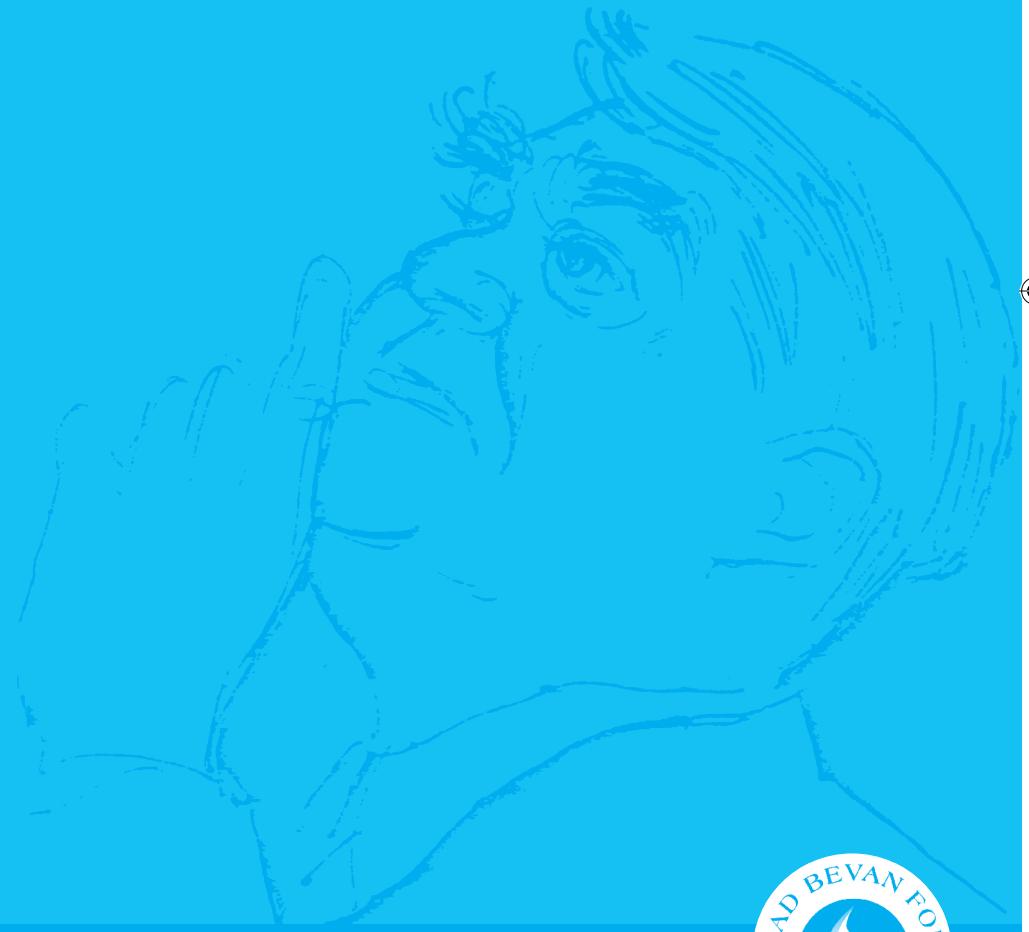
Improving Public Health
the Agenda for Wales

Dr Tony Jewell
Chief Medical Officer for Wales



Fifth Bevan Foundation Annual Lecture
24th October 2006

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It gives me great pleasure to deliver this year's Bevan Foundation lecture. It is an honour for me to do so, particularly in view of the distinguished speakers who have undertaken this role in the past.

Now six months into my new role as Chief Medical Officer for Wales, I will set out how Aneurin Bevan and other key "Welsh" leaders have shaped my thinking, put this into the current context of health and inequalities in Wales, and outline my personal priorities working for the Assembly Government. As I do so, I do this from a personal and professional perspective, not as a statement of official government policy.

The NHS of 2006 is, as one would expect, a quite different organisation from the one which came into existence on July 5 1948. But I think it's important to look back to the creation of the health service from the Welsh crucible before looking at the health of Wales today.

Above my desk in Cathays Park I have a picture of what I call the four architects of health in Wales.

Obviously the first is Aneurin Bevan, whose statue looks down at me from Queen Street every day. I will return to him in a minute.

The second is Lloyd George, whose 1911 national insurance scheme provided free consultations, free medicine and sick pay for wage-earners who paid into the scheme. It is estimated that the scheme covered about 30% of the population and it was a significant step towards the creation of the welfare state.

Indeed, current debate in England is even now re-examining the option of the NHS becoming an insurance system, simply commissioning rather than getting involved in the direct provision of services.

Lloyd George is still referred to today in the modern NHS when staff in GP practices refer to the A5 medical record folders as "Lloyd George's" which were brought into being in 1911 and seem somehow to have survived the A4 and IT revolution in many practices. I recall the phrase being used in my East London GP practice which changed to A4 records in the 1980s. His contribution to the development of the NHS however needs more recognition - at least in Wales!

The development of the NHS in 1948 was clearly not just an extension of the National Insurance Act. Now employing more than a million workers, there is an NHS public service ethos of which I am sure Bevan would approve.

My third architect is Archibald Cochrane who, despite his Scottish ancestry, made his main scientific and analytical contribution in and from Wales.

It would be difficult to overestimate Archie Cochrane's contribution to public health. In the thirties he served with the anti-fascists in Spain and later in the Second World War as a prison camp doctor having been captured by the Germans in Crete. He was an activist, taking to the streets in support of the NHS ideal with a slogan that still resonates: "All effective treatment must be free."

He worked at the Medical Research Council's Pneumoconiosis Research Unit in Penarth, for 10 years from 1948 where he conducted pioneering comparative studies of dust levels in the coal mines of South Wales. He launched the Rhondda Fach - Aberdare Valley ("two valleys") scheme to investigate the aetiology of progressive pulmonary fibrosis. He conducted long term follow-up studies of the population, with an interest in TB and pneumoconiosis. In his research work in the Rhondda he was able to achieve informed consent of an exceptionally high 90% from the subjects, thanks to his close working with the Miners Union.

In 1960 Cochrane was invited by the MRC to establish and direct a new Epidemiology Unit in Cardiff. The same year he was appointed to the David Davies Chair of Tuberculosis and Diseases of the Chest at the Welsh National School of Medicine.

The establishment of the Unit under his direction enabled him to develop his interest in randomised control trials as a means of producing unbiased estimates of the effectiveness of healthcare interventions, and it is this for that he is most widely remembered.

His 1971 Rock Carling Fellowship monograph "***Effectiveness and Efficiency - random reflections on health services***" was published, becoming hugely influential in medical thinking.[1] It is one of the key motivators of the paradigm shift which spawned the evidence-based medicine/healthcare movement.

Cochrane went on to be one of the founders of the Faculty of Public Health Medicine, where I saw him, and his name is still associated with the worldwide International Cochrane Collaboration. Ian Chalmers worked with him in Wales and was profoundly influenced by Cochrane and went on to do so much to develop the Collaboration. Coming new to Wales, I am amazed not

to find a Foundation Chair in Epidemiology in Cardiff University named after Cochrane.

My next architect is one I'm sure most of you will be familiar with, Julian Tudor Hart. His inverse care law, published in the Lancet in the same year as Cochrane's monograph, is rarely quoted in full but states:

> "The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."[2]

This "law" sadly still holds true today despite all our efforts to promote equity, to measure and recognise health inequalities and seek to reduce them.

Tudor Hart worked with Cochrane on epidemiological studies in the 1950s. In 1961 he started as a GP in Glyncorrwg, not very far from Llanelli where his father Alex had been recruited years before by the South Wales Miners Federation to work for the Llanelli Workers Medical Aid Society. The practice gained an international reputation for innovation, teaching and research over two decades. I was pleased to make my way from London while doing my training to visit the practice and benefit from his and Mary's hospitality. One of my GP partners was a Tudor Hart trainee and Julian's son now works in my former practice in East London.

Tudor Hart's rigorous approach to patient care demanded high-quality records and effective collaboration between practice staff. He argued that there was no lack of opportunity to monitor patients but, rather, failure to take the opportunities presented. He focused on smoking, blood pressure and diabetes and over 25 years reduced premature mortality by almost 30% in his practice population and the village community. His style of case finding and anticipatory care so well described in his classic book "***A new kind of doctor***"[3] has been reinforced recently in his new book on the political economy of health care as follows:

> "Our techniques were based on very high customary use rates typical of all coal-mining communities with long traditions of free care and heavy burdens of sickness and injury; on very high response rates to our research studies, secured through the trust generated by experience of continuing and emergency care readily provided; on staff embedded in the local community, with all the efficiencies inherent in caring for people already well known; on well-kept personal medical records, always available, used at every clinical contact, and reinforced by frequent informal contacts in

non-medical settings; and above all, on a registered, accurately defined population, so that every audit numerator had a population denominator - the absolute precondition for any sort of research relevant to health care policy."

As Julian showed, this style of "public health in primary care practice" makes a difference. During the period 1981-89 Glyncorrwg ranked in the bottom five most deprived of the 55 West Glamorgan wards. Using age-standardised mortality rates for under 65 year olds, it was 3rd place next to the more affluent wards in Swansea.

I was delighted for Julian and Mary Tudor Hart to note recently that he was awarded the first Discovery Prize by the Royal College of General Practitioners against strong international competition. He was nominated for this award by Professor Graham Watt, an ex Tudor Hart trainee and researcher and now Professor of General Practice in Glasgow. I look forward to local recognition - for example perhaps through the establishment of a Tudor Hart Chair in Primary Care in Swansea to continue the tradition of primary care based research, teaching and commitment to quality, and to help develop the new kind of doctors we need in Wales.

This takes me back to my first architect who is of course Aneurin Bevan, the founder of the NHS.

A moving quote comes from his wife Jenny Lee's book "***My Life with Nye***" about an event shortly after the NHS was founded in 1948:

"There was a strict rule in Nye's Ministry that any unsolicited gifts sent to him should be promptly returned. On one occasion, and only one, an exception was made. Nye brought home a letter containing a white silk handkerchief with crochet round the edge. The hanky was for me. The letter was from an elderly Lancashire lady, unmarried, who had worked in the cotton mills from the age of twelve. She was overwhelmed with gratitude for the dentures and reading glasses she had received free of charge...but the words that hurt most were 'Now I can go into any company.' The life-long struggle against poverty is what made all the striving worthwhile."[4]

Such individual examples find their place in Bevan's book "***In Place of Fear***" when he writes:

"Not even the apparently enlightened principle of the greatest good for the greatest number can excuse indifference to individual suffering."[5]

Aneurin Bevan had, of course, first-hand knowledge of the poverty and deprivation that made a free NHS a godsend for so many people. David Widgery, a GP colleague in East London, in his book "***Health in Danger***" makes three key observations about Bevan:

- "He knew at first hand the human suffering caused by a welfare system based on organised stinginess, where the price of lives were merely an item in the cost of things and there were no aims that could not be accounted for on a balance sheet...

- Second..."He knew, too, the medical traditions of the South Wales miners whose lungs, eyes and limbs suffered in the pits, and who formed working men's clubs to choose and supervise their own doctors in hospitals owned by the community.

- Third ..."He came from a world where collective action to organise society and active trade-union involvement in health was assumed. His father, who died in his arms of pneumoconiosis, was a founder member of the Tredegar Working Men's Medical Aid Society. Bevan saw health as a field in which individual commercialism ran counter to most social value...He wrote that 'a free health service is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst.'"[6]

The provision of health care before the NHS had been brought about by the collective efforts of working men. The Tredegar Medical Aid Society and the Medical Aid Fund in Ebbw Vale were both set up in the 1870s, and there were other schemes across South Wales, and in England and Scotland.

In 1902 Thomas Evans, Secretary of the Ebbw Vale Workmen's Doctors' Fund (as it was then called) surveyed medical schemes available to workmen across the country. Even the names of those in South Wales are redolent of times long past:

Rhymney Collieries and Works
Dowlais and Cyfarthfa Works and Collieries
Pyle and Blaina Works, Blaina
Patent Nut and Bolt Works, Cwmbran
North's Navigation Colliery, Maesteg
Powell Duffryn Collieries, Aberaman
Nixon's Navigation Collieries, Mountain Ash

The Tredegar Workmen's Medical Aid Society was one of the earliest schemes to be established, and was probably the most successful scheme in the Valleys. Everyone employed by the Tredegar Iron and Coal Company, who contributed 3d in the pound deducted from their wages, was entitled to free medical attention and medicine for themselves and their families. There was also a sick pay scheme.

The Society employed four doctors at the turn of the 20th century. It funded Tredegar Park Cottage Hospital which opened in 1904. Central Surgery in Church Street, Tredegar, opened in 1911. The year before, the Society had advertised the post of Chief Medical Officer. It received 47 applications. Everyone who paid subscriptions was entitled to vote and after three ballots a new CMO was elected.

Despite the work of such organisations, and charities, for many poor families the choice was between a visit from the doctor or food on the table. The link between poverty and disease was painfully clear.

Take the single most fundamental index, the infant death rate. In 1935 in the Home Counties it was 42 per thousand live births, it was 63 in Glamorgan, 76 in Durham, 77 in Scotland, 92 in Sunderland, and 114 in Jarrow - almost a threefold difference.

A BBC documentary called “Pennies from Bevan” broadcast in 1998 to mark the 50th anniversary of the NHS, recalled how women, in particular, suffered when medical treatment cost money. They put their family's needs first and often didn't have treatment at all or left it too late. Dr Barbara Clayton records that in Edinburgh shortly after the formation of the NHS she was asked to sort out the waiting list for treatment for prolapsed uterus. She found that some women had been on the list for 30 years.

Within a year of its birth, more than 41 million people were covered by the NHS. In the first year, 187 million prescriptions were written by more than 18,000 GPs. Eight-and-a-half million dental patients were treated, and 5,250,000 pairs of glasses prescribed. "I shudder to think," said Bevan, "of the ceaseless cascade of medicine which is pouring down British throats at the present time."[7]

But not everyone was impressed by the new service as reflected for example in The Daily Sketch newspaper in 1948:

> “The State medical service is part of the Socialist plot to convert Great Britain into a National Socialist economy. The doctors' stand is the first effective revolt of the professional classes against Socialist tyranny. There is nothing that Bevan or any other Socialist can do about it in the shape of Hitlerian coercion.”[8]

As you can see, the popular end of the British newspaper business was as sober and measured in its approach then as some of the tabloids are today.

But without doubt the NHS helped transform the health of the people of Wales. It helped rid the country of scourges such as tuberculosis, which caused thousands of deaths each year before the Second World War, and brought infant mortality roughly in line with the rest of the UK. This is the legacy of Aneurin Bevan, Minister for Housing and Health.

These four architects - Lloyd-George, Bevan, Cochrane and Tudor Hart help focus me on four main principles for action:

1. Social justice, human rights and community solidarity
2. The NHS and public service ethos and values
3. Public health evidence and the needs of defined populations
4. The importance of the primary health care delivery system for equity, effectiveness and efficiency

So what is the state of the nation's health today?

Professor Peter Townsend's final report, **"*Inequalities in Health: the Welsh Dimension 2002-05*"** provides dramatic scene-setting.[9] It points out that:

- Mortality rates in Wales are among the worst in western Europe.
- The death rate from heart disease in Wales is substantially higher than that in many European countries.
- Wales has among the highest rates of cancer registrations in western Europe.
- In the last census, Wales had a much higher percentage of people reporting long-term limiting illness than England.
- There is consistently poor health in the South Wales valleys - in 2000-2002 death rates in Merthyr were 50% higher than in Ceredigion.

If we regard average life expectancy as a key indicator, we see that the figure for Merthyr Tydfil (73.8) for men is almost 4 years lower than in Ceredigion (77.7). A similar pattern can be seen between the South Wales Valleys and much of the rest of the country. This then is a question of human rights and social justice.

These illustrate graphically the geographical inequalities in Wales which need to be addressed and the need for strategies such as the Heads of the Valley investments.

Spatial inequalities can be mapped to illustrate the historical working class communities in the old mining and steel valleys and urban South Wales.

However, poverty and ill health go together wherever individuals and families live and we know that there are large inequalities for the most common diseases and causes of premature death such as cancer and circulatory diseases when analysed by socio-economic group. For example, in data published in 2001 in a report on health inequalities, the European Age Standardised Mortality Rate in Wales for coronary heart disease among those under 65 was 33/100,000 of the population for the least deprived group and 69/100,000 for the most deprived.[10]

At a time when there is increasing recognition of the importance and value of better health, too many people in Wales suffer from diseases such as coronary heart disease, cancers, and mental illness, many of whose risk factors are preventable.

Circulatory diseases, mainly heart disease and stroke, and cancers account for two-thirds of all deaths in Wales, according to the Health Status Wales report 2004-2005. According to the Chartered Institute of Environmental Health, of the nine local authorities in England and Wales with the highest rates of reported poor health, seven are in Wales.[11]

Although the incidence of diseases such as coronary heart disease is declining, trends in other conditions are storing up severe problems now and for the future. The trend in childhood obesity, in particular, threatens to create a situation where grandchildren die before their grandparents; in the United States, where the obesity epidemic is more widespread, there are fears that children of this generation will not outlive their parents if the trend in obesity is not reversed.

Apart from the cost in human misery, treating the medical consequences of obesity - high blood pressure, type 2 diabetes and its associated blindness and renal failure (potentially necessitating long-term haemodialysis) - are significant. The prevalence of diabetes is increasing alongside the obesity epidemic. It is estimated already that the cost of treating diabetes alone accounts for 9% of the NHS budget.

We need to take urgent action on this front, and the need to mobilise parents to protect their children from avoidable disease, is pressing.

Though there has been a considerable reduction in premature mortality across the whole population, the gap between those with the best health and those with the worst health is widening.

Health improvement and narrowing of health inequalities between social groups will be achieved primarily by economic, social, environmental and public health policy rather than by medical or other personal health care services. Action to curb smoking - a major contributor to health inequalities since its impact is most keenly felt among the more disadvantaged people in society. In Wales, for example, 14% of people in the higher managerial and professional socio-economic group are smokers. Among the long-term unemployed and those who have never worked, 43% are smokers.

What are we doing to improve health and address health inequalities in Wales? And what is the role of the Chief Medical Officer?

The Chief Medical Officer advises the government on the strategic direction for public health in Wales, and acts as an advocate for health on behalf of the general public, including the most vulnerable in society.

The CMO also provides independent professional advice and guidance to the First Minister and other Welsh Assembly Government ministers, and to officials in the National Assembly for Wales on health and healthcare matters, and all matters that have an impact on health.

The classic definition of public health is that it is "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society."[12]

The World Health Organization's Bangkok Charter (2005) states that progress towards a healthier world requires strong political action, broad participation and sustained advocacy.

It says that all sectors must act to:

- Advocate for health.
- Invest in sustainable policies, actions and infrastructure to address the determinants of health.
- Build capacity for policy development, leadership, health improvement practice, knowledge transfer and research, and health literacy.
- Regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people.
- Partner and build alliances with public, private, non-governmental and international organisations and civil society to create sustainable actions.

Clearly, government has a central role to play in all these areas.

Since taking up my post in April, I have developed four main priorities. They are:

- Improving health and reducing health inequalities, including inequalities in access to services, and quantifying and demonstrating progress.
- 'Preventing the preventable' - protecting the health of the population through screening, immunisation, and wide-ranging (and cross-cutting) action to counter threats to health such as smoking and obesity.
- Working with the NHS and Social Care to ensure high standards of care to assure patient safety and quality.
- Fostering a stronger research and academic sector in public health, health service research and biomedicine.

The fifth priority is an underpinning one, namely to develop modern health information systems that enable us to support clinical service delivery, allow patients access to their records, benchmark and measure performance. I am pleased that the Informing Health Care project is making good progress in Wales to electronically link the citizens to the NHS and enable greater efficiency in service delivery and effectiveness in clinical practice.

There is also increasing evidence which points to fairer societies being healthier ones even when the per capita gross domestic product and health system funding is less. Government action to promote social inclusion, opportunity, and community cohesion will help to improve the health and well-being of the people.

So we need to address the determinants of health - economic, social and environmental factors that affect health - to bring about long-term improvement in the health of the nation.

To take a few examples of work my office is currently involved in:

- Working with the Social Justice and Regeneration Department and the National Public Health Service for Wales to develop targets for eliminating the effects of poverty on child health.
- Working with the Environment, Planning and Countryside Department to incorporate Health Impact Assessment in the Wales Waste Strategy.
- Health outcomes and indicators have been incorporated into the Transport Strategy consultation document.

- Working with a range of Assembly Departments on an 'early years' strategic approach, designed to give children in Wales the best possible start in life.
- The proposed ban on smoking in enclosed public places has involved extensive cross-departmental working, as well as partnership working with external bodies, such as local authorities. The smoking ban will have a significant impact on health inequalities since smoking hits disadvantaged communities hardest.

In Wales we are doing things differently. So differently in fact that NHS Wales was described earlier this year a “a placebo” against which the “reformed” health service in England will be tested.

The difference in approach between England and Wales was identified by First Minister Rhodri Morgan in what became known as his “Clear Red Water” speech:

“Our commitment to equality leads directly to a model of the relationship between the government and the individual who regards the individual as a citizen rather than as a consumer. Approaches which prioritise choice over equality of outcome rest, in the end, upon a market approach to public services, in which economic actors pursue their own interests with little regards for wider considerations.”[13]

This difference in approach is one reason why I'm pleased to be working in Wales to build on the firm foundations and frameworks created by my Four Architects - Lloyd-George, Bevan, Cochrane and Tudor Hart. They help focus me on what I believe to be the foundations for action to improve health:

- Social justice, human rights and community solidarity
- The NHS and public service ethos and values
- Public health evidence and the needs of defined populations
- The importance of the primary health care delivery system for equity, effectiveness and efficiency

Thank you.
Diolch yn fawr.

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Notes

Notes

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