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PREVENTION
RATHER THAN CURE
Making the case for choosing health

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PREVENTION RATHER THAN CURE

Making the case for choosing health

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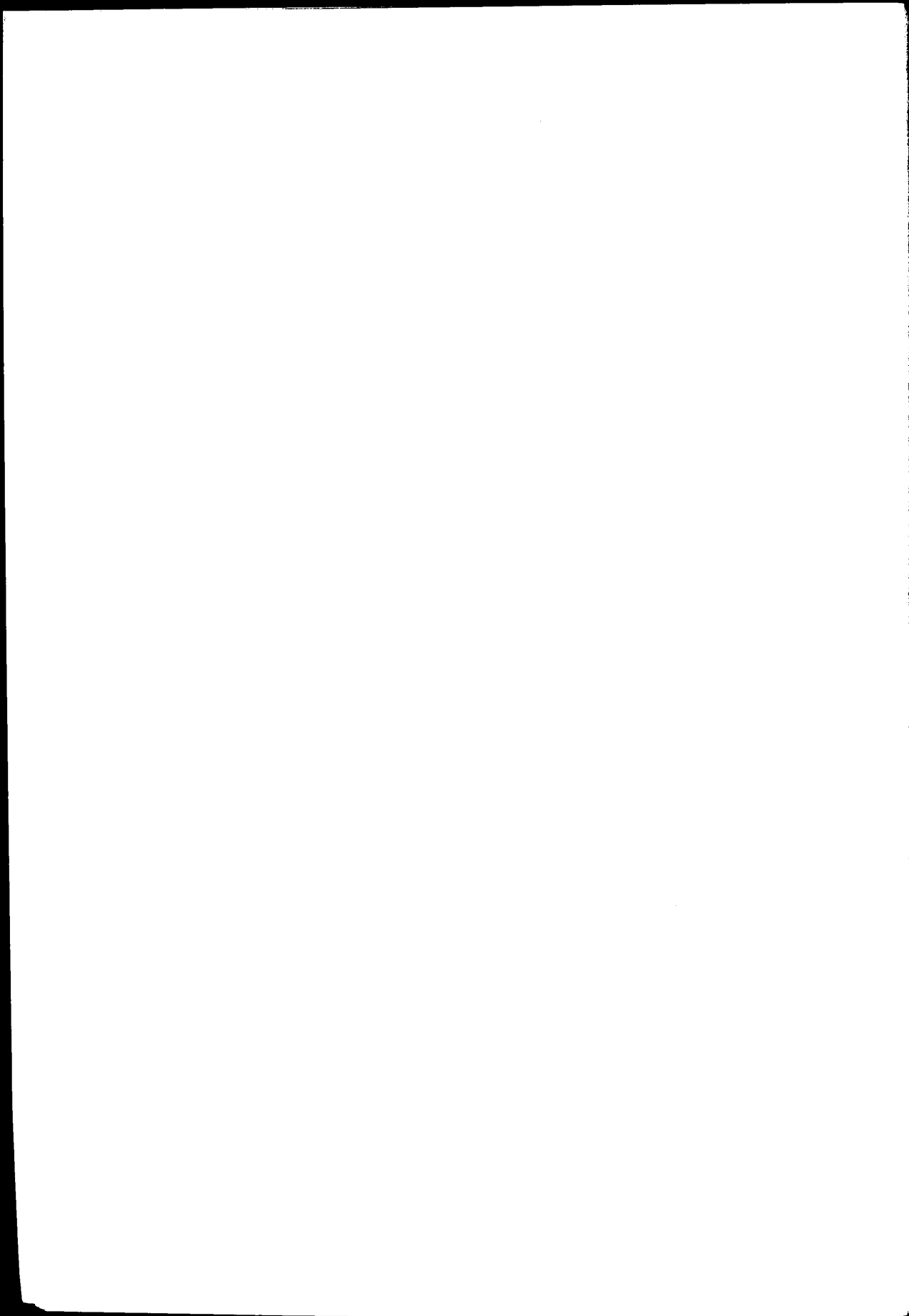
Foreword

There can be no more important issue than the future health of the nation. We have become used to the idea that increased prosperity and medical advances bring longer and healthier lives. But it is now clear that we cannot take those advances for granted. and that progress has been uneven – in particular, inequalities in health have persisted and in some respects are widening.

There is a growing awareness among politicians and the public that recent changes in lifestyle threaten our future health. Already we are seeing huge and unprecedented rises in the levels of obesity and diabetes, large increases in sexually transmitted disease, asthma, and the re-emergence of tuberculosis.

Smoking remains the biggest killer – responsible for the deaths of 120,000 Britons a year – and earlier success at reducing the number of smokers has not been maintained. Binge drinking among the young is now a serious health hazard.

Derek Wanless's second report, *Securing Good Health for the Whole Population*, has concentrated minds. He has warned that the huge sums invested in NHS modernisation will be wasted if high levels of preventable illness hit over the next 20 years. The health secretary, John Reid, is already consulting on ideas for a new public health white paper and at the King's Fund we will be actively involved in that process.

With this background, our Putting Health First programme could hardly be more timely. We want to create a vision of what a new kind of health system would look like – one that gives priority to promoting health and reducing inequality. And we want to explore practical ways of building such a system.

We believe individuals have a clear role to play in taking control of their own health and making the choices that will help them to live healthier lives, but we will not achieve change simply by exhortation. There is a need for a coherent approach to public health and we all a have a part to play, individuals, government, public and private institutions.

In this stimulating paper, Anna Coote makes the case for such a system, one that really enables people to choose health. We believe it will be a controversial and important contribution to this vital debate.

Niall Dickson
Chief Executive, King's Fund

Summary

Improving the population's health is suddenly at the top of the public policy agenda; a major concern for government, the media and individuals alike. There is a growing awareness of the dangers posed by obesity, increasing drug and alcohol misuse among young people, and higher levels of sexually transmitted disease, alongside alarm at rising health care costs.

Government departments and opposition parties have responded in quick succession. Derek Wanless' second report for the Treasury on future health spending, *Securing Good Health for the Whole Population* (2004), shows that the huge sums invested in NHS modernisation will be wasted if high levels of preventable illness hit over the next two decades.

Health secretary, John Reid, has promised a new public health white paper later in 2004, supported by widespread public consultation. Politicians are showing an interest in radical new ideas, such as a 'fat tax' on unhealthy foods. In recent months, the Conservatives and Liberal Democrats have issued policy proposals acknowledging the importance of public health.

Yet little has been said about why, until now, health has so often seemed a second-order issue for most policy-makers and professionals, and how this might influence health initiatives in the future.

Prevention rather than Cure argues that there are still powerful disincentives for governments to focus on health – as distinct from health services. The NHS has become an icon. It is tempting for politicians to try and 'save' it, without looking further than service delivery. This temptation is even greater when leaders are routinely

accused of wanting to create a 'nanny state' if they focus on preventing people from needing those services in the first place.

Individuals do need to take control of their own health and make choices to live healthier lives. But we will not achieve change simply by exhortation. They need help from national and local government, public services and private institutions.

We need a more coherent approach to public health, and we all have a part to play. We need to refocus attitudes, policies and behaviour across a wide range of stakeholders to produce a whole system that gives priority to securing health and reducing inequality.

Of course the NHS has an important role, and this will continue to develop as new treatments become available and patients' expectations rise. It provides a range of essential services to prevent ill health, from antenatal care to cancer screening. But so far, its focus has been on caring for people when they are ill, not keeping them healthy. The point is not to ignore the NHS, but to design and build a health system to promote health and reduce health inequalities.

Prevention rather than Cure starts to build a vision of what such a health system would look like. The policy environment seems more favourable to realising such a vision than it has been for the last 50 years. Now is the moment to start building a health system; one that really enables individuals to choose health.

Where we are now

The Labour Government elected in 1997 took two early and important initiatives in public health: the *Independent Inquiry into Inequalities in Health*, chaired by former chief medical officer Sir Donald Acheson, and the green paper, *Our Healthier Nation*. Both acknowledged that a wide range of measures was needed to improve health and reduce inequalities. The green paper outlined a 'national contract for better

health', in which individuals, local organisations, government and other national players work together.

However, this potentially radical agenda soon vanished beneath an avalanche of targets and measures to 'modernise' the NHS. Even now, the Government has yet to show it is willing to invest the money, energy and political capital in health that it has invested in health services. It faces significant obstacles in doing so. These include:

- **Vested interests** The position of the secretary of state for health is very near the top of the Cabinet pecking order. But the elements of the job that give it power and status relate to the NHS, not to the pursuit of health. There are heavy pressures to 'get things done' within the lifetime of a parliament – even more quickly if possible. Measures to improve health and reduce inequalities take much longer.

- **Powerful imagery** The NHS is full of powerful imagery for journalists who want to assess government progress, while images that convey the pursuit of health are less obvious. Headlines about health policy have focused on the NHS for so long that the public expects action on this front, leaving little room for debate about keeping people well.

- **Fear of the 'nanny state'** Policy-makers fear accusations of wanting to create a 'nanny state' that interferes unnecessarily in people's lives. Yet most public health measures are not about directly controlling individual behaviour, but providing the means for all people, regardless of their socio-economic status, to choose to live healthier lives.

Where we want to get to

We must build on what is already in place. There are some promising materials to work with, including a strong body of policies, such as

those laid out in the current Government's *Our Healthier Nation* and more recent *Tackling Health Inequalities: A programme for action* (2003). Regional and local structures are in place to promote population health, as well as strategies for social and economic regeneration in which health organisations work in partnership with others.

The Health Development Agency's Evidence Base initiative is looking for effective ways of improving health and reducing inequalities. The new Commission for Healthcare Audit and Inspection has a wider remit than its predecessor had, with scope to take a closer interest in public health.

The challenge is to turn all this into serious and consistent action. The King's Fund believes that change needs to happen in three key areas:

Changing the climate of public opinion

As a starting point, the Government should make a more powerful case for health and establish a new kind of dialogue with the electorate. The following issues need to be tackled:

■ **News agendas** Politicians may feel that telling a different story about health is a hazardous business because it means raising issues marginal to current news agendas. However, the media knows their audiences are interested in health and like to cover stories that are politically salient. If leaders attached a greater importance to health, there are good reasons to believe that news agendas would change too.

■ **Public attitudes** What is known about what the public thinks is defined, to a large extent, by the questions people are asked by pollsters and social researchers. They, in turn, are influenced by political and media agendas. As a result, there is abundant data on public attitudes to health services and health care policy, but relatively little on health and health policy. Yet new research

suggests people are interested in health, as well as health care issues such as waiting times, bed numbers and who owns hospitals.

■ **The role of individuals** In a new dialogue between government and electorate, citizens would be cast not just as patients or consumers of services, but as co-producers of their own health. This is not about shifting the blame for poor health to individuals. It is about acknowledging their autonomy to make health choices and empowering them to do so. Government would retain an active role, sharing responsibility for health with other organisations and individuals.

Evolving structures and mechanisms

Building an effective health system does not require another round of organisational change in the health sector. Rather, we need to consider how existing structures and mechanisms might evolve into forms more consistent with a focus on health. These include:

■ **Stronger national leadership** The King's Fund recently considered the case for an arm's-length agency to run the NHS, leaving ministers to play a more strategic role in health. Others have suggested that an independent public health body is needed to oversee policy and practice. Both ideas are controversial. We believe the challenge may be more about changing the mindset of ministers and professionals, than about formal power structures.

■ **Co-ordinated regional leadership** Economic development, regeneration, transport, housing and other determinants of health and wellbeing need to be tackled at a regional level, especially as the move to devolve power to regional assemblies gathers pace. Some assemblies already have health forums, a model best developed in London, and these may provide pointers for the future.

■ **Consistent local leadership** Primary care trusts (PCTs) are the local units responsible for population health is the primary care trust, and every PCT has a director of public health. They vary greatly in the way they approach their work and in the degree of leadership they provide. Models of local leadership from the United States and Europe may provide lessons for the United Kingdom.

■ **New types of local services** The first point of contact with a system that focuses on improving health and recognises individuals as co-producers of their own health might look rather different from a conventional doctors' surgery. We need local health organisations that provide individuals with appropriate knowledge and expertise on how to stay well, offering access to treatment as an additional role. Healthy living centres and Sure Start, the programme to improve life chances for 0-3 year olds, assume individuals' involvement is essential to success – an idea that also underpins foundation hospitals. Local health organisations could develop as something akin to a 'health club' – a place that people feel they belong to, and which gives them a route to involvement and influence.

■ **Valuing the role of advocacy** Those who are poor and socially excluded, including refugees and minority ethnic groups, will need effective links to any new local health organisation. A stronger cohort of community-based health advocates might offer these. There are more than 500 schemes for community advocates in London alone. They offer help ranging from home visits to accompanying people to meetings with professionals.

■ **Healthy and sustainable NHS policies and practice** The NHS has enormous power to influence health through its corporate activities – including employment, procurement, planning, building and the management of energy, waste and travel. NHS organisations should act as good 'corporate citizens', ensuring that sustainable use of its resources help improve the wider determinants of health.

Identifying levers to shift the focus towards health

When it comes to turning ideas into action, much depends on what leverage can be applied. Public opinion, media reporting and leadership are all levers. Others might include public health law and the impact of transnational bodies such as the EU and the World Health Organisation. We also need to consider:

- **Management, incentives and regulation** Incentive structures within the health sector tend to encourage those who work within it to give higher priority to health care delivery than to preventing illness or reducing inequalities. These incentives are layered into the system, and range from the tone of ministers' speeches, national targets and guidance, to professional standards and audit criteria. They need to be mapped and realigned to encourage the shift towards health.

- **Knowledge building, evidence and research** Evidence-based policy has been the mantra of the current Government. But in public health, the pursuit of 'what works' can be problematic. The research agenda has been dramatically skewed towards health care, and public health programmes present severe challenges to researchers, because they do not lend themselves readily to randomised or controlled trials. A more strategic approach is needed, coupled with stronger bridges between researchers, policy-makers and practitioners.

Issues and conclusions

We know a great deal about the extent and causes of ill health – although there is more to learn. We have many well-intentioned policies for tackling them, and structures in place to make a start. The challenge is how to achieve co-ordinated action that really makes a difference.

Creating a health system geared towards promoting health and reducing health inequality, rather than just delivering health services, will pose many dilemmas for policy-makers and practitioners. These include how

fast to move, how to tackle the powerful interest groups and how to define the parameters of the new 'health' agenda.

But this is the right time for the debate, not least because the current Government has everything to gain politically from moving in this direction. When it staked its reputation entirely on rescuing and reforming the NHS, it created a painful stick for its own back. Rows over waiting lists and who should run hospitals came to dominate public perceptions.

A government that grasps the opportunity to develop a health system that enables people to choose health – not just to make choices about what happens to them when they are ill – may collect more political credit than it ever could for trying to 'modernise' the NHS. There is no doubt that it would do more good.

Ways forward

Prevention rather than Cure marks the launch of a new programme of work at the King's Fund, Putting Health First: Changing attitudes, policy and behaviour, that seeks to stimulate debate and identify practical next steps. Activities planned at the time of publication include:

Research projects

■ **Understanding public attitudes** With support from the Health Development Agency, we have commissioned new research from Opinion Leader Research to find out what people think about health, as distinct from health services. FINDINGS MAY 2004

■ **Devolved government** The health and health care systems of the four countries of the UK are becoming more divergent. We have commissioned research to explore these differences, with the aim of learning what the different systems can learn from each other in terms of health improvement. PAPER MAY 2004

- **Regional leadership** The London Health Commission, established by the Mayor of London, is a partnership co-ordinating action to improve health and tackle health inequalities across the capital. We have commissioned University College, London University, to assess whether the commission's work could provide a model for regional leadership elsewhere. PAPER SUMMER 2004

- **A new type of local health organisation** We will explore options for a new type of local health organisation that provides individuals with appropriate knowledge and expertise on how to stay well, offering access to treatment as an additional role.

- **Building the knowledge base** We will publish new thinking about the nature of evidence and its use in effecting complex change within communities, and the relationship between research, policy and practice. This will draw on interviews with those involved in major UK social programmes, and an international seminar series conducted in partnership with the Rockefeller Foundation and the Aspen Institute. PAPER SEPTEMBER 2004

- **Incentives and regulation** We have commissioned David Hunter, professor of health policy at Durham University, to look at how incentives within the health sector might be realigned to produce a stronger focus on keeping people well. He will also examine the impact of regulatory bodies. PAPER NOVEMBER 2004

Development activities

- **Local leadership for health** The New Health Network, with support from the Nuffield Trust, visited Baltimore in the United States to see the work of its health commissioner. We will examine this and other models for local leadership, such as 'health mayors' in other EU countries.

■ **A health-promoting NHS** We are working with the Sustainable
   Development Commission and the Health Development Agency
   to encourage and enable public bodies, including health
   organisations, to implement socially responsible policies in
   relation to employment, procurement, capital build, waste, energy
   and transport. We are also linking up with the Government's Better
   Hospital Food Project to determine the elements of healthy and
   sustainable food procurement within the NHS. RESEARCH
   SUMMARY SPRING 2004

■ **The role of lay health advocacy** We are building on a major King's
   Fund grant programme to develop black and minority ethnic health
   advocacy services across London, due to complete in 2005. This
   involves a research project to map wider health advocacy initiatives
   in the capital and consider how these might play a greater role in
   improving the health of communities. We will also draw on learning
   from our Millennium Awards for community leaders that closed in
   2003 and a new community leadership programme currently in
   development. PAPER SUMMER 2004

■ **London working for better health** The King's Fund is sponsoring
   a new initiative within the London Health Commission that is
   working in partnership with health, employment and regeneration
   stakeholders across the capital to develop and implement strategies
   to improve health and reduce health inequalities through
   employment and enterprise.

See **www.kingsfund.org.uk/puttinghealthfirst** for updates.

Introduction

A common complaint among public health advocates is that the business of keeping people healthy – as distinct from caring for them when they are ill – is treated as a second-order issue by most policy-makers and health professionals. Yet obesity has trebled in the past nine years. Coronary heart disease and cancer – both largely avoidable – kill 200,000 people a year. Smoking kills 120,000 people a year. Inequalities in health between rich and poor have persisted and in some respects widened over the past ten years.

On the face of it, there can be no justification for this state of affairs. There are now abundant data on the determinants of illness and health inequalities and an accumulating body of evidence about which interventions are more or less likely to tackle and allay those causes, although there is still much to learn. There is also no shortage of policy. Since 1997, there has been a steady accretion of government documents aiming to promote health and reduce health inequalities. Politically, this is not highly contested territory: all three main political parties agree, on paper at least, that more should be done to improve population health.

Yet in spite of all this, it seems that health is not given the urgent attention it deserves. The weight of investment – not only of material resources, but of political capital, energy and collective enthusiasm – remains with health care services. Politicians, the royal colleges and even the media appear to be preoccupied with the treatment of injury and illness when these occur, rather than with keeping people well.

This discussion paper aims to stimulate discussion about practical options for shifting the emphasis towards health. It does not argue that health services are unimportant, or that health should be promoted at

the expense of health care, nor that extra billions of pounds must be found to fund a whole new set of initiatives. It simply asks what it might take to turn around the wagon so that the health horse is pulling the health care cart, not vice versa. To set out in the right direction, it may be helpful to think in terms of a 'health system' rather than a health service. For these purposes a 'system' is taken to mean a combination of organisations and relationships that includes health services but is not defined by them.[1]

The policy environment appears to be more favourable to turning the horse and cart around than at any time in the past 50 years. An early signal was the Treasury's decision to commission the second Wanless review of future health investment (*see* 'The Wanless reviews', p 8). By January 2004, there was a consistent message coming from leading figures in the Department of Health that the time had come to turn their attention towards public health. In February 2004, the Secretary of State for Health, John Reid, announced a major public consultation, with a view to producing a new public health white paper later in the year. In launching the consultation, Dr Reid said:

> *Improving public health is a priority for me, my department and this Government. But this is an issue for all of us as individuals. We know the medical evidence about how to improve health, but the Government can't force people to be healthy. And it should not tell people how to live their lives... However, the Government can help people to make healthy choices by providing information, encouragement and support, and by working with the right partners at the right levels.*[2]

Local government is also taking an increasing interest in its role in promoting wellbeing and tackling health inequalities.

This discussion paper briefly summarises the case for giving higher priority to keeping people well, before going on to explore why governments have consistently invested more heavily in health

care than in measures to improve health. It then examines three areas where changes might occur:

■ **The climate of opinion,** as it reflects the attitudes of government and professionals, patients and the wider public, and how it might be changed to give greater priority to health, as distinct from health care.

■ **Current structures and mechanisms,** and how these might evolve into forms that are more amenable to safeguarding and improving population health.

■ **Levers** that might be adapted or strengthened to help bring about the shift towards health.

This is not a paper about why ill health occurs or how health inequalities can be reduced. It focuses specifically on what might ensure that existing knowledge is acted upon and that the necessary muscle is put into realising policies which are already in place. It asks: what are the optimal conditions for effective action, and how can these be achieved? It puts forward ideas that appear to merit further argument and development rather than offering definite solutions, and there are many questions still to be answered (*see* 'Conclusions', p 39).

The paper also serves as an introduction to a new programme of work at the King's Fund called Putting Health First: Changing attitudes, policy and behaviour. This aims to develop some of the themes discussed here and to support and carry forward some of the key issues raised by the second Wanless review.[3] Work already underway for the Putting Health First programme is mentioned in the appropriate sections and under 'Conclusions' at the end of this discussion paper.
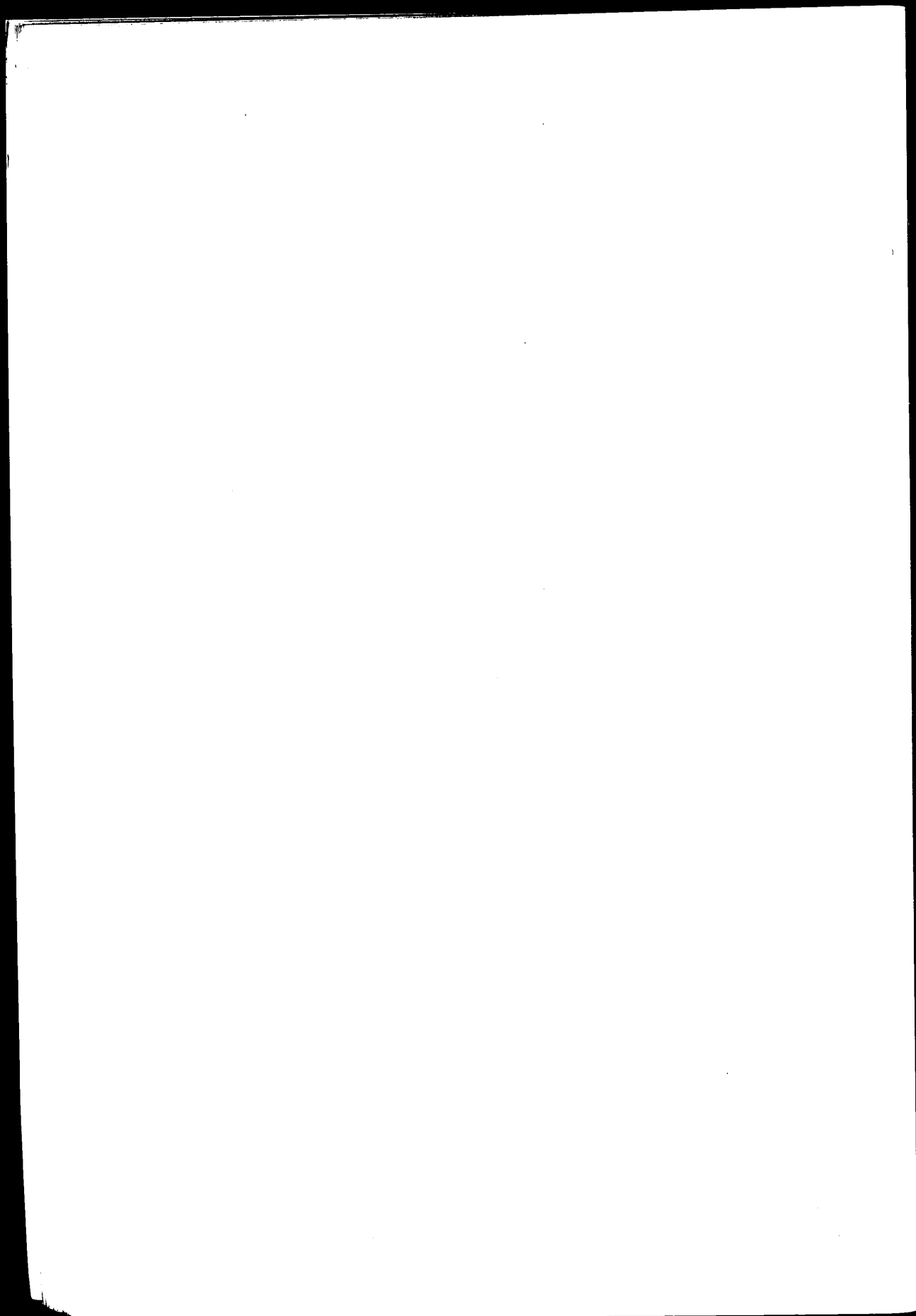
The case for health improvement

There are strong and well-rehearsed arguments for health to be given a higher priority. A just society and a robust economy need a healthy population, not simply efficient health services. Health services have an important but limited role to play in safeguarding and improving health. Inequalities in health between richer and poorer social groups have grown wider over the last decade and in order to reduce them it is necessary to tackle the social, economic and environmental causes of ill health.

Furthermore, as almost all of us can expect to live longer we cannot afford, in human or financial terms, to let preventable illness and dependency dominate our later years. If we want a viable long-term future for the NHS, we must give higher priority to keeping people well to help manage demand for health services. If demand is not checked, pressures on the NHS will intensify, the burden on taxation will grow and patients will receive diminishing health returns, while governments will risk incurring substantial political damage.

A system geared towards improving health for all and reducing health inequalities would have to comprise measures to tackle the underlying causes of ill health, promote better health, prevent illness and intervene early in the development of life-limiting and life-threatening diseases. This would involve, among much else: creating healthy environments through housing, transport, neighbourhood design, crime control and access to green spaces; promoting social and economic opportunities through education, employment and income distribution; creating optimal conditions for healthy living and working, including diet, exercise, alcohol, smoking, drugs and sexual health; preventing illness by means of antenatal and infant care, vaccination, screening and

regular health checks for older people; and intervening early to limit the effects of heart disease, cancer, mental illness and chronic conditions such as diabetes and arthritis.

It would acknowledge the role of individual responsibility, but also the ways in which an individual's capacity to act responsibly in health matters is influenced by the social, cultural, economic and environmental circumstances in which they find themselves. Overall, it would create the optimal conditions for people in all walks of life, and in all parts of the country, to make healthy choices about the direction of their life, lifestyle and environment.

The litany of measures required to address population health is entirely familiar to those working in the public health arena, and it informs the current government's strategy for reducing health inequalities. However, the Government has not yet embraced this agenda with obvious enthusiasm. It has not staked its reputation on improving health, made bold statements about investing huge resources in it, tried hard to sell it to the electorate, or sought to claim credit for pursuing it. It has done all these things for its policies on the NHS, but not for its policies on health. Why not?

Health and health care in government policy since 1997

Until recently, Labour's health policy in England has been shaped to a large extent by the ground staked out in its approach to the 1997 election. From the mid-1980s, the Conservatives focused on introducing market rules into public services, including the NHS. Labour challenged that agenda, promising to save the NHS and to improve the delivery of services. But this led it to fight on a narrow strip of territory: heavy new investment in services, new organisations to commission them, tighter quality assurance through national targets and indicators, and a new cohort of arm's-length regulatory bodies. More recently, it has sought to introduce a more 'customer-centred' approach and more local

control. While admirable to a point, this is essentially a technical and managerial agenda for sharpening up the processes of treating illness.

On the public health side, the Blair government began with two important initiatives. One was the *Independent Inquiry into Health Inequalities*[4] chaired by former chief medical officer Sir Donald Acheson. This analysed evidence of the causes of health inequalities and produced 39 detailed recommendations for reducing them. It advised that, out of these, priority should be given to improving the health of mothers and very young children, especially in disadvantaged groups, and that all policies should be scrutinised in the early planning stages for their likely impact on health inequalities.

The second initiative was the 1998 green paper on public health, *Our Healthier Nation*.[5] This acknowledged the wide range of measures needed to improve health and reduce inequalities, and proposed a 'national contract for better health' in which individuals, local organisations, government and other national players worked together. The aim was to build healthy workplaces, schools and neighbourhoods, and to reduce premature deaths in four target areas: cancer, coronary heart disease and stroke, mental illness and accidents.

Soon, however, this potentially radical agenda faded into the background. Its ambitions were partly overshadowed by the Government's commitment to quantifiable targets. The white paper that followed, *Saving Lives: Our healthier nation,*[6] focused much more narrowly on service-related measures in the four target areas, specifying the numbers of deaths to be avoided and the dates by which this was to be done. Mainly, though, the radicalism sank beneath an avalanche of measures to address the increasingly complex and politicised challenges posed by the NHS.

Since 2000, when *The NHS Plan*[7] was published, the major driver of health policy has been public service reform or 'modernisation'. This has focused on making services more effective and responsive

to patients, renewing buildings and facilities, making better use of technology, and building better relationships between policy-makers, service providers and users.

However, if 'modernisation' implies progress, what kind of progress is being achieved? In a speech to the Fabian Society in June 2003, the prime minister spoke of a 'progressive deficit', which he said must be made good by reforming public services in order to 'create greater opportunity and social justice'.[8] A reform process that focuses on people who are already ill may do little to reduce that deficit, because health is an essential underpinning of greater opportunity and social justice. Indeed, part of the 'progressive deficit' may lie in the failure to engage with citizens in all social groups – but especially the most disadvantaged – in ways that enable them to safeguard and improve their health.

The Wanless reviews

In 2002–03, there were at last signs that the Government was prepared to address the links between service reform and the patterns of illness that shape demand for treatment and care. In April 2002, the former NatWest Chief Executive, Derek Wanless, made his first report to the Treasury on the future costs of health care: *Securing Our Future Health: Taking a long term view.*[9] Wanless looked at three different scenarios, including a so-called 'fully engaged' scenario in which:

> *the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive with high rates of technology uptake.*

This scenario was calculated to be dramatically less expensive than the other two.

In 2003, Wanless was asked to conduct a second review for the Treasury 'with a particular focus on cross-departmental work on preventative

health measures and health inequalities'. The main purpose was to recommend how to 'invest in public health measures to help achieve the fully engaged scenario'.[10] An interim paper, published in December 2003,[11] confirmed that chronic diseases, such as coronary heart disease and cancer, were 'strongly related to lifestyle factors such as smoking, poor diet, physical inactivity and alcohol', that there was 'a strong social gradient to the prevalence of many of these risk factors, particularly for smoking', and that responsibility for public health lay 'with a wide range of individuals and organisations'.

The final report, *Securing Good Health for the Whole Population*, published in February 2004 just as this discussion paper was going to press, called for health services to 'evolve from dealing with acute problems, through more effective control of chronic conditions to promoting the maintenance of good health' and for resource allocation formulae to be revised accordingly. It recognised that responsibility for health ultimately lay with individuals, but that government and other organisations at national and local levels had important roles to play in enabling individuals to make healthy choices. It called for a clear framework, based on a coherent set of principles for delivering public health, with far greater consistency among targets for tackling the main causes of illness.

Serious gaps in the evidence base were pointed out, but the report concluded: 'the need for action is too pressing for the lack of a comprehensive evidence base to be used as an excuse for inertia. Instead, current public health policy and practice, which includes a multitude of promising initiatives, should be evaluated as a series of natural experiments.' A key recommendation was that 'primary care trusts, as the main NHS organisations responsible for improving population health, need appropriate incentives and performance management to enable them to priorities public health issues and to work in partnership with local players to achieve this.' Taken as a whole, the Wanless report could be taken as a significant rebuke to the health sector for failing – thus far – to grasp the nettle of population

health. It delivered a series of challenges that would only have effect if taken up and acted upon right across government.

Obstacles to change

As the political parties gear up for the next general election, 'thought leaders' on all sides are trying to define a winning political discourse. On the centre-left there is much discussion about the need to address globalisation, markets, migration, citizenship, consumerism, the knowledge economy and, of course, reform of public services. There is much less about how to pursue health, human happiness, equality, social justice or sustainable development. It is as though modern, social democratic politics has been reduced to a pragmatic engagement with process, focusing on the practical detail of service delivery rather than on how to achieve desired outcomes. The reluctance to move beyond process is particularly acute in health policy and it is worth considering why.

Vested interests

Many regard the position of secretary of state for health as very near the top of the Cabinet pecking order. After the Treasury, the Foreign Office and the Home Office, it is probably the most sought-after job. The Department of Health is the second-largest spending department after the Department for Work and Pensions, and home to the Government's biggest political investment – at least on the domestic front. But this means that the very elements of the job that give it power and status are the ones that relate to the NHS, not to the pursuit of health.

There are heavy pressures to be seen to 'get things done' and that means chalking up tangible, or at least measurable, results within the lifetime of a parliament, or more quickly if possible. Turning hospitals into foundation trusts or shifting budgets to primary care trusts (PCTs), appointing cancer 'tsars' or cutting waiting times can create an impression of a tough cabinet minister taking the health portfolio

by the scruff of its neck. Measures to improve health and reduce health inequalities take longer; they involve liaising with other departments and non-governmental sectors, and seldom provide clear and measurable results in less than a decade. Even when – or if – real progress is made in tackling problems such as waiting times, it will take a truly visionary and selfless secretary of state to lead a process of shifting priorities, focus on the long-term and start building up better opportunities for everyone, especially the poor, to enjoy good health.

Furthermore, for many of the powerful interest groups within the NHS – the royal colleges, most doctors, nurses, managers, support staff – it is illness not wellness that justifies their existence, draws in their salaries and provides them, in the treating of illness, with their main source of job satisfaction. It is not, of course, that they want people to be ill. But in order to make people well – an entirely admirable aim – they need supplies of people who are unwell. There is little incentive for them to change priorities or to become champions for health rather than health care. This point is discussed later (*see* 'Management, incentives and regulation', p 30).

Powerful imagery

The NHS has taken on an iconic status in the eyes of both government and the electorate as politics has become less readily defined by ideology. Few may want to believe in the market or the state any more, or in socialism or capitalism, but most people seem able and willing to believe in the NHS. It suggests that everyone can pull together and look after each other, it does reassuringly practical things and it does not threaten existing power relations. It is very tempting, then, for ministers and prime ministers of whatever political complexion to pin their colours to the NHS mast, promise to rescue and improve it, and ask to be judged accordingly, without looking beyond the mechanisms of service delivery.

In these media-conscious days the NHS is full of powerful imagery: men in white coats, angelic females in uniform, suffering children,

heroic rescues. This is as useful to government ministers who want
to win favour for pledging to improve the NHS as it is to journalists and
editors who want to thumbscrew the government for failing to fulfil its
pledges. Images that convey the pursuit of health are less obvious,
and a recent King's Fund study of health news coverage indicates
that a story without strong images is less likely to win hearts and
minds, however urgent it might be.[12]

The headlines about health policy have focused on the NHS for so
long that the public has come to expect the main action to take place on
this front. There is a mutually reinforcing process of narrative-building,
whereby governments promise to reform health services, voters expect
services to be reformed, media scrutinise government performance and
seek out stories about its failure to deliver, voters become increasingly
alarmed and government raises the stakes by making more promises,
intensifying the circle of claim and blame. A climate of opinion develops
that leaves little room for public discourse about how to reduce the
need for health services by keeping people well. Ways of addressing
this problem are discussed in the next section ('Changing the climate
of public opinion', p 16).

The 'nanny state'

In addition, policy-makers may think that health service reform is less
likely to lay the government open to the charges of operating a 'nanny
state' than measures to address health inequalities, which reach into
lifestyles and social relations. How measures are perceived by the
media or the public matters just as much as how they are experienced
or what intentions lie behind them. An agenda for health could have a
more empowering and enabling effect on individuals than the current
direction of health policy, for all the talk about patient choice and a
customer-centred service. And most public health measures are not
about directly controlling individual behaviour, but about providing
the means for people to choose to live healthier lives. The constituents
of a system geared towards improving health can be interpreted as

being more about extending choices and opportunities than about repression or social engineering. Nevertheless, by power of association, the idea that promoting public health equals 'nannying' has wormed its way into the national psyche, and politicians fight shy of it. Low levels of trust between voters and government exacerbate the problem.

Paying the political price

Higher income groups tend to enjoy relatively good health overall, so although they may get better access to health services when they are ill,[13] most of what they pay in taxation for health services is spent on long-term chronic diseases that are strongly associated with poverty and disadvantage. Depression and falls among older people, heart disease, diabetes and asthma are currently making the biggest calls on NHS resources. Poor diet, lack of exercise, high stress, smoking, air pollution, bad housing, social isolation, educational under-achievement, low self-esteem and insecurity are all known to increase the risks of incurring these conditions, and also to have a disproportionate impact on those who are poor and socially excluded.

While the middle classes suffer from the same conditions, the incidence is lower and resilience tends to be stronger, so that more people recover and fewer spend long, painful years with debilitating illnesses. Failure to tackle the root causes of ill health is one reason why demands on the NHS will continue to grow and intensify pressure on it, threatening to increase the resentment of taxpayers and deepening social and political divisions.

A complex picture

Of course, the picture is more complicated than these arguments suggest. Demands for health services increase because scientific advances make new treatments available, not just because old diseases continue to afflict the poor. Patients' expectations rise as they become better informed about what is on offer, which can be a good

thing. The NHS does provide a range of essential services that prevent ill health, from antenatal care and vaccinations to cancer screening and nicotine patches. New treatments sometimes reduce the incidence of otherwise costly illnesses; ulcer-busting and cholesterol-lowering drugs come to mind.

The point is not to ignore the NHS and focus only on the social and economic causes of illness, but to design and build a health system whose purpose is to maximise health and minimise illness. Health services should be part of that system – not, as they currently seem to be, a substitute for it. And the system should be geared towards reducing, not perpetuating or increasing, the need for health care services.

Where we want to get to

How could a system whose purpose was to maximise health and reduce inequalities be developed? Practically, there is no sensible alternative to building on what is already in place. And there are some promising materials to work with. As noted previously (see 'Introduction', p 1) there is a strong body of policies. The radicalism of the green paper Our Healthier Nation may have been buried in NHS 'modernisation', but there are still national strategies to encourage smoking cessation, prevent teenage pregnancy and promote healthy eating, as well as a programme of action on health inequalities.[14] Each of the national service frameworks, most notably those on mental health, older people, diabetes and coronary heart disease, has a significant section on preventing illness. Primary care trusts (PCTs) have a duty to promote population health, and in some localities directors of public health have been jointly appointed by local authorities and PCTs, to reflect the need for a cross-sectoral approach.

Scotland and Wales have used their devolved powers to design health systems that are more inclusive of local government and more focused on public health, effectively piloting approaches that may have useful lessons for England. The experiences of the Greater London Authority (GLA) and the London Health Commission (LHC) may help to develop appropriate models for other English regions. Strategies for social and economic regeneration have increasingly involved health organisations in partnerships with regional development agencies, as well as with local authorities and other statutory and non-statutory bodies. The Health Development Agency (HDA)'s Evidence Base initiative and the second Wanless review are committed to identifying effective ways of improving health and reducing health inequalities. And the new Commission for Healthcare Audit and Inspection (CHAI) has a wider

remit than its predecessor, with scope to take a closer interest in performance relating to public health.

This is not a comprehensive list, but it does suggest an accumulation of measures that provide useful building blocks for developing an effective health system.

Changing the climate of public opinion

The expectations of the public, patients, health professionals, politicians and the media are shaped by, and reinforce, a climate of opinion that can be more or less favourable to change. Social scientists and media theorists have argued for many decades about how attitudes are influenced and how they influence decisions in public policy. It is beyond the scope of this discussion paper to enter into these arguments but it accepts the premise, noted earlier (*see* 'Powerful imagery', p 11), that politicians' pledges to the electorate, public expectations and patterns of media reporting are often mutually reinforcing and have the effect of driving policy in particular directions.

As a starting point, the Government should make a more powerful case for a shift in direction. This would require a new kind of dialogue with the electorate about what health means, how it is secured and what to expect from others, including the NHS. The purpose should be to create a shared vision of a health system that is geared towards enabling all citizens to have an equal chance, within the bounds of unavoidable risk and disadvantage, to make choices that enable them to enjoy good health and long life.

This new conversation should aim to develop a wider understanding that health is not something we get from the NHS but a resource that we, as citizens, must nurture and protect, with encouragement and support from government and experts when necessary. It would seek to build higher levels of trust between citizens and government, acknowledging that the public are sometimes more radical in their thinking on health issues than media headlines suggest.[15] It would

invite voters to judge political leaders by the impact of all their policies on health, not merely on what they can do to 'modernise' health services. Ultimately, perhaps, expanding services for the treatment of illness could be seen as a symptom of failure, not success.

Governments can lead and shape public opinion if they have the will. If Tony Blair was prepared to argue the case – against powerful dissent – for going to war and introducing top-up fees for universities, why should he not make the case for investing in health, where there is little active opposition and a great deal of latent support? Three changes are needed to make this possible: governments need to change the way they interpret the news media's representations of health issues; governments and the media must change the way in which they elicit and interpret public attitudes on health; and everyone needs to understand the role of individuals in promoting and protecting their own health.

Changing interpretation of the news media

A recent study by the King's Fund, *Health in the News: Risk, reporting and media influence*, found that patterns of news reporting favoured health issues that were least likely to carry a severe risk to population health – including 'crises' in the NHS and health 'scares' such as those associated with the MMR vaccine and 'mad cow' disease and its human variant vCJD. Indeed, it found an inverse correlation between the volume of news coverage and mortality rates associated with the issues covered: issues that carried the most severe risks to health, such as smoking and mental health, were rarely reported. They appeared more often in features sections, but it was news coverage that was more likely to influence governments' investment decisions.

As the study observes, policy-makers care what the media say for three reasons. First, they believe the media may both reflect and influence public opinion. Second, the media generate debates and conversations among political elites that, in turn, influence the way power is exercised. And third, politicians' own fortunes at the ballot box are seen as

depending, to a large degree, on how they are portrayed in the media and how their words and actions are reported. Telling a different story about health may be seen by politicians as a hazardous business because it involves raising issues that are currently marginal to the main news agenda. It may therefore carry a risk of being vilified, ridiculed or – worse perhaps – ignored by the media. This may help to explain why so few policy-makers speak out consistently on public health, and why health care remains the more prominent topic of conversation.

One way of breaking this pattern would be to generate a better understanding of how news agendas emerge and why they are neither natural nor immutable. The news media manifestly like running stories about health-related issues. They know their audiences are interested in health, not just health services. They like to cover topics that are politically salient. If government ministers and other leaders in the health field made it clear that they attached greater importance to health and spoke out more often and more forcefully about it, there are good reasons to believe that news agendas would change too.

Changing understanding of public attitudes

The climate of opinion is determined most obviously by public attitudes, but it is also influenced by how these attitudes are perceived by policy-makers and the media. Politicians often claim, for example, that what the public 'really care about' is waiting times for health care, or choosing when to have an operation, or being able to influence decisions about their local hospitals. Certainly people do care, often passionately, about these things. But what is known about what members of the public think is defined in large part by what questions they are asked by pollsters and social researchers; these, in turn, are influenced by political and news media agendas.

There is an abundance of data relating to public attitudes to health services and to health care policy, but relatively little on public attitudes to health and health policy. For example, people are routinely asked how satisfied they are with health services and whether they want more

choice about the services they receive. But they are rarely asked whether they want more resources invested in measures to safeguard and improve health, or how much importance they attach to staying well. With support from the HDA, the King's Fund has commissioned new research to help fill this gap.

Changing the role of individuals

In a new dialogue between the government and the electorate, citizens would not be cast as patients or as consumers of services, but as co-producers of their own health. This is an active role within a dynamic relationship, geared towards a positive end.[16]

Instead of passively receiving health advice, or consuming from a menu of pre-determined treatments, individuals would enter into a dynamic relationship with health professionals, in which the goal of all would be health gain, not just the treatment of immediate ills.

The idea of co-production builds on current efforts to develop the capacity of the 'expert patient' but goes further, since it implies a more fundamental shift in power than giving patients more choice over such matters as the timing and location of treatment. Its perspective is longer term and more positive – health, not just a better patient experience, is the desired end.

Co-production, therefore, bears upon the way individuals interact with a range of professionals and service providers, on how well patients are informed and advised, and on how far the conditions in which they live give them real choices about how to use information and resources to safeguard their health.

It is not about shifting the blame to individuals, or about allowing government to renege on its responsibilities. It is about acknowledging the autonomy of individuals and empowering them, while also limiting public expectations of what the NHS and public services can do for people and what governments can do for public services.

It is also about giving government a wider role, so it shares responsibility for health with individuals and other organisations, from the neighbourhood level upwards. As noted earlier, a 'tripartite' contract along these lines was envisaged in the 1998 green paper.[17]

More work is needed to develop the idea of citizens as co-producers, and the King's Fund Putting Health First programme will take this forward. Dr Harry Burns, director of public health for Greater Glasgow health board, is already working on a model that seeks to explore the many factors that go towards creating health and how these affect the individual's capacity, in social, pyschological and physical terms, to combat ill health and make choices about good health. The King's Fund will examine this work later in 2004.

The work on co-production and the work that Dr Burns is doing should help to put arguments about 'nanny statism' (*see* p 12), into perspective.

Evolving structures and mechanisms

It is not the aim of this discussion paper to prompt another round of organisational change in the health sector. Indeed, the King's Fund has consistently questioned the value of the 'permanent revolution' to which successive governments have subjected the NHS. Many commentators have observed that structural changes can be counterproductive: they are usually introduced without adequate experimentation, they can serve as an unnecessary diversion for professionals and managers, and they often fail to deliver any compensating benefits.

That said, it is worth considering how existing structures and mechanisms might evolve, over time, into forms that are more consistent with a health system geared to improving health and reducing health inequalities. This section looks at how evolutionary change might strengthen leadership for health at national, regional

and local levels, improve delivery of services that enable citizens to safeguard and improve their health, provide appropriate support for disadvantaged communities and ensure long-term sustainability of the health system.

Strengthening leadership

An effective leader can provide an organisation or campaign with a clear sense of direction, visibility, credibility, energy, pace, collective buy-in, coherence and momentum. In some respects there has been strong national leadership for health care policy from the current Government and its predecessor, and a great deal is now being invested in strengthening leadership for health care at local level – for example, through the NHS Leadership Centre. When it comes to health, however, it is harder to find evidence of strong or effective leadership.

National leadership

Successive secretaries of state for health have so far acted chiefly as secretaries of state for the NHS. The great majority of their time, and most of their public statements, have been devoted to issues relating to the 'reform' or 'modernisation' of health services. Until now, the public health portfolio has been delegated to a succession of junior ministers who have lacked the political clout to turn around the agenda. If the emphasis is now shifting within government, there may be grounds for hoping that secretaries of state in future will give more time and energy to the public health agenda. Moves to devolve powers to foundation hospitals and, more generally, to cede more control from the centre and 'let the managers manage' would support this shift of emphasis.

The King's Fund recently considered the case for establishing an arm's-length agency to provide health services, leaving local trusts to manage treatment and care and the secretary of state to play a more strategic role in health policy.[18] Another idea, put forward by the Nuffield Trust, is for an independent public health commission at national level to oversee the development of policy and practice.[19]

The Conservatives have put forward slightly different plans for a public health commissioner, with a body of civil servants, to 'apply explicit pressure' to ministers on public health crises.[20] However, just as there will be issues about transferring the management of health services to an independent body, there are questions about how public health could be dealt with effectively outside the political process.

Arguably, the challenge is anyway less about formal power structures and more about the culture of the Department of Health and the NHS; what needs to change is the mindset of ministers, managers and professionals. The kind of change that is required is one that brings clarity of purpose, long-term commitment and enough sustained confidence to address controversial issues. Examples might include ensuring that the acute health care sector takes public health into the heart of its own planning and delivery,[21] that the food industry takes responsibility for reducing fat and sugar in its products, and that all employees have a right to work in a smoke-free environment.

Regional leadership

As the move to devolve power to regional assemblies in England gathers pace, there is a case to be made for stronger leadership for health at regional level. Following the devolution of powers to Scotland and Wales and the establishment in 2000 of the GLA, there are now proposals for three more regional assemblies to be established in England during this parliament, and for others to follow.[22] Measures to tackle the wider determinants of health need to be planned and implemented at regional level, not just at national or local levels.

Issues to be addressed at regional level include economic development, regeneration, housing, transport, waste disposal, energy, environmental protection, tertiary education, communicable disease and measures to address substance abuse, homelessness, mental health, and the health of asylum seekers and refugees. Measures to ensure that the corporate resources of the NHS and other public bodies are spent in ways that promote – or at least do no harm

to – health and sustainable development also need to be co-ordinated at regional level; examples include NHS employment and procurement policies, which are discussed below (*see* 'Corporate citizenship' and sustainable development', p 28).

Currently, each region has a director of public health (DPH) located within the government office for the region, a regional associate director of the HDA and a public health observatory funded by the Department of Health and tasked with tracking data relevant to population health and health inequalities. Arguably, however, more could be done to co-ordinate strategic planning and activity across the statutory and non-statutory sectors. Some regions, including the north east, have health forums attached to regional assemblies. This model is most fully developed in London, where there is a directly elected mayor and assembly.

The London Health Commission (LHC) is an independent body that brings together senior individuals from key organisations in health, local government, business and the voluntary sector to act as champions for improving health and reducing health inequalities. The chair is appointed by the mayor and there is a minimal secretariat located at the GLA. In the first three years of its life the LHC has focused on developing techniques for health impact assessment, which it has used to appraise all the main mayoral strategies, strengthening their positive impact on health.[23] It has tracked progress or otherwise towards health equality in London and has set up dedicated forums on black and minority ethnic health, children and young people, and community development. Overall, it operates by building relationships between organisations, and bringing lay and professional experts together to help them learn from each other and work together.

A study of emerging models of regional leadership for health is being undertaken by the Constitution Unit of University College, London University, with support from the King's Fund.

Local leadership

The local unit responsible for population health is the PCT, which operates on approximately the same scale as local authorities and, in London and elsewhere, shares the same boundaries. PCTs have significant spending powers, holding some three-quarters of the budget for health services. Each one has a DPH, sometimes jointly appointed with the local authority. Directors of public health were formerly based in health authorities. There are many more PCTs than health authorities and, partly because of this expansion, some appointments are now non-medics with experience in health promotion, community development and/or area-based regeneration.

There are huge variations between PCTs in the scope and quality of what they do to prevent illness, promote health and reduce health inequalities. Directors of public health vary widely in how they approach their work and in the quality and style of leadership they provide. In any case, it may reasonably be argued that leadership for health should come from the chief executive of the PCT, not just from the DPH. However, echoing the focus of national leadership, chief executives have been preoccupied with organisational matters and currently operate as leaders for health service provision rather than for population health.

Could things be different? It is worth considering leadership models in other countries, such as that of health commissioner at city and state levels in the United States. In Baltimore, Maryland, for example, the health commissioner, Dr Peter Beilenson, is appointed by the mayor. He has a high media profile and strong public recognition, as well as a significant budget and executive powers.[24] He has focused much of his energies on those who are poor and uninsured, and is campaigning for universal health care in the city. How other health commissioners do their job depends on the individual and the local political environment in which they work. At best, they can provide visible, personalised leadership, with direct powers focused on preventative services, based in elected local government. They can act as powerful

champions for health, using what Americans call the 'bully pulpit' to twist corporate arms and to lever in resources from public, private and charitable sources.

Further work is needed to explore this and other models, including the 'health mayor' in European cities such as Barcelona and Copenhagen,[25] and to draw out lessons for the United Kingdom. But local leadership should not be understood simply in terms of driving through big ideas. Sustained support for small changes initiated locally may be more effective in achieving 'tipping points' for change.[26]

Changing local services

The first point of contact with a system that gives priority to keeping well and acknowledges people as co-producers of their own health might look rather different from the doctor's surgery where, most commonly, people go when they feel ill, expecting to receive treatment.[27]

Ideally, what is required is a local health organisation that, as a priority, engages individuals with appropriate knowledge, advice and expertise on how to stay well, offering access to treatment and care as a secondary function. Such a local health organisation would accept the premise that most people start life with equal potential to be healthy but with unequal opportunities to realise that potential. It would be informed, as far as possible, by evidence of what makes those chances unequal and how they can be evened out. It would aim to bring those who are worse off up to the level of those who are better off. It would seek to offset the effects of inequalities that are unavoidable, such as inherited disabilities. It would draw on the capacity and resources of a range of public, private and voluntary organisations. It might, for example, collaborate with local employers to facilitate work-based health checks for staff. It would recognise that lay people have important knowledge and expertise, which, in the right circumstances, can contribute to preventing illness, managing chronic conditions and promoting better health.

Few in primary health care would dispute the virtues of this approach. Yet in practice the prevailing culture is treatment-led rather than prevention-led; it is more about doing things to people than working with them or enabling them to look after their own health.

Perhaps some inspiration could be drawn from healthy living centres, the lottery-funded initiative to explore new ways of meeting health needs in poor communities, and from Sure Start, the cross-sectoral programme to improve life chances for 0–3 year olds.[28] The first aim to reduce health inequalities are based on four assumptions: 'improving health requires more than medical intervention; for health promotion to be effective, communities and users must be involved; people want to improve their health; and partnership working can maximise impact and promote sustainability.'[29] The second aims to integrate health, social and educational services, and to work in partnership with parents to ensure that children born in disadvantaged circumstances get a fair start in life. Both are still at an experimental stage; their evaluations are incomplete and their future is not secure. But each bears a closer resemblance than a conventional doctor's surgery to the ideal model sketched out above.

That said, there are important elements within NHS trusts and hospitals that suggest there is potential for evolutionary change. PCTs are locally based health organisations, combining a range of health expertise and professional functions; they are powerful budget holders and provide a strategic and administrative hub for a range of neighbourhood-based health centres. They have a responsibility for local population health and are also expected to work with other organisations, such as local authorities, to design and implement community-based programmes to improve health and promote wellbeing. All these factors would also need to be part of an effective local health organisation.

Other aspects of the current primary care model would be less useful. These include a tendency in general practice to see each transaction as a needy patient presenting a problem that can be solved by a

professional, a greater focus on *ad hoc* clinical interventions than on a rounded view of the individual, priority given to cutting waiting times to meet targets rather than needs, too little attention to mental health except when problems become acute and an institutional culture that mitigates against productive partnerships with other organisations. So, primary care organisations as they stand do not fit the bill, but they could evolve in the right direction. Again, what needs to change is not so much the organisational structure, as the underlying philosophy and mindset, the order of priorities and the incentives that drive them.

Healthy living centres and Sure Start both assume that the involvement and commitment of local people is essential to the success of initiatives aimed at improving health and reducing inequalities. The idea of local allegiance or membership is also a feature of foundation hospitals, where a model of mutuality invites local people to acquire notional shares in the enterprise. Could this be extended to the primary care level, so that individuals had a stronger sense of belonging to their local health organisation than is currently associated with being on the list of a PCT or a local GP?

The local health organisation described above might be presented as something akin to a health 'club' that people could join, knowing it would help them to promote and safeguard their health, and provide them with a route to treatment when necessary. Allegiance or membership would derive from a combination of area residence and individual choice. It would be a route to involvement and influence, but need not imply formal control or direct payment. Rules and incentive structures would have to ensure there was no discrimination against disadvantaged groups or individuals.

A key aim of the King's Fund Putting Health First programme is to explore options for developing local health organisations along these or similar lines.

Valuing the role of advocacy

Disadvantaged individuals and groups would need effective ways of linking into the new health organisations to ensure they received the best possible health maintenance and care. It is well known that people who are better off and better educated tend to benefit more from health and other public services. Those who are poor and socially excluded, including refugees and minority ethnic groups, often find hospitals, clinics and doctors' surgeries distant, intimidating and mysterious places, where no one shares their experience or culture, or speaks their language – literally or metaphorically. One way of addressing this problem would be to develop a stronger cohort of community-based advocates to help disadvantaged and socially excluded groups gain access to the knowledge and means to secure good health.

There are already a great many projects providing different forms of advocacy. In London alone there are more than 500 advocacy projects and many have been going strong for several decades. Generally, however, advocacy schemes are piecemeal and marginal to the NHS, often limping from one insecure grant to another. The King's Fund is currently reviewing advocacy schemes in London to explore ways of developing them as a fully integrated part of the health system, without losing their distinctive features of using a predominantly informal workforce and taking on different functions in response to local needs.

'Corporate citizenship' and sustainable development

In considering how existing structures and mechanisms could evolve into an effective health system, it is important to bear in mind the ways in which providers of public services deploy their resources. This applies particularly to the NHS but also to local authorities, schools, prisons and other parts of the public realm.

The NHS is a vast institution. It is the largest single employer in the United Kingdom with more than 1 million staff. It spends more

than £11 billion a year on goods and services. It is the largest single purchaser of food in the country. It owns a huge amount of land and is now engaged in the biggest capital development programme in its history. Through all its corporate activities, including employment, procurement, management of energy, waste and travel, participation in spatial planning and economic development, and commissioning new buildings and refurbishments, it has enormous power to influence health in positive or negative ways, and to promote or impede progress towards sustainable development.

The King's Fund set out the case for using NHS resources in health enhancing and sustainable ways in the report *Claiming the Health Dividend: Unlocking the benefits of NHS spending* in 2002.[30] It is now liaising with the UK Sustainable Development Commission and the Department of Health to develop good practice across the sector, focusing initially on food procurement and capital development and the impact of these on regeneration. In addition, work is underway in most of the English regions, as well as in a number of NHS trusts, to promote sustainable practices, often in partnership with regional development agencies, local authorities and other players (including firms involved in building works funded through the private finance initiative). All this work seeks to promote the NHS as a 'good corporate citizen' and to create a 'virtuous circle' by which sustainable use of NHS resources addresses the wider determinants of health.

Identifying levers to shift the focus towards health

When it comes to turning ideas into action, much depends on the leverage that can be applied, to what and by whom. Public opinions and patterns of media reporting can act as levers for change, as can leadership, but two more levers are vital – the incentives that are applied to managers and professionals in the health sector and the knowledge base on which policies and actions are based.

This does not exhaust the list of what might be explored. Other examples beyond the scope of this discussion paper, but which may merit further investigation, include the case for a new public health law (currently being promoted by the Nuffield Trust), the experience of Scotland, Wales and Northern Ireland since devolution, the influence of transnational bodies (in particular the European Union and the World Health Organisation) and opportunities to learn from other countries.

Management, incentives and regulation

In his recent book *Public Health Policy*, David Hunter points out that politics is as much about doing nothing as doing something.[31] He observes a tendency in government circles to separate the process of policy-making from that of implementation, as though the former simply triggered the latter, and argues that effective policies can only be fashioned out of a thorough understanding of what it takes to put them into practice. This disjunction is especially damaging for a government committed to 'rowing less and steering more', when those at the helm have insufficient knowledge or experience of how to row.[32]

In addition, the conventions of management within the health sector can be an impediment to effective action. Managers tend to be judged by their ability to run institutions and facilities, not by their skills in guiding complex systems towards positive health outcomes. The 'new public management', which remains highly influential within the NHS, is imbued with the values of the commercial sector: it sees health in terms of products, patients as customers and output targets as the best way of measuring success. Hunter suggests a radically different approach: one that heeds the lessons of history and puts health before health care, where attitudes count more than numbers and managers are less like old-style bosses and more like leaders of a jazz ensemble, enabling members of a team to act creatively within complex relationships to achieve a shared outcome. These ideas deserve further, critical consideration.

As has been noted above (*see* 'Vested interests', p 10), the current incentive structures within the health sector tend to encourage those who work within it to give higher priority to health care delivery than to the prevention of illness or measures to reduce health inequalities. Incentives are layered into the system; some are explicit, others implied. They range from the tone of ministers' speeches, national targets, priorities and planning guidance issued by the Department of Health, to the fine detail of the Treasury's spending reviews, and from national service frameworks (NSFs), professional standards and criteria set by audit and inspection bodies to locally determined targets and performance indicators. Some exert more muscle than others, either because they are easier to comply with, or because they resonate with messages from the government about what matters most at the centre, or both. Hence the strongly worded first section of the NSF on mental health, which highlights the need to promote mental wellbeing for all and prevent mental illness, is less likely to spur local action than waiting targets.

The new Commission for Healthcare Audit and Inspection (CHAI), launched in April 2004, could do much to bring about this shift depending on how it sets its own priorities and how much emphasis it gives to assessing performance related to population health. It certainly has a remit to inspect for progress towards better health as well as for delivery of health care. At the time of writing, CHAI's transition team was exploring ways to integrate public health into all routine inspections and developing appropriate criteria for assessing performance. The role of the Audit Commission could also be highly influential – for example, through its auditing of local government and local partnerships and their impact on the quality of life of local residents.

The King's Fund has commissioned a study of incentives within the health sector with a view to reaching a better understanding of how they combine and interact, and why some are more powerful than others. This will prepare the ground for debate about how best to

review, amend and realign them to shift the hierarchy of ambition
as far as possible towards health.

Knowledge building, evidence and research

'Evidence-based policy' has been the mantra of the Blair government.
The prime minister famously declared in 1997 that New Labour was 'a
party of ideas and ideals, but not of outdated ideology. What counts is
what works.'[33] That message is now embedded in health organisations
across the country. However, in the realm of public health, the pursuit
of evidence of 'what works' can be problematic. Health services can be
more readily understood in terms of simple outputs, such as finished
consultant episodes, than services to improve health; clinical
interventions lend themselves more easily to testing through
controlled experimentation than do public health measures. There
has been a huge amount of research into health care, not least because
the pharmaceutical industry invests heavily in clinical trials (as indeed
it should). By comparison, research into effective public health
measures has been negligible,[34] although in December 2003 the
Department of Health did issue a tender inviting bids to establish a
Public Health Research Consortium to the value of £3.5 million over
five years.

'What works' and public health

Most of this Government's attempts to address inequality and
disadvantage have involved complex, cross-sectoral, long-term
initiatives that rely on action by local partnerships to put national
policies into practice. But they have been more value-driven than
evidence-based. Health action zones, the New Deal for Communities,
healthy living centres and health improvement and modernisation
plans have been inspired more by ideas about what should happen
than by any certainty about what would happen if particular strategies
were applied.

Many millions have now been invested in evaluating these programmes, but they present considerable challenges to researchers trying to find out whether they 'work'. They do not lend themselves readily to randomised or controlled evaluation methods, which many regard as the 'gold standard'. It is hard to trace cause and effect over time when so many interrelated factors bear upon the well being of local residents. And it may be that the effects of an intervention are not to be felt for ten years, while the funding for evaluation lasts five years or less.

Because much of the evidence that exists is fragmented, contested or inconclusive, practitioners in PCTs and local authorities often find it less than enlightening. If they are not to be paralysed by uncertainty, they may just ignore what evidence there is and plough on regardless. At government level, meanwhile, ministers regularly call for 'quick wins' so that they can show voters that their policies have been successful before the next election. Yet early signs of success may not herald long-term effectiveness. And conversely, initiatives that do not produce positive hits in a hurry are at risk of being aborted before they have had a chance to prove their worth.

Overall, knowledge of 'what works' has accumulated haphazardly. It is the result of many unrelated decisions by funders, combined with researchers' idiosyncratic preferences and the limits of evaluation 'science'. This is hardly a robust foundation on which to build a public health strategy. Insisting on doing only 'what works' could reduce the scope of activity to a small, eclectic band of simple measures that have little coherence between them. It could also discourage creativity, innovation and risk-taking, however much these may be needed to tackle problems that have proved intractable in the past.

A strategic approach to knowledge building

There needs to be a more strategic approach to expanding the evidence base in public health. The HDA has made useful progress in mapping out what we know and what we need to find out. The

balance of research funding must continue to be shifted towards public health. One obvious challenge would be to assess the effectiveness of implementing proposals in this discussion paper. For example, can the impact of leadership be measured? Is it possible to calculate the cost effectiveness of a local health organisation or evaluate the realignment of incentives and criteria for regulation?

There is a case for undertaking more experimental trials, which in some cases will help to isolate cause and effect. But there must also be a more enthusiastic and widespread embracing of multi-method approaches to evaluation, with qualitative studies valued equally with quantitative and experimental methods. This view is now endorsed by the Cabinet Office, but the idea clings on that methods must be judged by their place in a 'hierarchy' that ranks randomised controlled trials at the top and users' views at the bottom.

It is also necessary to move beyond asking 'what works' to understanding the processes involved in generating appropriate knowledge and linking it to learning and change. Stronger bridges will have to be built between practitioners in the field, researchers and policy-makers. Evidence needs to be presented in more user-friendly ways, especially for those who design and implement health measures at local levels. More emphasis must be given to enabling practitioners to learn from each other, contribute to the evidence base and inform policy.

There should also be a more extensive dialogue about the limits, as well as the potential, of evidence in public health. There are sometimes good reasons for acting without evidence which relate not just to gaps in research, but to the way people understand and deal with complex, uncertain conditions, the vagaries of science and the messiness of democratic politics. However, these are rarely discussed, let alone recognised as legitimate or desirable. Those involved in policy, practice and research will need to broaden their focus, from a search for evidence of effectiveness to an inclusive and continuing

process of knowledge building, in which frontline professionals, citizens and service users have a central role to play.

A report exploring these issues in more detail, based on an international seminar series conducted by the King's Fund in partnership with the Rockefeller Foundation and the Aspen Institute, is being prepared at the time of writing and is due for publication in 2004.

Problems and dilemmas

Inevitably this discussion gives rise to a range of dilemmas for those who make policies and for those who implement them. They cannot all be dealt with here; just three are mentioned briefly: the pace of change, interests at stake and defining the parameters of the 'health agenda'.

Managing the pace of change

One dilemma for central government is how far and how fast to change the focus of health policy, if it is minded to do so. It needs to persuade voters and taxpayers that investing in health – as distinct from health care – is worthwhile. Giving higher priority to the health agenda may carry a risk of alarming public opinion by suggesting that the government is downgrading its commitment to health care or that money will be taken away from the NHS to pay for preventative measures. This is partly about the phasing of investments and partly about the nature of the dialogue between government and the electorate, discussed earlier (see 'Changing the climate of public opinion', p 16). Given the history of this debate, there is little hope of winning voter support for a shift of gear towards health if the quality of health services appears to be in decline.

Eventually, however, a rebalancing of investment is unavoidable. Put crudely, if less were spent on treatment and care, more would be available for preventative measures and for education, housing and other services that address the causes of illness. At what point does the volume of investment in health services cease to yield satisfactory or commensurate dividends in terms of health outcomes? How much is enough? What limits on NHS spending will voters and taxpayers tolerate? Whose are the interests at stake and who will resist change? The King's Fund is planning work to explore these questions.

Recognising the interests at stake

Three powerful groups are likely to seek to influence the course of events. The first is made up of patients' organisations that represent, in the main, people with long-term chronic conditions. They are comfortable with the idea of a more patient-centred NHS, which is currently the main health policy 'story', and quite legitimately need an effective, responsive, state-of-the-art service. How are their interests served by a shift of focus towards keeping people well? Patients and their organisations may respond positively to policy developments that seek to give them a more powerful role in managing their own condition as co-producers, maintaining their independence as far as possible and safeguarding whatever levels of health they are able to enjoy. This suggests that the agenda for better health must be carefully integrated with the agenda for managing long-term chronic conditions; this is the subject of a major King's Fund study.[35]

Another powerful group with interests at stake is that of health care workers who, as suggested earlier (see 'Vested interests', p 10), have grown accustomed to building their job satisfaction, income and career paths on treating or curing rather than preventing illness. It may be unwise to assume that the health professions and the organisations that represent them will cheerfully support changes designed to stem the flow of patients into their wards and consulting rooms. This has implications for the way incentives are structured within the NHS, how clinicians and managers are trained and how career flexibility is managed within the service.

The third group is comprised of commercial organisations and these come in two categories. The first are those whose business is based largely on treatment or care of people when they are ill – for example, pharmaceutical companies and those involved in building or running hospitals or care homes. The second are those whose activities put health at risk in various ways, such as tobacco companies, some food manufacturers and retailers and companies whose activities pollute the environment. There are certainly profits to be made from illness and

unhealthy behaviour, but there is a strong case to argue that health is better for business. A healthier population means less sick leave and higher productivity. And there are strong commercial opportunities in promoting health, ranging from preventive pharmaceuticals to health foods, sport and fitness.

Defining the parameters of the 'health' agenda

This paper has argued that efforts to develop an effective health system must extend well beyond what is currently known as the 'health sector'. But the wider the net is cast, the more difficult it becomes to define the agenda as being about 'health' rather than other overlapping concepts like 'quality of life', 'wellbeing' or even 'sustainable development'. Where does responsibility for health begin and end in terms of public policy? What would be gained or lost by using terminology more familiar to local government? More specifically, how can the contributions of bodies outside the health sector be defined, organised, led and integrated with the contributions of those attached to the NHS and the Department of Health?

There may be little benefit in resuscitating the well-worn debate about whether public health should be located outside the Department of Health – for example, in the Office of the Deputy Prime Minister or the Cabinet Office. But clarity of definition and location is nevertheless important as it is likely to influence the commitment of different organisations and the extent to which their various inputs are focused, coherent and co-ordinated. Arguably, it is at the local level that strong co-ordination is needed most. The best hope may be to develop local strategic partnerships so that they play a more central role in co-ordinating activities in pursuit of local health objectives.

Conclusions

Prevention rather than Cure has addressed the challenge of how to move from knowing a great deal about the extent and causes of ill health and having a range of well-intentioned policies for tackling them, to achieving co-ordinated action across government that will really make a difference. It has tried to envisage what it would take to develop an effective health system – one that is geared to improving health and reducing health inequalities, including the NHS, but not defined by it. It has also argued that there are already many useful 'building blocks' with which a more effective system could be constructed. The aim is evolution, not more 'revolution' of the kind that has buffeted the NHS for at least two decades.

To summarise, three themes have been considered:
- how to change the climate of opinion so that is more favourable to a health-led agenda
- how current structures and mechanisms could evolve into forms that are more amenable to this agenda
- what levers can be found to bring about the desired shift towards health.

One closing irony: by staking its reputation chiefly on rescuing and reforming the NHS, the Blair government has created a painful stick for its own back. There is now an epidemic of obesity, growing problems of drug and alcohol misuse among young people and levels of sexually transmitted disease that threaten the fertility of a generation. The NHS seems powerless to do anything about any of these, yet the Government's effort to tackle the underlying determinants of health and health inequalities are failing to attract credit. This is at a time when policies are being put in place to improve health in the longer term and when there is a strategy to reduce health inequalities, with

targets to reduce differential rates in infant mortality and adult life expectancy. It includes measures initiated across government to end child poverty, get the long-term unemployed into work, raise family income through tax credits and the minimum wage, improve standards in schools, provide integrated education and care for 0–3 year olds, regenerate poor neighbourhoods, improve nutrition in schools and hospitals, step up smoking cessation programmes through primary care trusts... the list is much longer. There are gaps and weaknesses and discontinuities, but there is plenty going on.

What is missing? Strong leadership, political will, strategic coherence, clear messages, and a shared sense of public investment and ownership. Most voters do not know any of this is happening or, if they do, they don't associate it with health policy. All they have heard about, until very recently, is waiting times and rows about building and owning hospitals. A government that grasped the opportunity to develop and present to the electorate a national health system, based on the premise that people would rather choose health than choose what should happen when they are ill, would not only be doing more good, but would also collect more political credit than it ever could for trying to 'modernise' the NHS.

Ways forward

Prevention rather than Cure marks the launch of a new programme of work at the King's Fund, Putting Health First: Changing attitudes, policy and behaviour. This aims to stimulate debate – and act as a catalyst to new thinking – on a range of important questions, including:

■ **Building a new health system**
   – Is it possible to develop an effective health system – one geared to keeping people healthy and reducing health inequalities?
   – How might such a system evolve from current knowledge, policies, resources, structures and services?

■ **Changing the climate of opinion**
  - How can the Government talk to the electorate in new ways about health and health care?
  - How important do the public think wider health issues are? Do they feel we should spend more or less on preventing illness and promoting health?
  - How can we encourage more people to engage with and manage their own health – as 'co-producers', rather than passive recipients, of health services?

■ **Developing new structures and mechanisms**
  - How can the efforts of individuals, national and local government, and public and private institutions come together to help people live healthier lives?
  - How can public health leadership be strengthened at national, regional and local levels?
  - Could local people develop a fuller role as 'lay health advocates' for disadvantaged communities – building a bridge between them and the knowledge and services they need to stay healthy?
  - What more can be done to ensure that the NHS uses its corporate powers and resources in ways that maximise benefits to health and sustainable development?

■ **Finding the leverage**
  - What role could health managers and professionals play in shifting priorities towards health? What incentives and systems are needed?
  - What role should the Commission for Healthcare Audit and Inspection and other regulatory bodies play?
  - How can we develop a more strategic approach to gathering and deploying evidence in relation to public health issues?

Our activities will include:

Research projects

■ **Understanding public attitudes** With support from the Health Development Agency, we have commissioned new research from Opinion Leader Research to find out what people think about health, as distinct from health services. FINDINGS MAY 2004

■ **Devolved government** The health and health care systems of the four countries of the UK are different and becoming more so as devolved government beds in. We have commissioned research to explore these differences, with the aim of identifying what the different systems can learn from each other in terms of health improvement. PAPER MAY 2004

■ **Regional leadership** The London Health Commission, established by the Mayor of London, is a partnership co-ordinating action to improve health and tackle health inequalities across the capital. We have commissioned University College, London University, to assess whether the commission's work could provide a model for regional leadership elsewhere. PAPER SUMMER 2004

■ **Building the knowledge base** We will publish new thinking about the nature of evidence and its use in effecting complex change within communities, and the relationship of research, policy and practice. This will draw on interviews with agencies working in the field, and an international seminar series conducted in partnership with the Rockefeller Foundation and the Aspen Institute. PAPER SEPTEMBER 2004

■ **Incentives and regulation** We have commissioned David Hunter, professor of health policy at Durham University, to look at how incentives within the health sector might be realigned to produce

a stronger focus on keeping people well. He will also examine the impact of the Commission for Healthcare Audit and Inspection and other regulatory bodies. PAPER NOVEMBER 2004

Development activities

■ **Local leadership for health** The New Health Network, with support from the Nuffield Trust, visited Baltimore in the United States to see the work of its health commissioner. We will examine this and other models for local leadership, such as Europe's 'health mayors'.

■ **A health-promoting NHS** We are working with the Sustainable Development Commission and the Health Development Agency to encourage and enable public bodies, including health organisations, to implement socially responsible policies in relation to employment, procurement, capital build, waste, energy and transport. We are also linking up with the Government's Better Hospital Food Project to determine the elements of healthy and sustainable food procurement within the NHS. RESEARCH SUMMARY SPRING 2004

■ **The role of lay health advocacy** We are building on a major King's Fund grant programme to develop black and minority ethnic health advocacy services across London, due to complete in 2005. This involves research project to map wider health advocacy initiatives in the capital and consider how these might play a greater role in improving the health of communities. We will also draw on learning from our Millennium Awards for community leaders, that closed in 2003, and a new community leadership programme currently in development. PAPER AND EVENT SUMMER 2004

■ **London working for better health** The King's Fund is sponsoring a new initiative within the London Health Commission that is working in partnership with health, employment and regeneration

stakeholders across the capital, to develop and implement strategies to improve health and reduce health inequalities through employment and enterprise.

See **www.kingsfund.org.uk/choosinghealth** for updates.

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Linked publications

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opens up an important debate about how the NHS might put its corporate
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sustainable development – and how, in doing so, it can ensure it
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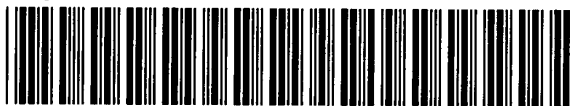Download a free summary at www.kingsfund.org.uk/summaries
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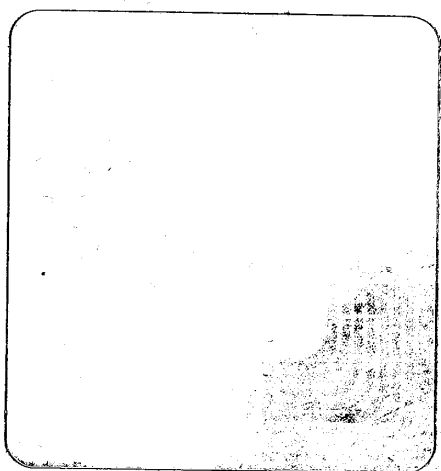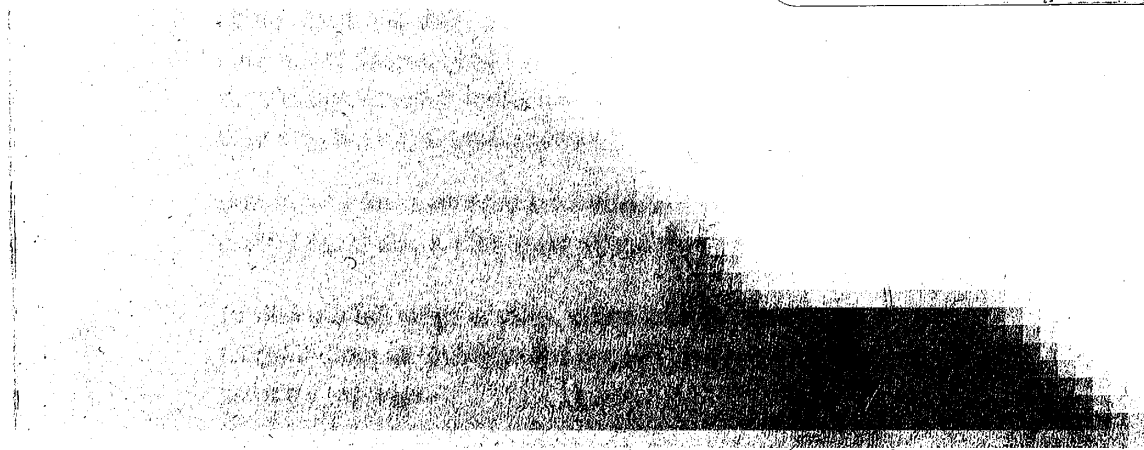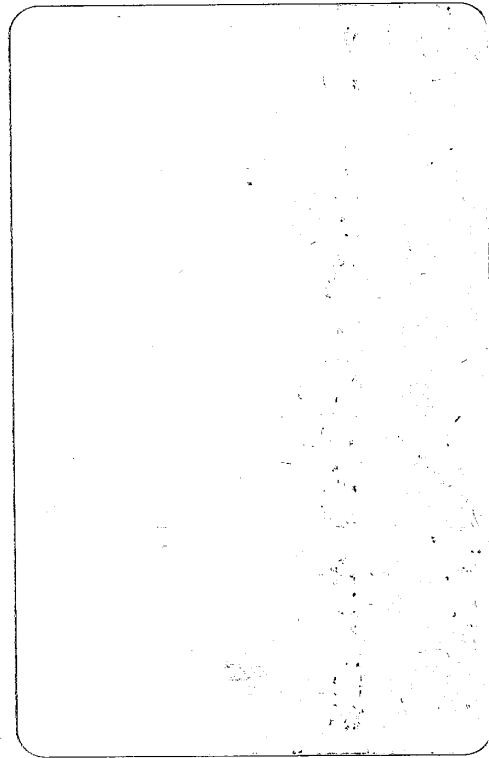
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The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through grants. We are a major resource to people working in health, offering leadership and education courses; seminars and workshops; publications; information and library services; and conference and meeting facilities.

Better living standards and medical breakthroughs have led many people in the UK to expect ever longer, healthier lives. But lifestyle changes are bringing new kinds of health risks. Levels of obesity, diabetes and sexually transmitted disease are up, and drug and alcohol misuse among young people is growing.

Failure to address avoidable ill health will put huge pressures on the future NHS, while deepening health inequalities. So why, until recently, has better population health seemed a second-order issue for most policy-makers? What mechanisms and incentives are needed to put health at the heart of attitudes, policy and behaviour?

Prevention rather than Cure argues that we must build a wider health 'system' geared towards keeping people healthy – as well as treating them when they are unwell. The Government seems increasingly convinced of the case for investing in health. What's now needed is concerted and purposeful action that engages the efforts of individuals, communities and organisations.

This discussion paper marks the start of a new King's Fund work programme, Putting Health First, designed to model ways forward. It:

- provides a timely critique of the Government's approach to health and health care
- analyses how the media influence public attitudes and policy
- explores the structures, mechanisms and levers needed for change
- highlights the need for clear evidence about what works
- argues for stronger leadership at all levels.

It will be compelling reading for policy-makers at national and local government levels, professionals and agencies working in health and social care, and for anyone who cares about the future health of our population.