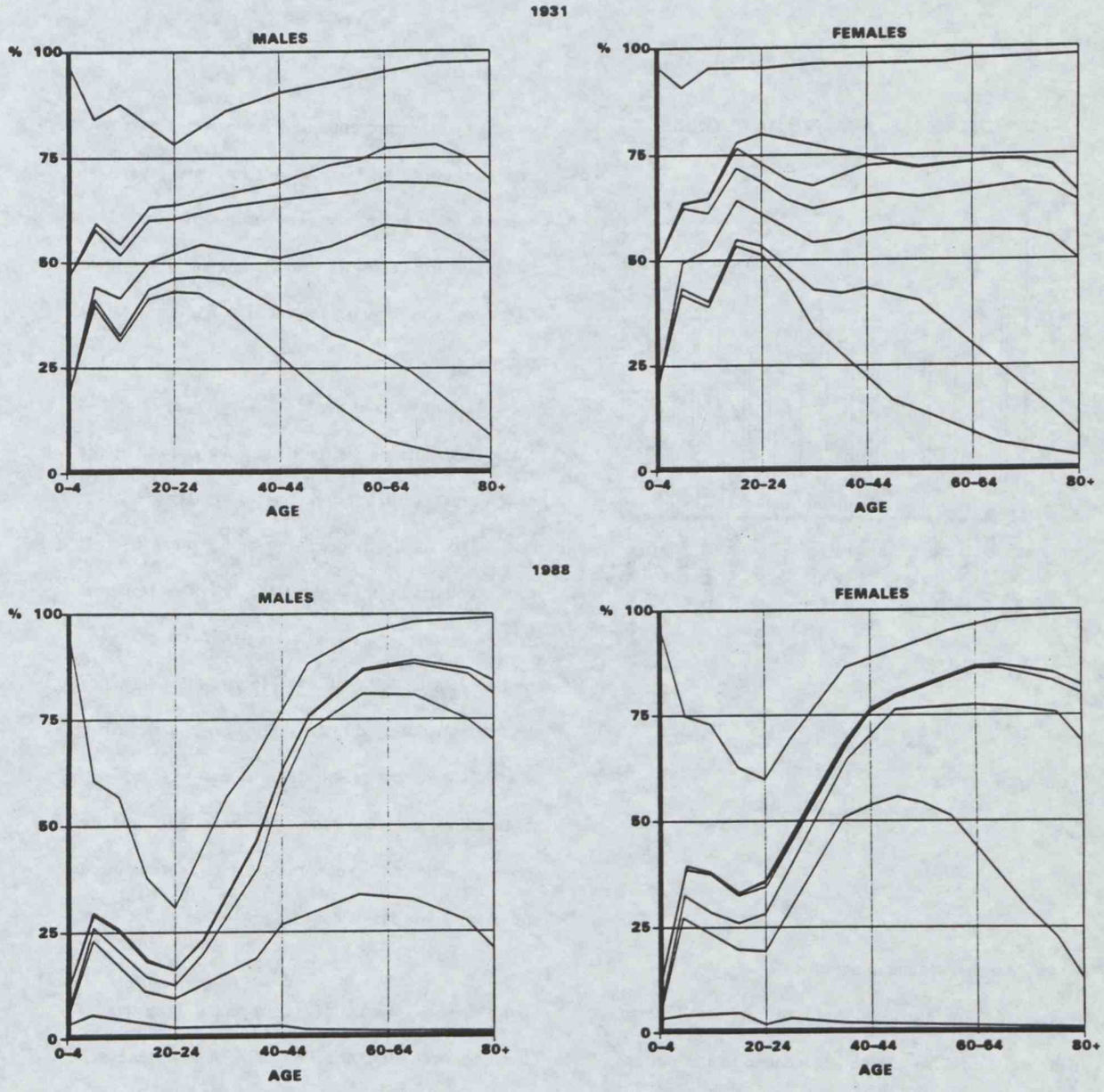
Figure 7 shows years of life lost between ages 15 and 64 years. This illustrates in particular the impact of the various causes of death occurring at younger ages. (For this analysis, a death occurring under the age of 15 years accounts for the loss of the full 50-year period between 15 and 64 years, whereas death at age 60 years contributes a loss of only five years of life.) In males, although circulatory disease and cancer still contribute substantially to loss of working life, other causes, such as accidents, become more prominent. In females, cancer – particularly cancer of the breast, cervix, uterus and ovary – is a major contributor to loss of life under 65 years.

Figure 8 shows trends in self-reported long-standing illness between 1972 and 1989 (GB data). There is an upward trend. But what does it mean? A longer life but not a better one in terms of health? Or a population more conscious of its ailments? Or better treatments leading more people to go to their GP?

[1] The definition of premature death as death before the age of 65 is a convention used by many countries. It provides a common statistical basis: its use in this document is not to be taken as meaning that deaths after age 65 may not also be premature.

DISTRIBUTION OF TOTAL DEATHS BY CAUSE

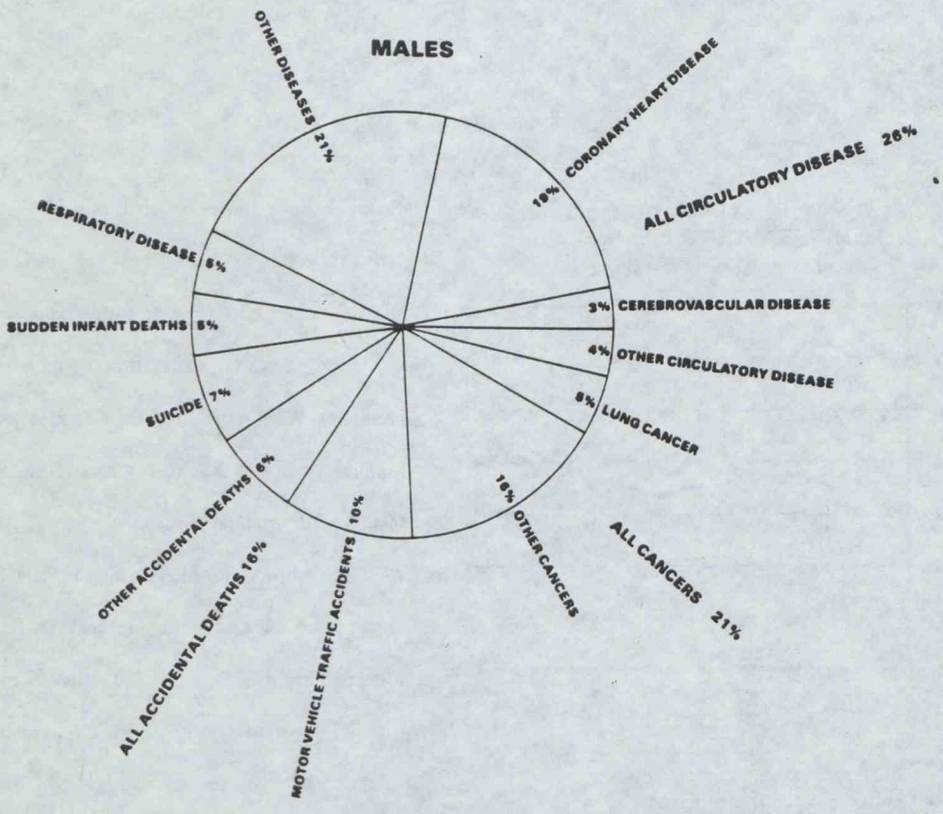
ENGLAND AND WALES 1931 AND 1988

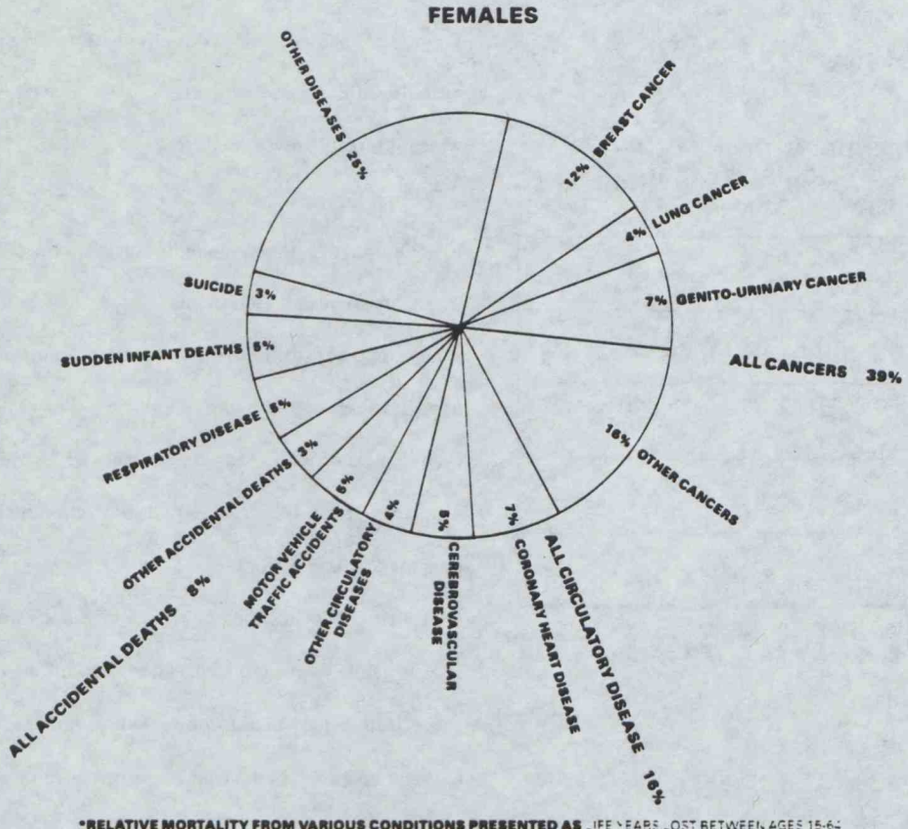


SOURCE REGISTAR GENERAL'S ANNUAL REPORT 193*
OPCS MORTALITY STATISTICS 1986

figure 6

LIFE YEARS LOST*: AGES 15-64
ENGLAND AND WALES 1988





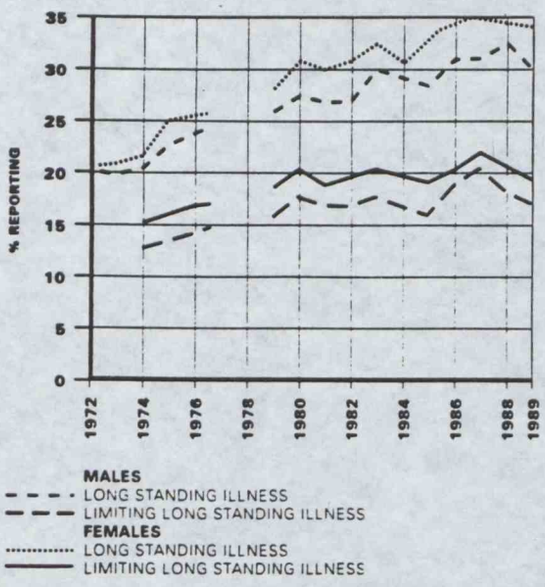
***RELATIVE MORTALITY FROM VARIOUS CONDITIONS PRESENTED AS** LIFE YEARS LOST BETWEEN AGES 15-64
ONLY DEATHS OCCURRING AFTER 28 DAYS **ARE INCLUDED**

SOURCE OPCS

figure 7

TRENDS IN SELF-REPORTED LONG-STANDING ILLNESS

GREAT BRITAIN 1972-1989



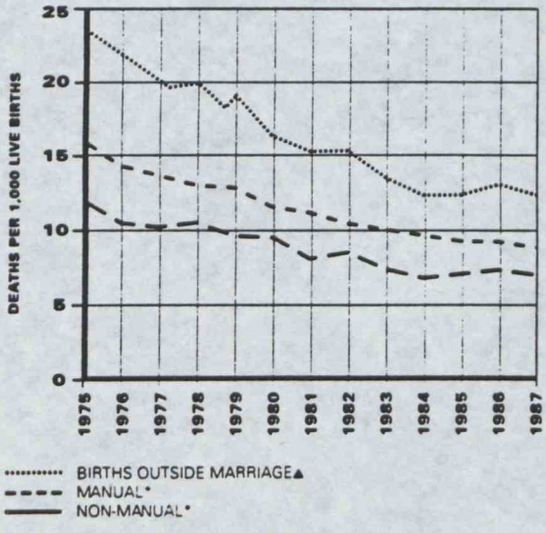
*DATA NOT AVAILABLE FOR 1977 AND 1978

SOURCE GENERAL HOUSEHOLD SURVEY

figure 8

TRENDS IN INFANT DEATH BY SOCIAL CLASS*

ENGLAND AND WALES 1975-1987



*SOCIAL CLASS OF BIRTHS WITHIN MARRIAGE AS DEFINED BY OCCUPATION OF FATHER

A NEW CLASSIFICATION WAS USED FROM 1979 ONWARDS

▲DATA ON ILLEGITIMATE BIRTHS AVAILABLE FROM 1979 ONLY

SOURCE OPCS DH3 SERIES

figure 9

Figure 9 shows trends in infant mortality by social class. All rates are declining but the differences persist showing the scope for further improvement. These variations in health persist through life here, as in other countries. The mortality rate for men aged 15-64 in manual groups is about 1.5 times the corresponding level for non-manual groups.

Figure 10 shows mortality from coronary heart disease at ages 35-64. The geographical pattern, which is longstanding, is striking and the reasons for this are not fully understood. Amongst men, there is a threefold variation between the area with the highest and lowest death rates.

Figure 11 shows the variations within England in mortality from cancer of the cervix, mortality from which is largely preventable.

ACTION

3.4 What needs to be done to secure better health? There are some common themes.

- There is a need to improve monitoring and understanding of what these sorts of figures mean.
- The NHS alone cannot address or solve these problems. It has a key role to play, but action is required on a much broader front.
- Exposure to conditions or risks which are inimical to health needs to be reduced. These conditions or risks come from either people's own behaviour or from the physical and social environment in which they live and work.

DEATHS FROM CORONARY HEART DISEASE 1989

ENGLAND ALL PERSONS AGED 35-64

STANDARDISED MORTALITY RATIOS (ENGLAND AND WALES = 100)

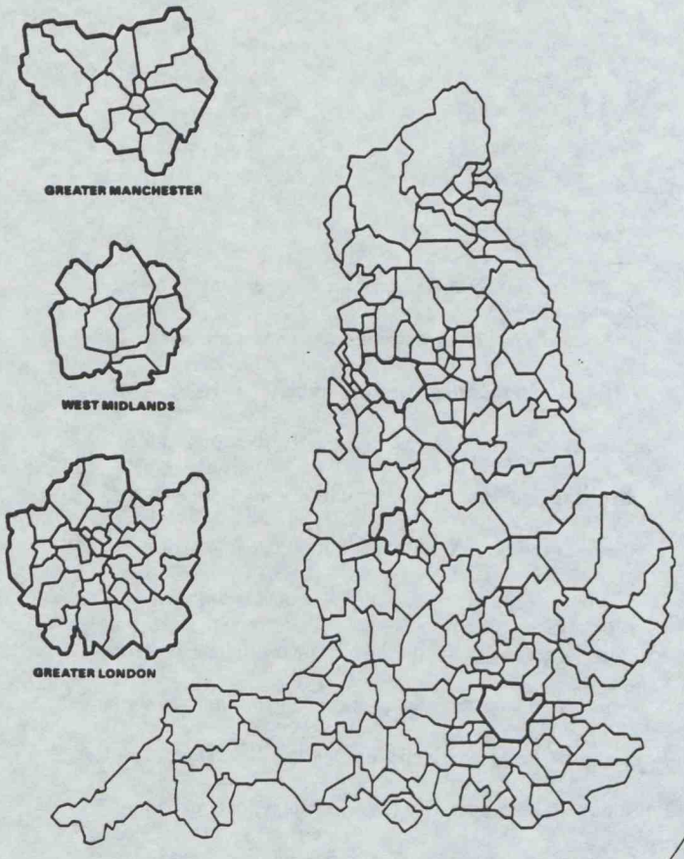


figure 10

DEATHS FROM CANCER OF THE CERVIX 1985-1989

ENGLAND FEMALES AGED 15-64

STANDARDISED MORTALITY RATIOS (ENGLAND AND WALES = 100)

figure 11

VALUES ABOVE 100 INDICATE HIGHER MORTALITY THAN THE ENGLAND AND WALES AVERAGE VALUES BELOW 100 INDICATE LOWER MORTALITY

• On **behaviour** – lifestyles – a balance of action is needed. People cannot be forced to behave sensibly in terms of their smoking, eating, exercise, alcohol or personal sexual habits. But efforts can be made to ensure that when they make a choice, they are exercising **informed** choice in circumstances where this is possible.

• On threats to individuals from the **external world** over which people have little or no control it is the responsibility of Government, or others, to take effective action, on behalf of the community as a whole, to monitor and, when necessary, to eliminate or minimise the threat.

• Both within the NHS (and for both treatment and prevention and promotion) and in relation to all initiatives taken, there is a need to ensure that the final measure of achievement is the **health outcome**, ie how health has been improved. Current NHS care, for example, still includes procedures which are unevaluated with the risk that ineffective interventions are usurping resources from known effective care.

3.5 The following figures illustrate these points:

Figure 12 shows a major NHS achievement, in respect of immunisation.

Figure 13 shows a significant fall in cigarette consumption. However, 32% of the population still smoke cigarettes. This is despite the clear evidence that cigarette smoking causes about 30% of all cancer deaths (some 29,000 deaths a year through lung cancer alone) and is a significant contributor to coronary heart disease, chronic respiratory disease and other diseases. Research shows that people know the risks – to themselves, and in the case of smoking during pregnancy, to their future children – but do not, for whatever reason, translate that knowledge into action.

Figure 14 shows that, despite considerable health education activity, in the last 10 years there has been virtually no change in the average contribution made by fat to the energy derived from food: it has remained at about 42% compared to the recommended maximum intake of 35% from the Committee on Medical Aspects of Food Policy (COMA). However, consumption of saturated fatty acids has declined from 19% of food energy in 1979 to 17% of food energy in 1989, compared

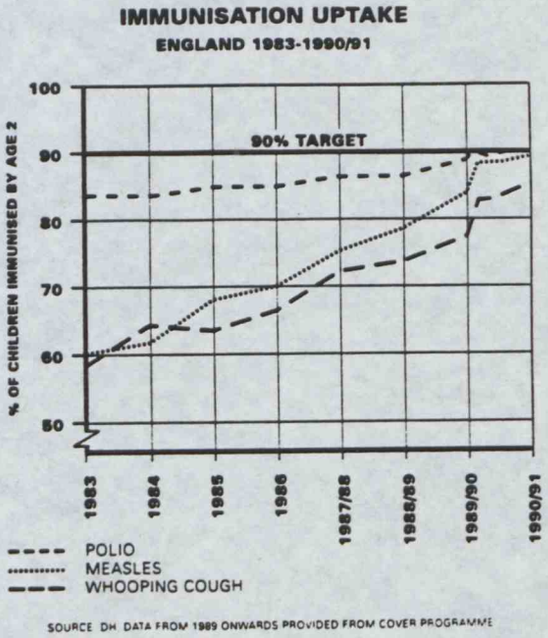
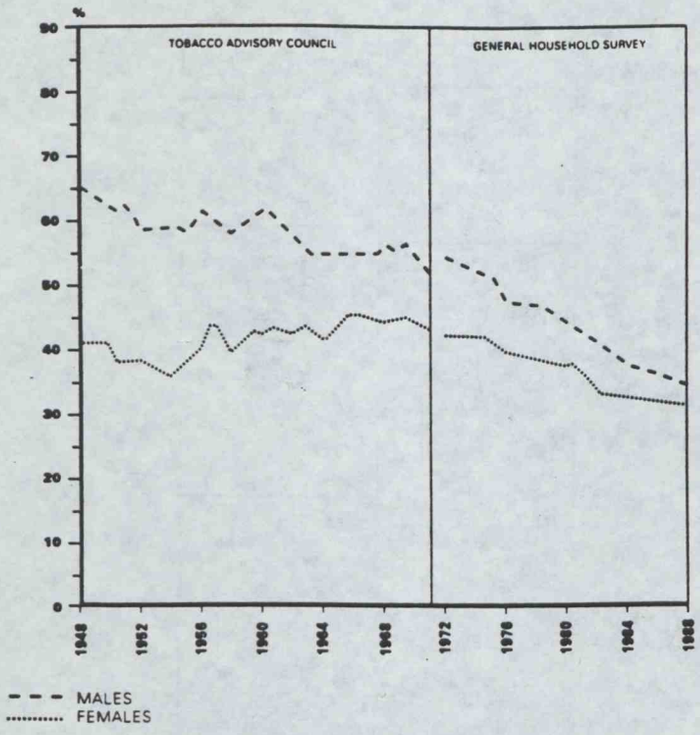


figure 12

PROPORTION OF CIGARETTE SMOKERS IN THE POPULATION

PERSONS AGED 16 AND OVER GREAT BRITAIN 1948-1988

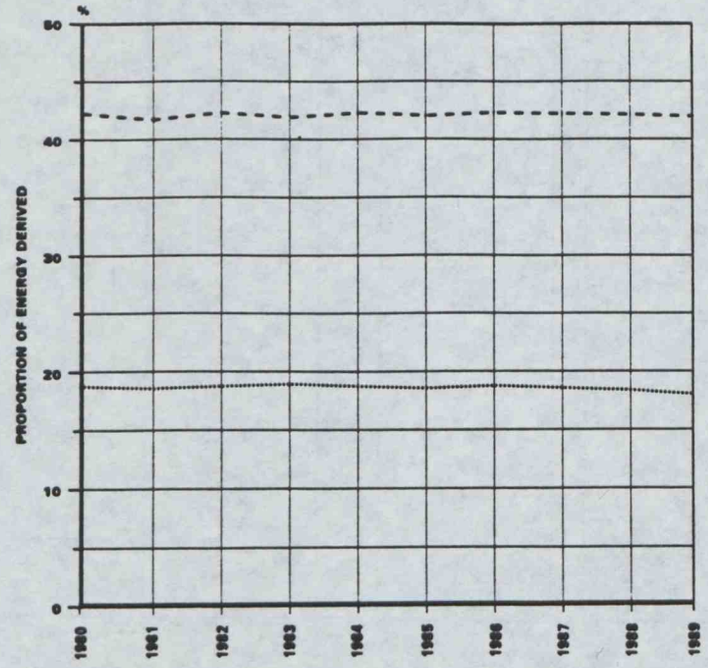


CAUTION TOBACCO ADVISORY COUNCIL & GHS STATISTICS ARE NOT ON EXACTLY THE SAME BASIS

figure 13

TRENDS IN CONSUMPTION OF FAT AND SATURATES

GREAT BRITAIN 1980-1989

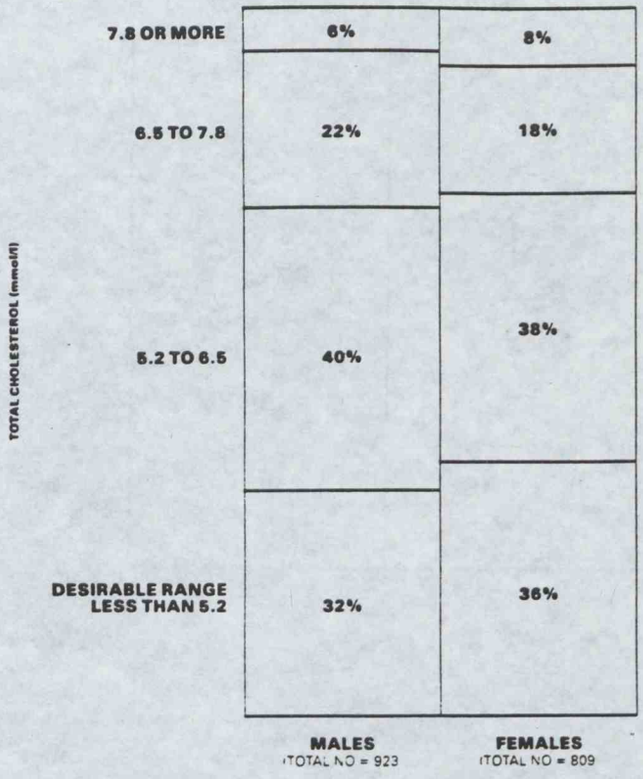


SOURCE MINISTRY OF AGRICULTURE, FISHERIES AND FOOD

figure 14

PERCENTAGE DISTRIBUTION OF TOTAL SERUM CHOLESTEROL

AGES 18 - 64 GREAT BRITAIN - 1986-7

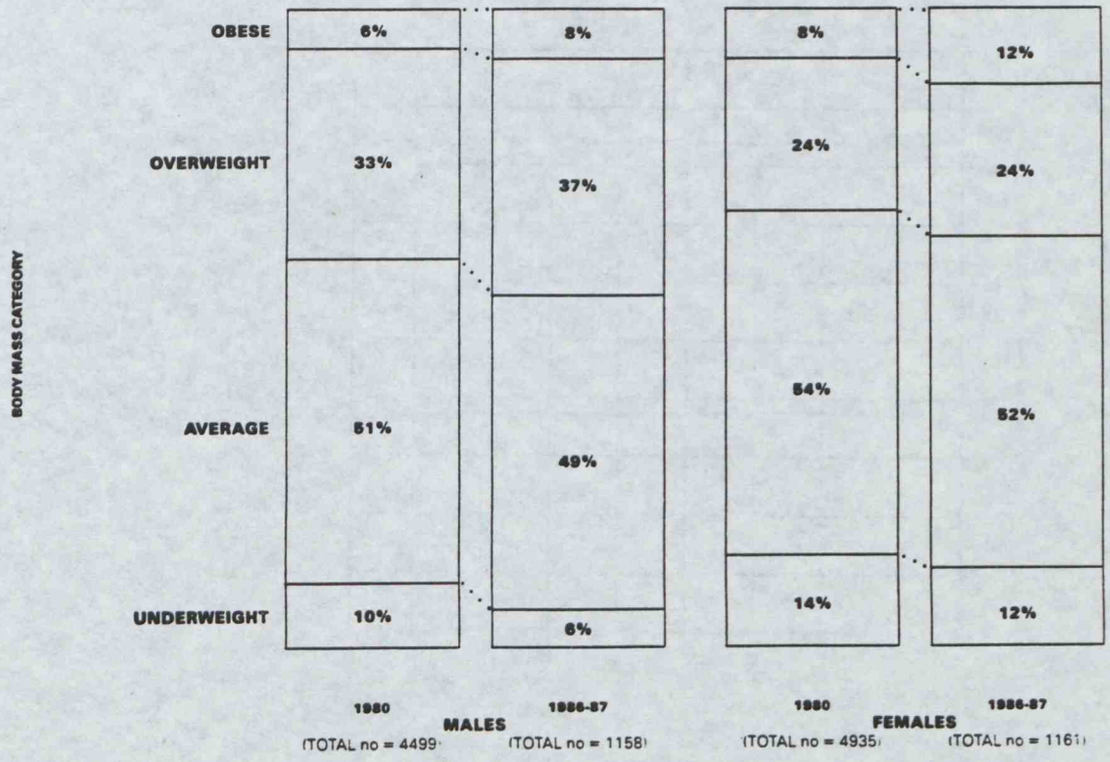


SOURCE: THE DIETARY AND NUTRITIONAL SURVEY OF BRITISH ADULTS

figure 16

PERCENTAGE DISTRIBUTION OF PEOPLE BY BODY MASS

AGES 16 - 64 YEARS GREAT BRITAIN - 1980 AND 1986-87



SOURCE: THE DIETARY AND NUTRITIONAL SURVEYS OF BRITISH ADULTS (DHSS)

figure 15

with a recommended maximum of 15%.

Figure 15 – between 1980 and 1987, the proportion of adults in Great Britain overweight or obese increased from 39% to 45% of men, and from 32% to 36% of women. Over the same period the proportion of obese men increased from 6% to 8%, and that of women from 8% to 12%.

Figure 16 – in 1986/87 only about one third of the adult British population had serum cholesterol levels in the desirable range (less than 5.2 mmol/l): 6% of men and 8% of women had severely elevated levels (7.8 mmol/l or more).

Figure 17 illustrates the relationship between alcohol consumption, deaths from chronic liver disease and the affordability of alcohol. 1.4 million people are 'heavy drinkers'. The graph shows the need for concerted action – by individuals to limit their consumption and by the Government and the industry together to help secure sensible drinking. Alcohol is also a major cause of accidents: about 20% of drivers and riders killed in road traffic accidents (in GB) have blood alcohol levels over the legal limit.

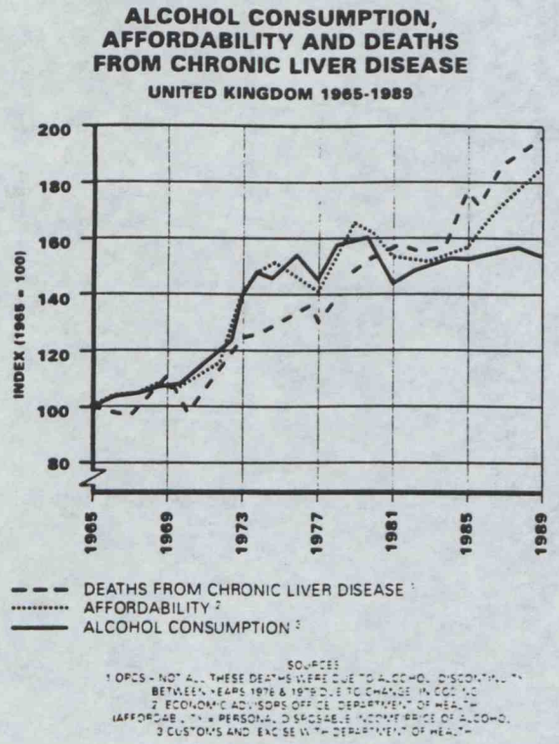


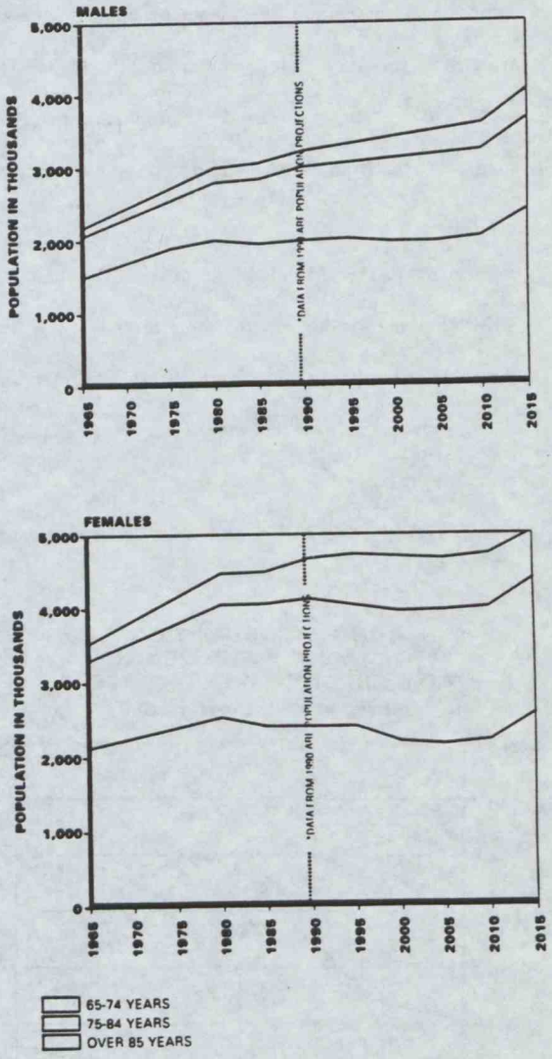
figure 17

3.6 But these new challenges are not the only ones. For example, redressing an imbalance between health promotion and prevention of ill health on the one hand and treatment and care on the other must not mean creating a new imbalance. There is a continued need to improve further the quality of care and treatment of people who fall ill or who need support. Waiting times remain a formidable challenge. There is, too, the ever-present challenge posed by new medical advances, not least the ethical issues to which many of them give rise. Clinical genetics, with the scope it offers for a major attack on congenital malformation and inherited disease, provides one example. Above all, there is the need to improve the quality of care and support for chronically sick people, elderly infirm people, mentally ill and handicapped people and those who are dying. These continued improvements are needed in the face of significant demographic change. Between 1981 and 1989 the numbers of people aged 74-85 has risen by 16%, and those over 85 by 39%.

Figure 18 shows how this growth will continue. High quality services must keep pace. Much of what this document says about prevention of heart disease, stroke and cancers is especially relevant to this growing number of elderly people. This is where the burden of avoidable ill health finally falls. The Government recognises, moreover, that success in reducing premature mortality will increase the number of elderly people and so, unless a healthier old age accompanies greater longevity, lead to a greater demand for services. That is why the emphasis on what is done must be as much on quality of life as on quantity of life.

ELDERLY POPULATION: AGE GROUP TRENDS

ENGLAND AND WALES 1965-2015



*BASED ON REGISTRAR GENERAL'S MID 1987 ESTIMATES
SOURCE OPCS

figure 18

FACING THE CHALLENGES
OPPORTUNITIES, STRENGTHS AND CONSTRAINTS

New opportunities: The reformed NHS – Strategic role for Health Authorities – Assessment of the state of the population's health – The Health Education Authority – Re-focusing of Department of Health on broader public health issues – Existing strengths: The wider Government role – Local Authorities – Industry and Commerce – The Voluntary Sector – Shared Commitment – Constraints: Knowledge and Resources.

OPPORTUNITIES AND CONSTRAINTS

4.1 What new opportunities and existing strengths can a strategy for health draw on in addressing the health challenges highlighted in the previous chapter? Within what constraints does it need to work?

NEW OPPORTUNITIES

4.2 New opportunities on which a strategy can build are twofold.

First, within the NHS where the effect of the reforms and other changes has prepared the ground for a more strategic approach.

Second, within the Department of Health itself where less involvement in day-to-day NHS service management allows a renewed emphasis on wider health issues.

THE NHS

4.3 While the NHS is not the only vehicle for improving health, it has a key role, one which has been significantly enhanced over the last two years. The changes stem from four major developments, each significant in itself, cumulatively more so: the implementation of the three White Papers "Working for Patients", "Promoting Better Health" and "Caring for People", and the recommendations in the 1988 Report on "Public Health in England".

STRATEGIC ROLE OF HEALTH AUTHORITIES

4.4 The change is profound. From being preoccupied with the provision of health services, Health Authorities have taken on a more strategic – "health" – role. Their job is to

- assess the state of health of the people they serve;
- assess what needs to be done to improve health;
- purchase effective services to meet these needs;
- stimulate and inform discussion of action needed at local level to address the wider issues of health promotion and disease prevention;
- work in co-operation with each other and with other local agencies – for example, Environmental Health Departments – in taking effective action on threats to health;
- assess the effect of policies and programmes against the key criterion "how has health improved?"

4.5 The initial assessment of the state of health and what is likely to prove an effective use of resources to

improve health is the basis of all that follows. Central to this first task are the newly appointed Directors of Public Health and the requirement on them to produce independent annual reports on the state of public health. But the rigorous assessment of the effectiveness of what is done – in terms of benefit both to individuals and the population as a whole – needs to inform the work of all health professionals.

4.6 A further important development at local level is the emphasis the new contracts for general practitioners have placed on health promotion. This, together with Regional Health Authorities' responsibility for the management of Family Health Services Authorities in addition to District Health Authorities, will facilitate concerted and co-ordinated NHS action on local health problems, building on the work already done by Health Visitors on health education and health promotion.

4.7 These changes at local level both encourage and require the Health Education Authority and Regional and District and Family Health Authorities to work together so that national initiatives can be followed through at local level and local needs reflected in the choice and form of national health education programmes. The Health Education Authority – with already well-developed strategic priorities and experience of successful approaches to health education – has a vital role to play in helping authorities act positively to meet their new role.

THE DEPARTMENT OF HEALTH

4.8 The changes at national level are as significant. Not only does the creation of the NHS Management Executive provide the opportunity to develop a more strategic 'head office' function for the NHS, but its creation also allows the Department of Health as a whole to re-emphasise that its reponsibilities go wider than the NHS. These functions have not been in abeyance, but they have tended to be eclipsed by the preoccupations and demands of the NHS itself.

4.9 The strategic role of the Department of Health is clear – it is to monitor and assess the health of the nation and take the action necessary, or ensure the action is taken – whether through the NHS or otherwise – to improve and protect health.

4.10 The major central functions which the changes have highlighted and enhanced, and on which a strategy for health can be developed, are:

- monitoring and assessing the state of the population's health and improving the methods for such monitoring and assessment. In both the Department draws on the work done by the Office of Population, Censuses and Surveys (OPCS) and the new reports from Directors of Public Health:
- through research, assessing, or stimulating the assessment of, the effectiveness of steps taken to improve health, whether these are aimed at the population as a whole, or at particular groups within it.

or are treatments for specific diseases. The Department has a key role in improving the ability to make such assessments;

• deciding on priorities, policies and programmes in the light of such assessments and taking action, or, where responsibilities lie elsewhere, arguing the case for action.

4.11 These changes build on the NHS's established strengths – a highly dedicated and professional workforce, rational and highly developed primary, secondary and tertiary systems of treatment and care, and a rational and cost-effective system of funding and management of the health care system as a whole.

THE WIDE RANGE OF HEALTH-RELATED ACTIVITY

4.12 If these changes within the NHS and DH both facilitate and provide the stimulus for a health strategy, there are existing strengths, structures and approaches, in health and health related activity elsewhere which provide a firm foundation on which to build. There are well developed systems in England for

• protecting the public from external hazards to health – environmental and industrial hazards, food, air and water safety, safety of consumer products;

• maintaining family, community and other social and economic structures conducive to the maintenance of the health of the individual and the population;

• providing general education and information to people to help them maintain their health as well as very specific information about, and support for, particular diseases or disabilities.

Responsibilities in all three areas fall variously throughout national and local government and the voluntary and industrial and business sectors.

4.13 Within central Government, the range of relevant responsibilities is extensive and includes:

• the **Department of the Environment's** general responsibility for all aspects of environmental quality and protection, housing, and inner cities;

• the **Department of Transport's** responsibility for road safety and other forms of transport;

• the **Treasury's** actions on excise duties on products which affect health;

• the **Home Office's** responsibility for action on illegal drugs, misuse of alcohol and fire safety;

• the **Ministry of Agriculture, Fisheries and Food's** responsibility to ensure food is safe for general consumption and that consumers have the information they need to choose a healthy and wholesome diet;

• the **Department of Education and Science's** responsibility to support a curriculum for all maintained schools which promotes the sound spiritual, moral, cultural, mental and physical development of its pupils and of society, and adequately prepares pupils for adult life – health eduction in schools and sport in both

schools and adult life are especially relevant, as is DES's funding of medical research via the Medical Research Council;

- the **Department of Social Security's** responsibility for delivering social security benefits totalling around £60 billion a year via a network of 160 districts;
- the **Department of Trade and Industry's** responsibility for raising public awareness about potential hazards in and around the home;
- the **Department of Energy's** responsibility for health and safety in the nuclear industry and also for the safe installation and use of electricity suppliers' lines and apparatus;
- the **Employment Department's** responsibility, through its Employment Rehabilitation Service, for assisting people with disabilities and long term health problems who wish to identify appropriate work and prepare for it;
- the **Health and Safety Commission and Executive's** responsibilities for health and safety in the workplace, and for the protection of the public from harmful consequences of work activities.

4.14 The spread of responsibilities offers both an opportunity and a challenge: an opportunity because it means a shared interest in health amongst Departments: a challenge because of the need to ensure policies and programmes are developed and action taken on a concerted basis across Departmental boundaries.

4.15 In addition to central Government are well established roles of local government, industry and commerce and, not least, the voluntary sector.

- **Local government** has a range of responsibilities which impact on health. It influences the general environment through planning, housing, and transport functions. It protects the public and workpeople from hazards and dangers through Environmental Health Departments and Trading Standards Officers, as well as through the fire and police services. It can contribute to opportunities for health promotion through provision of recreation and sporting facilities, and through its own information services (eg libraries). It has also responsibility for the provision of social services, and is to take on new responsibilities for care in the community.
- **Industry and commerce**, both as employers and producers, have responsibilities and opportunities for improving health. Not only must they provide a safe and healthy working environment, ensure that their products do not endanger the consumer and play their part in avoiding environmental pollution, but they also have considerable scope for investment in the health of their workforce. This is an area of growing significance, with increasing numbers of employers beginning to take advantage of opportunities
  - to promote healthy living by ensuring that their catering services offer healthy options or by providing exercise facilities

– to offer employees the chance to participate in workplace health initiatives, such as screening programmes.

• **Voluntary organisations'** contribution to the health of the nation is incalculable. The range and quality of activity is formidable. It embraces organisations ranging from those providing care services, funding and supporting research, self-help groups for patients, to those dedicated to health education and campaigning.

4.16 One of the prime aims of a strategy is to build on these foundations: they already provide a firm basis on which to foster a widespread shared commitment to better health and improve co-ordination and co-operation between all those involved.

CONSTRAINTS

4.17 Constraints are twofold: knowledge and resources. Idealism needs first to be tempered by recognition of the limitations of knowledge. While it is important to concentrate on what is likely to be effective given the present state of knowledge, at the same time efforts must be made to try to extend knowledge and understanding.

VARIATIONS

4.18 Tempering idealism with pragmatism is especially needed in relation to the challenge presented by the variations in the incidence of good health and illness noted in Chapter 3. England, like other developed countries, has wide variations in the incidence of both illness and death – variations between different parts of the country, different ethnic groups and different occupational and income groups.

• There is a variation of 2.5:1 between the district with the highest death rate from coronary heart disease (for men 15-64 years) and that with the lowest.

• The mortality rate for men aged 20-64 in manual occupations is about 1.5 times the corresponding level for non-manual occupations.

• Conversely, the incidence of breast cancer appears to be greater in social class I than in social class V.

• The death rate from coronary heart disease is some 20% higher in Asian men and 30% higher in Asian women than in the population as a whole. The prevalence of diabetes shows similarly marked variations and some diseases (eg sickle cell disease) affect particular ethnic groups but not others.

4.19 The reasons for these variations, and the degrees to which different groups of people are vulnerable to illness, are complex. The Government does not believe there is any panacea – here or elsewhere in the world – either in terms of a full explanation of the variations, or in terms of a single action which will eradicate a problem by itself. But neither difficulty is a reason for inertia. Progress can be made on three fronts:

first, through the continued general pursuit of greater economic prosperity and social well-being;

second, through trying to increase understanding of the

variations, the reasons for them, and the action which might effectively address them;

third, through specific initiatives to address the health needs of particularly vulnerable groups, whether geographical, ethnic, occupational or others who need specific targeted help.

4.20 The reformed NHS offers significant opportunities for action on the second and third points. Central, as already noted, is the explicit role of health authorities in producing their assessments of the health and health needs of their local populations, and the better integration of the organisation and delivery of family, community and hospital services. Together, these developments will better enable the NHS to identify areas or groups – geographical, ethnic, occupational or other – where the highest rates of sickness occur, and direct resources to meet needs. In the case of all these variations the Government believes the emphasis should be on disaggregation of the problems down to specific issues which can be targeted for effective action.

RESOURCES

4.21 The development of a health strategy highlights the persistent tendency – in this country as elsewhere – for the demand for health care to run ahead of supply with no obvious limit to the capacity of health services to absorb additional resources.

4.22 When the NHS was first established there was a belief that, once the backlog of unmet need had been addressed, the service could satisfy the demand for health care without large or continuing increases in expenditure. The reasons this did not happen are various but the problem is primarily one of success, not failure. More and more illnesses lent themselves to treatment. Usually – not always – the direction was towards more expensive treatment. There was also the additional cost of providing for a longer lived population. The result was, and is, that choices have to be made and priorities set.

4.23 Development of a strategy for health raises the resource question acutely. There is a need, just as much as for health services, for the broader health issues to be addressed to be put into priority order and resources – not just financial resources, but time, skills and enthusiasm – concentrated to tackle those priorities in a concerted way. It must be recognised that not everything can be tackled at once. Key to a strategy for health must be a rational approach to identifying the current major problems, assessing where action is most likely to be effective and concentrating resources there.

4.24 This does not mean priorities, once set, are set for all time. New problems will arise when those which confront the country now have been successfully addressed. A strategy for health will have succeeded if our successors judge in looking back that priority was given, and energies devoted, to what mattered most at the time. That is what this strategy seeks to do.

DEPARTMENT OF ENVIRONMENT

The Department of the Environment helps secure good health by improving the quality of the environment and seeking to ensure that a decent standard of affordable housing is available to all. It co-ordinates Government policy on environmental protection as set out in the White Paper "This Common Inheritance".

Health related action includes

- **Environmental Protection Act 1990**: introduction of controls by HM Inspectorate of Pollution and local authority environmental health departments to minimise industrial pollution of air, water and land; enhanced noise and litter controls; improved waste disposal and recycling arrangements.
- **Water Act 1989**: establishment of Drinking Water Inspectorate to set and enforce standards for drinking water quality and of National Rivers Authority to control discharges of pollutants into water.
- **Housing**: over the century two million slums cleared and six million subsidised dwellings built; since 1960s two million grants given for home improvement. Nearly £2 billion a year now being spent on renovation to improve the condition of local authority housing; £500 million a year is given in grants – mainly to less well-off owner occupiers – to improve unsatisfactory private houses; the output of housing association subsidised homes is planned to almost double between 1989/90 and 1993/94; and short-term programmes aimed at 11,000 households temporarily housed in bed and breakfast accommodation, and the 3000-5000 people sleeping rough on the streets.
- **Inner cities**: because poor health is often linked to the economic, environmental and social problems in inner cities the Government's inner city policies which aim to improve living conditions will also raise general levels of health. The Urban Programme also funds health promotion and disease prevention, improvements to primary health care, services for homeless mentally ill people and access to health care for ethnic minorities.
- **Sewage treatment**: requirement (implementing EC Directive) to end significant discharges of untreated sewage to inland and coastal waters by 1998 and 2005 and to improve bathing waters.
- **Vehicle pollution**: tight new emission limits for cars and heavy diesels introduced.
- **Toxic metals**: action has reduced human exposure to lead (by, for example, limiting the lead content of drinking water, food, petrol and paint) and other toxic metals, particularly mercury and cadmium; blood lead levels are now half those of the mid-1970s.
- **Radon**: guidance now allows householders in highest risk areas to make informed decisions about risks; free testing of radon levels in affected areas available.

DEPARTMENT OF EDUCATION AND SCIENCE

The Department of Education and Science makes a

significant contribution to health. The Government's policy is to encourage schools to equip their pupils with the knowledge, skills and attitudes they will need to make well-informed, independent judgements and to safeguard their long-term good health. Health education in schools lays the foundation for the individual's subsequent health-related behaviour and lifestyle: and sport makes an important contribution to individual health, both at school and in adult life.

The long-term effect of health education on young people is difficult to assess, though there are indications of progress. For example, recent research suggests that despite public concern about drugs, and their availability, the number of school pupils who have experimented with drugs remains very low. There are indications, however, that other forms of unhealthy behaviour are static or increasing – smoking and drinking alcohol are much more prevalent and a greater cause for concern.

The DES also has responsibility, through the overall funding of the university sector and the payment of grant-in-aid to the independent Medical Research Council, for basic medical education and medical and health-related research. In addition the education service is the major provider of initial training for nurses and staff in the professions supplementary to medicine.

Other health-related action includes

- **The school curriculum**: certain health issues are included within the statutory order for National Curriculum science. In addition, the National Curriculum Council identified health education as one of five cross-curricular themes and issued guidance which identifies nine key components for health education – substance use and misuse: sex education: family life education: safety: health-related exercise: food and nutrition: personal hygiene: environmental factors and psychological aspects.
- **Health education**: Since 1986, DES has funded local education authority initiatives to counter misuse of drugs and, since 1990, to support general health education.
- **Sport**: sport in schools is the foundation to encouraging greater overall participation in sport and physical education is therefore a compulsory subject for all pupils between 5 and 16 in maintained schools. DES and DH are jointly examining what can be done to encourage better co-ordination between local health based exercise initiatives and efforts by sports clubs and local authorities to promote greater participation in sport.
- **The Sports Council**: Sports Council targets for 1988-1993 include

(a) an increase in the percentage of women and young girls taking part in sport from 38% to 42%

(b) maintenance of the absolute numbers, and therefore an increase in, the percentage of young people taking part in sport in the context of the declining number of 18-25 year olds in the population.

EMPLOYMENT DEPARTMENT GROUP

The Employment Department Group provides help for people with disabilities and long-term health problems who wish to identify appropriate work and prepare for it. The Employment Rehabilitation Service undertakes both these functions, and medical practitioners can make use of its specialist services to seek practical advice for patients. Disablement Resettlement Officers and the Disablement Advisory Service provide help and guidance to individuals and employers about the integration of people with disabilities into the workforce. The Employment Department Group also helps meet the training needs of people with disabilities or long term health problems, provides help in training and employment through a variety of special schemes such as loaning equipment to individuals or providing grants to employers to alter premises, and enables people with severe disabilities to work in sheltered accommodation.

Health and safety of workpeople and the public affected by work activity is the responsibility of the Health and Safety Commission and Executive. This is carried out through

- negotiation and definition of standards, which can lead to new legislation;
- issuing guidance on standards and good practice;
- promoting compliance with legislation through inspection, advice and enforcement (170,000 preventive inspection visits were made in 1989-90, with 11,700 improvement and prohibition notices issued and 2,200 successful prosecutions);
- promoting better management of health and safety;
- carrying out research and investigations of accidents and ill-health (in 1989-90, more than 11,000 accidents and incidents were investigated, and the Employment Medical Advisory Service made 3000 workplace visits to investigate causes of occupational ill-health).

Cancers and lung disease remain the major apparent causes of work-related deaths, often reflecting exposure levels of many years ago which are now better controlled. Overall, there are possibly 2000 premature work-related deaths; 8000 to which work is a contributory factor and 80,000 new cases of work-related disease each year. There are gaps in information about work-related ill-health and HSC attach high priority to securing improved information on the scale and pattern of industrial ill-health.

DEPARTMENT OF TRANSPORT

More than 5000 people die on the roads each year, and a further 60,000 are seriously injured and 270,000 slightly injured. The Government has set a target of reducing road casualties by one third by the year 2000 and the Department of Transport is concentrating on three areas to meet the target. First, by raising the level of public awareness so that road safety is seen as an issue

for society. Second, by giving special attention to the most vulnerable road users, including children and the elderly. Third, by concentrating on proven and cost effective casualty reduction measures in vehicle and road engineering. In 1990, the Department of Transport, together with the Department of Education and Science and the Department of Health launched a major child road safety policy initiative. "Children and Roads: A Safer Way", which provides a focus for action to reduce child road casualties.

DEPARTMENT OF SOCIAL SECURITY

Provision of social security benefits is a key factor in maintaining health, particularly amongst the more vulnerable in society. Expenditure on social security has risen by 40% in real terms since the late 1970s, and the range of benefits includes those paid to sick and disabled people, community care grants via the Social Fund and payments to residents of independent residential care and nursing homes and local authority homes. Additionally, the Independent Living Fund makes payments to severely disabled people who need extra help to remain in the community. New disability benefits announced in the White Paper "The Way Ahead" are planned to come into operation in April 1992. DSS also operates the low income scheme for giving help with NHS costs. The Minister of State for Social Security also has special responsibility for disabled people.

MINISTRY OF AGRICULTURE, FISHERIES AND FOOD

A wholesome and safe diet is integral to good health. In ensuring that food is safe for general consumption, MAFF:

- takes action against diseases transmissible from farm animals (successes include the reduction of tuberculosis and brucellosis to very low levels; efforts are now being made to reduce the incidence of salmonella enteritidis in poultry)
- ensures the milk supply reaches the very highest EC standards (the UK is the only country other than Denmark to do so)
- carries out surveillance and research to identify risks to the food supply and ways of managing them.

MAFF is responsible for ensuring that information is available to allow consumers to choose a healthy diet; action is being taken to encourage better food labelling and more consumer education to underpin consumer choice.

DEPARTMENT OF TRADE AND INDUSTRY

The Department of Trade and Industry is concerned with the safety of consumer goods and with valid and analytical measurement, upon which the reliable

monitoring of many hazards depends. One of its other responsibilities is prevention of accidents in the home. Every year about 5000 people die and around three million need medical attention, making home accidents the biggest single cause of injury. The Consumer Protection Act 1987 provides a strong legal framework to protect consumers from unsafe consumer goods. DTI also mounts safety campaigns aimed at particular hazards or those most at risk. These have contributed to a fall in deaths from more than 7000 in 1966 to 5000 in 1988 (England and Wales).

TAXES, DUTIES AND HEALTH

HM Customs and Excise collects indirect taxes which raise substantial amounts of revenue for Government. The Government levies excise duties on products which can be harmful to health – such as tobacco products, alcoholic drink and leaded petrol. Raising these duties can help reduce consumption, or encourage the use of less harmful alternatives.

- The duty on tobacco products was increased in the 1991 Budget by 15%. The Chancellor of the Exchequer said: "There are strong health arguments for a big duty increase on tobacco. In recent years, the duty has fallen in real terms, and cigarette consumption, having declined in the early 1980s has begun to turn up again. Raising the duty will help to counter this unwelcome trend." As a result of the Budget the total real terms increase in the specific duty (and VAT) on cigarettes since 1979 is 55%.
- The introduction and widening of the duty differential between leaded and unleaded petrol has encouraged motorists to switch to unleaded and reduced the amount of lead in the atmosphere. Unleaded petrol now accounts for around 39% of the market.
- Since 1988, some low alcohol drinks have been taxed less heavily per unit of alcohol content than higher alcohol drinks in order not to discourage their consumption.

A Health Strategy for England

The way forward – Scope of a strategy – Key Areas – Objectives and Targets – Criteria for selection – The discipline of targets – Need for national targets.

A STRATEGY FOR HEALTH

5.1 The previous chapters have set out the challenges which a health strategy must address, and the constraints within which it must operate.

5.2 The ideal health strategy might perhaps be based on complete knowledge of the state of the population's health, a full understanding of the causes of that state of health and the actions needed to improve health, full and absolute power to take the necessary action and an ability to monitor and assess the effectiveness of the actions taken. The world is not ideal: waiting for such a full understanding would mean waiting forever.

5.3 The Government does not therefore propose that this strategy should immediately attempt to address every health and/or health care issue. Little real progress would be likely to result from such an approach. This does not mean the neglect of important areas of health or health care: it simply means that at certain times knowledge, effort, resources and opportunity need to be specially focused on specific key areas for significant progress to be made. Where knowledge and opportunity are as yet insufficient, the priority must be to improve understanding and ability to respond to the challenges.

5.4 What is proposed therefore is, on the basis of current knowledge:

- to identify key areas which are of greatest concern and where there is greatest opportunity for real improvements in health;
- to set objectives and targets for improvement in order to stimulate and direct coordinated action;
- to monitor and assess results;
- to develop the ability – over time – to include other key areas.

KEY AREAS

5.5 The strategy will focus on **key areas**. These will be areas judged against the following criteria:

***First*, the area should be a major cause of premature death or avoidable ill health (sickness and/or disability) either in the population as a whole or amongst specific groups of people;**

and

***Second*, the area should be one where effective interventions are possible, offering significant scope for improvement in health;**

and

***Third*, it should be possible to set *objectives* and *targets* in the chosen area and monitor progress towards their achievement through indicators.**

OBJECTIVES AND TARGETS

5.6 In each key area the first task will be to agree objectives and targets.

- Having clear **objectives and targets** is an essential discipline. They need to be realistic, but challenging.
- So far as is possible they should be expressed in terms of the **health improvements or – where appropriate – reductions in risk factors** (such as smoking) or precursors of ill health (such as high blood pressure) in the population.
- The discipline of targets should be extended to all levels.
- There should be flexibility about the **time span** for which targets are set. What can be achieved by 2000 in some areas will take longer in others.
- **Indicators** are essential to target setting. There must be the ability to monitor what the present position is, what achievement is required, and how progress is measured.

5.7 Above all, objectives and targets should be agreed by all those who have a part to play in their achievement.

CONCLUSION

5.8 This chapter has outlined the proposed approach. The next chapters look at the application of the three criteria and use them to help identify

- **a possible set of key areas**
- **possible objectives and targets at national and/or local level**
- **the action needed to improve ability to identify such key areas, judge the effectiveness of outcomes and set targets and monitor progress.**

KEY AREAS - THE CRITERIA

The three criteria – Identifying major causes for concern – Different conclusions from different vantage points – Public's perceptions of risks to health – International comparisons – Setting and monitoring targets.

INTRODUCTION

6.1 This chapter looks at the three criteria, set out in chapter 5, for helping to identify possible key areas:

The area should be a major cause of premature death or avoidable ill-health (sickness and/or disability) either in the population as a whole or amongst specific groups of people

and

The area should be one where effective interventions are possible, offering significant scope for improvement in health

and

It should be possible to set objectives and targets in the chosen area, and monitor progress towards their achievement through indicators

It identifies some problem areas through a "burdens of disease" analysis, makes national and international comparisons, and examines the ability to set national targets and monitor progress.

IDENTIFYING PROBLEMS: "BURDENS OF DISEASE"

6.2 There are a variety of measures which can be used to identify the most serious problems. One way is to look at three key "burdens of disease": mortality, morbidity and cost.

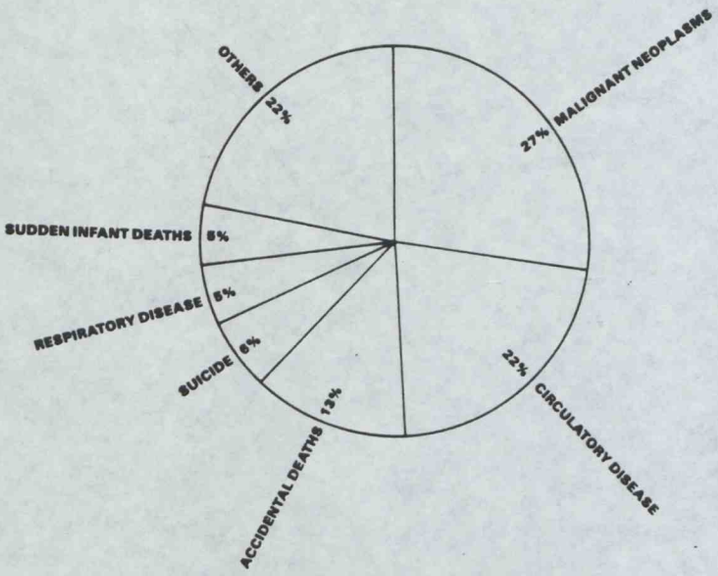
Death

6.3 The commonest and most comprehensive measure of "health" is that of life and death. National mortality data have been collected systematically since the first half of the 19th century. As well as 'crude' measures of numbers dying, health can be measured in terms of premature mortality, either by numbers of deaths below a certain age (typically 65 or 75), or else in terms of 'life years' lost. Figure 7 in chapter 3 showed the latter for both males and females, and explained the basis of the 'life years lost' approach. *Figure 19* gives the figure for both sexes combined.

Ill-health

6.4 Most ill-health is not fatal. Measuring morbidity (the incidence and prevalence of ill-health) is, however, much more difficult than measuring mortality. Whereas one death can be compared with another, morbidity covers a wide spectrum of experience both physical and mental health, from severe, but short-term pain, to life-long disability.

6.5 Typical measurements of morbidity for which routine data are available include reported time off work through sickness or invalidity, GP consultation rates and use made of other NHS facilities (hospital



YEARS OF LIFE LOST: AGES 15-64
ENGLAND AND WALES ALL PERSONS 1988

*DEATH UNDER 28 DAYS EXCLUDED
THEY ACCOUNT FOR ONLY A SMALL PROPORTION OF SUDDEN INFANT DEATHS

SOURCE OPCS

figure 19

episode data), levels of long-standing illness as reported in the General Household Survey and registrations of severe visual and hearing impairment. Not all of these are direct measures of health. Measures based on use of services reflect not only morbidity but also the availability of services and individuals' propensity to use them. Absence from work is similarly limited as a measure by the fact that it provides information about the health only of those in the labour market. *Figure 20* shows the findings from the General Household Survey.

Cost

6.6 A third measure of the burden of ill-health is cost. In England this would typically be costs to the NHS, though attempts are often made to measure wider social and economic costs (eg including lost production, social security etc). *Figure 21* shows NHS expenditure by diagnostic group.

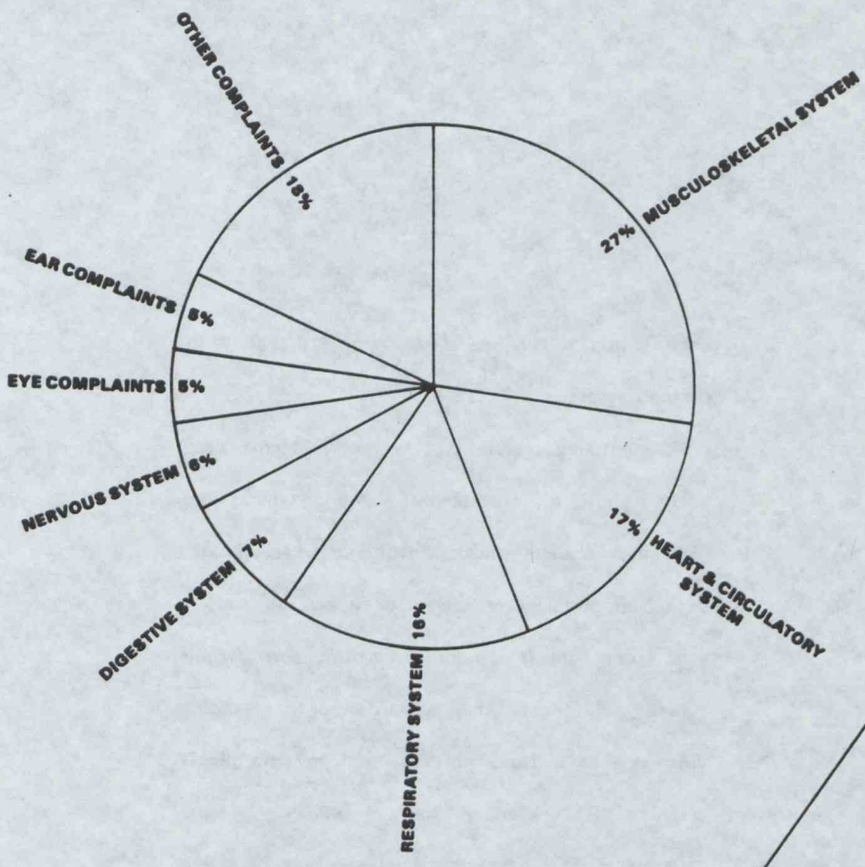
6.7 The striking feature is that the 'problems' each analysis shows differ markedly – with one exception. Circulatory diseases (including coronary heart disease, stroke) are prominent in each case. By contrast, cancers take a heavy toll in terms of premature mortality, but account only for a small proportion of longstanding illnesses. The diseases which cause long term illness and time off work are not the main killers, while the pattern of NHS expenditure does not closely follow the pattern of either premature mortality or of ill-health.

Different perspectives

6.8 Different perspectives produce different conclusions about priorities. People generally seem more willing to expose themselves to much greater risks than they are prepared to have imposed on them. The chance of an individual suffering from the effects of chemical pollution are very low compared with the chances of coronary heart disease as a result of smoking, poor diet, and lack of exercise. However, even if the balance of risks is accepted, that is not to say that people would consider the safety of chemicals a low priority. On the contrary, however risky personal health behaviour might be, people are likely to be concerned that safety measures against pollution be taken because the risk, although small, is entirely outside their control. An aim of the development of a strategy for health must be to

LONG STANDING ILLNESS BY DIAGNOSTIC GROUP*

GREAT BRITAIN ALL PERSONS 1988



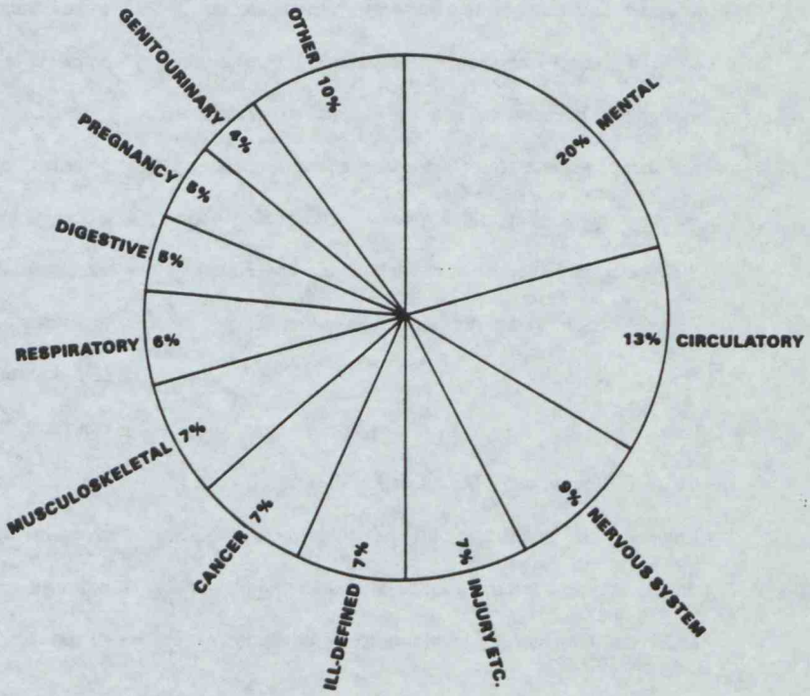
*DATA USED IS OF SELF-REPORTED ILLNESS
PERCENTAGES MAY NOT ADD UP TO 100 DUE TO ROUNDING ERRORS

SOURCE GENERAL HOUSEHOLD SURVEY

figure 20

NHS EXPENDITURE BY DIAGNOSTIC GROUP

ENGLAND AND WALES ALL PERSONS



SOURCE OPCS, IMIPE 1982; ROUTINE NHS COSTING RETURNS 1986/7.
NATIONAL MORBIDITY SURVEY 1981/2

figure 21

create greater general awareness of the relative risks to health: only this way will there be agreement on priorities.

6.9 It also needs to be remembered that this type of analysis fails to highlight the effectiveness of existing action which needs to be sustained. Communicable diseases do not rank high throughout, but their potential for harm remains, if efforts to prevent them were to be relaxed.

SCOPE FOR IMPROVEMENTS IN HEALTH

6.10 There are two main ways of determining whether there is scope for improvement – through comparison with performance elsewhere, and through knowledge of interventions which are known to be effective (and cost effective).

6.11 Comparisons of health between different places and groups of people can highlight scope for improvement. In the 19th century, figures showing that the death rate in Southwark was twice as high as that in Hampstead had a telling effect on Victorian public opinion.

6.12 The principle is simple, and as valid today. What is achievable in one population should theoretically be achievable in a similar population. In practice, however, the reasons for differences may not be equally amenable to change. Some differences might be due to remediable factors such as poor health service performance, or personal, social or environmental factors such as smoking and eating habits or poor housing. Others may be due to cultural factors, or to geographical or genetic reasons. Most will be a mixture.

6.13 Comparisons do not, of course, show all the room for improvement. For one thing, there is no reason to think that even the best position currently achieved could not be bettered, whether through natural changes or scientific advance. Nonetheless, they do at least stimulate debate about the reasons for differences and at best may indicate that there is much more scope for improvement.

INTERNATIONAL COMPARISONS

6.14 In many cases, England's health performance is very good. Appendix 1 shows England's position on a range of issues against the World Health Organisation's 38 "Health For All by the Year 2000" targets. In some areas, however, there is room for improvement, and the following tables highlight a number of these areas.

6.15 In each area there are two key issues: the rate of improvement and the size of the problem. The following charts for persons aged 55-64 compare England's performance with six other leading western countries in the important areas of cancer (all malignant neoplasms), lung cancer, breast cancer, coronary heart disease, and accidents. In each chart the countries are ranked in order of their percentage change in performance.

DEATHS FROM ALL MALIGNANT NEOPLASMS
PEOPLE AGED 55-64 YEARS

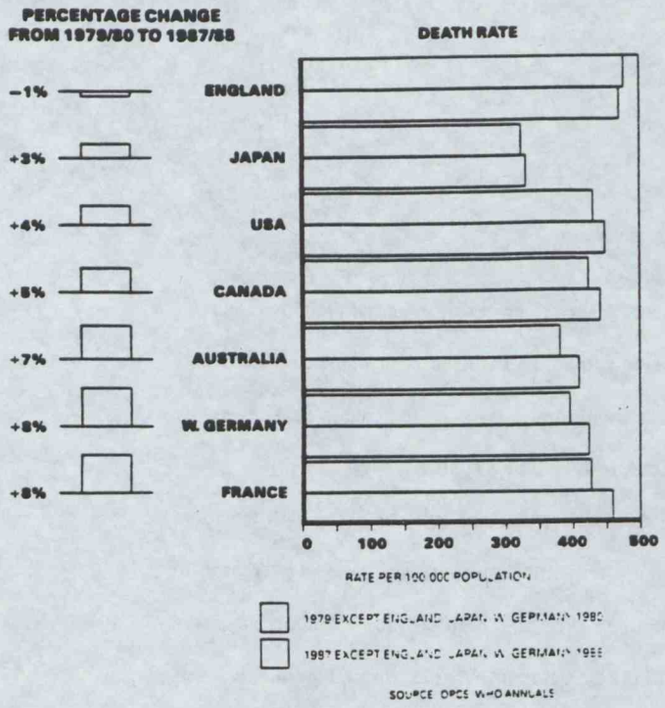


figure 22

DEATHS FROM LUNG CANCER
PEOPLE AGED 55-64 YEARS

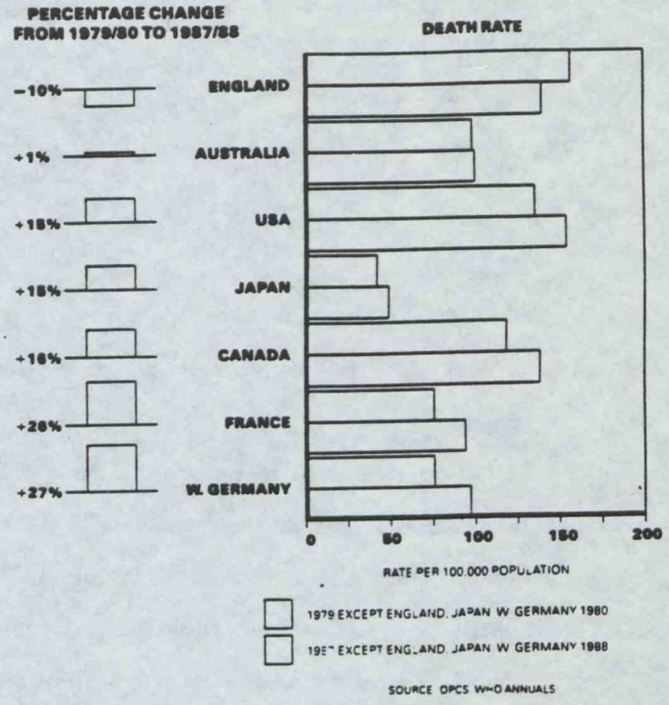


figure 23

DEATHS FROM CANCER OF THE BREAST
FEMALES AGED 55-64 YEARS

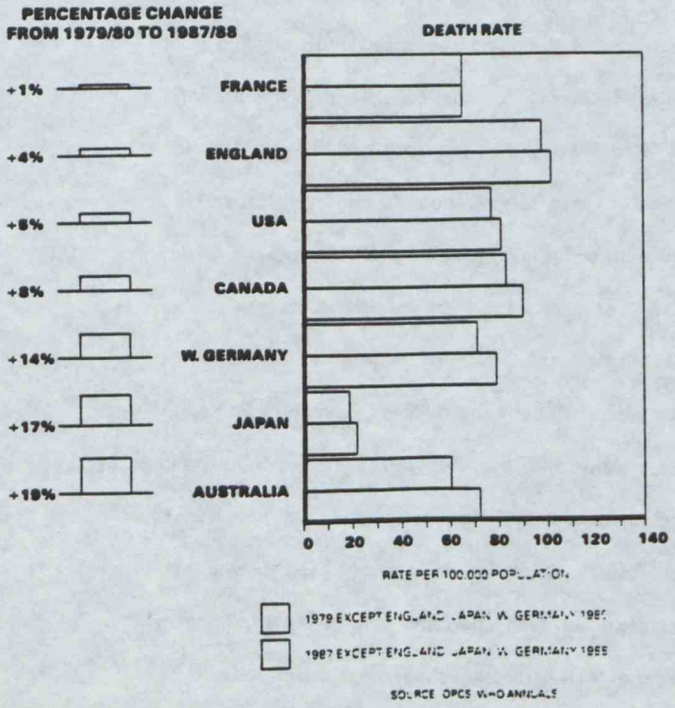


figure 24

DEATHS FROM CORONARY HEART DISEASE
PEOPLE AGED 55-64 YEARS

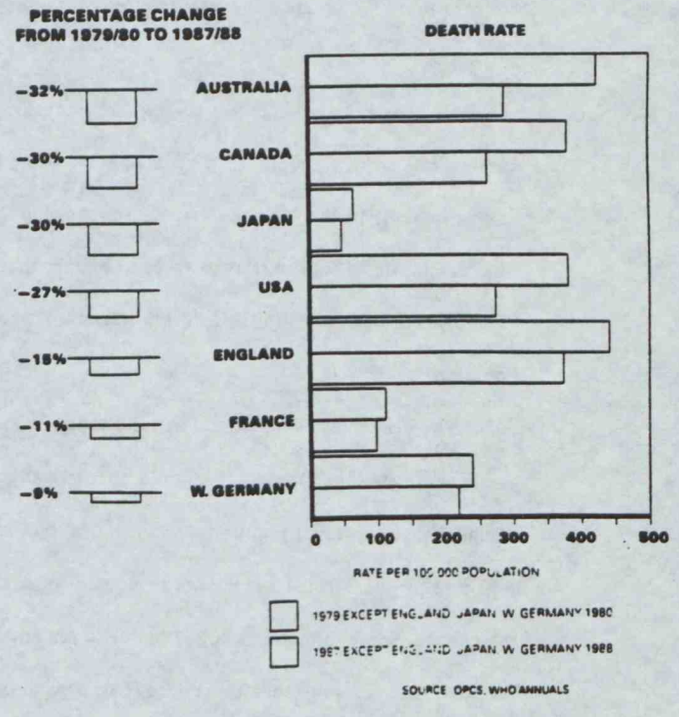


figure 25

Figure 22 shows that England alone has improved albeit slightly in its performance in reducing death from cancer, whereas each of the other countries has shown increases, in some cases appreciable. Much of this achievement is likely to be attributable to a marked decline in lung cancer mortality amongst men. Nevertheless, England's rate of cancer per head of population remains relatively high.

Figure 23 shows the position on lung cancer in detail. A 10% decrease in death in England compares well with up to 27% increases elsewhere. But there is considerable scope for more improvement in a disease which is to a large extent eminently preventable. The aggregate figures mask a further challenge – the fact that for women the death rate has risen, reflecting in part the fact that the decline in smoking amongst women has occurred only more recently than it has for men.

Figure 24 shows the comparison for breast cancer. England's absolute position is clearly poor, but at least it has not experienced the significant increases found in some other countries. And it is the size of the problem in England which stimulated the development of the NHS breast cancer screening programme, targeted on this particular age group.

Figure 25 shows that England has made progress in reducing death from coronary heart disease over the past decade, but other countries have done better.

Figure 26 shows that England has achieved a marked reduction in reducing death from accidents and here the country's absolute position is very good.

6.16 The fact that comparison with performance elsewhere, whether overseas or in different parts of this country, shows scope for improvement does not necessarily indicate that it is known how to take advantage of that scope. There must also be knowledge of what is actually effective in making improvements. Nor is it sufficient simply to identify potentially effective interventions; these must also be practical within resource and other constraints be they fiscal, social or moral. Interventions, though potentially effective, may be impractical by being disproportionate (in cost or scale) to the benefit to be achieved.

SETTING AND MONITORING TARGETS

6.17 The ideal form of targets is clear. At whatever level they are set they should be:

- related to actions known to be effective
- achievable but challenging
- monitorable through indicators.

Related to actions known to be effective

6.18 If targets are to be valuable they must be related to what can actually be done. Only where it is known that there is true opportunity for improvement is it worthwhile to set a target.

Acheivable, but challenging

6.19 A target which is beyond realistic expectations may perversely be a disincentive to action. At best it will be

irrelevant. On the other hand, targets must be challenging. There is similarly little point in aiming low.

Monitorable through indicators

6.20 It must be possible to monitor progress in moving towards targets. Each target will relate to an indicator of the change which is being sought. For example, an indicator for an improvement in coronary heart disease might be a decline in the death rate from that disease. In many cases appropriate indicators of progress are much less obvious – the sort of things which may easily be measured may not be unequivocal measures of genuine success. It is also necessary to have the data to quantify the indicator; some exist, some may need to be developed and/or collected.

6.21 The development of indicators and the collection of data is, of course, subject to the same constraints of resources, practicality and acceptability as other actions. Target setting must take into account the resource consequences and practicality of collecting the data needed to support the indicators. Just as cost-effective interventions are not always avilable, so too in some cases cost-effective indicators may be lacking. In these cases, too, effort should be directed towards further development of techniques and information policies which will fill those gaps.

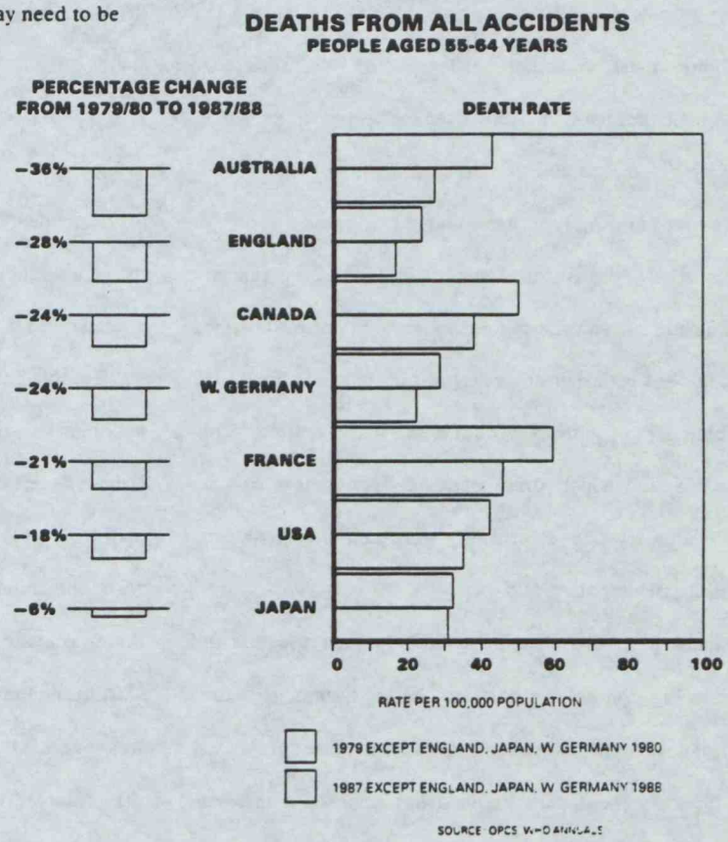


figure 26

Conclusion

6.22 This chapter has looked in detail at the three criteria to help selection of key areas. Key areas must be those which are a significant cause of concern and in which there is real scope for genuine and monitorable improvements in health. However, particular constraints such as limitations of current understanding about both levels of ill health and the scope for improvement, and lack of indicators would mean that strict application of the three criteria would, at the start of development of a strategy for health, unreasonably limit the scope for what might be included. It would also prevent an objective being set, or a possible target being proposed as a means of discussing not only objectives and targets but also what action **would** make significant progress. For this reason, a more pragmatic approach is suggested. Whilst striving to develop targets that do go towards the ideal, the Government believes there is a need to set targets in certain key areas knowing that understanding is far from what, ideally, is needed. This will however be on the basis that over time understanding would be improved with the setting of targets itself acting as a stimulus.

6.23 Chapter 7 takes this into account in suggesting some possible key areas. Chapter 8 looks at what more needs to be done to improve understanding of health problems and the means of addressing those problems more effectively.

IDENTIFYING KEY AREAS: POSSIBLE KEY AREAS, OBJECTIVES AND TARGETS

Possible key areas - objectives and targets - selection of initial set of key areas

INTRODUCTION

7.1 This chapter suggests possible areas from which an initial selection of key areas might be made. The areas covered reflect the diversity of possible candidates identified by the analysis in the previous chapter.

They include:

causes of substantial mortality

- coronary heart disease
- stroke
- cancers
- accidents

morbidity

- mental health
- diabetes
- asthma

contributing factors to both mortality and morbidity and to healthy living

- smoking
- diet and alcohol
- physical exercise

areas where there is clear scope for improvement

- health of pregnant women, infants and children
- rehabilitation services for people with a physical disability

areas where there is a great potential for harm

- HIV/AIDS
- other communicable diseases
- food safety.

7.2 The Government recognises that this set of possible key areas is by no means exhaustive. It believes however that the subjects cover those areas which most obviously meet all the criteria set out in chapter 5, together with a range of others which illustrate the types of approaches that could be taken to objective and target setting. **It will welcome views during consultation on additions and alternatives.**

7.3 The annexes to this document discuss each of the above areas in detail, relating each to the three criteria for selection as key areas. *Figure 27* sets out in summary form the conclusions of the discussions. In most cases it is concluded that the areas do meet the criteria. However in four cases the conclusion is that – for a variety of reasons – they are not currently suitable candidates for key areas.

OBJECTIVES AND POSSIBLE TARGETS

7.4 In each of the areas where the discussion concludes that they meet the criteria for selection, both overall objectives and possible targets are suggested. These are summarised below.

7.5 As discussed in chapter 6, ideally key areas should be those where genuinely measurable health outcome targets can be set on the basis of a detailed appraisal of their feasibility. However, this will not always be

Area	Criterion 1 Major cause of concern	Criterion 2 Scope for improvement	Criterion 3 Ability to set targets
Coronary Heart Disease	Greatest single cause of premature death	Healthy living Effective treatment	YES
Stroke	12% of all deaths 5% of deaths under 65 years	Healthy living Detection and treatment of raised blood pressure Rehabilitation	YES
Cancers	25% of all deaths	Not for all cancers For some – healthy living Screening for breast and cervical cancers	Not for all cancers Screening targets for breast and cervical cancer + see smoking target
Smoking	Largest single preventable cause of death	Not smoking	YES
Eating and Drinking Habits	Contribution to many aspects of health and ill-health	Healthier eating and drinking habits	YES
Physical Activity	Contribution to many aspects of health and ill-health	More people taking regular physical activity (though more information needed in relationship between activity and health)	Not at this stage – further information needed
Prevention of Accidents	Most common cause of death under 30	Improvements in engineering. design. environment etc Education. awareness Legislation and other controls	YES
Health of Pregnant Women. Infants and Children	Key indicator of the nation's health	Wide subject – scope varies for different aspects	YES
Diabetes	4-5% of total health care expenditure spent on care of people with diabetes	Effective treatment and care	YES
Mental Health	20% of total NHS expenditure	Transition to a district-based service	YES
HIV/AIDS	Greatest new threat to public health this century	Safe sexual and intravenous drug using behaviour	Not at this stage – further information needed
Other Communicable Diseases			
(a) preventable by immunisation	Potential for harm should immunisation rates fall	Immunisation	YES
(b) hospital acquired infection	40% of inpatients have an infection acquired in hospital	Good practice	YES
Food Safety			
(a) foodborne diseases	Cause of considerable degree of ill-health. though not many deaths. Underlying rising trend in cases	Improvements in hygeine. Increase in awareness Effective surveillance Regulation	Not at this stage – more needs to be known about incidence of food poisoning
(b) chemical safety of food	Undoubted potential for harm to human health in absence of effective measures	Continued research and assessment Regulation and other controls	Limited ability to set targets in terms of human health
Rehabilitation Services	Wide subject covering a variety of areas of concern	Scope for intervention varies	YES – in specific areas
Asthma	Substantial morbidity – lost schooling and sickness absence	Effective treatment and care	YES

possible because knowledge about potential health outcomes and how precisely they might be achieved is not uniform. Similarly, the data required to measure and monitor progress is not equally available in all areas.

7.6 The possible targets suggested are therefore of a variety of types. Where possible, targets in a key area are for health outcomes – ie actual improvements in health. However, in some cases this may not be possible, either through lack of the necessary data, or as yet insufficient development of outcome measures. In such cases, targets have been suggested which relate to services which are known to be effective in improving or safeguarding health.

7.7 In some cases, specific quantified national targets have been suggested. In others no target has been specified, and views are invited on what might be appropriate. In many cases, it is suggested that opportunities for target setting are greatest and potentially most valuable at local level. The mechanisms by which targets will be monitored vary according to the type of target. In some cases existing routine data could be used, in others new data will need to be collected, either on a routine or special survey basis. Medical and clinical audit may also provide a way of monitoring success in reaching certain targets.

AREAS NOT TO BE INCLUDED

7.8 In four cases the Government's conclusion is that the areas do not sufficiently meet the criteria for selection as key areas, for the following reasons:

- Cancers: although cancers are a very important cause of death and ill-health, only for some types of cancer are effective interventions available (criterion 2). It would therefore be inappropriate to treat cancers as a single area, though that is not to say that cancers should not be tackled in another way. As noted in the summary above, the discussion looks separately at breast and cervical cancer for which screening is effective. The many cancers which are caused mainly or partly by tobacco use are addressed in the annex on smoking.
- Physical activity: more needs to be known both about the relationship between activity and health, and also about current levels of participation in physical activity, exercise and sport (criteria 2 and 3). The current Allied Dunbar National Fitness Survey should help to provide more of this information.
- HIV/AIDS: more needs to be known about the current prevalence of the disease (criterion 3). The current series of anonymised sero-surveys may help to provide further information.
- Food Safety: in the case of foodborne diseases there is currently no sound basis for determining targets for reductions in incidence of food poisoning (criterion 3). The Department of Health's current studies will provide more information about the actual incidence of food poisoning in the community. There may also in time be scope for intermediate targets related to

activities of enforcement officers. In the case of chemical safety of food, the scope for identifying ill-health caused by the chemicals in food using epidemiological data, and consequently the ability to set measurable targets for improvement in human health, is limited (criterion 3).

SELECTION OF INITIAL SET OF KEY AREAS

7.9 It is not proposed that all the possible areas suggested should be included in the final initial national selection of key areas and targets. They are proposed here for consultation. **The Government hopes as a result of consultation to be able to agree a limited definitive initial set of key areas, objectives and targets** including perhaps no more than 5 or 6 areas in the first instance (except that smoking, eating and drinking would naturally accompany coronary heart disease and stroke for which they are risk factors).

7.10 Inevitably this will mean that a number of important areas will not initially be selected as key areas. This is in no way to deny their importance. Indeed, it is at the heart of the approach suggested that the strategy should build up over time into an ever more comprehensive portfolio.

SUMMARY OF POSSIBLE KEY AREAS WITH OBJECTIVES AND TARGETS

Coronary Heart Disease

Objectives

To reduce the occurrence of this disease and to reduce associated death and ill-health; and to improve the treatment and rehabilitation of those suffering from it.

Possible targets

- 30% reduction nationally in premature death below age 65 from coronary heart disease between 1988 and 2000.
- Also, perhaps, targets for treatment (eg coronary artery by-pass grafts; 30 minute "door to needle time" for intravenous thrombolytic therapy)

Stroke

Objectives

To reduce death and disability from stroke and to ensure the maximum quality of life for survivors.

Possible targets

Options include:

- 30% reduction nationally in premature death below age 65 between 1988 and 2000.
- 25% reduction nationally in death in the 65-74 year age group between 1988 and 2000.
- Possible targets (national or local) for incidence of stroke, early detection and treatment of raised blood pressure, and rehabilitation of stroke survivors.

Cancers

Objective

To reduce death and ill-health from cancers.

Possible targets

Cancers vary enormously and the scope for change varies from cancer to cancer. Therefore no global target is suggested. Tobacco-related cancers will be reduced by success in meeting targets for smoking (see below). For breast and cervical cancer. targets based on screening programmes already exist:

- to reduce breast cancer deaths in the population invited for screening by 25% nationally by 2000 compared to 1990
- to ensure that all women in the eligible age group will have been invited for cervical cancer screening by the end of 1993.

Smoking

Objective

To reduce death and ill-health caused by smoking, by reducing the numbers of people starting to smoke and increasing the numbers who stop smoking.

Possible targets

- to reduce the proportion nationally of men smoking to 22% by 2000 and of women to 21% (reductions of 33% and 30% respectively). The target can further be broken down by sex and age group:

Age in years	men		women	
	1988 %	2000 %	1988 %	2000 %
16-19	28	20	28	20
20-24	37	25	37	25
25-49	37	25	35	25
50-59	33	20	34	20
60+	26	15	21	15

Eating and Drinking Habits

Objectives

To reduce the amount of ill-health and premature death related wholly or partly to eating and drinking habits.

Possible targets

- by 2005 the proportion of the population who derive less than 15% of their food energy from saturated fatty acids should be at least 60%
- by 2005 the proportion of the population who derive less than 35% of their food energy intake from total fat should be at least 50%
- by 2005 the proportion of obese adults should be 7% or less
- by 2005 fewer than 1 in 6 men and 1 in 18 women should be drinking more than the sensible limits of alcohol.

Prevention of Accidents

Objective

To reduce the number and severity of accidental injuries.

Possible targets

Views are invited on the possibility of setting broad national targets for accident prevention. Issues include:

- should such targets look only as far as 2000, or beyond that?
- what indicators (of death and injury) could be used?
- should targets be for the population generally, for specific population groups, or should both approaches be used?

Health of Pregnant Women, Infants and Children

Objective

To reduce preventable death and ill-health amongst pregnant women, infants and children.

Possible targets

No single target is possible. Possibilities include:

- all Regional Health Authorities, their District Health Authorities and Family Health Services Authorities to have agreed targets by 1993 for reductions in stillbirths and infant deaths.
- all Regional Health Authorities by 1993 to have reviewed arrangements in consultant maternity units with a view to ensuring as soon as is practicable that each such unit should have a consultant obstetrician and anaesthetist readily available whose main priority was to oversee the labour ward.
- to increase the proportion nationally of infants who are breastfed at birth from 64% in 1985 to 75% by 2000.
- to increase the proportion nationally of infants aged six weeks being wholly or partly breastfed from 39% in 1985 to 50% by 2000.
- that by 2003, 12yearolds should have on average nationally no more than 1.5 decayed, missing or filled permanent teeth (with appropriate regional and sub-regional targets.)

Diabetes

Objective

To reduce death and ill-health caused by diabetes, principally by ensuring the effective provision of services.

Targets

While it would be possible to set service targets (for example, proportion of GP practices within a Family Health Services Authority who follow locally agreed protocols for services to people with diabetes) it should in principle soon be possible to set targets using health outcome measures. These would require better access to existing information sources. But the Government would welcome views on the feasibility at this stage of setting targets in areas such as:

- reduction in rates of blindness caused by diabetes
- reduction in rate of amputations for diabetic gangrene
- pregnancy outcomes in women with diabetes approximating to those of women without diabetes
- reduction in number of people with diabetes entering end-stage renal failure
- reduction in death and ill health from coronary heart

disease among people with diabetes.

Mental Health

Objective

To reduce the level of disability caused by mental illness by improving significantly the treatment and care of mentally disordered people.

Possible targets

In the present state of knowledge it is not currently realistic to set health outcome targets for mental health services. However, it is clear that patients and their carers benefit from the transition from traditional large hospital based care to a district based service. A single measurable target might therefore be:

- substantially to complete the shift of service provision to district based care, thereby allowing many of the remaining 90 large psychiatric hospitals to be closed before 2000.

Such a target would have to be supported by measures of success in providing appropriate and high quality alternative district based hospital and community services.

Communicable Diseases

(a) Immunisation-preventable communicable diseases

Objective

To reduce or eliminate these diseases, principally by preventing their spread.

Possible targets

- increase the national target for childhood immunisations from present 90% to 95% coverage by 1995
- 90% reduction nationally by 1995 on 1989 levels of measles notifications

(b) Hospital acquired infections

Objective

To reduce as far as possible the incidence of hospital acquired infections.

Possible targets

Targets could be set on the basis of what can be achieved through good practice. These might initially relate to procedures to be adopted. Medical and clinical audit will allow continuing development of target setting and monitoring in individual units.

Rehabilitation Services For People With A Physical Disability

Objective

To enable people with physical disabilities to reach their optimum level of functioning.

Possible targets

Given current developments in the service, and its diverse nature, it is not at present appropriate to set national targets for rehabilitation services. There is however scope for specific targets to be developed to support the widespread and effective delivery of services. Health Authorities could set targets aimed at certain specific disabling conditions, eg incontinence.

contractures and pressure sores. In respect of this last an annual reduction of at least 5-10% would be a reasonable target.

Asthma

Objective

To reduce death and ill-health attributable to asthma in the short to medium term by the effective provision of services and in the long term by establishing its aetiology.

Possible targets

It is not appropriate at the moment to set health outcome targets for asthma. It may be better to develop targets for defined populations based on specific aspects of services delivery, such as

- adherence to published clinical management guidelines
- the establishment of agreed protocols between GPs and hospital clinicians
- the development of local strategies
- take-up of peak flow meters on prescription
- development of self-management plans agreed between patient and doctor.

MONITORING, EFFECTIVENESS AND HEALTH OUTCOMES

Action being taken to remedy weaknesses – Central Health Monitoring Unit – New health survey programme – Research and development – Developing health outcomes.

8.1 The discussion in chapter 6 about objectives and targets has highlighted weaknesses in understanding of the effectiveness of interventions, and the ability to monitor progress in a wide number of areas through, amongst other things, health outcome indicators. The Department of Health, with the NHS and others, is taking action in these areas, particularly in the development of outcome indicators. These initiatives – vital to the further development of a coherent health strategy – are described in this chapter.

DEVELOPING THE ABILITY TO MONITOR THE HEALTH OF THE POPULATION

8.2 Effective monitoring of the health of the population is the starting point for any strategic approach to health. Although in many respects the UK's 'health' data are as good as, if not better than, those collected in other countries, they are still weak in certain major areas. Although measuring mortality is routine, there is significantly less information about both ill health and, above all, about health generally – about the risk factors (such as smoking) or combinations of risk factors from which ill health arises and the precursors of ill health (such as high blood pressure and raised levels of blood cholesterol).

8.3 The Government is committed to improvement. Three important steps have been taken.

- First, the ability to monitor health has been significantly advanced by the appointment of **Directors of Public Health** with the function of producing annual reports on the health of their local population.
- Second, the Government has established a **Central Health Monitoring Unit** within the Department of Health to act as a focus for monitoring and analysing epidemiological information about the health of the population and to improve the epidemiological input into policy making. The Unit will be publishing a series of overviews of topics. The first two publications will be epidemiological overviews of the health of elderly people and children.
- Third, a **Public Health Information Strategy** is being developed which aims to ensure the Department has the information necessary to support its role on public health issues.
- Fourth, a new **national health survey programme** is under way, designed to fill gaps in key indicators as a major development for monitoring the public health. The new survey programme will begin in the autumn 1991. Initially it will consist of two types of survey:
  - a series of biennial detailed *dietary and nutritional surveys* to be conducted by DH and Ministry of Agriculture, Fisheries and Food, each covering a

specific age group

- an annual *general health and nutrition survey* initially covering adults and concentrating on cardiovascular disease and its associated precursors and risk factors.

BETTER UNDERSTANDING OF EFFECTIVENESS

8.4 The development of better understanding of the effectiveness – and cost effectiveness – of interventions is essential. It is fundamental not only to setting strategic objectives; it is fundamental to all health planning and to each individual decision about how use resources, be that choice of treatment for individual patient, or legislation on environmental protection.

8.5 To underpin this, a research and development base for public health and the NHS is necessary to provide reliable and appropriate information for health policy, service planning and health care delivery. To achieve this, research and development needs to embrace public health research, clinical research and health service research, and to be closely aware of developments in basic science.

8.6 A research and development strategy, developed by the Department of Health's new Director of Research and Development, and just published, sets out a structure for achieving this by:

- a strategic and managed approach by the NHS to research and development to provide a sound scientific basis for action to improve health;
- the development within a broad framework of a countrywide research and development programme through Regional Health Authorities – this strategic framework will include the setting of national research priorities, complemented by Regional activity;
- a requirement on RHAs to prepare, publish, resource and implement (and be held to account for) research and development plans;
- collaboration with other research funding bodies in addressing issues of agreed national priority.

8.7 Examples of the contribution research is already making to the assessment of the effectiveness of health care interventions include:

- provision of four summaries of current knowledge in specified clinical conditions to assist DHAs in their purchasing role;
- development of outcome measures of primary health care for asthma, diabetes and hypertension;
- development of other health outcome and quality of life indicators;
- skill mix and effectiveness of nursing care;
- cost effectiveness studies of community versus hospital based care for mental illness;
- impact of new technology on investigations in general practice;
- summaries of knowledge in particular conditions to assist DHAs in their new purchasing role;

- recently commissioned research by the Department for the development of outcome measures of primary health care for asthma, diabetes and hypertension;
- development of other health outcome and quality of life indicators.

DEVELOPING ABILITY TO MEASURE SUCCESS – HEALTH OUTCOMES

8.8 Improving understanding of the ways in which changes in health are measured is central to the development of epidemiologically-based evaluation of health policy at all levels. Outcome measurement – that is measurement of the success of particular actions or sets of actions in improving health – shows not only change, but relates that change to identifiable actions, resources, or events. It enables specification and quantification of objectives increasingly to be set in terms not of process, but of improvements to health. It allows the effectiveness of policies to be evaluated. In the long-term it will increasingly be developed as a way of holding the NHS and others to account for the success of their activities.

8.9 Much work is currently being developed in the field of outcome measurement. Projects under way or about to be launched by the Government at national level include:

(a) **Development of outcome indicators** A working group was set up in 1989 by the Chief Medical Officer to (i) examine the nature of outcome indicators and how they might be used and linked to health service objectives; (ii) examine the use of routinely available data; and (iii) recommend how work be taken forward. The group has proposed a starter list of outcome indicators which could be produced using data routinely available to the NHS. In addition, essential criteria for valid and reliable indicators have been established. A feasibility study will now assess each proposed indicator against the criteria and make recommendations for the production of indicators. An initial set of indicators recommended by this study will be produced in September 1991.

(b) **National Clearing House** A national clearing house is shortly to be established to collect and collate the most up to date information on resource requirements, methodology, data collection systems, analytical and interpretation skills and expert advice on assessment of health service outcomes. It would make these available to the Department of Health, NHS and other statutory and voluntary agencies.

(c) **Outcomes Research** The Department of Health is funding a number of research and development projects on all aspects of outcomes assessment. These include:

- work by epidemiologists and clinicians on the development of indicators of outcome of care, particularly hospital outcomes by specialty and clinical condition; outcome of primary health care for asthma, diabetes, raised blood pressure; and

outcome of mental health care

– follow-up studies on avoidable deaths: £250,000 has been made available for RHAs for projects either investigating reasons for high local rates of "avoidable death" or developing "avoidable death" indicators

– research on better methods for assessing health, ill health and change in health for use in outcome assessment

– project linking clinical standards and quality of delivery of care to outcomes.

MAKING PROGRESS ACHIEVING OBJECTIVES AND TARGETS

From What to How – Shared responsibility – Different approaches in each key area – Common themes – The Government role – English Health Strategy Steering Group

FROM WHAT TO HOW

9.1 Chapter 12 describes the consultation exercise which will follow publication of this document. This chapter looks beyond that to how the strategy will develop in practice.

9.2 A strategy with objectives and targets is valuable only to the extent that it secures progress. The challenge is to ensure objectives and targets are translated into action.

9.3 In some countries central action stops at the point of setting and agreeing objectives and targets: the **what** has been set, the **how** is left to those concerned to deliver, with central Government monitoring and appraising progress. The argument is that if ownership has been secured both to the overall aims of the strategy and to the particular objectives and targets, then sufficient momentum may have been generated to carry action forward: the objectives and targets will themselves stimulate the necessary action. A common purpose will have been secured and results will follow.

9.4 The Government does not believe this is a sufficient response for England. Although the need for delegation and local discretion has been identified as very important in an English health strategy, avoidance of central prescription of how action should be taken does not mean the absence of central oversight and responsibility. Furthermore, the existence of the National Health Service, the reforms, and the roles of the Department of Health and other Government Departments provide opportunities for a more concerted approach at national level.

VARIETY OF RESPONSES: COMMON THEMES

9.5 This view if reinforced by the fact that, with some exceptions, the majority of the objectives and targets suggested in this consultation document do not fall within the responsibility of any one agent. Those involved in any area may include:

- individuals
- families
- communities
- health care services
- health professions
- the education service
- voluntary sector
- industry, commerce and trade unions
- the media
- Government, central and local
- international organisations.

9.6 Co-operation is essential: the number and variety of those involved illustrate the difficulty of securing such co-operation. This document has already touched

on the core responsibility of the Department of Health within Government to secure concerted action at national level. Concerted action at local level within communities is as – if not more – important

9.7 There is no single approach to securing progress in the proposed key areas. As each falls to a range of different agencies, so different approaches will be needed to make progress. This is not to say there are no themes across the different areas: as well as the need for collaboration, themes that recur include the need to improve capacity to monitor health and appraise the effectiveness of interventions and the need for effective health education.

THE ROLE OF THE CENTRE

9.8 The concerted approach needed to secure improvements in health demands that Government act in a variety of ways to ensure progress is made. It needs to lead, facilitate and monitor the translation of aspiration into action. Specifically it needs to

for itself

- adopt appropriate policies and programmes
- ensure that agencies directly accountable to Government play their full part

for the strategy as a whole

- lead and facilitate the translation of aspiration into action
- encourage and where necessary facilitate co–operation between different sectors in the pursuit of the strategic objectives and targets
- monitor and review progress, and review objectives and targets in the light of changing circumstances and advancing knowledge
- develop new key areas.

9.9 To assist him in this role, the Secretary of State for health will seek views from a new **English Health Strategy Steering Group**. This group will provide a forum through which the experience and interests of those involved in health can be brought together in support of the strategy for health. Its membership will need to be representative of the many agencies and interests with a role in health, although naturally a balance will have to be struck between wide representation and keeping it to a manageable and effective size. It will be supported by a task force. Although the primary purpose of this Steering Group will be to help take work forward after the Government has responded to the results of consultation on this document, the Government intends to establish it during the consultative period to assist in the scrutiny of responses.

THE NHS ROLE IN A STRATEGY FOR HEALTH

The NHS Role – Translation of targets to local level: Key issue for consultation – Regional Health Authorities – District Health Authorities Family Health Services Authorities – Provider Units – Health Education and Promotion – The Health Education Authority

INTRODUCTION

10.1 This document has identified a wide range of responsibilities for health. One of its key themes has been that responsibilities go beyond the NHS. That does not mean, however, that the NHS, like the Department of Health, does not have a major and unique role to play. As chapters 4 and 9 have noted, the NHS reforms have provided the NHS with new opportunities to tackle successfully broader aspects of the country's health, as well as continuing to develop treatment and care services in response to demographic changes and medical advances. This chapter considers how the NHS can play its part in a health strategy. It also looks at the particular role health education has to play in addressing the risks leading to many of the most common illnesses and diseases.

KEY AREAS, TARGETS AND LOCAL ACTION

10.2 Objectives and targets in key areas for health improvements will provide a guide to how the NHS, and others, might respond, but it will – intentionally – be far from a blueprint of the action that the NHS and others will need to take at local level. Action at local level must be determined in the light of local circumstances, and other local priorities. The challenge for the strategy and for the NHS will be to make the link between national objectives and local action.

10.3 Achievement of targets will require the commitment of everyone in the NHS to the principles and to the specific aims and objectives of the strategy. Without such commitment, no progress will be made. Although targets are likely to be expressed at a global level, they are achieved with individuals through the efforts of each health professional and those who support them. A link must be forged between the target of better health and the actual service which is delivered.

10.4 To harness and direct interest and commitment, the strategy must be built into NHS management systems – contracts, collaborative arrangements, audit, planning, monitoring and review, including the NHS Management Executive's "corporate contracts" with Regional Health Authorities and, in turn, with Districts and Family Health Services Authorities.

10.5 For the successful adoption and realisation of targets these systems must ensure at all levels:

- the problem to be addressed is is understood: what is the size of the challenge? where is it most acute? what further information is needed?
- the problem is addressed effectively: what services can

and should be provided? for whom and how?

• progress is monitored: are services being provided effectively? is the problem being addressed fully? what progress is being achieved? This will be about the audit of success of individual activities as much as about indicators of change at population level.

10.6 Where national targets are agreed and adopted, the NHS will need to assess:

• ways of deriving targets for the NHS's contribution to the national targets

• ways of agreeing the necessary contribution from each Region

• how far these mechanisms should be extended to DHA and FHSA level.

10.7 The precise details of how commitment can be secured and key areas built into NHS planning and review systems will need to be addressed by the NHS, the NHS Management Executive and the NHS Policy Board. The Government intends that discussion of these questions should form a major part of the consultation; chapter 12 proposes how this be taken forward.

PRACTICAL STEPS TO SUPPORT A STRATEGY FOR HEALTH – THE ROLE OF HEALTH AUTHORITIES

10.8 There are many practical ways in which health authorities can support a strategy for health. Responsibilities will differ according to the type of health authority.

REGIONAL HEALTH AUTHORITIES

10.9 Regional Health Authorities can contribute to the national strategy for health by:

• providing a strategic framework which is agreed and shared by purchasers of health care, which takes account of both national objectives and targets and the particular needs and priorities of each Region

• supporting purchasers in developing and producing local strategies and the production of purchasing plans which translate Regional and local priorities into action

• providing a focus for collaborative working on a Region-wide basis

• agreeing standards for improvements in health jointly with FHSAs, DHAs and GP fund holders against which performance in achieving health objectives can be monitored

• providing an active link between national, Regional and local health programmes and support activities, including those of the Health Education Authority

• encouraging innovation and research.

DISTRICT HEALTH AUTHORITIES

10.10 The DHA's duty to purchase a comprehensive range of high quality health care services to meet the

needs of local populations and achieve optimum desirable health outcomes, requires it to plan health promotion and disease prevention services together with services for diagnosis, treatment, care and rehabilitation. As this document has emphasised, the continued provision of existing services remains at the heart of their function. Each District Health Authority's responsibilities, to complement those of Family Health Services Authorities, will include:

- collection, analysis and interpretation of routine and ad hoc information about the health of the population, including epidemiological data, consumer and community surveys and preparing annual reports which analyse current problems affecting the health of local populations
- agreeing priority areas for the targeting of effective service interventions in relation to those populations most at risk and for assessing the impact of services
- bringing to the attention of the local community (from individuals to community and other leaders) their role in promoting and maintaining health locally
- collaborating with others on the development of joint policies and strategies for health promotion and disease prevention, including with FHSAs on primary care, and with local authorities over wider public health issues such as environmental health and accident prevention
- making specific recommendations for achieving health outcome objectives which relate to the purchasing of services by the DHA, as well as point out action required by other organisations to help improve the health of the population.

FAMILY HEALTH SERVICES AUTHORITIES

10.11 Family Health Services Authorities have a key part to play within an integrated local health strategy. Like DHAs, FHSAs have responsibility for assessing local needs for family health services (drawing on the expertise of Directors of Public Health), and for planning and developing services to meet those needs and achieve optimum health outcomes. In fulfilling these functions, they need to work closely with DHAs, particularly in securing high-quality health promotion and disease prevention services and tackling major local health priorities in an integrated way across primary, community and hospital care. In particular, FHSAs need to:

- develop with DHAs joint health profiles of the local population, agree priorities and set targets, and contribute to DsPH annual reports on the health of the population;
- target cash-limited resources at areas of greatest need and assess the impact of service developments;
- establish consumer groups to feed into the planning process;
- establish joint planning arrangements and contribute to joint working with District Health Authorities and Local Authorities, voluntary groups and community

groups;

- agree joint policies over the service and health programmes shared with District Health Authorities, such as child surveillance, cervical and breast cancer screening, health education, and care of elderly people;
- encourage and support multi-disciplinary team working and training in primary health care;
- fund facilitator services to enable and support organisational change within general practice, including the adoption of minimum standards for screening, audit of records etc;
- support family health practitioners in developing high quality, consumer-responsive services which meet local needs;
- make recommendations for achieving health outcomes objectives which relate to the services provided by family health practitioners and, like DHAs, point out action by other organisations which could help improve the health of the population.

'PROVIDER' UNITS

10.12 Provider units are those from which DHAs will purchase health care services – in the main, hospitals. They, too, have a role to play. The hospital sector can:

- ensure that health professionals are able to provide effective patient education and counselling as part of the diagnosis, treatment and care as well as ensuring appropriate ongoing care on discharge from hospital;
- maintain an environment which promotes and protects the health of all who come into contact with hospital services (including a smoke-free environment, health education materials and posters, healthy nutrition through the catering service);
- provide more intensive counselling and advice linked with specific health programmes (prevention of childhood accidents, smoking cessation, particularly with advice to general medical and surgical patients) in liaison with the primary care services.

10.13 Family doctors and dentists, high street pharmacists and opticians have an equally important role to play in the delivery of high quality health care services. For the majority of people they are the most frequent point of contact with the NHS and where they turn to first for treatment and advice. They also have a key role in promoting better health and preventing sickness. Their commitment – and that of their staff – will therefore be central to achieving the aims of the strategy.

HEALTH EDUCATION AND PROMOTION

10.14 One of the main themes emerging from this consultation document is the importance of health education and promotion in securing good health. The White Paper "Promoting Better Health", with its emphasis on health promotion, began the process of shifting the focus of care away from an illness-dominated services of the past to the increasingly

preventive service of the future NHS. It led to new health-promotion based contracts for GPs and family dentists and has resulted in a 25 per cent increase in GP practice staff, many of whom are engaged in additional health promotion activities, with members of the primary health care nursing team.

10.15 Already the new national contract for GPs has produced major health benefits. For example, together with the activities of Health Visitors, it has contributed to the achievement of the national targets for immunisation in only a year.

10.16 Nurses in the community play a central role both in providing direct nursing care to people in their own homes, in health centres and surgeries and in promoting better health and preventing illness. Together with GPs, they are in the front line of NHS care and have a direct influence over the general health of the population and the demand for acute sector services. They therefore remain a key resource for the NHS of the future; and NHS authorities need to ensure that their skills and talents are deployed to best effect.

10.17 District Health Authorities and FHSAs are also involved in more general promotion and education activities in their areas. For instance, most DHAs have a Health Promotion Unit whose role is to co-ordinate and direct the NHS contribution to health promotion and education services within the District, often in conjunction with the Family Health Services Authority. As with all services this responds to local needs. To do this well involves close liaison with various other local agencies, for example the Local Authority, Local Education Authority, voluntary groups, schools, community organisations and local business. The NHS will either take the lead or play its part in initiatives begun elsewhere.

HEALTH EDUCATION AUTHORITY

10.18 Within the NHS, but with a national role, is the Health Education Authority (HEA). The HEA was formed in 1987 by the reconstitution of the then Health Education Council as a Special Health Authority. This helped the HEA develop a closer working partnership with the NHS and begin to influence its strategic planning in the direction of health promotion. Work at local level must reflect, support and in turn be supported by the health education and health promotion activities of the HEA at national level.

10.19 More widely, the HEA provides direct public education, including the UK-wide mass media campaigns on HIV/AIDS, and fosters and supports other activities both nationally and locally level. It can provide a framework for co-ordinated action, as with the Look After Your Heart programme. It can fund local activity and research, disseminate new ideas and examples of good practice, and produce resource materials for health and health education professionals, schools, local authorities, community organisations,

employers. It is important that the resources it can provide should be used fully by authorities and other bodies in the health education and promotion fields.

10.20 HEA's strategic plan, launched in 1990, already gives priority to seven key health topics: HIV/AIDS and sexual health; coronary heart disease; cancer; smoking; alcohol; nutrition and dental health; and family and child health – areas which, in the main, complement the key areas put forward for consideration in this document.

QUALITY OF SERVICE

Health and health care: the balance – Clinical care – Quality of Service in NHS – New initiatives – Quality prescribed in contracts – Quality targets required at all levels.

INTRODUCTION

11.1 The proposals in this document focus primarily on improving health in terms of the incidence, prevalence and effects of disease. The emphasis throughout has been, however, that this necessary refocussing of activity on the prevention of disease and the promotion of good health must not be at the expense of NHS treatment and care services. A better balance is needed, not a bias in one or other direction.

QUALITY OF CARE

11.2 People are concerned that they should receive the best possible standard of care and/or cure as quickly as possible. There are two interrelated aspects to quality standards of clinical care and general standards concerning the way in which care is delivered. So far as clinical care is concerned proposals in "Working for Patients" have led to major new initiatives on medical audit as well as addressing care delivery issues. Other recent initiatives particularly the primary care reforms under "Promoting Better Health" have been designed to improve quality of care to patients. For example, the new contracts for GPs and family dentists include amongst their aims not only health promotion but also making services more responsive to consumers and raising standards of care.

11.3 A key part of quality is how care is delivered. For example, "Was sufficient information given? Were staff friendly and helpful?" The importance of the quality of service in terms of the patient's perception of their health care experience should not be underestimated. The quality of service can have a therapeutic value and be of enormous psychological benefit. This is important from first contact with a receptionist, GP or primary health care professional and particularly so for longstay and terminally ill patients. Good clinical care may not be perceived as such if communications with professionals and the quality of service generally are poor.

NHS – QUALITY OF SERVICE INITIATIVES

11.4 Work is underway in the NHS to achieve improvements to the quality of service. Several health authorities have introduced Total Quality Management programmes. These aim to improve the level of quality at all levels and at all areas of service. Many hospitals have targeted particular areas for improvement, including public waiting areas, individual appointment systems and information for patients. The Department has provided funds for specific projects in these areas and the publication 'Demonstrably Different' described the outcome of a number of projects aimed at improving quality in out-patient departments. Atten-

tion has also been paid to customer-service training for staff, particularly receptionists, clinic and hospital ward staff.

11.5 The NHS Review White Paper "Working for Patients" recognised the very powerful influence which doctors have on the health outcomes of patients using the health services. Participation of all doctors in medical audit is therefore seen as vitally important in order to conduct a systematic critical analysis of the quality of medical care. The influence of other health professions has also been recognised and emphasis placed on the introduction of audit, particularly in the nursing profession and professions allied to medicine. Work on nursing audit is being taken forward in tandem with other initiatives and a "Framework of Audit for Nursing Services" is to be published. Health care is often delivered by multi-disciplinary teams, and when this is the case joint appraisals of the way they work and the results of that work is ultimately expected to enhance further the quality of patient care.

CONTRACTING FOR QUALITY

11.6 A key aim of the NHS Reforms was to improve the quality of service to patients. One of the main mechanisms for achieving this is the system of contracts for health care, where Health Authorities define the level and quality of service which they require for their patients. The system is in its early stages but it is already clear that in their new purchaser role Health Authorities have already begun to give attention to quality. Quality standards have been included in DHA contracts and as part of service development plans in the Family Health Service. In addition to clinical measures, these include important areas: reliable appointments, waiting times for outpatient appointments, maximum waits for patients once they arrive at a hospital for an appointment. They also include other qualitative measures such as improvements in communications both to patients and their GPs and in the physical environment of a hospital or GP practice. As contracting develops, the Government will be looking to both sides of the service providers and purchasers to pursue higher quality standards.

11.7 The Government believes quality of service targets are likely to be far more challenging and have the commitment of staff if they are set locally and are part of a general push by management to ensure that the search for improved quality is a high priority and absolutely integral to the delivery of health care. In the letter ((EL(89)/MB/117; 22 June 1989) to health authorities from the Chief Executive of the NHS Management Executive highlighted four areas for improvements in quality of service: outpatient appointments, information to patients, reception arrangements and waiting areas, and customer satisfaction surveys. Regions need to continue to look at these areas to achieve further improvements and also identify other

areas for quality improvements where it is possible to set clear quantifiable targets. Out-patient appointment systems is one area which particularly lends itself to the setting of local targets and the **Government will expect local targets to be set**. Continuous improvement to quality must be made by the NHS and in order to do so it is important that other areas for improvement are identified and acceptable standards of service agreed upon. **The Government will therefore be looking to all levels of the service – DHAs, FHSAs, providers – to set high quality standards and for Regions to drive this forward**. The NHS Policy Board will, in particular, keep this under review.

11.8 The Government will ensure through the NHS management structure that such targets are both rigorous and met. These proposals will be taken forward by the NHS Management Executive during the consultation period.

Consultation, Next Steps and Summary of Points For Consultation

Consultation – Towards the definitive Strategy – Expert working groups – Conferences – Key issues for consultation – Method of consultation – Closing date for comments

POSITIVE CONSULTATION

12.1 The Government intends through this document to start a full and widespread discussion of the proposal for a health strategy for England. It is anxious for the views of all those involved to ensure that:

- the aims and objectives of the strategy are shared throughout the country
- the strategy is based on the best available information and expertise.

12.2 A short version of this document is available. It outlines the proposals and suggested key areas, objectives and targets. The Government hopes that it will be read widely and that readers will respond to the ideas set out.

12.3 The Government intends, in the light of comments received on this consultation, to issue a further document which will define and set in motion a health strategy for England. It is planned that that document should include the first definitive key areas and targets.

12.4 During consultation, two expert working groups will be looking at issues raised in connection with the development of the strategy:

First, an NHS working group to examine how the strategy will be implemented *in the NHS*;

Second, a group to look at the *wider public dimensions* such as health education, the role of industry, and the media.

12.5 The Department of Health will also, as necessary, establish a number of small working parties to examine the specific options for objectives and targets either suggested in this consultation document or arising during the consultation period.

12.6 In addition, the English Health Strategy Steering Group, discussed in chapter 9, will help the Secretary of State in his consideration of the response to consultation and the preparation of the Government's definitive proposals.

POINTS FOR CONSIDERATION

12.7 Views are now sought on all aspects of the consultation document and the issues it raises. The Government wishes to provoke a wide-ranging discussion, while focusing particularly on the specific questions posed in this cosultation document. The main points for consultation are:

A The form of the strategy

The proposed strategy aims to concentrate efforts on those areas where there is both the need and the opportunity for improvement. Issues are:

1. Is this cumulative approach based on key areas and targets appropriate?
2. Are the criteria for selecting key areas appropriate?

3. How many key areas should be selected initially?

B Key areas, objectives and targets

In each key area, the first step will be to agree objectives and targets. These must be challenging but achievable.

1. Which should be the first set of key areas?

2. What is the objective in each area?

3. What targets should be set in each area? Who should set these? Which should be national and which local?

4. Where quantified targets have been suggested, are these sufficiently challenging?

C Turning the strategy into action

Objectives and targets are valuable only to the extent that they lead to action and improvements.

1. What must be done to achieve shared commitment to the aims and objectives of the strategy?

2. What are the major obstacles to success? What must be done to resolve these?

3. How should the strategy be reflected in NHS planning systems?

D Future development of the strategy

1. What procedures should be adopted for working up further priority areas into this strategic approach?

2. What further developmental work is needed over and above what is already mentioned in this document to improve the further development of this strategic process and the selection of key areas and setting of targets?

THOSE BEING CONSULTED

12.8 All views will be welcomed. In particular, views are sought from

- the general public
- patients' organisations
- the health professions
- NHS management and staff
- voluntary organisations
- local authorities
- independent health care sector
- employers and employers' organisations.

METHOD OF CONSULTATION

12.9 Written comments are invited. The Department of Health will also be holding discussions with national and representative organisations. The Government also hopes that many organisations will wish to take the opportunity to hold discussions and seminars on this consultation document. The Department of Health will be happy to discuss with those organisations how it could usefully contribute to such activities.

12.10 Written comments and other queries about this document and the issues raised in it should be submitted by **31 October 1991** to:

Health Strategy Unit

Department of Health

Room B1208 Alexander Fleming House

Elephant and Castle LONDON SE1 6BY

CORONARY HEART DISEASE

BURDENS

A.1 Coronary heart disease (CHD) encompasses a group of clinical conditions ranging from asymptomatic disease to angina pectoris, acute myocardial infarction (heart attack) and sudden death. It is one of the main causes of death in England (140,509 in 1989 – 26% of all deaths), and is also the main single cause of premature death (to age 65). It is estimated that CHD related illness takes up some 5,000 NHS beds every day; accounts for around 2.5% of total NHS expenditure; and results in about 35 million lost working days.

A.2 The death rate from CHD in England has been declining slowly since the early 1970s although it remains one of the highest in the world - it is about six times as high as in Japan. The rate for men has dropped by around 19% and for women by about 15%. The biggest percentage reductions have taken place in younger age groups, as shown in figure A1. The downward trend started earlier and has been more marked in countries such as the United States and Australia. There are considerable variations in the trend between social classes and between different regions of England.

OBJECTIVES

A.3 Firstly, to reduce the occurrence of this disease and to reduce associated death and ill-health. Secondly, to improve the treatment and rehabilitation of those suffering from it.

SCOPE FOR MEETING THESE OBJECTIVES

(a) Prevention

A.4 CHD is caused by a combination of factors - personal and genetic (such as age and family history of heart disease) - which are unalterable; and factors related to lifestyle, which can be **influenced**. The main risk factors for CHD are now accepted to be cigarette smoking, high blood cholesterol levels, raised blood pressure, overweight and obesity and lack of exercise. All these risk factors are determinants modifiable by changes in lifestyle. When combined they interact and multiply. However there are also other factors thought to have an effect on CHD including socioeconomic factors, influences in early life and stress. These are areas where as yet knowledge is limited.

A.5 Because many of the factors which cause it can be influenced, **much heart disease is preventable**. The direct link with lifestyle means that an important way of lessening the risk of heart disease is a change to a healthier way of life. This is clearly recognised by many people, as well as public, private and voluntary sector organisations. Health education is important. England has a national CHD prevention programme, "Look After Your Heart", run by the Department of Health and the Health Education Authority.

A.6 Interest in healthy lifestyles is widespread and increasing. There is, for example, a demand for healthier alternatives to a number of food products and.

increasingly, manufacturers are responding - the range of food choices for a healthy diet has never been better. Employers have been quick to see the advantages of maintaining a healthier workforce - nearly 500 in both the public and private sectors are now actively associated with 'Look After Your Heart', covering well over 3 million employees.

A.7 The NHS, too, is playing an increasing part in the prevention of CHD, both through developments in primary health care (eg the new GP contract, the national nurse facilitator scheme) and the development of the District Health Authority role. Patients at risk from overweight and obesity, smoking, raised blood pressure etc will increasingly be identified in the primary care setting, and appropriate advice, help and treatment given.

(b) Treatment and rehabilitation

A.8 Though the emphasis of a strategic approach must be principally on prevention, successful treatment has its part to play in reducing premature death and ill-health. The most common way of managing CHD is by drug treatment. In the case of angina possibilities for treatment range from drugs to coronary artery bypass graft (CABG) or angioplasty. For emergency conditions like myocardial infarction, intravenous thrombolytic therapy (ITT) or defibrillation may be called for. Following myocardial infarction, rehabilitation which reduces the debilitating effects associated with unneces-

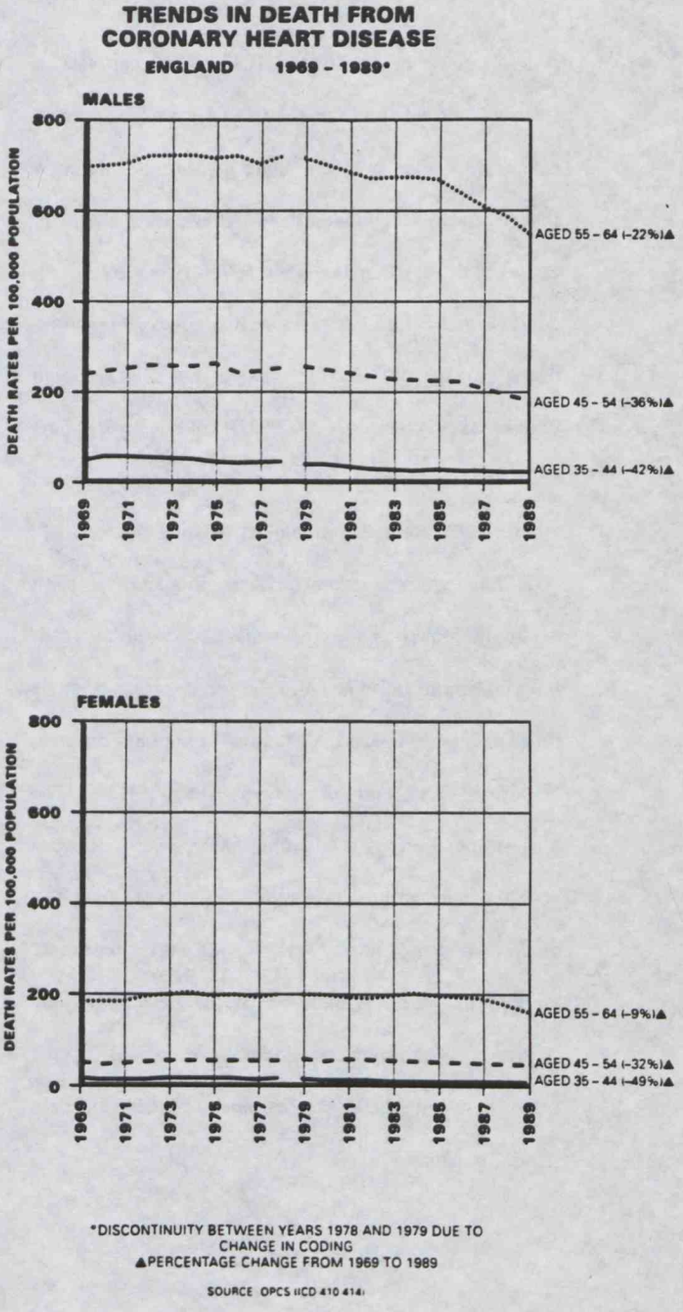


figure A1

sarily prolonged inactivity or restricted activity can benefit patients' self-confidence and physical fitness.

A.9 Since 1984 there has been increasing awareness of the role of ambulance staff in emergency cardiac care. It has recently been announced that all qualified ambulance staff must be trained in defibrillation by the end of 1991. All front line ambulances are now equipped with defibrillators and the Government's objective is that by 1997 every emergency ambulance should have at least one paramedically trained crew member.

POSSIBLE TARGETS

A.10 Though it does not include a specific coronary heart disease target, the WHO European Region 'Health For All by the Year 2000' strategy does have a target for all circulatory diseases, namely to reduce mortality in the Region from these diseases in people under 65 by at least 15% from 1980 to 2000. Circulatory disease includes not only coronary heart disease but also stroke and other conditions. Between 1980 and 1989 the death rate in England from diseases of the circulatory system in the population of England aged under 65 fell by 30%, thus considerably exceeding the WHO target.

A.11 Although there is no current national target for reduction of heart disease in England, the 'Look After Your Heart' programme aims to contribute to a decrease of 25% in premature deaths from coronary heart disease by the year 2000. However, given the scope for further action **a target of 30% reduction nationally in premature death under 65 years from coronary heart disease between 1988 and the year 2000 would appear to be achievable.**

A.12 Prediction of future trends is subject to wide errors because of the multiplicity of factors that need to be estimated, including the likely impact of preventive and medical interventions, trends in risk factors, and the effect of birth cohorts each with different risks of disease. On some extrapolations of recent trends, a target reduction of 30% might be thought to be little more than a continuation of current trends. However, after an initial review of trends in England and other countries, the Government's assessment is that, in the light of all the factors, the suggested target is both challenging, yet achievable.

A.13 The main risk factors for coronary heart disease which can be altered smoking, diet (including blood cholesterol), and physical fitness are discussed below in Annexes D, E and F. Raised blood pressure is discussed more fully in Annex B on Stroke.

A.14 It is also possible that specific targets could be set for treatment:

- the effectiveness of ITT decreases with time from the onset of myocardial infarction. A possible target of "door to needle" time following arrival at hospital of 30 minutes might be appropriate
- there currently exists a target for numbers of coronary

artery bypass grafts (CABGs). In 1986, a target of 300 CABGs per million population (pmp) was set. Between 1978 and 1985 numbers of operations rose from 57 pmp to 210 pmp. This rise however slowed down and on latest (1987) figures the rate for the UK as a whole was 225 pmp (some 12,820 procedures). The present target of 300 per million population is significantly below the target adopted by most countries. Strenuous efforts are required to reach the present target (which should have been attained by the end of 1990).

A.15 The Government would welcome views on the further extension of target setting for treatments of CHD. These might include percutaneous transluminal coronary angioplasty as well as CABG.

STROKE

BURDENS

B.1 The term "stroke" encompasses pathological conditions such as cerebral infarction, intracerebral haemorrhage and subarachnoid haemorrhage. It is one of the commonest causes of death in adults. In 1989 there were 63,407 stroke deaths in England, approximately 12% of all deaths. Of these 5,067 were under 65 years, and 11,384 in the 65-75 age group (approximately 5% and 9% of all deaths in these age groups respectively).

B.2 Strokes are a major cause of disability and institutionalisation among elderly people. It is estimated that stroke related illness takes up 15,791 NHS beds every day and accounts for about 7.7 million lost working days.

B.3 In England, as in other western countries, the incidence of stroke and resulting mortality have both been falling for several decades. As shown in *figure B.1*, between 1969 and 1989 in people under 65 stroke mortality in England dropped by about 50%. As for coronary heart disease, the biggest percentage reductions have been in younger age groups – 49% in men and 58% in women aged 40-49.

OBJECTIVES

B.4 To reduce the amount of death and disability from stroke and to ensure the maximum quality of life for survivors.

SCOPE FOR MEETING THESE OBJECTIVES

(a) Prevention of stroke

B.5 Like coronary heart disease, stroke is caused by a combination of factors, some unalterable, such as family history and age, but others **which can be influenced**. The main risk factor for stroke which is amenable to intervention is raised blood pressure. Stroke is uncommon in people whose blood pressure is below normal levels; the risk of stroke rises with increasing blood pressure, particularly at higher levels. Raised blood pressure alone may account for up to 60 per cent of all strokes.

B.6 Blood pressure can be reduced:

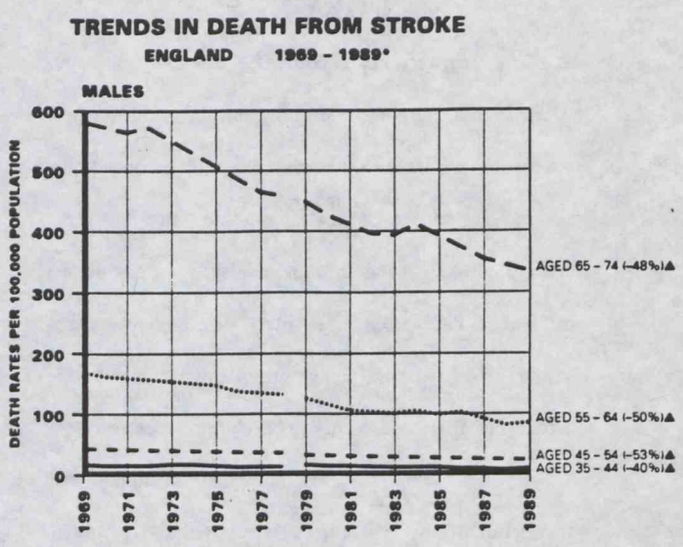
- by changes of lifestyle. Of the major contributors to raised blood pressure obesity, excessive alcohol and salt intake are amenable to change. The very considerable opportunities for individuals, employers, the NHS, public, private and voluntary bodies are generally similar to those for coronary heart disease.
- by early detection and treatment, usually in the primary care setting.

B.7 Smoking too has an effect on stroke. Recent studies comparing the incidence between smokers and non-smokers have highlighted the increased risk of stroke that results from the combination of smoking and raised blood pressure.

(b) Rehabilitation after stroke

B.8 There is some evidence that effective rehabilitation

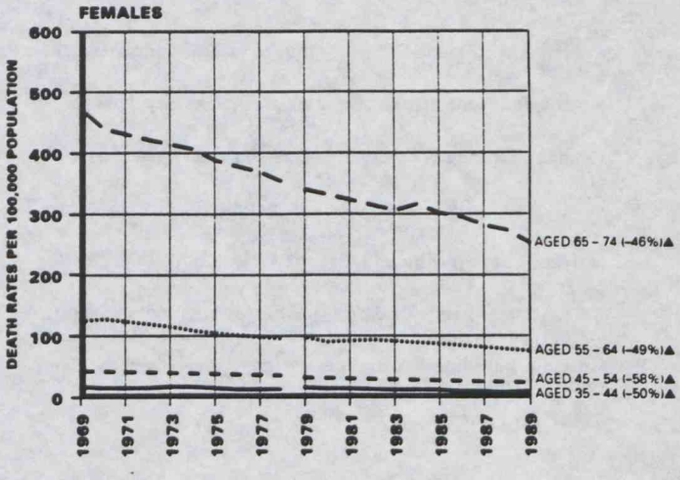
after stroke can improve outcomes and reduce morbidity. It is particularly likely to be effective as part of a well defined rehabilitation service. Effective rehabilitation should encompass the physical, psychological and social management of the disabilities which result from stroke. If they are to be able to regain the maximum independence of life those recovering from stroke should have access to appropriate services, including physiotherapy, specialist nursing, occupational therapy and speech therapy, as well as suitable equipment, housing and transport.



POSSIBLE TARGETS

(a) Reduction in Premature Death

B.9 The current trend of mortality from stroke remains downward. The reduction in mortality in under 65 year olds was 32 per cent between 1980 and 1989. Between 1987-89 in the same age group, the fall was 12.4 per cent. In the USA a similar downward trend in stroke mortality occurred, but there is now a marked reduction in the rate of decline amongst under-65s which has been evident since the early/mid 1980s. Given the multifactorial nature of stroke, such a reduction in the rate of decline of mortality could also occur in this country, especially since the rapid reduction in mortality rate experienced to date is partially unexplained. Equally, with the widespread adoption of a healthier lifestyle and further progress in detection and treatment of raised blood pressure, the trend could become steeper.



*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
▲PERCENTAGE CHANGE FROM 1969 TO 1989

SOURCE OPCS (ICD 430-438)

figure B1

B.10 Options for a target for reduced numbers of deaths might include:

- a reduction in death below age 65 from stroke between 1988 and 2000. A target of perhaps 30% nationally would appear to be achievable.
- a reduction in death in the 65-74 year age group over the same period. An achievable figure for this might be 25% nationally.

(b) Others

B.11 The Government would welcome views on other targets that might be developed. Possibilities would include:

i. Reduced incidence of stroke: the Government would welcome views on the feasibility of targets for incidence (either national or local) and of collecting the data necessary for setting and monitoring such targets.

ii. Early detection and treatment of raised blood pressure: targets might be developed either nationally or, perhaps more profitably, locally for screening and treatment of high blood pressure. Views are welcome on the value of such an approach, on the population groups for whom it would be appropriate, and on the ways in which such targets might be monitored.

iii. Rehabilitation: views are invited on the feasibility and value of setting targets in connection with rehabilitation. Options would include targets for the proportion of stroke survivors who are able to live outside institutional care after a given period.

CANCERS

BURDENS

C.1 After coronary heart disease, cancers are the most common cause of mortality. In 1989, cancers accounted for 26% of all deaths and 27% of the total life years lost between 15 and 64 years. Something like 7% of NHS expenditure goes on cancer treatment and prevention.

C.2 Cancers include a large number of very different conditions. In men the most common are lung cancer (25% of total registrations in 1985), followed by skin cancer (other than melanoma) (13%) and cancer of the large intestine and rectum (11%). In women, breast cancer accounts for 22% of registrations, cancer of the large intestine and rectum 12%, skin cancer (other than melanoma) 11%, and lung cancer 10%. In terms of deaths under age 65, the most frequent causes are lung cancer in men and breast and lung cancers in women.

C.3 Overall rates of cancer incidence and mortality have changed little since the mid-1970s, although death rates under age 65 have declined, particularly amongst males. There have also been changes in the balance between different cancers. Skin cancers for example have increased, while stomach cancers have decreased. *Figures C1 and C2* show trends in three cancers lung, cervical and breast.

OBJECTIVE

C.4 To reduce death and illhealth from cancers.

SCOPE FOR MEETING THIS OBJECTIVE

C.5 Cancers vary enormously, and the scope for reducing the ill-health and death they cause varies commensurately. Some can be prevented, some cannot. Early detection is valuable in some cases, but not in others. Some cancers can be treated, some as yet cannot.

(a) Prevention

C.6 The causes of cancer are not fully understood. It is estimated that up to 85% of mortality is potentially avoidable. The most significant factor is undoubtedly tobacco. Tobacco use accounts for around 30% of all cancer deaths, including about 90% of the 32,500 deaths in England from lung cancer each year. Diet may contribute to a variety of cancers, being responsible for at least 10% of the total. Current evidence suggests that less than 2% of cancer deaths are caused by environmental factors, such as air pollution and ionising radiation, which cause so much public concern.

(b) Screening and early detection

C.7 There has been considerable activity in recent years to develop effective and cost-effective ways of detecting cancers when they are curable. These include the introduction of screening programmes for cancer of the breast and cervix.

(c) Treatment

C.8 The standard methods of cancer treatment are surgery, radiotherapy and chemotherapy, singly or in

combination. The effects have been estimated as:

cured by surgery alone	22%
cured by radiotherapy alone	12%
cured by a combination of surgery and radiotherapy	6%
cured by chemotherapy alone	1.6%
cured by chemotherapy combined with other methods	2.5%

Hormone therapy is also increasingly used.

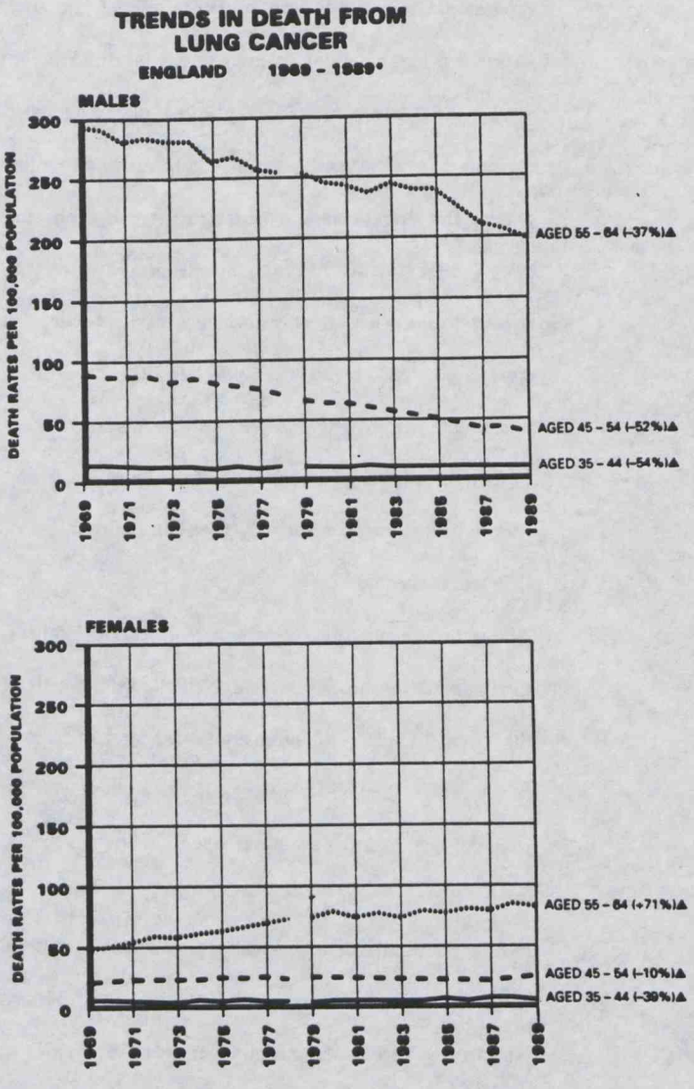
POSSIBLE TARGETS

C.9 Cancers are a heterogenous group. and must be tackled as such. The scope for change varies from cancer to cancer. and it would be wrong to treat them as a single subject. This document therefore concentrates on two types: firstly. those cancers where tobacco is the major cause these are dealt with by Annex D on smoking: secondly. the two cancers. breast and cervix. where cost-effective screening is possible and has been implemented.

C.11 The current position on these latter is:

Breast cancer

The causes of breast cancer are not fully understood. though reproductive history and obesity are thought to play a part. International comparisons suggest that difference may be due. amongst other things. to social and environmental factors. England has the highest rates in the world of breast cancer mortality. About 13.000 women die of breast cancer each year. To combat the problem. the NHS Breast Screening



*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
▲PERCENTAGE CHANGE FROM 1969 TO 1989

SOURCE OPCS / CO [illegible]

figure C1

Programme was introduced in 1987, one of the first national programmes of its kind in the world. Women aged 50-64 are being invited for mammographic screening at three-yearly intervals. Successful screening detects the disease at a stage when there is scope for effective treatment. **The aim of the programme is to reduce breast cancer deaths in the population invited for screening by 25% by 2000 compared to 1990.** To achieve this target the programme will aim to ensure that all women in the eligible group have been offered and encouraged to accept screening during this period.

Cervical cancer

About 1700 women die each year from cervical cancer. Early detection through screening of changes in cells of the cervix which *may* progress to cancer can significantly reduce mortality. The majority of women who die from cervical cancer have never been screened. The UK is now the first country in the European Community to have a comprehensive cervical screening service based on computerised call and recall. All District Health Authorities and Family Health Services Authorities in England have now implemented these systems and the intention is that screening should be available to all women between the ages of 20 and 64 at least every five years. The current target is that **all women in the eligible age group will have been invited for screening by the end of 1993.** In addition target payments have been introduced for GPs who achieve coverage of 50% or 80% of the women registered with them.

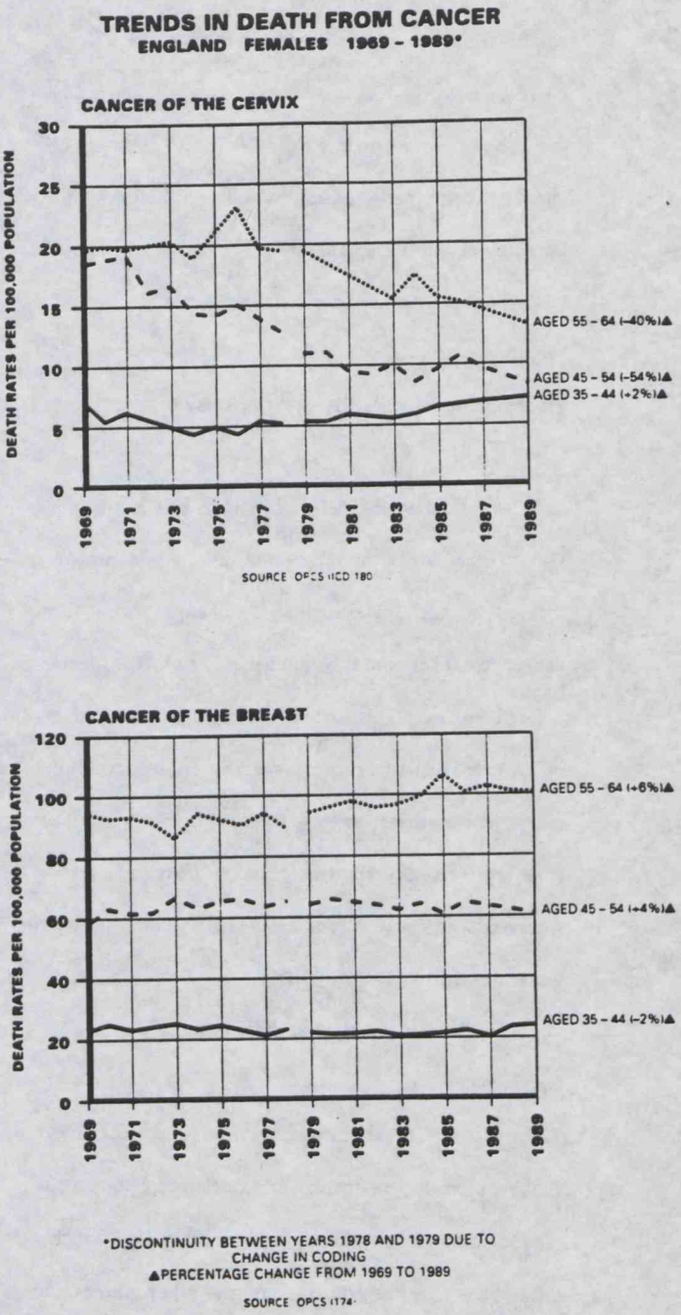


figure C2

SMOKING

BURDENS

D.1 Smoking is the largest single preventable cause of mortality. It accounts for a third of all deaths in middle age (40-64 years).

- In addition to cancer of the lung (90% of which is smoking related) smoking also contributes to cancer of the mouth, larynx, pharynx, oesophagus, pancreas, bladder and other organs.
- It is a cause of about 20% of all coronary heart disease deaths and an important risk factor for stroke, particularly when it occurs in association with other risk factors such as raised blood pressure.
- Cigarette smoking is one of the main causes of chronic obstructive airways disease.
- There is some evidence that most cases of aortic aneurysm and intermittent claudication (pain in the leg when walking) due to peripheral vascular disease are caused by smoking.
- Smoking in pregnancy is associated with low birthweight.
- The inhalation of environmental tobacco smoke (passive smoking) carries a small, but not insignificant, risk of lung cancer in adults and respiratory disease in infants and children.

D.2 Currently, 32% of the population smokes- 33% of men and 30% of women. This has fallen from 45% in 1974.

OBJECTIVE

D.3 To reduce death and ill-health caused by smoking, by reducing the numbers of people starting to smoke and increasing the numbers who stop smoking.

SCOPE FOR MEETING THESE OBJECTIVES

D.4 Reduction in smoking prevalence depends fundamentally on the choices made by individuals. However, experience has demonstrated that there is much that can be done to support individuals by giving them information, advice and practical help. There are roles for Government, the NHS, health educators, voluntary and community groups and employers, including:

- health education, particularly that aimed at discouraging the young from taking up the habit in the first place (for example the Department of Health and Health Education Authority's "Teenage Smoking Programme")
- health promotion advice from primary health care staff and others on the risks of smoking, and techniques of quitting
- workplace (and other public area) smoking policies
- continued recognition of the importance of controls on advertising of tobacco and of the health consequences of changes to tobacco duty levels and therefore price.

POSSIBLE TARGETS

D.5 Currently, some 33% of men and 30% of women smoke. Predictions of future trends are hard to make and are subject to wide error. However, if activity on smoking is maintained at least present levels, on current trends it could be expected that by 2000 this might drop to something like 24% for both sexes. This would represent a reduction of about 27% in men and 20% in women.

D.6 However, the Government suggests that efforts be made to reach a target somewhat in excess of current trends. **Bearing in mind current age and sex distribution of smoking and current trends, a suitable target for the year 2000 might therefore be to reduce the smoking prevalence to 22% in men and 21% in women (reductions of 33% and 30% respectively).**

D.7 The slightly lower percentage reduction for women does not represent a difference of ambition – on the contrary, it would actually represent a greater percentage improvement on current trends than for men. Similarly, the higher intended prevalence figure for men in 2000 is principally a product of demography-women tend to live longer, and elderly people tend to have the lowest smoking prevalence. Hence, the women's total is more heavily weighted by the elderly women non-smokers.

D.8 It would be sensible to set age and sex specific targets, to provide a more detailed set of goals at which to aim. The information with which to monitor progress is available every two years from the General Household Survey. Such targets might be as follows:

Age in years	men		women	
	1988	2000	1988	2000
	%	%	%	%
16-19	28	20	28	20
20-24	37	25	37	25
25-49	37	25	35	25
50-59	33	20	34	20
60+	26	15	21	15

REDUCING NUMBERS STARTING TO SMOKE

D.9 The overall target for reduction in smoking will be achieved in part by existing smokers quitting, and in part other people choosing not to take up the habit. Amongst older age groups reductions will principally come through quitting, since it is uncommon for older people to take up smoking. Reductions in the younger age groups, particularly teenagers, will on the other hand largely reflect success in lowering the numbers of young people who start to smoke. In the long-term it is clearly this latter which offers the greatest scope for reducing overall levels of smoking in the population.

D.10 The current prevalence of smoking amongst children aged 11-15 in England is 8%. The Health Education Authority's Teenage Smoking programme aims to reduce this by one third by 1994. Longer term targets will need to be considered at the end of the programme.

SMOKING IN PREGNANCY

D.11 It is important for the health of both mother and child that women do not smoke during pregnancy. Smoking during pregnancy is associated with low birthweight and also with a 28% increase in perinatal mortality in babies.

D.12 In recognition of the need for further action, the Government recently announced funding of £1m over two years for the Health Education Authority to carry out a project in this area to be launched later in 1991. The project will aim to provide information and support to women to enable them to stop smoking during pregnancy. It may also help to provide more data on smoking prevalence during pregnancy, and it may be possible using this and other material to consider whether useful targets could be set.

EATING AND DRINKING HABITS

INTRODUCTION

E.1 Food ought to be enjoyable as well as providing the energy essential to life. Eating a variety of foods which give a good balance of nutrients is vital for the proper working of every part of the body. The main nutrient groups needed for healthy growth and development and for the continuing repair and renewal of the body throughout life are protein, carbohydrates, fats, vitamins and minerals.

E.2 Nutritional deficiencies no longer present a major public health problem in England, and an improved diet has contributed to a longer lifespan. Nevertheless many people still eat and drink in ways which, over time, can contribute to the risk of developing serious ill-health and of premature death. As annexes A, B and C make clear, people's eating and drinking habits may play a significant (though by no means the only) part in the development of coronary heart disease, stroke and probably some cancers. Current studies estimate that dietary factors and smoking together account for at least half of all coronary heart disease (some 70,000 deaths) in the country. Obesity is a diet-related condition whose complications include diabetes and gallstones.

E.3 Many people enjoy moderate drinking. However if consumed to excess or at the wrong time, alcohol can cause significant physical, psychological and social harm. The medical Royal Colleges have recommended 21 units of alcohol a week as a sensible limit for men, and 14 units per week as a sensible limit for women. A unit is the equivalent of 8 grammes of alcohol, approximately half a pint of beer, a glass of wine, or a pub measure of spirits.

E.4 Alcohol misuse can be associated with obesity (particularly in the early stages of heavy drinking) and it is possible that alcohol accounts for raised blood pressure in 10-15% of patients with the condition. In 1989 deaths from cancer of the mouth, pharynx, larynx, oesophagus and liver totalled 8,963 (England and Wales), in which excessive alcohol consumption (particularly in combination with tobacco), is an important risk factor. In the same year deaths from cirrhosis, which are strongly associated with alcohol misuse, totalled 2801 (England and Wales).

OBJECTIVE

E.5 To reduce the amount of premature death and ill health related wholly or in part to eating and drinking habits.

SCOPE FOR MEETING THIS OBJECTIVE

E.6 The scope for improvement in the national diet can be measured by comparing information on what people are eating with the model of a healthy diet derived from the expert advice of the Committee on the Medical Aspects of Food Policy (COMA).

E.7 COMA's current advice on the broad changes which people should make in their eating habits is as follows:

- to reduce the amount of energy from saturated fatty acids to 15% or less of their food energy intake.
- to reduce the amount of energy from total fats to 35% or less of their food energy intake.
- to eat less non-milk extrinsic sugars and to eat sugary foods less often
- to seek ways of eating less salt
- to replace fatty and sugary foods by cereal and starchy foods
- to avoid an excessive intake of alcohol.

E.8 Information on people's purchasing and eating and drinking habits is derived from surveillance – mainly data from the National Food Survey (collected and published quarterly by the Ministry of Agriculture, Fisherise and Food), from the Dietary and Nutritional Survey of British Adults (1986/7 data – first published in 1990) and from the OPCS ad hoc surveys of drinking habits.

E.9 These sources show that although there has been a strong trend towards purchasing "healthier" forms of food such as skimmed or semiskimmed milk, the national diet differs from that recommended in several major respects:

FATS – over 85% of people are eating more than the recommended levels of fats – particularly saturated fatty acids.

SALT – overall intakes of salt are needlessly high and contribute to high blood pressure.

ALCOHOL – one in four men, and one in twelve women, are drinking more than the recommended sensible drinking limits.

E.10 Significant risk factors for a variety of diseases, including CHD and stroke, include:

OBESITY/OVERWEIGHT – Obesity is increasing in both men and women – in 1986/7 12% of women and 8% of men were obese, compared to 8% and 6% respectively in 1980. In addition, overweight is common 37% of men and 24% of women in 1986/7.

HIGH BLOOD CHOLESTEROL – In 1986/7 about two thirds of the population had blood cholesterol levels above the desirable range. Levels were higher in those eating a high proportion of saturated fatty acids and in those who were obese or overweight.

HIGH BLOOD PRESSURE – Higher blood pressures are associated with obesity and overweight, excessive alcohol consumption and with unnecessarily high salt and low potassium intakes.

E.11 It is clear that many people could improve their dietary habits, thereby reducing the burden of diet-related ill health. The principal means being used to bring about change are of two main types:

- education, advice and information about the need for balanced diets as part of a healthy life-style, and about the risk of alcohol misuse and sensible maximum levels of consumption.
- encouraging shops and catering establishments (both in the public and private sectors, including those in hospitals, schools and other institutions) to offer a

range of foods which enables people to make healthy eating choices, and to make alternatives to alcohol routinely available.

SUGGESTED TARGETS

E.12 An unbalanced diet often acts in combination with other elements of an unhealthy lifestyle. It would be possible to target the three significant risk factors mentioned. For obesity, it is important to reverse the trend of recent years. The target proposed would reduce the prevalence of obesity to its level at the start of the 1980s.

E.13 Both high blood cholesterol and raised blood pressure are linked with obesity. In the case of high blood cholesterol, it is not proposed to set a separate target as the same objective would be served by a target reduction in obesity, together with a specific target for intake of total fats and saturated fatty acids. Similarly raised blood pressure would in part be addressed by targets for obesity and for alcohol consumption. Raised blood pressure has also been discussed in section B (stroke) where it is suggested that targets might be developed for early detection and treatment.

E.14 For the main nutrients, possible targets are linked and could be expressed in various ways. Indeed COMA is reviewing its findings on diet and cardiovascular disease and this could lead to some adjustment. The proposals below represent broadly halfway to achieving the COMA recommendations on fats. For total fats, this may be an ambitious target, since there has been little change in the ratio in recent years.

E.15 COMA has not set quantified figures for the consumption of sugars, complex carbohydrates, fibre and salt, although it commented that consumption of salt was needlessly high. The report of COMA's review of recommended daily amounts which is expected soon may address some of these issues. For this reason, no targets are suggested here. Targets for dental health are discussed in annex H.

E.16 The target for alcohol consumption could be related to the recommended sensible drinking limits or to heavy consumption. The latter would concentrate on the group most at risk, but for positive good health it is important to keep within the sensible drinking limits.

E.17 The specific targets proposed for the year 2005, on which the Government would welcome comments, are as follows:

- the proportion of the population who derive less than 15% of their food energy from saturated fatty acids should be at least 60%
- the proportion of the population who derive less than 35% of their food energy intake from total fat should be at least 50%
- the proportion of obese adults should be 7% or less
- the proportions drinking more than the sensible limits of alcohol should be fewer than 1 in 6 in men and 1 in 18 in women.

PHYSICAL ACTIVITY

INTRODUCTION

F.1 Appropriate physical activity or exercise, like food and sleep, is a necessity for healthy living. It also helps to prevent heart attack, to control overweight, to strengthen the bones, and to preserve independence in the elderly and people with a disability.

F.2 Different forms of activity particularly benefit different parts of the body. To prevent obesity any form of physical activity is helpful; for bone strength the activity has to involve weight bearing as in walking; to protect the heart the exercise has to be regular and aerobic, using the big muscles of the body more vigorously than is customary, as in brisk walking, cycling, and swimming.

F.3 Unfortunately, most people do not have enough of the right kinds of exercise. However, surveys suggest that participation in sports and physical activity is increasing slowly. In Great Britain as a whole the percentage of adults participating in sports, games and physical activity in 1988 was 33%. Within that there are wide variations between different groups of the population. Women are less likely to be physically active than men, and participation decreases with age.

OBJECTIVE

F.4 To improve the health and well-being of the nation through appropriate physical activity.

SCOPE FOR MEETING THIS OBJECTIVE

F.5 Encouragement of physical activity and exercise has a central place in the promotion of healthy living:

- Physical Education is now a compulsory curriculum subject for all children aged 5-16, which will help to establish early habits for physical activity for future health
- the Sports Council (the channel for Government's own funding of sport) pursues a policy of encouraging participation in sport and promoting better provision of facilities. It has set itself specific targets for increasing the percentage of women and young people participating in sport.
- the Department of Education and Science and the Department of Health are committed to working together to ensure good coordination between local health oriented initiatives and efforts by sports clubs and local authorities to promote greater participation.
- physical activity has formed a part of many of the Health Education Authority's programmes—including "Look After Your Heart" and "Health in Old Age".
- Initiatives encouraging participation are also run by many bodies, including local authorities, employers and employee organisations, voluntary agencies and community groups.

POSSIBILITY OF SETTING TARGETS

F.6 There is, however, a lack of data in this area. More needs to be known both about the relationship between activity and health, and also about current levels of participation in physical activity, exercise and sport.

F.7 In 1990, to help improve the available information, the Allied Dunbar National Fitness Survey was launched, funded jointly by Department of Health, Health Education Authority, the Sports Council and Allied Dunbar. This national survey, which includes a physical appraisal, will provide "benchmark" data on participation and the effectiveness of different types of exercise. Results will be available later this year.

F.8 The Government will be looking closely at the emerging conclusions from the survey and in the light of it will consider possible targets. Physical activity will then be a prime candidate for inclusion as a key area in the future development of the strategy. It may permit detailed proposals for all sections of the population aged 16 and over, to improve the health and wellbeing of the nation through regular physical activity.

PREVENTION OF ACCIDENTS

BURDENS

General

G.1 Accidents are a major cause of death and serious ill-health. They are the most common cause of death in people under 30. They account for something like 13% of all years of life lost between 15 and 64 years, and 7% of NHS expenditure. As "*figure G1*" shows, there has been a downwards trend in accident deaths overall. A further reduction in the number and severity of accidents would make an important contribution to the prevention of premature death and disability, as well as reducing the demands made of the NHS – not only accident and emergency services, but also primary care and rehabilitation services.

Accidents in the home

G.2 Accidents in the home are the biggest single cause of injury. Each year about 5,000 people die and around 3 million need medical attention following accidents in the home. Although there has been a welcome reduction in the numbers of deaths from home accidents – down from well over 7,000 in 1986 to a little over 5,000 in 1988 – accidents needing medical attention remain stubbornly high.

Road traffic accidents

G.3 In 1989 more than 4,500 people died on England's roads. In Great Britain as a whole some 60,000 people are seriously injured each year and 270,000 slightly injured. Costs to the NHS are in excess of £175 m each year.

Accidents at work

G.4 Seen over the longterm the trend in accidents at work is encouraging; fatal injury rates have fallen by two thirds since the early 1960s and by a half since the early 1970s, with employee fatalities generally static in the latter half of the 1980s. In 1988–89, there were 730 fatal accidents attributable to work activities. Further decreases are likely as a result of forecast shifts in employment away from high risk industries. However, major injury rates are still rising in some sectors.

Children

G.5 Children are particularly vulnerable. Accidents are the commonest cause of death among children over the age of 5 and they cause one child in six to attend a hospital Accident and Emergency department every year. Road accidents account for about a quarter of all deaths among schoolchildren, and about two thirds of all accidental deaths in the same group.

OBJECTIVE

G.6 To reduce the number and severity of accidental injuries.

SCOPE FOR MEETING THIS OBJECTIVE

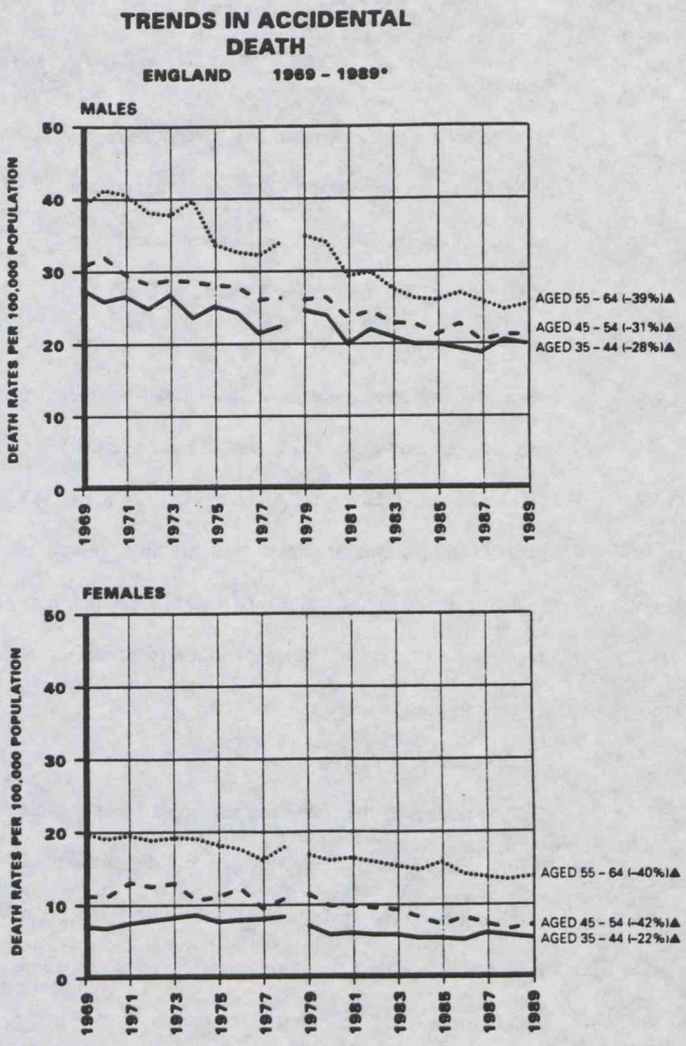
G.7 In theory, at least, all accidents should be preventable. Action ranges from legislation, to improved engineering and design, improvements in living and working environments, educational initia-

tives, and, in the end, increased awareness and carefulness of individuals. The range of those with the opportunity to contribute is equally wide – accident prevention is *par excellence* an example of an area where the best results are achieved by cooperation and collaboration.

Alcohol and accidents

G.8 A high proportion of accidents are attributable to the misuse of alcohol. It is estimated that alcohol is a factor in something like 25% of all deaths in road traffic accidents, 40% of all deaths from falls, 40% of all deaths in fires, 15% of all drownings and 60% of all accidents at work. The Government is committed to reducing alcohol-related harm in all its forms, and Ministers from all Departments with an interest in the use and misuse of alcohol meet regularly to coordinate policy and initiate action. In 1989 the Department of Health significantly increased its grant to the Health Education Authority to enable it to raise public awareness of the dangers that result from alcohol misuse and to encourage sensible drinking. A number of initiatives have recently been launched to expand and improve services for problem drinkers.

G.9 A range of drugs (both legally prescribed and deliberately misused), particularly sedatives and tranquillising drugs, also impair the performance of skilled tasks, especially when combined with alcohol, and may therefore lead to accidents.



*DISCONTINUITY BETWEEN YEARS 1978 AND 1979 DUE TO CHANGE IN CODING
DATA FOR 1981 AFFECTED BY INDUSTRIAL ACTION BY REGISTRATION OFFICERS
▲PERCENTAGE CHANGE FROM 1969 TO 1989

SOURCE OPCS (ICD 8800 E945

figure G1

Legislation

G.10 Legislation, backed by effective enforcement, can set and maintain standards of safety. Examples include

- The Consumer Protection Act 1987 which provides a strong, yet flexible, legal framework to protect consumers from unsafe consumer goods, and is backed up by a range of regulations covering specific products.
- Regulations introduced in 1989 requiring drivers and passengers travelling in the front seats of cars to wear seat-belts have saved some 200 lives and 7000 serious injuries a year. Regulations requiring children to wear rear seat restraints where fitted were introduced in 1989 and this requirement will shortly be extended to adults.
- The 1974 Health and Safety at Work Act puts responsibility to take care on those engaged in industrial activity: mainly employers, but also self-employed people and others such as suppliers.

Public awareness

G.11 Law and safety standards are only part of the picture. It is also essential to change people's attitude to safety and raise awareness of the potential hazards. Education of children about safety is particularly important. Publicity and awareness campaigns are central to any accident prevention strategy. They may either be general or be targeted on particular hazards or groups who are most at risk – for example, the Department of Transport's current high profile child road safety publicity campaign.

The value of collaboration and local initiative

G.12 Everyone can contribute in some way to accident prevention. The results of accident prevention initiatives can be greatly enhanced when the various people and organisations involved work closely together and learn from each other's experience. There is much to be gained both nationally and locally from a coordinated approach which draws together all those who have a contribution to make, including Government, industry, employers, local authorities, schools, health services, voluntary groups, community groups, consumer organisations, and individuals themselves.

G.13 Recent Government initiatives which exemplify and encourage such an approach include

- "Approaches to Local Child Accident Prevention (ALCAP)" published by the Child Accident Prevention Trust on behalf of the Department of Trade and Industry and the Health Education Authority.
- "Children and Roads: A Safer Way", launched in May 1990 by the Department of Transport in conjunction with the Department of Education and Science and the Department of Health, which aims to provide a focus for concerted action to reduce child road casualties.

Role of the Health Services

G.14 The NHS deals with both the immediate and long-term consequences of accidental injuries. It has a legitimate interest in the prevention of accidents and an important role to play.

- It collects and provides vital data on the incidence and

effects of accidents.

- It is a source of expertise on accidents – locally the NHS is in a very good position to identify the scale and nature of problems that need to be tackled.
- It can contribute this expertise to collaborative initiatives with other agencies.
- Health service professionals, including midwives, health visitors and GPs, have opportunities to advise and influence individuals on safety.

G.15 Last year the Government commissioned from the Health Education Authority a report on how best the NHS could contribute to improving child road safety. This report, to be published later in 1991, should help to clarify and develop the opportunities open to the NHS.

POSSIBLE TARGETS

G.16 Effective approaches to accident prevention are well established in this country and continue to be developed and refined. Systems for collecting information about accidents and their effects are also well developed, although there is of course significant scope for further development, particularly in integrating the various existing sources of information. There are consequently considerable opportunities for the use of specific and meaningful target to focus and direct action.

G.17 Accident prevention is a diverse subject, and approaches to it both nationally and locally must reflect that. However, the Government would welcome views on whether there would be advantage in setting broad national targets for accident prevention. These might act as a tangible expression of the widely shared commitment to accident prevention which already exists, and as a goal to be worked towards together.

G.18 The WHO European target for accidents is that by **2000, death from accidents in the Region should be reduced by at least 25% from 1980 levels through an intensified effort to reduce traffic, home and occupational accidents**.

G.19 From 1980-89, accident mortality in England fell by some 24%, suggesting that the WHO target will be exceeded easily. This is despite the fact that mortality from all causes of injury and poisoning in England is already one of the lowest in Europe (though this does not apply equally to all categories of accidents).

G.20 There are therefore good reasons to think that targets could well be set which were more exacting that the WHO target. The Government has already adopted such an approach in relation to road traffic accidents where it has set itself the target of reducing road casualties by one third by the year 2000 (using the average 1981–5 levels as a baseline).

G.21 The Government would welcome views on a target or targets that might usefully be set:

- should they look only as far as 2000, or would long-term development be better served by looking beyond that date?

- the indicator for the WHO target is mortality. What scope would there be for using other indicators, such as measures of temporary or permanent injury and morbidity (eg long absence from work, length of stay in hospital)?
- should targets be for the population generally, or for specific population groups (eg children, elderly people), or should both approaches be used?

HEALTH OF PREGNANT WOMEN, INFANTS AND CHILDREN

INTRODUCTION

H.1 The health status of pregnant women, infants and children are important indicators of the general state of health of any population. The health of pregnant women influences the health of their babies, and foetal and infant health is one of the main determinants of health in childhood and later in life.

H.2 The vast majority of births in England result in healthy babies, but there is no room for complacency about the remaining levels of morbidity and mortality amongst both infants and mothers. Infant mortality (to age 1) at 8.4 per 1,000 live births is at its lowest level ever, but better rates have been achieved overseas and the average masks significant variations within England.

H.3 *Figure H1* shows the distribution of causes of death in newlyborn infants (neonates), infants and children aged 1-4 and 5-14. In the younger group the principal causes of death are: injury and posioning and congenital abnormalities. In the older group injury and poisoning and cancers are the principal causes of death. In both groups, respiratory diseases are the most common reason for consulting a GP and the most common cause of hospital admission.

OBJECTIVE

H.4 To reduce preventable death and ill-health amongst pregnant women, infants and children.

SCOPE FOR MEETING THIS OBJECTIVE

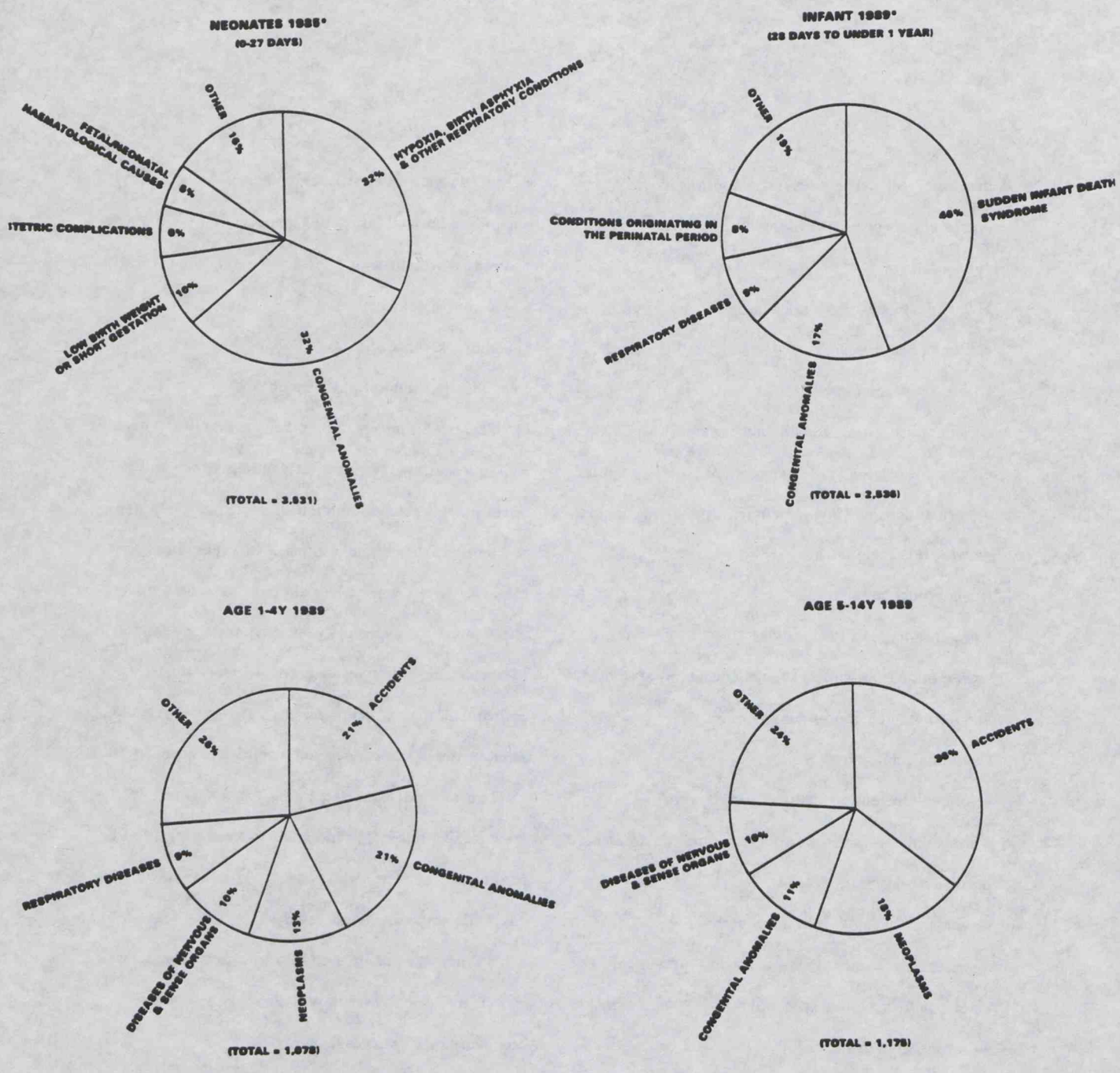
(a) Mothers and babies

H.5 The scope for safeguarding and improving the health of mothers (before, during and after pregnancy) and of babies includes:

- adoption of a healthy lifestyle, especially good nutrition and avoidance of smoking and more than minimal alcohol consumption during pregnancy;
- protection against infectious diseases (eg rubella);
- high quality maternity care services (tailored where appropriate to the needs of particularly vulnerable groups such as unsupported mothers and certain ethnic minorities);
- good infant nutrition;
- improving general socio-economic and environmental circumstances, in particular quality of housing;
- health education and promotion (about all of the above).

H.6 Healthy lifestyles contribute both to the general health of pregnant women and to that of their babies. Women should aim to maintain a nourishing and varied diet not only from the earliest days of their pregnancy, but even from before they are pregnant. An increased calorie intake should be avoided, as it is not necessary and contributes to obesity. Vegetables and fruit are particularly important for the health of both mother and baby. On the other hand, maternal smoking, addictive drug use and excessive alcohol intake during

DISTRIBUTION OF MAJOR CAUSES OF DEATHS IN CHILDREN
ENGLAND AND WALES



*A NEW NEONATAL DEATH CERTIFICATE WAS INTRODUCED IN JANUARY 1986, FROM WHICH IT IS NOT POSSIBLE TO ASSIGN AN UNDERLYING CAUSE TO DEATHS UNDER 28 DAYS

SOURCE OPCS

figure H1

pregnancy all carry risks for unborn children. (See Annex D for a discussion of smoking.)

(b) Children

H.7 The scope for safeguarding and improving children's health includes:

(i) For younger children

- immunisation against childhood diseases
- early detection of congenital and acquired abnormalities including impairments in hearing, vision, growth and development

(ii) For older children

- promotion of healthy lifestyles
- prevention (particularly though education) of smoking and misuse of alcohol and drugs

(iii) For all children

- accident prevention and safety education
- improvements in the qulity of the environment, particularly housing
- avoidance of smoking in the household
- prevention, identification and treatment of emotional/behavioural problems
- prevention of dental decay

POSSIBLE TARGETS

H.8 There are so many determinants of the health of pregnant women, infants and children that it cannot be encompassed by a single target. However, the Government suggests that there is scope for consideration of a number of specific targets:

- reduced stillbirths and deaths in infancy
- improved hospital care during labour
- increased breastfeeding
- reduction in dental caries

in addition to those on

- childhood immunisations see Annex L.

H.9 Suggested targets in other areas will have consequences for the health of children. Some will be directly applicable to children as much as adults (eg accidents, diabetes and asthma). In other areas the effects of targets will be less direct or have both direct and indirect consequences – for example the adoption of the healthy lifestyles required to meet targets for reducing coronary heart disease and stroke should improve the health of pregnant women and mean fewer children adversely affected by maternal smoking (and later passive smoking), and children benefiting from a healthier diet during childhood.

(a) Stillbirths and deaths in infancy

H.10 While the infant mortality rate in England may be at its lowest ever level, there is no room for complacency. Key issues remain:

- significant geographical and social class variations
- levelling off in the rate of decline
- the continued prevalence of low birthweight babies due to avoidable factors such as maternal smoking
- the number of deaths attributable to Sudden Infant Death Syndrome.

H.11 The Government has launched several initiatives

to address these issues. They include a requirement that Regional Health Authorities conduct epidemiological surveys to investigate the patterns and trends of stillbirths and neonatal deaths in their populations. It is also considering the introduction of a national confidential enquiry into stillbirths and deaths in infancy, which would seek to identify ways in which the risk of death might be reduced.

H.12 The Government believes that these investigations will be of considerable value in increasing understanding and prevention of stillbirths and infant deaths. One consequence of this increased understanding will be a greater ability to set appropriate targets in the field. The Government believes that such targets would be valuable. In order to relate these most effectively to actual circumstances, targets should not be national, but rather be set locally in the light of results from the epidemiological surveys and in due course the confidential enquiry. **The Government suggests that an appropriate ambition in this field would be that all Regional Health Authorities (and in turn their District Health Authorities and Family Health Services Authorities) should by 1993 have established for themselves targets for reductions in stillbirths and infant deaths (with, possibly, separate targets within that for deaths from different causes).** Regional Health Authority targets will need to be agreed with the NHS Management Executive.

(b) Maternal deaths

H.13 There has been a substantial reduction in deaths in pregnancy, childbirth and the puerperium. Between 1955-7 and 1985-7 maternal deaths in the UK fell from 67.1 to 7.6 per 100,000 births. The number of maternal deaths is now so low that the total in an individual year is likely to be too small to provide a reliable indicator of trend. However the aggregated data over the three year periods covered by reports of the Confidential Enquiry into Maternal Deaths (CEMD) remain an important indicator. The CEMD shows that preventable deaths do still occur, and the recently published CEMD report on Maternal Deaths in the UK 1985-87 included a recommendation that every consultant maternity unit should have a consultant obstetrician and anaesthetist readily available whose main priority was to oversee the labour ward. The availability of staff with this level of experience would offer scope for improving the management of many obstetric emergencies.

H.14 The Government therefore suggests that an appropriate target in this field would be for all Regional Health Authorities to have reviewed arrangements in consultant maternity units by 1993 with a view implementing the recommended level of cover as soon as is practicable.

(c) Breastfeeding

H.15 There is no doubt that breastfeeding is the best means of giving infants a healthy start to life. It is natural and provides not only the amount and balance of nutrients for healthy growth and development but

also protects against infection and allergy.

Possible targets might be:

- **to increase the proportion nationally of infants who are breastfed at birth from 64% in 1985 to 75% by 2000.**
- **to increase the proportion of infants nationally aged six weeks being wholly or partly breastfed from 39% in 1985 to 50% by 2000.**

(c) Child health

H.16 Suitable targets for child health surveillance and health promotion present themselves less obviously. Given improved understanding of the problems and effective measures that can be taken to address them, areas where target setting might in future be desirable would include:

- prevention and reduction of ill-health caused by respiratory disaeses (including asthma – see annex O);
- the early diagnosis of impairments of hearing, vision, growth and development;
- improved sexual health, eg reduction in pregnancies below the age of 16;
- the prevention of behavioural disorders in children.

(d) Dental caries

H.17 In recent years there have been great improvements in the dental health of children. Dental decay, however, remains one of the most common childhood diseases, causes pain and discomfort, affects wellbeing and appearance, and is a prime example of preventable morbidity – there is no clinical reason why dental decay in children could not virtually be eliminated.

H.18 The chief causes of dental decay are diet (particularly dietary sugars) and poor oral hygiene. Changes in these together with the use of fluoride toothpaste and the effects of fluoridated water, can all reduce the incidence of decay. Health education and dental care also have important roles. The new contract for family dentists, introduced in October 1990, should encourage preventive care in the General Dental Service, backed up by the screening and residual treatment role of the Community Dental Service.

H.19 There continues to be an overall downward trend in the incidence of dental decay in 12-year-olds. The 1983 decennial national survey of child dental health reported that, on average, 12-year-olds in England had 2.9 decayed, missing or filled permanent teeth. Studies carried out in 1988/89 by most District Health Authorities suggest a further improvement since 1983, but also significant regional variations, with the most serious problems in England occurring in North Western and Mersey Regions.

H.20 The WHO dental health targets for 2000 include **". . . 12-year-olds to have, on average, not more than 3 decayed, missing or filled permanent teeth".** This has already been achieved in England as a whole. With the help of oral health education and the preventive care of the dental profession, it should be possible to achieve a much more ambitious target. **The Government considers that such a target might be that by 2003 , 12-year-olds**

should have, on average, no more than 1.5 decayed, missing or filled permanent teeth. Regional and sub-regional targets are particularly appropriate in this area, as some regions will be able to set even more challenging targets, while others have more severe local problems.

DIABETES

BURDENS

I.1 Diabetes mellitus manifests itself in three main forms

- insulin dependent diabetes mellitus – NIDDM
- insulin dependent diabetes mellitus INIDDM
- gestational diabetes (diabetes of pregnancy).

I.2 Estimates indicate that the prevalence of clinically diagnosed diabetes in England is about 1%, ie about half a million people. Estimates from surveys suggest that between 40% and 50% of diabetes may be undetected. It is estimated that between 4% and 5% of total health care expenditure is spent on the care of people with diabetes, including the cost of dealing with its complications.

I.3 The prevalence of diabetes is higher in certain sub-groups of the population, such as the elderly and people of Asian and Afro-Caribbean origin. For those of Asian origin the prevalence of NIDDM is nearly five times that in comparable European populations.

I.4 The incidence in children and adolescents (those aged 0-19) in England is between 10 and 15 new cases per 100,000 population each year, and this appears to be increasing.

I.5 The main complications of diabetes are cardiovascular disease, renal disease, visual impairment and neuropathy. People with diabetes are at a greatly increased risk of death from coronary heart disease and stroke and about one in every 1000 known diabetics will develop end stage renal failure. Diabetes also causes visual impairment, although it is not known what proportion of people with diabetes will go on to develop visual complications. The commonest problem arising from diabetic neuropathy is reduced sensation in the feet which can rapidly lead to ulceration, infection and even gangrene and amputation.

I.6 It is difficult to quantify the number of deaths to which diabetes has contributed, because diabetes is not always mentioned on death certificates as a contributory cause of death, particularly amongst younger age groups.

OBJECTIVES

I.7 To reduce death and ill-health caused by diabetes, principally by ensuring the effective provision of services.

SCOPE FOR MEETING THIS OBJECTIVE

(a) Prevention

I.8 IDDM is caused by a failure in the production of insulin by the pancreas. NIDDM is caused by impaired production of insulin and/or impaired utilisation. Each form has a genetic component, but obesity is an additional risk factor for NIDDM, which means there is scope for prevention of that type of diabetes through the adoption of healthy lifestyle and maintenance of a healthy weight.

(b) Treatment

I.9 There is no evidence that a national screening programme for diabetes would be cost-effective. Screening of high risk groups is, however, effective. Identifying people with diabetes allows the management of the disease to reduce the incidence of complications and improve the quality of life.

I.10 To avoid the complications, blood glucose must be controlled and maintained within normal levels. In the case of IDDM this involves the regular injection of insulin. For NIDDM, the treatment is usually by a carefully controlled diet, often in conjunction with oral hypoglycaemic drugs. All people with diabetes require a carefully controlled diet and regular checks of the level of glucose in their blood or urine to monitor their condition. It is also important to check blood pressure regularly and to look for the early signs of circulatory problems and complications such as ulceration of the feet, retinopathy or renal disease.

I.11 There is significant scope for reducing the impact of diabetes. Of particular importance are:

- collaboration between purchasers of services and providers, and between purchasers (Family Health Services Authorities, District Health Authorities and GP fund-holders). Shared policies are needed for diabetes, covering diagnosis, referral and other clinical decisions that have to be made to provide services for people with diabetes.
- the availability of comprehensive services, involving diabetologists, general physicians, geriatricians, ophthalmologists, opticians, specialist and general nursing services, dieticians, and chiropodists.
- shared treatment plans drawn up between patients and their doctors.

POSSIBLE TARGETS

I.12 The nature of diabetes is such that targets have to be focused on the complications, which must be considered individually.

I.13 In October 1989 organisations from all European countries and WHO met with diabetes experts and the International Diabetes Federation in St Vincent, Italy. The St Vincent Declaration agreed the following targets:

- reduce new blindness due to diabetes by one third or more
- reduce by one half the rate of limb amputation for diabetic gangrene
- achieve a pregnancy outcome in diabetic women that approximates to that of non-diabetic women
- reduce the numbers of people entering end-stage diabetic renal failure by at least one third
- cut morbidity and mortality from coronary heart disease in diabetes by vigorous programmes of risk factor reduction.

I.14 Although the St Vincent Group is working on the development of baseline data for these targets, the information necessary for monitoring them is not currently available in England. Some of it should be

available in the fairly near future, the remainder will take some time to develop. It is expected that the first two areas in which the necessary data are available will be pregnancy outcome and end-stage renal failure.

I.15 It is known that certain service activities are likely to produce good health outcomes. Until it becomes possible to use outcome measures such as those of the St Vincent Declaration, these activities could be measured as a proxy for health outcomes. Examples are:

- **the proportion of GP practices within a Family Health Services Authority area who follow protocols agreed locally between hospital clinicians and primary care staff for providing services to people with diabetes**
- **the proportion of people with diabetes screened, within a given period, for the long term individual complications of diabetes**
- **the proportion of people with diabetes who have received a free NHS eye test in the preceding year. (This should be superseded in time by a specific diabetic retinopathy screening programme for all those at high risk. Work is taking place on this at the moment within the Department of Health.)**

The level of each target will need to be agreed by consultation between the Government, NHS and other interests.

MENTAL HEALTH

BURDENS

J.1 Mental disorders are a major cause of morbidity accounting for 14% of days off work on certified sickness and invalidity (exceeded only by circulatory disorder – 17% and musculoskeletal disorder 16%). – They account for 23% of NHS in-patient costs and 25% of pharmaceutical costs. The wider costs of mental illness are huge. The total direct and indirect costs (including lost production) of depression and anxiety have been estimated at up to £4.6 billion a year and of schizophrenia at up to £2.1 billion a year.

J.2 Most people with mental illness are not in hospital. Of every 1000 people, 230 attend their family doctor each year with symptoms of mental illness but only 21 are referred to hospital. Over six times as many people attend consultant psychiatrists as outpatients as are inpatients.

OBJECTIVE

J.3 To reduce the level of disability caused by mental illness by improving significantly the treatment and care of mentally disordered people.

SCOPE FOR MEETING THIS OBJECTIVE

J.4 Against a background of steadily improving medical and nursing care, the arrival in the 1950s of drug treatments giving effective relief from the symptoms of major illnesses such as schizophrenia had a dramatic effect in improving the quality of life of people with severe mental illness enabling the great majority of patients, who previously would have faced long-term care in hospital, to be treated in the community. There remains considerable scope for further improvement in treatment with the aim of reducing the level of disability caused by mental illness.

J.5 The 1975 White Paper "Better Services For the Mentally Ill" set out the Government's commitment to move the services away from their traditional base in large remote institutions into a district based service with a balance of hospital and community based services as near as possible to where people live. Experience since 1975 has demonstrated the essential strengths of the White Paper's approach when this has been properly implemented. The 1989 White Paper "Caring for People" reaffirmed that approach and described the main elements of a modern district based service.

J.6 Much has been learnt since 1975, particularly the requirement to pay close attention to the needs of those with long-term illness and to ensure that local services, including the need of some seriously disabled people for "asylum", are properly developed before the older hospitals are closed. The new Care Programme approach supported by the Mental Illness Specific Grant to local authorities underlines the commitment that there must be effective plans tailored to the needs of every patient needing continuing specialist care in

the community. There is also a firm commitment that Ministers will not approve any closure until they are satisfied that adequate alternatives have been developed.

J.7 Effectively implemented, new style services offer a much higher quality of life to mentally ill people and a service which is more appreciated by their families than is possible in the traditional large and often remote mental hospital. Moreover these hospitals represent increasingly poor value for both patients and for the NHS resources invested. Of the £1.5 billion spent by the health service on the specialist mental illness service, over half supports the 40,000 beds in the old traditional hospitals. The vast majority of patients requiring specialist care who are treated in the community, some as seriously ill as those in the old hospitals, are supported by less than half the available resources. Not surprisingly services to those in the community are often experienced as less than satisfactory. There is a clear need to reinvest the resources tied up in the old hospitals in more appropriate services.

SUGGESTED TARGET

J.8 Some progress has been made in developing both needs assessment and appropriate outcome measures for mental health. However, there is at present no straightforward, objective way of describing, aggregating nor monitoring outcomes of care, nor any agreement on clear and reliable measures which could be confidently used as proxies for outcome measures. The work which has started in this area needs to be followed up vigorously to ensure that progress is made. However in the present state of knowledge it is unrealistic to set health outcome targets for these services.

J.9 Experience to date does however suggest that there is clear benefit to patients and their carers from the transition to a district-based service and that this gain is likely to be achieved most effectively as a result of a planned closure programme rather than a gradual shift from one type of service to another. **A single measurable target over the next decade would be substantially to complete this shift, thereby allowing many of the remaining 90 large psychiatric hospitals – relics of an outmoded pattern of care – to be closed before 2000.** But it would be essential that successful achievement of this target was not measured by hospital closures alone. It would be necessary to develop assessable parameters related to the provision of appropriate district-based hospital and community services and to their performance. The aim would be to ensure that there were demonstrable improvements in mental health services based as soon as practicable on measures of outcome. In the meantime, **the objective should be to reach agreement on measures of structure and process which, taken as a whole, would act as reliable, unambiguous monitors of progress.** What overall target and what measures of progress might be set will need to be discussed with NHS, local authority, professional and other interests.

HIV/AIDS

BURDENS

K.1 HIV/AIDS is arguably the greatest new threat to public health this century. It has been estimated that about 5,000 new cases of AIDS will be reported in homosexual men in England during 1989-93. Predictions for numbers of cases acquired by transmission through heterosexual intercourse and injecting drug use are more difficult, but it is possible that by 1993 over half the new cases could be in these two categories compared with only 7% of reports in the first nine months of 1989.

K.2 By the end of December 1990 there had been a total of 3,817 reported cases of AIDS in England of whom 55% had died. There were 12,985 known HIV antibody positive people of whom 1,099 were female. The figures for known HIV positive people are likely to be substantially less than the true number.

K.3 AIDS cases in homosexual and bisexual men still account for 81% of the total, however the rate of increase in new cases amongst this group during 1990 was only 46% compared with an 82% increase in cases acquired by heterosexual intercourse during the same year and an even greater increase in the number of people infected by contaminated drug injecting equipment. Cases amongst women increased by 119%, rising from 37 at the end of December 1989 to 81 by December 1990.

K.4 As with AIDS cases, there is evidence of rapid growth of the number of people infected with HIV through heterosexual intercourse. Reports in this group increased by 65% during 1990, compared with 20% for homosexual or bisexual men. Just under half the infected heterosexual people are women.

OBJECTIVE

K.5 To reduce numbers of new cases of HIV and AIDS, primarily by controlling the spread of HIV through education about and adoption of safe sexual and intravenous drug taking behaviour.

SCOPE FOR MEETING THIS OBJECTIVE

K.6 The spread of HIV can be prevented by the adoption of safe sexual and intravenous drug taking behaviour. There is much that can be done to foster the necessary awareness and behaviour. In addition, though there is no cure, there is some evidence that the early detection of HIV offers some opportunities for treatment which may delay the onset of AIDS.

K.7 The main plank of the Government's strategy to limit the spread of HIV is public education. The Health Education Authority runs national and more targeted campaigns in close co-operation with the health departments and Government generally.

K.8 The national campaign is complemented by educational initiatives at local level for which the NHS has been given funding. The recently appointed District HIV Prevention Co-ordinators have a key role in pulling

together the work of statutory, voluntary and community agencies. Co-ordinators have also been asked to mobilise and develop the preventive role of genito-urinary medicine (GUM) and other health services, and to work with local authority education workers to develop HIV educational work in schools and colleges.

K.9 As well as cases of HIV/AIDS, some 560,159 new cases of other sexually transmitted diseases (STDs) were seen in GUM clinics in England in 1988. Whilst other STDs have tended to be overshadowed by HIV/AIDS they are nevertheless important and disabling in their own right and may facilitate the spread of HIV. Their prevention should be considered alongside HIV/AIDS. Health education and other preventive activities are the key to reducing STDs. In addition the recent Monks report has made a number of recommendations which should result in improved services for those seeking confidential advice and treatment for HIV and for other sexually transmitted diseases from GUM clinics.

POSSIBILITY OF SETTING TARGETS

K.10 An essential first step at looking at the possibility of target setting is improving our understanding of the prevalence of the disease. A fuller understanding of the prevalence of HIV will assist service planning and the better targeting of public education campaigns. At present, information is not yet sufficient to allow targets to be set for limiting the spread of HIV.

K.11 To improve the available information, the Medical Research Council, funded by the Department of Health, began a series of anonymised sero-surveys in January 1990. The preliminary results of the first study on women going to antenatal clinics and of attenders at drug misuse and GUM clinics are expected in mid 1991. In time, as these studies become more generalised the results should enable more accurate predictions to be made on the state and distribution of the epidemic in the UK.

OTHER COMMUNICABLE DISEASES

(a) IMMUNISATION PREVENTABLE COMMUNICABLE DISEASES

Burdens

L.1 While communicable diseases are not at present a major cause of death in the UK they are a significant cause of morbidity and lost working days and economic loss. Furthermore because the incidence of these diseases is now at very low levels due to immunisation there remains a very great potential for ill-health should immunisation rates fall.

L.2 Prior to the development of effective vaccines and of national immunisation programmes, some infectious diseases had a devastating effect on the health of the population, particularly young children. Before 1940 *diphtheria* led to an annual average of 60,000 cases, with 3,000 deaths in England and Wales. As late as the 1950s *poliomyelitis* resulted in an average of 2,800 cases a year, with 320 deaths. *Whooping cough* reached more than 100,000 notification per annum until immunisation was begun in the 1950s, though notifications returned temporarily almost to that level in major epidemics in 1977–79 and 1981–83, when public and professional anxiety about the safety of the vaccine led to a fall in acceptance rates. All these diseases can still lead to death, and in many cases permanent disability.

L.3 Meningitis is another important communicable disease. In 1990 (provisional figures) there were 1142 notifications of meningococcal meningitis and 282 notifications of meningococcal septicaemia. There were 165 deaths from all meningococcal infections. Invasive disease from Haemophilus influenzae b infections, especially meningitis, has been increasing, though a vaccine will be introduced in 1992 (subject to licensing and adequate supplies being available). Similarly, pneumococcal infections cause considerable morbidity and mortality, especially pneumonia in the elderly and meningitis in younger people. There are good prospects for more effective vaccines which may be available within the next few years.

Objective

L.4 To reduce or eliminate these diseases, principally by preventing their spread.

Scope for meeting this objective

L.5 The present generally low level of communicable disease rests in part upon the many benefits of the public health reforms of the 19th and early 20th centuries. Immunisation policy has played a major role in controlling many of these diseases and will play an increasing role in the future. The national surveillance and monitoring systems coordinated by the Public Health Laboratory Service have had and continue to have an important role in supporting communicable disease policy.

L.6 Actions to prevent and control these diseases can be classified as:

- immunisation to protect individuals and also, if

sufficient individuals are immune, to break the "chain of transmission" and eliminate the disease;

- effective surveillance to identify cases as early as possible, coupled with out-break control – treating the source and protecting close contacts through immunisation or antibiotic prophylaxis;
- early diagnosis to allow appropriate treatment;
- health education to encourage acceptance of immunisation.

L.7 The national immunisation programme now provides immunisation for young children against seven childhood diseases: diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps and rubella. This programme is due to be augmented in October 1992 by the addition of a vaccine against Haemophilus influenzae b (Hib), a major cause of meningitis in children under 5 years.

L.8 The programme is supported by

- professional and public information and education campaigns on the benefits and safety of immunisations;
- extensive use of computer services for call-up and recall, and for feeding back immunisation data to service providers;
- use of immunisation coverage targets in the health promotion/disease prevention objectives of Regional Health Authorities;
- appointment of immunisation coordinators to take responsibility for the immunisation programme in all District Health Authorities;
- special payments to GPs who achieve target levels of immunisation coverage in their practices.

Possible targets

L.9 Targets for immunisation are already well developed and are used effectively in the management of the immunisation programme. Target 5 of the WHO European Region's "Health For All by the Year 2000" strategy states that "by the year 2000, there should be no indigenous poliomyelitis, neonatal tetanus, diphtheria, measles or congenital rubella syndrome in the European Region". Although that target does not include mumps or whooping cough, it is the Government's aim that these should also be eliminated. In 1985 the Government agreed the World Health Organisation's recommendation to aim for 90% coverage of immunisation nationally by 1990, as a step towards elimination.

L.10 Estimates show that the national averages for immunisation coverage for England in February 1991 were 90% for diphtheria, tetanus and polio, 89% for measles, mumps and rubella and 85% for whooping cough. However this will not achieve permanent elimination of these diseases, particularly in the case of whooping cough and measles. The Government has therefore considered the need to revise the national 90% targets. This has been endorsed by the Joint Committee on Vaccination and Immunisation, which advises on all aspects of immunisation, and some health districts have already taken the initiative and set

themselves higher targets. **It is the Government's intention, therefore, to set new national targets of 95% coverage by 1995.**

L.11 As indigenous poliomyelitis, diphtheria and neonatal tetanus have already been eliminated, outcome targets for disease reduction for these diseases are unnecessary. Measles elimination will be harder to achieve, although the progress is good, as *figure L1* shows. The World Health Organisation has recommended that by 1995 countries should have achieved a 90% reduction of measles notifications from pre-immunisation levels. This has already been met in England. **The Government therefore suggests a realistic target would be a 90% reduction by 1995 on 1989 levels.**

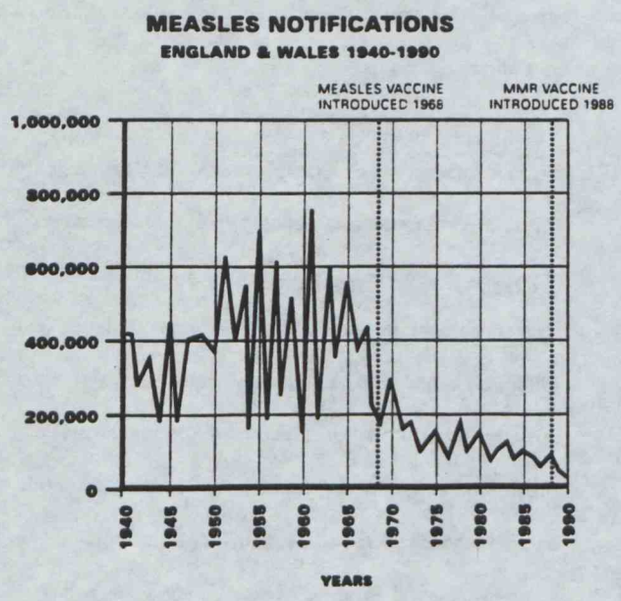


figure L1

(b) HOPSITAL ACQUIRED INFECTION

L.12 Studies in the UK and abroad indicate that approximately 10% of in-patients have an infection contracted in hospital. Although some of these infections are trivial, others complicate treatment of the underlying condition and lead to increased morbidity and mortality. All increase the costs of hospital treatment.

L.13 The long-term objective should clearly be to reduce as far as possible the incidence of these infection. Action to reduce the risk of patients becoming infected will include improvements in medical and nursing practice, arrangements for managing patients who are particularly vulnerable and infected patients who pose a threat of cross-infection to others. A range of support services may contribute to reducing infection, including cleaning and maintenance services.

L.14 Given the existence of interventions which can reduce levels of infection there is scope for setting targets. These might initially relate to procedures to be adopted. Targets could be set on the basis of what can be achieved through good practice. The surveillance of hospital acquired infections is now considered to be an essential part of medical and clinical audit and experience from this will allow the continuing development of realistic targets in individual units taking into account patient mix and other relevant factors.

FOOD SAFETY

(A) FOODBORNE DISEASES

Burdens

M.1 Food poisoning causes a good deal of illness, though not many deaths. The number of cases notified in England and Wales rose from almost 40,000 in 1988 to nearly 56,000 in 1990. The figures have been increasing since 1982, as shown in *figure M1*. There is undoubtedly an underlying rising trend even though recent concerns about food hygiene are likely to have led to increased reporting. Furthermore many cases are not notified: the Department of Health is initiating surveys to provide the first ever well founded data on the actual incidence of food poisoning.

M.2 Salmonella isolations in laboratories rose from over 27,000 in 1988 to a little over 30,000 in 1990: cases of campylobacter reported by laboratories rose from nearly 29,000 in 1988 to nearly 35,000 in 1990. There were 61 registered deaths where salmonella infection was given as the underlying cause in 1989, and 2 deaths due to other bacterial causes, neither being campylobacter. Cases of listeriosis recorded in England and Wales fell from 281 in 1988 to 116 in 1990. Death occurs in about a quarter of the cases of listeriosis and the infection can affect the fetus and the new born baby.

M.3 These figures represent considerable morbidity and economic cost, particularly sickness-related absence from work. It is difficult to estimate the full economic cost of this illness, but tangible costs of foodborne infection in England and Wales in 1988 have been estimated as something like £28 million (including health care and investigation costs, lost productivity and associated costs for the family, but excluding the cost to industry of preventive measures such as withdrawing food).

Objective

M.4 To reduce death and ill health resulting from foodborne disease.

Scope for meeting this objective

M.5 Salmonella and other organisms such as listeria and campylobacter are widespread in the environment. Foreign travel is likely to be a continuing source of infection. The transmission routes of diseases due to these organisms are generally well understood and there is therefore scope for action to reduce the incidence of infection from them. A concerted effort will be needed on a number of fronts:

- all sectors of the food industry will have to improve hygiene standards. For example, an Audit Commission survey in 1990 found that almost 1 in 8 of food premises presented a significant or imminent health risk. The stricter obligations imposed by the Food Safety Act 1990, increased use of quality assurance systems, recently introduced rules about the temperature at which food should be kept, and better training for food handlers should all contribute to higher standards.
- Environmental Health Officers (EHOs) can help by using the new and stronger powers obtained under the Food Safety Act 1990 and by seeking more uniform

enforcement. They can also increase their educational and training role.

- Consumers need to be more aware of hygiene problems. A public health education campaign has encouraged consumers to be more aware of the simple guidelines on food hygiene and to take more care in the kitchen.
- Government will continue to provide the necessary statutory framework for preventive action (eg to reduce the incidence of salmonella enteritidis in poultry flocks); to carry out research and surveillance; and to give general advice. It has set up a new expert advisory committee on the microbiological safety of food. It is also setting up a new surveillance system to identify risks and the need for action.

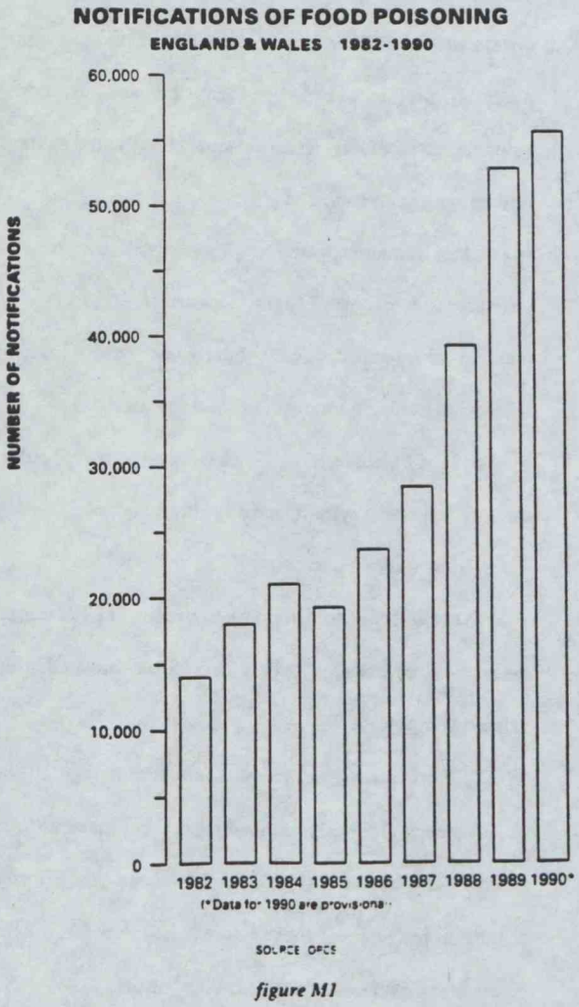


figure M1

Possibility of setting targets

M.6 The obvious target would be to reduce the incidence of food poisoning by a stated amount at a given date. There is however no sound basis for determining a target in this way and it may thus be premature to do so. The results of the Department's current studies, which are intended to give a better idea of the actual incidence of food poisoning in the community, should make it possible to identify target areas for further initiatives. It would however still be necessary to allow for the unpredictable way in which particular organisms can increase or decrease.

M.7 Intermediate measures might be obtained from an analysis of the activities of enforcement officers. From mid 1991 onwards the results of enforcement action will be reported regularly in accordance with an EC directive. When some experience of this has been obtained the possibility of setting targets might be considered. It would also be valuable to look again at hygiene standards in food premises to identify how much progress had been made in improving the situation found by the Audit Commission.

(B) CHEMICAL FOOD SAFETY

Burdens

M.8 Food supports life by providing nutrients which are chemicals that can be absorbed and used in the body. Even essential nutrients can however be harmful if taken to excess; and some chemicals may have undesirable effects at levels which could occur in a normal diet.

M.9 There is no easy way of assessing the potential risk to health posed by the presence of toxic chemicals in food. Occasionally, human epidemiological data are available, but usually they are not. In the absence of human data, laboratory animal studies must be used to assess potential hazards and risks.

Objective

M.10 To ensure the safety of food supplies by preventing, as far as possible, adverse health effects arising from toxic chemicals in food.

Scope for achieving objective and possibility of setting targets

M.11 The potential for ill-health can be reduced by means of research, assessment of risks and, where necessary, regulation or other action.

M.12 Chemicals in food which need safety assessment range from food additives or food contact materials, which can be assessed before introduction and whose presence in food can be relatively easily controlled, to environmental contaminants and natural toxins, which are less easily monitored and controlled. New food chemicals or processes are thoroughly tested and assessed. A long history of human exposure of itself may not however guarantee safety. For the majority of food additives sufficient toxicity data are available to allow judgements to be made about safety. But for food contaminants or natural toxins the problem is one of setting priorities for further research and surveillance in order to fill any gaps in scientific knowledge.

M.13 The Government has in place a comprehensive system of surveillance of the chemicals in food so that potential problems can be identified and avoided. Priorities are set for research and surveillance taking into account such factors as:

- length of human exposure
- frequency of exposure (daily, occasional, etc)
- extent of human exposure, based on known concentrations in food and amounts of food consumed
- exposure of possible high-risk groups in the population, eg infants, pregnant women, elderly people
- any known data on toxicity
- in the absence of toxicity data or gaps in the database, assessment of possible toxicity based on knowledge of related compounds.

M.14 Risk assessment, and to some extent regulation, are increasingly being co-ordinated by international bodies such as the EC. There is a need for priority setting in the work of these bodies also, which can help to prevent unnecessary duplication of effort.

M.15 In contrast to foodborne diseases from microbiological sources, the scope for identifying ill-health caused by the chemicals in food using epidemiological data, and consequently the ability to set measurable targets for improvement in human health, is limited. The Government believes that all the necessary measures are being taken, but would be glad to receive views.

REHABILITATION SERVICES FOR PEOPLE WITH A PHYSICAL DISABILITY

BACKGROUND

N.1 Rehabilitation is an integral part of medical practice and a major component of specialities such as cardiology and geriatrics. It is also a designated speciality in its own right providing services aimed at the restoration of optimum functioning following illness or injury irrespective of the cause.

N.2 In recent times, although there has been an ever increasing number of people with chronic and multiple disability including those disabled through accidental injury, there is a widespread lack of understanding of what rehabilitation can do to restore functioning. There is a tendency for NHS hospitals to concentrate on the acute phase of care. On discharge, health and social care may be available in the community, but often with the emphasis being on helping to maintain the individual at a lower level of functioning than before his or her illness or injury. Individual and group expectations among those with chronic illness or disability have traditionally been low.

OBJECTIVE

N.3 To enable people with physical disabilities to reach their optimum level of functioning.

BURDENS OF DISABILITY

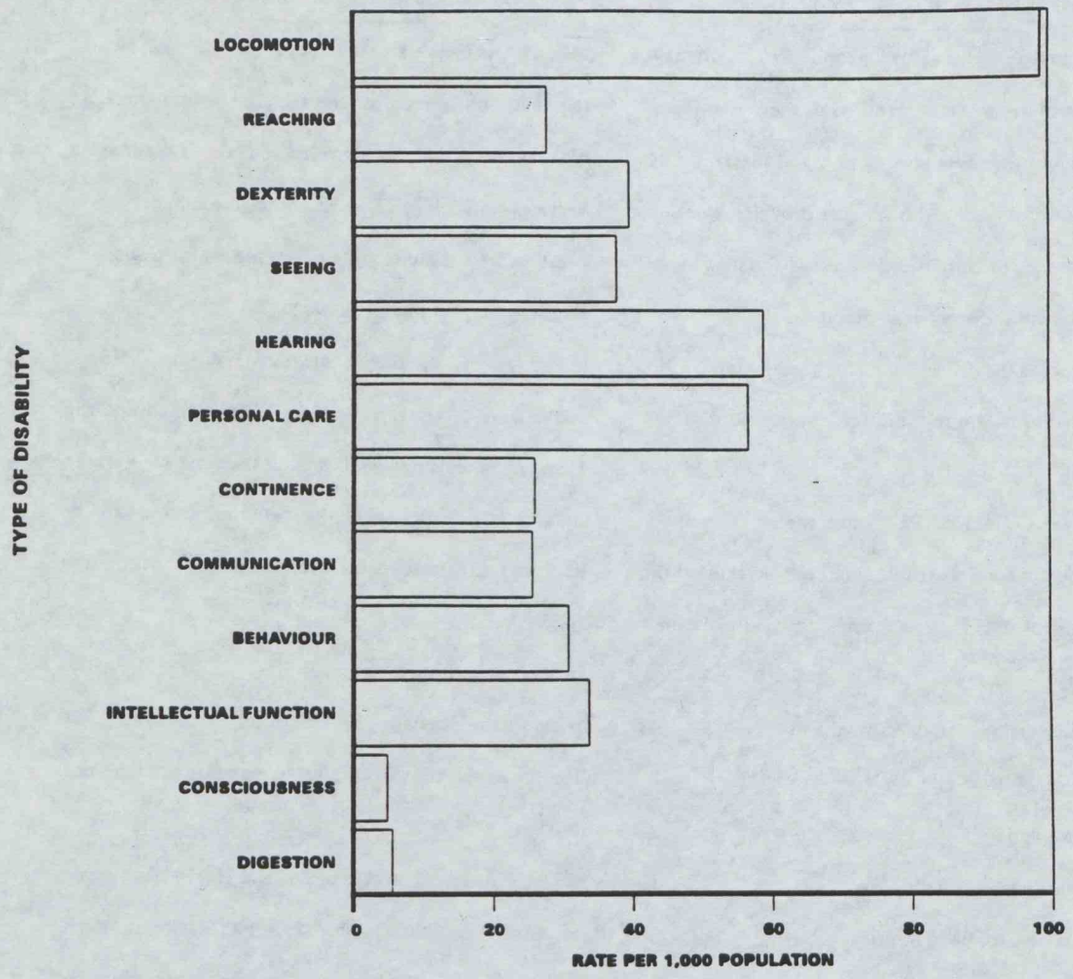
N.4 Few statistics are available regarding the overall effects of disability on premature mortality. Some conditions considerably reduce life expectancy (for example, motor neurone disease). Other conditions, such as paraplegia, were once associated with death soon after injury but now are increasingly expected to have an almost normal duration of life. Many of those who suffer brain injury have little reduction in life expectancy.

N.5 Thanks particularly to the OPCS Survey of Disability there is extensive information available about the effects of physical disability on morbidity. It is estimated that there are over six million people (14% of the total) in the adult population in GB who have one or more significant disabilities. *Figure N1* shows the distribution of the types of disability. Physical disability causes much personal suffering and reduces the quality of life for many people. Physical disability affects the individual, the family, the community and – through economic and other costs – society at large.

N.6 There are no overall figures regarding the cost of disability to the NHS, but these costs are thought to be very high. As long ago as 1982 the cost to the NHS of back pain alone was estimated at more than £156 million. Pressure sores have been estimated currently to cost more than £60 million a year. Some £100 million a year is being provided to run artificial limb and wheelchair services for the coming two years. Many millions of £s are spent on items such as surgical appliances, incontinence aids and appliances, and drugs.

ESTIMATES OF PREVALENCE OF DISABILITY

ADULTS AGED 16+ **GREAT BRITAIN 1985**



SOURCE: OPCS DISABILITY REPORT

figure N1

CURRENT PROVISION

N.7 NHS services for disabled people are provided in hospitals and in primary care. But there has been criticism about the level of provision and the failure to complement or dovetail with services provided by other people. Concern has also been expressed about

- the shortfall in the number of therapists
- deficiencies in the provision of aids and appliances
- the provision of appropriate information to disabled people.

N.8 A Royal College of Physicians report (November 1990) on health services for disabled people showed the proportions of NHS health districts which did not provide any: %

- Consultant sessions for assessment and rehabilitation of disabled people 48
- Young disabled units 56
- Special stroke recovery services 66
- Special services for head injuries 73
- Special services for amputees 81

N.9 The report also stated that

- 53 District Health Authorities provided no training courses on disability
- in 47% of the District Health Authorities the Community Health Council (CHC) had expressed concern about rehabilitation services in general
- in 22% of District Health Authorities there had been formal representations by the CHC.

A TIME FOR CHANGE

N.10 1991 provides a unique opportunity for developing rehabilitation because of the integration into the NHS of services formerly provided by the Disablement Services Authority (DSA). Other factors include:

i. the wider debate stimulated by the Royal College of Physicians report and the DSA itself;

ii. the effects of the employment by the NHS as consultants of doctors who formerly worked for the DSA in wheelchair and prosthesis services – these doctors have experience in rehabilitation and can be expected to attract wider responsibilities within the NHS;

iii. the allocation of an additional 15 senior registrar posts in the specialty. and the offer by most Regional Health Authorities to take up these posts over the next few years;

iv. the change in the role of District Health Authorities to purchasers although this change in itself will not be enough; what will be required is a consensus that they **should be purchasing** rehabilitation services.

N.11 There is a danger that opportunities may not be grasped and momentum may fall away unless

- there is a clear lead from the centre
- there is effective monitoring of NHS authorities' performance in purchasing effective and appropriate services.

THE WAY FORWARD AND THE POSSIBILITY OF TARGETS

N.12 Some steps have already been taken. Guidance from the Department of Health has stressed the importance of rehabilitation: a lead Regional General Manager and Regional Director of Public Health have been identified.

N.13 In addition to this, consideration is currently being given to:

- how a model specification for rehabilitation services might be drawn up, piloted and disseminated;
- how take-up of the model by purchasing District Health Authorities might be monitored;
- how the Department of Health can liaise with and encourage the relevant professional bodies in the development of the specialty.

N.14 Because of this, and the diverse nature of disability and rehabilitation, it is considered inappropriate at this stage to propose specific national targets for rehabilitation services. However, suitable targets should be developed in the future to support widespread and effective service provision. It has been decided to set up a small Advisory Committee on Rehabilitation Policy to advise Ministers and the Department of Health on these matters. It will act as a focus for views from interested bodies and offer an independent stimulus to further development.

N.15 There is, however, scope in the mean-time for Health Authorities to set targets aimed at specific disabling conditions, for example pressure sores, incontinence and contractures. But there are many others for which standards should be set.

N.16 Pressure sores in particular have been estimated as affecting 6.7% of the adult hospital population and costing about £60 million per year. They are largely preventable by a district-level multi-disciplinary programme of intervention. **The Government's view is that an annual reduction of at least 5% – 10% in their incidence would be a reasonable target.** Clearly the first task for Health Authorities would be to establish the baseline incidence and prevalence of the conditions to be targeted.

N.17 In respect of incontinence, the Department of Health recognises the importance of effective continence services for elderly and disabled people. It is therefore currently conducting a review of its policies on these services. The aim of this review will be to identify and disseminate good practice.

ASTHMA

BURDENS

O.1 Asthma is a common chronic condition in which the airways narrow easily in response to a wide range of triggers. This may manifest as coughing, wheezing, a sensation of tightness in the chest or shortness of breath.

O.2 It is estimated that there are some 1.7–2 million asthmatics in the United Kingdom of whom upwards of 700,000 will be children and adolescents under the age of 16. Asthma accounts for about 1800 deaths a year and 40% of these occur before 65 years of age.

O.3 There is significant morbidity associated with asthma in terms of lost schooling and sickness absence. More than 5.5 million days of certified sickness absence were recorded in Britain in 1987/88 representing of the order of 7 million actual days lost. The estimated cost of this was some £350 million in lost productivity, £60 million in sickness benefit and something of the order of £400 million to the NHS.

O.4 There seems little doubt that despite the availability of effective preventative therapy the prevalence of asthma as assessed by GP consultation *(figure O1)* and the occurrence of acute asthmatic attacks has been rising. Mortality trends are more complex, although there is some evidence of a rise during the first part of the 1980s. It seems unlikely that the changes can be attributed to shifts in diagnostic labelling (for example from "bronchitis").

OBJECTIVES

O.5 To reduce deaths and illhealth attributable to asthma in the short to medium term by the effective provision of services and in the long term by establishing its aetiology.

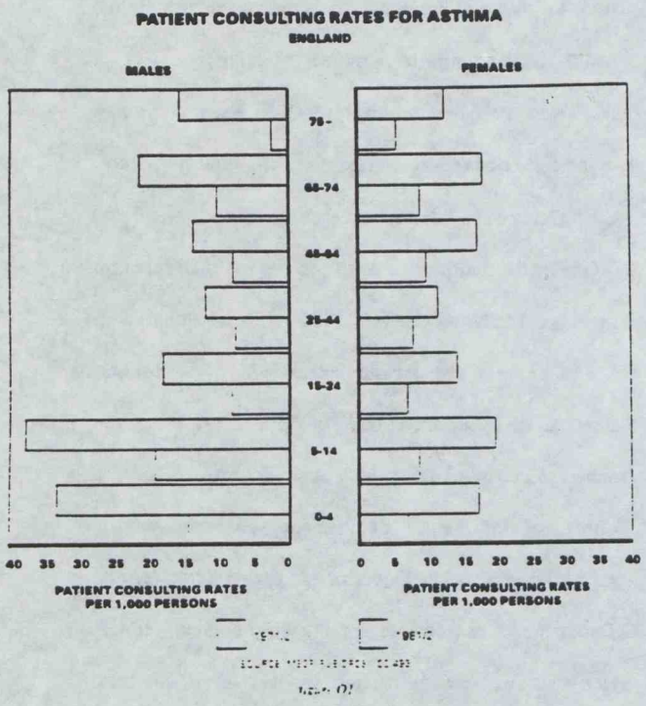
SCOPE FOR MEETING THESE OBJECTIVES

(a) Prevention

The causes of asthma are incompletely understood. There are certain well recognised causes of occupational asthma and outside the occupational setting attacks in individuals may be triggered by agents to which they are sensitive. There is thus some scope for reducing the risk of an attack by the avoidance of exposure to such agents. However most cases of asthma are not strongly influenced by external factors so that avoidance of exposure has limited potential.

(b) Treatment

O.7 Effective recognition and treatment of asthma offers scope for a reduction in the mortality and morbidity. Therapy is directed at preventing an attack and should an attack occur at early recognition and effective treatment. An important aim is to minimise side-effects and treatment-induced complications. With those aims in mind a number of treatment protocols have been suggested. Peak flow meters enable individual sufferers to make objective measurements of their own airways function. These meters were recently made



available on prescription. There is thus scope for improved management by the individual patient and clinician, for example through the earlier detection of deteriorating airways function and the tailoring of treatment regimes to avoid both undertreatment and over-treatment.

O.8 Collaboration between GPs, clinicians and Health Authorities in order to establish shared policies on access to services, agreements between clinicians and GPs on treatment protocols, and the more wide-spread use of self management protocols agreed between patient and doctor should have a favourable impact on the burden imposed by asthma on the individual and the community.

POSSIBLE TARGETS

O.9 There are a number of difficulties in the setting of targets – firstly, in the identification of the targets themselves; and secondly, in their quantification. The setting of simple targets related to reductions in mortality is difficult because the factors which lead to death are not sufficiently well understood. Targets should therefore concentrate initially on reducing the amount of avoidable ill-health.

O.10 It may thus be best to develop targets for defined populations based on adherence to published clinical management guidelines, the establishment of agreed protocols between GPs and hospital clinicians, the development of district wide strategies etc. Monitoring the uptake of peak flow meters on prescription and the development of self-management plans may also offer some scope for target development.

O.11 Work will be necessary to establish the linkage between such measures and health outcome. Consultation between the Government, the NHS and other interested parties will be necessary to develop suitable targets.

THE WORLD HEALTH ORGANISATION EUROPEAN REGIONAL TARGETS "HEALTH FOR ALL BY THE YEAR 2000"

1 The member states of the European Region of the World Health Organisation (WHO) agreed that, in order to improve the health situation in Europe, efforts should be concentrated on the promotion of healthy lifestyles, the reduction or elimination of preventable diseases, and the provision of comprehensive health coverage for the whole population based on primary health care, particular attention being given to the vulnerable groups in society. A move away from focusing on treating disease to one of avoidance of disease. The strategy is popularly known as "Health for All by the Year 2000" (HFA).

2 To underline their commitment to this movement, and to monitor progress, a set of 38 targets was formulated. While they cannot be legally binding on member states, they are intended to help member states set their own targets that will reflect their specific needs, priorities and values. A number of Regional, District and Family Health Services Authorities have already adopted the European Targets framework as a model for their own strategic plans.

3 The targets can be broken down into three subsets:

(a) targets for improvements in health (reducing or eliminating preventable conditions, (childhood diseases) or reducing mortality (from heart disease, cancer, accidents etc):

(b) targets for activities needed to bring about these improvements in health (policies to bring about improvements in lifestyle, eg reducing tobacco consumption, alcohol and drug misuse, reducing environmental health risks and improving the environment):

(c) targets designed to improve the management and organisation of the health services, the quality of care, the training of health workers etc.

4 One of the major goals of the strategy is the reduction by at least 25% by the year 2000 of the inequalities in health between the various groups within the population. Another important tenet of the strategy is that the achievement of better health depends not only on the efforts of the health departments but requires the cooperation of other Government departments (eg the Departments responsible for the environment, education, social security, social services etc), of local authorities and nonGovernmental organisations and, most importantly, the active participation and motivation of the people themselves.

5 The member states have been monitoring their progress towards the regional targets. The Department of Health carried out such an exercise in respect of England at the end of 1989. The baseline year for the exercise is 1980. To allow for changes in the age structure of the population over time, mortality rates are expressed as age standardised rates based on the European standard population, as published in the WHO Statistics Annual.

6 Broadly speaking, England shows a good balance sheet in relation to the majority of the Regional targets although it is unlikely that the actual differences in

health status between the groups will be reduced by 25% by the year 2000 as aspired to by the first Regional target England has reached or surpassed the Regional targets for life expectancy at birth and infant and maternal mortality. England is making satisfactory progress towards the targets for the eradication of childhood diseases. Cases of poliomyelitis, diphtheria, tetanus and congenital syphilis have been all but eradicated. The introduction of MMR (measles, mumps and rubella) vaccination will be reflected in further reduction in the incidence of measles cases, and figures on reported cases of congenital rubella show a continuing decline.

7 Although England has some of the worst mortality figures for circulatory diseases, there has been a significant downturn in mortality over the past 10 years with a percentage reduction of (30%), which is higher than that set by the Regional target (15%). Death rates from all cancers in the under 65 years age-group declined by only about 8% over the same period against a Regional target of 15%. However, England is doing well in reducing deaths from lung cancer in males (mainly as a result of the significant fall in smoking amongst males) but less well in the female population. Deaths from cervical cancer are declining overall, although a rise has occurred amongst younger women, but there is little change in deaths from breast cancer. Deaths from motor vehicle traffic accidents are amongst the lowest in Europe. The overall suicide rate has declined over the past ten years and England is thus achieving the Regional target.

8 There have also been improvements in adopting healthy lifestyles particularly in such areas as cigarette smoking (in 1988 about 68% of the population were non smokers) and in improved dietary habits. There has however been no improvement in other areas such as alcohol misuse and drug abuse, and little significant improvement in physical activity.

9 On environmental issues, England has satisfied the targets requiring policies that effectively protect the human environment from health hazards and adequate machinery for monitoring and controlling such hazards. Effective mechanisms are in place to control water and air pollution and waste management.

10 In so far as primary health care and coverage of the population is concerned, England is among the leaders in Europe and here, again, meets the Regional targets. England has some of the best management and information systems for the administration of the health services and continuous improvement in the standards and quality of care through professional audit and effective management are key features of the continuing programmes of primary care reform under "Promoting Better Health" and "Working for Patients".

11 The full list of HFA targets and a more detailed account of where England stands in relation to them is given at annex 1.

ENGLAND'S PROGRESS TOWARDS HFA 2000 TARGETS

TOXIC CHEMICALS

Monitoring, assessment and control of environmental hazards due to toxic chemicals have been subject to regulatory mechanisms for many years. Notification and assessment schemes for new chemicals prior to placing them on the market were introduced in 1983 and stricter controls on pesticides in 1986. Regulations to control chemicals in the workplace have likewise been introduced.

WATER POLLUTION

The population has ready access to safe drinking water. The Water Act 1989 has set statutory limits defining "wholesome water" and it also changes the regime for controlling the water quality of rivers, lakes and coastal waters.

AIR POLLUTION

The Government intends action on air quality to be increasingly based on the definition of acceptable standards for the protection of health and the wider environment. Statutory standards in Britain already exist, backed by European Community Directives, for smoke, sulphur dioxide, lead in air and nitrogen dioxide. These are now met in all but a very few areas, and the Government is committed to ensuring full compliance as soon as possible. The Government is also encouraging the establishment of European Community guidelines for ground level ozone concentrations and is establishing an expert panel to advise on further air quality standards. Meanwhile, sulphur dioxide and smoke emissions have continued with falls of 24% and 10% respectively between 1980 and 1989, and estimated lead emissions from petrol engined vehicles have fallen by 65% between 1980 and 1989, and the unleaded petrol share of the total petrol market is now approaching 40%, following a publicity campaign and the introduction and progressive increase of fiscal incentives. Tighter European standards on new car emissions, operative from 1992, will help curb the rising trend of emissions of carbon monoxide, nitrogen oxides and volatile organic compounds.

HOUSING

The Government's housing policy aim is to put decent housing within reach of all families. The quality of the housing stock has continued to improve steadily, mainly through private investment, but assisted by Government-financed slum clearance, renovation grants to private owners, and construction of subsidised housing. The main focus of housing policy is on providing enough subsidised rented housing for households who need it; special programmes exist to reduce the need for families to be temporarily housed in often unsatisfactory bed and breakfast accommodation, and to provide housing for single people sleeping rough in London.

WASTE MANAGEMENT

Legislations is in place to ensure the safe disposal of hazardous wastes. A system of "integrated pollution control" for the most polluting sectors of industry is being introduced and will be enforced by a strengthened pollution inspectorate. A major effort has also been made to clean up those coastal waters which have been affected by poorly sited sewage outfalls.

APPROPRIATE CARE

26 By 1990, all member states, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined in the Alma-Ata Conference

27 By 1990, in all member states, the infrastructures of the delivery systems should be organised so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population

28 By 1990, the primary health care system of all member states should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high risk, vulnerable and underserved individuals and groups

29 By 1990, in all member states, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, family and community groups

30 By 1990, all member states should have mechanisms by which the services provided by all sectors relating to health are co-ordinated at the community level in the primary health care system

31 By 1990, all member states should have built effective mechanisms for ensuring quality of patient care within their health care systems

The Regional targets recommend that the primary health care system, based on teamwork, should provide a wide range of health-promotive, curative, rehabilitative and support services to the population, and should give special attention to high risk, vulnerable and neglected groups. Effective mechanisms for ensuring quality of patient care also feature prominently in this group of targets.

England has in place an established primary health care system based on teamwork, which already meets these targets, as well as existing statutory and management mechanisms to ensure that District Health Authorities, Family Health Services Authorities and Local Authorities co-ordinate action at community level. Several mechanisms exist for assessing quality of care and health technologies within the health service. Rapid progress is being made in implementing medical audit systems in hospital, community, and general practice following the stress laid on it in Working for Patients. The use of performance indicators, health service audit techniques and measures of value for

money are all intended to promote better and more efficient use of resources. The aim is to maintain and improve the health service so that patients can receive the best possible care within the limits of the available resources.

HEALTH DEVELOPMENT SUPPORT

32 Before 1990, all member states should have formulated a research strategy to stimulate investigations which improve the application and expansion of knowledge needed to support their national "Health For All" developments

33 Before 1990, all member states should ensure that their health policies and strategies are in line with "Health For All" principles and that national legislation and regulations make their implemention effective in all sectors of society

34 Before 1990, member states should have a managerial process for health development geared to the attainment of "Health For All" actively involving communities and all sectors relevant to health, accordingly, ensuring preferential allocation of resources to health development priorities

35 Before 1990, member states should have health information systems capable of supporting their national strategies for "Health For All"

36 Before 1990, in all member states, the planning, training and use of health personnel should be in accordance with "Health For All" policies, with emphasis on the primary health care approach

37 Before 1990, in all member states, education should provide personnel in sectors related to health with adequate information on national "Health For All" policies and programmes and their practical application to their sectors

38 Before 1990, all member states should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national policy and economic restraints

This group of targets recommends the establishment of a managerial process for health development ensuring preferential allocation of resources to health development priorities, efficient information systems, and the remodelling of health personnel training to emphasise the primary health care approach.

MANAGERIAL PROCESS FOR HEALTH FOR ALL

A managerial process for health development ensuring preferential allocation of resources is an established feature of the administration of the health services. Information technology has been, and is continuing to be, developed and introduced to support the efficient and effective operation of the health services. Record linkages are also now an established feature. Changes in

medical education have taken place in only a very patchy manner. The nursing profession has adopted a strategy which encompasses planning, training and the use of nursing personnel in line with Health for All policies and the primary health care approach.

EQUITY IN HEALTH

1 By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the levels of health of disadvantaged nations and groups

There is a persistent gap between death rates among manual and non-manual classes, and the Regional Target of reducing the actual differences in health status between groups within countries by at least 25% by the year 2000 does not seem likely on present evidence to be achieved, at least with respect to these social groups. There have however been marked reductions in national perinatal and infant mortality rates over the past 10 years in each of the social classes, with some reduction in the disparity between manual and non-manual classes. However, in 1987 the perinatal and infant mortality rates were still more than 50% greater in social class V (unskilled occupations) than social class I (professional occupations)

GENERAL HEALTH AND WELL-BEING

2 By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives

3 By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life

4 By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%

6 By the year 2000, life expectancy at birth in the Region should be at least 75 years

Life expectancy at birth is currently 75.20 years (72.5 for males and 78.1 for females). England has thus already attained the Regional target for this indicator. Assessment of trends in general health and well-being is hampered to some extent by lack of appropriate data. Recent trends in self-reported morbidity as collected in the General Household Survey have indicated that, although between 1979 and 1987 there was little change in the prevalence of "acute sickness", there was some evidence that the rates of self-reported longstanding illness had increased during the 1980s.

Using the General Household Survey measure of limiting longstanding illnesses, which is sometimes used as a proxy for disability, it has been shown that, in England and Wales, over the ten year period from 1976

and 1985, while the expectation of life has increased, the expectation of life without disability has changed little. This is true for both men and women. These findings may simply reflect changing perceptions of illness or a greater propensity to report it, but they do emphasise the importance of considering trends not only in life expectancy, but also those which reflect the quality of life.

COMMUNICABLE DISEASES

5 By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the Region

England compares well with most other European countries and is making satisfactory progress towards the European targets for the eradication of childhood diseases. Over the last five years there have been no indigenous cases of poliomyelitis caused by wild poliomyelitis virus. Cases of diphtheria are either imported or cutaneous. There has also been a declining trend in the number of measles cases although the elimination of the disease will require a sustained vaccination uptake of at least 95% (the uptake for the year ending 31 March 1990 was 90%). The introduction of measles, mumps and rubella (MMR) vaccinations should be reflected in further reductions in the incidence of measles cases. Figures on reported cases of congenital rubella syndrome show a continuing decline. Cases of congenital syphilis have fallen by 61% from 119 in 1980 to 46 in 1987. The appointment of named immunisation co-ordinators in every District Health Authority in England has helped to improve the management of the immunisation programme and will continue to contribute significantly to improving uptake.

INFANT AND MATERNAL MORTALITY

7 By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births

8 By the year 2000, maternal mortality in the Region should be less than 15 per 100,000 live births

Infant mortality in 1989 was 8.4 deaths per 1,000 live births. England is one of the European countries that have already achieved the Regional target, although, in 1986/87, eleven out of 28 European member states for which data are available had lower infant mortality rates; some substantially lower than the target. The maternal mortality rate was 6.1 per 100,000 live births in 1988. This is well below the Regional target.

CARDIOVASCULAR DISEASE

9 By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%

Between 1980 and 1989, the death rate from diseases of

the circulatory system in the population in England under 65 years-of-age fell from 121 per 100,000 to 85 per 100,000 population. This represents a reduction of 30%, which already exceeds the reduction of at least 15% from the 1980 baseline by the year 2000. This decline reflects falls in mortality for both ischaemic heart disease (27% decline) and cerebrovascular disease (32% decline).

CANCER

10 By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%

The death rates from malignant neoplasms in the under 65 years age-group declined by 8% in the period between 1980 and 1989, the decline being greater in males than females. Amongst males, the mortality rate for lung cancer – which accounts for about a third of all deaths from malignant neoplasm in the under 65 years age-group – has fallen by 29%, declines having occurred in each of the ten year age-groups between the ages of 25 and 64 years. Amongst females – where lung cancer accounts for about 15% of all deaths from malignant neoplasm – there has been little change in the mortality rate over the decade. Differing age and sex trends are attributable to different smoking patterns in the past reductions in smoking rates among women have occured later than in men. Amongst women, between 1980 and 1989 there was a 5% decline in mortality from all malignant neoplasms. Cervical cancer diminished by 20% but there was little change in breast cancer mortality, which accounts for over one quarter of all cancer deaths in the under 65 years age-group.

ACCIDENTS

11 By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents

Mortality from all external causes of injury and poisoning, and particularly from motor vehicle traffic accidents, is one of the lowest in Europe. There has been a 24% fall in accident mortality in England over the past nine years, from a rate of 25.2 per 100,000 in 1980 to 19.2 in 1989.

SUICIDE

12 By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed

Although the Regional target recommendation of a reversal in current rising trends in suicides is being achieved – the overall suicide rate declined by 18% between 1980 and 1989 – differing trends have occured by age and sex. During this period, the suicide rate fell by only 1.4% in males but 46% in females. Amongst males the largest rise occurred in young adults, particularly in males age 20-24 years (71% rise in the period 1980-1989).

ENGLAND'S PROGRESS TOWARDS HFA 2000 TARGETS

CONTINUED

LIFESTYLES

13 By 1990, national policies in all member states should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making

14 By 1990, all member states should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles

15 By 1990, educational programmes in all member states should enhance the knowledge, motivation and skills of people to acquire and maintain health

16 By 1995, in all member states, there should be significant increases in positive health behaviour, such as balanced nutrition, non-smoking, appropriate physical activity and good stress management

17 By 1995, in all member states, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs, and dangerous chemical substances; dangerous driving and violent social behaviour

Although there has been a discernible improvement in the awareness of the population as to what constitutes a healthy lifestyle, much remains to be done. In areas where overall encouraging trends have occurred, such as smoking, diet and road traffic accidents, further improvement is required and in a number of areas related to health-damaging behaviour, such as alcohol misuse and drug abuse, there has been no improvement so far.

SMOKING

The prevalence of cigarette smoking in adults in England has continued to fall. In 1980, 61% of the population were non-smokers. By 1988 that figure had risen to 68%. Reductions in smoking rates among women have been slightly smaller than in men, and smoking among teenage boys and girls, and women in their early twenties, has declined more slowly than at older ages.

HEALTHY DIET

As far as the national diet is concerned, there has been an improvement in nutritional quality: the diet contains less fat, saturated fatty acids and energy, mainly due to a decline in consumption of red meat (decline by over 25%) and full fat dairy products, and an increase in fibre, white meat, reduced fat milks and fruit. The main problem is that saturated fatty acid consumption still supplies about 17% of energy on average, compared to the Department of Health's target of 15% maximum. Fat consumption still accounts on average for 42% of total energy intake, well above the Department of Health's recommendation of 35% maximum. The ratio of polyunsaturated to saturated fatty acids, however, has risen to 0.37, towards the current target of 0.45.

PHYSICAL ACTIVITY

Although participation in sport and recreational physical activity has increased over the last decade, it is still a minority activity. In 1986, 46% of adults reported participating in at least one such indoor or outdoor activity in the four weeks before interview in the General Household Survey: 57% of men reported some physical activity in 1986, compared with 53% in 1980; for women participation had increased from 33% in 1980 to 37% in 1986. Women's participation in indoor activities increased sharply over this period, but their participation in outdoor activities showed no change. In addition to the increase in participation rates between 1980 and 1986, there was also some increase in the number of occasions that each person participated. The most popular activity was walking, which accounted for about a third of all occasions.

ALCOHOL

Alcohol consumption in the United Kingdom (UK) fell in 1981 and 1982 but has since risen steadily, and annual consumption in 1988, at 9.3 litres of alcohol per head of population aged 15 years and over, exceeded that in 1980 (9.0 litres). Over this period, there is some evidence of a fall in men's consumption but a rise in women's consumption – which is, however, still much lower than that of men. Between 1970 and 1988 alcohol consumption per head rose by nearly 40%.

ILLICIT DRUG USE AND OVERUSE OF PHARMACEUTICAL PRODUCTS

The number of notified new and former addicts has risen from 2,233 in 1980 to 13,700 in 1989, representing a six-fold rise. The 1989 figure includes re-notified addicts who were not included in the 1980 count, which was an underestimate. There has also been a three-fold rise in deaths from solvent abuse from 26 in 1980 to 87 in 1987. With regard to prescribed drugs there has been a 22% drop in the number of prescriptions in general practice for benzodiazepines over the nine-year period 1980 to 1988 (23.912 million in 1980 to 18.682 million in 1988).

ENVIRONMENT

18 By 1990, member states should have multisectoral policies that effectively protect the human environment from health hazards, ensure community awareness and involvement, and effectively support international efforts to curb such hazards affecting more than one country

19 By 1990, all member states should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biochemical agents

20 By 1990, all people of the Region should have

ENGLAND'S PROGRESS TOWARDS HFA 2000 TARGETS

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adequate supplies of safe drinking water, and by the year 1995 pollution of rivers, lakes and seas should no longer pose a threat to human health

21 By 1995, all people of the Region should be effectively protected against recognised health risks from air pollution

22 By 1990, all member states should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives

23 By 1995, all member states should have eliminated major known health risks associated with the disposal of hazardous wastes

24 By the year 2000, all people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment

25 By 1995, people of the Region should be effectively protected against work-related health risks

The Regional targets recommend that member states should have policies that effectively protect the human environment from health hazards and adequate machinery for monitoring and controlling such hazards. Adequate supplies of safe drinking water, effective protection against recognised health risks for air pollution, and the removal of threat to human health from pollution of rivers. lakes and seas are likewise recommended.

CONFIDENTIAL

DEPARTMENT OF HEALTH

23 April 1991

The Rt Hon Lord Waddington QC
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Telephone 071 210 3000
From the Secretary of State for Health

Dear David,

HEALTH STRATEGY AND TARGETS

I have thought about how best to carry forward this initiative in the light of your letter of 19 April and the comments of other colleagues. I have also discussed matters with the Chancellor of the Duchy. My conclusion is that it is better to aim for publication in mid-May rather than next week.

There were two main reasons for this. First, I wanted to be sure I had fully reflected colleagues' helpful comments. Second, I was not satisfied that the short popular version which I want to publish at the same time was quite ready.

While I am working on the popular version, about which I shall be writing to colleagues, it might be helpful to say a little more about the aim of the main document.

As you say, two important aspects of the consultation document will be to show how the nation's health has improved and to present positively the role of other Government departments. But the underlying theme of the document, as Kenneth Clarke pointed out in his letter, is that our reforms of the NHS have made it possible to embark with confidence on a health strategy. The reforms were a means to an end, better health and better health care, and not an end in themselves.

To get this message across we have to address two distinct audiences, the general public on the one hand and the NHS, the health professions and other interested groups on the other. The latter are a very sizeable audience in their own right.

It is of course essential that we get our message across to the first audience. But it is just as important that we get it across to the second audience. We must convince them that we are indeed embarked on a serious attempt to develop for the first time a health strategy for England. To do so we must not appear just to be re-stating the case for the NHS reforms or setting out the Government's health record. That is why we need a well argued and fairly detailed consultative document.

This does mean, as David Mellor points out, that the document has less appeal for the general public. For this reason I am also producing the popular version I mentioned earlier.

So far as the main document is concerned, we have been sharpening up the draft to take on board the helpful points made. In particular, we have underlined the link with the NHS reforms and brought out the Government's achievements more clearly. The figures have been refined and those on housing dropped. The role of other Departments now includes more material provided by them and has been generally agreed by all the Departments concerned. This part of the document will in any event be presented in a more eye catching way than might have appeared from the earlier draft. I will circulate the latest version later this week so that colleagues can see how it looks and comment further if they wish. I shall myself be doing some further work on it to see whether we can further strengthen the positive note on the Government's record.

I am copying this to the Prime Minister, members of HS Committee, other members of the Cabinet and Sir Robin Butler.

WILLIAM WALDEGRAVE

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CESG

CENTRAL MIDDLESEX HOSPITAL NHS TRUST

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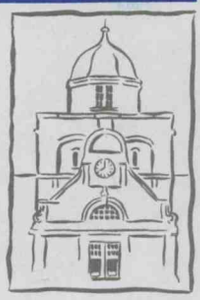

April 3rd 1991

Mr Barry Potter
10 Downing Street
London SW1A 2AA

Dear Mr Potter

Thank you for your letter. I am very happy to join the Prime Minister on 27th April.

Yours

Dr Martin McNicol
Chairman

Acton Lane, Park Royal, London, NW10 7NS.
Telephone 081-965 5733 Direct Line 081-453

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10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

25 March 1991

SEMINAR ON THE HEALTH SERVICE: 27 APRIL

I attach a sample of letters which were sent today to invitees to the seminar.

I trust you will make the necessary arrangements for inviting internal candidates within the Department of Health.

BARRY H POTTER

Stephen Alcock, Esq.
Department of Health

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

25 March 1991

Dear Mr Ross,

The Prime Minister would be very pleased if you could join him and colleagues from the Department of Health for a discussion about the further development of the National Health Service and, in particular, about the Government's forthcoming consultation paper on a health strategy.

The discussion will take place at Chequers on Saturday 27 April and will last from 1030 until 1500. Lunch will be served. The Prime Minister will also be inviting a number of other senior representatives of the NHS.

If you are able to attend I will send you a full agenda nearer the time.

Yours sincerely,

Barry H. Potter

(BARRY H. POTTER)

A.P.J. Ross, Esq.

file

MRS. GOODCHILD

I mentioned to you on the telephone that the Prime Minister wanted to have a buffet lunch on Monday 17 October. I have now had a chance of clarifying this with her, and she would like it to take place in the Large Dining Room - a cold buffet which people could help themselves to, and sit as they wish at the State Dining Room table.

I know you have spoken to Sherry about this. Numbers are still at 12, but it may be wise for Sherry to cater for 14, as I am sure that Paul will tell me next week that he wants to add some more.

Tessa Gaisman

7 October 1988

PRIME MINISTER

Following yesterday's meeting on the NHS, I have set up the next seminar you requested on Monday 17 October. Everyone will arrive at 1030 and have been asked to stay on for lunch.

Could I clear with you what kind of lunch you would like this to be and where it should take place? The meeting will take place in the Cabinet Room and Paul thought that it might be best if sandwiches and drinks could be provided so that the meeting can run straight on without a break. Are you content with this, or would you prefer to have a buffet lunch upstairs? In either case Sherry is available.

Tessa

Tessa Gaisman
5 October 1988

Meeting in Cabinet Room — Check for Buffet lunch upstairs

P.S. Or the meeting could take place upstairs in the dining room if you thought that we should not have food in the Cabinet Room. TG.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

5 October 1988

This is just to confirm that the next NHS Review Seminar will be held here at 1030 on Monday 17 October and those attending are invited to stay for lunch. The meeting should break at about 1415.

I am copying this letter to the diary secretaries at the Scottish Office, Welsh Office, Northern Ireland Office, Treasury, Chief Secretary, Minister for Health and Trevor Woolley and Richard Wilson (Cabinet Office).

Tessa Gaisman

Mrs Flora Goldhill
Department of Health.

10 DOWNING STREET

Tessa

PM announced to the NHS meeting this p.m. that we will meet again at 10.30 on Monday 17th October and continue through a buffet lunch! Can you arrange please - and tell Mr Kentfield it is a command performance; neither Rothschild nor King turned up today.

P.

SLH

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

15 June 1988

Dear Gerald,

This is just to confirm timings for the NHS Review Seminar which the Prime Minister wishes to hold here on Friday 8 July. Those attending should arrive here at 0930 and lunch will be promptly at 1300 hours, thus allowing people to be away from here by 1430 at the latest.

I am copying this letter to the diary secretaries at the Scottish Office, Welsh Office, Northern Ireland Office, Treasury, Chief Secretary, Minister for Health and Trevor Woolley and Richard Wilson (Cabinet Office).

Yours sincerely,

Tessa

MRS. TESSA GAISMAN

Gerald D'Souza, Esq.,
Department of Health and Social Security

PART 3 ends:-

DR FROGGAT to PG. 23.5.88

PART 4 begins:-

TG to DHSS 15.6.88

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