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The Health of the Nation: responses

First steps towards a strategy for health

Richard Smith

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.

This quote from Mr William Waldegrave, Secretary of State for Health comes from his introduction to *The Health of the Nation*, the consultative document that sets out a strategy for improving the health of the English.¹ It's a pity that the strategy for the NHS didn't follow the same philosophy (and Mr Waldegrave has said so himself),² but it is true that the strategy for health will not work if the many individuals and organisations that will have to act to make it work do not feel any ownership. As John Harvey-Jones, the former chief executive officer of ICI, explains in his book *Making it Happen*, this does not have to mean that the strategy degenerates to the lowest common denominator that everyone can agree on: people and organisations will put their backs into making a strategy work as long as they are convinced that they have been heard—even if not all of their proposals have been accepted.³ And they cannot all be. As Mr Waldegrave says elsewhere in his introduction: "priorities are meaningless if they include everything."

Taking Mr Waldegrave at his word on wanting to listen to everybody, we have commissioned a series of articles in response to *The Health of the Nation*. They address each of the 16 key areas identified in the strategy and other subjects that might qualify as key areas. For each key area we have asked authors to make the case that it should be a key area; consider the case against; identify what the targets should be within the key area; suggest a strategy for reaching the targets; and then identify barriers to reaching them. Not all of the papers will follow exactly this format. We are also publishing with this article a paper by Allyson Pollock from the Radical Statistics Health Group: she is strongly critical of the strategy (p 299).⁴ Readers are invited to contribute to the debate through our correspondence columns, and this has already begun (20 July, p 148).^{5,6} At the end we will attempt a summary. We plan to publish all of these articles before the end of October, when the government's consultation period ends.

Why a strategy?

Effective organisations know where they are going. "The secret of success," said Benjamin Disraeli, "is constancy to purpose." Organisations that drift—like much of British industry in the past—are prone to disappear. Organisations that have strategies can concentrate on what they do best and devote resources (which are always limited) accordingly. The strategy should motivate people and allow them to work hardest at the activities that will produce the richest return. Setting a strategy also forces people to look to the future, making it more likely that they will see emerging opportunities early and be able to exploit them and notice the spot on the horizon that is an express train coming to destroy them—giving a chance of getting out of the way.

The figure is a device for analysing the effectiveness of organisations. The more effective live in the top right hand corner and have a clear vision that is shared by most of those within the organisation: Toyota, IBM, Sainsbury's, the Vietcong, and Intentional Physicians for the Prevention of Nuclear War have been in this square. Most organisations exist in the least effective, bottom left hand corner—with little sense of collective vision. The NHS has probably been in the bottom right hand corner with a vision that has been shared but unclear. *The Health of the Nation* might push it to the effective top right hand corner, or

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disagreements and poor morale within the service might push it into the bottom left hand corner, where even the sense of working together on something important is lost. The next few years will tell.

The Department of Health has come late to the idea of a strategy with targets.^{7,8} The World Health Organisation set targets in 1978 with its slogan of "health for all by the year 2000."⁹ and the European Office of WHO followed this up with its 38 targets in 1985.¹⁰ The United States,¹¹ Wales,¹² Scotland,¹³ Northern Ireland,¹⁴ and many other countries⁷ have all set targets during a time when the English Department of Health seemed sniffy about the whole process. Why, cynics inevitably wonder, has the department come round? Is it a change of minister or, as *The Health of the Nation* suggests, because the reforming of the NHS has made possible what was previously impossible? Or is it to divert political attention from the agonies of the NHS? Whatever the reason the strategy deserves to be taken at face value, and that is what we are doing. It will be highly worth while as long as the consultation is genuine—which Mr Waldegrave insists it will be.

What sort of strategy?

Once an organisation has decided that it needs a strategy there are various ways to go about developing it. Essentially the organisation must make a detailed analysis of its present position (and the professors of strategy have many ways to cut the cake); then it must decide where it wants to go and how it is going to get there. The Department of Health has many difficulties with this process: the data for fully assessing the present position are, as *The Health of the Nation* concedes, inadequate; it is politically difficult for the department to draw up a full list of weaknesses and strengths in the way that a company would do behind closed doors; and the strategy is not just for one organisation but for many. The glossy document is disappointingly repetitious and defensive, and, as the Radical Statistics Health Group argues (p 299),⁴ there is much more on the NHS than on the broader aspects of health.

The Department of Health has defined the aim of the strategy—"to improve the span of healthy life"—and then combined this aim with some "key strategic policy objectives and guiding principles." These comprise

Possible key areas

Causes of substantial mortality

- Coronary heart disease
- Stroke
- Cancers
- Accidents

Causes of substantial ill health

- Mental health
- Diabetes
- Asthma

Contributing factors to both mortality and morbidity and to healthy living

- Smoking
- Diet and alcohol
- Physical exercise

Where there is clear scope for improvement

- Health of pregnant women, infants, and children
- Rehabilitation services for people with a physical disability
- Environmental quality

Where there is a great potential for harm

- HIV and AIDS
- Other communicable diseases
- Food safety

Criteria for indicators and targets

Indicators and targets should be:

- *Credible*—Address important public health issues that are likely to remain current
- *Clear*—Easily appraised by and relevant to a wide general audience
- *Selective*—The choice of topic should be used to highlight areas that are a high priority for action
- *Compatible*—With current public health strategies
- *Achievable*—Interventions should be available or potentially available. The target must take account of evidence of effectiveness and the delay between intervention and effect
- *Balanced*—Monitor progress through a mixture of process and outcome measures
- *Quantifiable*—Data for the whole United Kingdom are required; if necessary proxy indicators should be used or specific recommendations made for the collection of data
- *Ethical*—Respect the autonomy of individuals and avoid unnecessary value judgments

focusing on the "main health problems"; concentrating as much on promotion of health as on treatment, care, and rehabilitation (but without setting up a false conflict between either); recognising that the health services are only one influence on health; encouraging greater cooperation between those inside and outside the NHS; combining central strategic direction with "local and individual direction, flexibility, and initiative"; and securing the best use of resources.

Following these guidelines the department has then begun to identify "key areas." There are three criteria for a subject becoming a key area: it should be a major cause of premature death or avoidable ill health; interventions offering "significant scope for improvement in health" must be available; and it must be possible to set targets within the key area and then monitor them. The box shows candidate key areas identified in the strategy.

Within each key area targets are to be set that are "realistic but challenging." They are "so far as is possible [to] be expressed in terms of health improvements or—where appropriate—reductions in risk factors... or precursors of ill health." "Above all," says the strategy, "objectives and targets should be agreed by all those who have a part to play in their achievement." Other criteria might have been used, and the Faculty of Public Health Medicine has recently emphasised the criteria used by McGinnis (box).^{15,16}

Most health strategies revolve around measurable targets, and most would agree that this is wholly right. There are, however, problems with targets, as the Faculty of Public Health Medicine has emphasised in its report this summer on levels of health in the United Kingdom.¹⁵ Firstly, they may lead to spurious priority being given to that which is measurable. Secondly, they may represent an oversimplistic description of policy. Thirdly, they may appear unrealistic and be easily dismissed as unattainable.

There may also be practical problems in setting a target. Thus some have used computer modelling, but the government seems to have largely plucked its targets out of the sky. They are the product of "informed judgment," or guesswork.

Making it happen

The easy part of strategic planning is devising a strategy. The difficult part is making it happen. And this is especially true when so many groups are potentially involved. The last box lists some of those who may have a part to play in implementing England's

Those with a role in implementing the strategy

- Individuals
- Families
- Communities
- Health care services
- Personal social services
- Health professions
- The education service
- Voluntary sector
- Industry, commerce, and trades unions
- The media
- Government—central and local
- International organisations

health strategy. The Department of Health is inviting comments from anybody interested and plans after consultation to "issue a further document which will define and set in motion a health strategy for England."

Some governments have set targets and then left it to others to work out how to achieve them. The Department of Health insists that it will be more hands on, but at the same time it doesn't want to stifle "local discretion." Thus the secretary of state has set up an "English Health Strategy Steering Group" to advise him. It will be supported by three expert working groups: one to cover "the wider public and political dimensions" and link industry, the media, and other government departments; one to consider health priorities and measure progress and develop scientific interventions; and one to look at how the NHS can implement the strategy.

Within the NHS the secretary of state can at least crack the whip and make sure that the strategy is "built into NHS management systems—contracts, collaborative arrangements, audit, planning, monitoring and review." The green paper spells out what regional and district health authorities, family health services authorities, and "provider" units might do.

For the health strategy to have real impact the other groups who may have a part to play in implementing the strategy will also have to take action, especially as the health services themselves have only a limited impact on health. And why should Thames Television, Nuneaton Social Services, or the BMA do their bit for the health strategy? They will have to be persuaded, which is why real consultation is so important. And most difficult of all to persuade might be other govern-

ment departments (not least because they are chasing their tails trying to deliver on the citizen's charter (27 July, p 203)¹⁷). The Department of Health is way down the Cabinet pecking order, and why should the Treasury reduce its income from tobacco, or the Department of Trade and Industry give up on its plans to promote the alcohol industry, one of Britain's biggest exporters and employers? But if the government is at all serious about health then these big fish must be encouraged to swim with the strategy otherwise the many small fish will be reluctant to contribute.

The next problem after initial implementation is to sustain motivation and commitment. This is a particular problem with politically driven strategies—because another party coming to power may be unwilling to follow its opponent's strategy or indeed any strategy.

Conclusion

Many of the contributors to this series will be critical of aspects of the government's strategy, but almost all of them support the idea of a strategy. The government should welcome vigorous debate of its proposals because that is the only way to arrive at a robust strategy to which everybody will be keen to contribute.

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Missing: a strategy for health of the nation

Radical Statistics Health Group

In 1978 the World Health Organisation took the lead towards a clearly defined and quantifiable global strategy for promoting health.^{1,2} Through Health for All by the Year 2000 the WHO called on each of its regions to identify appropriate targets for health to be achieved by the year 2000.^{3,4} The United Kingdom government was a formal signatory but has consistently failed to endorse the 38 targets for health identified by WHO's European region⁵ despite the fact that over 70 local authorities and health authorities in England have independently adopted the European strategy.⁶

Now, after a decade of resistance, does the publica-

tion of the green paper *The Health of the Nation* mark a change in policy?⁷ We have serious reservations. Although the government has monitored its progress towards WHO's targets,⁸ it seems to have rejected many of them and is now setting its own. The targets it proposes seem to be restricted by two concerns: to maximise the efficiency or output of the NHS and to change the behaviour of individuals. Absent from the paper are three principles that are central to the WHO strategy. These are the philosophy that all government policies should take into account their impact on the health of the population, the need to redress social inequalities, and the importance of community partici-

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