This simple approach to a health strategy would allow the health of the nation to be improved to the greatest extent whatever resources are available.[5] Yet the strategy document fails to get even close to such an approach. As a result it is flawed in its central logic.

Objectives and targets

A large part of the document is concerned with the objectives for the chosen key areas and what the quantified targets are. With respect to the objectives we suggest that there is a case for re-examining these often rather vague statements to see whether they represent the true objectives of the population. For example, the objective for the cancer programme is stated as, "To reduce death and ill-health from cancers." However, the emphasis is on screening for breast cancer and cervical cancer. Although whether the emphasis is justified is debatable, what is more important is to recognise the concept of reassurance or avoidance of anxiety in such screening programmes. For these health services and many others there is more to the objectives than just health.[6]

The targets given in the green paper are in practise quantification of the objectives. The target for coronary heart disease, for example, is a 30% reduction nationally in death in people aged under 65 years. Why 30%? Why not 40% or 28%? The basis for many of the targets seems to be: "This is where we are heading according to current trends. So if we set the target just a bit better than that, then maybe we can present the challenge to get there." That is a rather appealing way of looking at the issue, but we would question whether it is a sensible way of planning the health of a nation. If the target were set at 28% for deaths from coronary heart disease, what would the implications be for use of resources? And if it were 40%—would it mean that far too many resources were spent on coronary heart disease in the sense that the loss of opportunity would be too high in other programmes? These key issues are not even raised, far less answered, in the strategy document.

Thus the targets are not based on efficiency concerns and consequently are most unlikely to promote efficient use of resources in the future health strategy. The good intentions on which the document is based are admirable. The question is whether they are an adequate basis for promoting the health of the nation.

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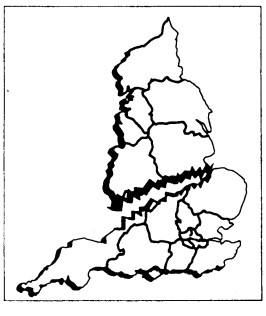

What the government should do

Sheila Adam, Spencer Hagard

In his foreword to *The Health of the Nation* the secretary of state throws down a gauntlet not only to the NHS but also to Whitehall. He reminds ministers and politicians, as well as the NHS and the people it serves, that it is the responsibility of his office to "take all such steps as may be desirable to secure the preparation, effective carrying out and coordination of measures conducive to the health of the people."[1]

The challenges are immense. How to ensure that the NHS uses its finite resources to provide services that are clinically effective, appropriate for each patient's needs, responsive to user preferences, and value for money. How to jolt other central government departments out of their constitutionally established sectional interests and into a commitment to better health. And how to set the process in a framework which is genuinely democratic and participatory and thus more likely to deliver better health.

Can *The Health of the Nation* offer the first step towards a comprehensive health strategy for England? We believe that it can, but only if the government is prepared to recognise and respond to the criticisms of the document and then establish a long term planning and implementation strategy. It must also take steps to ensure early integration of the strategy into both NHS and multisectoral activities.

The criticisms

Criticism of *The Health of the Nation* is becoming an industry, with critics coming from all sides. We have summarised what we consider to be five key criticisms and indicated the ways we think the government should respond.

Although the document describes progress on the World Health Organisation European region 38 targets, the approach has been criticised for failing to encompass the WHO global strategy for Health for All initiated in 1977,[2] and for not building on international experience in developing local Health for All strategies (which have been summarised in a publication from the Department of Health's operational research service.[3] Thus, *The Health of the Nation* does not, for example, refer to the essential prerequisites for achieving the health targets: peace and freedom from fear of war, equal opportunities for all, and the satisfaction of basic needs (adequate food and income, basic education, safe water and sanitation, decent housing, secure work, and a satisfying role in society). Sceptics, many of whom are highly committed to the concept of a health strategy, have described the government's approach as too narrow and overmedicalised.

In particular the document has been criticised for failing to deal with strategic issues relating to inequalities. Equity and participation are stressed in Health for All strategies but not in *The Health of the Nation*. Health inequalities are real and associated primarily with income, social networks and perceived social worth, and lifestyle.[4] The variables are linked but each also operates independently.

The next criticism has been expressed in two opposite directions. Firstly, that the strategy focuses too much on the NHS and, secondly, that it focuses too much on other sectors. The temptation to interpret equal noise on both sides as a positive sign should be resisted as an effective strategy needs to balance both elements. There are clear opportunities for the NHS to use its resources more effectively to achieve health gain, but it can have only limited impact on wider health problems.

Harsher critics have described *The Health of the Nation* as little more than pre-election political flannel, though this was not the view of the shadow health secretary Robin Cook; he welcomed the initiative. But

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Corporate contracts must include more health targets such as that for childhood immunisation

critics point out that even if the Department of Health is seriously committed to it, the lack of commitment and priority from other departments may be too powerful for the Secretary of State for Health to overcome.

The priority areas have also been criticised: the inclusions, the exclusions, and the specific targets. Previous articles have commented in detail and we will add only two comments. Firstly, the danger of considering only the easily measurable. As McLellan's article on rehabilitation showed,[5] even the harder to measure can be included and hardening the softer targets in priority areas needs to be an early research and development priority. Secondly, the exclusion of elderly people and their needs, both explicitly in the absence of a separate section in the green paper and implicitly in the emphasis on premature mortality, must be remedied in the white paper.

Government's response to criticism

The government must signal that it has heard and is prepared to respond to criticisms of *The Health of the Nation*, and the white paper due in the spring should provide for:

- Closer alignment with Health for All by the Year 2000 and a determination to learn from the experience of other countries
- A crossdepartmental approach (at central government level) to health and social policy that relates health and social gain to wealth creation and use of resources
- Additional resources to develop and implement a health strategy. These should include bridging funds to enable new areas of work to begin in advance of resources being released from activities that will no longer be necessary
- Action to address problems such as low income, poor housing, unemployment, and subsidies on unhealthy food, all of which are known to have an adverse effect on health. Initially the action is likely to be limited, but the government needs to begin to move to a position in which all of its policies are consistent with its health strategy.

Short term strategies: the next three years

The immediate priority is to create acceptance and gain time for the full development of the health strategy and construction of all the necessary means to assure its implementation. The green paper is ambitious and has raised many legitimate aspirations. It is particularly at risk in a pre-election period. The proposed strategy represents a major reorientation of health policy and implies a considerable reorientation of other sectors of society. Time, commitment, and considerable human effort will be needed to plan and implement its long term success. The government's most urgent responsibilities are therefore to begin a programme of work to ensure robust implementation, and, at the same time, to ensure that some early results are achieved which can assist its acceptance.

The NHS Management Executive holds regional health authorities to account, and these authorities similarly hold their constituent district health authorities and family health services authorities to account through individual corporate contracts. These represent the range of key objectives that each authority agrees to achieve by a defined date. Initially, the focus of corporate contracts has been on finance, activity, and manpower, but during 1991-2 corporate contracts have often included objectives on immunisation, breast and cervical screening, and other outcome related issues such as resettlement programmes for long stay hospital residents with mental illness or learning difficulties.

Although these objectives apply to only limited areas and are measured by process rather than outcome, they represent an initial attempt to build health targets into the management framework. With the publication of the green paper and associated changes following the NHS reforms, the management executive must follow up its guidance for 1992-3[6] and strengthen the health target component of the corporate contract. Given the continuing central priority given to financial control,[7] these changes will require considerable determination and courage in Whitehall.

The corporate contract represents an amalgam of central direction and local priorities. The health strategy, while requiring clear government leadership, must also reflect the views and preferences of local communities. Assessment of needs is not simply a technical issue with "right" answers. Rather it must incorporate values and preferences alongside epidemiological, clinical, and technical advice. For example, the professional advice on the relative needs for neonatal intensive care and for services for mentally frail people can help decision making but must be considered in the context of the preferences and priorities of the local community.

It will therefore be necessary to require health authorities to defend publicly the basis of their health priorities. Various approaches are available—for example, surveys (self completed or by interview), open meetings, panels as in market research methods, or community participative approaches using existing groups and opinion leaders. For most health authorities this is a new activity and there are no tried and tested methods. A dialogue between health authorities and their residents will, however, be essential if the national direction of health targets is to be balanced by a rounded view of local needs and priorities. To assure success, a health strategy must be seen to be founded on the principles of democracy and citizenry; the experiences of formulating Healthy People 1990 and Healthy People 2000 in the United States provide confirmatory evidence.[8]

Health targets require the NHS to do things better and other sections of society to become fully committed to health. Two major strands of change management therefore need to be created and woven together. There is a risk of losing the symmetry, either through clinicians or NHS managers, or both, failing to contribute to the wider social agenda or through the issues being regarded by politicians as exclusively within the

NHS. Two examples relating to suggested health priorities illustrate this.

The first example relates to coronary heart disease. The NHS is responsible for diagnosing and treating this disease and at least some of its risk factors and each year spends £500m on these activities.[9] Clinicians and managers need to ensure that the available resources are used to maximum effect—that procedures are introduced only after proper evaluation, that services reflect the wishes of their users, and that the care provided for each patient is appropriate for his or her needs. If these principles are followed benefits will ensue and will almost certainly include release of some resources as well as better quality care.

The second example relates to smoking, the single most important preventable cause of death and ill health. Creating a positive climate of public opinion, developing health education in schools, and the increased role of general practitioners in helping smokers to stop, have all contributed to a decrease in smoking over the past 20 years, especially among non-manual workers and their families. Smoking rates among manual workers remain higher and the fall among women has been substantially less than among men. A recent study showed no decrease in smoking prevalence among schoolchildren.[10] The commitment of clinicians to a national health strategy will depend on ministers ensuring that effective action is taken in other sectors to support the NHS in reducing smoking prevalence. The continuing failure of government to outlaw the advertising and promotion of tobacco threatens its credibility with clinicians and their commitment to the strategy.

Credibility with managers will be determined by the priority government is prepared to maintain for *The Health of the Nation*. Health service managers have delivered a major change agenda coupled with considerable reductions in resources over the past three years. There is evidence that at least a significant minority are enthused by the health gain agenda. But there is a limit to the hours in the day and, if the government really wants health targets achieved it may have to be prepared to make slower progress on some other important issues.

Finally, the strategy for health will need to exert a major influence on the new agenda for research and development in the NHS[11]; this implies the government standing firm against the research and development programme being dominated by biomedical scientists or even clinical scientists. Instead it must be focused on enabling the NHS to improve health both directly, through its own sphere of action, and indirectly, through its influence on other organisations. Research will therefore need to be related to policy development and implementation, to enable the programme to enhance decision making throughout the NHS and other sectors.

Longer term strategies: the next 43 years

A national strategy for health, once developed, needs to continue forever, and therefore a useful vantage point from which to consider the construction of longer term strategies is the year 2034, which lies as far in the future as the foundation of the NHS does in our past. A strong health policy is most likely to be reached if a health strategy is firmly established in the first full parliament of the first British health strategy. The first strategy should include the following measures.

Firstly, a broad political and social consensus needs to be achieved not only for the concept of a national health strategy (a situation which now seems close) but for the necessary innovations in policy making and implementation which will be required to nurture and sustain it. These innovations are by no means assured; indeed the need for them has been largely ignored in the national strategy debate so far. The changes needed are:

- Charging the Secretary of State for Health with explicit responsibility for coordinating and monitoring the efforts to achieve the national strategy in all sectors of society—both other government departments (directly at national level) and the remainder of society (through the NHS authorities at national, regional, and local levels)
- Providing the resources at all levels to take the strategy forward and implement it. This is currently the most underdiscussed issue of all. We are not used to working across sectors in our society and have tended to attribute past failures (for example, in joint health and local authority planning) to anything but its root cause of insufficient intellectual and managerial investment. We seem unaware of the great development effort which will be needed to implement a national health strategy.

Secondly, NHS management needs to be harnessed more securely to measures necessary to achieve health gain—for example, applying sound management to existing knowledge, as in subjects such as managing cervical screening programmes and preventing stroke, and cost effectiveness in research investment, such as in measures to support greater contentment among infirm elderly people or higher levels of physical activity in the population.

Thirdly, investment in surveillance, analysis, and assessment should be increased to greatly improve recognition of health problems and analysis of determinants; identification of the potential for specific improvements in health; identification of the specific knowledge we require; and consequent information gathering and research. Lastly, all these measures should be undertaken in collaborative programmes with other nations which are drawing up national health strategies.

Conclusions

Although we recognise the validity of many of the criticisms of *The Health of the Nation*, we warmly welcome its publication. If the government responds positively we believe that a framework can be established which will ensure the better health of our population.

As Smith said in a recent paper,[12] health can be viewed in two ways:

> Individuals are healthy to the extent that their mental and physical capabilities permit them to discharge the obligations and enjoy the rewards associated with membership of their community, while that community is healthy to the extent that its members are healthy in this sense.
>
> This definition implies two distinct but complementary strategies for the pursuit of improved public health: one aims to promote the capabilities of individuals so that they may function in the widest diversity of social contexts; the other aims to promote such a diversity of social contexts as to permit successful functioning for individuals with the widest diversity of capabilities. We have made some progress with the first kind of strategy but have scarcely begun to embark on the second.

With government vision, commitment, and resolution, the health strategy could enable us for the first time to address these two complementary approaches to securing the better health of our population.

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Junior Doctors. The New Deal

Using the potential of all staff

Angela Thomas

This is the last in a series of articles which explore the new deal on junior doctors' hours of work and explain how it will be implemented.

There are a host of other factors apart from long hours which cause low morale and stress among junior doctors. Some affect patient care directly and some affect the doctor alone. *The New Deal* contains important agreements which address these problems.[1]

A recurrent complaint among juniors is the varying role that nurses play in different disciplines and in different hospitals. In some hospitals clinical work is shared between nursing or midwifery staff and medical staff—for example, in accident and emergency, oncology, gastroenterology, and maternity units. In others this does not happen and nursing staff are unable to use their skills to the full. This is particularly frustrating for them and for junior doctors if they have just moved from a hospital or department where an extended role is practised. A doctor can be disturbed at night simply to give an intravenous injection which could more easily and with less delay be given by the nurse on the ward. There are many other tasks which could be more appropriately undertaken by nursing or midwifery staff to the benefit of patients, nurses, and doctors but which are not because of a lack of agreed local policy. This leads to frustration and often resentment among doctors and nurses. There is scope for an extension of shared care and the ministerial group on junior doctors' hours has recognised this.[2]

The Secretary of State for Health said when the deal was launched that the resources to achieve the hours deal would be made available.

"Making the best use of the skills of nurses and midwives" gives guidance on the need to review local policies on tasks which appropriately qualified nurses and midwives could reasonably undertake to improve the quality of care. The guidance is supported by all those participating in the discussions on hours, including the chief nursing officer and should enable all staff to be used to their full potential.

Another problem which *The New Deal* addresses[3] and which the University of London has recently highlighted[4] is the question of junior doctors spending more time than necessary on clerical and administrative tasks and too much routine technical work such as phlebotomy. London University has clearly stated that posts where junior doctors do too much of this sort of work may well have training approval withdrawn and some other universities have followed suit. A certain amount of technical work does have a place in the early training of a junior doctor but this does not justify requiring them to do two to three hours of blood taking before the normal day can start. Finding beds is an increasing headache as ward closures and the increased turnover of patients make placing of newly admitted patients difficult and time consuming for the junior doctors.

In the past these problems have not been solved because of the lack of priority given to them in the allocation of resources. Hard pressed haematology laboratories cut staff to save costs and lose their in-patient phlebotomists and cardiac departments lose their team of technicians, but the junior doctor is always there to do the jobs at no extra cost. A central organisation for locating beds run by a designated and appropriately qualified team of clerical staff would be of enormous benefit and would give junior doctors several more hours a day to devote to their training. Again, all members of the ministerial group were convinced that sorting these problems out, although not directly decreasing hours, would decrease the workload, improve the efficiency of junior doctors, and do much to alleviate the frustration and disillusionment that many now feel. The representatives of NHS management accepted that there would need to be a reallocation of resources to allow for the employment of the necessary support staff but they were enthusiastic that this should be done.

Scandalously inadequate

Hospital is home for many junior doctors, particularly the most junior, but their living conditions are often scandalously inadequate, despite guidance on accommodation from the Department of Health, the latest in 1986 after vigorous representations by the Hospital Junior Staff Committee (now Junior Doctors Committee). Many residential areas, on call rooms, catering facilities, and communal areas still fall short of the minimum standards set by the government. Recently training recognition of juniors' posts was withdrawn at one hospital in London because of poor facilities. Surely it is not too much to expect clean linen in the on call room when you are on duty?

In an attempt to improve the position guidance on living and working conditions and job descriptions, which form part of the doctors' contract, has been issued under the new agreement.[5] Is this guidance any more likely to be followed than the last? I believe so because, firstly, it has the full backing of the ministerial group, including the Minister for Health, and, secondly, there is now a path which leads back directly to the group if the guidance is not followed. If problems occur junior doctors will be able to raise them at national level.

All the above initiatives depend on local activity and commitment followed by local cooperation and agreement. If problems fail to be resolved there is a way that pressure can be exerted to bring about change. The regional task forces are charged with monitoring the progress of the implementation of all aspects of the

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