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## **Health in Mersey – an exercise in community diagnosis**

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**THE process of producing a community diagnosis for the Mersey Region is described. Such an exercise is recommended for its potency in agenda-setting, and establishing a frame of reference for health promotion within the context of the strategy of Health For All By The Year 2000.**

THE power of information is often alluded to, particularly in community medicine, and our tradition of the use of statistical information goes back to Graunt and beyond<sup>1</sup>. William Henry Duncan, the first Medical Officer of Health, demonstrated how effective local health information can be when he produced his pamphlet *The Physical Causes of the High Rate of Mortality in Liverpool* in 1843<sup>2,3</sup>. This pamphlet was based on two lectures which Duncan had delivered to the Liverpool Literary and Philosophical Society, and drew on the evidence he had assembled three years previously for the House of Commons Committee on the Health of Towns, and prior to that for the Poor Law Commission; this had included a survey of housing conditions in Liverpool<sup>4,5</sup>. Duncan's evidence, lectures and pamphlet played an important part in making the case for medical officers of health, and led indirectly to his own appointment in Liverpool in 1847. They also provided information which was drawn on in the drafting of the first Public Health Act 1848, and helped to establish the precedent of the annual reports produced by medical officers of health until the National Health Service reorganisation in 1974.

In recent years, the passing of the MOH's annual report has been increasingly lamented, despite the limitations of form and content which often characterised it. There has been a renewed awareness of the importance of appropriate local health data in the form of a community diagnosis to assist in the process of agenda-setting for opinion-formers and decision-takers, and to provide a systematic framework for the

deciding of priorities<sup>7,8</sup>. Although the annual report from the Chief Medical Officer at the Department of Health is still produced in the United Kingdom, its format has changed little to enable it to fulfil its potential as a galvanising focus for improvements in the nation's health.

At a regional and district level, there are indications that annual reports may be re-emerging. However, one danger is that in the new climate of post-Griffiths they will be focused narrowly on accounting and on efficiency rather than on effectiveness. At present, the gap left by the disorientation of community medicine has to some extent been filled by the more imaginative and effective of the community health councils<sup>9</sup>.

This paper describes the production of a regional community diagnosis for the Mersey health region as part of the overall strategy for health promotion in that region.

### **The production of a community diagnosis**

The emerging strategy for health promotion in the Mersey region has been described elsewhere<sup>10</sup>. One central part of preparing the groundwork for such a strategy was recognised to be agenda-setting for key opinion formers and decision-takers in the Mersey region. It was felt that despite the 10 years of discussion about preventive medicine which has taken place in developed countries following the publication of the Lalonde report in Canada<sup>11</sup> and the series of prevention-orientated reports which followed it<sup>12</sup>, confusion persists at a local level about what health authorities and other statutory and voluntary bodies should actually be doing.

Moreover, there seems to be a considerable ignorance of the wider context, including the World Health Organisation strategy of Health For All by the Year 2000. It was felt that if there were to be any real prospect of developing a multi-sectoral approach to health promotion based on the extended concept of primary health care espoused by WHO, it would be necessary to produce a document which placed local health data firmly in the local context, but which drew clearly on the WHO strategy. The target for this document was to be local politicians, members of

a beginning. It seems to have had that effect. As a result of the report there is now a prominent and full chapter on health promotion in the regional strategic plan, and health promotion is now built into the regional review process – this in particular seems to be a powerful tool in enabling health promotion to be taken seriously.

The strength of the positive response towards the original report from around the region would seem to indicate that even if health workers have sometimes been slow to appreciate the importance of health promotion and prevention, the general public and the representatives of the public are in little doubt about it.

The process of writing and producing the report was itself an important one in identifying gaps in the information base for health promotion. As a direct result of this exercise, a regional 'Korner' on health promotion statistics has now been carried out, and it is intended to develop a comprehensive approach to health promotion data collection over the next few years. Although the yellow report itself was intended as a one-off, there is no sign of any reduction of interest in it, and a steady flow of requests for it continues; at some point a follow-up will need to be produced. Clearly the value of documentation and analysis remains as prominent in Mersey today as it was in 1843.

The production of a community diagnosis can be recommended as an apparently useful exercise, and as a very satisfying deployment of community medicine skills.

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Health in Mersey – A Review can be obtained from Barbara Jones, Mersey Regional Health Authority, 24, Pall Mall, Liverpool.

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health authorities, members of community health councils and local authorities, the active members of local community groups and charities with a health interest, and health staffs of all kinds within the region.

The compilation of the report required the committed support of the regional statistics section of the health authority with a willingness to work closely with the author, who had an overview of what was needed. This overview was not initially shared by statistical staff. It also required the identification of essential non-health service data bases such as those relating to education, social services, and the police, and the collation of such data which was not routinely used by the health authority (Table 1). The assistance of a part-time research worker was provided by the regional health authority for this purpose.

Additional analyses were carried out by the regional health authority statistics section to refine the data for presentation, to enable district comparisons to be made, and to construct novel indices such as the standard years of life lost ratio (prior to age 75).

In all, the work involved was probably equivalent to one half-time health authority statistician for four months, with a similar half-time commitment from a university-based research assistant. The data gathering and collation culminated in the author spending one full month writing the report, in addition to one to two days weekly over the previous four months.

### Format of the report

The outcome of the work described was the production of a 90 page report written in a style which would be easily understood by the informed lay reader. The assistance of an interested local graphic artist was obtained in presenting visual material in an attractive way.

The report was intended to present a historical and ecological account of health within the region, and to highlight the major causes of premature death and disability and the priorities for health promotion at each stage of the human life cycle<sup>13</sup> (Table 2).

From a review of the state of health within the region and the discussion of Health Strategy in other countries, twelve priority topics for Health Promotion in Mersey emerged (Table 3).

For each of these topic areas a section was written which attempted to synthesise the necessary action for a concentrated approach to health promotion. The resources and expertise available for health promotion within the region were reviewed, and the facilitating and hindering factors identified where this was possible.

### Handling the report

The report *Health in Mersey - A Review*, later to become generally known as 'the yellow report' on account of the cover, was initially produced for the first Mersey Health Promotion conference held at Warrington in April 1984.

This conference was a briefing for 550 key opinion-formers and decision-takers from around the region. Those attending were acquainted with health promo-

**Table 1**  
**Types and sources of data used in the production of 'Health in Mersey'**

Type of Data	Source (n) Number of organisations
Census data related to living and working conditions	OPCS/RHA/County Councils (2)
Fertility and mortality statistics	Local District Authorities (13)
Hospital morbidity data (HAA)	Regional Health Authority
Family doctor preventive medical services and other family doctor data	F.P.C.'s (5)
Health authority preventive medical services. Community health manpower and resources	DHA's (10)
Special educational needs data	Local Education Authorities (5)
Road traffic deaths, narcotic and other offences	Merseyside and Cheshire County Constabularies
Chronic sickness and disability data	Local Social Services (5)
Consumer interests	Community Health Councils (11)

**Table 2**  
**Contents of 'Health in Mersey'**

<b>Chapter 1</b>	The nature of the health field
<b>Chapter 2</b>	Defining the problem. The determinants of health
<b>Chapter 3</b>	Health in Mersey - The ecology of the region
<b>Chapter 4</b>	The population of Mersey health region
<b>Chapter 5</b>	The causes of death and ill-health
<b>Chapter 6</b>	Prevention or cure - the development of a strategy for health promotion
<b>Chapter 7</b>	Health For All by The Year 2000
<b>Chapter 8</b>	12 Priorities for Mersey
<b>Chapter 9</b>	A strategy for action including information and research needs

**Table 3**  
**Priorities for 'Health in Mersey'**

1.	Planned parenthood
2.	Control of sexually transmitted disease
3.	Antenatal care including genetic screening
4.	Improved child health and increased immunisation uptake
5.	The prevention of death and disability from accidents and environmental causes
6.	Improved dental health
7.	Some specific aspects of lifestyle related to premature death (including diet, exercise, stress, tobacco, alcohol and drugs)
8.	The effective control of high blood pressure
9.	Early detection of cancer
10.	Reduction of disability in the elderly
11.	Dignity and comfort at the time of death
12.	A healthy mind and healthy body - Positive health especially as it relates to a health strategy for young people

tion initiatives in different parts of the country, and provided with perspectives on contemporary health problems which cross the boundaries of discipline. It was the intention that people should leave the conference with a copy of the yellow report and the stimulus of the ideas to which they had been exposed, and return to their own authority or organisation where they would begin to question what they could and should be doing about the 12 priority topics - in this way the agenda-setting for the region would begin.

The conference and the report itself were extensively covered by the mass media. Such has been the interest arising from the report that at the present time 4000 copies have been printed and distributed by the regional health authority printing department, almost entirely in response to requests.

### Consolidation and follow-up - where do we go from here?

The intention behind the yellow report was to make