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New thoughts for the Health Education Council

In January the Health Education Council will have a new chairman, Mr Brian Bailey, and in November Dr David Player took over as director. We welcome this new blood and have great hopes that these changes will galvanise the HEC and set it about its massive task with a new energy. Dr Player comes with a reputation established as director of the Scottish Health Education Group, and undoubtedly Scotland's loss is England's gain. The Scottish group has so often led—for instance, with its sponsorship of the Scottish football team in the World Cup—with the HEC either limping along behind or not following at all. Now the lead should come from south of the border, and the proximity of the HEC to Westminster and Fleet Street will mean not only that busybodies will be peering over the director's shoulder but also that his every achievement will be noticed in the right places.

Mr Bailey is a newcomer to the vicissitudes of health education, but he is said to be a clear thinking man of action—both attributes that are badly needed in health education. His experiences as chairman of the South-west Regional Health Authority and of Television South West will both be very useful because, as we elaborate later, the HEC needs better and closer links with both the NHS and the media. His knowledge acquired as a trade union organiser will also be invaluable.

But these two new recruits have a formidable task ahead of them. Death rates from coronary artery disease have only just begun to fall in England and Wales, and are still much higher than in Scandinavia. The prevalence of smoking has fallen a little, but it has not fallen as far or as fast as in many other countries, and social classes IV and V are still smoking almost as much as they did 10 years ago. Alcohol problems are at a crescendo. We have an epidemic of sexually transmitted diseases, and unplanned pregnancies are still all too common. Inequalities in health between different classes and different parts of the country show no signs of diminishing, and these are just some of the more serious problems which the HEC will have to help alleviate.

The HEC has achieved little since it started in 1968. Dr Player will be its fourth director, and yet somehow it never seems to have got properly off the ground. It has a poor image among many of those concerned to raise the health standards of Britain: they think of the HEC as unimaginative and bureaucratic. Among the general public we suspect that the HEC has no image at all—most people never seem to have even heard of it.

Hence one of the first things the new director and chairman must do is to give the HEC a higher profile. They might even consider changing the name to the Health Promotion Council, a change that might have several advantages: it would signify a new start; avoid those tedious arguments about whether the HEC is an educator or a propagandist (undoubtedly it must sell health); and allow it to shift its emphasis from threatening people with the horrors that await them if they continue to smoke and drink to convincing them of the benefits of full health. With a new name the HEC must then go out and court the media. Fleet Street is on its doorstep; the chairman has connections with the independent television companies; with programmes like *So You Want to Stop Smoking* the BBC has already shown its willingness to make health promotion programmes; and Channel 4 has a statutory requirement to make educational programmes. The HEC cannot control the media but if it responds quickly and brightly to their inquiries (which it has not done until now) and creates news rather than simply reacting to events then it will soon have a much higher profile. And, remember, copy on editorial pages and items in programmes come free and attract more attention than the advertisements. The HEC will never have the £200m that the tobacco and drink companies have to splash around on advertising, but it can inveigle itself on to the editorial pages more easily than these can, for it is one of the "good guys."

But the HEC must court many other groups as well. The whole country is interested in being healthier, and if it approaches them in the right way most people will be on its side. It should start perhaps with the NHS itself. As a doctor, the director will not find it difficult to work with doctors, and he should forge strong links with the royal colleges, the BMA, medical schools, and all other organisations of doctors. Health education has not always commanded the respect of doctors, but people still listen to them—both collectively and individually—and the HEC must work closely with them. General practitioners in particular must be brought on to its side: in one week several million people in Britain come into contact with their GPs, a golden opportunity for health education.

Nurses, health visitors, midwives, and the many other groups of health workers must also be courted. One particular group

that should be approached are the health service administrators. Undeservedly they get a bad press, and yet, with the Department of Health and Social Security's policy of devolving power to the districts, administrators will be crucially important if more emphasis is genuinely to be given to prevention. The HEC should participate in training all these groups, supplying them with information, aids, and support. It must also create closer links with groups outside the NHS—especially industry and the trade unions.

One group of the greatest importance are the politicians. As Sir George Young has said, many of the country's health problems can be better managed by decision at the cabinet table rather than by incision on the operating table. Trying to limit the consumption of tobacco and alcohol has a considerable political component, but the HEC's job will be more to work with the DHSS and the Government than to antagonise them too much. Putting in pins where they hurt may be left to Action on Smoking and Health, Action Against Alcohol Misuse (if it ever gets started, and we are sure that it must), the Coronary Prevention Group, and other pressure groups, but the HEC will have to make its voice heard on political action to improve health problems. It should also let members of Parliament know what it is up to, possibly by inviting them in small groups to informal briefings at regular intervals. All MPs should be interested in the health of their constituents even if they are consultants to tobacco companies.

Once the HEC has impressed the politicians with its energy and enthusiasm—not to mention the immensity and importance of its task—it might ask them for more money. At the moment it has £8½m a year, but, given that prime time television advertising costs about £80 000 a minute (the whole HEC budget would not make a two hour commercial), that the drug industry spends £120m a year promoting its products within the NHS, and that the HEC has such a wide range of problems to cover, that sum does not seem nearly enough. It needs at least £25m, and, furthermore, it should have no difficulty in producing economic arguments that effective campaigns might lead to savings in lost productivity and to the NHS of much more than this amount.

So what must the HEC do with its new friends, influence, and money? Smoking must be its priority. We have incontrovertible evidence on the dangers of smoking, and as many as 95 000 Britons a year may die prematurely because of their smoking. Yet Britons continue to smoke heavily and the Government refuses to take effective action. Indeed, it has just signed a very weak voluntary agreement with the tobacco industry on the promotion of tobacco products, and the wicked web of tobacco sponsorship of sport and the arts seems to extend a little further each day. If sponsorship is not effectively countered then many of the leisure pursuits of the British will depend irreversibly on tobacco money. The HEC must be imaginative and opportunistic in its campaigns to limit smoking, and it should sell the British people the joy of not smoking and living a healthier life style. We are confident, too, that it will not touch the £11m so cynically provided by the tobacco companies for research into any kind of health promotion that does not include studies of smoking—"blood money" as Dr Player himself has so aptly called it.

Next on the list must be alcohol problems. Hit by the recession the country is drinking less, but alcohol is still causing an immense amount of social and health damage. Britain needs to drink less, and the HEC must convince not only the British people but also the Government of this. After several false starts the campaign in the north east to change people's attitudes to alcohol seems to be showing signs of success. The time has surely come to extend that campaign to the rest of the country.

HEC campaigns to convince people of the benefits of not smoking should contribute to bringing down the mortality from coronary artery disease. But perhaps the time is also right to start campaigns on diet and exercise. The evidence on the link between the two and coronary artery disease is hardening all the time. But is it time to act and what advice should be given? The HEC needs expert advice on this problem, as it does on several others, and, we believe, it should appoint more expert advisers. The HEC should be a centre for definitive information on current health problems, and it might well consider putting out regular position papers on rapidly developing topics.

Contributions of expert and academic advice would also be useful for the vitally important HEC evaluation programmes. It must know that it is getting maximum value for its money, and, as well as evaluating the effectiveness of campaigns, it should make pilot studies before launching any campaign. Too often the HEC's slogans have been misunderstood. The corollary of piloting and evaluating is that it must scrap those activities that are not working. Dr Player has already shown himself willing to take decisions to abandon projects on this ground.

Finally, there are two other possible new directions. Firstly, the HEC should try to do something about the regional inequalities in British health. A good start might be to create a regional office with its own director in both Wales and Northern Ireland. Secondly, it should consider directing more of its campaigns specifically at women and their problems. Women are beginning to catch up men in their smoking and drinking habits, but are at the same time more concerned with the importance of health than men. As part of its drive to force better links with the media the HEC should not forget women's magazines, which are read by millions of British women every week.

So here are a few ideas for Christmas stockings and New Year resolutions for the new chairman and the new director. Excited by their appointments, we look forward to working with them to see Britain healthier at the beginning of 1984 than it is at the beginning of 1983.

Measles and Indians

One hundred years after Columbus discovered America in 1492 the population of indigenous Indians in the Caribbean, Mexico, and Central and South America had dropped from around 130 million to 1·6 million.[1] This catastrophic decline was due to disease introduced from the Old World, with smallpox and measles the main killers. The peaceful Arawaks and the warlike Caribs were virtually extinct and the Aztec and Inca civilisations had crumbled away while the Spaniards, immune to the infections since childhood, were able to claim divine protection.

Smallpox and measles have much in common: very infectious, they have a high mortality in populations not previously exposed while giving survivors lifelong immunity. Both are recent introductions to the burden of human disease. They were unknown to Hippocrates, who could not have failed to describe such distinctive, dramatic infections. Probably fevers