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Public health

Health and social care service changes: the potential to increase inequalities

D A C Elliman, H Bedford

Perspective on the paper by Granerod *et al* (see page 805)

The paper by Granerod *et al*¹ shows how children seemed to have been “lost” when the Child Health Information Systems (CHISs) were interrogated to provide the routine immunisation statistics (COVER). This was at a time when the reports changed from being based on a resident population to being based on the primary care trust (PCT) responsible population, i.e. those children who were patients of the PCT's GPs, but not necessarily resident within the PCT's geographical boundaries.² The United Kingdom has probably the most accurate and timely system in the world for monitoring immunisation uptake.³ Most other countries rely on either knowing the numbers of doses of vaccine administered or on representative surveys.^{4–5} It is of concern that this system was compromised, but the trend of improvement in accuracy reported by the authors is encouraging. However, currently (April 2006), 10 of the 31 PCTs in London are unable to produce any COVER statistics because they are in the process of installing new “interim” CHISs.⁶

What the authors do not mention is that the CHISs are also frequently used to generate appointments for vaccination. This is particularly so in areas such as inner London. If the systems cannot produce statistics for immunisation, are

they able to produce appointments for all their population? We know they cannot do this currently in London, and anecdotally, there are difficulties in other areas. At the time of writing, a new immunisation schedule is about to be introduced.⁷ Whereas previously, the programme was fairly simple to remember and the vaccines given at 8, 12, and 16 weeks were the same on each occasion, in future, they will differ. In addition, there will be new boosters in the second year of life and a pneumococcal catch-up campaign. Without an efficient information system, it will be very difficult to ensure that appointments for this new programme can be generated and the new programme which includes the introduction of a new vaccine will not be effectively monitored.

But this has wider ramifications than “just” the immunisation programme. CHISs are used to monitor routine screening throughout childhood, e.g. newborn blood spot screening. Results are recorded on the systems and those children for whom there is no result available should be followed up, either to obtain a lost result or to take a repeat sample.⁸ Since the introduction of PCTs in 2002, there has been a discordance between the population for whom they commission services and those for whom they directly provide services. Health visitors traditionally provide services to the resident

population, whereas the PCT is responsible for providing services to the patients of “their” GPs and anyone resident in their area if not registered. It is primarily health visitors who are involved in ensuring that all children have had their newborn blood spot screening performed and often also that they have been immunised. The discordance in roles outlined above means there is potential for children to slip through the net.

Just as the team evaluating the Sure Start programmes commented that “the people who have missing data are not randomly distributed in the population studied and may include some of the most disadvantaged”,⁹ the same is likely to apply here. Those who are most disadvantaged are those we may have most difficulty in tracking and facilitating their access to health and social services. This may result in an increase in health inequalities. Reporting on the early outcomes, the Sure Start Evaluation Team noted that, among disadvantaged families, greater benefits were achieved in the moderately disadvantaged families than those with severe disadvantage, thus increasing inequalities. They also noted that some of the most disadvantaged families fared worse in areas where a Sure Start programme had been introduced, than where one was yet to be applied.

In 2005, the Health Inequalities Unit reported on progress in reducing inequalities.¹⁰ Although infant mortality in all socioeconomic groups decreased in the period 1994–2003, the ratio of routine and manual socioeconomic groups to all socioeconomic groups increased from 1.15 to 1.19, indicating an increase in inequality. Similarly, between 1998 and 2003, despite an overall reduction in childhood injuries, the absolute difference between areas of different socioeconomic status remained unchanged and the relative difference increased. Over the same period, teenage

pregnancies fell overall, but there was a small increase in the relative difference. This potential of well intentioned programmes to increase inequalities has also been noted in the USA.¹¹

So, what lessons can we learn from these examples? It is fundamental that, as far as possible, any potential adverse effects have been considered before embarking on a new initiative. However, it is not only the effect on the population as a whole, but the potential effects, both adverse and beneficial, on the more vulnerable members of the community that have to be considered. This analysis may lead to a realisation that during the introduction of some programmes—new CHISs or changes in responsibilities—safeguards have to be put in place to ensure that the more disadvantaged do not suffer.

One of the hypotheses put forward by the Sure Start Evaluation Team to explain the worsening of some outcomes in the more disadvantaged families was that, in a more “client responsive environment”, services are used more by the relatively less disadvantaged groups, leaving fewer services available to the most disadvantaged. This has major implications for the current “choice” agenda that is being rolled out. There is a real danger: “to those that hath shall be given; from those that hath not, shall be taken”. Bearing this in mind, it is extremely important that we have a strong public health programme for children; that we monitor the overall

effect of all health and social care initiatives; and, equally importantly, their effects on the most vulnerable members of our society are closely monitored. In the current climate of the NHS, we have a duty to ensure that this is not lost in the need to cut costs and remember “the public health experience of historic patterns of the NHS, which has viewed prevention programmes as the easiest to cut and the most difficult to defend”.¹²

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Endocrinology

Very high dose inhaled corticosteroids: panacea or poison?

G Russell

Perspective on the paper by Paton *et al* (see page 808)

Only the older readers of *Archives* will remember a time when inhaled corticosteroid therapy (ICT) was not the mainstay of asthma treatment. In the 1960s asthma was an unpredictable and more or less untreatable disease, and the diagnosis was made with reluctance by doctors and accepted with dismay by parents. The therapeutic options were limited. For acute relief, isoprenaline (isoproterenol) was given by pressurised metered dose inhaler, but its effects lasted for only a few minutes, and it fell into disrepute

after only a decade, when its use appeared to be associated with increased mortality.¹ In hospital, subcutaneous adrenaline backed up by oral or intravenous corticosteroids was the mainstay of therapy. Interval management was mainly with bronchodilators such as ephedrine, theophylline, and the belladonna alkaloids, and compound preparations such as Tedral, an unlikely mixture of theophylline, ephedrine, and phenobarbital, were popular. These drugs were of undoubted benefit, but disappointingly large numbers of

children required maintenance therapy with oral corticosteroids.

The asthma clinic at the Children's Hospital in Aberdeen was established primarily to manage children who were on long term systemic corticosteroids for their asthma. My brief was to ensure that all other therapeutic possibilities were explored so as to keep the dose of corticosteroids to a minimum. Other than introducing the use of ACTH to protect growth,² I doubt if my ministrations made much difference until the arrival in rapid succession of salbutamol,³ sodium cromoglycate (cromolyn),⁴ and finally beclomethasone,⁵ which together transformed the management of asthma. As can be seen from fig 1, these new drugs rapidly made the original raison d'être of the clinic an irrelevancy, and I became a committed devotee of ICT.

INTRODUCTION OF HIGH DOSE ICT

Early experience with ICT suggested that it was more panacea than poison,⁶ and emboldened by the lack of evidence of adrenal suppression in early studies using