PRACTICE OBSERVED

Practising Prevention

How the Health Education Council can help

ALAN MARYON-DAVIS

Health education is the basic tool of prevention at all levels, from promoting healthy lifestyles to managing illness and rehabilitation. In primary care, giving patients information and advice is a fundamental part of the job. Yet the practical difficulties of getting the salient facts across in the time available, so that they may be understood, remembered, and acted on, are often so daunting as to reduce the attempt to little more than lip-service. But help is at hand through the local health education unit and from central organisations such as the Health Education Council (HEC).

Health Education Council

The HEC is a Government-funded but otherwise independent body, whose role is to promote and co-ordinate health education in England, Wales, and Northern Ireland. In Scotland the equivalent body is the Scottish Health Education Group (SHEG). To the general public the most visible aspect of the HEC's work is its mass media advertising campaigns, such as "Look After Yourself!" (diet, exercise, and smoking), "Superman" (children's smoking), and "Mother and Baby" (antenatal care). Less widely known is the extent to which health education has been promoted in schools by using specially developed HEC packs of materials to facilitate teaching. But there are several ways in which the HEC, working closely with the 400 or so health education officers throughout Britain who are employed by district health authorities not the HEC, can contribute more directly to health education in general practice.

Publications

The most immediate and practical support comes in the form of leaflets, booklets, and posters. There are 175 different items in the HEC's Publications Catalogue, most of which are

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appropriate for use in general practice. All have a strong preventive bias and deal with subjects ranging from infant immunisation to self-care for cystitis. Apart from posters and "pick-up" leaflets for the waiting area, more and more booklets are designed specifically to support and extend the verbal advice given in the consultation. An example is the GUS Kit (Give Up Smoking), which was developed jointly with Action on Smoking and Health. The package comprises a patient's booklet on how to give up smoking, a booklet with facts about smoking for the doctor, posters for the waiting room, and a note for the receptionist on how to use the kit. The patient booklet has the facsimile of a prescription form and the words "Give Up Smoking." By adding the patient's name and the practice stamp, the doctor can "personalise" the booklet so that the patient is more inclined to retain it and follow its advice. Another booklet for use by general practitioners is *Minor Illness: How to treat it at home*. This gives practical advice on self-help for coughs, colds, sore throats, minor trauma, vomiting, and diarrhoea. It was written and evaluated by Morrell,¹ who found it had an important moderating effect on requests for consultations and home visits.

Like all HEC publications, the GUS Kit and *Minor Illness* may be obtained free of charge from district health education units, or, in case of difficulty, direct from the HEC Supplies Section. The latest edition of the HEC Publications Catalogue, including items in Welsh and Asian languages, may also be obtained from the same source.

Using local radio

There are nearly 60 local radio stations in Britain providing an important potential for health education. Although health experts, particularly general practitioners, are much in demand for interviews and phone-ins, many opportunities are wasted through poor broadcasting technique. The HEC, in conjunction with the BBC Local Radio Training Division, organises one-day workshops in basic technique for beginners, offering practical advice in a real studio setting. Although intended primarily for doctors, the workshops are open to other health care personnel, tuition fees being met by the HEC. Many of the doctors who

Number and percentage of children in the practice who were immunised against diphtheria, tetanus, polio, pertussis, and measles, and the number and percentage of children who were immunised by general practitioners

Year of birth	No. in age group	Diphtheria No. (%)	Tetanus No. (%)	Polio No. (%)	Pertussis No. (%)	Measles No. (%)	No. (%) immunised by GPs
1 March 1975-29 February 1976	121	102 (84.5)	102 (84.5)	102 (84.5)	45 (37)	36 (31.5)	25 (20.5)
" 1977-28 " 1978	127	106 (83.5)	106 (83.5)	106 (83.5)	46 (36)	37 (31.5)	26 (20.5)
" 1979-28 " 1980	115	100 (86.9)	100 (86.9)	100 (86.9)	47 (41)	38 (33)	27 (23.5)
" 1980-28 " 1981	120	111 (92.5)	111 (92.5)	111 (92.5)	52 (43.5)	42 (35)	28 (23.5)
" 1981-28 " 1982	136	133 (98.5)	133 (98.5)	133 (98.5)	60 (44)	48 (35.5)	30 (22)

We made a survey of the annual take-up rate for primary immunisation in children born between 1 March 1975 and 28 February 1981. Our census date was 1 March. We will audit six-monthly.

Method and results

The children were identified through the age-sex register and their immunisation status retrieved from their records and health authority clinic records (table). The immunisation take-up rates for Enfield and Haringey District Health Authorities are shown in the figure. The immunisation schedule was as follows: at 3 months diphtheria, pertussis, tetanus, oral polio; at 4½ months diphtheria, pertussis, tetanus, oral polio; at 9½ months diphtheria, pertussis, tetanus, oral polio; at 15 months measles.

Percentage of children in Enfield Health District who were born between 1976 and 1980 and were immunised against diphtheria, tetanus, polio, pertussis, and measles; and percentage of children in Haringey Health District who were born between 1976 and 1980 and were immunised against diphtheria, tetanus, polio, pertussis, and measles.

Discussion

Since we started developmental surveillance and immunisation of the children in our practice in September 1975 our take-up rate has improved as the number of children immunised by the general practitioner has increased. The rate for whooping cough has increased by 40%, despite adverse publicity by the media, and has overtaken the take-up rate at health authority clinics. Our take-up rate of diphtheria, tetanus, and polio is also better

than the health authority clinics. We think that this is in no way a criticism of the health authority clinics, but rather that general practitioners have the advantage over the community doctors in being concerned with families over a long time, thus having the opportunity to "think prevention" with parents before the child is even conceived. The number of children with no record of immunisation has decreased.

Our immunisation rate for measles is poor. Some of the children acquire measles before the age of 15 months, and an appreciable number fail to attend for immunisation. When we discussed this at our last meeting of mothers and toddlers the mothers admitted that they forget about appointments and get out of the habit of attending clinic after the child has reached 1 year of age. They also felt that measles was not such an important or serious disease as diphtheria or polio. We hope to encourage defaulters by doing more counselling, sending them second appointments, and offering immunisation when the children attend for their assessment at 3 years.

In Devon general practitioners provide an average of 83% of immunisations in children. A notable improvement in the immunisation rate for diphtheria, pertussis, tetanus, polio, and measles has been seen.² Our survey shows a similar trend.

Conclusion

The results of a survey to audit our primary immunisation programme confirmed what we thought—that preventive health care for children can be carried out in general practice. The accessibility of the general practitioner and the continuing relationship between doctor and patient make health education and counselling much easier. Good team work with health visitors, midwives, clinic clerks, and receptionists is a great advantage. This supports the conclusion of the Court Report,³ that therapeutic and preventive child care should be integrated into the work of the primary health care team.

We are grateful to Mrs Ann Crick and Mr Anthony Powell for doing the research into the age-sex register and records; to Mrs Crick for typing; to Miss Teresa Perugini for sending all our appointments; to our midwife and health visitors past and present, particularly for not giving conflicting advice; and to our secretaries and receptionists for running the clinics smoothly.

References

- 1 Immunisation against infectious disease. Joint Committee on Vaccination and Immunisation for the Secretary of State for Social Services. May 1982.
- 2 *Healthier children—thinking prevention*. London: Royal College of General Practitioners, 1982.
- 3 Committee on Child Health Services. *For the future*. 1976. (Court SDM, chairman.)

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have attended workshops are now regular broadcasters on local radio. Details are available from the author.

Research

The HEC funds research into health education in general practice. For example, a major study undertaken by the Health Education Studies Unit has analysed over 2000 audio-taped consultations to find ways of improving doctor-patient communications and using the many preventive opportunities that arise. Results will be published shortly. At the Welsh National School of Medicine the ways in which the lifestyle of working class mothers affects the attitude and actions they take to pursue health and avoid illness is being studied.

The HEC is expanding its research funding in general practice and will consider projects on a large or small scale that have a substantial health educational element, especially if they relate to the HEC major programmes concerning heart disease, misuse of alcohol, or antenatal care.

Training

One of the main aims of the HEC is to promote the teaching of health education skills to health professionals. To this end the HEC sponsors diploma courses, seminars, and workshops for nurses, health visitors, and doctors. More and more vocational training courses are incorporating sessions on health education in general practice, to which the local health education officer, or the HEC itself, can contribute by providing speakers and teaching aids.

Other activities

On a broader front the HEC can help less directly by contributing to the public's overall awareness of healthy lifestyles and

how to cope with illness. By promoting health education in schools and by working closely with journalists and producers of radio and TV programmes, the HEC can help people to take on a greater responsibility for their health and to avoid illness. The HEC has provided, literally, millions of booklets to back up various television series: most recently the three BBC series "Feeling Great," "Play It Safe," and "So You Want to Stop Smoking."

Important target groups for health education are those who shape our lives more than anybody else: politicians, planners, and managers in industry. In line with its politically independent status the HEC attempts to put the view of health educators as a whole with regard to such issues as sports sponsorship by tobacco companies or nutritional labelling of foodstuffs.

Further information

The HEC's regular newspaper *Health Education News* is sent free of charge to those who request it. Further information on any aspect mentioned in this article may be obtained by writing to the author at the address below:

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78 New Oxford Street
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The Scottish Health Education Group
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Reference

- 1 Morrell DC, Avery AJ, Watkins CJ. Management of minor illness. *Br Med J* 1980;280:769-71.

Practice Research

Survey of immunisation in a north London practice

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Our practice has a population of roughly 8000 patients, who are mainly in socioeconomic groups 3, 4, and 5. We are a partnership of four principals in a purpose-built health centre in north London. We work with attached health visitors, a midwife, district nurses, and geriatric visitors, and employ secretaries, receptionists, and a practice nurse, and liaise with social workers. In September 1975 we began a developmental assessment and immunisation programme for children. The clinics were run as separate sessions outside normal surgery hours by general practitioners and health visitors, with help from the secretarial

reception staff. The injections were and still are given by the doctor. All new babies, whether born in hospital or in a GP obstetric unit, are seen when they are 10 to 14 days old at home, and then at the clinic at age 6 weeks, 3 months (when the immunisation programme begins), 7½-8 months, and 2½-3 years. Immunisation is always mentioned at the 6-week visit to allow parents at least six weeks to think about the procedure. We always discuss fully the indications and contraindications for immunisation and mention particularly the difficulties caused by the media about whooping-cough vaccine. Parents are encouraged to take up immunisation for their children if there are no contraindications. They are invited to return during "ordinary" surgery for further discussion if any doubt remains in their minds. Appointments are sent for all attendances at the "baby clinic." All the reasons for not immunising a child are entered in both the ordinary records and the clinic records. Whooping-cough vaccine is not given if parents refuse consent.

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Meeting Report

No progress in Bloomsbury

TESSA RICHARDS

If you are a pensioner and live in central London your chances of being accepted on to a doctor's list can be as low as one in five. This inflammatory statement fuelled a debate on the state of general practice in the central London district of Bloomsbury. This was organised by the local community health council, and there was no lack of participation from the heterogeneous audience—psychotherapists, social workers, patients, local GPs, and stalwarts from the family practitioner committee (FPC) as well as the members of the Bloomsbury Community Health Council (CHC). The truth of the opening statement was argued acrimoniously and at length.

Alan Berson, the chairman of the CHC, introduced Eileen O'Keefe who gave a quick summary of CHC's *raison d'être*—maintaining community services in an area dominated by teaching hospitals. She then launched into the findings of their recent survey, which looked at primary health care in the new health district of Bloomsbury (formerly South Camden and Westminster North East). This area has special problems: a large elderly population, a rapid turnover of people, and a large number of single people living in bedsits. The impression of CHC, supported by the findings of previous reports, including those of Acheson and Jarman, suggested that the GP service in Bloomsbury was not meeting the needs of patients and of the elderly in particular.

The survey followed the fate of fake patients, a young single woman, a woman with two young children, and an old age pensioner. They telephoned the 62 practices listed by the FPC in the Bloomsbury Health District, and spoke to either the receptionist or a doctor, and asked to be registered. Less than half of the contacts resulted in definite acceptance. In general, single handed practices seemed less willing to accept new patients than group practices, and a hard core of 10 single handed practices seemed to refuse all NHS patients. As had been suspected, it was the elderly patient who had most difficulty in getting registered. Advancing age seems to be a feature not only of the patients, but also the doctors in this area, where nine in five of the GPs are over 65 and one in 10 more than 70.

Over the last few years there have been several surveys looking at general practice in inner London, and there now seems little doubt that primary health care in many areas—especially Bloomsbury—is not working well. The CHC's report does not seek to lay the blame (with the exception of the 10 practices mentioned above) entirely at the feet of the single handed practitioners. Indeed, they seem to take a slightly higher percentage of old people on to their lists, and their list

sizes compare favourably with their colleagues in group practices.

The questions raised by this report and its predecessors are endless, and most remain unanswered. Do elderly doctors really pull their weight? Why are they not given incentives to retire at an earlier age? If they did, would substitutions of bright young things fresh from their vocational training schemes solve the problem? Do doctors in these inner city areas have too many commitments outside the NHS, or is it that there are too few doctors? If this is so, who should take responsibility for putting pressure on the medical practitioner committees, and where would the money come from to finance these extra doctors and their new surgeries? The urge to go on asking speculative questions is great, and it is unfortunate that the arguments they generate all too often lead to non-productive emotional discussions. So what constructive dialogue came out of this meeting? Alas, not a lot. The methodological faults of the CHC's survey were mercilessly exposed by a well briefed representative from the FPC. Like a conjurer with his rabbit he pulled a mass of statistics out of his hat, which were convincing if at times confusing, and nearly demolished the CHC contingent. More fak came from a local GP who pointed out that most patients get on a doctor's list by coming up to the surgery or requesting a home visit—hence the telephone based survey was misleading and probably invalid. After nearly an hour of fruitless argument, one or two helpful proposals were put forward. GP units in the teaching hospitals could have a much larger role in the community, though exactly how this might be achieved was not discussed. Several people thought there was a definite need for two or three new health centres in the area. The FPC representatives defended the single handed GPs and reminded us that the FPC welcome members of the general public approaching them for guidance on how to find a suitable doctor. They were not complacent, and expressed a desire to enter into discussion with the appropriate authorities, with doctors, and with the residents of Bloomsbury. They ultimately emerged as doves, eager to fly back and forth promoting communication. The Medical Practitioner Committee was seen as hawish: it has the power to create new GP posts but for some mysterious reason seems most reluctant to do so.

No one could criticise the audience for a lack of sincerity, and all were concerned that the patients in Bloomsbury may not be getting a fair deal. By the end of the evening few were denying that a problem exists, and most agreed that something should be done to improve the primary health care service in the area. But as Dr Conrad Harris wryly implied in his closing remarks, one had been there before. The tenor of the meeting and the progress that was made could be summarised in the words of a representative from the newly formed Bloomsbury Health Authority. "We are very concerned, but we don't have any policies yet."

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