AT THE COAL FACE **Julian Tudor Hart**

A few lessons in screening for Gordon Brown

The prime minister seems just to want to offer more consumer choice for the worried well

Prime minister Gordon Brown has just announced that he will allocate funding for a national screening programme concentrated on diabetes, cardiovascular and renal diseases, and stroke (*BMJ* 2008;336:62-3). He said these were now seldom available except through private care but would over the next three years be made available to everyone.

The politicians, civil servants, and managers who devised this plan may believe it is evidence based. I'm not so sure. So far as I know, there has been only one controlled trial of such a policy. In it we compared age standardised mortality over five years associated with traditional demand-led care alone in Blaengwynfi, against similar care in Glynccorwg, where this had been integrated with proactive screening and follow-up for chronic conditions (which included those listed by the prime minister) over the previous 20 years (*BMJ* 1991;302:1509-13). The two communities were socially almost identical. Both were in the bottom 5% of social ranking within the 55 local authorities then composing West Glamorgan. The results were remarkable. Standardised mortality ratios for deaths at all ages were 36% above the UK mean in Blaengwynfi, 2% below it in Glynccorwg. For deaths under age 65, SMR was 60% above the UK mean in Blaengwynfi, 6% below it in Glynccorwg.

The anticipatory care programme in Glynccorwg evolved over 20 years, starting with blood pressure control and personal interventions on smoking, ending with a large bundle of interventions of many kinds, but all covering the entire population at risk. The population in Blaengwynfi was larger; medical staffing was smaller, with less continuity; and demand-led workload was higher (probably because anticipatory care eventually reduced contact rates). But it is hard to see how any such study could be more ideal than this. We were working in the real world,

in an area of exceptional morbidity and mortality, with exceptional difficulties in recruiting and retaining medical staff, and accepting net incomes about half the UK average as a necessary price for good care. But our paper is rarely referred to, and I have never been consulted by anyone at the Department of Health since it was published.

What Gordon Brown probably has in mind is screening as it has been developed as a commodity in the private sector, essentially a way for well people to buy reassurance, a great deal of it false or without evidence of benefit. For New Labour, the Big Idea is to make whatever richer consumers want more accessible to poorer consumers, and thus broaden the market for its corporate friends and shrink the NHS further.

Anticipatory care works. With all its limitations, our study showed that by tackling the hitherto undetected half of almost all important chronic disorders in an organised way at an early stage, integrated with demand-led care, there can be huge health dividends, and probably reduced loads on hospital care. If we ever get a UK government that listens to people experienced in the front line of health care, it will need to pay some attention to the following three preconditions for screening success.

Firstly, it must be properly resourced. Health promotion, screening, and dedicated clinics were placed on the GP menu by the Royal College of General Practitioners in 1981. But in the absence of proper resourcing this work competed unsuccessfully with demand-led care, which is just as necessary and more obviously satisfying to both staff and patients. If the prime minister's programme suggests anything new, it is that more screening will be handed over to for-profit corporate providers.

Secondly, to get a larger product from investment in anticipatory care we should target our sickest, most disadvantaged communities, especially

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in conditions of increasing polarisation of wealth that deregulated business can only increase. Most health promotion activity is still concentrated in affluent areas with a smaller, demand-led workload. Almost certainly, the high yield in health gain in our study reflected the huge amount of unmet need in the South Wales valleys, typical of all areas where heavy industry and manufacturing have been sacrificed to the new paper economy. But why would GPs in poor areas, already submerged under high, demand-led workload, welcome additional gratuitous burdens from well-man and well-woman clinics, other than to get the fees? The answer is that we must face up to the larger staffing needs of poorer communities, for doctors as well as nurses and other support staff, and make NHS authorities, run by people experienced in health care and familiar with local staff and patients rather than business schools, give a clear lead.

Thirdly, we have to integrate anticipatory care with demand-led care, so that screening procedures are applied imaginatively at times and in places where patients are already seeking help. We got exceptional compliance with treatment from our patients because they were given exceptional latitude to discuss whatever problems they wished. We knew them, and they knew us. We built everything on continuing friendly relationships with patients. That is not what happens when GPs bolt health promotion and screening onto their demand-led care as an entirely separate operation.

One day somebody with power may understand that more votes might be won from continuity, real personal concern, and restored trust.

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