

Self-care: whose health is it anyway?

By Terry Maguire, a community pharmacist and vice-chairman of PharmacyHealthLink

It has taken 50 years but the truth is finally out: the NHS can be bad for your health. You do not agree? Why, then, in the league of big killers, does iatrogenic disease come an impressive fourth? Some achievement for a service whose mission is to save lives. And then there are health inequalities — the difference in the health of the best off in our society compared with the worse off is nothing short of a national scandal.

Ivan Illich, philosopher, doctor-baiter and one-time priest, was thought to be barking mad when, in the 1970s, he made this claim in *The Lancet*. He suggested a conspiracy by the medical profession and the drug industry to bring about the “medicalisation of society” for the sole purpose of profit. Drugs and other medical technologies, he was convinced, removed personal responsibility for suffering and created dependence on health professionals resulting, ironically, in worse health.

Doctors and other health care professionals, with their unique body of knowledge, claim they know better than the rest of us so the contract is that we hand over to them responsibility for our health. For many, personal health is the GP’s problem not the individual’s. Some social research even suggests this contract between the doctor and his or her patient might be as much to do with ensuring the social and financial standing of the doctor as it has to do with caring for the patient.

Today, Illich (who died in 2002) is no longer seen as just another vulgar Marxist but as someone whose views, while extreme, hold some merit and might explain the lack of public health gain in recent years. There is an old and, perhaps, tired argument about whether the NHS is a “sickness service” or a “health service” but the culture of the NHS must share some of the blame for the pronounced inequalities in health in the UK.

Yet the successes of the NHS over the past 50 years cannot be denied. I have three patients with cystic fibrosis, all in their late 20s and in relatively good health. Had they been born, as I was, in the 1950s, none would have lived beyond childhood. But the paradox, as Illich pointed out, is that such developments run the risk of creating hubris in service providers. In this context of impressive medical technologies, medicine as a profession has developed a patrician arrogance that, it is claimed, strangles individual responsibility for health and robs individuals of the capacity to do things for themselves. This may seem an extreme view but it is all too easy to see

when you look for it. For example, I have lost count of the number of continuing professional development meetings I have attended where the speaker, normally a male doctor, makes fun of the patient who visits his surgery with a sheaf of paper downloaded from the internet.

The Government knows about this, appreciates the long-term dangers and commissioned Derek Wanless to come up with appropriate solutions. Wanless restated the obvious: we need better support for disease prevention services and we need people to take more care of their own health. Wanless wants people to “engage” with services that are truly designed to support good health.

True patient “empowerment” only exists when patients are educated, facilitated and supported to make decisions about their own health.

The Government’s self-care initiative is a key element of its wider public health policy. It is set to re-engineer significantly the way NHS services are designed and delivered. More subtly, self-care has the potential to reverse the balance of power within the patient-doctor relationship and that will be a good thing.

Self-care is more than a do-it-yourself approach to health. It instils and articulates public health principles and philosophies, and it includes avoidance of disease and self-treatment of common ailments, as well as managing long-term conditions.

Post-Wanless the challenge will be to make self-care happen. This requires a major change to the culture of the NHS rather than simply creating a whole raft of new services. The irony is, of course, that the self-care the Government would dearly wish to establish as a cultural norm is the very self-care that was practised by everyone before the NHS was established. In that paradigm, community pharmacy was a key resource in supporting people to look after themselves — a pharmacist was the poor man’s physician. And, in the new paradigm, pharmacy must again become a key player.

Indeed, 85 per cent of what community pharmacists do on a day-to-day basis could be considered public health, we just do not call it that. Pharmacists, and the pharmacies we work in, make a major contribution to the social capital of local communities. Social capital is the level of support that a community can access when needed as opposed to help given by health professionals, which is often viewed as being forced on it. The challenge for pharmacy is to ensure that its serv-

ices are actively promoted and used in the proper way by its communities.

Smoking cessation services, emergency hormonal contraception, minor ailments schemes and obesity clinics all mark the beginning of a change in the way pharmacy engages with and supports local communities. But we must ensure that in offering these services we do not adopt the paternalism currently so inherent in the practice of medicine. We need to refrain from telling people what to do and listen more. I find that the biggest challenge is to get pharmacists to stop giving advice and to start finding out what the client needs to bring about change. An answer may be to train pharmacists in brief intervention techniques, such as motivational interviewing.

Some years ago I sought funding to set up a diabetes service. One requirement for getting money from an innovative public health project (the “Building the Community Pharmacy Partnership”) was that I needed a community-based partner. I linked up with the Falls Women’s Association but it dismissed my idea of a diabetes service. It wanted to address the wider determinants of health in the community so we agreed on a service to address obesity. When the time came to prepare a leaflet for the scheme, the association objected to the words “fat” and “obese” being used. “Fat” and “obese”, it told me, were pejorative terms and repelled the people we sought to support. I had missed this key point. In the end, we used “healthy weight challenge” instead. During the support sessions we ran, I also came to understand that the reasons for an individual becoming obese were complex and many, and not just down to eating too much or not taking enough exercise.

Some of the 35 women who enrolled on our programme had alcohol problems, sexual abuse problems and domestic violence issues, and these contributed to their weight problem (and their increased risk of developing diabetes). Only by addressing these problems could individuals begin to resolve their obesity. I am not a trained counsellor and could only act as a signposting agency when social issues emerged. The initiative turned out to be an effective service in its primary aim of improving individual understanding of the role of nutrition and exercise in obesity. Individuals lost weight and, more importantly, they were able to do it for themselves and their families.

Ivan Illich was partly right — reactive paternalistic care, the main offering of the current NHS, is seldom successful in addressing the behaviours that present the greatest risk of disease. We need to give people back the right to look after themselves. After all it is their health, not ours.

Self-care is a key element of public health