It is not difficult to think of reasons why an initiative like this might not succeed. It is essential that the slimmed down Department of Health when it announces its priorities acknowledges that those not included are left out because of resource limitations. It would be wrong and unrealistic to expect doctors and other health professionals to strive to achieve higher and higher standards within their duty to care and to chase centrally set targets without giving them extra resources. The exercise is central to all health service activities and it should therefore be implemented through contracts between health authorities and provider units, all provider units. Even so it will be important to engage the new managers in the spirit of the exercise.

It was encouraging to read the section in the green paper giving the contribution of other government departments to the health of the nation. Many of the initiatives will fail without some requirement that the various departments act together. With respect to child health, there must be local arrangements that ensure the departments of health, social services, and education and local authorities cooperate rather than compete. There has been little success in recent memory. Just look at the special needs registers of the different authorities.

My last concern is one that continually taxes paediatricians in neonatal intensive care: Will we ever be able to adopt a health care policy that admits it cannot afford the most recent expensive high tech approach and that chooses to take a long term, "green" view of its responsibilities?

Closing comment

One of the criteria for a target area is that it can be measured. Quality caring rather than quality care is not easily measured, but it is what patients want. Caring will always depend on the dedication and the professionalism of the staff. The document identifies a "highly dedicated and professional workforce" as one of the strengths of the NHS. That, in no small measure, reflects the education and inspiration provided by those who teach, an aspect of our service in Britain that must not be overlooked in our desire to set clinical standards and outcome measures and desirable targets that can be measured.

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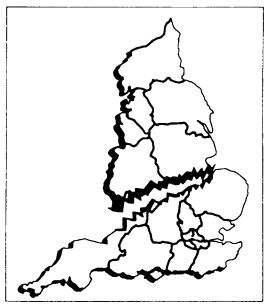

Cancer

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The Health of the Nation is a wide ranging consultative document.[1] Though reduction in cancer mortality and morbidity is included as a suggested key objective, only limited aims are included in the section on objectives and targets for action. This is somewhat surprising as cancer is the second leading cause of death and causes more lost years of life than any other disease in Britain.[2] Indeed, as the document makes clear, England has the highest mortality from cancer among the industrialised countries. Thus cancer fulfils the first of the criteria by which the document judges the key areas—it is a major health problem.

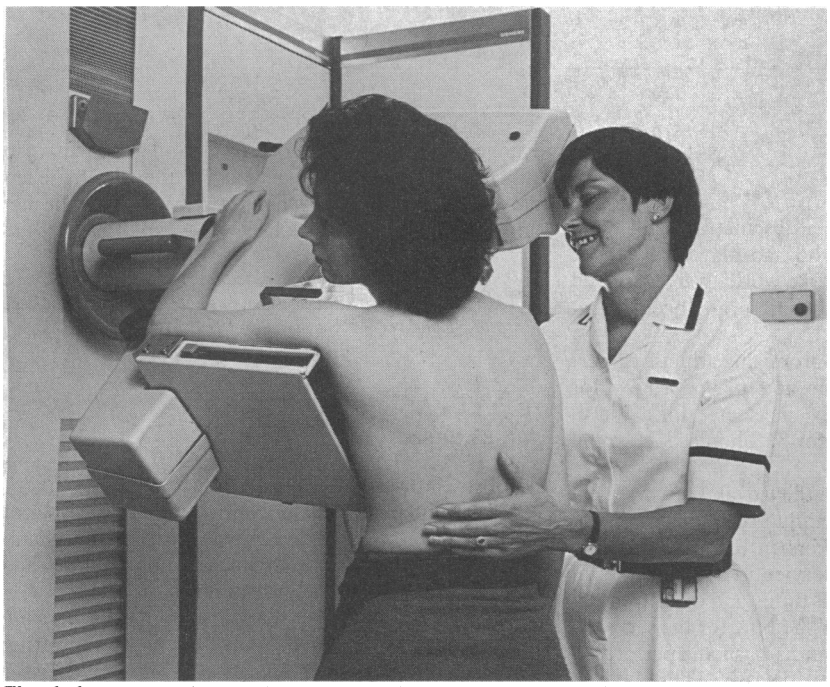
One of the problems with cancer is that it is often thought of as a single condition. Only when viewed as individual tumour entities do some types of cancer achieve the second of the government's criteria for key areas—namely, that effective interventions are possible. The specific targets for cancer identified in the document are shown in the box. Only the targets relating to breast and cervical cancers are mentioned specifically in the section on cancer, though there is clearly an overlap with other topics covered in the document, particularly smoking.

Government's targets for cancer

- To reduce deaths from breast cancer in women aged 50-64 (the group invited for mammographic screening) by 25% by the year 2000 compared with 1990 values
- To invite all women aged 20-64 for cervical screening by the end of 1993
- To reduce the prevalence of smoking to 22% in men and 21% in women (reductions of 33% and 30% respectively) by the year 2000. This target for cancers associated with smoking is mentioned specifically in the annex on smoking

Scope for breast and cervical cancer

The scope of the objectives for breast and cervical cancer contrasts bizarrely. It seems laudable, though optimistic, to expect in a national population a 25% reduction in deaths from breast cancer during a 10 year period when some research workers doubt the effectiveness of screening[3,4] and when some randomised trials and case-control studies have failed to identify such a large benefit in a similar population.[5,6] In support of the document's aims two overviews suggest that such a reduction in mortality is possible.[7,8] It is too early to assess what has been achieved in Britain, but in 1988 the UK Trial of Early Detection of Breast Cancer Group reported the results of mammography every other year in 45 841 women.[5] A further 63 636 women were offered teaching of breast self examination, and there was a comparison group of 127 117 women for whom no extra services were provided. These cohorts of women were enrolled between 1979 and 1981. Mortality was reduced in the women screened by mammography. The unadjusted reduction was 14% (relative risk 0·86%, 95% confidence interval 0·69 to 1·08) and even when other factors were adjusted for the reduction in mortality did not reach conventional significance. The reputation of the two screening districts (Edinburgh and Guildford) is high and such skill in breast screening is not available nationally. The acceptance rates of 60% and 72% in Edinburgh and Guildford, respectively, may not be achieved in the long term in a national programme, although it is encouraging that breast cancer is primarily a disease of middle class women and that breast cancer rates among non-acceptors in some studies are lower than those among acceptors.[9] The authors of this paper emphasise, however, the need for high acceptance rates and high sensitivity of screening (with a likely loss of specificity) if targets are to be achieved. Whether the



Though the government's target for reducing deaths from breast cancer might not be achievable, even a 10-15% reduction in mortality would be worth while

target can be achieved remains to be seen, but even a 10-15% reduction in mortality is likely to be worth while.

In contrast to its target for breast cancer, all the government suggests for cervical cancer is that all eligible women be invited for screening. As non-attenders are those at greatest risk,[10] a much more vigorous campaign is required if it is to have an impact on survival—the simple aim that all women be invited is likely to achieve a political target without significantly affecting mortality.

Scope for other cancers

Early detection of cancer has been called into doubt,[11] and its clinical significance pales in comparison with the impact of reducing smoking, which is included as a separate key area. Achievement of the government's aim, reduction in smoking rates to 22% for men and 21% for women by the year 2000, is bound to reduce mortality from lung cancer as well as that from several other smoking related cancers. In addition, the reduction in the risk of cardiovascular and respiratory diseases is an important bonus. Nearly all commentators will agree that reduced cigarette smoking should be the prime aim of any health programme for the nation. With these targets in mind, however, it seems overambitious to rely so heavily on the effects of education. Although previous educational programmes have been effective in reducing smoking, further attempts are likely to suffer from the law of diminishing returns and may succeed simply in reinforcing the present level of consumption. This one key area is the acid test of the government's will to improve the nation's health. Whether it will grasp the nettle and progressively increase cigarette prices and taxation and reduce the amount of advertising and sponsorship are open to question. Only when this government introduces progressive policies on taxation and advertising for smoking will the nation be convinced that disease prevention is high on its political agenda.

The section on diet also overlaps with cancer—in their monograph on the causes of cancer, Peto and Doll rate diet alongside smoking as a major cause of this disease.[12] Data are, however, insufficient to recommend a specific diet. The rather bland assertion in *The Health of the Nation* to reduce the intake of saturated fatty acids and total fat together with reducing obesity rates and excessive alcohol consumption may well have some effect on cancer. Several common malignancies, such as breast cancer, are directly correlated with increasing obesity,[13] and a reduction in fat intake and consequent obesity may reduce the risk of some tumours. Similarly, cancers of the mouth, throat, larynx, and oesophagus are closely correlated with high alcohol intake and there is a synergistic relation with smoking.[14] However, though many people may understand this and wish to change their (and their families') diet, financial constraints may prevent it. If this happens we may end up blaming the victim.

Other indirect gains may come from other key areas. These include HIV infection and AIDS (there are no specific targets included), in which changes in sexual habits and the increased use of condoms may reduce the risk of cervical cancer if recent theories on viral aetiology are correct.[15] Similarly, reduced exposure to environmental carcinogens may be beneficial—though Peto and Doll estimate that such exposure accounts for less than 5% of all cancers in the United States.[12]

Conclusions

Overall, *The Health of the Nation* is an encouraging document in that it tries to identify the key problems, asks whether there are means for improvement, and then targets objectives. However, the consultation process will need to greatly strengthen what is currently an anodyne document. Though successful screening for breast and cervical cancers are attractive goals, they are far less cost effective than reducing the rate of smoking. Although the document talks about treatment, rehabilitation, and counselling in other key areas, there is little mention of these topics in relation to cancer. Targets could easily be set in terms of providing information, training medical and nurse specialists (staffing in Britain is far below that in other industrialised countries), and providing counselling services and rehabilitation facilities. By focusing on two issues, that the public believes are important (screening for breast and cervical cancer) the government is in danger of merely tinkering with the problem. Above all else, it should make clear that it is willing to reduce smoking through legislative means. Only then are screening, diet, information, and counselling kept in proportion. In addition, the government has the machinery, the resources, and the infrastructure to deliver high quality care to those who need it. Improvements in survival and quality of life are likely to be achieved when all of these measures are implemented.

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