Health of the nation

EDITOR,—The white paper *The Health of the Nation* has failed to tackle health inequalities linked to poverty,¹ which the World Health Organisation's "health for all" strategy ranked as an important priority.² John Gabbay's editorial highlights WHO's health for all principle of encouraging the community to participate in decisions rather than telling them what to do.³ Thus they "own" the issues and have a genuine investment in and commitment to them.

The health of populations lies fundamentally in the extent to which they are empowered and able to influence what happens in society around them.⁴ When patients living in the large postwar peripheral council housing estate of Hartcliffe and Withywood, which we serve, were asked "What do you think would improve your own health?" the commonest replies were better housing, a better environment, more money, less smoking, and less stress.⁵ Thus our disadvantaged patients identified socioeconomic and environmental inequalities as pivotal to their health, rather than the lifestyle issues that the government wishes to concentrate on.

On the day that our "forgotten area of deprivation" of Hartcliffe and Withywood⁶ failed for the second time to win resources from the Department of the Environment's city challenge competition major riots occurred. These two events are not unconnected. Grants of £37.5 million should have attracted further resources to a total of £180 million over five years. This would have helped improve housing, the environment, and transport systems; create new jobs and the training for them; and create recreational facilities. All of these would have helped to improve the health and wellbeing of our patients. Wilkinson has shown clearly that differences in health within developed countries are principally a function of inequality of income,⁷ and this explains why social class differences in health have not narrowed despite growing affluence and the fall of absolute poverty.

The social unrest in Hartcliffe is a cry for help—help that is desperately needed to make this population feel part of our society again and to give it "an average chance of health."⁸

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1 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (Cm 1986.)

2 World Health Organisation. *Global strategy for health for all by the year 2000*. Geneva: WHO, 1981.

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EDITOR,—Mental illness is a major cause of disability and premature death, so the emphasis on a reduction in the suicide rate in the white paper *The Health of the Nation* is welcome.¹ The white paper seems, however, to rely on old research findings which claimed that most people who committed

suicide had been in contact with health services and that most had a mental illness.² We have audited all suicides in our district, and our data contradict these views.

We searched the coroner's records in Nottingham and Chesterfield for all verdicts of suicide and accidental death and open verdicts for residents of our catchment area (population 305 000); the notes were reviewed and summarised if suicide was a possible cause of death. All cases previously known to our services were presented by the relevant consultant and peer reviewed. The summaries of the coroner's records of those not known to the psychiatric services were also reviewed.

Thirty nine of the patients were known to the psychiatric services (table), and it was thought that in only four of these cases might the suicide have been averted if the patient had been managed differently. This suggests that the white paper's target of a 33% reduction in suicides in those with severe mental illness is unrealistic.

Numbers of people who committed suicide known and not known to psychiatric services

	Known		Not known
	Currently	Last seen >1 year previously	
1988, 1989	20	8	25
1990	8	3	18
Total	28	11	43

Of those not known to the psychiatric services, less than half were judged to have had a mental illness. A common cause of suicide was the break up of a relationship. This was looked for in the suicides in 1990. Of the 18 people not known to us, eight (seven male, one female) committed suicide after a spouse or partner left them. These deaths were the more tragic because the people were younger and did not have intolerable chronic psychological or physical problems. Conventional psychiatric services would have little impact on this group, and a public education approach may be more relevant.

The strategies recommended by the white paper include reorganising existing resources, and encouraging good practice through clinical audit. Our audit has made us more alert to the risk of suicide in younger men whose relationships have recently broken down, but we do not yet have the figures for 1991 to check whether this has influenced the suicide rate. Even so, we do not expect to see the required 15% reduction in the overall suicide rate. We suggest that additional resources will be needed to reach people at risk of suicide who are not known to existing services.

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1 Delamothe T. Towards a healthier England. *BMJ* 1992;305:135-6. (18 July.)

2 Barraclough BM, Bunch J, Nelson B, Sainsbury P. A hundred cases of suicide: clinical aspects. *Br J Psychiatry* 1974;125:355-73.

EDITOR,—Like John Gabbay, I welcome the white paper *The Health of the Nation* as a huge step

forward for health policy in Britain.¹ I also welcome the emphasis that it places on research, described as "essential to any strategy to improve health."

Several of the government's targets can be advanced with considerable confidence because they build on knowledge deriving from past investment in research and development. Further research is needed to provide the information on which future targets can be set as the strategy develops. The government has identified candidates for key area status for which further research and development are needed before targets can be agreed, such as rehabilitation, the health of older people, asthma, back pain, and drug misuse. The Medical Research Council and its research boards are now discussing what contributions they can most effectively make both in these specific areas and more generally to the new health strategy and the parallel initiatives in Scotland, Wales, and Northern Ireland.

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Promoting sexual health

EDITOR,—Richard Smith's editorial on promoting sexual health highlighted the difficulties in delivering health messages regarding preventing HIV infection and the need for a favourable attitude towards discussion on sexuality and rightly predicted that the government's white paper, *The Health of the Nation*, would prioritise sexual health.^{1,2}

These issues have special relevance for targeting adolescents and teenagers. A range of indicators supports research findings that adolescents are becoming sexually active younger and have more partners; but they lack behavioural skills to negotiate safer sex and experience unexpected consequences of their sexual activity—for example, pregnancy and sexually transmitted diseases.

The conception and abortion rates for girls under 16 increased by 24% and 30% respectively between 1977-9 and 1987-9.^{3,4} The fall in new cases of gonorrhoea between 1980 and 1988 occurred in people over 25. Between 1981 and 1990 female patients under 20 outnumbered male patients under 20 for all sexually transmitted diseases except HIV infection, AIDS, and syphilis.⁵ Mortality from cervical cancer also shows a worrying trend in younger women: the percentage increase in women aged 25-34 was 154% from 1971-3 to 1986-8.⁶

These data support the findings of a survey in which 65% of young people aged 16-19 reported that they were sexually active.⁷ Some reported having had four or more partners in the previous 12 months. Most respondents were concerned with preventing pregnancy and regarded the contraceptive pill as the best protection against pregnancy. Awareness that condoms protect against infection was high, but the young people were unable to translate this awareness into perception of their personal risk. Few young people perceive their behaviour and lifestyle as relevant to practising safer sex. Other studies confirm that awareness and knowledge of AIDS and contra-

ception are high among adolescents but that they lack the sense to assess personal risk.^{8,10}

These studies suggest that cognitive development plays an important part in adolescents' sexual behaviour. Hein mentioned four features of adolescent sexual behaviour: feelings of invulnerability, concrete versus abstract thinking, peer conformity, and denial.¹¹ Adventure and gratification (short term and immediate) could also be included in this list.

We need to teach adolescents skills and values in making decisions about their sexuality, including delaying sexual intercourse. These interpersonal behavioural skills are more likely to be acquired in a supportive social and economical environment and a society that is comfortable when talking about both the positive and negative consequences of sexual relationships.

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- 1 Smith R. Promoting sexual health. *BMJ* 1992;305:70-1. (11 July.)
- 2 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (Cm 1986.)
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EDITOR,—In his editorial Richard Smith writes of a meeting of social engineers of indeterminate status at Leeds Castle.¹ This faceless group's purpose is to change people's attitudes in some unspecified way that is supposed to promote sexual health—a term used without definition. The intended propaganda offensive seems to be but an intensified and more explicit version of the sort of thing in place now, replete with a jauntier but equally meretricious alternative slogan to "safe sex." The wish is to encourage "a more erotic, positive, and diverse kind of sexual behaviour" as a contribution to the struggle against HIV.

In the front line as a general practitioner and a parent, I thought this approach wrong 30 years ago and feel sufficiently vindicated to prophesy that it will continue to be counterproductive: it has been accompanied by increasing promiscuity, abortions, venereal disease, and broken marriages.

Ominously, Smith says that those at this meeting not only condemned opposition to their views from moralists but, with breathtaking hubris, determined that it was their "duty not to bend to these people." No doubt there are those in the group who have the power to manipulate opinion in the media, including the *BMJ*, to suppress argument uncongenial to "amoralists" or "immoralists" (whatever the suitable word is for the opposite of people labelled moralist). I would hope that professional integrity would induce them to turn from such wickedness, but I am not the least bit confident of this now that they have proclaimed a higher duty.

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EDITOR,—In discussing the best way to tackle HIV infection Richard Smith mentions that people should be able to exercise choice in sexual relationships.¹ To make an informed choice, however, people need to know certain facts about use of condoms. A discussion of attempts at developing a condom made of plastic stated, "While a more expensive material than latex, plastic is more uniform with fewer pinholes or variations in thickness."² In the same issue of *Population Reports* a recent analysis for the World Health Organisation of data from nine published studies was quoted. It found that people using condoms faced a risk about two thirds that of non-users of developing gonorrhoea, trichomoniasis, or chlamydia infection; when data on transmission of HIV from 10 studies were combined the analysis found a relative risk of 0.4 for people using condoms (M Rosenberg *et al*, strategies for viricide research meeting, World Health Organisation, March 1990).

A survey of people experienced in using condoms from a family planning clinic in Manchester reported that "52% of respondents had experienced condoms bursting or slipping off in the previous 3 months."³ The authors went on, "We were surprised to find how commonly our clients had experienced 'accidents,' even those who had apparently relied on condoms as their method of choice for contraception." The senior author of the above report also criticised the statement that "Most condom failure is due to incorrect usage" and added "We do the public no favours by promoting the idea among medical staff that it is all the fault of the user when things go wrong."⁴

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EDITOR,—Richard Smith's editorial on promoting sexual health addresses an important and sensitive public health issue.¹ His statement that "Roughly half of 16 year olds in Britain have had sexual intercourse" requires close examination, particularly because his article, rather than original data, is liable to be used by the mass media.

National statistics are not available, but recent surveys have shown that most teenagers are not sexually active before their 16th birthday.^{2,3} Although half of teenagers are probably not virgins by their 17th birthday, so that Smith's statement is technically correct, we believe that his statement may mislead and be interpreted, particularly by the media, as suggesting that the rate of sexual activity is higher than it actually is for teenagers below the age of consent. For example, a recent headline in the *Independent* read "Nearly half of young people lose virginity before 16,"⁴ even though the original article quoted did not give this information.⁵ An analysis of the given data (presuming that the age cohorts are equal) suggests a figure of roughly 34%—that is, a third rather than half, which is entirely consistent with other data.²

Society's view of what is normal has an important influence on individual behaviour.⁶ "Everyone's doing it" is a common myth among teenagers. Those attempting to reduce risk taking by teenagers in other aspects of their lives have found it useful to expose similar myths.⁶ If teenagers are led, by both the medical and the general press, to believe that most of their peers are sexually active this will increase pressure on them in their relationships still further. Those under 16 who are virgins may be labelled as a minority group, with an implication of abnormality.

Should we perhaps be more circumspect in our reporting of such figures? There is enough heat

within teenage relationships without the medical profession stoking the fire.

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- 1 Smith R. Promoting sexual health. *BMJ* 1992;305:70-1. (11 July.)
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EDITOR,—Richard Smith highlights the problems encountered at a recent conference at Leeds Castle in finding a way of changing sexual behaviour to reduce the chances of HIV infection and unwanted teenage pregnancy.¹ The present emphasis is on the need to find a clear and readily understandable message. Given the gravity of the risks, would it be wrong to suggest that this should be "No sex outside marriage"? Such an approach might ease the burden on some teenagers, who may perceive themselves to be under pressure from their peers and the establishment to embark on sexual activities for which they are not really ready.

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- 1 Smith R. Promoting sexual health. *BMJ* 1992;305:70-1. (11 July.)

EDITOR,—We endorse Richard Smith's view that the struggle against HIV needs reinvigorating and agree that the clarity of messages regarding health is important.¹ We are concerned that messages from some professional bodies are not only unclear but also damaging. For example, a statement from the Royal College of Surgeons of England earlier this year includes the recommendation: "If a patient is in a high risk category, he or she should be offered an HIV test, provided that facilities for counselling are available both before and after the test."² This is with a view to an operating surgeon deciding what extra precautions should be taken to minimise transmission of HIV during treatment or surgery.

No guidance is given regarding who should be included in such a category (it does not include known or suspected cases of HIV infection, for which there is a separate recommendation). Any assessment of high risk would require a detailed history, not just about injecting drug use and homosexual practice but also about heterosexual activity since the proportion of adults with AIDS reported to be heterosexual is 20%.³ We doubt whether such a history is part of the routine preoperative assessment undertaken by surgeons. In our view, the term "high risk category" is inappropriate and stigmatising and, in the context of control of infection, leads to false reassurance with regard to patients who are not perceived as being at high risk. Indeed, the recommendation is contrary to that given by the World Health Organisation, which advocates universal precautions regarding blood and body fluid (that is, that all blood and certain body fluids are assumed to be infectious for hepatitis B virus and HIV and other bloodborne pathogens) as the cornerstone of preventing transmission of bloodborne infections.⁴

Terminology and messages are important: the continued use of the term high risk category suggests that there is still a widely held belief that HIV infection occurs only in specific well defined