

# The health of their nation: how would citizens develop England's health strategy?

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## SUMMARY

**Background.** England's first health strategy, *The Health of the Nation*, was formulated without systematic input from the citizens whose health it targeted. Several studies indicate that citizens, when asked to prioritize services, rank interventions for acute and life-threatening conditions highest. But how they view and what they want in the areas of prevention, public health, or care for the chronically and mentally ill is not known.

**Aim.** To explore citizens' attitudes towards England's health strategy as set out in *The Health of the Nation* and to elicit their ideas for developing it further.

**Method.** The study was conducted in four general practices and a secondary school in southwest England. The design was a qualitative analysis of testimony from 24 audiotaped focus groups. Twenty-three groups were drawn from lists of National Health Service registered patients, stratified by *The Health of the Nation* target category, and one group was drawn from 13 to 15 year-old girls at a mixed secondary school. In all, 173 citizens took part in the 24 focus group meetings.

**Results.** In group discussions, these citizens demonstrated an understanding of *The Health of the Nation* strategy, which enabled them to form views and develop relevant arguments. They produced 26 specific ideas for developing the strategy across its five key areas. There was congruence with the action plans of a national expert group convened by the Department of Health and charged with reviewing the strategy's progress. The focus groups went beyond the experts' proposals, with further practical ideas to achieve *The Health of the Nation* targets.

**Conclusion.** Citizens in this study contributed a broad range of relevant, appropriate, and innovative ideas on how to develop health strategy. The use of focus groups to achieve this is practical and efficient.

**Keywords:** *The Health of the Nation*; qualitative analysis; health care provision.

## Introduction

Of all cooperative enterprises, wrote William Mayo, public health is the most important and gives the greatest returns. In 1992, after 44 years of free personal health services, England launched its first ever coordinated strategy to improve the public health across the whole nation: *The Health of the Nation*.<sup>1</sup> At the same time, moves were made to involve citizens more in health

matters. The health service reforms of 1990, Parliament, the Audit Commission, the Chief Medical Officer, health scientists, and citizens themselves<sup>2-8</sup> each called for public involvement in setting standards of health care and medical services.

Mostly, when asked to prioritize services, citizens rank interventions for acute, life-threatening conditions, particularly in children, above prevention, care for the chronically and mentally ill, and services for people with self-inflicted conditions<sup>8-10</sup> — the very issues targeted in *The Health of the Nation* strategy.<sup>1</sup> The five key areas chosen in the strategy were: mental illness, heart disease and stroke, accidents, HIV/AIDS and sexual health, and cancers. What remained unknown was how citizens view these areas of health policy, or what they want for them. The consultation process on formulating the targets in the five key areas outlined in *The Health of the Nation*, despite following a Green Paper,<sup>11</sup> included no system to collect or incorporate citizens' views. This study, therefore, posed two questions. First, what are citizens' attitudes towards *The Health of the Nation* strategy? Secondly, what ideas could citizens generate to develop it?

An expert report on progress towards *The Health of the Nation* targets three years into the programme, entitled *Fit for the Future*,<sup>12</sup> provided us with a chance to compare citizens' ideas contemporaneously with those of the Department of Health, and so to gauge how 'in tune' ordinary citizens were with mainstream expert opinion. More recently the government published a consultation paper, *Our Healthier Nation*,<sup>13</sup> which suggests fresh targets up to the year 2010 for mental illness, heart disease and stroke, accidents, and cancers. It is our intention that the ideas of these citizens inform the next strategy.

## Method

The research aim was to elicit citizens' ideas on developing England's health strategy as published in *The Health of the Nation* documents. We chose a qualitative approach as the specific method as it is the better way to elicit ideas, attitudes, and feelings from individuals and focus groups because of their ability to aid recall and stimulate discussion in a cumulative, elaborative way.<sup>14-17</sup>

After approval by the Exeter research ethics committee, the research was conducted in four general practices: three in Exeter and one in Plymouth. Exeter is a cathedral city, with a population of 109 000, whose economy is based on Devon's surrounding agriculture, light manufacturing, insurance, and local service industries. Levels of deprivation in Exeter are at the United Kingdom average, and levels of crime and unemployment are below average. The port of Plymouth has a population 255 000. The naval dockyard, ferry port, fishing fleet, and clay mining underpin the economy of the city. Levels of crime, drug abuse, unemployment, and deprivation are high: Plymouth has recently been designated a health action zone. Around 1.5% of the citizens of both cities are of non-white ethnic origin.

The discussions held by 24 focus groups were taped, transcribed, and analysed between November 1994 and June 1995. We estimated that four groups discussing each topic would exhaust the likely pool of ideas.<sup>18</sup> Six groups were given the topic of accidents in order to cover the age spectrum in this key

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area. Purposeful samples were drawn from stratified lists of patients registered in the four practices.<sup>19</sup> They were stratified according to the target categories outlined in *The Health of the Nation* and to maximize homogeneity in each invited group. Individuals were invited by letter to participate in one focus group each. One group of 13 to 15 year-old girls was recruited from a mixed school in Exeter.

Because we were seeking lay and typical attitudes and ideas from citizens without special knowledge, we excluded from invitation to the cancer and the coronary heart disease and stroke groups people with a personal history of or experience in caring for someone with cancer, heart attack, or stroke. People with a current diagnosis of depression or psychosis were excluded from invitation to the mental illness groups. Parents of children on an 'at-risk register' were excluded from invitation to the accidents groups. Anyone with a history of HIV or AIDS, or recorded as an injecting drug user, was not invited to the general HIV/AIDS groups. Injecting drug users in one practice were specifically invited to an intravenous drug users group.

Anyone with a first degree family bereavement within 12 months or a personal hospital admission for any reason within three months was excluded from all invitations on ethical grounds. The synoptic booklet *The Health of the Nation and You* accompanied each invitation.<sup>20</sup>

The average group size was seven participants; meetings lasted 90 minutes, and proceedings were audiotaped with written permission from participants, who were invited to receive a transcript of their meeting. The authors, all experienced facilitators, each led eight meetings held in the practices where the participants were patients. The 13 to 15 year-old girls' group was held at their school. To ensure conformity between groups and facilitators, we followed an agreed scheme of stem questions for each key area, approved by the ethical committee. Groups were not asked to prioritize their ideas, nor to discuss their cost.

The three authors — the researchers — are experienced and trained in small group leadership. Neither general practitioner (NB, KS) led a group in his surgery or with his own patients. Groups led by a general practitioner produced similar numbers of ideas on a given topic as those led by the health scientist (MW).

Transcripts were analysed using line by line coding and based on grounded theory<sup>21</sup> to produce a series of ideas. Each idea was allocated a number to provide an audit trail back to the original testimony. Annotations indicated hesitation or laughter. Our analyses were validated as accurate, consistent, and full by two independent qualitative researchers, each of whom was given one meeting's transcript, asked to analyse it by identifying the main themes, and not to apply other paradigms.<sup>14</sup>

## Results

The acceptance of invitations varied as a function of age and topic. Using 1991 census data at enumeration district level linked to postcode, there was no strong social class bias compared with national proportions for those who accepted the invitation to attend. Table 1 demonstrates the likely effort required, and hence the cost, to recruit future focus groups of this type.

We present here a qualitative analysis of the 24 transcripts by key area.

### Mental illness

*Attitudes.* Three groups criticized the principle, quality, and funding of care in the community:

*'It's like throwing a person out of the place before they've found another place to go.'*

All groups saw general practice as central but unequal to treating the mentally ill:

*'The GP is the only person I would know of [if you were depressed]. But I don't think it should fall to the GP.'*

*Fit for the Future* targets farmers, young men, and doctors as high suicide risks. The groups identified for themselves the risks to farmers and young men, and suggested a campaign:

*'These farmers are committing suicide because of money; or they feel failures.'*

*'Is it like working men in the 30 to 40 age group that don't go to the doctor, or very rarely...?'*

The theme is that the mentally ill need looking after better, in and out of hospital, with more specialist psychiatric help and better information about depression and suicide for the public. The ideas raised by the groups on this topic are shown in Box 1.

### Coronary heart disease and stroke

*Attitudes.* All groups said that messages about smoking, drugs, exercise, and alcohol should be stronger, and two groups discussed citizens' responsibilities to preserve their own health:

*'I think people should basically look after their own bodies.'*

Two of the groups thought that sport at school is pivotal for health. All felt that general practitioners were important in cutting heart disease and stroke. The groups matched both *Fit for the Future* targets on diet and exercise. The theme is that individuals' responsibilities for their own health should be developed through schools and primary care. The ideas raised by the groups on this topic are shown in Box 2.

### Accidents

*Attitudes.* Responsibility for the prevention of accidents at home was seen to rest with the families of the elderly and the young:

*'I think it should be left to families as much as possible.'*

All groups wanted controls on drink driving:

*'I don't see any problem with spot checks for drunk driving.'*

*Fit for the Future* highlights accidental deaths in the elderly at home. The groups matched this, recommending cooperation with the police, councils, social services, and Age Concern. The theme is that the competent, working age adult should share responsibility for accident prevention in the young and elderly. Educational messages should reach all adults, not just the populations at risk. The groups' ideas on this topic are shown in Box 3.

### HIV/AIDS and sexual health

*Attitudes.* Two groups did not know about gonorrhoea's use as a marker for HIV/AIDS:

*'Don't people who get HIV get it through needles? Well, how is that related to gonorrhoea then?'*

Another group was not clear how HIV spreads. Two groups said that the benefits system encourages some girls to have a baby and that pregnancy can confer a feeling of being special with heightened esteem among peers:

*'It would be good if we could get given condoms at the surgery.'* (A request from the group of schoolgirls.)

Most participants saw benefits in needle exchanges. The drug-using group expressed distrust and little confidence in primary

**Table 1.** Invitation and attendance figures for the 24 focus groups.

Key area (No. of groups)	Number invited	Number attending	Ratio invited/attended
<b>Cancer</b>			
20–39 years of age (2)	107	18	5.9
40–74 years of age (2)	53	23	2.3
<b>Mental illness</b>			
20–39 years of age (2)	55	13	4.2
40–74 years of age (2)	65	16	4.1
<b>CHD/Stroke</b>			
20–39 years of age (2)	197	12	16.4
40–74 years of age (2)	105	18	5.8
<b>Accidents</b>			
16–24 years of age (2)	158	10	15.8
25–39 years of age (2)	72	10	7.2
65–74 years of age (2)	78	12	6.5
<b>HIV/AIDS</b>			
16–20 years of age (2)	83	10	8.3
21–64 years of age (2)	89	13	6.8
Schoolgirls (1)	10	10	1.0
Intravenous drug users (1)	8	8	1.0
<b>Total (24)</b>	<b>1080</b>	<b>173</b>	<b>6.2</b>

The focus groups proposed the following ideas for action for the prevention of mental illness and for the improvement of health care in this area:

- The Samaritans to receive extra funding,
- Young men to be offered parenting and life skills training,
- Teachers to be educated about the warning signs of depression,
- School counsellors to be employed in secondary schools,
- Family support workers to be provided for the mentally ill,
- Employers to be encouraged to nurture the mental health of their employees,
- To provide protected half-way houses for the mentally ill immediately after hospital discharge, and
- To provide foster homes for mentally ill adults in a family setting.

**Box 1.** Mental illness. Individual group sizes ranged from four to 13 members, with an average of seven people in each group.

The focus groups proposed the following ideas for action for the prevention of coronary heart disease and stroke and for the improvement of health care in this area:

- To develop healthy eating into healthy shopping,
- To ban tobacco advertising completely,
- To encourage employers to help their workers take more exercise,
- To introduce cheaper sports facilities, and
- To expand the law to make it harder for children to buy cigarettes.

**Box 2.** Coronary heart disease and stroke.

The focus groups proposed the following ideas for action for the prevention of accidents and for the improvement of health care in this area:

- To introduce education and proficiency testing for child minding and baby sitting,
- To introduce education and proficiency testing for all cyclists over a certain age,
- To expand community wardens' supervision of the elderly into owner-occupied homes, and
- To encourage DIY stores to offer expert safety advice.

**Box 3.** Accidents.

care teams.

*Fit for the Future* highlights compulsory sex education; and this was a common theme within the groups. In contrast to the other key areas, primary care here was seen as peripheral. Distrust of doctors by drug users and disrespect by citizens for a benefits system that may, paradoxically, encourage girls to become pregnant were further themes. Further ideas on this topic are outlined in Box 4.

### Cancers

*Attitudes.* All groups thought that the harmful effects of sunlight are too often ignored. Each group identically rehearsed the arguments about the forces encouraging young people to smoke — advertising, peer pressure, self-image, role models, pleasure, addiction — and the forces that discourage smoking — price, disease, no-smoking areas, legislation, health warnings, smell, and peer pressure. Three groups favoured frightening, disgusting health messages for deterring people from smoking:

*'Show videos of lung cancer operations, or something, you know, shock treatment.'*

Three groups would ban tobacco advertising and the sponsorship of sport by tobacco companies. Three groups criticized what they perceived as poor funding for breast and cervical cancer screening. *Fit for the Future* proposes a strategy to improve referral, diagnostic, and treatment services for all cancers, which was also an idea produced by one group (further ideas are shown in Box 5):

*'It would be great to have a cancer centre in every district ... where you could get speedy access to a consultant.'*

In every group for each key area, schools and television were viewed as more influential than health services for educating and informing.

The focus group formed the unit of analysis throughout. The number and range of ideas in each group did not vary significantly between the facilitators. Few, if any, new concepts or ideas emerged after the third group in a given key area. The cost of running one focus group of eight members lasting 90 minutes

The focus groups proposed the following ideas for action for the prevention of HIV/AIDS and sexual ill health and for the improvement of health care in this area:

- Sex education should emphasize the emotional and moral aspects of relationships,
- Sex education should acknowledge that homosexuality exists,
- Educators to persuade teenage magazines not to promote sex,
- To provide a needle exchange in every town, through local chemists, and
- GPs should be able to prescribe condoms.

#### Box 4. HIV/AIDS and sexual health.

The focus groups proposed the following ideas for action for the prevention of cancer and for the improvement of health care in this area:

- To provide mobile skin clinics situated on beaches, advising about protection,
- For travel firms to provide information about avoiding skin cancer in brochures and with travel documents,
- For cosmetic companies to be encouraged to cut the price of sunblock preparations, and
- For a mobile screening unit to tour deprived areas where take-up of cervical screening is low and rates of cervical cancer are high.

#### Box 5. Cancers.

was £365. This sum included the costs of recruitment, facilitating and recording the meeting, transcription, and analysis. Taken together, the membership of the focus groups constituted a population that was demographically comparable to the population of England as a whole.

### Discussion

The public has participated in previous quantitative studies regarding the prioritization of health services,<sup>8,9,22,23</sup> but this is the first reported exercise asking citizens how they would develop England's health strategy. The groups were limited to two cities in the southwest of England, but that in itself is not a reason to suspect their testimony as any more or less credible or information-rich than that of citizens in other English cities. We explored their attitudes and asked for their ideas using focus groups, which encourage interaction between participants to develop a line of discussion, and can give insight into beliefs and attitudes that underlie behaviour.<sup>24</sup>

Why were sufferers of diseases under discussion excluded? First, we saw an ethical objection to asking someone with cancer, stroke, depression, or AIDS to discuss with strangers how their condition might have been prevented. The chance of participants experiencing distress with no prospect of benefit seemed unacceptably high. Secondly, there was the practical problem that many sufferers would be too ill to take part. Thirdly, in a study looking for ideas from ordinary citizens, we needed to avoid the bias of insider knowledge.

To take citizens' ideas seriously requires confidence in their understanding of the issues involved. We report the attitudes expressed in the groups in order to provide context and credence to the ideas that flowed from them. These citizens did demonstrate a grasp of the issues, and the focus groups proved a useful tool for exploring them. Their ideas for development matched and went beyond the proposals of an expert body, except on the issue of suicide in doctors (and this omission was not explored). The breadth and relevance of their ideas suggest that the public could helpfully contribute to health strategy — a notion shared by those experimenting with citizens' juries.<sup>23</sup>

The ideas generated here, if acted upon, would impact on three particular areas of public life: business, education, and parliament. The citizens appealed to businesses to nurture the mental health of employees and to make in-house exercise facilities available, to market cheaper sunscreens, and to promote 'healthy shopping'. These ideas are already normal practice for some American companies.<sup>25</sup> The groups felt that teachers should learn to recognize the signs of depression, and provide more and better sex education. They favoured pressure on editors of teenage magazines not to promote sexual activity among youngsters. Some ideas would need legislation: proficiency tests for cyclists, child minders, and baby sitters, and a complete ban on tobacco advertising.

We think that there is work for citizens' focus groups to do in feeding fresh ideas into the regular reviews of England's health strategy; a point made by Elkan *et al* in their discussion of the use of targets to improve the quality of care.<sup>26</sup> They are inexpensive, feasible, and in tune with a modern approach to involving the public in their own health. England's first ministry of public health creates a structure for business, parliament, education, and health services to network in the interests of the health of the nation. Documented here are 26 ideas as a start.

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