

The health of the nation

A new consensus emerges

Despite endorsing the Alma Ata declaration on primary health care (1978)¹ and the World Health Organisation's strategy of Health for All by the Year 2000 (1981)² the government has consistently refused to confront the impact on health of its policies (or lack of them) on employment, housing, education, transport, food, young people, and the environment. Now, with its green paper *The Health of the Nation* the cabinet has endorsed an agenda that links them all.^{3,4} Having for so long resisted adopting health targets and openly discussing WHO's strategy to reduce inequalities in health, the government has produced a document that seems to embrace the whole package.

Despite rumours about a document of 300 pages (supposedly one for each contributor) *The Health of the Nation* is remarkably succinct and focused. Its main section runs to a mere 54 pages, including tables and graphs of high quality. Annexes discuss possible key "areas," objectives, and targets for the national health strategy. Five months of intensive consultation now begin, after which a further document defining and setting in motion a health strategy for England will be published. (Scotland, Wales, and Northern Ireland have their own initiatives.) A health strategy steering group, together with three expert working groups focusing on the role of the government, specific options for objectives and targets, and implementing the strategy within the NHS, will contribute to the formulation of the definitive strategy.

There are no real surprises in the document—it has after all been based on epidemiological analysis, and the input from public health advisers has clearly been considerable. Sixteen potential areas for action have been identified, which fall into five groups. These are causes of substantial mortality (coronary heart disease, stroke, cancers, and accidents); causes of substantial ill health (mental illness, diabetes, and asthma); risk factors for mortality and morbidity (smoking, diet and alcohol, and physical exercise); areas with clear scope for improvement (maternal and child health, rehabilitation, and the environment); and areas with a great potential for harm (HIV and AIDS, other communicable diseases, and food safety).

Targets are suggested for many of these areas, and others may be introduced during consultation. Four areas (cancer, physical activity, HIV and AIDS, and food safety) are flagged, but the document suggests that identifying targets in these areas is difficult at present.

Throughout the green paper the need for intersectoral

policy and collaboration is repeatedly emphasised, and the central importance of directors of public health as conductors of multidisciplinary and multisectoral orchestras is apparent. The document goes a long way towards spelling out the infrastructure of research, monitoring, and evaluation that will be needed to ensure that the chosen targets are met.

Certain omissions exist, and the Labour party was quick to criticise the green paper for not discussing poverty. (Indeed, it did so the day before *The Health of the Nation* was published.⁵) But it is nothing short of amazing that a Conservative government has now acknowledged that "wide variations between different parts of the country, different ethnic groups and different occupational and income groups" exist and accepts that progress can be made not only "through the continued general pursuit of greater economic prosperity and social well being" but also through "trying to increase understanding of the variations and the action which might effectively address them" and "specific initiatives to address the health needs of particularly vulnerable groups whether geographical, ethnic, occupational or others who need specific targeted help." The government also acknowledges that it has a role in addressing "threats to individuals from the external world over which people have little or no control" and that "it is the responsibility of Government or others to take effective action on behalf of the community as a whole." This is far removed from the policies of minimalist intervention and individualism that characterised the Thatcher years.

In an appendix showing Britain's progress towards achieving the 38 European targets for Health for All a clear note of complacency is struck with regard to the environment. It is becoming clearer day by day that the old sanitary standards for the environment are inadequate and that we need to move into a new era of ecological standards with some urgency.⁶ There should, however, be no shortage of input to the consultation emphasising this point.

The document is in a recent tradition linking it to public health reports that began with that by Lalonde in Canada in 1974 and continued with a stream of similar documents at a national, regional, and local level.⁷⁻¹⁰ We can complain that it has taken us so long to come to this point compared with other countries in Scandinavia, North America, Australia, or New Zealand.¹¹ Or we can choose to see things differently, that a broad measure of agreement now exists between the Conservative and Labour parties about what the key public

health issues are. The challenge to any government is how to respond to them.

To have reached this point is in itself a major achievement. If one party had run away with the Health for All ball we would have been faced with the usual British nonsense whereby good ideas are opposed just because the other party thought of them first. Something of this has been evident in the Labour party's response to the green paper and in what could be an interminable argument about who has stolen whose clothes. Such argument is a diversion; to a large extent they are WHO's clothes anyway, and the former director general, Halfdan Mahler, and the current European director, Jo Asvall, have a right to some of the credit. So too does the current chief medical officer, Sir Donald Acheson, whose hand is in there somewhere. At present the Labour party is attacking the wrong goal, and if it wins the next election it is likely to be more than happy to base its policy on the green paper. What it should be concentrating on now is the government's continuing weakness—the level of NHS funding and the mechanisms of accountability.

Those who have criticised the green paper for not going far

enough are overlooking the effect of having an explicit document from which there can be no going back. The policies listed in the future election manifestos of all the political parties will be judged by their likely success at solving the problems acknowledged in *The Health of the Nation*.

JOHN ASHTON

Head of Department, Department of Public Health,
University of Liverpool,
Liverpool L69 3BX

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The daughters of stilboestrol

Grown up now but still at risk

Stilboestrol (diethylstilbestrol, DES) is a synthetic non-steroidal oestrogen, first described in 1938¹ and promoted in the late 1940s for preventing miscarriages and preterm births.² In 1971 an association was reported between in utero exposure to stilboestrol and the subsequent development of clear cell adenocarcinoma of the vagina in young women.^{3,4} The use of stilboestrol in pregnancy was prohibited in the United States that year. In 1973 the Committee on Safety of Medicines in the United Kingdom advised against the use of stilboestrol in pregnancy. An estimated two to three million American women received stilboestrol during pregnancy.⁵ A postal survey in 1974 suggested that 7500 women had received the drug in Britain, mostly during the 1950s.⁶

Further study of the daughters of women who received the drug in pregnancy led to the recognition of various teratogenic effects of in utero exposure. Stilboestrol affects the Müllerian duct system, leading to abnormalities of the uterus, cervix, and upper vagina. Benign structural anomalies of the cervix and vagina (collars, rims, cockscomb cervix, and pseudopolyps) are found in 25-40% of women exposed to stilboestrol.^{7,8} Colposcopy shows epithelial changes in the vagina and cervix in 65-90%,⁹ with vaginal adenosis (the presence of glandular epithelium in the vagina) being present in 30-75%.¹⁰ With time this glandular epithelium is replaced by squamous epithelium by a process of squamous metaplasia. As in the non-exposed population, this process may become abnormal, resulting in cervical and vaginal intraepithelial neoplasia. Reported rates of cervical and vaginal intraepithelial neoplasia in women exposed to stilboestrol vary widely.^{9,10} A multicentre study in 1984 found a twofold increase in the incidence of cervical intraepithelial neoplasia among these women.¹¹ Currently there is no evidence of an increased incidence of invasive squamous carcinoma in women exposed to stilboestrol.

The risk of clear cell adenocarcinoma of the vagina is low, being about one per 1000 women exposed in utero. Of 519 patients with this carcinoma registered in the United States up to 1985, 60% had documented proof of exposure to

stilboestrol, of whom 91% were 15 to 27 years old.¹² Though most cases present with vaginal bleeding or discharge, cases diagnosed by screening asymptomatic exposed women have been reported.^{13,14} Prognosis is related to the stage of disease at diagnosis.¹⁵ Three cases of vaginal clear cell adenocarcinoma have been reported in Britain in women exposed to stilboestrol.¹⁶⁻¹⁸

In 1977 abnormalities of the upper genital tract (most frequently a T shaped uterus) were described in 40 of 60 women exposed to the drug.¹⁹ Although no conclusive evidence exists of increased primary infertility in exposed women,^{20,21} rates of spontaneous abortion are higher and the risks of ectopic pregnancy and premature labour are increased, and women should be counselled about these risks.^{21,22} Hysterosalpingography is unhelpful in predicting the outcome of pregnancy, and the role of cervical cerclage is disputed.^{23,24} Despite these problems about four out of five women exposed to stilboestrol who conceive will have at least one live full term birth.²¹

Though most reports are devoted to women exposed to stilboestrol in utero, those for whom the drug was prescribed during pregnancy and their sons were also exposed to the drug. To date, the only significant untoward effect among mothers has been a small increase in the incidence of breast cancer, the relative risk being 1.4 (95% confidence interval 1.1 to 1.9) 20 years after exposure.²⁵ The incidence of benign abnormalities of the genital tract (epididymal cysts, hypoplastic testes, and cryptorchidism) in men exposed to stilboestrol in utero is more than three times that in unexposed men.²⁶ There have been unconfirmed reports of impaired fertility in men exposed to stilboestrol²⁶ but no evidence of an increased risk of cancer.

How should those who have been exposed to stilboestrol be managed? Young women presenting with abnormal vaginal bleeding or excessive vaginal discharge should be examined under anaesthesia. Screening for neoplasia of the genital tract should include inspection, palpation, and cytological and colposcopic examination of the cervix and vagina. Colposcopy