groups engaged in doing the reviews and overseeing their implementation, to prevent duplication of effort and waste of money—not an easy task. Recently, programmes in the Netherlands and Denmark have been started in which the different parties engaged in preparing reviews, developing guidelines, analysing cost effectiveness, and performing dissemination and implementation research work together.

Thirdly, explicit attention should be paid to the values and judgments underlying specific guidelines. These values reflect the value structure of the teams developing the guidelines but may be different across countries. Differences in practitioners' barriers, patients' barriers, and cost barriers may also restrict generalisability, especially when it comes to implementation. Guidelines developed in different countries on the same topic are often different and may not always be interchangeable.

Finally, the NHS needs coherent strategy for disseminating and implementing guidelines. Huge gaps exist in our knowledge about what comprises

efficient dissemination and implementation, so research into these should be stimulated as well. Co-operation with centres for evidence based medicine and health care groups within the Cochrane Collaboration, such as the effective professional practice review group and the review group on consumers and communication, will certainly be fruitful. The Commission for Health Improvement will be in a position to evaluate what actually happens in daily practice and provide important data and feedback about research based health care.

Guideline development, dissemination, and implementation can thus be improved. However, it may be a challenge for the Commission for Health Improvement, as top down organisation, to assess and really influence daily practice in the NHS: improvements can only really be made by those engaged in providing the services. The bottom up nature of disseminating guidelines of the National Institute of Clinical Excellence may make its task somewhat easier.

From health care to health

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Health is not merely the absence of disease; nor is the role of the NHS only within health care. This message is made very clearly on the first page of the white paper, with the vision of "an NHS that does not just treat people when they are ill but works with others to improve health and reduce health inequalities." To achieve this vision, we are told, means changing our approach to tackling disease and inequality—with the government ensuring that locally the NHS works with those who provide social care, housing, education, and employment.

The emphasis on the wider health agenda places the white paper among other recent government initiatives—for example, Welfare to Work for young people, the Crime and Disorder Bill, the national child care strategy, and the education white papers—which all highlight the impact of social inequalities and the need to address the problems of the socially excluded. The lead for addressing the health impact of inequalities is firmly placed with health authorities, who will be responsible for coordinating health improvement programmes for their districts across health service organisations and other agencies (see figure).

This responsibility signals a changing role for health authorities and a step forward on the pathway from health care to health. In future, health authorities will provide strategic leadership, freed from unnecessary administration. In partnership with others, health authorities will create a framework for health based on an analysis of health needs and monitored by indicators of quality health care and population based outcomes. These will be jointly agreed, published, and open to public scrutiny. Performance will, in future, be measured not on the discredited efficiency index, which rewarded admission to hospital and throughput, but on indicators which include health improvement and the health outcome of NHS care. The timescale for plans will be a

three year rolling programme—which recognises the long term nature of such an approach so often ignored in the annual contracting cycle. Health action zones, which are to come into being in April,¹ will blaze the trail to developing health improvement programmes. Their accent will be on partnership and innovation, finding new ways to tackle health problems and reshaping local services. In addition the emphasis on clinical effectiveness, quality of care, patients' views, and the public's perspective highlights the contribution to health made by effective and responsive health services.

So far so good—but how this will work in practice is uncertain. As yet we have only some of the pieces of the health policy jigsaw on the table. Developing the health agenda will be a key theme of the green paper *Our Healthier Nation*, expected soon. Without this and the results of other initiatives, such as the chief medical

officer of England's review of the public health function and Sir Donald Acheson's report on inequalities, it is unclear how some of the policies, such as joint working with local authorities, will work in practice. The new statutory duty of partnership is mentioned but not explained. It is unclear how local accountability will be shared between statutory authorities, how the democratic deficit in the NHS will be resolved, how health and local authorities will make their relative contributions, or what role will be played by community health councils and voluntary organisations. The health improvement programmes proposed for England are more ambitiously multisectoral than their Scottish counterparts—which lie purely within the healthcare system.²

This lack of detail, and the recognition that the agenda is evolving, provide opportunities to find better ways of working which must not be missed. Yet the demands of intersectoral working should not be underestimated. The skills needed to develop effective partnerships within the community will require resources and training. Broadening the horizons of those who have traditionally worked only within health care and developing public understanding will take

time. Promoting health is a far less easy concept to grasp than providing clinical care, and measures to tackle the root causes of poverty or crime may not bear fruit for many years.

Previous experience with national (and international) initiatives—for example, the Health of the Nation³ or Health for All⁴—should warn us to be cautious. Although commendable strategies, they were often not seen as core business by health authorities or local practitioners and less important than financial concerns. The need to maintain financial control remains unchanged, and even within the current government's experience we have seen the practical difficulties of banning tobacco advertising. Whatever these difficulties, this white paper places health in the centre of the stage. The challenge now is to turn the aspirations into a reality.

1 Jacobson B, Yen L. Health action zones. *BMJ* 1998;316:164.

2 Secretary of State for Scotland. *Designed to care: renewing the National Health Service in Scotland*. Edinburgh: Stationery Office, 1997.

3 *The health of the nation: a strategy for health in England*. London: HMSO, 1991.

4 World Health Organisation. *Alma-Ata 1978. Primary health care*. Geneva: WHO, 1978.

Continuing medical education

Changes in health care and continuing medical education for the 21st century

Angela Towle

Major trends in health care

A revolution in health care is occurring as a result of changes in the practice of medicine and in society. These include changing demographics and the pattern of disease; new technologies; changes in health care delivery; increasing consumerism; patient empowerment and autonomy; an emphasis on effectiveness and efficiency; and changing professional roles. These are the challenges which will face the medical profession in the 21st century and to which continuing medical education must respond.

Demographics and the pattern of disease

In 20 years' time the proportion of most rich countries' populations aged 65 and over will have doubled to around 20-25%. Old people today consume about a third of total health care spending; if present trends continue, by the year 2000 they will be consuming half.¹ The consequences will be a shift in the need for preventive and curative health care in the direction of the chronic health problems of older people and a large increase in demand for care of very frail or ill dependent elderly patients. There will be even greater pressures to cap spiralling healthcare costs.

No major changes in overall patterns of morbidity are expected, but some health problems will increase. Health loss areas will include the widening of social class disparities, increasing alcohol consumption and

Summary points

The education system must be better able to respond to rapid changes in the outside world and involve employers and users of health services

The culture of the education system, now largely shaped by performance in examinations and emphasis on factual content, must be changed to one which values self directed learners and problem solvers

There is a need to improve the effectiveness of continuing medical education, such as developing better programmes on doctor-patient communication and interprofessional continuing education

drug addiction, and increasing numbers of cases of senile dementia. Areas of uncertain progress or change include cancers, heart disease, and suicide. Solutions to health problems will increasingly rely on disease prevention, encouragement of healthy lifestyles, and improvement of environmental conditions, which may require a reassessment of the roles and responsibilities of health professionals.

This is the first in a series of seven articles looking at international trends and forces in doctors' continuing professional development

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