Health promotion and children and teenagers

Why it is mainly the government's responsibility

The *Health of the Nation* contains several targets directly affecting the health of present children and teenagers and future adults.[1] These include reducing smoking in 11-15 year olds by one third, reducing the proportion of energy derived from fats to 35%, reducing deaths from accidents by one third in under 15 year olds and by one quarter in those aged 15 to 24, reducing suicides by 15%, and halving the conception rate in girls under 16.

The idea that these targets might simply be achieved by a cosy consortium between the health and education services begins to crack with research reported by Nutbeam *et al* in this issue (p 102).[2] But how could we believe that health and education services could be the main players in achieving these targets? Was it arrogance and the need to be needed on the part of doctors and teachers or duplicity on the part of the government? Most research suggests that the health of a nation is mainly due to socioeconomic factors with medical and educational interventions accounting for very little. After 13 years of Conservative government this country is in rapid economic decline, and yet the medical and education professions seem intent on bearing responsibility for not being able to avoid the inevitable result—a decline in the nation's health.

Thus Nutbeam *et al* are disappointed that two well tried instruments for preventing children from smoking failed to have any effect, especially when the schemes worked elsewhere. One of their interventions, the family smoking education project, had worked in Norway, but at the same time as the price, availability, and promotion of cigarettes were being controlled.[2]

Children's motivations for certain behaviours are highly complex. In a study of nearly 650 children aged 14 to 17, 98% knew that smoking harmed their health and 89% knew that passive smoking was harmful—yet one in five were, or had been, smokers.[3] This gap between children's knowledge about what endangers their health and how they use this knowledge is largely uncharted territory. What we know is that simple interventions in a single area—like a school health education programme—are unlikely to work on their own. We know that peer group pressure, cigarette advertising, imitation of parents, boredom, the need to experiment, and self image all affect children's decision to begin smoking. We also have a good explanation of why children continue to smoke: cigarettes are highly addictive. It is the proposed solutions that are simplistic.

To change behaviour requires tactics that match the complexity of the causes. These should include asking the children themselves how to solve the problem, feeding back their own views to them, and enacting effective laws and enforcing them (in a recent survey carried out by the local trading standards department of 54 premises selling cigarettes in Oxford a 12 year old was able to buy cigarettes in 13 of them). In addition, government policies need to be believable; banning cigarette advertising would almost certainly cut consumption.[4,5] Two papers in this week's journal show how much further ahead Australia is when it comes to implementing government policies that attempt to improve health.[6,7]

The position of the health professional—doctor, health visitor, or nurse—is not to pretend that their bit of health promotion is going to have more than a small additive effect to all the other necessary inputs, and they should be aware that they may be wasting their time if the other inputs are not there. Rather they should continue to point out that health promotion is mainly the government's responsibility, as are the economy and the laws of the land.

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Drugs, secrecy, and society

Less secrecy about drug regulation is in the public interest

Later this month a private member's bill that would require the government to disclose information on the safety and efficacy of drugs to the public should receive its second reading.[1] The Medicines Information Bill is founded on two main principles: that those who keep secrets should not have the last word on where secrecy begins and ends and that openness should be the rule and secrecy the exception.

Secrecy confers power on those who know the secret while those who do not are at a disadvantage. In pharmaceutical medicine the culture of secrecy is deep and strong,[2] and much evidence exists of its negative effects on health, organisational performance, and honest scientific inquiry.[3] Secrecy hides not only what is known but how much is unknown. When it threatens the conduct of science and the spirit of democracy it should be curbed.[4]

British law requires the authorities to withhold all information about licensed drug products, including counterfeit medicines.[5,6] Even government policies on disclosure are secret because the deliberations of the Committee on Safety of Medicines and other parts of the control system are also entirely confidential. At least one member of the committee has no objection to the committee's papers being publicly available and believes that most data in licence applications could, with little loss to anyone, be made publicly available.