interventions and from policies in other sectors, such as vehicle safety. But there are many other determinants of health. For example, in industrialised countries the health of populations reflects long established dietary patterns that owe more to climate, and thus the nature of agricultural produce, than to any contemporary policy. Thus, it is unsurprising that many of the countries performing best are characterised by "Mediterranean" diets. The growing evidence of how events throughout life influence health creates a further difficulty.[3] Health system inputs that affect infant and child health may have consequences many years later.

A second problem is the availability of data.[4] Many governments have only the vaguest idea of how many people live in their territory. Some have not undertaken censuses for many years,[5] in some cases because large areas are outside their effective control. In many parts of the world population registration systems are fragmentary, and even in some industrialised countries significant gaps exist in coverage of some groups—for example, native Americans.[6] Equally, there are substantial problems with comparability of data on the other measures used, health expenditure and education. The authors recognise this problem and have constructed an elaborate set of procedures to address it, so generating figures for disability adjusted life expectancy[7]—itself a highly controversial measure.[8] Fundamentally, however, one cannot create data where none exist, so each step requires a series of often heroic assumptions and extrapolations.[9] Unfortunately, though the *World Health Report* and its associated working papers note that many figures are estimates, it is not easy to discover just how extensive this process has been. Using complex models to generate estimates of uncertainty fails to tackle the underlying problem.

Other criticisms of this exercise have been aired elsewhere and include concern about the ideological values underpinning it and the intrinsic limitations of performance ranking.[10] But some of these difficulties are insuperable, and a fairer question to ask is whether the report has achieved anything.

Despite its many limitations, arguably it has. Firstly, the WHO has stated clearly that governments have a responsibility for their health systems. It has invoked the concept of stewardship,[11] which implies a much more active involvement in promoting health than most governments have previously assumed.[12] Secondly, it has provided a useful conceptual framework that begins to tease out the goals of health systems. Thirdly, it has emphasised the need for a much better understanding of the undoubted impact that health systems have on health.[13] It has not, however, provided a valid answer the question of whether one system is better than another.

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Fabricated or induced illness in children

Munchausen by proxy comes of age

In 1970 the Department of Health issued a small orange booklet, *The Battered Baby*. For 25 years the association of fractures and subdural haematoma with wilful violence had been known, but Kempe had coined this emotive title only eight years before. That form of abuse is now only part of the whole range of harm to children that society has recognised. Last month the Department of Health continued the story by issuing multidisciplinary guidance on fabricated or induced illness in children.

Significant harm to children such as smothering or poisoning which simulated illness and which involved and deceived doctors has been known for at least 40 years. It took the honesty of Roy Meadow to describe his personal experience and his journalistic flair to label it "Munchausen by proxy" in 1977.[1] His article drew the world's attention to fabricated or induced illness and led to more accounts, to reviews,[2] and to research—though research has not been helped by arguments about what is or is not Munchausen by proxy.[3]

Even today one has to state clearly that some carers, including parents, do harm children, and that they sometimes involve health professionals in doing so. Doctors and others may not only fail to understand the

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origins of a child's reported symptoms but actually deliver some of the harm through inappropriate investigation, treatment, or surgery.[4] The Department of Health and the Royal College of Paediatrics and Child Health are agreed that the focus must be on the welfare of the child, and both now refer to the problem as "fabricated or induced illness in children by carers." The department has just published draft guidance from an interdepartmental group for consultation.[5] The college is about to issue guidance for paediatricians.

Induced physical illness does lead to death and handicap, but less acute fabrication and illness induction (such as presenting a child with mild arthritis as having severe disease and being wheelchair bound) can cause significant harm to children and is more common. Neither may be easy to detect, so rates are underestimates and the harm (which often starts in infancy) may take some time to be identified.[6]

Preventive measures emerge late in the life history of a disorder, but small studies have shown that intervention is effective in some cases and allows some children to be safely integrated with their families.[7] This may require separation, work to help carers recognise the harm they caused, therapy for the carer and others who allowed harm to occur, and long term therapy and support for the child. The new guidance indicates that doctors should be looking at the welfare of children before serious harm has occurred. The doctor-parent relationship can conflict with the doctor-patient (child) responsibility, particularly in primary care. It may be difficult to reconcile the extreme overanxiety of parents with the fact that their asthmatic child is being grossly overtreated and is being conditioned to believe that he or she is physically disabled.

Another interdepartmental document issued last year, *A Framework for the Assessment of Children in Need and their Families*,[8] can help professionals in looking at the situation from the child's perspective. Until recently there has been little training on this for health professionals. In the triangular dynamics of a consultation on a child, it is normally to the child's advantage to have a carer as an advocate. However, this is not always so, and clinicians' prime responsibility remains the welfare of their patient—the child. Earlier referral to social services on the grounds of need can make it clear that we are trying to help the family, which may prevent harm to the child and siblings, and that this is not an accusation of abuse. A child's doctor is not required to clarify whether inappropriate parental care is due to mental illness, deprivation, distorted views of science, or persisting overanxiety before acting to promote the welfare of the child. We must also learn what is not our responsibility and what belongs to the social services and police, and joint working and joint training on these latest guidelines from the Department of Health is essential.

Health authorities and trusts have responsibilities to provide adequate resources, including advice by designated doctors organised through named doctors. Equally, social service departments should be expected to provide adequate social work support in every paediatric and child health department if this excellent guidance is going to succeed.

The draft guidance on fabricated or induced illness quotes its origin from the Griffiths report into the research framework in North Staffordshire NHS Trust, a report prompted by complaints against doctors prominent in research into fabricated or induced illness in children.[9] But the guidance fails to address the unsatisfactory procedures for investigating complaints against doctors or nurses who work with fabricated or induced illness. Trusts have failed to carry out competent investigations,[10] and there is no protection for professionals who are attacked by complainants.

The guidance has not acknowledged the need for comprehensive investigation of unexpected deaths in children. Coroners' inquiries do not meet the standards required in normal paediatric practice or child protection investigations. It is not surprising that there are subsequent queries on whether death might have been induced.

Munchausen by proxy has had an honourable life and valuable effects beyond its own confines. Professionals are now more aware of the protean forms of harm to children. The understanding of the processes involved in a consultation,[11] of the fact that doctors and parents can misjudge a child's health or illness whether they agree or disagree, of the need always to have the child's welfare as the focus and when possible obtain the child's views are all difficult but need to be part of continuing training. The role of society in providing procedures, resources, and support to both professionals and families is strengthened in the new document.

The implementation of this guidance will give an enhanced responsibility to designated and named doctors and nurses. Nevertheless, improving care for these children mostly depends on the much greater number of clinicians who meet children face to face. We need to have open minds and to develop our skills to understand the complex origin of children's symptoms and illnesses and protect those at risk of being harmed.

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