

be explained by diagnosable spinal disease,<sup>1</sup> and cultural factors might influence its reporting. Cultural preoccupation with the back is nothing new: rail travel in the 19th century was accompanied by a multiplicity of symptoms and public debate about "railway spine."<sup>12</sup> The rise in work incapacity has focused attention on low back pain. Increasing public knowledge of the "low back pain epidemic," media attention, government reports, and even back pain surveys are all likely to have made back pain a more prominent part of life in the 1990s. The increase in low back pain reporting may reflect this.

Any explanation must strike a balance between the reality of the pain for the sufferer; the likelihood that mechanical factors can aggravate symptoms; the strong evidence that distress and dissatisfaction in daily life make back pain more likely and more persistent; and the possibility that public attention was increasingly drawn to the back during the 1990s. Whether the rise in symptom reporting reflects the way we live and work or our current pattern of preoccupation with illness, Palmer et al's study provides empirical evidence that it has occurred. Is this finding important? The answer lies in the importance that patients and their doctors attach to the symptoms.

The dominance of a medical model which sees low back pain exclusively in terms of spinal disease and injury may generate inappropriate investigations and treatment and contribute to the persistence of symptoms.<sup>13</sup> Neurophysiological advances are helping us to understand how pain can persist in the absence of

injury and under the influence of culture and belief. The challenge is how to change the culture and the beliefs and keep faith with the person with the pain.

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## Consulting the public about the NHS

*We need a culture of involvement not policymaking by 12 million leaflets*

Patients and members of the public in England have just been consulted by the government on how they would spend the extra funding promised to the NHS over the next five years. The consultation is meant to inform the government, which in July is publishing its plan for the NHS, defining how the increased funding will be spent (Department of Health, press release, 23 March 2000). Twelve million leaflets with prepaid response forms have been distributed through supermarkets, pharmacies, opticians, hospitals, and general practices, asking, "What are the top three things you think would make the NHS better for you and your family?" "Census day" was 31 May, when service providers were asked to actively encourage their users to fill in the leaflet. The public consultation process also includes a website, two public forums, patient representation on the six action teams for modernisation, and meetings between patients' organisations and ministers.

Public involvement has an increasingly high profile in health services policy. Justifications for this trend include the need to ensure the democratic basis of publicly owned health services and the view that user involvement leads to services with better outcomes. There is already substantial research on how to achieve public involvement of a high quality. In a recent policy

statement from the Department of Health on public consultation, both integration and inclusion were defined as essential to initiatives on patient and public involvement.<sup>1</sup> Yet these qualities are not evident in the current consultation process.

To achieve an integrated approach to public involvement, NHS organisations should "strategically and systematically build patient and public involvement into the way they operate."<sup>1</sup> As the Department of Health's guidance makes clear, this aim is not served by treating patient and public involvement as an "add-on" task. Yet this is exactly what has happened in this instance. When the prime minister, Tony Blair, launched the consultation process in March, he identified leaders of the professions and health organisations as the key stakeholders—no mention was made of the involvement of patients and the public. The announcement of the broader public consultation strategy came in May, some time after six working groups on modernisation had been established and almost two months into an already intensive four month process.

The leaflets were issued on 22 May, to be returned by 5 June. The analysis and incorporation of potentially millions of people's views before the plan is published on 15 June will be challenging indeed.

Failure to take meaningful account of the opinions of the people you canvass is a sure way to engender cynicism.

To achieve an inclusive approach to public involvement, NHS organisations were told "to make special efforts to involve under-represented individuals, groups and communities."<sup>1</sup> Other widescale consultation exercises have shown just how difficult it is to engage with the public in general, let alone with more marginalised groups.<sup>2,3</sup> Little evidence exists of such efforts being made in this exercise. The leaflet is wordy and only available in English and was disseminated through NHS service providers and supermarkets without any support from the local community. In the absence of specific interventions geared to engaging people and communities across the whole population, many groups will remain on the margins of healthcare decision making.

The involvement of patients and the public in the NHS is a long term goal. A transparent, responsive health service in which patients, carers, and the public are genuine partners is still some way off. Partnership requires engagement with people on their own terms, with a genuine sharing of interests. Considerable commitment to this process exists at local level, despite the overwhelming pace of change in the NHS.<sup>4</sup> National high speed exercises, which return to the secrecy of the government as rapidly as they emerge from it, leave

people squarely outside the system. This may actually undermine local involvement processes and cause "consultation fatigue."<sup>5</sup>

How much these problems will matter depends to some extent on the way the results are used. The lack of clarity of the aims and scope of the consultation, however, will make it difficult to assess its impact. International examples have shown that meaningful consultation, especially at a national level, is complex, lengthy, and expensive.<sup>6</sup> With its overly simplistic approach, the exercise may produce some useful ideas, but, at worst, it will undermine the long term partnerships which the NHS should be seeking to build with its own staff, its users, and the public.

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## Diabetes care needs evidence based interventions to reduce risk of vascular disease

*Individual risk factors in isolation are poor predictors of risk*

The absolute risk of a first myocardial infarction is influenced by factors that include age, sex, blood pressure, the total concentration of high density lipoproteins, the cholesterol ratio, and diabetes.<sup>1</sup> The prevalence of diabetes increases with age, and having the disease removes the protective effect of female sex against cardiovascular disease. Diabetes is commonly associated with hypertension, and an unfavourable lipid pattern combined with these factors contributes to the increase in the relative risk of myocardial infarction. In people with type 2 diabetes the risk of myocardial infarction is between two and six times higher than that of the general population.

The initial threshold for using lipid lowering treatment for the primary prevention of myocardial infarction as recommended by European and British guidelines is 2% and 3% risk per year, respectively.<sup>1,2</sup> This is similar to the average risk of recurrence of a myocardial infarction.<sup>3,4</sup> People who have had a first myocardial infarction are considered to be at a sufficiently high risk to be eligible for secondary prevention with lipid lowering treatment,<sup>1</sup> whereas many people who have never had a myocardial infarction have a risk well below the threshold. In contrast, people with diabetes and a single other

cardiovascular risk factor may have a risk of a first myocardial infarction that is above this threshold.<sup>5</sup> For example, in men 60 years old who have diabetes and hypertension the absolute risk of a first myocardial infarction is predicted to be >3% per year.<sup>1</sup> Thus, the primary prevention of coronary heart disease in people with diabetes approximates to the secondary prevention of coronary heart disease in people with normal glucose tolerance. To predict the risk in people with type 2 diabetes, assessment tables such as those provided in the joint British guidelines should be used.<sup>1</sup>

How does evidence suggest that we should intervene to reduce the impact of cardiovascular disease in people with diabetes? The benefits of controlling their weight, stopping smoking, increasing their physical activity, and eating a Mediterranean diet have not been shown for people with diabetes. Large randomised controlled trials support the use of aspirin, angiotensin converting enzyme inhibitors, and lipid lowering agents (either statins or fibrates) in people with a high absolute risk of coronary heart disease.<sup>3,4,6-9</sup> Extrapolating from the limited evidence suggests that these treatments are likely to be effective in people with diabetes if their absolute risk of myocardial infarction is >3% per year.

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