A SYMPOSIUM ON IMPROVING PEOPLE'S HEALTH: MAKING IT HAPPEN*

M.R.S. Bain, Consultant in Public Health Medicine, Information and Statistics Division, Common Services Agency, Edinburgh and Professor E.M. Russell, Professor of Social Medicine, University of Aberdeen

Scotland's health is among the worst in the developed world. The international 'league tables' of mortality rates from coronary heart disease, cancer and stroke show Scotland to be either at or near the top for all three of these major causes of death. Most people know what could be done to improve this position, but achieving improvement in risk factors is difficult. Current strategies in Scotland are not as effective as they should be; for example, the gap between Scotland and England in death rates from coronary heart disease is increasing, and rates of smoking are rising in young women.[1] The White Paper *Towards a Healthier Scotland* has set out a multi-phasic strategy to improve health by improving life circumstances, lifestyles, and the management of illness. The challenge for the NHS and other public agencies in Scotland is to translate strategy into action. A joint symposium of the Royal College of Physicians of Edinburgh, the Royal College of Nursing and the Royal College of General Practitioners held at the College on 14 May 1999 considered how the health of the Scottish people can be improved, using the approaches of the White Paper. The range of speakers at the symposium was deliberately broad, as befitted the agenda: experts in public health medicine, health promotion, primary care and clinical medicine considered different aspects of improving health, with the focus on HOW to do it; the lessons influence both strategy and practice.

STRATEGIES FOR HEALTH

Effective strategies for health require several key principles to be applied. There is the paradox that, although individuals with the highest risk factors have the greatest risk of disease, they are only a small proportion of the population. Numerically, most cases arise in those with lower risk factor levels, because they greatly out-number those at highest risk. Therefore, to achieve reductions in disease rates in the community, the strategy requires risk factor reduction in the whole population. There should be evidence-based interventions. Randomised controlled trials are essential in planning effective interventions; these interventions must be achievable outwith the trial setting, in the general population. Moreover, what works in Japan or the US cannot be assumed to do so in Scotland because the risk factors and the environments are different. This means that interventions have to vary according to the population or community. Individuals must be prepared to change before information is acted on.[2] Approaches to improving health must be both 'bottom-up' and 'top-down'. A strategy for health must include participation, co-operation and empowerment of individuals in the community as well as resourcing medical care. People in the community who can make things happen need to be involved and supported by public policy. Finally, the policy and its implementation must be designed and evaluated on realistic timescales. Improvements in cancer therapies can show a reduction in deaths from specific causes within five years, whereas the effects of healthier life circumstances in children may take at least 20 years before a reduction in risk markers and illness becomes measurable.

The experience in North Karelia in Finland shows that health can be improved by a concerted regional and national strategy. Through a community-based project to tackle the major coronary heart disease risk factors, a 70% reduction in deaths from coronary heart disease in men aged 35–64 was achieved over a 25-year period. Reductions in deaths from cancer (particularly lung cancer) and stroke were also seen.[3] Success depended on involving people in activities which influenced many aspects of individual and community behaviour. The media, formal and informal community leaders, and community organisations were all involved. Alongside this there was social and environmental action. While the precise approach in North Karelia may not be directly applicable in Scotland, we should be able to take the principles and attempt to attain comparable effects. The key message is: 'If *you* want to change things, *you've* got to change things!'

Scotland now has the White Paper *Towards a Healthier Scotland*. This provides the basis for a wide-reaching strategy for health. In particular, the introduction of National Demonstration Projects introduces the possibility of adopting proven initiatives to improve Scotland's health as a whole. Different ways of involving communities in activities for health improvement have already been established in Scotland. They include a practice-based initiative in Tayside, a complex of community-based projects in Glasgow, and a series of business partnerships in Grampian. Some focus on health problems, while others are directed at improving life circumstances at earlier stages. These projects are relatively new, but they resemble closely the types of initiatives in three of the national demonstration projects. It is therefore useful to describe some of them more fully.

INVOLVING PEOPLE IN HEALTH

Based in a general practice in Tayside, a 'lifestyle' project was initiated in 1997. The foundation for these initiatives was the recognition that it is extremely difficult to teach adults anything; it is however relatively easy to provide the conditions under which people will teach themselves. Using the North Karelia approach, a multi-disciplinary strategy with complementary 'bottom-up' and 'top-down' methods was devised. Projects included health walks for everyone; cooking skills courses for young parents; exercise on prescription and bicycles on loan to post-myocardial infarcts (MI) patients; training of home care workers in promoting health awareness and healthy practice in their clients. The

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Berry Scotland Project was based on forging a partnership with the fruit growers of Tayside, and other professional bodies to promote the benefits of increased consumption and growth of soft fruit.

Glasgow experiences some of the worst health in Scotland, reflecting the high proportion of individuals living in poor socio-economic circumstances. The Director of Public Health reported in 1995 that 80% of Greater Glasgow's excess mortality is due to deprivation, and it has seven out of ten of the UK's unhealthiest parliamentary constituencies. In Glasgow, life expectancy for males is four years less and for females three years less than the rest of Scotland. The initiatives in Glasgow have, therefore, targeted lower income families through primary care. As in Tayside, it is a multi-project strategy. For example, there is a partnership involving the community, health professionals and local companies which has fitted home safety equipment in 900 homes, targeting lower income families, while also providing skills training for unemployed people. Health information cards have been produced for homeless people, informing them about 'first aid', services for women, mental health services, and patient rights including the right to have a doctor; these have been distributed among *The Big Issue* vendors and through hostels. Parental support and education was in the form of group-based education, encouraging mutual support and sharing of knowledge. A primary care-based scheme to increase the uptake of welfare benefits resulted in £67,000 of benefits recouped in its first year; now it stands at around £120,000 *per annum*. A 'Choices Clinic' for mental health support in primary care has won the approval of both practice staff and patients. Pharmacy information cassettes have been developed for ethnic minority communities covering the use of antibiotics, diabetes, anti-infective skin preparations, general health medical products and inhalers. Fresh fruit is provided to children's nurseries, working with local community food initiatives or a local supermarket.

This imaginative package of projects demonstrates that health care can play a role in reducing health inequalities, and that both primary and secondary care can benefit (Figure 1). The NHS cannot change people's lives, circumstances or lifestyles. However, there is major potential for health services to be involved in such action as part of wider partnerships, with all partners seen as equal participants. Long-term sustainable solutions have to be installed, and these require enduring partnerships with workers outside the setting of mainstream clinical and health services.

Improving health means empowering people to act on their own behalf. Current examples in Scotland of the NHS involving people in health include the 'Burnfoot Project' in the Scottish Borders and the work of 'Health Promotions', a division of Grampian Health Board.

Burnfoot is an area in the Borders with poorer health than its surroundings and a bad overall economic environment. The rate of 'did not attend' (DNA) for General Practice appointments stood at 37%, which is very high; patients blamed this on their uncertainty about whether, in the face of transport difficulties and costs, it was worth the effort to attempt to attend. The willingness of the local community coupled with development work by the Health Promotion Department and the Community Trust attempted to bring some level of health to the community and to encourage flexibility. A community health worker spent a year getting to know the community and learning to understand the local people's concerns about health. On this foundation, the worker and other partners were then able to operate flexibly with the community, tackling local issues. A community flat was established and was used to develop or import baby clinics, parents' groups, a dental van, relaxation classes and a 'breakfast club', all provided within the community and with community ownership. A much stronger sense of self-esteem and self-confidence has thus been developed among the local people, taking forward initiatives for health and well-being.

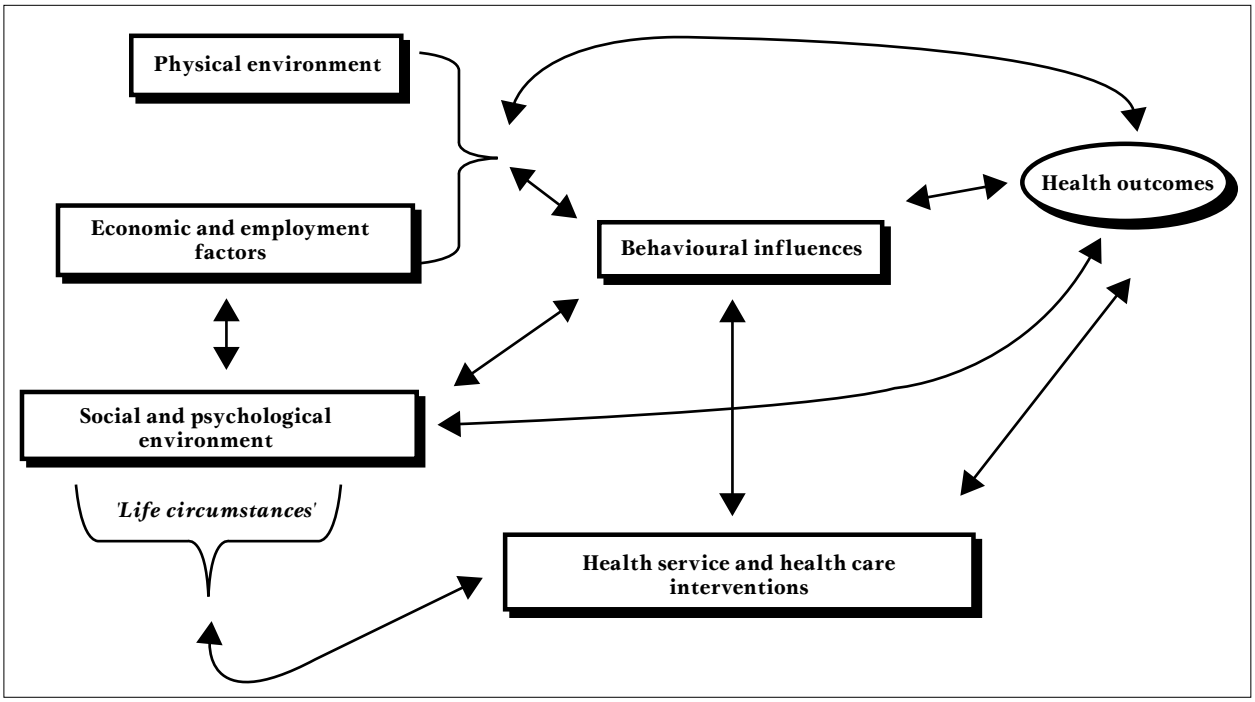

FIGURE 1
Package of projects which can play a role in reducing health inequalities to the benefit of both primary and secondary care.

In contrast, the Grampian region is generally perceived to be a wealthy area with a high employment rate and many successful businesses, though in fact it has a challenging mix of urban and rural populations, experiencing both affluence and poverty.

'Health Promotions', a separate division of Grampian Health Board, works in partnership with communities and other agencies and has strived to 'help health happen' through local authorities, the voluntary sector, further and higher education facilities, the media, the National Health Service, churches, the business community and many other organisations. 'Health Promotions' is guided by a board of management composed of representatives from local organisations which include the business, health and education sectors. Its main principles are: influence, information, investment, integration, innovation and evaluation.

A leading part of the Grampian strategy is working with local government. By creating jointly funded posts, 'Health Promotions' and the three local councils were able to work together on strategy development and professional training. Grampian thus combines a strategic, enabling approach with practical partnerships at local level.

Evaluation is based on outcomes and a monitoring of a wide range of health indicators, such as diet, physical activity and stress. For example, the *Grampian Youth Lifestyle Survey* conducted in 1998 suggests that, contrary to national trends, a 2% drop has occurred since 1995 in the number of fifth year pupils who smoke, and a 13% increase in children who eat breakfast, compared to 1992.

MAINTAINING HEALTH AFTER ILLNESS

Secondary or post-illness interventions also require a community-level approach. In particular, rehabilitation following strokes or MI may often fail for precisely the same reasons that primary prevention does, i.e. hopelessness and lack of personal skills. It is crucial that any health service programmes are locally specific, and involve families and community agencies ensuring that patients' fears and lack of confidence be recognised, and an enabling environment be created.

Cardiac rehabilitation has to start soon after the MI to address adequately these issues. Important components include a reduction of any high levels of emotional disturbance, depression and anxiety. Education of the patient and his/her family and clear communication are required, with consistency of advice from primary and secondary care, and from doctors and others. Secondary prevention, by promoting healthier lifestyles, smoking cessation and appropriate medication, is also important. However, uptake of, and adherence to, cardiac rehabilitation programmes are notoriously poor. St John's Hospital in Livingston, West Lothian, created a shared cardiac rehabilitation programme to tackle problems such as a high refusal rate and lack of transport. Working with the local health visitors, they introduced a heart manual, an exercise class and an evening class on self-care with a marked improvement in the uptake of the rehabilitation programme, a reduction in the prevalence of smoking, and improved adherence to medication. Further partnerships had to be forged with primary care staff, and also a development of leisure and activity facilities for both primary and secondary prevention. Continued training of staff is also important.

For stroke patients a specifically designated 'stroke unit' is very effective.[4] Its essential elements are that it is multi-disciplinary and holds regular meetings. Regular upgrading of the education of staff and carers has to be maintained. However, only 65% of the Scottish stroke patients who are admitted to hospital have access to a 'stroke unit', and those not hospitalised may be further disadvantaged in their initiation of rehabilitation. Experience from Newcastle suggests that a community-based stroke discharge service may be as effective as hospital rehabilitation, and its success has depended on involving and enabling the family and the community services and, above all, the patient and carer. The early supported discharge service comprises flexible provision of home care – covering 24 hours as required – and a stroke discharge team providing physiotherapy, occupational therapy, speech and language therapy, social work support and a district nurse. Care pathways may help to improve the quality of care. Regular review meetings are held in the patient's home and it is emphasised that the professional staff are there as the patient's guests. Users and carers can comment on and contribute to service development through a discussion forum. By transferring resources to support this programme, the result is a reduction in the length of hospital stay from 22 to 13 days, and a greatly improved self-esteem and motivation of the stroke patients in their homes.

MAKING IT HAPPEN

Following the Acute Services Review in 1998, a Coronary Heart Disease Task Force was established in Scotland with a remit to develop an effective clinical network of services for coronary heart disease; its challenge will be to ensure co-ordination of primary, secondary and tertiary care. Although it does not include a remit to consider prevention, it is recognised that there must be a partnership between prevention and medical management. Treating those patients who present with symptoms of coronary heart disease ignores the much larger reservoir of ischaemic heart disease in the community. Such issues as hypertension, diet and smoking all need to be addressed, and the context of the White Paper will encourage efforts in this direction. A new approach is required: the medical model of risk factor management, such as was used in the MRFIT programme in the US,[5] has been shown not to have the desired impact in primary prevention – precisely because it did not involve communities.

Prevention must be balanced with adequate and effective treatment for those with established disease. The Task Force will work with others to develop a population-wide strategy which will offer both management of acute illness in the short-term and a long-term attack on the underlying life circumstances and lifestyle factors which create a risk of disease.

The clear lesson from initiatives to improve health which were successful is that multi-faceted and multi-agency strategies are required. This concept was reinforced by all the symposium workshops, which focussed on HOW to achieve change. Coalitions are required to reduce duplication and save resources and enable communication and build trust. Supermarkets were shown to have an effective role in healthy food initiatives. Flexible funding works wonders when it can be arranged. Partnerships contribute to sustainability and allow the 'buy-in' of the stakeholders. These should include the civic and commercial

sectors whenever possible because they have perspectives which complement health. The Berry Project in Tayside involved farming, medicine and health care, nutrition, operational research, rural diversification, product development and marketing – a strong mix of interests covering both 'top-down' and 'bottom-up' approaches. However, the benefits for those involved in such enterprise have to outweigh the cost of participation. Strong leaders, good project management – and the recognition that measures to build capacity and achieve continuity are required – are of key importance. A difficult issue is how much to spend on evaluation. Everyone recognises that evaluation in principle is essential for effective future development, but most projects are funded on a shoestring and there is simply no money for evaluative data collection. The evaluation strategy of any national demonstration projects in this field will therefore be extremely important.

Finally, there is the support that innovators can derive from other innovators who have common goals. In recognition of the fact that the major threats to health in developed countries are now non-communicable diseases, the World Health Organisation established the Countrywide Integrated Non-communicable Diseases Intervention (CINDI) programme in 1984. The focus of this programme is heart disease, cancer and other non-communicable diseases. The emphasis is on reducing modifiable risk factors such as smoking, obesity, high blood pressure and high cholesterol, and currently 24 countries are involved. The programme includes demonstration areas. The key components of these are community involvement and multi-sectoral collaboration. Importantly, each participating country has slightly different problems, with differing priorities and strategies. However, CINDI gives opportunities for participating countries to share their experiences and provides training and education for health professionals. The programme holds an extensive database with information on indicators of health promotion and disease prevention, and a record of the programme's success. Discussions are now underway about the possibilities of Scotland joining the CINDI programme.

The overall conclusion from the meeting was that the time is ripe for consideration of a new strategy for health. The knowledge, the enthusiasm and the skills to change things are all there, and with these and the current political climate there probably has never been a better time for all to work together to improve the health and well-being of the people of Scotland.

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