New Perspectives in Public Health

Second Edition

EDITED BY Siân Griffiths and David J Hunter

Foreword by Sir Kenneth Calman

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Siân Griffiths
Professor of Public Health
Director, School of Public Health
The Chinese University of Hong Kong

and

David J Hunter
Professor of Health Policy and Management
and Director, Centre for Public Policy and Health
School for Health, Durham University

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Sir Kenneth Calman
Vice-Chancellor
Durham University

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Foreword

It is tempting in writing a Foreword for *New Perspectives* to look back and compare these perspectives with the past. However, the landscape and environment have changed so much that it is almost impossible to do so even if it was thought to be worthwhile. Perhaps it is more important to look at functions and see how things have evolved. The fact that a few years after the first version of this book a second edition is published recognises how much has changed and how the scope of public health has developed. This slightly philosophical introduction must therefore begin with an examination of the function of public health and what all this activity is for.

The function of public health is to maintain and improve the health of populations. This is carried out by a series of practitioners but must also include communities themselves, organisations, politicians, individual members of the public, single issue groups, social movements and a whole host of other actors. The first lesson from this book therefore is that restricting action to a few qualified practitioners will have limited value, and this is well illustrated throughout the book.

The second issue is more complex. Is health a means or an end? Does improving the public health mean that all should have 'good' health and if this is to be the case, are there limits? How far do we go to improve the health of each individual, if this is at the expense of others? This is an issue which is touched on in many of the chapters and needs a full consideration. For example, if a pill to reduce obesity becomes available how will it be used, who will get it and who will pay for it? This is not a fanciful vision but one which will happen. Would it not be better to help people to eat less and take exercise than prescribe a pill? This implies of course that evidence exists to support the value of other interventions, hence the crucial issue of the evidence base for developing public health actions. This is a key issue. Politicians, community groups, patients and each of us would like to know how best to tackle lifestyle and socio-economic issues. In several of the chapters, and in one specific chapter, the matter of evidence is dealt with in detail. The need for evidence is urgent if we are to improve the health of those who are disadvantaged, deprived and where inequalities persist.

One of the most interesting issues in the book is the range of topics dealt with. Public health is all pervasive and it touches many aspects of life, if not all, and covers a huge area of public policy. Where are we to find the people with the capability and capacity, and indeed the vision to cover this range of subjects? Part of this must be in conveying to those in training that being involved in public health matters, is exciting, and that change can occur to the health of people and communities. This also means positively encouraging people to join the specialty. Another important issue is to ensure that in the organisation of the public health function, at whatever level in the population, a wide range of skills and expertise is available. This implies the development of teams. It will also mean a sharing of expertise, effective mentoring and working together. This is where leadership matters and this is covered in several chapters.

One issue which is not specifically covered, though is addressed in many parts of the book, is that of ethics. This surely is an area worthy of consideration. Most of the decisions made by practitioners will be related to uncertainty and issues of risk. Most will need to consider the rights of the individual against the needs of the wider public and link these to the duties individuals and groups have to society. Some of these decisions will relate to the allocation of resources and others to issues surrounding legal issues and the curtailing of choice and freedom for some people. The recent, and welcome, ban on smoking in Scotland, and now England and Wales, would be an example of that. However, such judgements are the day-to-day work of the public health practitioner and such professionals need to be clear about the scientific and socio-economic basis of the problem, be able to recognise the moral issue, be able to consider the arguments for and against the ethical dilemma, and have the ability to make decisions and be able to justify them. This is one reason why public health is such a topical and exciting specialty to be involved with. Managing risk and uncertainty at the level of the population is a major responsibility and this book will go a long way to help to prepare effectively all those who have that task.

There are many definitions of public health. My favourite is a simple one. It is any method for improving the quality of life of individuals or populations. What a great thing to be able to do, to help in the process of healing and improving health. It is not easy and it is necessary to show humility and recognise that we do not know all the answers and indeed may be far from achieving our goals; hence the importance of research and development. This is not a sterile activity designed to produce publications or support the research ratings of the academic unit. For public health practitioners it is a fundamental activity to improve health.

Sir Peter Ustinov, when Chancellor at Durham University, used to say that 'doubts unify, certitudes divide'. We need to be open to new ideas, be prepared to doubt, to be curious and always try to improve what we do. If we know we are right, the certitude of Sir Peter, we are likely to miss opportunities and be blind and unresponsive to new ventures and ideas. This is a positive message to all concerned with improving the quality of life; things can and will change if we harness all the energy, skills and expertise which we have for the greater good of others.

Sir Kenneth Calman
Vice-Chancellor
Durham University
August 2006

About the editors

Professor Siân Griffiths OBE, MB BChir, FFPH, FRCP, FHKCCM, FDSRCS(Eng) is currently Professor and Director of the School of Public Health at The Chinese University of Hong Kong. She is the immediate past president of the Faculty of Public Health. Prior to this she was Co-Chair of the Association of Public Health and played a key role in its merger with the Public Health Alliance to create the UK Public Health Association (UKPHA). She has practical experience at local and national level as regional and district Director of Public Health, as well as a long-term commitment to teaching and research. She continues to advise governments on health policy, most notably as adviser on *Choosing Health*, as Co-Chair of the Hong Kong Special Administrative Region (SAR) government's enquiry into the SARS (severe acute respiratory syndrome) epidemic and as a member of the National Health Authority for Qatar. Among national appointments she was a founding Board member of both the Health Protection Agency and the Postgraduate Medical and Education Board. Now based in Hong Kong she is following her interest in public health in China as well as keeping in close touch with her UK roots.

David J Hunter has been Professor of Health Policy and Management at Durham University since 2000. Prior to that he occupied the same chair at the University of Leeds where he was director of the Nuffield Institute for Health from 1989 to 1997. At Durham, he is director of the Centre for Public Policy and Health at the School for Health in the Wolfson Research Institute. David is Chair of the UK Public Health Association and was formerly Co-Chair of the Association of Public Health, one of the organisations which formed the UKPHA. David is a member of various committees, including the Healthcare Commission's Public Health Expert Reference Group, and the National Institute for Health and Clinical Excellence's Research and Scientific Advisory Group. He is a member of the External Advisory Group of the Glasgow Centre for Population Health. David is a special adviser to the World Health Organization and a former Board Director and President of the European Health Management Association. He is the author of several books and numerous journal articles. He is currently writing a book called *Managing for Health* to be published by Routledge. David is an Honorary Member of the Faculty of Public Health and a Fellow of the Royal College of Physicians of Edinburgh.

List of contributors

Fiona Adshead
Deputy Chief Medical Officer, Department of Health

Ken Aswani
General Practitioner, Leytonstone;
NE London PEC Chair, Waltham Forest PCT;
National PEC Chair Lead, NHS Alliance

Helen Bevan
Director of Service Transformation
NHS Institute for Innovation and Improvement, University of Warwick
(formerly, Director of Service Improvement, NHS Modernisation Agency)

Yinglen Butt
Nurse Advisor, Public Health, Department of Health

Anna Coote
Head of Engaging Patients and the Public, Healthcare Commission

Paul Corrigan
Health Adviser to the Prime Minister

Edward Coyle
Consultant in Public Health, National Public Health Service, Wales

Caroline Davey
Policy Manager, Family Planning Association

Peter Donnelly
Deputy Chief Medical Officer, Scottish Executive

Chris Drinkwater
Professor of Primary Care and Head of Centre for Primary and Community Care Learning, University of Northumbria

Tony Elson
Head of Public Health, Department of Health;
Freelance consultant

Daragh Fahey
Health Improvement Directorate, Department of Health, London

Steve Feast
Clinical Improvement Director (Primary Care), NHS Modernisation Agency

Neil Goodwin
Chief Executive, Greater Manchester Strategic Health Authority

Diane Gray
Consultant in Public Health

Muir Gray
Programmes Director, UK National Screening Committee;
Director of Clinical Knowledge, Process and Safety for the National Programme for IT

Selena Gray
Professor of Public Health, University of the West of England

Scott L Greer
Member of The Constitution Unit, University College London;
Assistant Professor of Health Management and Policy, University of Michigan School of Public Health

Kit Harling
Head of Occupational Health and NHS Plus, Department of Health

Andrew J Hayes
Programme Director, SmokeFree London

Nicholas R Hicks
Director of Public Health, Milton Keynes Primary Care Trust

Lord Hunt of King's Heath
Parliamentary Under Secretary (Lords)
Minister of State, Department for Work and Pensions
Former Parliamentary Under Secretary of State for Health (Lords)

Tony Jewell
Director of Clinical Services and Public Health, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority

Paul Johnstone
Regional Director of Public Health, Yorkshire and Humber Regional Directorate for Public Health

Lionel Joyce OBE
Chair, Mental Health Providers

Michael P Kelly
Director, Centre for Public Health
National Institute for Health and Clinical Excellence

Mark Kroese
Consultant in Public Health Medicine, Public Health Genetics Unit
Cambridge/Greater Peterborough Primary Care Partnership

Tim Lang
Professor of Food Policy, City University London

Paul Lincoln
Chief Executive, National Heart Forum

Mark McCarthy
Professor of Public Health and Honorary Consultant in Public Health Medicine, University College London

Martin McKee
Professor of European Public Health, London School of Hygiene and Tropical Medicine

Angus Nicoll
The Health Protection Agency UK and the London School of Hygiene and Tropical Medicine

Sara Osborne
Director of Policy, British Dental Association

Jean Penny
Head of Learning, NHS Institute for Innovation and Improvement, University of Warwick
(formerly, Head of Improvement Development, NHS Modernisation Agency)

Rowena Pennycate
Senior Policy Officer, British Dental Association

Geof Rayner
Visiting Research Fellow, City University London

Paul Redgrave
Director of Public Health, Barnsley Primary Care Trust

Harry Rutter
Deputy Director and Head of Impact Assessment, South East Public Health Observatory

Simon Sanderson
Clinical Lecturer in Primary Care Genetics, University of Cambridge

Allison Thorpe
Networks Development Manager, Thames Valley Strategic Health Authority

Derek Wanless
Author of *Securing Our Future Health: taking a long-term view* and *Securing Good Health for the Whole Population*

Anne Weyman
Director, Family Planning Association

Jane Wilde
Director, Institute of Public Health in Ireland

John Wilkinson
Director, North East Public Health Observatory, Durham University Queen's Campus

Jude Williams
Head of Public Health, Healthcare Commission

Jenny Wright
Director, Public Health Resource Unit, Oxford

Ron Zimmern
Director, Public Health Genetics Unit, Cambridge

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Introduction

Siân Griffiths and David J Hunter

> *The preventive health services of modern society fight the battle over a wider front and therefore less dramatically than is the case with personal medicine. Yet the victories won by preventive medicine are much the most important for mankind. This is not so only because it is obviously preferable to prevent suffering rather than alleviate it. Preventive medicine, which is merely another way of saying collective action, builds up a system of social habits that constitute an indispensable part of what we mean by civilisation.* (Nye Bevan)

> *The time is now right for action. At the start of the 21st century England needs a new approach to the health of the public, respecting the freedom of individual choice in a diverse, open and more questioning society but also addressing the fact that too many groups have been left behind or ignored.* (*Choosing Health*, Secretary of State for Health 2004)

In 1999 when we published the first collection of essays with the title *Perspectives in Public Health* (Griffiths and Hunter 1999) the new Labour government was still in its first flush of enthusiasm. Having been elected in May 1997 following 18 years of Conservative administration, New Labour, as the government came to be known, was impatient to make its mark on public policy, including health. The UK public health community, in the midst of recovering from a turbulent period of almost continuous organisational and managerial change in the running of health services, was hopeful of great things in terms of improving the public's health and moving the policy agenda away from a preoccupation with healthcare and acute care in particular. It was eagerly awaiting publication of what turned out to be the first of two public health white papers Labour would produce – *Saving Lives: our healthier nation* (Secretary of State for Health 1999) – and to greater engagement in the wider determinants of health promoted as a priority by the first Minister for Public Health, Tessa Jowell.

With her arrival and with the support of the Secretary of State for Health, Frank Dobson, a renaissance in public health seemed about to happen. In her Foreword to the first edition, the Minister highlighted the importance of addressing health inequalities: '*health inequality is unacceptable in a civilised society and we must bend our efforts to a long-term haul to reduce them*' (Jowell 1999). She also stressed the key role of partnership: '*the new public health is about partnership and mutual responsibility at all levels of society and between all levels of society – individual, community and national*'. And in stating that the new public health '*is as much about wider socio-economic and environmental policies as it is about those policies that fall within the portfolio of the Department of Health*', she acknowledged the importance of the cross-government agenda. Indeed, 'joined-up' government was an early theme of the Labour government.

We published the first edition in a spirit of optimism. Were we justified in doing so? What, if anything, has changed? And what about those things that have not changed? As Derek Wanless (2004) observed, we are not short of reports and lofty rhetoric full of good intentions. Since our edited collection appeared, the

intervening period has witnessed a steady flow of government reports concerned with, or relevant to, public health together with parliamentary select committee reviews, and an overall increase in media reporting of public health issues all denoting a growing public interest in health. It is now some 8 years after that initial heady mix of optimism and hope and a new future. But perhaps we were expecting too much. While progress has undoubtedly been made, in England (though not elsewhere in the UK) major structural change is once again imposing its burden on the public health system as the National Health Service (NHS) undergoes its third reorganisation since 1997 and its 12th since the first major restructuring in 1974. Specialists are once again buffeted by job insecurity and local communities bemused about how they can engage with shifting structures. Health Action Zones and Healthy Living Centres have been replaced by social marketing and health trainers. Just as the delivery plan for implementing *Choosing Health* was published, the new consultation on primary and social care was announced. It gave rise to a new white paper published in early 2006, *Our Health, Our Care, Our Say: a new direction for community services* (Secretary of State for Health 2006). Avoiding the pitfalls of many government documents it explicitly builds on the legacy of the previous white papers, although many observers are critical of whether it was actually necessary at all. It does not say anything that is not already familiar or part of current policy. For decades, despite periodic attempts, successive governments have failed to bring about the necessary shift in either resources or attitudes. Once again, the white paper acknowledges that the NHS '*which channels people into high-volume, high-cost hospitals – is poorly placed to cope effectively*' with the burden of ill health. The real challenge, as Derek Wanless recognised, remains one of effective implementation and of ensuring that the requisite resources and political commitment exist to enable the desired changes to occur. Without these, this and other white papers will remain largely aspirational and risk going the way of previous attempts to shift the balance from healthcare to health. Maybe it will be different this time with the white paper's assertion that '*there has to be a profound and lasting change of direction*'. But, at the time of going to press, the jury is out.

Our Health, Our Care, Our Say tasks primary care organisations with prevention and health promotion as well as developing community care in its widest aspects. At the same time they are once more embracing the purchaser–provider separation with primary care in the driving seat, albeit using the language of practice-based commissioning. This is against a backdrop of growing social inequalities, especially in respect of the widening income gap between social groups. Continuing social injustice is well documented by, among others, the Institute for Public Policy Research (Paxton and Dixon 2004), which highlights that progress has been faltering, inconsistent and generally disappointing in terms of the pace of change envisaged in the early years. But, as Marmot has commented, this is not entirely surprising since addressing health inequalities is both a long-term initiative and also one which will be achieved through government-wide policy not just health sector action: '*to change social inequalities in life expectancy means both important social changes and translating these differences into changing disease rates*' (Department of Health 2005a). What remains uncertain is the degree to which a government that is in thrall to markets and anxious not to appear as the 'nanny state' is prepared to act tough when it comes to exercising leadership in the pursuit of health goals. Those concerned with improving public health are aware

that we need to achieve the step change or paradigm shift that Wanless and others have insisted is essential if we are to make progress towards implementing what he termed '*the fully engaged scenario*' (Wanless 2002, 2004). If weak implementation and delivery have been stumbling blocks in the past they remain so now as the government acknowledged in its second public health white paper, *Choosing Health* (Secretary of State for Health 2004). Indeed, the government seems to share the sense of unease and frustration evident in, and perhaps provoked by, Derek Wanless's trenchant critiques of policy in the area of health as distinct from healthcare. Above all else, it is his reports that have made policy makers sit up and take note. Despite already having a health strategy in the shape of the 1999 white paper, the government used the occasion of the second Wanless report in 2004 to launch a major public consultation on public health and the respective roles of individuals and government in its pursuit. The outcome of this exercise was a new public health white paper published in late 2004 which also reflected a different philosophy concerning the merits or otherwise of government action as opposed to empowering individuals to act for themselves. *Choosing Health* refocused the emphasis on improving health through individual action to make healthier lifestyle choices, tipping the balance away from government-led interventions. In fact, as the two quotes cited at the start of this Introduction nicely illustrate, whereas in its first white paper the government extolled the virtues of healthy public policy with government offering a clear lead, by 2004 the government's thinking about public sector reform in general (not just in health) had moved significantly in the direction of market-style solutions based on the exercise of choice and personal engagement in determining outcomes (Hunter 2005). Government's role is to facilitate the exercise of choice by providing information to enable informed healthier choices to be made. The chapter by Paul Corrigan (Chapter 8), adviser to two health secretaries between 2001 and 2005 and now health adviser to the Prime Minister, offers a clear statement of the government's approach to public service reform which began to emerge during its second term of office.

Many other contributors to this second edition also pick up on these issues in their respective chapters. But a major factor in the lack of progress in advancing public health objectives remains, as in many other parts of the world, a preoccupation with the healthcare sector and its increasing cost. While the government entered office in 1997 committed to delivering a public health policy, it was not long before it inevitably became embroiled in micro-managing the NHS and setting it on a new course. Perhaps inevitably, the government came to the conclusion that the financial and managerial problems plaguing the NHS were of such severity that before it could turn its attention to upstream issues, the modernisation of healthcare downstream had to be the priority during its first term in office. In return for injecting significant sums of new money, the government wanted to be assured, and to reassure the electorate, that the investment would result in real change and not be absorbed by a system that was clearly failing its users. Indeed, the Prime Minister had staked his personal reputation on improving the NHS and ensuring that it was fit for the 21st century. Perhaps inevitably, therefore, the familiar story of hospitals, beds, waiting lists, access to care and budgets all came to dominate the policy agenda both nationally and locally.

It would be wrong to imply there has been insignificant progress in improving health or in developing public health policy. Death rates for coronary heart

disease have fallen as services have improved. When primary care trusts (PCTs) were introduced in England in 2002 they were given a clear remit to improve the health of their local communities. Achievement has been patchy largely because the focus of attention from their inception has been on delivering improvements in healthcare provision. Initially the performance management regime and target culture proved to be biased towards achieving gains in the priority areas of reducing waiting lists and strengthening capacity to treat more people quicker. But in the summer of 2004, following the appearance of the second Wanless report, the NHS Chief Executive felt able to say with confidence that the modernisation of the NHS was well underway and with key targets being hit there was now an opportunity for the NHS to lift its gaze and take heed of the wider health landscape and its role in contributing to health improvement (Department of Health 2004). Many PCTs engaged with their local authority and other colleagues to create initiatives which addressed the wider determinants of health such as play spaces, exercise referral and healthy schools initiatives.

But with the NHS in the midst of another major restructuring (*see* below), with familiar financial problems once again looming large as it heads for a deficit approaching £1 billion by the end of the 2005–6 financial year, and with the new investment the NHS has enjoyed in recent years coming to an end in 2008, doubts are being expressed about how far, and for how long, the NHS will truly embrace a public health agenda as opposed to retreating into the familiar territory of acute services – a dilemma Wanless was quick to identify in his first report (Wanless 2002).

Of course not all changes in the profile of public health are the result of planned policy or can even be foreseen or anticipated. Events such as 9/11, the outbreak of SARS (severe acute respiratory syndrome) in 2003, and the devastation of New Orleans following Hurricane Katrina dramatically highlighted the need for national public health infrastructures across the world. As the Institute of Medicine for the US so clearly stated:

> *the glare of a national crisis highlighted the state of the infrastructure with unprecedented clarity to the public and policy makers: outdated and vulnerable technologies; a public health workforce lacking in training and reinforcements; lack of epidemiological systems; ineffective and fragmented communications, incomplete domestic preparedness and emergency response capabilities; communities without access to essential public health services.* (Institute of Medicine 2003, p.3)

These words were echoed in reports following SARS (Naylor, Chantler and Griffiths 2004), acting as the stimulus to review and develop public health systems to be better able to respond not only to crises but to meet the demands of fulfilling '*society's interest in assuring conditions in which people can be healthy*'. In Canada, a new national agency, the Public Health Agency of Canada (www.phac-aspc.gc.ca) has been established with the mission of promoting and protecting the health of Canadians '*through leadership, partnership, innovation and action in public health*'. Stimulated by their experiences, the government in Hong Kong has established the Centre for Health Protection (www.chp.gov.hk). Sweden has also produced a new public health strategy, and Stockholm is to host the new European Observatory on Health Systems and Policies (www.who.dk/observatory).

Addressing inequalities

Internationally, the words may differ but solutions to reducing disparities in health as a result of social and economic differences are sought in many societies. The World Health Organization (Murray *et al.* 2002), Kickbusch (2004, 2005) and Strong *et al.* (2005) have described the gross inequalities between developing and developed nations and the potential of prevention in respect of tackling chronic disease. For example, by the year 2020 there will be nine million deaths caused by tobacco compared to almost five million now; five million deaths attributable to overweight and obesity compared with three million now, many of these in countries with rapidly developing economies such as China. At the same time, 110 million healthy life-years will be lost by underweight children, lower than the current 130 million but still unacceptably high. An estimated 40% of the world's burden of disease is caused by 20 risk factors, many of them preventable (World Health Organization 2002). Underlying factors influencing the disease burden from both communicable and non-communicable disease include the need for clean water and air, food, literacy, and an adequate income. Basic services are still needed in many parts of the world. Three quarters of the world's children are being reached by essential vaccines but only half the children in sub-Saharan Africa have access to basic immunisation against common diseases such as measles, tuberculosis (TB), tetanus and whooping cough. In poor and isolated areas of developing countries only 1 in 20 children may be reached. In contrast, parents in the UK have the luxury of debating the science and evidence of the MMR (measles, mumps and rubella) vaccine and its attendant risks. Faced with these challenges, public health cannot merely sit on the sidelines and observe and commentate but must engage in positive action.

Notwithstanding our earlier comments on the lack of sustained attention accorded public health, important progress on raising its profile and developing policies to address inequalities has been made across the UK. In line with the early commitment of the new government in 1997, the prominence of inequalities as a major national health issue has been addressed through mainstream policy. The independent inquiry into health inequalities by Sir Donald Acheson published in 1998 made 40 recommendations ranging from poverty, income, tax and benefits, education and employment to mothers, children and families and ethnicity (Acheson 1998). Indeed, only three were specifically concerned with the NHS thereby illustrating the breadth of both the problem and the policy response required. The English health strategy *Saving Lives: our healthier nation* (Secretary of State for Health 1999) and the accompanying report *Reducing Health Inequalities: an action report* (Department of Health 1999) appeared in July 1999. While *Saving Lives* emphasises the need to focus on major threats to health and to engage individuals, communities and governments in improving health, the action report set out what was needed to address the inequalities through actions across government to tackle the underlying causes of ill health, including socio-economic factors. Building on these reports, prevention and inequalities were put firmly on the agenda in the *NHS Plan* (Department of Health 2000) which set out expectations of the NHS both in terms of service delivery and expectations of partnership working by the NHS with, and through, other agencies. Local targets for reducing health inequalities were set and then underpinned further by the creation of national health targets. The strategy laid out

in *Tackling Health Inequalities: a programme for action* (Department of Health 2003) targeted resources to:

- supporting families, mothers and children
- engaging communities and individuals
- preventing illness and providing effective treatment and care
- addressing the underlying determinants of health.

Progress on these targets will be monitored through the government-wide public service agreement (PSA) targets which were agreed in the 2004 Spending Review and which expect action and progress in reducing geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. Faster progress in reducing the gap is expected in the most deprived fifth of areas with the worst health and deprivation indicators. They receive extra resources based upon local authority areas that are in the bottom fifth nationally for three or more of five indicators:

- male life expectancy at birth
- female life expectancy at birth
- cancer mortality rate in under-75s
- cardiovascular disease mortality rate in under-75s
- Index of Multiple Deprivation 2004 (local authority summary).

These indicators help them tackle the many wide-ranging factors that need to be addressed but the challenge of reducing inequalities is not to be underestimated. Without commitment at all levels and at all strata inequalities will persist.

Developing capacity

Another area in which there has been progress is in the infrastructure of public health. Multidisciplinary specialist practice was given impetus by *Saving Lives: our healthier nation*. The specialist public health profession has moved forward and specialist skills are now becoming competency based, and dependent on ability rather than on a designated professional qualification. Directors of Public Health (DsPH) no longer need to be medically qualified and nor is professional development confined to the NHS. Yet, as we have already described, one of the problems facing public health delivery is that the public health workforce is continually under threat, or in the throes, of structural change. Indeed, at the time of writing and in little under 2 years since its last major reorganisation, the NHS is facing another period of major upheaval and organisational churn. Whatever the merits of the outcomes of such engineering, they come at a heavy price in terms of staff morale and an increasingly disenchanted and disengaged workforce. The price paid is high in terms of a diversion of managerial energy and effort from dealing with the direction of the organisation and its outcomes to its internal operations and processes. Arguably, such organisational rejigging amounts to a huge distraction from the business of securing improved health. In an atmosphere of constant change – a feature of the NHS since 1974 which has intensified in recent years with shorter periods between major changes – it becomes extremely difficult to plan and achieve objectives, especially those in public health which generally have a long lead time to prove themselves. The partnerships necessary across many professions and organisations need a stable environment to succeed and these

become more vulnerable if personnel and organisations change frequently. The nature of the position of the Director of Public Health (DPH), for example, means he or she is closely associated with managing and organising healthcare services and since the management structures seem to be in constant, rapid evolution if not revolution there are inevitable effects on jobs and careers and on the stability of the partnerships they are expected to nurture and work within. This instability leads us once again to call for a public health system (Griffiths, Jewell and Donnelly 2005) which places the health of populations at its heart rather than the structural demands of the English healthcare system. Examples from the Celtic countries making up the rest of the UK demonstrate the benefits of stability and also recognise, rather than pay lip service to, the strengths of networks and clearly identified expertise, as described in Chapters 1, 3 and 4. The commitment in *Our Health, Our Care, Our Say* to redefining and strengthening the role of DsPH and the support for joint appointments between primary care organisations and local government is welcome although we urgently need evidence on whether the introduction of joint posts is effective. The signs are promising but, at present, there is only anecdotal evidence to support such a move. If it can be demonstrated that joint posts are an important means to secure lasting change across organisational boundaries, then such support needs to be translated into action. It will be important to ensure, too, that the important progress made in opening up PCT DPH appointments to non-clinicians is preserved in future when there will be far fewer PCTs in existence.

But can we learn from constant change? In 1998 the structure of the English public health system was based on a network with regional and district nodes. Ninety district health authorities had DsPH with departments of ranging strengths and sizes, linked to university departments in various ways and collected into regional units. The sudden announcement of *Shifting the Balance of Power in the NHS* (Department of Health 2001a) by the then health secretary, Alan Milburn, in April 2001 led to the rapid dissolution of these departments without a clear plan for the future delivery of public health in the newly proposed PCTs. It was over 6 months before the acting Minister of Public Health, Lord Hunt, a good friend of public health, announced in his November speech to the Faculty of Public Health (Department of Health 2001b) that it was proposed there should be a DPH for each of the 300 PCTs and that such individuals would not be required to be medically qualified. It represented a breakthrough for the wider public health and a recognition of the skills of those working in public health from backgrounds other than medicine.

> *The engine of public health delivery will be at the front line around the primary care trust. Every primary care trust will have a director of public health and support team. These directors of public health will be board level appointments working at the heart of the new organisations. The focus of their activity will be on local neighbourhoods and communities leading and driving programmes to improve health and reduce inequalities. They will also play a powerful role in forging partnerships with, and influencing, all local agencies to ensure the widest possible participation in the health and health care agenda.*
>
> *The director of public health will not be a remote, strategic figure – she or he will be well known, respected and credible with local people – particularly those in the most deprived communities, local authorities, general practitioners and other local clinicians.*

A new wider role for regional public health was envisaged shifting the focus from the NHS to influencing the wider determinants such as environment, housing, transport and employment. To quote the Hunt speech again:

> *The new role of the regional director of public health is an exciting one. They will be uniquely placed to address the wider determinants of health in their regions, working with other government departments and local strategic partnerships. They will also have a lead role for health protection and will have some responsibilities in relation to the NHS, accounting for these links to the new regional directors of health and social care.*

Confusion remained about how this would work out, particularly since the public health role at strategic health authorities was left unclear and the regional responsibilities in the health system somewhat confused. To further confound the capacity problems of extending the specialist profession in this welcome but unplanned way, the Chief Medical Officer's (CMO) report, *Getting Ahead of the Curve*, was published in January 2002 (Department of Health 2002), proposing the establishment of the Health Protection Agency (HPA) in April 2003. Stimulated by events such as 9/11 and outbreaks of new diseases such as Ebola and West Nile Fever and the risk of an avian flu pandemic, the strategy proposed the creation of a new national agency to combine responsibility for communicable disease control and services to protect people's health from infectious diseases, poisons, chemical and radiation hazards. While the creation of the HPA undoubtedly adds to the strength of the public health infrastructure, it further highlights the capacity problems of the public health community. Public health specialists in health protection are no longer employed and working alongside their generalist colleagues in the local NHS public health departments, thereby increasing fragmentation and stretching already scarce resources. Inevitably, tensions have resulted in some localities, overcome through good will, common sense and high-quality professional practice supported by local agreements or memoranda.

Continual change is not reserved for local level practice. At national level, new structures created in one white paper have been changed by the next – for example, the Health Development Agency (HDA) established in *Saving Lives* was merged into the National Institute for Health and Clinical Excellence (NICE) in *Choosing Health* (Secretary of State of Health 2004). But such changes are not unique to public health. The Healthcare Commission was no sooner established, having replaced the Commission for Health Improvement, than it was told it would be joining with the Social Care Inspectorate. The Modernisation Agency, Leadership Centre and NHS University proposed in the NHS Plan have metamorphosed into the NHS Institute for Innovation and Improvement. The upside of recent change is the inclusion of public health in the mainstream and its place near the top of the health policy agenda. The downside is the anxiety about the capacity to deliver while absorbing the ever-changing roles, structures and expectations.

But capacity can be increased not just by more of the same but by working differently – a clear lesson to emerge from the Modernisation Agency and Leadership Centre. The NHS and local government sectors are now working much more closely together, utilising tools such as local planning mechanisms and common targets. The boundaries are increasingly blurred between local government and the NHS with new opportunities for developing models of co-commissioning and co-delivery and for joint appointments of DsPH between local authorities and primary care organisations. This model of joint posts, universal in Wales, is generally

welcomed if it allows the true nature of multidisciplinary public health to be developed. Joint working with Regional Development Agencies and Regional Government Offices at regional level offers opportunities to promote health through tackling the wider determinants. The increasing focus on health is also reflected in healthcare organisations with a requirement that they take public health seriously. However, these new ways of working raise not only a capacity issue but a capability one. Public health practitioners, wherever they are located, require the necessary skills for working in complex and often highly political organisational contexts. It is arguable whether the appropriate leadership and management development skills have been provided in sufficient quantity and quality to equip people to take on the new jobs in public health. Indeed, many practitioners feel ill-equipped for the tasks expected of them (Brocklehurst *et al*. 2005; Hunter and Goodwin 2004). However, there are signs that these deficits are both recognised by the Department of Health and being addressed (Hannaway, Plsek and Hunter 2005).

Another area of weakened practice under review is the academic sector, particularly its relationship with service public health. While joint working between the NHS and academia is recognised as essential, collaboration between academic and service public health remains problematic in many areas. Local issues perceived as relevant to primary care organisations may be inappropriate areas for academic departments who are often involved in work related to national and international priorities with their greater value in the Research Assessment Exercise which drives the priorities and policies of universities. Moves are now being made to redress this tension through developing mutual understanding and engagement in the national health research strategy (Department of Health 2005b).

In compiling this second edition of *Perspectives*, we have sought to reflect these and other contemporary themes and issues in UK public health. Much of the contribution is England focused but we believe that most of the issues raised here are generic to public health systems elsewhere. We have sought to include coverage of recent structures, policy and practice. We invited each of the chapter authors to reflect on recent history, to identify current issues, and to highlight challenges for the future. We have not sought to produce a totally inclusive volume covering all aspects and angles of public health – but the themes selected will enable the reader to gain a sense not only of current public health issues but of progress over the last few years and future challenges. We have not repeated Ashton's historical account from Liverpool (Jowell 1999). Instead, we open the book with a lecture given there by Sir Derek Wanless. Some authors have updated their previous contributions; others are new. We hope we have succeeded in our objective of providing a new perspective in public health that both updates the first edition and shows how ways of thinking about public health, especially the focus on individuals and choice, have caused shifts in policy that were certainly not fully anticipated in the late 1990s.

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Setting the agenda for public health

Derek Wanless

Sir Derek Wanless has been a major influence on the direction of health policy in general and public health development in particular through his two major reports to government. Since 2002 he has become a critical and valued friend to public health. His analysis leads him to stress the need for a step change in practice, involving a revolutionary not evolutionary approach. His chapter synthesises the key elements of his reports and gives a critique of the response by government as set out in Choosing Health. *His message is both clear and unequivocal – there is no need for further analysis and policy but for action at both government and individual levels. Action needs to be taken in a long list of areas which include an increase in the capacity of the skilled workforce, in self-care, in the engagement of healthcare professionals in preventive approaches. Workplaces, both within the NHS and across other sectors, need to focus on improving the health of their employees. This is not just an agenda for government but for individuals, and efforts are needed to improve health literacy and develop social marketing. Primary care organisations and their local public health consultants/specialists need to be engaged in ensuring local engagement particularly with local government partners, with whom coterminosity is desirable. New organisations such as NICE face a challenging agenda. Better use of information technology and enhanced research to promote evidence of cost-effective interventions are urgently needed along with better management of prevention.*

My report for government in 2004 opened with a quote from Dr Elizabeth Blackwell. Born in 1821, she was our first woman doctor and she caught the spirit I wanted to convey. '*We are not tinkers*', she said, '*who merely patch and mend what is broken … We must be watchmen, guardians of the life and health of our generation, so that stronger and more able generations may come after*' (Wanless 2004).

Now is a fascinating time for public health, full of opportunity but also of danger that the opportunity will be missed. To capitalise successfully on the opportunity will be complex, requiring patience to do the groundwork for the substantial shifts needed to build a physically and mentally healthier population in the UK.

There are vital roles for government – national and local – in public health across many major determinants of health. But what we do not need is simply a list of frenetic and uncoordinated short-term activity, which can be stopped as easily and quickly as it began. Rather, we need sustained, coordinated and well-evaluated efforts which will make a difference to the population's health.

My first report for the Treasury in 2002 sought to answer the question: 'what resources will be needed in 20 years' time to provide high quality health services in the UK?' (Wanless 2002).

Taking as a starting point a vision of what we thought people might want and the UK might need, we consulted widely, received strong support, and then drew up three scenarios to capture some significant uncertainties.

- *Slow uptake* – which was a very unattractive view of the future where little changed from the UK's historic path.
- *Solid progress* – which essentially meant succeeding with announced plans while enhancing productivity. Life expectancy was assumed to improve to 80.0 for men by 2022 and 83.8 for women.
- *Fully engaged* – which assumed further life expectancy improvements (81.6 and 85.5 for men and women) and significant further improvement in levels of engagement in prevention. For example, smoking by 2010 was assumed to fall to 17% of adults, against 27% and 24% in the other two, less-attractive scenarios. These were not marginal shifts.

What was the state of healthcare in 2001? Compared with many other developed countries in terms of outcomes, the UK was not doing well. This was understandable given the history of relative under-investment demonstrated by too few doctors, nurses and other professionals, too many old and inappropriate buildings and late and slow adoption of medical technologies. On the positive side, there was scope for more productive use of resources, particularly by more appropriate use of ICT (information and communications technology), further skill-mix shifts and better use of money and information flows to enhance decision making at delivery level. We consulted on a range of issues (*see* Box A).

Box A Key issues from consultation and analysis

- Patients would want more choice in future, although the immediate issue was access to services.
- There was a desire for choice in non-clinical issues rather than in clinical matters.
- Ageing was an important factor driving up healthcare costs though not the main factor over the coming two decades.
- The main pressures were forecast to be medical technologies, including drug costs, and the costs, direct and indirect, of more staff.
- Primary care would play a proportionately bigger role.
- Productivity rates and the success of prevention were major uncertainties.

To cost health services in 2022, we needed to capture some major uncertainties, in particular how successful we will be in preventing ill health and in improving productivity of our use of resources.

In all three scenarios, we concluded that significantly more money was needed. However, money would not solve the problems without radical reform. The three scenarios we modelled illustrated the huge prize to be gained from higher productivity on the supply of health services, and from greater public engagement and healthier lifestyles on the demand side.

The 'C' word that dominated the first report was *capacity* rather than choice! Without adequate capacity, much of the debate about options, about the possible

pace of change, and about the practical implementation of opening up choice cannot in practice be contemplated.

The headline-grabbing conclusion in 2002 was that the difference in spending between the worst scenario – 'slow uptake' – and the best – 'fully engaged' – was £30 billion per year in 2022. Not, as often claimed by overzealous public health practitioners and by lazy journalists, £30 billion from prevention but £30 billion from better prevention and higher productivity.

The first report encouraged government to think more about healthcare system standards and the processes it controlled. The second report, published in early 2004, looked at public health and in particular sought to address the question: 'How could we get on track for the "fully engaged" scenario?' It set out essential changes in approach if we want to move towards full engagement. It requires high productivity in public health as well as healthcare; adequate workforce capacity, with appropriately broad skill mixes expanded by self-care and imaginative use of the knowledge and time of patients and of those with particular risks; revolutions in the use of technology and information handling; redirection of resource to areas of proven effectiveness; enhanced research programmes; and better measurement tools. The report sought to put forward recommendations which would enable the key determinants of our future health to be tackled. They were by no means all for government. And they were not intended to be a 'pick and mix' list but an attempt to tackle all the most important reasons for our past failures.

The existing definition of public health – '*the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society*' – seemed to me inappropriately narrow. It may well be valid where protection at a population level is what we need and where much of the great public health of the past has its focus. But it fails to describe what *preventive* public health should become in the early 21st century.

The definition should be debated and changed to include the need to operate not simply through 'the organised efforts of society' but rather 'through the organised efforts and informed choices of society, organisations, public and private, communities and individuals', recognising that population health is primarily affected at present by issues and organisations outside the health sector. As the 2004 white paper, *Choosing Health*, states:

> *Public health was often seen as something that was done to the population, for their own good, by impersonal and distant forces in Whitehall and the public bodies and professionals that it directed, with varying degrees of success.* (Secretary of State for Health 2004)

Examining smoking, obesity, salt consumption, physical activity and health inequalities illustrated the conceptual muddle. We found inconsistencies in ambition, realism and timescales in the setting of targets. From back of the envelope over a weekend to wild ambition based on dubious international comparators. For none of the major determinants did the target-setting process encourage a belief that resource management was remotely near optimal. No wonder targets historically have not helped to mobilise engagement.

We *do* need national objectives – short and medium term – for all the major determinants. To inform resource planning and priority setting and to drive action, to enable us to measure progress, and to feed back new knowledge and information.

Research, analytic thinking and consensus building are needed. Sub-groups – for example children, ethnic groups and the economically deprived – will often need separate objectives.

I concluded that public health objectives require more ambition if we are to become 'fully engaged' and that the white paper would need to show how objectives, plans, budgets and research programmes would be ratcheted up to a different level in order to create an irreversible momentum for change.

Public health targets set in 2004 after I reported still appear tentative and not adequately ambitious to be considered 'fully engaged'. Nor is there transparency in the process by which they were reached. Objectives for all the key determinants should be based on independent advice, medical and managerial, and that advice should be published.

Government should fix the objectives to help mobilise activity by many types of organisation, public and private, national and local. It is locally that the design of networks to tackle local issues will happen. National objectives should inform local decisions but should not lead to the imposition of centrally calculated targets on local organisations. Passing out smoking cessation targets to PCTs has probably been the worst example of that sort. We need better management than that.

Local networks know best their own local problems, priorities and complex trade-offs. Much planning and delivery will be local, for example in tackling activity levels or availability of healthy foods; national action, such as resource allocation and the design of financial and information flows, objective setting, performance management and audit, must not distort decision making nor cause unjustifiable spending to achieve marginal gain. Crude bureaucratic administrative systems corrode professionalism but well-coordinated and directed central efforts can add value.

We have failed in the past, too, because the evidence base about cost-effectiveness is so weak. Lack of funding of public health intervention research has contributed; so has very slow acceptance of economic perspectives within public health; so has the lack of a clear, coherent set of government priorities for research. The future research programme will be technically very demanding and will require greater resource and greater expertise and depth in core disciplines. I called on the government to tell us how such a research programme will be delivered. The white paper increases central funding for public health research from April 2006 and establishes a welcome new public health research initiative backed by projects focusing on effective health interventions and the National Prevention Research Initiative.

We have also failed because of the related problems about the adequacy and usefulness of the information base; often it is not telling us in sufficient detail what is happening or why.

All those thinking about use of resources need to have access to, and understand, a consistent cost-effectiveness framework. Such a framework would allow the comparison of the cost-effectiveness of different public health interventions within and across both risk factors and disease areas, including those directed towards the wider determinants of health. It would be most useful if there were to be substantially enhanced information, nationally and locally.

Meanwhile, the need for action is too pressing to allow a lack of comprehensive evidence to excuse inertia. Activity underway, albeit haphazard, should help build the evidence base quickly. It must be drawn into a comprehensive research

programme with an agreed framework for evaluation. The sound methodology being developed by NICE should be the base, forcing consideration of costs and benefits (exceptionally difficult to assess, partly because they are so difficult to conceptualise) and introducing techniques to involve 'real' people in making difficult assessments of value. NICE has done that well. The decision to abolish the Health Development Agency (HDA) and put its functions into NICE was risky. It threatens both to slow down NICE's traditional work at a time when that work also needs expansion, and to disrupt the useful work the HDA had underway. Nor should it produce public health assessments even more skewed towards clinical care. The need for a long-term view in assessing benefits is crucial, as is the rate of discount. QALYs (quality-adjusted life years) are a good sensible start but the quality component must reflect people's views.

The announcement of an Executive Director for Health Improvement by NICE and additional resources for NICE are a start but there is a lot to be done to deliver the necessary service to sufficient quality and volume.

There are roles for government and its agencies nationally. Only they can set national objectives, create the framework, use economic instruments and allocate resources. They can ensure information is adequate and good practice is shared. They need to get feedback from the population and to ensure that a research strategy and the capacity to undertake it are there.

But much action needs to be local. The white paper agrees. It makes the commitment that local authorities and PCTs will have more flexibility to develop local targets through local partnerships in response to local needs. Local area agreements (LAAs) will be piloted in 21 areas and PCTs will develop targets to meet the needs of people in their area that are agreed with local partners to help us meet national targets. The words read well but all who work locally will need to ensure they become much more than words.

In the past, capacity problems, the impact of repeated organisational changes and the lack of alignment of performance-management systems have limited achievement. PCTs have spread resources thinly yet are vital in making new mechanisms – such as new contracts – work to advantage rather than becoming a bureaucratic nightmare and a diversion away from sound professionalism towards opportunistic point-scoring.

Our well-developed network of primary care providers could provide a unique resource for evaluation and health promotion. If the NHS is to be 'the best insurance policy in the world', it must start to think like an insurance company and manage risks.

Pooling of resources between PCTs and local authorities should be closely reviewed to see if it produces the expected benefits. Coterminosity should be examined carefully to see if it brings benefits. The white paper promises to give PCTs the means to tackle health inequalities and improve health through funding to give greater priority to areas of high health need and it promises development of new tools to help PCTs and local authorities jointly plan services and check on progress. So again there are some useful promises but it will be necessary to make sure they are followed through and that the research lessons are identified and learnt for everyone's benefit.

Workforce capacity planning needs much more attention, including assessment of the significant skill shifts needed. It must develop to encompass the wider public health workforce and the social care workforce. Planning this, and delivering the

accreditation likely to be required, is a massive task. It will need to incorporate new types of advisory and support roles and must include recognition of the need to create effective teams capable of sharing and using information.

There is, in one respect, a crucial gap in related government policy. Failure to integrate thinking about healthcare and social care is a massive weakness which must be tackled. All work in this area is incomplete without it. However, it will open up difficult issues about choice and funding and it will throw an even sharper focus on the role of local authorities. All involved should use their various influences to encourage integrated thinking and use their experience to inform the thinking when it happens.

The capacity planning will need to take a long-term view, taking into account the way delivery is likely to develop; for example, as primary care transforms. The opportunity which is opening up to consider what primary care should become over the next couple of decades must be taken. How will knowledge of genetic make-up and of individual risk assessment influence personalised health promotion and disease prevention?

Information technology (IT) will drive change, and marketing techniques will be facilitated and will find their place. A key message is: 'Bring in the marketing professionals.' Beware in the future the way medical models have tended to dominate in the recent past. Again there are hopeful signs. My own instinct, for example, is that the recent smoking adverts concentrating on the psychological problems of quitting are more likely to have an impact on key audiences than the medically orientated adverts of the past. But the lack of good information bases and the inability yet to mobilise modern communication techniques mean that obvious tricks are being missed.

Huge commitments being made to improve technology will have, as part of their justification, identification of personalised risk profiles. But also government must address the threat to public health research arising from the difficulty of obtaining access to data. Debate is needed about the balance between individual confidentiality and the public policy benefit of enhanced knowledge.

A well-structured pilot in the provision of personalised risk management and prevention could pay huge dividends in teaching us what works. But a revolutionary and not an evolutionary approach is called for. So far, instead, we have, for example, loose proposals for personal trainers, which do not seem well rooted in evidence or particularly clearly thought through. They will have to prove they are effective and not gimmickry. If they are seen that way, they will not survive and will discredit the public health function.

Primary care will only be one support. Many organisations need to be shown the business case, the self-interest, in helping their employees, members, insurees and so on to engage. The potential for employers to help their employees engage is under-used. Some examples are emerging. 'Investors in health', for example, is a concept with a chance of catching on.

I said in my report that the NHS as an employer should be showing the way. It is very welcome to see the white paper set out what the NHS will do to become a 'model employer'. There are 1.3 million people following that commitment closely and they should make sure it is delivered.

Private sector organisations can help too by creating and developing markets to deliver products and services which will be built taking full account of individuals' preferences, their choices. Individuals' concerns about their and their families'

future health will change their buying patterns. Such organisations work in the long term not just by pushing product but by recognising the pull from customers. They should be encouraged not vilified.

Government's role extends across all departments. A Cabinet member, the Secretary of State for Health in my view, should ensure action across government is having its public health impact assessed and that coordinated action is tackling the wide-ranging objectives for the determinants of health. We must do better than those limited assessments in the past, for example of agricultural or built environment policies, which have led to situations so difficult to resolve, even in the long term.

It is necessary to correct systemic, socio-economic failures in public health which influence decision making at the individual level. These include a lack of information about preventive action across the population, the inability of individuals always to take account of the wider costs to society of their behaviours, and failures in the social and environmental context which contribute to poor health and to health inequalities.

Information failures are understandable. Much health information is ultimately about probabilities and risks. It is scientific and difficult to digest and people's understanding of risk may be inadequate to assess options. Their 'health literacy' may not be sufficiently well developed. Those seeking to change people's behaviour need to ask regularly whether their messages have reached the public. Indeed, have they always reached the health professionals?

Health literacy is an important precondition for success. The language used and the medium must be right. Research should regularly be undertaken to identify what forms of intervention best improve health literacy and how messages should be targeted at sub-groups, including those with low health literacy, where the prevalence of chronic diseases is often high.

People's understanding of the health and social consequences, both costs and benefits, of their behaviour needs to be considered by policy makers on the evidence available. Each individual has primary responsibility for their own and their children's health. But many need help. Given the failures outlined, individuals are often not living in circumstances which encourage healthy behaviour. Interventions will generally be needed if we are to reach the outcomes sought. Those objectives need to be set and reset on a regular basis as successes and failures become apparent, here and internationally, and as the value of behaviour changes becomes clearer. There needs to be continual reassessment of how far 'fully engaged' can go. What will be acceptable and achievable? 'Fully engaged' will ultimately need to mean the maximum attainable shift in behaviour and attitudes.

The report suggests principles to govern the government's choice of actions to determine when its various levers, information or taxation or subsidies or regulation or deregulation might be justified to help individuals make informed choices; not, generally, to impose choice but rather to inform choice and to encourage changes which make healthy choices easier. Those principles, I said, should also govern government's actions to help overcome the lack of information and confusion of messages, for example in food labelling; to check whether messages have been received, believed and understood; to ensure people take account of the wider costs of their behaviours; to help shift social norms, a legitimate activity for a government when it has worked through and gained commitment for objectives for behaviour change; to find out what works at acceptable cost, even those

programmes which worsen inequalities in isolation provided they are accompanied by programmes addressing the resulting inequalities; and to report on progress annually. The white paper commitment from 2006, through the public health observatories, to publish new reports for local communities and a national composite report will help, provided the reports are tailored to their users.

Leadership will be the difference between success and failure. Recognising that individuals are ultimately responsible for their own and their children's health but they need information and support. And their right to choose does need to be balanced against any adverse impacts those choices have on the quality of life of others. In our society, strong, persuasive leadership is most likely to be effective, nationally and locally, by establishing aggressive goals, building widespread consensus, encouraging action by the self-interested as well as by the community conscious and driving through voluntary engagement. And powerful feedback from local deliverers needs to be heard, loud and clear, by all those fixing national policy, resource and information planning. Public health practitioners must make their voices heard.

I was pleased that the government reacted to my report with its consultation and a white paper. The consultation period gave an opportunity to build consensus and shared priorities for action. That and the white paper are welcome but certainly not in themselves enough to guarantee success. As the white paper states:

> *The time is now right for action. At the start of the 21st century, England needs a new approach to the health of the public. Respecting the freedom of individual choice in a diverse, open and more questioning society but also addressing the fact that too many groups have been left behind or ignored.*

My report was designed to establish a checklist against which the government's responses can be judged. There is, in summary, much to applaud in the white paper. My judgement is that most of the recommendations have survived and have chances of being taken forward. The issue for me in the white paper's plans is pace and, longer term, the issues will be persistence, rigour and the need for continued commitment to local solutions in local situations. There are too many signs of tentative attitudes and a lack of openness or logic to give either full confidence or an unequivocal welcome. A crucial element still not well enough developed is the assessment of the value of outcomes.

But, just as the government's response to my report can be judged and debated, so can the responses of all those others who have parts to play if we are to achieve the prize of full engagement. And what *is* clear is that a 'fully engaged' solution does lie in many hands.

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Part I

The UK, Europe and international

Introduction

Our first edition was published before the impact of devolution on UK public health. In this edition we have asked five authors to comment on country-specific public health issues and developments, and Scott Greer to comment on a UK perspective. Mark McCarthy describes the European dimension, and Martin McKee highlights some of the global issues facing public health.

For Scotland, devolution has provided opportunities to introduce primary legislation on important public health issues. The Scottish Parliament has had the freedom to lead on changing legislation to ban smoking in public places and to promote breastfeeding as well as initiate protection for sex workers through zones of tolerance. Open discussion within the Scottish Parliament has promoted democratic discussion, underpinned by the Scottish Executive's strategy of focusing on health in early years, during teenage transition, health in the workplace and community development. The strong public sector ethos and structural stability of public health within Scotland has also promoted a climate in which public health is integral to decision making by health boards supported by national structures.

In England it is, however, a less stable story. In contrast to Scotland, constant change in organisational structures and national bodies is once again destabilising the public health delivery system. This is not to deny the policy progress in the last 5 years in developing a greater public health presence at national and local levels across health-sector policy. The understanding of the impact of socioeconomic determinants on health, the importance of addressing health inequalities, the Wanless reports, and the most recent white paper, *Choosing Health*, are all testament to an increasing mainstream presence. However, shifting structures amid the introduction of payment by results, practice-based commissioning, patient choice, the reintroduction of the commissioner–provider separation, and the complexities of plurality of provision, including foundation trusts, could either contribute to or, as critics believe, undermine some of the progress in developing joint work with local authorities. Progress such as joint appointments of Directors of Public Health and developing a multidisciplinary specialist profession needs to be nurtured as does the focus on local performance management against national standards which are now inclusive of public health.

Wales has taken a different route again, and the development of the National Public Health System supported by the Wales Centre for Health is a model which is being closely observed across the UK. Welsh public health heroes such as Archie Cochrane and Julian Tudor Hart remind us of the importance of research for effective interventions and the need to seek solutions to challenges posed by, for example, the industrial legacy of high levels of permanent sickness in the valleys. Although the Welsh Assembly does not have the autonomy of the Scottish Parliament there is a distinctive feel to Welsh public health policy, focusing as it does on a systematic approach to community-wide action. Coterminosity with local government has helped to underpin the population base.

Jane Wilde's chapter reminds us of the progress being made in Ireland. While the Republic of Ireland and Northern Ireland are two separate structures for government, administration, finance, healthcare systems and priorities, the Institute of Public Health straddles the two entities as a unifying force for public health. Recent history underscores the importance of political leadership and the increasing climate of cooperation and stability. North and South are now learning and sharing together how best to address the public health problems they jointly face.

As Scott Greer's analysis of the devolved systems within the UK shows, it is not surprising that there has been substantial divergence in public health policy making in the first decade of devolution. Each of the devolved governments is responsible for the dedicated public health function in its area. In drawing out the differing characteristics of the four systems he contrasts the policy emphasis on hospitals and healthcare in England with the Northern Irish history of local organisational autonomy. Further contrast is evident in the Welsh commitment to reducing inequalities which has polarised the debate between determinants and services, while the most successful public health system appears to be in Scotland with its long tradition of professional leadership.

At the same time as these developments in public health and healthcare systems across UK, the relevance and importance of the European dimension of public health has grown. Public health in Europe is both the sum of public health within its member states and also their collective action, both between countries and by all countries working together. Networks such as the World Health Organization (WHO)-sponsored *Healthy Cities* movement allow the exchange of best practice in developing community-based approaches to promoting health. But, as McCarthy points out, while the WHO and EU (European Union) play key roles, public health and healthcare services remain under the control of national governments and are subject to national legislation. So within the EU, while governments may have similar objectives, the structures and practices they develop will differ. The recent expansion of the EU coincided with the development of the three programme themes for health: preventing diseases and injuries (including mental illness, cancer, cardiovascular diseases, rare diseases and accidents); improving cooperation between health systems (including patient safety, transnational specialist centres and cross-border care); and developing structures for emergency preparedness and threats. These themes will be the focus for discussion and collaboration for member states, along with action flowing from environmental charters on transport, air and water. The UK Presidency of the EU during the second half of 2005 saw an emphasis placed on action to reduce inequalities in health culminating in a major health summit held in London in October. Two expert reports specially commissioned for the summit respectively described the substantial inequalities in health which persist and reviewed the various public policy goals and targets being set in different countries.

We are aware that there are many aspects of global public health that we could have included, not least the challenges of the Millennium Goals, the growing awareness of the problems of non-communicable disease as well as the threats of avian flu. The basic public health problems of clean water and sanitation remain challenges in many parts of the developing world. Tobacco companies continue to extend their markets, and obesity rates continue to reach epidemic proportions. The impact of political changes has led to the demise of public health systems in Eastern Europe and China, where privatisation of healthcare systems and

a focus on high-tech medicine rather than basic prevention has led to growing inequalities and in some instances falling life expectancy. HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) rates are rising not only in sub-Saharan Africa but also in countries such as Ukraine and India.

Aware of these multiple issues and the public health challenges they pose, the final chapter in this part of the book by Martin McKee emphasises what we are increasingly aware of, that no government acts alone. The forces of globalisation are evident walking down the high streets of any city or town across the world. The same goods are available, the same fast-food outlets, the same tobacco and other brands. The WHO's framework convention for tobacco control is an example of the awareness of the need for global action and for governments to act for the benefit of their populations' health, not just to support corporate profit or economic success. McKee focuses his analysis on the adverse impact of US neoconservatism, and the need for solidarity and sustained efforts rather than self-interest in addressing the global health challenges of the 21st century.

Chapter 1

Public health in Scotland: the dividend of devolution

Peter Donnelly

Scotland's challenge

For many years Scotland has been known in public health circles as 'the Sick Man of Europe'. Scotland's high prevalence of smoking and alcohol misuse became the stuff of comic caricature. Its diet was almost legendary in its alleged awfulness. What other country could have invented the deep-fried Mars bar?

Yet such a tabloid and populist representation of Scotland's health challenge is a partial story. A more balanced and intellectually rewarding account is given by Leon *et al.*(2003) in their careful study which suggests a number of things about Scotland's health. First, Scotland's health is improving but not at the rate of some of its European counterparts. Second, the shortfall in terms of health improvement performance is relatively recent in that it has only occurred since around 1950, before which Scotland's health was improving on a par with others. The third observation is that the health deficit in Scotland is not due to problems at the extremities of life. Neonatal and perinatal mortality are unremarkable and the old are just as likely to become very old in Scotland as elsewhere. Rather, Scotland's health deficit is focused upon men and particularly women of working age who die before their time from largely preventable conditions such as ischaemic heart disease, stroke and chronic obstructive pulmonary disease. Finally, this burden of ill health and premature mortality is disproportionately borne by those in lower socio-economic classes.

The opportunity of devolution

Unlike other parts of the UK, the devolution settlement presented Scotland with a Parliament with primary legislative powers. Furthermore, as a result of a separate question in the Devolution Referendum it also has tax-raising powers of plus or minus three pence in the pound. Thus far these tax-varying powers have not been utilised but the primary legislative powers certainly have been and what is more they have been used in the field of public health.

To understand fully why this has happened, one has to consider the make-up of the Scottish Parliament. Its partially proportionate system means that coalition government is always likely and that parties who may not gain representation in an exclusively first-past-the-post system do have members in the Chamber. Thus, for example, in the current Parliament (2003–7) the Green Party has seven representatives and the Scottish Socialist Party has six, and the coalition in this Parliament as with the last Parliament (1999–2003) is a Labour/Liberal Democrat one. The most numerous opposition party is the Scottish Nationalist Party (SNP). Unlike many nationalist parties in other parts of Europe, the SNP is not of the

right, with most political commentators considering it to be slightly to the left of the ruling coalition, although not as far to the left as the Scottish Socialist Party. The opposition from the right in terms of the Scottish Conservative and Unionist Party is numerically smaller.

The single-chamber nature of the Scottish Parliament, and a prevailing ethos at the time of devolution which placed great store upon involving the public, has given rise to a number of interesting procedural consequences. For example, any member of the public can start a petition and if they are successful in obtaining the requisite number of signatures have a right to present this to the Petitions Committee and to be heard. The single-chamber nature of the Parliament means that considerable effort is put into the Committee stages of legislation and at Committee stages an emphasis is placed upon fact finding and discussion, rather than overtly party political argument.

The legislative response

It is instructive, given the above background in terms of Scotland's ill health and the devolution of powers, to examine a number of pieces of actual or proposed public health legislation and to compare and contrast what motivated their proposal and what has governed their progress. These three pieces of legislation are the Breastfeeding Act, the Bill which bans smoking in all enclosed public spaces in March 2006, and finally the Private Members' Bill which has not yet reached, and indeed may never reach, the Statute Books but which argues for the creation of prostitution tolerance zones. The first Bill on breastfeeding makes it illegal for any café owner, publican or hotelier to stop a woman in Scotland breastfeeding her child. It was a popular measure politically and met with little opposition and its importance was in sending a very firm signal of national intent on an important public health issue. Arguably it could have been pursued in other ways, although the very process of proposing and achieving legislative change brought a great deal of attention to this crucial but underexplored area of public health policy.

The second Bill relates to smoking. Here again it is probably easier in Scotland to make progress than in certain other parts of the UK, partly because of the make-up of the Parliament as described above. Indeed, of the parties mentioned above, only the Scottish Conservative and Unionist Party opposed the legislation, arguing instead for a voluntary code with, for example, the retail publican trade. Such opposition as there has been has come from outside of the Parliament in the form of the organised retail publican trade as well, of course, from predictable sources such as the Tobacco Manufacturers' Association. At the time of writing the Bill has successfully progressed through Parliament and very recently received Royal Assent and so is now law, becoming effective in March 2006.

The decision to pursue this course of action in Scotland is distinct from that which is being pursued in other parts of the UK at present. In particular it goes further than the initially proposed policy in England. A number of factors may be responsible for this, including the aforementioned parliamentary balance of power. Another factor may be the realisation that Scotland's needs were greater and that it needed to make its own policy and follow its own course in this regard.

Some would see the asynchronous political cycles as also being relevant with a Scottish election being at least 2 years further on than the date of the UK general election.

Commentators might also argue that this was a test of devolution. What better issue for Scotland to do something different than on smoking when so much of its poor health record is tobacco related? At the time of writing, it seems less likely that the issue of legislation on prostitution tolerance zones will be seen as such a public health touchstone. The Bill has been championed by the former SNP, now Independent MSP (Member of the Scottish Parliament), Margo Macdonald and seeks to create a legislative basis that would empower local authorities if they wished to create 'zones of toleration' within which street prostitutes would not be prosecuted by the police. Those who argue for such an approach say that it would facilitate the concentration of health and social services on a highly vulnerable group of women and it could at least remove the additional stigma and disadvantage brought about by criminalisation. Those who are against have adopted this position for a number of reasons. Some are simply morally repelled by any suggestion of condoning or tolerating prostitution. Another group sees any form of prostitution as abuse and any toleration of such as condoning abuse. A third strand driven by residents is focused upon where such zones would be sited and their opposition is largely one of location and the avoidance of considerable inconvenience and unpleasantness.

The parliamentary system has at the very least allowed this difficult and sensitive issue to be thoroughly rehearsed and a wide variety of different pieces of evidence gathered. Whether it finally results in legislation creating 'zones of toleration', or whether it simply better informs the de facto zones that already exist in some cities as a result of police forces exercising their discretionary powers of non-pursuance and non-prosecution, remains to be seen.

Overall however, it appears heartening that a relatively new devolved administration can find parliamentary time to debate, discuss and progress issues as diverse as breastfeeding, smoking in enclosed public places, and prostitution tolerance zones.

The policy response

Of course Scotland's policy response to its challenging health status goes beyond legislation. Before describing this it is perhaps first worth rehearsing what has not been done because that is equally important. In particular, and in marked contrast to England, there has not been a series of system-wide reorganisations. The NHS in Scotland, and indeed local government, has over the immediate past period been fairly stable. Scotland for many years has had 15 geographically defined health boards. Following consultations about one of these being integrated with neighbouring boards there are now 14 health boards. However, this occurred for specific local reasons rather than because of a policy shift. These geographically defined boards have become unified in that they are once again responsible for the operational running of what previously were NHS trusts. However, this change has been achieved with the minimum of fuss, has been seen as popular, and has brought in many people's eyes the 'NHS family' back together. Scotland is also blessed with strong national agencies in terms of Health Protection Scotland (formerly known as the Scottish Centre for Infection and Environmental Health), Health Scotland (an amalgamation of the former Health Education Board for Scotland and the Public Health Institute for Scotland), and the Information and Statistics Division of NHS National Services Scotland, which provides much of the nation's health and

health services intelligence. Box 1.1 illustrates the organisation of the Scottish public health system. Scotland also has a culture of strong professional engagement and professional influence with policy makers. In his comparison of devolution arrangements across the UK and analysis of growing health policy divergence, Greer indeed picks out the importance of professional influence within Scotland (Greer 2001).

Box 1.1 Scotland's public health system (2005)

Tier 1
Community health partnerships between one and five per unified board. Have a leading role in health improvement and tackling health inequalities – generally coterminous with local authorities and technically sub-committees of the 15 boards.

Tier 2
Fourteen unified health boards combine strategic and operational responsibilities with there being no separate trusts. The Director of Public Health and their departments remain key, with responsibilities for health protection, health improvement and public health input to service planning and service quality.

Tier 3
The 14 boards are grouped into three regional networks. Much of the emphasis is on the commissioning of specialist services. However, formal mutual aid arrangements exist between public health departments and appropriate topic-specific cooperation occurs.

Tier 4
National agencies have an important role and interface with both the policy centre and territorial boards. They include:

- NHS Health Scotland
- National Services Scotland including the Information and Statistics Division, Health Protection Scotland and Quality Improvement Scotland
- NHS Education Scotland.

Tier 5
Scottish Executive Health Department public health leadership comes from the responsible Civil Service Policy Group headed by a board-level appointee and from the Chief Medical Officer discharged via one of two Deputy CMOs and his Public Health Professional Group.

Scotland's response to the Leon *et al.* (2003) analysis is encapsulated in the *Challenge* document (Scottish Executive 2003). It talks about four pillars of endeavour, namely: early years, teenage transition, health at work, and community development (*see* Box 1.2). It also has a special focus upon sexual health, diet, exercise, alcohol and mental health (*see* Box 1.3). Each pillar was an attempt to address different aspects of the Scottish Challenge. First, early years was seen as an important time when children could be given the best start in life through breastfeeding,