increasing practice of placing patients on remand or from court diversion schemes in general adult or medium secure units further intensifies demand for these beds. There is therefore no scientific basis to judge at this stage whether secure hospital beds or staffed community places should receive priority for investment to reduce rates of relapse, readmission, and reoffending.[11]

Hospital inpatient beds are the most expensive component of any mental health service, accounting for nearly three quarters of total costs.[13] Efficient management of beds is central to the debate on how many psychiatric beds need to be commissioned. Evidence is accumulating of inefficiency—with huge variations in spending on local mental health services (up to 40-fold differences in the costs of inpatient days[6]), which are not related to local service needs, along with unacceptably high rates of bed occupancy in some metropolitan areas.[14] Managing beds sparingly depends on the following factors: home assessment when possible, senior clinical gatekeepers for admissions, clear statements of the purpose of each admission, frequent inpatient review meetings with the authority to discharge patients, immediate transfer to housing services when the patient is homeless, and mental health teams with control over admission to and discharge from their own beds.[15,16] The prevention of further admissions, when this is clinically appropriate, is best effected by a policy of prioritising the most seriously mentally ill patients. Such patients will usually include those who have had multiple admissions in the past, those who have often been detained under the Mental Health Act, and those who have failed to adhere to treatment.

The debate on numbers of hospital beds should now be widened to included the contributions of agencies other than health providers, such as social services, housing, and voluntary agencies, which substantially reduce the need for inpatient care. In particular, long term NHS psychiatric beds are rapidly being replaced by places in smaller, voluntary or for profit residential care and nursing homes, which may be poorly regulated and not have 24 hour staffing.[2] In this mixed economy, effective collaboration among agencies assumes a new importance, both for service provision and for commissioning. Without such collaboration shortages and duplication of services are likely.

Without more information along the lines suggested above, the debate about how many psychiatric beds are needed will be guided more by moral and political than by clinical or research considerations. We shall lose sight of the fact that, when patients are asked for their views, they universally prefer community based services—where these are good.[16]

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The limits to health promotion

They lie in individuals' readiness to change

Everybody knows that prevention is better than cure, but the opposite, equally attractive, principle of paying tomorrow for what you can have today is an efficient way to use your resources: health economists call it "discounting."[1] Discounting is efficient because resources usually devalue over time, and numerous unexpected events are likely to overtake the person who delays gratification. To "eat, drink, and be merry for tomorrow we die" is a discounting approach to life. This is a challenge to the health promotion movement, particularly in relation to those in their teens and 20s, for whom tomorrow is a long way off. Health promotion has, of course, been achieved through traditional public health measures—for example, clean water and air and manipulation of the population[2,3]—but success in local communities and with individuals is more controversial when people's choices are an important factor. Indeed, the limits to health promotion lie in the paradox that "a measure which brings large benefits to the community offers little to the participating individual."[2]

Health is not a unidimensional concept, and many research workers have found that personal concepts of health vary according to context.[4-7] Energised, health seeking people or families[8] remain a minority in our society because most people regard health as a free asset to be used or enjoyed.[5-9] Health can certainly be viewed as a resource that will devalue through aging and accidents. Most people struggle to modify their homes, work, diet, or habits in the interests of greater security, comfort, social desirability, or health and safety, but any health gains achieved are often difficult to sustain against social circumstances.[10,11]

Twelve field projects, mainly from the less developed parts of the world, show how providing practical opportunities for healthy choices in a non-coercive way can be important. The Peckham Pioneer Health Centre in south London in the 1930s was a cross between a health centre, modern leisure centre, and city farm.[12] The Valley Trust sociomedical experiment in rural South Africa was launched in 1950 to promote healthy eating, gardens providing produce, environmental awareness, local sports facilities, outlets for home craft, clean water, and fish cul-

ture to the underprivileged Zulu people.[13] In 1975 Newell published an account of 10 projects in less developed countries where innovative approaches to food, education, and productivity in poor areas had had a considerable impact on people's health when delivered in an integrated way together with basic medical care.[14]

These projects were remarkable for trying to kindle a sense of community responsibility and involvement, individual and group self sufficiency, and the feeling that people can have a unity between their land, their work, and their household. Each used basic primary medical care to meet a need that was felt and to spearhead contact with the community. Each project was practical, and the one that resulted in the best documented decline in malnutrition emphasised the value of cultural diversity and of being cautious about contradicting or opposing local beliefs and customs.[13] The founders of these projects were practical people with a deep respect for local cultural values. They seemed to understand that readiness to change beliefs or habits is usually the product of inner change combined with the external opportunity to consider practical alternatives at a time and pace appropriate to each person. Are these insights being integrated into modern primary care?

Coercion may increase resistance

Despite professional belief in the power of medical authority to kindle change,[15,16] attempts to coerce or encourage changes in behaviour may increase resistance or resentment.[17] Readiness to change has probably not been taken into account.[17,18] Such readiness seems to vary both within and between individuals. Evidence is emerging that the practitioner's approach should be more sensitively matched to the patient's readiness to change. For example, while an action oriented smoking programme may help those who are ready for change, it does not work for those who are unsure about it.[18] Those who are unsure need not advice but an opportunity to weigh up the advantages and disadantages of changing their behaviour. Trying to assess readiness to change also has the merit of focusing on the person rather than the message.[15] Further evidence about more sensitive matching of interventions to individuals should emerge over the coming years, but the study of health promotion at the individual's level, with its focus on change in behaviour, is still in its infancy.

The results of a secondary prevention trial of health promotion in patients with angina published in this week's *BMJ* (p 993) shows that some lifestyle gains can be made after active intervention in primary care.[19] However, the differences between intervention and control groups were reduced by lifestyle gains in the control group, and in both groups many subjects managed no change despite having a major physical symptom (angina) to motivate them. Knowing the subjects' degree of readiness to change for each lifestyle factor would have been of interest in interpreting the data. So would more details about how the health visitors conducted the four monthly "appropriate health education."

The preliminary data from two recent largescale evaluations of lifestyle and risk factor intervention[20,21] lead us to question the value of a blanket approach through primary care without practical opportunities in the community for change as described in the early field experiments. Rewarding general practitioners for population coverage rather than using more sensitive and practical approaches to individuals is unlikely to build on the natural advantages of primary care. Personal continuity and easy access to care should be combined with the development of local resources that facilitate healthy choices. In a democratic society people have the right to eschew the healthy options, and social conditions often militate against politically correct choices.[10,11]

Doctors with a public health orientation can be quick to say what general practitioners should be doing on the basis of population data. Yet doctors and nurses in general practice face the frustration of being bribed or bullied by governments to achieve targets that many patients are not ready to accept for personal and social reasons. Nothing is more likely to reduce the likelihood of long term "success." Coercion may in the short term achieve apparent health gain targets, but at what cost to relationships and the professionals' feelings of integrity and self respect? The opportunity costs are still unevaluated.

When Ivan Illich wrote *Limits to Medicine* in 1976 he called for a shift in society away from a focus on disease,[22] and Thomas McKeown reinforced this call.[23] Nearly 20 years later the limits to health promotion are being defined by those who see the hollow rhetoric of an approach that focuses too much on the individual and too little on the context. People need individual care when they are frightened or ill; they will often support sensible legislation for environmental improvement; but their willingness to change cultural and social habits comes in small steps in response to external opportunities for change[24] and an inner readiness to change. The challenge to the government and health professionals is how to meet the need at the time it arises and also create the practical opportunities for change while becoming more skilful and less impatient about people's inner readiness to change.

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