Public health strategy will tackle inequality in England

John Warden, *parliamentary correspondent, BMJ*

A new health strategy for England, to break the cycle of ill health due to poverty and deprivation, was initiated this week by the recently appointed minister for public health, Tessa Jowell.

She committed the government to a major change in policy, which recognises the link between poverty and health and produces an integrated approach. All government policies will in future be evaluated for their potential impact on health.

"You might call it being tough on the causes of ill health," she told a conference in London. "Poverty, unemployment, bad housing, social isolation, pollution, ethnic minority status, and gender have for too long been regarded as peripheral to health policy. Public health has been marginalised, and its laws and structures have been neglected."

Although such sentiments found a welcome response, there was dismay that the new policy is still so formative and has no new funding. Ms Jowell, however, did announce several paving initiatives over the next 12 months. These will consist of:

- A green paper to be published in the autumn, bringing together all the strands of the public health strategy, followed by consultation with the professions leading to a definitive white paper next summer.
- An independent review of

health inequalities by Sir Donald Acheson, former chief medical officer (21 June, p 1781). His report will identify priority areas for future policy development—"within the broad context of the government's overall financial strategy." It will contribute towards the new strategy for health.

- A review of the previous government's Health of the Nation policy and how it can contribute to the public health strategy. The aim is to build on what has been done, but with a relatively small number of health targets. David Hunter of the Nuffield Institute and Naomi Fulop of the London School of Hygiene and Tropical Medicine have been commissioned to carry out the review.

- A £1m (\$1.6m) programme of research into the effects of air pollutants in the home, such as tobacco smoke, allergens, and damp.

Ms Jowell said that government policies for a minimum wage, welfare to work, improved housing, education, a food standards agency, and tackling smoking would have a marked effect on people's health. These connections would be taken explicitly into account in developing policy, with legislation if necessary.

A coherent strategy with clear targets would guide action at local level, exploiting the

Tessa Jowell recognises the link between poverty and health

potential in the health promoting roles of local authority departments. Directors of public health would lead local action, and public health would be part of locality commissioning, building on the enthusiasm of GPs. "Health action zones" and "healthy living centres," funded from the national lottery, would feature in the plans.

Ms Jowell promised to strengthen the role and performance of the NHS with regard to public health. The department of health has initiated new research and development on health inequalities.

Two areas for priority will be schools and workplaces. Healthy schools could help to break the cycle of inequality, said Ms Jowell. Teenage pregnancy was a cause

as well as a symptom of deprivation: "If healthy schools can keep a child from following her mother by getting pregnant at 17, she has a better chance of breaking out of the loop."

The workplace is seen as another promising setting. Last year 187 million days were lost to sickness, 12 million more than in 1994. To reverse the trend would need different approaches for varying groups. The government would spread awareness of the benefits of a healthy workplace among individuals and businesses. Ms Jowell said that across Britain "the poorer you are the less healthy you are likely to be." She added: "Deprivation and inequality are blots on our society, and we want to remove them." □

Health inequalities cited by Ms Jowell

- In parts of Birmingham and Coventry, male life expectancy is below retirement age
- A baby born today into social classes I or II can expect to live five years longer than a baby born to parents in social class IV or V
- If the whole population had experienced the same death rates as non-manual groups, there would have been 550 fewer stillbirths and 800 fewer deaths in the first year of life in 1994 and 600 fewer deaths in children and 13 500 fewer deaths in men aged 20-64 in 1991

NHS gets £1.2bn cash boost

John Warden,
parliamentary correspondent, BMJ

Having vowed to keep within the previous Conservative government's spending plans for the health service, Gordon Brown, the chancellor of the exchequer, doubled the spending in the Budget by releasing an extra £1.2bn (\$1.9bn) for 1998-9.

But as the extra comes from raiding the £5bn contingency reserve, the Treasury claims that there is no U turn in policy. The new funding, however, was unexpected and confirms the looming financial crisis that the health secretary, Frank Dobson, inherited (17 May, p 1433). A delighted Mr Dobson said that the increase gives the NHS ample time to plan ahead for this year and next.

The increase amounts to an extra 5%, or 2.25% above inflation. This is slightly less than was allocated for the current year and falls below the 3% annual average increase by the Conservatives. With a £500m debt overhang already, health resources will remain overstretched, especially in the coming winter. Mr Dobson said that the extra money would not remove the need for greater efficiency and financial discipline or avoid the hard choices that the NHS had to make.

The chancellor said that the new money was being granted on the firm agreement that administrative reforms in health

would be fully implemented. More cash would be generated by action already initiated against prescription fraud, private capital for hospital building, merging trusts, and abolishing the NHS internal market. Hospitals would be expected to recoup from insurance companies the full fees of up to £3244 per patient for treating people hurt in road traffic accidents.

The new funding for the NHS will provide £1bn in England, £107m in Scotland, £60m in Wales, and £31m for Northern Ireland.

Other budget measures included the abolition of tax relief on private health insurance for about 550 000 people aged over 60, some of whom will end up on the NHS waiting list. The £140m saved will offset a reduction in value added tax on domestic fuel. A higher health tax on tobacco will mean that in future tobacco duties will rise on average by at least 5% a year in real terms rather than 3%. The tax on a packet of 20 cigarettes will go up by 19p from December.

The chairman of the BMA council, Dr Sandy Macara, said that the extra money was a pleasant surprise and added: "This is a recognition of our distress call. The worry is that we won't get it until next year. There is no way we can get through the crisis this winter unless we can draw in advance on the cheque."

Robert Maxwell, the King's Fund chief executive, said: "We are delighted that the Chancellor has decided to give extra money to the health service. But we must not be complacent. This

Gordon Brown wants health service reforms in return for the money

will not take the pressure off the service, and the Government must still look at how the money is to be used most efficiently."

A building programme of 14 new hospitals costing £1.3bn funded by the private sector and leased to the NHS under the

private finance initiative was also announced during last week's Budget speech. But negotiations for another 23 schemes under the private finance initiative were cancelled. The government said that this was necessary to "unlock the PFI gridlock." □

Clinical indicators for hospitals announced

Jacqui Wise, *BMJ*

League tables of 15 clinical indicators for hospitals in England are to be published for the first time, the health minister Baroness Jay announced at this week's launch of the NHS performance league tables for 1996-7.

The Labour government has not yet come to a decision about the future of the performance league tables, which give infor-

mation mainly on waiting times, but it believes that there needs to be a greater focus on measures of quality. The clinical indicators initiative, which was instigated under the previous Conservative government has been taken up by Labour, which wants to speed up and expand the programme. The tables will be published within the next four weeks.

Baroness Jay said: "This is an important first step towards meeting our commitment that hospitals will meet high standards, monitor services, spread best practices, and ensure rising standards of care."

The 15 clinical indicators all focus on care in hospital and have been developed in consultation with the Joint Consultants Committee. They include heart complications after surgery, deaths in hospital in the 30 days after a surgical procedure, adverse reactions to drugs in hospital, repeat operation rates after prostate surgery, frequency of dilatation and curettage in

women under 40, wound infection rates, damage to organs following surgical procedures, and emergency readmission rates.

The first set of clinical indicators will be anonymised, with only the name of the trust published, but the government says that it wants the names of hospitals to be published in the future.

The information is based on data for 1994-5. The Department of Health says that it wants to expand the programme and needs to examine what data should be collected in the future. The government also plans to develop primary care indicators. □

Researchers identify gene for fatal cholesterol disorder

Susan Mayor, *London*

Researchers have identified the gene responsible for an inherited disease characterised by abnormal accumulation of cholesterol—namely, Niemann-Pick C disease. Learning how the gene functions offers the first real hope for effective treatment of this fatal condition and gives new insight into how cholesterol is metabolised.

A team from the National Institute of Neurological Disorders and Stroke at the National Institutes of Health in Bethesda, Maryland, located the gene—NPC1—by a combination of approaches including positional cloning techniques and a strategy using yeast artificial chromosomes containing large pieces of human DNA to pinpoint the region on chromosome 18 (*Science* 1997;277:229-31).

Thirty families with nearly 80 members with Niemann-Pick C disease took part in the study, a

major international collaboration with participants from the Czech Republic, France, Israel, Japan, the Netherlands, and Britain, in addition to the United States. So far, eight different NPC1 mutations have been found in nine unrelated families with the disease. At the same time, collaborating scientists identified the same gene in a mouse model for Niemann-Pick C disease (*Science* 1997;277:232-5).

The disease is rare, affecting one in every one million individuals, although improved diagnosis is now picking up more cases. It is a lipid storage disorder in which there is lysosomal accumulation of low density lipoprotein-derived cholesterol. The excess cholesterol damages the nervous system and leads to a gradual loss of motor ability, and speech, and eventually leads to death, often in childhood, although some cases are not

diagnosed until much later in life. "The discovery of the gene should now enable the development of genetic tests for prenatal diagnosis and assessment of carrier status in families affected by this devastating disorder," said the researcher who headed the collaboration, Dr Gene Carstea, now director of the Saccomanno Research Institute at St Mary's Hospital in Grand Junction, Colorado.

The finding also opens the way to improved diagnosis of Niemann-Pick C disease and to the eventual design of treatments that may correct the underlying problem. "This is very exciting," commented Bryan Winchester, professor of biochemistry at the Institute of Child Health in London, "Niemann-Pick C was the last lysosomal storage disease that had not yet been worked out."

The finding also has wider significance by starting to explain how cholesterol is processed in the body, which may contribute to the understanding of atherosclerosis. "Although the research team does not yet know precisely how

it works, the NPC1 protein is similar in structure to several other proteins involved in cholesterol regulation. A similar protein has also been found in yeast and worms, suggesting that it is important for survival because it has remained largely unchanged over millions of years of evolution," explained Dr Carstea.

Inserting copies of the NPC1 gene into cultured skin cells from affected patients was found to correct abnormal build up of cholesterol, suggesting that gene therapy might eventually be able to cure the disease. "It will be a huge challenge to get the gene into cells in the central nervous system, but this finding gives us a real starting point from which to move on," said Dr Carstea.

The research provides further evidence for the value of working on relatively rare disorders. Professor Winchester pointed out: "There is always a problem in getting funding to work on rare genetic disorders. But this is a classic example of how much can be learned about basic cellular processes by studying such conditions." □

Ovarian cancer linked to p53 gene

Susan Mayor, *London*

Researchers have found evidence suggesting that over half of all ovarian cancers may be linked to mutations in a critical regulatory gene that is strongly linked to ovulation.

A team from Duke University Medical Center in the United States tested for the presence of mutations in the regulatory gene—p53—in samples of ovarian tumours from 197 patients. All of these women were asked about their age at menarche and menopause, use of oral contraceptives, pregnancy, and breast feeding so that the number of lifetime ovulatory cycles could be calculated.

Women with tumours positive for the p53 gene were over four times more likely to have had a moderate number of cycles and over nine times more likely to have had a high number than a control group of

more than 3000 women without cancer (*Journal of the National Cancer Institute* 1997; 89:932-8).

"We found that the subgroup of ovarian cancers associated with p53 mutations is linked to ovulation," said one of the researchers, Dr Joellen Schildkraut, who is assistant professor in community and family medicine.

The finding provides the first molecular explanation for previous studies suggesting that the suppression of ovulation—due to breast feeding, number of pregnancies, and use of oral contraceptives—decreases the risk of ovarian cancer.

"This strongly suggests that women at risk for this type of cancer can protect themselves by suppressing their ovulation," pointed out Dr Schildkraut. The results showed a dose response, with the risk of ovarian cancer increasing with the number of cycles. The group postulated that constant ovulation, which causes cells in the ovary to divide, may spontaneously damage DNA in those cells over time. This may lead to mutations in the p53 gene, which normally stops cells from proliferating

Constant ovulation may damage DNA in cells

into cancer. Previous research has shown that p53 mutation occurs in around half of all cases

of ovarian cancer and is a prominent feature in the most aggressive forms. □

Woman can challenge hospital over forced caesarean

Clare Dyer, legal correspondent, BMJ

A woman who was detained in hospital against her will and forced to undergo a caesarean section was given permission last week to challenge her treatment in an important test case.

Three judges at the Court of Appeal gave the 29 year old woman from London leave to seek a judicial review against the social worker who sectioned her for assessment under the Mental Health Act; the NHS trusts responsible for Springfield Hospital, the psychiatric hospital where she was first detained; and St George's Hospital, where

the operation was performed. The High Court had refused the woman, named only as Ms S, permission to challenge her treatment because she was four months outside the legal time limits for taking action. But in the appeal court, Lady Justice Butler-Sloss said that the case had such exceptional features that the court would overlook delays in launching the claim.

The appeal court decided "exceptionally" to hear the case itself rather than sending it back to the High Court, which normally hears judicial review appli-

cations. At the same time, the court will hear Ms S's appeal against the order sanctioning the caesarean obtained by St George's Healthcare Trust from Mrs Justice Hogg. The permission for the case to proceed will force the trust to explain how its counsel came to inform the judge that Ms S had been in labour for 24 hours, when she did not go into labour at all.

The trust went to court without telling Ms S it was doing so, even though she was known to have contacted a solicitor. The wrong information given to Mrs Justice Hogg required investigation by the appeal court, said Lady Justice Butler-Sloss. "There can be little doubt in reading the transcript of proceedings before Mrs Justice Hogg that somehow or other she was misled," said

the judge. "She was told the woman had been in labour for 24 hours. That fact, which has been the reason why in the past judges have granted declarations, was not present in this case. Somebody ought to examine how this happened."

The case is seen as an important test of the use of the Mental Health Act to justify forced obstetric intervention. One issue is whether the law can be used to detain a pregnant woman against her will to undergo invasive medical examination and treatment for a physical rather than mental disorder. Ms S, who has an aversion to medical intervention, was showing signs of pre-eclampsia when she was detained in April last year for assessment under section 2 of the Mental Health Act. □

Infant mortality falls among Israeli Muslims

Judy Siegel-Itzkovich, Jerusalem

Infant mortality among Israeli Muslims is 73% higher than in the Jewish community, yet it is falling faster than that for Israeli Jewish babies and is far lower than in any Arab or Muslim country in the world.

Just 20 years ago, 32.6 Muslim infants died per 1000 live births in Israel, compared with 15 in the Jewish sector. By 1995, the rate had fallen to 9.7 and 5.6 respectively, according to a new report, *Health and Demographic Profile of the Settlements in Israel 1990/1994*, issued by Israel's health ministry and the Central

Bureau of Statistics. The 329 page report is the first to provide health statistics on all the settlements in Israel that have more than 200 residents.

The report shows that the health gap between the Jewish and Arab populations remains significant, but it is rapidly narrowing, said Gabi Bin-Nun, the ministry's deputy director general for economics and health insurance. Infant mortality is twice as high in neighbouring Jordan and four times higher in Egypt, he added.

Following financial incentives, 99% of all Israeli Muslim women now give birth in hospitals, said Mr Bin-Nun, whereas decades ago, most had their babies at home. Pregnant women receive regular medical checkups, and mobile clinics have been provided for the Negev Bedouin living in outlying encampments. □

Infant mortality among Israeli Muslims is falling

A quarter of preventable diseases are environmentally caused

Josh Hamilton, New York

A quarter of preventable ill health worldwide is due to environmental factors, concludes a World Health Organisation report launched to coincide with last month's conference looking at progress since the earth summit of 1992 at Rio de Janeiro.

Health and Environment in Sustainable Development: Five Years After the Earth Summit is a comprehensive report analysing trends in health and environmental issues from the early 1970s to the present. The study also projects current trends to the year 2020.

Almost 25% of preventable worldwide ill health is due to environmental factors, and in the case of some diseases, such as malaria and diarrhoeal diseases, the figure reaches 90%. Around 60% of cases of acute respiratory infection, the leading preventable illness worldwide, can be attributed to environmental causes, the WHO calculates.

During the international conference held at the United Nations headquarters in New York, the WHO convened an expert panel to discuss the frequently neglected links between health and sustainable development. Particularly important, and largely ignored, said Dr Wil-

fried Kreisel, WHO's executive director for health and environment and organiser of the expert panel, is the link between climate change and health. If global warming does occur, or if poor land management allows the current "desertification" in Africa and elsewhere to proceed, disease patterns will change geographically, with previously unknown diseases migrating to areas where the population is neither resistant nor prepared. Additionally, heat waves lead to "much higher mortality and morbidity, especially in cities," said Dr Kreisel.

Even in the absence of global change, changes in habitat such as encroachment of human settlements on forests and jungles and rapid urbanisation lead to the introduction of new diseases within human populations—for example, Ebola virus and dengue fever—and to the promotion of old ones.

There are many diseases susceptible to environmental management, said Dr Kreisel. In the Solomon Islands, for example, the incidence of malaria was reduced by 90% over three years entirely as a result of controlling environmental factors. Over 500 million people are affected by malaria worldwide. □

London's elderly get poor deal

Jo Waters, *London*

Admission rates for older people in deprived districts of inner London are up to 15% lower than for similar areas in the rest of the country, a new study has found.

The Health and Care of Older People in London, a report to the King's Fund London Commission prepared by Tony Warnes, professor of social gerontology at the University of Sheffield, also reveals that older residents of inner London occupied around a fifth fewer beds than their equivalents in provincial urban areas.

Professor Warnes said that there were three possible explanations for London's low admission rates compared with provincial rates: the admissions policies of central London hospitals differed; the referral practices of inner London GPs differed; or the elderly population of deprived inner London is healthier than similar groups outside the capital.

Professor Peter Millard, professor of geriatric medicine at St George's Hospital Medical School, London, said: "There has been enormous pressure to close down beds in many areas of London. At first we were pruning

dead wood but now we are closing occupied beds. We can't speed up the treatment because there aren't the residential homes to send the patients on to."

Dr Laurence Buckman, a GP in north London, said: "GPs have so long been pressured by the absence of beds in London that they now don't bother to try and refer. We try every other avenue." He added: "We need to see a large expansion in the number of low tech and rehabilitation hospital beds, which don't seem to exist at the moment."

The study also found considerable problems with community care, concluding that older people with complex needs are falling through the cracks between agencies. The standard of general practice has also failed to improve in line with other areas of the country, with many GPs still working from substandard premises and failing to carry out annual checks on patients aged over 75.

The King's Fund London Commission will be publishing its full report—and its recommendations on the future of health care in the capital, *Transforming Health in London*—on 16 July. □

The Health and Care of Older People in London is available from the King's Fund bookshop (tel: 0171 307 2591), price £4.

There is a lack of hospital beds in London for elderly people

Court rules that doctors do not have to tell parents the truth

Clare Dyer, *legal correspondent, BMJ*

Doctors have no duty to tell parents the truth about the death of their child, the Court of Appeal ruled last week. The court unanimously struck out a claim by the parents of a boy who died of Addison's disease for damages for psychological trauma caused by the discovery of an alleged cover up by doctors after the death.

Robert Powell, who died aged 10 in 1990, had been treated at Morrision Hospital in Swansea four months before his death. The consultant paediatrician treating him considered the possibility of adrenal insufficiency but did not carry out a test to see if an injection of adrenocorticotrophic hormone would

make the adrenal glands work.

He was well for nearly four months after discharge, but over the last two weeks of his life he was seen by doctors in the group practice at Ystradgynlais Health Centre, first with a sore throat and pain in the jaw, then weakness, lethargy, and vomiting.

On the afternoon of the day he died, one of the GPs was called but refused to refer him to hospital. When the parents called her again, she visited and agreed to write a hospital referral letter but not to call an ambulance. Robert's parents took him by car to hospital, where he died of cardiac arrest 2 hours and 45 minutes after arrival.

Mr and Mrs Powell sued

West Glamorgan Health Authority and the GPs for negligence over Robert's death. The health authority admitted liability for the consultant's failure to diagnose and treat his illness, and paid Mrs Powell £80 000 (\$134 000) damages plus £20 000 costs. The settlement included compensation for the panic disorder that she developed as a result of Robert's illness, treatment, and death.

But Mr Powell became obsessed with the belief that there had been a conspiracy over his son's death, after first being shown his general practice file just after his death, and then seven months later while pursuing a complaint against the GPs. He developed post-traumatic stress disorder and was unable to work. The family's lawyers added claims for compensation for this, and for making Mrs Powell's panic disorder worse.

The Powells alleged that the

GPs had removed two documents from Robert's file, replacing them with different documents, and added to the file a letter of referral to hospital dated five days before his death but actually typed after he died. The letter did not appear in the hospital records.

Lords Justices Stuart-Smith, Morritt, and Schiemann held that doctors had no "free standing duty of candour," which, if breached, could lay them open to damages claims for personal injury by relatives of patients. That would involve "a startling expansion of the law of tort," Lord Justice Stuart-Smith said.

Doctors owed a duty of care to their patients, but not to relatives such as parents, said the judge. Explaining about a death did not put them into a doctor-patient relationship with relatives, even if the relatives were also the doctor's patients. □

BMA opposes legalisation of euthanasia

Linda Beecham, *BMJ*

The BMA has overwhelmingly opposed any change in the law to allow euthanasia or physician assisted suicide.

Speakers at the BMA's annual representative meeting in Edinburgh last week said that it was the job of the medical profession to help patients rather than to kill them. Dr Fay Wilson, a Birmingham GP, told the meeting that patients had asked her to end their lives and later

thanked her for not doing so. "However much I wanted to help their suffering, I wasn't able to kill them. We are doctors, our function is to heal and comfort. We must not change the law that would take us down the slippery slope to an expectation that our function is to kill those we see as not worth while."

There was a call from one or two representatives for a royal commission on the issue, but Dr Michael Stuart, a GP in Southend, said that there had been three royal commissions in the Netherlands without the situation being resolved. Dr Stuart said that he had worked in the hospice movement for 30 years and had received tentative requests from patients asking

him to "finish them off." When he had explained what would be involved none had followed up the request. "With symptom control the patients led good quality lives—it would have been a grave mistake to have acceded to their requests," he said. Dr Fiona Randall, who specialises in the care of dying people in Christchurch, Dorset, said that legalised assisted suicide would put pressure on patients to seek their own deaths because they would not want to be a burden on their carers and relatives.

Dr Jane Orr, a GP in Surrey, agreed that "bad deaths do sometimes occur." That, she said, was due to bad medicine. "The answer to bad medicine is not to kill people but to create

good medicine. We must work to improve professional standards and encourage a holistic approach to terminal care."

The inclusion in the motion of the words "for the time being," implying that the subject would be reopened in the future, caused problems for some speakers. But, the chairman of the BMA council, Dr Sandy Macara, said: "We should not allow a suggestion that now, or at any time in the future, we are envisaging a change in the law." He said that doctors should do nothing to betray the trust of patients. The BMA should campaign for adequate palliative care. "This is the responsibility of all of us and not just the hospice movement." (See also p 128.) □

Women doctors believe medicine is male dominated

Roger Dobson, *Gwent*

Women doctors believe that medicine is still a male dominated profession in which they have to work harder to compete, have less status, get passed over for promotion, and find it difficult to get a GP partnership, according to new research.

At the same time male doctors see themselves as having to deal with the worst and the most aggressive patients, being

required to cover for female partners, and being forced to take on organisational roles and "carry the can."

A survey of nearly 1000 GPs and consultants also comes to the conclusion that the women who took part in the study (283 GPs and 224 consultants) tended to be younger and have fewer children than the men (264 GPs and 215 consultants). The

women were more likely than the men to be single, the men more likely to be married.

The research, led by Vivien Swanson of the anxiety and stress research centre at Stirling University, found that more than half of women thought that female traits—being caring, gentle, understanding, and sympathetic—were an advantage in medicine. Only 12% of men believed that masculine traits—being dominant, assertive, decisive, and paternalistic—were an advantage. The findings have not yet been published in a journal.

But it was in the comments made to the researchers that

many of the participants revealed their thoughts. Women reported less respect from staff, patients, and colleagues and said that they had to compromise in their choice of specialty. There was less private practice; training and career progress were difficult; and there was a sense of isolation. An absence of role models and higher expectations from colleagues were also reported.

Sexual harassment from male patients, vulnerability to attack during out of hours calls, aggressive patients, and lack of stamina were among the other issues detailed by women doctors.

Male doctors said that they were on call more and under too much pressure, that more was expected of them, that they were unable to change careers, and that they saw fewer female patients. They also reported stress, sexual harassment, and complaints and litigation from female patients.

One women consultant told the researchers: "There is a bias throughout the NHS, particularly in hospital medicine, in favour of males." A male consultant said: "I wish to be involved in bringing up my children, but there is not enough part time work."

Ms Swanson said: "In the survey we asked the doctors to specify what it meant to be male or female working in medicine today in terms of advantages and disadvantages. One of our findings was that the younger age group of males held less polarised views, particularly in their perceptions of male and female traits." □

Women doctors think that "feminine" traits are an advantage in medicine