OUR HEALTHIER NATION

A RESPONSE TO THE PUBLIC HEATH GREEN PAPER

1. INTRODUCTION

1.1. The following comments on the Green Paper on public health, *Our Healthier Nation*, reflect the views of a group of individuals from a wide range of local and national agencies with a role to play in implementing the national public health strategy. These views were expressed during three seminars, jointly organised by the King's Fund, the Health Education Authority and the Association for Public Health.

1.2. The three seminars were structured to address the following questions and issues.

- *Our Healthier Nation*: is the framework appropriate?
- Tools for equity in health: asking the right questions and monitoring progress.
- Partnerships for health: What enables effective joint work and action planning?

1.3. Appendix A shows the chairs, speakers, and facilitators for each seminar who helped to generate the lively debate at the seminars and the comments and ideas set out below. We would like to acknowledge our gratitude to them. Appendix B shows the list of people who attended any or all of the seminars, from whose ideas, experience and enthusiasm the comments in this report are derived.

2. OVERVIEW

2.1. In general, *Our Healthier Nation* was welcomed. It was felt that it presented a wide range of opportunities for promoting health and reducing health inequalities. These opportunities relate to:

- The acknowledgement, articulated in the national contracts for health, of the broader economic, social and environmental determinants of health, which bring a wide range of other actors into public health.
- The explicit aim of tackling inequalities in health and the recognition that to do this the Government must address inequalities more generally.
- The explicit aim of improving quality of life, which is especially important for older people.
- Health Authorities (HAs) being held formally to account for improving health and required to work in partnership with Local Authorities (LAs).

- Health Improvement Programmes (HIPs) as the central mechanism for taking forward both public health and health service objectives.
- Health Action Zones, which aim to reduce red tape and provide new freedoms and incentives.
- Local Authorities to be given a duty for the economic, social and environmental well-being of their populations and represented on Health Authority Boards.
- A performance management framework that includes both health improvement and fairness of access.
- Less competition between providers and collaboration underpinning future relationships and long term agreements.
- The inclusion of the business/commercial sector through, for example, Welfare to Work schemes.
- The recognition of the need for health impact assessments at both the national and local level.
- Increased dialogue with communities.
- The acknowledgement of the influence of EU legislation in the area of public health, and the commitment to work in Europe to develop this further.

2.2. Against this generally positive background of support for the vision of the Green Paper, the main debate centred on a number of key areas. First, in relation to the framework for the Green Paper, there was considerable debate about the main mechanisms for focusing on public health issues: targets and settings. Secondly, there was concern about the national policy agenda in terms of its ability to deliver 'joined-up solutions'. At the local level concern fell into two main areas: messages about the relative priority of public health against other agendas, and how to establish and maintain effective partnerships. Finally, there were a number of concerns about the implementation of the subsequent White Paper in terms of capacities, resources and skills to deliver its agenda.

3. FRAMEWORK

3.1. A general concern about the framework was that the emphasis on deprivation and inequality had given the Green Paper a rather urban focus, and that in the White Paper more consideration needs to be given to the specific public health issues of rural areas. More specifically, concern was expressed about the proposals in relation to targets and settings.

3.2. Targets

3.2.1. There was considerable debate about the value of the inclusion in *Our Healthier Nation* of the four national priority targets, which focus on death and disease. These do represent significant public health challenges. However,

participants at the seminars had two major concerns. First, the biomedical disease-focused model on which they are based does not have a high degree of relevance to the wide range of organisations who need to engage in the broad public health agenda, in particular those addressing the range of factors influencing health contained in the national contract. Secondly, there was significant concern about the lack of a national target for reducing health inequalities. While, overall, people recognised that the four disease targets had a certain value (with perhaps the exception of the target for suicide), there was a strong assertion that there should also be an inequalities target and targets covering some of the determinants of health.

3.2.2. Given the explicit aim of "(improving) the health of the worst off in society and (to narrow) the health gap" the overwhelming consensus of opinion was that targets should be set to monitor progress in achieving this aim. In considering the issue of targets for equity, it needs to be borne in mind that targets serve both symbolic and inspirational functions as well as pragmatic ones. They serve to inspire, motivate, create a climate of opinion and encourage co-operation between agencies. It was pointed out that they are sometimes unmeasurable but this does not undermine their symbolic power. The classic example of this kind of target is Target 1 of the WHO European Region's *Health for All* strategy. "By the year 2000, the differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the health of disadvantaged nations and groups". Many commentators have pointed out that although it is almost impossible to operationalise this target it has had considerable symbolic significance, legitimising actions to address health inequalities during a period when there was very little support for this kind of activity from the national government in the UK. Such targets are particularly important therefore when national government has pledged itself so powerfully to an assault on health related inequalities. A range of principles for setting targets for inequalities in health were generally agreed by the seminar participants. These are elaborated in a forthcoming edition of *The Lancet*, which also contains examples of equity targets from other countries.[1]

3.2.3. There was also overwhelming agreement that targets that address the determinants of health and intermediate outcomes such as lifestyle factors should be included in the forthcoming White Paper. These would not only provide milestones in what is a long-term strategy but also explicitly acknowledge the contribution of agencies addressing housing, environmental sustainability and poverty issues for their part in the public health agenda.

3.3. Settings

3.3.1. The two most well-defined settings - schools and workplaces - which build on initiatives under *Health of the Nation*, could be socially excluding. These could actually increase health inequalities because they may well be set up in more affluent areas, and explicitly exclude groups such as the jobless or

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[1] Whitehead. M. Scott-Samuel, A and Dahlgren G. Setting targets to address inequalities in health. *The Lancet* 1998; 351: 1279-1282. (April 25)

children who play truant and the under-fives. At a minimum, steps should be taken to ensure that such initiatives are developed in disadvantaged areas.

3.3.2. Alternatively it was suggested that healthy settings could be replaced with a focus on population groups, which encompass these settings but which have broader scope. For example, healthy children would include the healthy schools initiatives, but also focus on children who do not attend schools through truancy or other forms of exclusion.

3.3.3. There was overwhelming support for a much greater emphasis on the health of older people in the White Paper. This would help meet the aim of improving quality of life. However, this needs to be a broader strategy, which is developed in its own right rather than tacked onto healthy neighbourhoods. In particular, it needs to link to the *Better Government for Older People* initiative and the planned reform of pensions.

3.3.4. The concept of healthy neighbourhoods is exciting, but it was felt there needed to be a much clearer vision in the White Paper about what these should be and how they will these fit in with various other 'zone' initiatives - Health Action Zones, Education Action Zones, Employment Action Zones. One model put forward for them is the Health Promoting Localities Initiative. An example of such a framework from Calderdale and Kirklees is attached at Appendix C.

4. INTEGRATED NATIONAL POLICY

4.1. Further work is required by Central Government to integrate the broad range of public policies that are currently in the process of being developed, consulted on or implemented, which may have an effect on health or on different agencies' ability to meet the public health agenda. In relation to the Green Paper seven key areas of development are required.

- The public health White Paper requires a much more explicit cross-Government commitment to its aims and action. This should be symbolised by the Preface being written by the Prime Minister and a wide range of Cabinet Ministers signing up to the national contracts. The White Paper must have a much broader ownership so that it is not seen as a Department of Health/NHS initiative.

- The broad ranges of policies that affect health need to be integrated effectively in the White Paper. Appendix D illustrates one health authority's local assessment of the inter-relationships between the cross-Government policies and health. Further work is required to integrate these policies at the national level so that sensible strategies can be developed to tackle the public health agenda.

- The mechanisms for 'joined-up' policy development suggested in the Green Paper need strengthening. The work of the Cross-Government Cabinet Committee for Health needs to be publicly accountable in some way and the approach to health impact assessment needs to be rethought and carried out as discussed below (para 4.2). The Government could consider the establishment of an independent Public Health Ombudsman to

monitor its record in promoting the public's health.

- Public health should have higher priority within Government. This would be easier to achieve if the Minister for Public Health were to become a cabinet post. This could be achieved by the Secretary of State having prime responsibility for public health.
- The public health agenda needs to be built much more explicitly into the structures proposed by the White Paper, *the New NHS*. While the role of Health Authorities and Health Improvement Programmes is clearly linked and reinforced in both strategies (see paras 5.1 and 6.2 below), much more thought is required about how *Our Healthier Nation* can be built into the NHS performance management framework and the remit of Primary Care Groups (PCGs).
- Clear guidance is required in relation to the enlarged public health role of Local Authorities. Many of the policy directives and initiatives within local government (particularly those relating to regeneration, housing, environment, community safety, employment, social welfare) make a major contribution in improving the public's health. Work should be undertaken to define a set of performance management indicators for local government that recognise, measure and monitor this contribution. These should related to both outcome and process indicators.
- Given the centrality of joint partnerships between Local and Health Authorities consideration should be given to the development of a joint performance management framework for Health and Local Authorities in relation the public's health.

4.2. Health Impact Assessment

4.2.1. The Government's whole policy agenda has potentially massive health impact, recognition of this is very welcome. The prediction and evaluation of these potential impacts are therefore critical in ensuring success. The Minister for Public Health noted this in launching *Our Healthier Nation* last July when she stated that "(We) shall look urgently at ways to ensure that policies across Government can be evaluated for their impact on the public's health". *Our Healthier Nation* itself refers to the Department of Health's guidance on *Policy Appraisal and Health* issued in December 1995. This sets out an approach to health impact assessment, which relies heavily on the Treasury's economic appraisal methods, describing the quantification and evaluation of health impacts using measures such as Quality Adjusted Life Years. It is our view that this approach to health impact assessment needs to be extended to include a range of impacts, not all of which will be quantifiable. To illustrate, if the example is taken of the local impact of a road building programme, the effects on social cohesion may be just as important for the public's health as an impact on traffic flow.

4.2.2. However, it is acknowledged that these kinds of impacts may be hard to measure; that expertise in evaluating the impact of policies in this way is very limited and that responsibility for evaluating the impacts of policy will be

shared by a range of agencies at local and national level. It is encouraging that the Department of Health recognises the limits of the 1995 guidance and is working towards a replacement. The new guidance should take into account the following:

- an approach to health impact assessment which is multi-disciplinary and synthesises a range of methods;
- the importance of equity audit;
- the need for a user-friendly approach to establishing targets.

4.2.3. In the context of the *Our Healthier Nation* and *The New NHS*, it is clearly vital that all relevant local agencies, Health Authorities, Local Authorities and Primary Care Groups have access to a shared framework for assessing and evaluating the impact of policies; and that they are equipped with the necessary skills. Within this framework, local Health Improvement Programmes can be developed by agencies on the basis of a clear assessment of the likely health gains. This will enable the establishment of realistic targets and sensitivity to the equity issues that need to be woven into all attempts to improve and sustain health.

4.2.4. Moreover, future guidance must take account of the needs of the diverse agencies that will now have responsibility for working in partnership to deliver the new agenda in public health. It must be accessible to all sectors and backed up by considerable investment in training and a national development programme. The recently published report of the Chief Medical Officer (CMO) to *strengthen the public health function* offers important opportunities to take forward innovation on this level. The work of EQUAL, the Equity in Health Research and Development Unit on health impact assessment provides one possible model. It is important for the Minister for Public Health to ensure that the new partnerships and relationships required to implement the *Our Healthier Nation* vision are enabled to do this at the strategic level. This will be vital to successful implementation.

5. RELATIVE PRIORITIES AT LOCAL LEVEL

5.1. Public Health and the NHS Agenda

5.1.1. The timing and status of various policy documents and guidance means that the emphasis within the health service is on the White Paper: *The New NHS* rather than public health agenda; this needs to be rebalanced urgently. PCGs will have a significant role as a focus for interagency planning and action at a local level based on engaging communities. PCGs are to emerge from a range of models. Most GP-led models have not previously been concerned with addressing wider community health needs. It is important that medical perspectives and health care issues do not dominate PCGs if they are to develop and fulfil their potential for taking forward the public health agenda. Guidance and ongoing support for PCGs needs to address this issue.

5.1.2. Prevention and health promotion services will need to be given greater emphasis within primary care. The role of GPs and other primary care team

members, particularly community nurses, needs to be expanded in the public health White Paper. For example, accountability and incentive mechanisms will need to ensure that PCGs and primary care teams develop their contribution to improving health as well as combating ill health.

5.1.3. The role of specialist health promotion personnel and units is not well addressed in the Green Paper. Health promotion skills and expertise will be required within Health Authorities in supporting the development of Health Improvement Programmes and at locality level in the development and delivery of programmes and initiatives. Guidance needs to be provided on the role of specialist health promotion units and their relationship to Health Authorities and PCGs. It was acknowledged that the review of the health promotion function, currently being taken forward by the Health Education Authority is likely to inform future developments in this area.

5.1.4. The role of clinical services in both the treatment of diseases and in health promotion is inadequately covered in the Green Paper. Without greater discussion about their role, their contribution is unlikely to be fully exploited.

5.2. Public Health and the Local Authority Agenda

5.2.1. Concerted action by LAs is crucial to the success of the public health strategy. While the role of local government is acknowledged in the Green Paper this could be developed much further in the White Paper. Moreover, it is important to ensure that while LAs have a legitimate role in debating contentious health care issues, such as the closure of a hospital, this should not detract from the development of their public health role in partnership with the NHS and other agencies. It should be recognised that this will be a difficult balance for LAs to achieve.

5.2.2. Local authorities are currently developing work in relation to a number of new White and Green Papers. It is unclear how these different initiatives relate to each other and link to LAs' potential for public health. This could be made more explicit. It is particularly unclear how the Best Value framework can be utilised by local authorities to promote social and economic well-being. This needs to be tested for its applicability in relation to the public's health. The forthcoming public health White Paper should make this more explicit than it currently is within the Green Paper and should, moreover, develop proposals for the ways in which LAs will be held to account for their contribution to the public health agenda.

5.2.3. It is not clear who should lead local government public health strategy. Action is required across LA departments, to ensure corporate commitment. Also a clearly defined interface with other agencies must be identified.

6. EFFECTIVE LOCAL PARTNERSHIPS

6.1. Leadership and statutory responsibility

6.1.1. There are many issues still to be resolved about who should lead the public health effort at the local level. Current statutory arrangements may need to be

reconsidered and revised to ensure that the new public health is underpinned by appropriate legislation in which statutory duties and responsibilities are made clear. If Health and Local Authorities are to be joint partners, this should be reflected in a new public health Act.

6.1.2. The duty of partnership placed on the HAs to consult LAs, and the right of LA chief executives to attend HA meetings needs to be reciprocated. What does a duty of partnership mean? How can it be implemented and monitored?

6.2. Health Improvement Programmes

6.2.1. Health Improvement Programmes are the central linking mechanism at the local level, connecting *The New NHS* agenda to the new public health strategy. Further guidance is required, particularly with respect to contributions by Local Authorities. Both agencies should be held to account through a multi-sectoral performance management framework.

6.2.2. The current timetable for developing HIPs has been too tight to ensure that the broad principles of *Our Healthier Nation* are fully incorporated. This must be adjusted in the future. Engagement of communities requires time.

6.2.3. The Government's commitment to addressing equity and reducing social exclusion is welcomed. It is crucial that HIPs include a comprehensive approach to equity, i.e. class, race, gender, disability, age, geographical location, and an explicit focus on excluded groups. There needs to be a commitment to tackling the 'Inverse Care Law' where it applies as well as other local equity issues. PCGs must work with HAs and LAs to tackle inequalities. Equity audits are an important tool for ensuring that commitment to equity is applied in practice. This should be an essential requirement for all HIPs and required in guidance.

6.3. Joint planning and partnerships

6.3.1. Experiences of joint planning show that personal relationships and networks across organisations have often been a significant factor in bringing about successes. Joint planning based on networks and personalities tends to be fragile, but have nonetheless been effective despite constant political and organisational change. Effective joint planning involves taking risks, breaking rules and overcoming perverse incentives. These attitudes and skills need to be explicitly encouraged and supported.

6.3.2. HAs and local government are facing further continual major structural and organisational changes and therefore achieving effective, robust and sustainable joint working and partnerships represents a significant challenge. Lessons can be learned from the success and limitations of models such as the SRB projects, and Drug Action Teams. Joint appointments, joint public health teams, joint community development strategies, joint information strategies, joint need assessment exercises are examples of practical measures for improving joint working. Directors of Public Health's reports could be a valuable mechanism for achieving joint ownership of plans based on a joint assessment of local needs. Good practice needs to be widely publicised to

support the new agenda. The announcement of a joint database between the Local Government Association and the Department of Health on 'what works' is therefore very welcome and must cover effective methods for joint working as well as specific interventions.

6.3.3. Further guidance on approaches to joint working would be valuable, particularly in relation to the problems which occur when there are multiple Local Authorities to each Health Authority and/or multiple layers of local government responsibility in an area. Coterminosity between matching unitary Local Authorities and Health Authorities has aided joint ventures in the past. Unfortunately, this is an increasingly rare situation and one threatened by the possibility raised in *The NEW NHS* White Paper of HA mergers in the future. The interface between localities served by the new PCGs and Local Authorities is therefore a high priority for national guidance and monitoring.

6.3.4. *Features of Effective Joint Working and Partnerships*

A framework for effective joint planning and partnerships locally is likely to have the following features.

- A shared set of values, beliefs and styles. Public sector values transcend organisational boundaries and focus attention on 'serving the community'. Emphasis on prevention and equity gives priority to early intervention and dealing with structural inequalities. Collaboration not competition makes for partnerships working rather than point scoring. Leadership should be about enabling organisations to collaborate, be flexible, creative and promote a 'can do' attitude.

- Leadership by example through the cross-departmental collaboration at central government level.

- A comprehensive understanding of the public health agenda and the ability to assess the contribution of different organisations and mechanisms for pooling and investing resources to best effect. This has big implications for training and communication as discussed below (para 7).

- A multi-sectoral performance management framework and set of measures and targets underpinned by equity that clearly acknowledge the different contribution that Health Authorities and local government can make. Measures should relate to community health and well-being as well as individual health (e.g. a well-being index). Each agency should be able to relate to these measures and targets. Tools and methods must enable measurement and evaluation.

- Public health clearly given a high priority (politically, organisationally, managerially); positive marketing; with a sense of urgency and importance.

- A focus on areas where there is likely to be clear major health gains such as particular client groups or neighbourhoods. This means combining highly targeted efforts with broader health improvement initiatives.

- Joint planning structures can be assisted by:

  ◊ coterminous boundaries defining 'shared communities' which

encourage ownership and passion;

- ◊ different joint planning forums with clearly defined, complementary powers and roles which inter-lock through cross memberships and chairing;
- ◊ joint development units and dedicated resources that support and service joint planning work, and access to national networks of expertise.

- Recognition of the time and resources involved in developing trusting relationships and robust partnerships i.e. 'jointness' as well as the need to concentrate on delivering joint projects.
- Primary Care Groups as a focus for improving public health locally through both commissioning and providing roles.
- Local solutions to local concerns through local people using local capability, resources and strengths. This means new approaches to planning, commissioning, service development and delivery at a local level.
  - ◊ Multi-agency and multi-disciplinary teams that are location based responding to local needs.
  - ◊ Joint commissioning of partnership services; based on the scarce and common expertise, skills and resources across agencies e.g. joint interpreting services and joint community transport services.
  - ◊ Schemes that tap into the skills and resources of local people and use alternative economies such as local credit unions and LETS.
- Investment of effort, time and resources developing partnerships and building relationships with communities to ensure local people are genuinely involved and empowered. Sustained support for community groups and voluntary bodies through core funding to build their capacity - a core infrastructure.
- A multi-agency and multi-disciplinary public health function; not dominated by public health doctors but based on a much broader range of experiences and expertise.

7. IMPLEMENTING THE PUBLIC HEALTH WHITE PAPER

7.1. A national development programme is required to enable agencies at local and national level to discharge their new roles and responsibilities in public health. The following essential elements need to be included.

7.2. **Funding:** Traditionally public health issues and strategies that focus on inequalities and involving communities have been given less priority than other areas, particularly acute sector health care. While some additional monies through Health Action Zones and Healthy Living Centres are welcomed, further additional pump-priming money will be required to support the programme for implementing *Our Healthier Nation.* New money needs to

be invested in some of the key social policies, which may mean reconsidering public spending limits, if real progress in tackling inequalities in health is to be achieved.

7.3. **Public Health Capacity:** It is clear that the public health function needs strengthening and broadening to meet this agenda. The CMO report on strengthening the public health function must be implemented rapidly.

7.4. **Workforce Development and Training.**

7.4.1. A communication strategy is required to educate staff about public health issues. The public health agenda demands new ways of working and competencies at all levels of health and local government. There are significant human resource implications for both health and local government staff. Training and development of different kinds of professionals, including those working in the NHS, Local Authorities and other agencies (at all stages), needs to enable staff to understand their role in improving health and in developing new skills and competencies for undertaking their 'public health' role. This will need to include skills for working across organisational boundaries and within multi-agency, multi-disciplinary teams.

7.4.2. Senior management in particular will need to be more concerned with developing the necessary strategic relationships to understand the complexity of each others differing agendas and organisational structures if they are to agreed shared priorities for public health.

7.5. **Research:** Research is required to development new health and well-being indicators. Work needs to be undertaken to develop effective methods and tools and guidance for the measurement and evaluation of the impact of policies and programmes (e.g. health impact assessment, equity audits) at both national and local levels. More work is also required to develop, evaluate and dissemination effective interventions and approaches in this area. In particular the role of LAs in public health should be an important research topic.

7.6. **Acute Sector Reconfiguration and Public Concerns:** In many districts the closure of hospitals or other changes in acute service provision dominate public concerns about health and makes the release of any resources for the development of a more community-orientated pattern of primary and community care extremely difficult. A communication strategy is required to increase the public's awareness of public health issues and choices between alternative investments (even beyond health services) that are likely to have greater longer-term health gains.