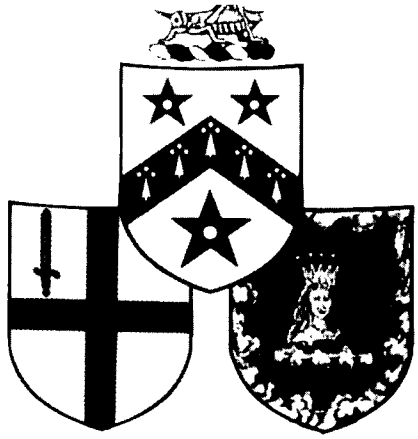
G R E S H A M

COLLEGE



HEALTH PERSPECTIVES FOR THE NINETIES

A Lecture by

PROFESSOR SIR KENNETH STUART MD FRCP
Gresham Professor of Physic
(and the other biological sciences)

19 November 1990

HEALTH PERSPECTIVES FOR THE NINETIES

Professor Sir Kenneth Stuart, MD, FRCP

19 November 1990

In spite of the wide international thrust towards better national systems of health care that has been taking place simultaneously in most countries of the developed and developing world there still remains in most of them the same inequities and inequalities in the distribution and availability of health care facilities; the same imbalance between preventive and curative medicine; the same uneconomic use of health resources; the continued expenditure of more than 80 per cent of national health care resources on less than 20 per cent of national health problems.

This search for an improved quality of life, and the relevance of health to that search, is not only of importance, for the poorer countries. Their needs may be specially urgent, but affluence does not remove the necessity for insistence on a more equitable and efficient use of resources. Health planners of the developed world can no more evade their responsibilities in this respect than can their colleagues in the less developed countries. In every part of the world health has always been at once a condition for and a consequence of development. Now, however, contemporary social and economic pressures and the rapid tempo of change have given it the urgency which health planners throughout the world recognise today.

In selecting my topic for this lecture it seemed to me that you would have approved my attempt to chart what many now think would be the most likely avenues of change if efficient and effective national systems of health care are to be established during the next decade. I will not address my comments to specific medical issues in Britain. Many of you know much more about these than I do. I would prefer to share with you my own perceptions of some of the medical imperatives that are emerging for the wider world community and of perspectives and trends that are being developed in relation to them.

Let me start with a milestone which is already well known to most of your. In September 1978, 134, more than 80 per cent of the member countries

of the World Health Organisation, met at Alma-Ata in the USSR and pledged their support for a worldwide effort to bring "Health for all by the year 2000'. This pledge has been termed "the most optimistic statement of purpose ever made by the world community".

Although the Declaration of the Alma-Ata, as it came to be called, achieved dramatic global publicity, it merely gave formal recognition to trends and shifts in international medical priorities that had been under way for the past two or three decades. The Alma-Ata pledge underlined these shifts in priorities and is part of the widening global emphasis on, and demand for, a more equitable spread of resources within and between countries. It is a demand for social and economic justice for people whose privileges are less than others. It is a call for a new international order in health, a call that stems from the same social awareness that has led to the more widely publicised demands for a new international economic order.

Primary health care has been identified as the essential route to be followed, especially by developing countries, in response to this call; and probably the most important outcome of the Alma-Ata Conference was the strengthening it gave to the resolve of WHO member countries to focus greater effort on the development and expansion of their systems of primary health care. I know that many of you already know what is meant by primary health care but let me comment briefly on it for those who might not.

Primary health care places emphasis on several related health activities many of which are not necessarily centred around doctors. It includes health education of the public, new approaches to the education of doctors and other health professionals, family care, the availability of effective drugs at costs that people can afford; it sees the involvement and participation of individual community members as an essential element. It means making health care facilities as available to the rural poor as to the urban rich. It lays emphasis on health approaches that are relevant and appropriate rather than on what is sophisticated and fashionable. It is seen as part of a broad system of health care stretching from the most basic village resources to the most sophisticated urban facilities. It includes not only health care for individual sick patients, but also nutrition, sanitation and immunisation services and control of endemic disease. It lays special emphasis on the **prevention** of avoidable physical and mental disability.

These, ladies and gentlemen, will be among the central health issues for the developing and much of the developed world, not only for the coming decade, but for much of the foreseeable future. They will be the central planning agenda items for all health ministries for many years to come. They are issues that go far beyond the contemporary emphasis on the diagnosis and treatment of disease **after** people become ill. They carry implications for change in our most fundamental concepts of medical education and practice; for changes in society's health awareness and expectations, for changes in the planning and management of national systems of health care, in the roles and responsibilities of the individual citizen, in the commitments and accountability of all levels of health professionals.

These issues are all related and cannot be tackled in isolation. They need to be addressed more or less simultaneously if the health goals to which he countries of the world have so unanimously dedicated themselves are to be achieved. And, I should add, they are not merely theoretical or academic ideas. The international community is already talking about how these ideas can be made to work. It is with some of these ideas and the the issues that stem from them that much of my lecture will be concerned.

When I was asked a short while ago to give the Charles Duncan O'Neal lecture in Barbados I spoke of the role of medical schools in national health development. I selected this topic because it seemed to me that the professional education of doctors, nurses and other members of the health team is likely to be one of the most important determinants of the direction of change and of the effectiveness of national health care systems. Changes in these systems cannot take place without corresponding changes in education.

Another need I referred to in that lecture was for better coordination of the goals of medical schools and their training, academic and research programmes with the policies and responsibilities of ministries of health. The training of doctors and other health professionals commonly seems to bear little relationships to the quantity and quality that are needed and there is often wide divergence between the training goals of medical schools on the one hand and national health service requirements on the other. The absence of such coordination has, in my view, contributed significantly to some of the current shortcomings in medical education and practice - in both developing and developed countries. Although there are already many examples

of how this collaboration between medical schools and ministries of health might be achieved, I am particularly drawn to the example from the Negev in Israel. Here the medical dean and the minister of health are one and the same person. Even if extreme this is certainly an effective way of ensuring cooperation.

One of may most gratifying tasks as Commonwealth Medical Adviser was the opportunity I had of convening a few years ago in Sri Lanka a consultation between deans of medical schools and ministries of health of Commonwealth countries with medical schools to plan how the gap between them might be bridged. The conclusions of this consultation included recommendations for coordinating the roles of medical schools and health ministries in national health development programmes; for appropriate curricular changes by medical schools in relation to primary health care; for helping to make them more effective consultative resources to governments than they had been in the past; for ensuring the relevance of their training and research programmes to the new international health priorities and for enabling them more effectively to provide and academic dimension and background to national health concerns.

Each year the World Health Organisation selects for detailed technical discussions the topic which it considers to be most critical for national and international health development. It has selected at the topic for 1984, "The Role of Higher Education in the Strategy of Health for All by the Year 2000". This is further evidence of the importance that is being attached by international health planners to revisions of the educational systems of doctors, nurses and other health professionals.

Several examples might be chosen of the inappropriateness of current trends in the teaching and practice of medicine - in both the developed and the developing world. Some of the more obvious are to be found in the area of disease prevention and control. In comparison with curative medicine it has always been difficult to gain and sustain public and professional interest in preventive and control approaches; and what has now become a matter of wide international concern is the limited knowledge of, or motivation towards, preventive approaches shown by the average medical practitioner, whether in relation to communicable or non-communicable diseases, whether in developed or in developing countries. Prevention always seems to be a role to be relegated

to others. The result is that many eminently preventable disorders are hardly tackled at all.

Let me quote at this point from an editorial in the BMJ which appeared in the issue of 17 November 1990 and which focussed on the need for the better education of medical students about the prevention of coronary heart disease:

"There is no consensus about what to teach medical students about prevention coronary heart disease or who should teach it and consent teaching nationwide is patchy and inadequate. These were the two main messages to emerged from a conference on undergraduate medical education held by the National Forum for Coronary Heart Disease Prevention and British Heart Foundation. It was emphasised that coronary heart disease is the leading cause of death in Britain, and in Scotland is incidence is still among the highest in the world.

The seven more important risk factors for coronary heart disease are smoking, lack of exercise, obesity, stress, total serum cholestoerol levels and blood pressure. Lowering the serum cholesterol level, which is to a very large extent determined by diet would be an invaluable contribution to CHD prevention in individuals and in the communities.

The future of medical education lies in encouraging analytical thought, providing more teaching aids for independent coronary and protecting our students from teachers."

Prevention is one of the aspects of health on which there is not likely to be much disagreement. For most medical disorders prevention is clearly cheaper, more humane and more effective than intervention or treatment after they occur. This observation is hardly new; but it gives us the opportunity to look back critically at the past and forward to the opportunities for the future. I invite your reflection on why prevention has failed so far to engage the attention of the medical profession; on why prevention has not become a more important element in the health expectations of the public; on the distinction between medicine as a social institution and medicine in its more limited role of caring for the sick; on how in its larger role medicine could come to grips with the wider issues that influence health;

on the true meaning of health and on how this meaning might be made more central to the concerns of both medical education and medical practice.

It was in order to give prevention its appropriate place that Sir Richard Doll selected "Prospects for prevention" as the title for his 1982 Harveian Oration to the Royal College of Physicians of london. "How can we respond," he asked, "more effectively to Harvey's exhortation to search and study out the secrets of medicine by way of experiment than by carrying out the ultimate experiment of putting the conclusions of research to the practical test of their ability to change the world?" His statement not only gives the highest endorsement to prevention as a professional imperative, it confirms it as a logical and ultimate objective of science.

Progress will continue to be made by improvements in the treatment of diseases and by the provision of more and better facilities for health care; but the opportunities for improving health by the prevention of disease are even greater. A major constraint against effective preventive measures is almost certainly the fact that a person who suffers harm from an illness that might have been prevented is immediately identifiable, whereas the one whose disability is avoided or whose life is saved by preventive measures may remain totally anonymous.

Without being too technical let me give some examples of the potential benefits of prevention. Rheumatic heart disease is of special relevance in much of the developing world, and is still hugely relevant here in Britain. In spite of the declining prevalence reported from most parts of the developed world and in spite of the fact that guidelines for its control are clearly established, there is overwhelming evidence that in global terms rheumatic heart disease is still today the commonest form of acquired heart disease in children and young people and one of the commonest in adults. It is a medical irony that this should continue to be true for one of the few really preventable chronic diseases known to medicine. It is not by heart transplant surgery, but by prevention that the global problem of rheumatic heart disease is to be dealt with. A recent Lancet editorial points out that "an immediate reduction of the prevalence of rheumatic heart disease in countries where it is still high could be achieved by the adoption of the

practical and economic public health measures that are currently available to health planners and trained medical personnel.

GRESHAM COLLEGE

Policy & Objectives

An independently funded educational institution, Gresham College exists

- to continue the free public lectures which have been given for 400 years, and to reinterpret the 'new learning' of Sir Thomas Gresham's day in contemporary terms;

- to engage in study, teaching and research, particularly in those disciplines represented by the Gresham Professors;

- to foster academic consideration of contemporary problems;

- to challenge those who live or work in the City of London to engage in intellectual debate on those subjects in which the City has a proper concern; and to provide a window on the City for learned societies, both national and international.

Gresham College, Barnard's Inn Hall, Holborn, London EC1N 2HH
Tel: 020 7831 0575 Fax: 020 7831 5208
e-mail: enquiries@gresham.ac.uk