Personal Paper

Are health services important to the people's health?

J N MORRIS

The notion is spreading that health services are of little moment to the people's health.^{1 2} There could scarcely be a more important issue, so it may be worth trying yet again to set some of the record straight before the view becomes the conventional wisdom, casting a shadow over the whole debate about health services.

The notion is misconceived and stems from over-attachment to history. In Victorian times health could be assessed by the absence of disease (for instance, cholera) and the course of horrendous death rates. Today living standards are high and death rates low, close to half the population is over 40, and there are new insights into the natural history of the prevalent chronic diseases and the ranges of their manifestations.³ So the idea of health as the absence of "disease" is altogether too simple and except for the perinatal period, when clinical services surely have contributed to the recent decline, the level of death rates is not necessarily the main criterion. Our health care task is different—as are our capabilities to help.

Thus in the host of chronic conditions that we do not know how to prevent (many of the disabilities of aging for a start) treatment today may be able to make all the difference to the quality of life—that is, to health. Symptomless hypertension as a precursor of stroke is a topical example. Maintenance, repair, and restorative medicine in an aging population are still "prevention," even if late. Arthroplasty of the hip can offer relief from suffering and greater wellbeing, functional improvement, and social independence—that is, better health—to many old people. The contribution of clinical services to health cannot be judged without statistics on such achievements: as we haven't the statistics we shouldn't make the judgments. Incidentally, when in its short life did this operation cease to be "high technology" (that reprobate status) and become "intermediate" (rather chic, this)—and is it yet "low"?

The standardised ratios for "arthroplasty" in 1974-5 (OPCS figures) ranged from 70 in Trent to 125 in South-west Thames. The ratio for "operations on the lens" varied from 70 (West Midlands) to 133 (Northern Region) and for prostatectomy from 60 (West Midlands again) to 134 (Mersey). Such general figures, however, are only the beginning of a modern health-service accountancy, and they also have to be followed back into the needs and forward to outcomes.

None of this after 150 years of social medicine is to gainsay the continuing salience of the classical social factors and the social inequalities in health, in morbidity as well as mortality,

that still disgrace our national record.⁴ This is not a matter of "either or." To offer something like equal opportunity to the under-5s, for example, on which there is (or was until recently) a modicum of national consensus, will entail improvements, of course, in child benefits and the physical environment, but also a different scale of nursery school and child-minding facilities, new initiatives in health care and surveillance, and a huge effort at education in parenting—all of which would fall heavily on health as on other services.

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This takes us into the future. Today's main hope for better health is the movement for health and prevention through changes in the social system, in culture patterns, and everyday ways of living—the product of 30 years of research, world wide, on the aetiology of coronary thrombosis, lung cancer, alcoholism, motor-vehicle accidents, and many other things. Here Government, unmindful of the lessons of nineteenth-century environmental hygiene and twentieth-century personal health services alike, has in essence placed the responsibility for change squarely on the individual, while giving some (though not too much) more money to the Health Education Council. But, smoking apart, far too little pressure has been put on Government by community medicine or anyone else to discharge its responsibilities.

To illustrate these from food and nutrition: shouldn't statutory food labelling be used for health education? The only way a mother will know that the tin of Coca Cola she gives her child contains five teaspoonfuls (10 lumps) of sugar is by reading a slimming magazine. If we want to promote brown and wholemeal bread the price should be the same as white—which means a subsidy since there is no way that individuals can reduce the price. If Government is serious about reducing intake of saturated fat, as both official and independent committees have advised, real freedom of choice should be offered—with, for example, a readily available low-fat milk such as is already enjoyed in several European countries. And so on. . . . These examples are a further reminder that the machinery of Government for health is no longer adequate; it does not reflect how much other departments *and budgets* as well as those for health are implicated. Exercise, smoking, and alcohol raise the same issue. The Royal Commission has not helped with any of this, and it is time that we started a serious debate.

However, what is expected of society is bedevilled, too, by historicism and by nostalgia for a simpler past.⁵ What is wanted today is a new type of partnership between society and the individual.⁶ The authorities can enable people to mend their ways, and Government itself has the responsibility to counter the multi-million antihealth forces. But in the end the individual—and parent—has to decide his behaviour. In the unavoidable uncertainties of the new knowledge, and the variability of personal needs, this will often be so difficult that many people, including many GPs, wonder whether the movement can

London School of Hygiene and Tropical Medicine, London WC1E 7HT

J N MORRIS, D SC, FRCP, departments of community health and human nutrition

succeed unless individual guidance is offered. This applies particularly among the lower social classes, who need it most and whose life style is responding least to the general message—so assuring the continuation of social inequalities in health. The primary health care team is uniquely placed to give such support as part of comprehensive care. It would mean a revolution in general practice, in training and resources as well as in attitudes. A glorious future?

MATERIA NON MEDICA

Botched

Having just had my car battery replaced at the garage, as soon as I noticed the mechanic struggling with the screw of the retaining plate (must have stripped the thread, he said), I knew at once that the "botch factor" was again at work. I am certainly not the first to suffer from it but may be the first to describe it. It appears to affect all workmen who enter my house or deal with my car.

It means that if I ask a television service engineer to repair the tuner on my set, I know with quiet certainty that the following day the switch or volume control will give up the ghost. Or, as happened recently, if the flame failure device on our gas cooker needs replacing one knows instinctively that when ultimately the job is carried out the delayed-action mechanism will no longer work.

Why should this be? Those of you who lack this factor will tell me that disturbing one delicate mechanism puts another out of joint, but it is my firm belief that the job is simply botched—done as quickly as possible for the maximum charge obtainable. Thus we must postulate that some people or their houses or cars secrete the botch factor, an antibody-like substance which exerts its malign influence on all involved with them.

I have no idea how to deal with it, unless somebody can discover a substance as simple as ABC (anti-botch chemical). Until then I will continue to suffer from sinking of the heart (cardiolapsus) triggered off by hearing those fateful words "service engineer."—MYER GOLDMAN (consultant radiologist, Liverpool).

A coup defeated

La Paz, Bolivia, 1.11.79, 7 am. "Can we have a taxi to the airport, please?"

"Sorry, there was a military takeover at 2 am and the airport is closed. Keep off the streets—it is very dangerous."

We had stumbled into Bolivia's 182nd revolution in 200 years. A National Assembly had been elected three months before by the first free elections for 15 years. Colonel Natusch Busch had been an energetic minister in a previous military administration, and, ostensibly because of inefficiencies of the present democracy, he now led most of the Army in a sudden takeover.

During the first day there seemed little reaction. In the suburbs of La Paz many Indians treated the day as a holiday, but we found the main street blocked by tanks and we were not allowed through; far away I could hear gunfire. A Belgian managed to get through to St Francis's Square, where there were workers' and students' demonstrations which he said were put down by tank charges and machine-gun fire.

On the second day we were allowed into the town from our hotel. In Government Square 18 tanks were massed with 30 or more armoured cars with machine guns at the ready. Civilians were allowed up the sides of the square but hundreds of soldiers pointed automatic weapons at us. The National Assembly was closed by armed troops. I looked at the lamp post from which a reforming President had been hanged in the 1940s.

On the third day civilian reaction and demonstrations began. Armed troops were everywhere, some perched menacingly on high buildings and small hills, armoured cars patrolled the streets, and ambulances careered down them with Red Cross flags displayed. Planes and helicopters flew low over the city, occasionally attacking the crowds. Several tourists tried to get to the airport but could not get through because of barricades put up by workers fighting the troops. Among the dead bodies near these barricades lay women with babies in their arms, they told me.

References

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The National Assembly met secretly and for the most part proclaimed its resistance to Colonel Busch. Martial law was introduced and the population ordered back to work. They turned up for an hour or two in the morning and then went home. Offices, newspapers, and public works did not function and civilian opposition was almost total; some police and army units joined them.

On the sixth day gunfire increased and nervous troops were everywhere. Bursts of random gunfire killed people in the main street and the atmosphere grew tense and menacing. The diplomatic corps organised a convoy of stranded tourists out to the airport escorted by tanks, helicopters, and hundreds of armed troops who lined the route. The first plane to fly for six days took us to Lima after the longest and bumpiest take-off of my life.

During the next seven days the strikes and non-co-operation with the régime continued and the National Assembly still held out despite many threats. All US aid was cut off; the Andean Pact countries actively opposed the régime and no country recognised it. Colonel Busch and his ministers found that they could not govern and had to resign. The former President of the National Assembly, a lady, is now President of a once-more democratic Bolivia.

It was a privilege to see how largely unarmed civilian resistance could overcome a violent and bloody military coup. Estimates of deaths lay at 200 to 400 and the coup was regarded as one of the bloodiest in Bolivia's history. The resistance was a heartening demonstration of determined and successful democratic power. No doubt the remaining South American military régimes have noted this—even Chile denied complicity in the military coup. President Carter's pursuit of democracy in South America should be applauded, while democracies all over the world must stick together.—ARNOLD PINES (consultant physician, Hertford).

A new flirtation

The most rabid protagonists are invariably the newly converted. So is it with my current relationship with the humble pushbike.

My scoffing at colleagues while they divest themselves of bicycle clips and capes has ceased; no longer shall I snigger during ward rounds as the houseman's comments on Mrs Smith's occult blood tests are obscured by rising wraiths of steam from his drying trousers, for the two-wheeled revolution has arrived, and I have firmly climbed aboard.

Nowadays the physical enjoyment in quadrupling gluteal lactate production is matched by the smugness in overhauling one's consultants, who, with vasospastic coronary arteries due to sympathetic overdrive, sit traffic jammed. The coup-de-grâce delivered by the urban cyclist is parking, and there is no better illustration than the hospital car park.

The aggression displayed by irate doctors, who circle gladiatorially hunting for space, while their outpatient numbers steadily increase, is scarcely credible. It is difficult not to gloat as when waving cheerily and padlocking the trusty steed to convenient railing, a blaring of horns and clangour of bumpers announce the loss of yet another no-claims bonus.

To be fair, as with all new flirtations, there are drawbacks; undoubtedly the Scottish topography and climate are chief amongst these, and Edinburgh's reputation for icy blasts is matched by its precipitous, and frequently cobbled, streets. Even worse are the intrinsic disadvantages, and saddle designers have not yet heard of the adverse effects of intermittent prostatic massage. Still, all things can be turned to profit and I may yet be credited with the definitive account on the diagnostic and treatment of "cyclist's crotch."—COLIN ROBERTSON (registrar in renal medicine, Edinburgh).