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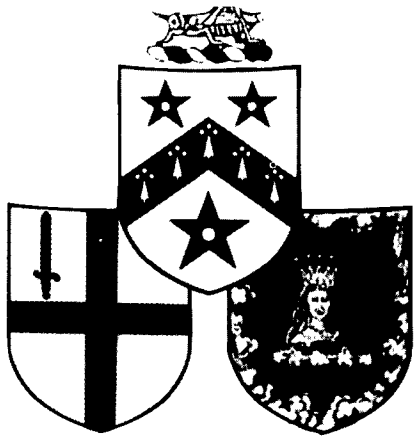

PERSONAL RESPONSIBILITY AND HEALTH

A Lecture by

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5 December 1990

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It is in modifications of personal life-style that some of the greatest opportunities for preventive action are to be found. We need not all be doctors to see that, despite the dazzling advances of scientific medicine, the leading causes of disability are intertwined with culture and custom and now we live own lives; and many of these causes can be prevented. Here are four examples, which I am sure you will accept in which modifications of life-style would clearly reduce disease - smoking, alcohol, diet and exercise.

Smoking. The avoidance of smoking alone would almost completely eliminate chronic bronchitis and emphysema and the complications of peripheral vascular disease in most countries of the world. It would reduce the mortality from coronary heart attacks by about 25 per cent; and it would reduce the mortality from all forms of cancer by more than 30 per cent.

A report of a working party of the Royal College of Physicians published in London a few years ago stressed its grave concern about what it termed "a needless holocaust". It says that the death rate from smoking is now so large that it completely dwarfs well-known causes like alcohol, road accidents and suicide. In spite of some decline in smoking by adults tobacco still accounts for 15 to 20 per cent of all deaths in Britain. Appreciation of the magnitude of the problem is helped by putting the figures in context, says the report: "Among a thousand young male adults in England and Wales who smoke cigarettes an average of one will be murdered, six will be killed on the roads and 250 will be killed before their time by tobacco".

Alcohol. The harmful effects of alcohol are, of course, known to all of you. They consist not only of the production of disease in the drinker himself. They include injuries inflicted under its influence intentionally or otherwise on others. But, even ignoring these secondary effects, the high and rising levels in mortality rates due directly to alcohol-induced disease cannot but cause the most serious concern to all of us.

Diet. There is broad agreement among research workers that the most healthy type of diet is one that provides a high proportion of its calories in whole grain cereals, vegetables and fruit; that provides most of its animal protein in fish and poultry; that limits the intake of fats and oils; that reduces the intake of sugar and is sufficiently restricted in amount to prevent obesity. This is true whether the object is to avoid hypertension, diabetes, diverticulosis, constipation, duodenal ulcer or coronary heart disease or cancer.

Physical activity. Another characteristic of modern life that distinguishes it from the past even more than diet is the low level of physical activity. There is evidence that it contributes to obesity and high levels of blood pressure and blood fats and consequently to what is colloquially known as hardening of the arteries, all of which may be reduced by a programme of vigorous activity. I am not necessarily recommending strenuous jogging or sudden uncustomary exertion. This too can be harmful. I would prefer like Roger Bannister, to put forward a plea for national policies that associate good health with positive enjoyment and promote the expansion of sporting activities and facilities for all sections of the community.

Let me remind you that all of the disorders I have just mentioned - hypertension, coronary heart disease, diabetes, obesity, cancer, obstructive lung disease - are markedly influenced both in incidence and severity by life-style. They are disorders which WHO reports have shown to be rising alarmingly in developing as well as developed countries. I won't quote detailed statistics but this trend has been observed in Nigeria and Ghana in West Africa; in Kenya and Uganda in East Africa; in Swaziland in Southern Africa; in Fiji in the Pacific; and in the Caribbean, in Jamaica, Trinidad and Barbados. They are all disorders which are associated with affluence and rising standards of living. It is an ironic commentary on the health choices we make in parts of the developing world that the prevalence of these disorders of affluence seems to be rising even faster than the fall in the disorders that characterise underdevelopment - tuberculosis, malaria, hook-worm, diarrhoea, malnutrition and similar disorders.

Preventive action of course, is not entirely the responsibility of the individual. There are certain measures that only governments and national health ministries can take. The designation of 1981 by the United Nations as

the year for disabled persons focussed wide national and international awareness on disablement and, among other things, on how much of it can be avoided by preventive action. In spite of the flurry of temporary interest and activity that was generated little sustained national action has been so far achieved. Wide international concern has been expressed for deafness, blindness, mental retardation and other types of disablement. Although many of these may be due, for instance, to rubella, otherwise known as German measles, in a pregnant mother, there has been little corresponding concern for the development of programmes of vaccination against rubella to prevent the recurrence of further epidemics. In most countries, and Britain is no exception, it is the voluntary organisations and benevolent non-governmental associations that have recognised the need and mobilised the appropriate action both for support of the disabled and for the prevention of disability. The crucial question is to what extent governments will acknowledge and share these responsibilities and take the requisite steps. Examples of appropriate national measures were the launching recently in Britain of its National Rubella Campaign under the patronage of the Princess of Wales, and the launching in India of its IMPACT initiative for the reduction of avoidable disability and for stimulating other countries to similar action.

Apart from what might be the appropriate action for governments or non-governmental organisations a critical remaining question is what can be done about educating and motivating individual members of the public towards the healthier life habits and towards the community participation that is essential for improved community health? Many people even in an audience like this, are unaware of or do not know how to utilise the personal, community and environmental health services provided for them - immunisation and vaccination services, health visitors, nutrition and public health facilities, hospital and health clinic resources, family planning services. In most countries these services which are provided at great expense are only partially utilised - commonly due to lack of information about them or of adequate motivation towards their use. It is here that one of the weakest links in the chain of health is commonly found.

But there is another link that is probably even weaker. It is in the attitude of the individual citizen himself to his own health. The weapons of modern medicine are aimed at the pathology of disease; and health services are designed to deliver these weapons mainly through the hands of doctors, nurses,

hospitals, health centres. A participatory role for the community member, however, has hardly been identified at all or has been, at best, marginal. What is commonly ignored is the fact that the effectiveness of national systems of health care must in the final analysis depend on the health awareness, attitudes, perceptions and demands of individual community members, on how effective a custodian of his own health the man in the street can become. The prime object of the promotion of community health participation is to create and maintain a sense of individual responsibility, self-reliance and self-importance in health matters and community education is the key. it is perhaps here that there has been least progress and it is here that advances are most needed. The old emphasis has tended to disguise the true nature of ill health and to obscure individual responsibility and capability for countering it. There is need to shift the health focus from the hospital and the doctor to the individual and the family. There can be no more paralysing assumption that the notion that the individual may shelve his responsibility for making decisions about his own health by passing it on to a doctor, a nurse or other specially trained health professionals.

Of the complex calculus of benefits with which good health is associated each of us is in turn a custodian and a participant, a trustee and a beneficiary. It is a dangerous pretence for any to assume, but worse still to believe, that his health interest can be served by approaches that ignore his individual responsibility.

However efficient their hospitals and however sophisticated their resources for the delivery of health care, however effective their training programmes for doctors, nurses and other members of the health team, a major challenge for national health planners for the foreseeable future must be to inform people, to influence their behaviour and to prepare them as individuals for more personally responsible health roles. The search for methods for meeting this challenge has now become one of the highest health priorities for all countries whether of the east or west, north or south.

What governments need to do in this respect is, I think, evident; greater emphasis needs to be placed on the national community health education programmes. There is one particular instrument for community health education, however, to which I would wish to make special reference. I am referring to the public information media - the press, radio and television.

The roles played by journalists and others who control the media, written and audio-visual, are greater than ever before and they will continue to increase. In the health field, they have been almost completely ignored. The extension of primary health care services, the strengthening of community health systems and the growth of community participation will all be determined in the final analysis by the strength of public opinion and the reliability and effectiveness with which it has been informed. No real progress will be made until health ministries and their training agencies, universities and medical and other professional organisations come to grips with the reality of the power that the media wield in guiding public opinion, in the health field as in others, and the need for planned strategies in relation to it. Its potential for influencing national health care systems can no longer be disregarded.

The assumptions that underlie the emerging importance of the roles of the media in the health field are simple. One is that health is a result of a conscious attitude on the part of the individual and is a matter of personal responsibility. Another is that, since the major influences on health behaviour are the individual's own health perceptions and his concepts of his role based on such perceptions, major improvements in the health of communities can be achieved only by methods that can significantly modify these perceptions. There can be no more effective channel for achieving this in any society than through its media of public communication; but they cannot do it without the full cooperation of health ministries, the medical and nursing professions, the universities and other national education institutions.

And surely the task should not be beyond us of setting up appropriate arrangements for collaboration between these groups to expand popular comprehension of an interest in health affairs and in advances in health which will inevitably affect the lives of each member of society. The challenge is only partly to make connections between these groups and the media, it is also to demonstrate their personal and human implications for the average man and the place for the informed judgement of the individual citizen in national health concerns; and the need is greatest in countries where facilities and resources are least.

The processes involved inevitably make health a matter of education and public policy. We learn the causes of disease; we find a means to interrupt the chain of causation, we teach the meaning of this in terms of people's daily lives. It is this blend of news and education that gives the media their unique potential in the health field. When the appropriate kinds of health messages are available to the public, there should be no difficulty in obtaining either audiences or understanding. If we find the right answers and use the media appropriately they will have a pivotal role to play in the future of world health.

My last comment about community health education is directed towards the medical profession itself. The importance of its role is unlikely to be questioned. Medical men often either have not the patience to undertake it or o frequently take the view that the communication of knowledge in a form that is comprehensible to lay members of the society is a responsibility for others. This has done much to retard popular appreciation of, and commonsense action on, some of even the basic concepts of existing health knowledge.

I should hasten to add that this communication gap is not confined to doctors. Many of my other professional friends share it. They seem to forget that the economist is a layman in relation to the skills of the engineer, and the engineer is a layman in relation to the skills of the attorney-at-law, and both of these are laymen in relation to the skills of the biochemist. The concerns of even such highly-trained groups are often incomprehensible to each other, far less to laymen, even well-educated laymen. There is a need in all societies for their professional leaders, if they are to deserve to be called leaders, to attempt to transmit their expertise in such a manner that it could become a logical and rational basis for thought and action by individual members of the community.

What is involved is a matter of professional accountability and brings me to the last topic I wish to discuss - health planning and management. Custodians as they now are for the health of fifty countries, one quarter of the world's peoples, Commonwealth health ministers get together every three years for a week-long meeting on what they consider to be the most critical health issues facing their member countries. The theme of the last meeting I arranged as Commonwealth Medical Adviser in 1985 was Health Planning and Management. The choice of this theme was based on the perceptions that

inadequacies of the national health planning care systems of member countries are due as much to deficiencies in planning and administration as to limited resources; that in the present international economic climate the provision of substantial additional resources for national development generally is unlikely; that in health as in other sectors, possibly even more emphasis needs to be placed on the efficient management of available resources than on the search for new ones.

There were three elements of this theme on which Commonwealth health ministers focussed special attention: on the practical measure that might be adopted for more effective health planning and management; on the specific approaches that would be feasible and appropriate for their varying circumstances and on the choices and priorities that they needed to identify. They concluded that the assessment of priorities, the setting of targets and the allocation of resources to meet them constitute the nub of the health planning problem. They agreed that many of the decisions involved would be essentially political and that their outcome would depend mainly on the strength of the political commitment with which they were supported. A point they also agreed on was that an important stimulus for political action is the informed and articulate public opinion to which I have already referred.

What they thought was particularly urgently needed, however, was a radical revision of their current systems of health administration which had not been designed to deal with the kinds of health issues with which they were now confronted. They acknowledged, for instance, that most of the factors which have the greatest bearing on health - agriculture, planning, housing, education and others - **lie outside** the normal areas of responsibility of health ministries and **within** government sectors that have no primary responsibility for health. They recognised that these factors cannot be confined to one sector or identified as the sole responsibility of any single ministry. This is the health planning dilemma that has to be faced by all countries, rich and poor alike. The question and the challenge therefore is what modifications can be made within and between related ministries for ensuring coordination of the sectoral interests and resources that bear on health. They will call for a new ordering of political priorities in relation to health, for alternative approaches to management, for new administrative structures, for imaginative and radical interventions and, in particular, for

new mechanisms for coordinating inter-ministerial government roles with those of relevant groups.

Sri Lanka is the best example I know of what can be achieved by bold and imaginative health administrative reforms by a poor country; and it has lessons for richer countries. A recent World Bank report has quoted Sri Lanka as evidence of the high level of health care that can be achieved with only modest national resources. This is undoubtedly due to the thorough revision of their system of health management that they had recently undertaken. Recognising that health can no longer be the full responsibility of a single government department they have set up broadly based inter-ministerial health councils for ensuring multi-sectoral involvement in both the planning and implementation of national health policies. Their use of the mass media for community health education is well advanced with mass media programmes specifically geared to create and sustain awareness in the population of prevalent health problems and needs. Staff from the health department, the university, and the media work together in the preparation of these programmes.

Ladies and gentlemen, having ranged over these health-related issues I conclude by returning to the one that all of us are, and will continue to be, most concerned about when we are ill - the question of medicines. Adequate supplies of effective drugs at reasonable costs is one of the central requirements at all levels of health care. They are essential to the quality of health systems, to the cost of health services and to the credibility of health workers themselves. Most of you, I know, are aware of the efforts of the World Health Organisation in this field and the attention they have drawn to the economic waste involved when poor countries, for instance, spend large proportions of their health budgets on expensive patented drugs which have little advantage over cheaper non-patented ones.

What you are probably not aware of are the dimensions of the problem. The money spent on drugs in many developing countries often represents up to 50 per cent of their total health budget. It represents a foreign exchange drain that few of them can afford. What makes matters worse it that much of this expenditure is wasted. More, and often more expensive, drugs are prescribed than are necessary; many have side effects that are worse than the illnesses they are supposed to treat; many are of substandard quality and have no beneficial effects; and many, if they have beneficial effects,

relieve symptoms rather than effect cures. A price of international development seems to be the illusion, for which the medical profession itself must share part of the responsibility, that there is a "pill for every ill".

The institutionalised hypochondria which characterises the western world and of which this explosion of drug usage is a symptom is spreading like an infectious disease to the developing countries. In Britain today health statistics show that an average of half the adult population and a third of children take some form of medication every day. This mirage of development is one that developing countries simply cannot afford to follow. The need for them to rationalise and harmonise their drug purchasing and prescribing policies is particularly urgent.

The question you might now ask, ladies and gentlemen, is what can the few of us in this room do about the issues I have been discussing, issues which, I predict, will affect not only every citizen in our society but in the wider world community. My answer would be that you can do a lot - by assuming greater personal responsibility for your own health, by participating in community health programmes, by collaborating in and supporting voluntary health projects and in other ways. Many of us here are considered to be leaders in our field. In the slow process of advance and change it is what people like us do, the emphasis we give and the positions we take up, that determine progress - in health as in other areas of development. I suspect that this is what Tagore meant when he said "the few are more than the many". It is **our** conversion to the need for change that provides the greatest impetus for it.

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