Coronary heart disease—planning for prevention

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Introduction

Although there is a need for more research, the major challenge for those working in health services is to implement what is already known and although there are debates about the significance of certain factors associated with coronary heart disease, there is a common core of information that is generally agreed. The responsibility of those who work in the health service, as opposed to those in academic and research units, is to implement the knowledge that is known. This we have failed to do in the United Kingdom, and one of the reasons we have failed is that we have not developed a strategy for prevention.

Principles of planning

To be effective, any strategy must be based on a set of coherent principles and the principles of primary health care planning suggested by the World Health Organization provide a very useful basis for planning prevention. The key ones are: (1) Services should be developed to meet the needs of the whole population; (2) There should be effective and efficient use of resources; (3) No service should be planned in isolation; (4) There should be consumer involvement in all stages of planning and management.

These form the basis of WHO's drive, not only for health for all but also for healthy hearts for all by the year 2000.

Formulating a plan

The concept of planning is alien to some people who assume it entails rigid central control and direction but a plan is simply the definition of a set of steps towards a goal. There are five main steps: The definition of the problem; the identification of interventions that are effective in preventing the problem; the setting of objectives; the choice of indicators that can be used to monitor progress or the lack of it and; the development of services which would allow implementation and evaluation.

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The definition of the problem

Although there is debate and dissension there is also agreement and for the doctor, health educator or nurse interested in prevention there is a generally agreed body of knowledge about the problem and about the particular characteristics that should be tackled as high priorities. Although it is important to conduct more research studies, there is no need to wait until they have been reported before giving the public some information. It is important to accept that members of the public can cope with uncertainty. They do not wish only absolute definitive information; they wish the best information on the basis of the evidence currently available and it is possible to say to members of the public that the advice that they have been given is on the basis of the best available evidence and that it may change. The one mistake that professionals consistently make is to underestimate the ability of the public to cope with uncertainty and doubt.

The effective interventions

There is currently a debate in which the relative effectiveness of the high risk approach and the population approach is argued but it is essential to accept that these are not mutually exclusive alternatives. They are interdependent interventions. Both are needed although there is, quite rightly, a debate about the appropriate balance between the two. Central organizations such as the Coronary Prevention Group and the Health Education Council are ideally placed to develop whole population prevention campaigns but this approach is ineffective unless it is complemented by an approach both at District Health Authority level and in the primary care team, focussing on those individuals who are at high risk.

Setting objectives

The general aim of 'preventing coronary heart disease' is too vague to be useful. More specific objectives need to be chosen and the two main objectives are to add years to life, namely to prevent

premature death, and, secondly, to add life to years, which is to prevent disability.

Coronary heart disease is not only a cause of sudden death, it is also a cause of chronic disability and it is particularly important to emphasize the latter. We must accept that even though deaths from coronary heart disease are impressive to statisticians and dreadful when they strike the individual family, death from a myocardial infarction is not so dreadful a prospect to many people as death after years of disability from dementia or stroke or Parkinson's disease. It is therefore important to set objectives not only in terms of mortality but also in terms of disability. It is also important to set specific objectives for diet, cigarette smoking, hypertension control, and exercise.

Choosing appropriate indicators

Although it is much more difficult to select indicators which can allow progress, or lack of it, to be measured in the field of prevention than in some other fields of health service activity, it is essential that we do identify those that can be used as quickly as possible. The new NHS planning system will, quite rightly, give resources to those who can identify the means by which their efforts can be evaluated and it is important that those interested in prevention make the same attempt to identify appropriate indicators.

Unfortunately the data available at local level, namely mortality and hospital utilization data, are not the most valid for evaluating the effectiveness of prevention in the District Health Authority or primary care team. The numbers involved are too small even though the problem is sizeable. However, the mortality data are not without their uses at District or primary care team level. Although the numbers are too small to provide statistically valid data, the numbers are large enough to be dramatic and to allow members of the health authority, of the Community Health Council and of the public to perceive the magnitude of the problem and the need for urgent action. It is important that those working in the field do not believe that their data are invalid. They need to remember that the presentation of data is very important as a means of continuing to educate the public, of maintaining a need for prevention in the public eye, and as a means of auditing the performance of health authorities and primary care teams. Just as the Medical Officer of Health's report previously allowed the local health committees to identify how their local authority stood in comparison to others, we need a modern MOH report showing health authority and Community Health Council members how their own particular locality stands in the preventive stakes.

The development of the appropriate services

Usually debates about service planning focus on the delivery of services but this should only come as a fifth step in a plan after the four previous steps have been taken.

Ideas for action

Before discussing the contributions that the various statutory services can make, it is essential that we accept that the commonest type of health care is, and always will be, self-care. The second commonest type is informal care which is that given by relatives, friends, neighbours and voluntary associations. This relates just as much to the prevention of disease as to its treatment. However, self-care and professional care are not mutually exclusive alternatives. They are interdependent and we need a strategy for prevention that links all the relevant statutory services.

The primary care team

The primary care team has a vitally important part to play because it allows an effective and efficient means of contacting individuals at high risk. In a project in Oxford we have demonstrated that the practice nurse and practice manager can together deliver an effective preventive service with, of course, the involvement of the general practitioner. What is required is an initial injection of skill and energy to help the team shift from the demand-led style of work to one in which the practice is determining the pattern of work rather than the patients. After this initial injection, the practice has to provide extra resources but this it can do by increasing the amount of staff employed and being reimbursed by the Family Practitioner Committee.

These measures allow the principles expressed in the Royal College of General Practitioners' report on prevention of arterial disease to be implemented effectively and efficiently. It requires close co-operation between the primary care team, the health authority and the Family Practitioner Committee for this approach to be effective.

The District Health Authority's contribution

The District Health Authority can:

- (1) Provide support for primary care teams of the sort described in the previous section;
- (2) Provide adequate resources for the health education unit and link closely with the local education authority to harness its skills and resources for community education and school health education;
- (3) Link with the District Councils responsible for recreation and leisure;

- (4) Link with the Family Practitioner Committee to develop an explicit common plan for coronary prevention;
- (5) Continue to support and develop community nursing services;
- (6) Produce an annual report on the state of the public health which focuses on the prevention of coronary heart disease;
- (7) Provide information for local Members of Parliament on coronary heart disease and the related risk factors.

Regional Health Authorities

Regions have an important part to play. They can:

- (1) Encourage Districts who find it difficult to develop health education units or plans for prevention, in part by providing plans and ideas from other Districts, in part by including these topics in the annual review of the District's performance;
- (2) Provide skills not available within Districts, for example the skills of the Region's public relations officer;
- (3) Act as an entrepôt encouraging an exchange of ideas from one District to another within the Region.

The D.H.S.S.

The Department of Health can:

- (1) Promulgate action in the Regions by including coronary prevention and health education in its Regional reviews;
- (2) Develop a government policy on the prevention of coronary heart disease by linking with other appropriate departments;
- (3) Provide support for the Health Education Council, the Coronary Prevention Group and Action on Smoking and Health;

- (4) Develop an agreed set of indicators that can be used as a basis for monitoring progress and which can be used by each health authority to allow it to audit its own performance in comparison with the performance of other similar authorities.

Bringing about change

The publication of documents by central bodies, no matter how worthy, will not bring about change. Change does not come about because a wish is expressed in the centre and communicated directly to all the units in the periphery. The most effective way of accelerating change is to develop closer links between the peripheral units, to encourage the flow of information from one unit to another and to encourage the exchange of ideas. It is obviously important for each health authority and primary care team to develop its own particular plans for prevention but too often such an approach is carried too far and each unit in the periphery goes through the process of reinventing the wheel or, even worse, reinventing the flat tyre. This is not to say that the centre has no part to play in bringing about change. It has a very important part to play. Its principal contribution, other than conducting research and providing authoritative summaries of reports, such as those produced by the World Health Organization or the Department of Health, is to facilitate exchange of information in the periphery. We must identify ways in which more people can learn about what is going on in other parts of the country before results are published. We must also remind those who are less active in the prevention of coronary heart disease that others are more active than they are and provide them with ideas for action which others have taken to tackle coronary heart disease. The challenge for the future is partly to learn more about coronary heart disease but it is of equal importance to implement what is already known.