Useful addresses:

The Royal Association For Disability and Rehabilitation (RADAR), 25 Mortimer Street, London W1 8AB, tel: 071-637 5400

British Limbless Ex-Servicemen's Association (BLESMA), 185-187 High Road, Frankland Moore House, Chadwell Heath, Essex RM6 6NA, tel: 081-590-1124

National Association for Limbless Disabled (NALD), 31, The Mall, Ealing, London, W5 2PX, tel: 081-579-1758/9

Useful publication:

If Only I'd Known That a Year Ago.... published by RADAR. This booklet reviews what is available to disabled people, their families, and friends and includes the addresses of many useful organisations and associations

The artificial limb and appliance centres were criticised in a report published in 1987 to the Department of Health by a committee chaired by Lord McColl. The committee suggested that the service could be improved by raising the technical standards of amputation; by setting up specialist multidisciplinary hospital teams that would work in close cooperation with the medical staff at the centres and take an active part in rehabilitation; by giving more responsibility to prosthetists and encouraging them to be responsible for continuing care; and, finally, by restructuring of management. Some changes have already been implemented—such as the integration of the service into health regions with integrated budgets. Prosthetists may now tender for provision and service contracts, thus allowing them to become independent of the major suppliers of artificial limbs.

The demands of amputees on the medical and associated services will vary according to their independence. Some will need little medical help; a new elderly amputee, however, will require extensive support and supervision if he or she is to be discharged from an acute hospital and return to the community. After discharge from hospital the general practitioner will not only look after the immediate physical requirements of the amputee but also coordinate the community support, the hospital services, and the services of the disablement service centre.

We thank Mr Kiril Gray and Mr Ray Holland (BLESMA) for their help, and Dr Linda Marks of the DSA limb fitting centre, Stanmore, for her criticisms and comments. We are grateful to the Royal College of Surgeons of England for permission to reproduce the picture of the amputation in the eighteenth century, and we acknowledge with thanks the assistance of the audiovisual department, St Mary's Hospital, London, in the preparation of the illustrations.

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The ABC of Vascular Diseases has been edited by Mr John H N Wolfe.

Leading for Health

Setting a strategy for health

Alwyn Smith

This is the second in a series of articles responding to the questions raised by the BMA's document, "Leading for Health." The document looks well beyond the coming British election and raises questions about health and health care that will be on the agenda of many countries into the next century.

The international debate on the need for national health strategies and what they should contain has been proceeding for several decades without significantly attracting the involvement of the medical profession in the United Kingdom. Indeed, the worldwide crisis of confidence in traditional attitudes to the form and content of professional health practice has often seemed irrelevant to British doctors because of our complacent satisfaction with the NHS and our consequent belief that we have little need to be concerned. This attitude has changed with the government's health reforms, and in *Leading for Health* the BMA has set an agenda for discussions on health and policy setting for the 1990s.

The health crisis

When the NHS was introduced parliamentary and public debate identified a set of objectives more far reaching than the simple one of providing medical care free at the time of use. These were to promote the nation's health; to ensure the equitable distribution of health care; to render the health service accountable to the nation; and to invest the activities and development of the NHS with a sense of purpose. It is disappointing after more than 40 years to examine its record of achievement against these objectives. The nation's health has progressed less well than that of many other

countries; there remain serious inequalities in health and access to health care; accountability of the service to the electorate has almost disappeared; and we have only just begun to develop a strategy for the national health. However, the conversion of the government to the notion of a national health strategy is to be welcomed enormously, and the responses of the main opposition parties and of the BMA encourage the hope that the long overdue debate on the politics of health is about to begin. The pursuit of the national health is as important a matter for political debate as the national economy or the defence of the realm.

It is not only in the United Kingdom that there is a preoccupation with health strategies; indeed, we have come to the subject quite late and after many other countries have been pursuing formally stated strategies for a decade or more. The international public debate arose from a mid-century crisis in the progress of public health services that had several identifiable origins:

- Reduced mortality and a reduced birth rate have led to populations with a larger proportion of elderly people, which has in turn halted the crude decline in mortality and increased the prevalence of chronic and often intractable disease
- Demand for health care has grown and most countries have found it politically difficult to match this growth with a commensurate increase in supply

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HULTON DEUTSCH COLLECTION

Wartime rationing applied equally to everyone. Can rationing of health care be as fair?

- The traditional view that improved health over the past 200 years was largely the consequence of a more widely available and more scientifically based medical practice is now generally considered to be untenable
- There remain serious inequalities in the global and national distribution of health and of health care
- There has been a general concern about the growing political power of the medical profession and its appetite for resources
- Anxiety over the possibility of new environmental hazards has accompanied the proliferation of industrial innovation and the huge growth in the transport of goods and people.

What is health?

The debate over the development of health strategies includes consideration of the political nature of health and of its determinants. For some, health is a public resource that is necessary as a basis for many other national enterprises. Publicly provided personal health services in this country originated after the shocking discovery that a large proportion of young men were not fit to fight in the South African war. Health may also be seen as a commodity for distribution, requiring some consideration as to how and to what purpose it should be distributed. The World Health Organisation has declared health to be a basic human right—a proposition to which the United Kingdom has subscribed, although many have questioned whether anything can be a right if it cannot be guaranteed. The organisation in an earlier pronouncement has defined health as more than the absence of disease. The difficulties arising from this distinction can be avoided if we quite reasonably define disease as the absence of health, from which it follows that health is the absence of disease.

Some issues emerge quite clearly from the confusions of this debate. It is evident that health is relative—that is, some people are healthier than others. It is also contingent on circumstance—an impairment that would disable a professional athlete might be no more than an inconvenience to most people, and the functional impairments that inevitably accompany aging are quite compatible with a notion of a healthy old age. A useful definition of health is that people are healthy to the extent that they are able to meet their obligations and to enjoy the rewards associated with membership of their community. This definition im-

plies the possibility of two distinct but complementary strategies for the pursuit of the public health. The first entails measures which protect and promote the capabilities of individual people to function in the widest diversity of social contexts. The second entails the development of a society which permits the successful functioning of individual people of the widest diversity of capabilities. Traditionally, we have concentrated largely on a strategy of the first kind—and with some success. What is now required is the concurrent development of strategies of both kinds.

Determinants of health

A strategy for the national health must take some account of the determinants of health, which may be broadly considered under the headings of heredity, environment, lifestyle, services, and policies.

HEREDITY

Heredity needs little consideration, mainly because through evolution we have adapted to a wide variety of environments and most people who survive the neonatal period are well fitted to survive to an old age. Treatment of the minority who incur genetic disease has been one of the more successful developments of clinical medicine. Possibly the most important contribution of heredity to the problems of the public health arises from its role in determining the usual life span of our species and, therefore, the part it almost certainly plays in the genesis of the disease processes by which that life span is eventually terminated in the absence of environmental intervention. The importance of heredity in the aetiology of the diseases of old age may be much greater than has generally been supposed. This would have profound implications for the future pattern of health care.

ENVIRONMENT

Environmental determinants of health embrace both the life sustaining elements whose sufficiency needs to be assured and the life threatening elements whose presence needs to be contained. We need enough and appropriate food, clean water, clean air, and shelter, and the provision of even these basic requirements to all citizens of the world—or even of this country—continues to elude us. We need protection from natural and man made environmental hazards. Our industrial ingenuity contrives to render man made hazards a recurrent challenge.

LIFESTYLE

Lifestyle as a threat to health is a currently fashionable preoccupation as well as politically controversial. Any attempt to formulate national policies in relation to lifestyle seems to provoke considerable reaction (in both the general and the political sense). The individual's right to choose is invoked against the encroachment of the "nanny" state. The government's stated policy has been to ensure that individual choice is informed and not to influence choice.

We cannot, however, assume that the free and informed choice of individuals would always be for the healthy option, and risking one's health—for example, by smoking, binge drinking, and sexual promiscuity—cannot be generally condemned by any state that may call up people to fight in a war or by people who look favourably on those who risk their lives in sporting activities.

Reaction tends to assume that individual choice is free. This seems most improbable. For example, the national diet has changed profoundly even in the present century. This is not simply the aggregate of individual choices but a reflection of the availability and pricing of foodstuffs and the effects of marketing

designed to promote what is profitable to the producers and distributors of food. These in turn are the consequence of political policies governing the use of subsidies and other devices in pursuit of economic objectives. It would not be a new intrusion on individual liberty for these policies to be guided in the interests of the national health.

SERVICES AND POLICIES

The originators of the NHS were largely driven by a desire to increase access to health and medical care. Almost from its inception, however, the preoccupation of those responsible for managing it, at both the national political and the local administrative levels, has been with the control of that access and even with its restraint. It would have been politically difficult in the early years of the service, in the aftermath of the privations of war, to be explicit about the need to ration care, but the word "rationing" is now openly used, even by politicians, in debate about the NHS. There is a general acceptance that demand for health care inevitably exceeds supply, and undoubtedly such a mismatch has been increasingly evident over the past 20 years or so. Management of the resulting situation has been largely delegated to the periphery, and indeed mainly to clinical judgments about priorities. As these tend to be based on urgency there has been an increasingly evident neglect of the less urgent but more numerically and socially important care needed for chronic, progressive, and disabling disease and for the prevention of illness and the promotion of health.

A more explicit rationing procedure has become a central issue of the debate about the provision of treatment and care. Unfortunately, many of the realities of rationing have yet to be confronted. The wartime rationing of food, fuel, and clothing was successful mainly because it was generally understood to be necessary and had to be universally applied. For wealthy people to purchase these goods beyond the rationed allowance was not only punishable as a crime but generally condemned as immoral. If health care were to be rationed in the NHS—for example, by the adoption of a restricted list of available procedures—it is difficult to see how we could prevent the use of the scarce resources—mainly staff—for procedures unavailable in the NHS but available for payment in what would be likely to be a growing commercial market.

There are other difficulties in the development of a formal rationing system for health care. Perhaps the most intractable is that of identifying a principle and associated criteria by which procedures would be admitted to or rejected from the approved canon. Two conflicting approaches require consideration. Economists tend to see it as axiomatic that we should seek to maximise the surplus of health benefit over service cost. To that end they urge the use of the mean added years of good quality life as a selection criterion. An alternative objective might be the reduction of health variance, a policy which would seek to provide most care to those most ill. The economist's approach sees the health care system as an element of the national productive economy; the alternative sees it as an element of the national apparatus of justice. Either is a defensible approach: only political debate will lead to an informed national choice.

A national health strategy

A national strategy for health would ideally be based on an explicit national health policy in which the importance of health alongside other national goals

such as defence, economic growth, education, and transport is appropriately stated. The weight to be given to health implications in the formulation of these other policies will also need to be considered. We must acknowledge not only the importance of other goals but also the choices that need to be made when health aims conflict with other aims—for example, when industrial safety conflicts with economic competitiveness as in the issue of the European Community social chapter. These are important political questions requiring overt debate.

It is also important to be clear about the part which the pursuit of health should play in national policies. For example, should health be seen primarily as an economic output which we should seek to generate as efficiently as possible for a given resource input or is it a commodity for distribution to individual people? If it is for individuals do we seek to distribute it as equitably as possible or do we favour its unequal distribution as part of the system of differential rewards that may help to drive a competitive economy? Do we agree with the World Health Organisation that the highest attainable level of health is a basic human right, and are we prepared to restructure society so as to redress the disadvantage that derives from impairment of capacity—in other words, to discriminate positively in favour of the sick instead of compounding their disadvantage as at present?

Whatever answers to these questions are to drive the national health strategy, they need to be politically debated. Equally, the detailed objectives of the strategy need to be based on the best possible assessment of their feasibility and be subject to continual monitoring and revision in the light of changing policies, needs, and technical opportunities. There will be a need for appropriate structures and procedures for achieving this both locally and nationally.

Conclusion

The NHS as it has remained for over 40 years and through a series of upheavals, has always lacked both the resources and the remit to adopt more than a reactive role in relation to the demands made on it by patients. A case may be made that the national health is too important to be left to the NHS or to the professionals who work in it, but they remain the principal repositories of the technical and scientific knowledge on which a feasible strategy will need to draw.

For those concerned about the adequacy of health professionals and the present health service the challenge is to contribute not only to the formulation of a health strategy but also to its continued appraisal and development at national and local levels. This may require a reversal of existing policies which tend to isolate the NHS from national and local politics and to restrict its role to the marketing of procedures. The objectives of the government's recent changes included the containment of public expenditure on health services and to that end the limitation of the medical profession's power to consume resources. If we seek to influence the national health strategy we shall have to begin by recognising the weakness of our present position and our need to develop a more productive relationship with the political process.

The views expressed in this article are my own and do not necessarily reflect those of Lancaster Health Authority.

1 BMA. *Leading for health. A BMA agenda for health*. London: BMA, 1991.