necessary it should be performed by an experienced surgeon, avoiding direct pressure over the distal fragment, which may damage the skin.

We thank Mr B F Meggitt and Mr B G H Lamberty for permission to report their patients.

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The Health of the Nation: responses

Children's health

David Hull

The main theme of *The Health of the Nation*¹ is the prevention of ill health and the promotion of good health. One of the suggested key areas is the health of pregnant women, infants, and children. I have been asked to consider the health of infants and children and to discuss what if any are the appropriate targets and how they should be met.

Selection as key area

The consultative document proposes three criteria for the selection of key areas: the areas should be a major cause of premature death or avoidable ill health, effective interventions should be possible, and it should be possible to set objectives and targets. On this basis there is ample justification for including child health as a key area.

The key areas proposed do not have like characteristics; some are concerned with avoiding diseases or their effects (such as asthma) and others with avoiding hazards (such as accident prevention). All the areas are as relevant to children as they are to adults, indeed in many instances, more so. Strategies for disease prevention are likely to have most impact in childhood and the risks of the hazards to health are often greater in the vulnerable years. The benefits of a clean safe environment, immunisation programmes, a healthy diet, avoidance of accidents, psychological wellbeing, etc, are more likely to be greater and last longer when applied to infants and children. The health of children is not only an area it is central to the whole strategy, and so it seems inappropriate to isolate parts of it for specific targets.

Can the government deliver, and if it cannot will it do more harm than good to be identified as a key area? Over the years the government has issued documents urging health promotion and sickness prevention without clear directions on how their recommendations should be implemented. To succeed the strategy has to be central to all health service activities—primary, secondary, and tertiary; health promotion should not be the responsibility solely of enthusiasts with little or no clinical responsibility. The cardiac surgeon should aim at avoiding the need to operate, not at being rewarded for increasing trade.

The authors of the strategy are optimistic because of the opportunities presented by the NHS reforms and the release of the Department of Health from day to day management of services. That suggests a confidence in the future which those of us who see patients would like to share. It was the reformers of 1974 who failed to appreciate the importance of the public health

Possibilities for improving child health and targets in green paper

The scope for safeguarding and improving children's health includes:

(i) For younger children

- Immunisation against childhood disease
- Early detection of congenital and acquired abnormalities including impairments in hearing, vision, growth, and development

(ii) For older children

- Promotion of healthy lifestyle
- Prevention (particularly through education) of smoking and misuse of alcohol and drugs

(iii) For all children

- Accident prevention and safety education
- Improvements in the quality of the environment, particularly housing
- Avoidance of smoking in the household
- Prevention, identification, and treatment of emotional and behavioural problems
- Prevention of dental decay

TARGETS

To increase nationally the proportion of infants who are breast fed at birth from 64% in 1985 to 75% by 2000.

To increase nationally the proportion of infants aged 6 weeks being wholly or partly breast fed from 39% in 1985 to 50% by 2000.

By 2003, nationally, 12 year olds should on average have no more than 1.5 decayed, missing, or filled permanent teeth.

function and planned the contraction of the child health and school medical services, whose primary tasks were precisely those outlined in this new document. Nevertheless, children's doctors have every reason to be optimists and tend to trust those in authority, and we would all like to see the government succeed in this initiative.

Appropriate targets

Though the overall objectives for the health of infants and children are in general admirable, the three proposed targets are weak (box). Two are concerned with breast feeding. There was a welcome increase in the rate of breast feeding during 1970-80² but there has

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Strategies to promote health are likely to have more impact in children

been little sign of increase since; if anything there has been a slight fall. I doubt this reflects mothers' ignorance of the relative merits of breast and bottle feeding but rather social attitudes and expectations. Given the social conditions of our times some might challenge the net benefit of higher rates of breast feeding. The rate of breast feeding in Hong Kong is much lower than that in Britain, but their overall health statistics are better. If health statistics depend on economic success and if economic success depends on two income families then it is employers who can do most to improve the rate of breast feeding. An alternative target might be to reduce the percentage of mothers who express a wish or intention to breast feed on booking for pregnancy care who fail to do so. It is to be hoped that the current breast feeding initiative will succeed and the government's targets will be reached long before the year 2000.

The third target relating to children is to reduce dental caries. This is already a considerable success story, and it is both reasonable and desirable to expect more.

Thus little in these three targets challenges the paediatric and the child health services or the other authorities and departments whose activities affect the health of children. For this reason I wish to suggest some new target areas. The areas are only a sample, and I could suggest many more.

PREMATURE BIRTH

A major cause of neonatal (and therefore infant) death is premature birth. In Nottingham neonatal mortality in babies born before 32 weeks' gestation has improved little over the past 10 years. The rate compares favourably with that in other countries whereas total neonatal mortality, though comparable with the national figure, is above that in some European countries, Japan, and Hong Kong, mainly because we have a higher incidence of premature births. Only 10% of neonatal deaths are in infants over 32 weeks' gestation without lethal congenital anomalies. One target could be to reduce the numbers of preterm births. The percentage of low birthweight infants is one of eight measures used by the Center for the Study of Social Policy in the US for comparing the wellbeing of children in different states. As a target it would have more to recommend it than mortality alone, for if the rate of preterm birth was reduced mortality and morbidity would fall whereas reducing only mortality might increase morbidity.

Preterm births, however, would be only a long distance measure of child health services and are

perhaps more directly an outcome of obstetric care. The strategy document argues that geographic, age group, and social class differences are strong grounds for believing that there are remedial causative factors. Therefore, an alternative target would be to reduce the variation in the numbers of preterm births.

SURVEILLANCE PROGRAMMES

It is important that we learn from the success of the vaccination programme in the past 10 years. In my view success is attributable to two factors. Firstly, there is a strong central leadership which has moved from a permissive stance to actively promoting the programme, exploring the reasons why it was failing, identifying both general and local factors, and addressing them directly and, secondly, a network has been established across the health districts, with doctors identified in each health authority to be responsible for promoting the service.

The same framework is being established for child health surveillance programmes, and they should be given targets within the national strategy. One aim could be the identification of children with poor growth in the first year of life, with a target to reduce the number of children below a certain size at 1 year of age. There is some evidence that poor weight gain in the first year of life is associated with early death from heart disease. Another could be the incidence of iron deficiency anaemia. Chronic iron deficiency is associated with poor performance at school. A third could be the identification of all children in a district with a severe disability (physical, mental, hearing, vision) and to set a target to reduce the incidence over five years and to reduce the difference between the social groups. These tasks would not be that exacting as they are central to any surveillance strategy, but the remedies would require a multidisciplinary programme.

CHILD CARE AND PROTECTION

Family break up is increasing and it is occurring when the children are younger.³ Child care and protection are making increasing demands on many services, including the health service. Homelessness and misery in adolescence also seem to be increasing. It should be possible to identify targets in these areas—for example, that the health of children in care should be equal to that of those who are not (for example, vaccination rates) and that the numbers of adolescents who suffer for want of a sensitive service should be reduced to a minimum, as indicated, for example, by the rates of teenage pregnancies, suicides, or drug misuse.

To meet the green paper requirements a target must be important, avoidable, and measurable. This means that many important problems will be overlooked. I can see no reason why a marker of the problem—for example, teenage pregnancies—cannot be used as a pointer to the health care of adolescents. It would of course require that the association between the marker target and the problem was explored.

Meeting the targets

It would be impossible to do more than outline the strategies needed to address the new targets I have proposed. They all depend on establishing a comprehensive, coordinated paediatric and child health service in every health district. The interface between this support service and the family practitioner service must be clearly defined. Clear central guidance would be needed on priorities and data collection, with informed analysis within each health authority. Success will depend on the wholehearted, informed cooperation of parents; parent held records are a first but important step in enabling parents to share in promoting the health of the nation's children.

It is not difficult to think of reasons why an initiative like this might not succeed. It is essential that the slimmed down Department of Health when it announces its priorities acknowledges that those not included are left out because of resource limitations. It would be wrong and unrealistic to expect doctors and other health professionals to strive to achieve higher and higher standards within their duty to care and to chase centrally set targets without giving them extra resources. The exercise is central to all health service activities and it should therefore be implemented through contracts between health authorities and provider units, all provider units. Even so it will be important to engage the new managers in the spirit of the exercise.

It was encouraging to read the section in the green paper giving the contribution of other government departments to the health of the nation. Many of the initiatives will fail without some requirement that the various departments act together. With respect to child health, there must be local arrangements that ensure the departments of health, social services, and education and local authorities cooperate rather than compete. There has been little success in recent memory. Just look at the special needs registers of the different authorities.

My last concern is one that continually taxes paediatricians in neonatal intensive care: Will we ever be able to adopt a health care policy that admits it cannot afford the most recent expensive high tech approach and that chooses to take a long term, "green" view of its responsibilities?

Closing comment

One of the criteria for a target area is that it can be measured. Quality caring rather than quality care is not easily measured, but it is what patients want. Caring will always depend on the dedication and the professionalism of the staff. The document identifies a "highly dedicated and professional workforce" as one of the strengths of the NHS. That, in no small measure, reflects the education and inspiration provided by those who teach, an aspect of our service in Britain that must not be overlooked in our desire to set clinical standards and outcome measures and desirable targets that can be measured.

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Cancer

C J Williams

The Health of the Nation is a wide ranging consultative document.¹ Though reduction in cancer mortality and morbidity is included as a suggested key objective, only limited aims are included in the section on objectives and targets for action. This is somewhat surprising as cancer is the second leading cause of death and causes more lost years of life than any other disease in Britain.² Indeed, as the document makes clear, England has the highest mortality from cancer among the industrialised countries. Thus cancer fulfils the first of the criteria by which the document judges the key areas—it is a major health problem.

One of the problems with cancer is that it is often thought of as a single condition. Only when viewed as individual tumour entities do some types of cancer achieve the second of the government's criteria for key areas—namely, that effective interventions are possible. The specific targets for cancer identified in the document are shown in the box. Only the targets relating to breast and cervical cancers are mentioned specifically in the section on cancer, though there is clearly an overlap with other topics covered in the document, particularly smoking.

Scope for breast and cervical cancer

The scope of the objectives for breast and cervical cancer contrasts bizarrely. It seems laudable, though optimistic, to expect in a national population a 25% reduction in deaths from breast cancer during a 10 year period when some research workers doubt the effectiveness of screening^{3,4} and when some randomised trials and case-control studies have failed to identify such a large benefit in a similar population.^{5,6} In support of the document's aims two overviews suggest that such a reduction in mortality is possible.^{7,8} It is too early to assess what has been achieved in Britain, but in 1988 the UK Trial of Early Detection of Breast Cancer Group reported the results of mammography every

Government's targets for cancer

- To reduce deaths from breast cancer in women aged 50-64 (the group invited for mammographic screening) by 25% by the year 2000 compared with 1990 values
- To invite all women aged 20-64 for cervical screening by the end of 1993
- To reduce the prevalence of smoking to 22% in men and 21% in women (reductions of 33% and 30% respectively) by the year 2000. This target for cancers associated with smoking is mentioned specifically in the annex on smoking

other year in 45 841 women.⁵ A further 63 636 women were offered teaching of breast self examination, and there was a comparison group of 127 117 women for whom no extra services were provided. These cohorts of women were enrolled between 1979 and 1981. Mortality was reduced in the women screened by mammography. The unadjusted reduction was 14% (relative risk 0.86%, 95% confidence interval 0.69 to 1.08) and even when other factors were adjusted for the reduction in mortality did not reach conventional significance. The reputation of the two screening districts (Edinburgh and Guildford) is high and such skill in breast screening is not available nationally. The acceptance rates of 60% and 72% in Edinburgh and Guildford, respectively, may not be achieved in the long term in a national programme, although it is encouraging that breast cancer is primarily a disease of middle class women and that breast cancer rates among non-acceptors in some studies are lower than those among acceptors.⁹ The authors of this paper emphasise, however, the need for high acceptance rates and high sensitivity of screening (with a likely loss of specificity) if targets are to be achieved. Whether the

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