A new stage in prevention of coronary heart disease

IF words alone could change the world, 1984 would have been the start of a new era in control of coronary disease. We had the Canterbury multidisciplinary conference convened by the Health Education Council,[1] drawing attention to the 25 per cent fall in coronary mortality in the United States since the early 1960s, associated with massive public campaigns and professional activism, neither of which have had any counterpart in Britain. If they can do it, why can't we? At last our leading academics have agreed to sink their remaining differences, and with the publication of the report by the Committee on Medical Aspects of Food Policy (COMA)[2] we have realistic guidelines for reform of national diet which command support from nearly all professional opinion, except those serving the brief of the Butter Council or offended by their omission from the committee. Preceded by reports from the Royal College of Physicians,[3] our own College[4] and the World Health Organization,[5] this is an overwhelming professional consensus for action. Because this report has already received immense, mainly well-informed publicity in the media, at least the appearance of effective action can no longer be delayed.

This is the background to the statement in Parliament by Junior Health Minister John Patten acknowledging 'the valuable part played by the Royal College of General Practitioners in encouraging general practitioners to take a more practical approach to the prevention of heart disease', and that the way to tackle coronary prevention is through family doctors.

Once again, public knowledge of advances in medical science (what can be done) has forced the Government to discuss implementation (what will be done). In practice though not in theory, this seems to take two forms — practical and rhetorical. The practical policy is to continue a slow and reluctant development of high-technology salvage (bypass grafts) available to a generally poorly informed public on a first-come, first-served basis. The rhetorical policy is primary prevention by voluntary agreements with commercial interests such as the tobacco and food industries; wishful thoughts that healthier ways of living will develop spontaneously despite mass unemployment, and negligible investment in cycle paths, playing fields, swimming pools or local sports instructors; and secondary prevention on the personal initiative of general practitioners. At first glance, it may seem flattering that the Minister has been so readily converted to the primacy of primary care, but second thoughts suggest that we may be loved less for ourselves than for our two most outstanding attributes in the eyes of all governments; our work is relatively cheap, and if we do it badly or not at all, no one, least of all them, can be held to account for it.

The ball is therefore in our court. Government looks to us for the next move, perhaps scarcely believing that we shall come up with a serious and therefore costly answer. Professor Hoffenberg, President of the Royal College of Physicians and a good friend of general practice, has invited our College to join his working party on practical policies for control of coronary disease. If we really have something uniquely useful to contribute, the floor is ours.

I think we do have some new things to say in what may otherwise become a wearisomely predictable litany of righteous acts to be performed by others. First, we have to decide on some priorities in our work. Risks of coronary death are halved by stopping smoking, a far higher yield than for any other action and without any of the risks of medication; we must find ways to give this the priority in consultation it deserves. Reduction in quantity and change in quality of dietary fat is clearly possible, and we have got to equip ourselves with the knowledge we need to answer the intelligent questions our patients are certainly going to ask about what they should and should not eat. A good start in getting up to date would be to read the COMA report itself, rather than rely on the weekly comics; it is a carefully worded report repaying repeated study. We have got to approach obesity in a new way, with particular attention to organized group work. While the most popular first step in community prevention, namely systematic search for and treatment of high blood pressure, is an extremely useful first exercise in neighbourhood community medicine and is effective in preventing stroke, there is still no convincing evidence that it is effective in preventing coronary deaths.[6] Although proof of a direct preventive effect by regular exercise remains elusive (and is by its nature virtually impossible to test by randomized controlled trial), most experienced workers in the field are impressed by the way in which exercise programmes assist the comprehensive shift in lifestyle necessary to change diet and smoking. The indirect effect seems to be more powerful, and there is surely a role here for general practitioners as powerful local figures who could help to expand sport

facilities for a much wider and older public than participates at present.

We have also got to consider the implications for practice organization, workload, staff structure and training, of taking on this large new dimension of local population care. It is clearly absurd to suppose that our existing teams can do this work by mighty acts of will and personal sacrifice; nor can the situation be transformed by closer links with the tiny numbers of community nutritionists and health educators presently employed by district health authorities (DHAs). Our first task will be to get our records into a state where we have more than garbage to offer a computer. Running this a close second will be employment of more staff to organize a programme and make space for it against competing priorities, a job we are unlikely to do ourselves even if we had the time. In all this we still have one greatly underused resource: the 70 per cent staff wages reimbursement scheme. The extent to which this is taken up is probably the true measure of our commitment to anticipatory care of the population. These expanded teams need training, of the type already organized by Gareth Beevers in Birmingham, without cost to participating practices. Such teaching will be ineffective unless it is done by people with personal experience of the problems of translating theory into practice; a serious limitation on the pace at which even the most enthusiastic of us can proceed.

Setting up local workshops of this kind is the first practical help which DHAs could give, to show that deeds are going to match the promises implied by the mountain of paper we already have. The Hoffenberg working party will have to be very much a nuts and bolts affair, if the hopes rightly raised in the general public are not to be betrayed.

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References

1. *Coronary heart disease prevention: plans for action. Report based on an interdisciplinary workshop at Canterbury 28–30 September 1983.* London: Pitman, 1984.
2. Committee on Medical Aspects of Food Policy. *Report of the panel on Diet in Relation to Cardiovascular Disease. DHSS Report on Health and social subjects no. 28.* London: HMSO, 1984.
3. Joint Working Party of the Royal College of Physicians of London and the British Cardiac Society. *Prevention of coronary heart disease.* (Published as a pamphlet) Royal College of Physicians of London, 1976.
4. Subcommittee of the Royal College of General Practitioners' Working Party on Prevention. *Prevention of arterial disease in general practice. Reports from general practice 19.* London: RCGP, 1981.
5. World Health Organization. Prevention of coronary heart disease. Report of a WHO expert committee. *Tech Rep Ser* 1982; no. 678.
6. Hart JT. Prevention of coronary heart death in general practice. *Postgrad Med J* 1984; **60:** 42-46.

Limited list, limited vision

WITH the abrupt announcement by the Secretary of State for Social Services, Mr Norman Fowler, of the Government's proposals to limit the range of drugs that can be prescribed by general practitioners the period of consultation is now over. The initial response from the medical profession and from the general public has been one of bafflement and a questioning of the real purpose of the proposals.

The Government is rightly concerned about the rise in the cost of drugs in the National Health Service and the proposals have been put forward as a simple means of saving money. However, this shopping list approach to prescribing under the NHS indicates either poverty of thought within the Department of Health and Social Security or the start of a series of manoeuvres the ultimate aim of which is unclear.

If the set of proposals is a one-off exercise in trimming costs, then the Department is being naïve since the projected savings cannot be accurately predicted. Pharmaceutical firms will try to protect their own profitability and this could result in medicines still under patent becoming even more expensive. The Government has already got ample powers to limit the costs of drugs through the price regulatory scheme, and as the monopolistic purchaser it could insist on the pricing of proprietary drugs matching that of the generic equivalents.

If the set of proposals is the first of a series, then the NHS is destined for management by diktat. The Minister has said that the detail but not the principle of his statement is negotiable. It is hard to discern a principle in a piecemeal approach to an issue which requires a systematic and reasoned strategy. If the promised green paper on primary care is of that ilk, then for primary care read second rate.

What is the basis of the profession's response? First, let us see the proposals for what they are: they are crude and brutal but they do focus attention on our lack of information about the effectiveness of prescribing in general practice. We should be clear about what the proposals are not: they are not an attack on clinical freedom — such freedom is always relative and doctors are not prohibited