

Summary and Implications

Since the 19th century public health has evolved from being predominantly concerned with the prevention of communicable diseases to include the prevention and management of chronic diseases. With this evolution, there has been a shift of emphasis from interventions at a population level towards targeting individual behaviour change at a population and individual level. This latter emphasis has also evolved to reflect the influence of socio-economic, environmental and cultural influences on behaviour, and the importance of health inequalities.

The definition of “public health” has now evolved to describe a phenomenon that can be influenced by collective action, and that has significance for the population as a whole, or for sub-groups within it, for example by age, ethnicity or socio-economic status. This Review defines public health in a very wide sense as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.”

The major drivers of public health have been recognised since the 1970s, with numerous “upstream” and “downstream” public health strategies having been proposed. However, 30 years on, despite some successes, implementation has been partial at best. To achieve the “fully engaged” scenario will require a step change in effort and achievement. The fundamental challenge is now to “make it happen”, particularly focusing on incentives, levers and delivery.

Public health – the promotion of good health and the prevention of disease - should be central to the work of a tax financed NHS. Numerous policy statements and initiatives in the field of public health have not resulted in a rebalancing of policy away from health care (a “national sickness service”) to health (a “national health service”). This will not happen until there is a realignment of incentives in the system to focus on reducing the burden of disease and tackling the key lifestyle and environmental risks. Reducing the burden of disease in England needs a clear articulation of the priorities for action with accountabilities defined for those both within and outside of the NHS for delivering them, and reflected in the performance and inspection regimes for the NHS and local government.

THE EVOLUTION OF THE CONCEPT OF PUBLIC HEALTH

2.1 In the 19th century public health was mainly concerned with the consequences of environmental factors, in the context of the safety of food, air and water. In terms of diseases it was largely concerned with infectious, toxic and traumatic causes of death, often associated with absolute poverty¹.

2.2 By the late 20th century, public health had adapted to meet the challenges of a new set of diseases associated with longevity, industrialisation, inequalities in health, and environmental damage. This change was accompanied by the growing belief that many of the underlying factors for these diseases could be amenable to prevention through social, environmental or behavioural change². The perceived relationships between health, health care and disease have changed over time.

¹ *Evaluating Health Promotion: Practice and Methods*, V Berridge, 2000

² *What's new in public health?*, Lancet Editorial, 1991

2.3 The traditional view of health care was seen as trying to cure existing disease, or care for the consequences of disease, rather than dealing with the factors causing it. Within this framework new disease, high levels of disease and new treatments would all tend to lead to more health care being demanded.

SHIFT FROM TREATMENT TO PREVENTION

The Lalonde Report (1974)

2.4 The 1970s saw a move to investigate the influence of lifestyle, environmental and biological factors on health as health care costs increased, while a number of studies indicated the considerable scope for improving the cost-effectiveness and appropriateness of health care utilisation. By 1974, in Canada, the increasing costs of healthcare led the Minister of National Health and Welfare to produce a document entitled “*A New Perspective on the Health of Canadians*”³, known as the *Lalonde Report*. It called for a shift away from focusing on health care as the only determinant of health, and proposed consideration of the areas of lifestyle, environment and human biology.

2.5 The Report identified the paradox that, although most of the burden of ill health was a result of lifestyle, environment and human biology and not a lack of health care, most of the expenditure on health went into the treatment and care of the ill. It advocated improvements in the environment and in lifestyle as the most effective means of reducing mortality and morbidity. Essentially, the *Lalonde Report* signalled the need for a shift in emphasis from the treatment of illness to the prevention of illness or, as Lalonde later remarked, “*more positively, to the promotion of health*”⁴.

2.6 The Report focused on factors individuals could do something about, especially in terms of individual risk factors for specific diseases, concentrating on drugs (alcohol, tobacco, pharmaceuticals and psychotropic drugs), diet and exercise, accidents and sexually transmitted diseases. Interventions began to be aimed at the individual. Underlying this policy development was the implicit model that individuals choose unhealthy lifestyles due to ignorance, and that, once provided with the appropriate information, they would change their lifestyles and improve their health status. This perspective ignored the possibility that individuals may be informed and still choose unhealthy behaviour because they enjoy it, as discussed in Chapters 7.

THE WIDER DETERMINANTS OF HEALTH

2.7 Since 1974, a considerable amount of research evidence has amassed which goes beyond the Lalonde framework. With the *Black Report*⁵ on inequalities in health it has become increasingly clear that social deprivation is a major determinant of poor health status⁶. This has been particularly evident in the UK and US, where although there has been an overall decline in death rates, socio-economic differences in death rates have been increasing⁷.

³ *A New Perspective on the Health of Canadians (Lalonde Report)*, Department of National Health and Welfare, Canada, 1974

⁴ *Beyond a New Perspective - the fourth annual Matthew. B. Rosenhaus lecture*, M Lalonde, 1977

⁵ *Inequalities in Health, Report of a Research Group (Black Report)*, DHSS, 1980

⁶ *United Kingdom Country Report, International Handbook of Public Health*, C Birt, 1996

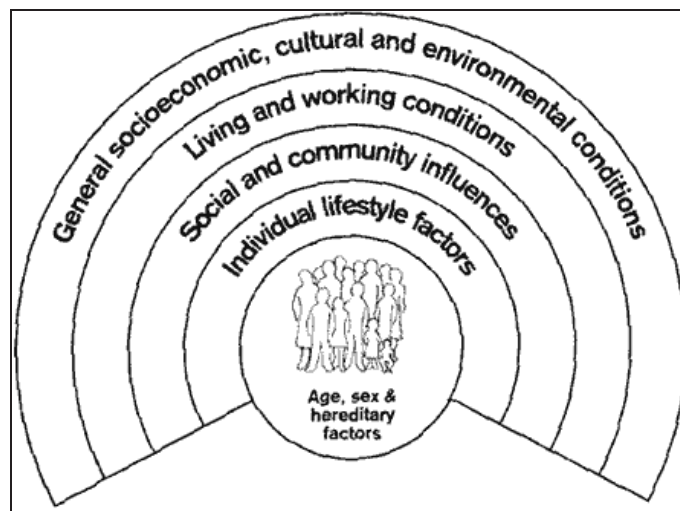
⁷ *Social Inequalities in Health: next questions and converging evidence*, M Marmot et al., 1997

2.8 Social class, whether measured by education, income, or occupation⁸, is a robust predictor of health outcomes. Occupational social class is strongly associated with overall and non-cardiovascular mortality, and education is more strongly associated with cardiovascular death⁹. These inequalities in health may be due to in utero and early life experiences¹⁰, psychosocial factors, such as low control in the work environment and lack of social support^{8,10}, or a lack of social capital¹¹, as well as social and environmental factors such as housing and income.

2.9 In addition, public health may increasingly reflect the emerging knowledge about genetic predisposition to disease, and the importance of interactions between genetic endowment and the environment, both physical and social, as well as research on biological pathways linking the mind, the nervous system and the immune system¹². In the future, knowledge of genetics and individual risk factors could play an increasing role in delivering the fully engaged scenario through individualised health promotion and preventative actions.

2.10 Researchers^{12,13} have suggested public health frameworks encompassing these issues, including behavioural as well as biological responses to the individual's environment. Frameworks such as the Social Ecological Theory¹⁴ and that of Dahlgren¹³ (see chart 2.1) attempt to conceptualise the current views on the relationship between the individual, their environment and disease. Over time, the themes of such frameworks have begun to be reflected in public health policy acknowledging the influence of the wider determinants of health, such as poverty, education, and employment.

Chart 2.1 – The determinants of health



Source: *Policies and strategies for promoting social equity in health*. G. Dahlgren and M. Whitehead, 1991.

⁸ Socioeconomic Determinants of CHD Mortality, M Marmot, 1989

⁹ Education and Occupational Social Class: which is the more important indicator of mortality risk?, G Davey-Smith et al., 1998

¹⁰ Infant mortality, Childhood Nutrition, and Ischaemic Heart Disease in England and Wales, D Barker, 1986

¹¹ *Bowling Alone*, America's declining social capital, R Putnam, 1995

¹² *Producing health, consuming health care*, R Evans et al., 1990

¹³ *Policies and Strategies for Promoting Social Equity in Health*, G Dahlgren and M Whitehead, 1991

¹⁴ *Translating Social Ecological Theory into Guidelines for Community Health Promotion*, D Stokols, 1996

Box 2.1 Definitions of Health and Health Policy

The World Health Organisation (WHO) defines “health” as:

- A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity¹⁵;
- A resource for everyday life, not the objective for living ... a positive concept emphasising social and personal resources, as well as physical capacities¹⁶;
- A resource which gives people the ability to manage and even to change their surroundings¹⁷.

Within these definitions there is a sense of health being the absence of physical and mental disease and disability, as well as a resource that gives individuals the ability to interact with their surroundings, socially and physically. In addition, WHO defines the “Prerequisites for Health”¹⁶, the fundamental conditions and resources for health, as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. This fits with the definitions of health as being concerned with the individual and their environment.

“Health policy” can be defined as the actions of government and other players, which are aimed at maintaining and improving the population’s state of health. It has two goals¹⁸:

- Adding years to life – an increase in life expectancy and reduction in premature death;
- Adding life to years – increasing years lived free from ill-health, reducing or minimising the adverse effects of illness and disability, promoting healthy lifestyles, physical and social environments and, overall, improving quality of life.

Definition of public health

2.11 The definition of “public health” has now evolved to describe a phenomenon that can be influenced by collective action, and that has significance for the population as a whole, or for sub-groups within it, for example by age, ethnicity or socio-economic status¹⁹. J Last defined “public health” as “the combination of science, practical skills, and beliefs that is directed to the maintenance and improvement of the health of all people ... through collective or social action”²⁰, while the definition of the Acheson Report on the public health function²¹ reflects how public health is currently perceived within UK health policy:

“The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society”.

¹⁵ Constitution of the World Health Organisation as adopted by the International Health Conference, WHO, 1946

¹⁶ The Ottawa Charter: principles for health promotion, WHO, 1986

¹⁷ Formulating Strategies For Health For All by the Year 2000, WHO, 1979

¹⁸ The Health of the Nation, Department of Health, 1992

¹⁹ Public Health Status and Forecasts: the health status of the Dutch population over the period 1950-2010, RIVM, 1994

²⁰ Public Health and Human Ecology, J Last, 1987

²¹ Public Health in England, D Acheson, DH, 1988

2.12 In this review of public health, “the organised efforts of society” are viewed in the widest sense, to include not only government, public and private sector organisations, and communities, but also the aggregate efforts of individuals in respect of their and their families’ health status. A more appropriate definition for the future might be:

“the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.”

PUBLIC HEALTH POLICY IN ENGLAND: 1976 TO 2003

The Black Report (1980)

2.13 During the late 1970s, through the publications of the Department of Health and Social Security (DHSS), England’s failure to match the improvement in health that was observed in some other countries, and the relationship of this to persistent inequalities in health, became apparent²². In 1977, a working group on inequalities in health was appointed, headed by Sir Douglas Black, to assess the national and international evidence, and the implications for policy.

2.14 The *Black Report* argued that many of the problems of health inequalities lay outside the scope of the NHS, being related to social and economic factors, such as income, employment, environment, education, housing, transport and life-style factors. It promoted a wider public health strategy with the underlying aim of improving the living standards of the poorest people in society, with two main policy thrusts²³:

- advocating a total approach to health, not just a service-orientated approach; and
- advocating a radical overhaul in the balance of activity and distribution of resources within the health and associated services.

2.15 Black made thirty seven recommendations covering improving information, research and organisation; giving more emphasis to prevention, primary care and community health; and improving the material conditions of poorer groups, particularly young children and mothers, and people with disabilities. Above all, the Report advocated that “*the abolition of child poverty should be adopted as a national goal for the 1980’s*”. The three objectives underpinning these recommendations were:

- to give children a better start in life;
- to encourage good health among a larger proportion of the population by preventative and educational action; and
- for disabled people, to reduce the risks of early death, to improve the quality of life whether in the community or in institutions, and as far as possible to reduce the need for the latter.

²² *Prevention and Health: everybody’s business*, DHSS, 1976

²³ *Inequalities in Health: The Black Report*, P Townsend and N Davidson, 1988

2.16 The Report stressed that effective prevention required commitment across the DHSS and other government departments, as well as individual initiatives. Its analysis found that people’s behaviours were in many ways constrained by structural and environmental factors outside their own control. Government initiatives were encouraged with regard to smoking, physical activity, diet and alcohol consumption. Black concluded that legislation, fiscal and other financial measures might be required to encourage behaviour change, in addition to a wide range of social and economic policies.

2.17 At the time of its publication, the Report’s recommendations were not endorsed by the Government on the grounds of the up-front cost, estimated to be upward of £2 billion a year (in 1980), and so development of public health policy, particularly with regard to health inequalities, remained low on the political agenda.

WHO Policies

2.18 During this period the WHO had been a leading advocate of public health at an international level. Beginning with its ten point *Alma-Ata Declaration* at the International Conference on Primary Health Care in 1978, WHO expressed “the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world”²⁴.

2.19 Then in 1981 the WHO issued its *Health for All by the Year 2000* document²⁵, the objectives of which were “the attainment by all people of the highest possible level of health” and “that as a minimum all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live”.

2.20 This was followed in 1985 by *Targets for Health for All 2000*²⁶, in which the WHO defined thirty eight targets for all regions of the world, including Europe, with specific figures for reductions in infant mortality, maternal mortality, mortality from diseases of the circulatory system, cancer mortality, and deaths from accidents. These targets needed to be updated in 1991²⁷, since some of the targets for 1990 had not been met.

2.21 In 1986, the *Ottawa Charter*¹⁶ was produced at the first WHO Conference on Health Promotion. It built on the *Alma-Ata Declaration* and provided a basis for the development of health promotion policy, identifying five key areas for action:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- re-orientating health services.

²⁴ *Alma Ata 1978, Primary Health Care*, WHO, 1978

²⁵ *Global Strategy for Health for All by the Year 2000*, WHO, 1981

²⁶ *Targets for Health for All 2000*, WHO, 1985

²⁷ *Health for All Targets, The health policy for Europe (Summary of the Updated Edition)*, WHO, 1991

2.22 Although the UK Government had endorsed the *Alma-Ata Declaration* and *Health for All by the Year 2000*, since 1979 it had not acted on the issues raised and was seen to be resistant to setting health targets^{28,29}. This changed in 1992 with the introduction of the Health of The Nation targets.

The Health of The Nation (1992)

2.23 Following the lead set by the WHO with its *Health for All by the Year 2000* targets, and in an attempt to address the rising demands on the health care system in England & Wales, the Government published its *The Health of The Nation* White Paper in 1992. This set out targets for reductions in the death rates from coronary heart disease, stroke, cancers, suicide and accidents, in the incidence of sexually transmitted diseases; and in the prevalence of cigarette smoking, alcohol consumption and obesity. However, the document was largely silent on the impact of poverty and inequalities^{29,30,31}.

Independent Inquiry into Inequalities in Health Report (1998)

2.24 In 1997, Sir Donald Acheson was asked, by the Minister of Public Health, a newly created appointment, to review the evidence on inequalities in health in England, and to identify areas for policy development likely to reduce inequalities.

2.25 The Independent Inquiry into Inequalities in Health Report³² made thirty nine recommendations for future policy development covering poverty, income, tax and benefits; education; employment; housing and environment; mobility, transport and pollution; nutrition and the Common Agricultural Policy; mothers, children and families; young people and adults of working age; older people; ethnicity; gender; and the National Health Service.

2.26 The Inquiry identified three key actions as being crucial to reducing inequalities in health:

- all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities;
- a high priority should be given to the health of families with children; and
- further steps should be taken to reduce income inequalities and improve the living standards of poor households.

2.27 Although only three of the thirty nine recommendations related to the NHS, many others related to promoting healthier lifestyles (box 2.2). The Report highlighted that health related behaviour is an important determinant of health and inequalities in health. It reasoned that the differences in individual behaviours, more particularly the inequalities in health behaviour, are complex and include the influences of early life experiences, the social and economic environment, work or school, and the cultural milieu, as well as individual characteristics.

²⁸ *Health Targets*, BMJ Editorial, J Catford, 1991

²⁹ *The Health of the Nation*, BMJ Editorial, J Ashton, 1991

³⁰ *Health, but Not for All*, Lancet News, M Dean, 1992

³¹ *Increasing Inequalities in the Health of the Nation*, BMJ Editorial, G Davey-Smith and J Morris, 1994

³² *Independent Inquiry into Inequalities in Health*, D Acheson, DH, 1998

2.28 The Report stressed that policies designed to change behaviour needed to act at different levels, both “upstream” (policy interventions) and “downstream” (individual interventions), and that Government had to accept that behaviour change might take time to become apparent. Policies need to avoid blaming individuals or groups for their health related behaviours, but should be based on the principle of increasing information and choice, and so enabling individuals and communities to make healthy choices.

2.29 Since 1998, the Independent Inquiry has played a crucial role in shaping policy and provided direction on subsequent initiatives, particularly relating to tax and benefit reforms, and transport, as well as introducing performance management systems across a number of areas³³. Since 1998, the Government has directly responded to some of the recommendations and has introduced:

- a strategy and target for tackling child poverty, reforming the Welfare Food Scheme;
- a strategy and targets for Sure Start – a programme to promote the physical, intellectual and social development of babies and young children, particularly those who are disadvantaged;
- initiatives linked to Healthy Schools programmes, working with the food industry on diets to reduce fat, salt and sugar, the Five-A-Day programme and the National School Fruit Scheme;
- strategies for reducing traffic deaths and injuries, particularly traffic calming schemes, safety campaigns and school programmes, extension of the safe routes to school initiatives;
- sexual health and HIV strategies;
- the teenage conception target and local teenage pregnancy strategies;
- the *Smoking Kills* White Paper³⁴; and
- nicotine replacement therapy (NRT) on prescription.

³³ *Tackling Health Inequalities since the Acheson Inquiry*, M Exworthy et al., 2003

³⁴ *Smoking Kills*, Department of Health, 1998

Box 2.2 Acheson recommendations concerning key health related behaviours**General Lifestyle Behaviours**

- Policies which promote the adoption of healthier lifestyles, particularly in respect of factors which show a strong social gradient in prevalence or consequences.

Diet and Nutrition

- Further measures to improve the nutrition provided at school, including: the promotion of school food policies; the development of budgeting and cooking skills; the preservation of free school meals entitlement; the provision of free school fruit; and the restriction of less healthy food.
- Policies which will increase the availability and accessibility of foodstuffs to supply an adequate and affordable diet.
- Further development of policies which will ensure adequate retail provision of food to those who are disadvantaged.
- Policies which reduce the sodium content of processed foods, particularly bread and cereals, and which do not incur additional cost to the consumer.
- Policies which improve the health and nutrition of women of child-bearing age and their children with priority given to the elimination of food poverty and the prevention and reduction of obesity.
- Policies which increase the prevalence of breastfeeding.

Physical Activity

- Further measures to encourage walking and cycling as forms of transport and to ensure the safe separation of pedestrians and cyclists from motor vehicles.
- Policies which promote moderate intensity exercise including: further provision of cycling and walking routes to school, and other environmental modifications aimed at the safe separation of pedestrians and cyclists from motor vehicles; and safer opportunities for leisure.

Smoking

- Further development of programmes to help women to give up smoking before or during pregnancy, and which are focused on the less well off.
- Policies to reduce tobacco smoking including: restricting smoking in public places; abolishing tobacco advertising and promotion; and community, mass media and educational initiatives.
- Increases in the real price of tobacco to discourage young people from becoming habitual smokers and to encourage adult smokers to quit. These increases should be introduced in tandem with policies to improve the living standards of low-income households and policies to help smokers in these households become and remain ex-smokers.
- Making nicotine replacement therapy available on prescription.

2.30 The Report's emphasis on areas outside the remit of the NHS that could reduce inequalities in health was welcomed³⁵. However, its recommendations were not costed, and the resource implications were not taken into account^{36,37,38}. Other comments made were that the recommendations were not clearly prioritised³⁵, and were thought to under-emphasise that inequalities in health are largely dictated by inequalities in wealth³⁶. The recommendations were seen as too vague, and did not specify how their aims would be achieved^{36,37}. It was not within the Inquiry's remit to produce targets, but it was felt that targets were needed if the general recommendations were to be turned into detailed operational plans³⁷.

Smoking Kills (1998)

2.31 The Government signalled a commitment to tackle the leading public health issue, smoking, with the publication in 1998 of the *Smoking Kills* White Paper, backed by a fairly modest investment of £100 million over three years. The strategy focused on three areas in particular:

- reducing the number of under 16s who smoke;
- helping adults, especially the disadvantaged, to stop smoking; and
- giving special support for pregnant women.

2.32 The White Paper highlighted strategies around the 8 key areas, proposing specific government initiatives, as well as presenting three new smoking targets by which to measure its success. However, the implementation of many of the strategies promoted within *Smoking Kills* has been patchy, as discussed in further detail in Chapter 4.

2.33 Since the publication of *Smoking Kills* similar topic based public health strategies have been developed around drugs³⁹, teenage pregnancy⁴⁰ and sexual health and HIV⁴¹.

Saving Lives: Our Healthier Nation (1999)

2.34 In 1999, the *Saving Lives: Our Healthier Nation* White Paper⁴² was published, building on the targets of the *Health of the Nation*. The main differences between *Our Healthier Nation* and the *Health of the Nation* were of the importance given to the role of inequalities in health⁴³ and the recognition in *Our Healthier Nation* that health depends on social and economic conditions, as well as the environment, lifestyle, access to services and genetic risk factors. The White Paper also signalled the establishment of the Health Development Agency (HDA).

³⁵ *Commentary on the Acheson Report*, Health Economics Editorial, A Williams, 1999

³⁶ *The Independent Inquiry into Inequalities is Welcome, but its recommendations are too cautious and too vague*, BMJ Editorial, G Davey-Smith et al., 1998

³⁷ *Better Benefits for Health: plan to implement the central recommendation of the Acheson Report*, D Black et al., 1999

³⁸ *The 39 Steps: the mystery of health inequalities in the UK*, Health Economics Editorial, S Birch, 1999

³⁹ *Tackling Drugs to Build a Better Britain, the Government's ten year strategy for tackling drug misuse*, DH, 1999

⁴⁰ *Teenage Pregnancy*, Social Exclusion Unit, 1999

⁴¹ *The National Strategy for Sexual Health and HIV*, DH, 2001

⁴² *Our Healthier Nation*, DH, 1999

⁴³ *Our Healthier Nation, Possibly*, R Horton, 1998

2.35 The aims of *Our Healthier Nation* were:

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness; and
- to improve the health of the worst off in society and to narrow the health gap.

2.36 Four priority areas were identified and targets to be achieved by 2010 were set:

- heart disease and stroke – target to reduce the death rate from coronary heart disease and stroke and related diseases in people under 75 by at least two fifths - saving up to 200,000 lives;
- accidents – target to reduce the death rate from accidents by at least a fifth and to reduce the rate of serious injury from accidents by at least a tenth – saving up to 12,000 lives;
- cancer – target to reduce the death rate from cancer in people under 75 by at least a fifth – saving up to 100,000 lives; and
- mental health – target to reduce the death rate from suicide and undetermined injury by at least a fifth – saving 4,000 lives.

2.37 Underlying these targets were less defined action points, which replaced the more explicit risk factors targets of *the Health of the Nation*.

2.38 The priority areas were similar to those of *the Health of the Nation*, apart from the exclusion of HIV/AIDS and sexual health, which was encompassed in a wider plan on public health along with drugs, alcohol, food safety, water fluoridation, communicable disease, genetics and the health of black and minority ethnic groups. In addition, physical activity was added to the CHD agenda.

The smaller number of national targets was presented as offering greater flexibility to focus on particular health problems and on health inequalities, while the broader nature of these targets was seen as offering additional challenges and opportunities compared to the strategies of the Health of the Nation. However, as with previous documents, analysis and presentation were expressed above specific actions and deliverability, without any specific allocation of funding for reducing health inequalities^{44,45}.

2.39 The White Paper used mostly mortality measures in its assessment of the disease related targets (possible due to little other data being available at the time), emphasised disease-based health care over wider public health concerns⁴⁶, and lacked plans for the implementation of its policies⁴⁴, with its rather vague action points. As a result, implementation has been patchy at best.

The NHS Plan for England (2000)

2.40 In July 2000 the *NHS Plan for England*⁴⁷ set out how the extra money announced in the Budget would be allocated and spent, based on a number of priorities identified through public consultation.

⁴⁴ *Our Healthier Nation: alpha for presentation, beta minus for deliverability*, JECH Editorial, R Maxwell, 1998

⁴⁵ *Inequalities in Health: the evidence*, D Gordon et al. (eds), 1999

⁴⁶ *Saving Lives or Sustaining the Public's Health?*, BMJ Editorial, N Fulop et al., 1999

⁴⁷ *NHS Plan for England*, DH, 2000

2.41 The majority of the document dealt with issues relating to improving healthcare rather than promoting better health *per se*, particularly with regard to increasing NHS staff numbers, improving NHS facilities, improving access and waiting times, setting standards and monitoring performance, linking health and social care, changing working practices, increasing choice for patients, increasing the role of the private and voluntary sector, and identifying clinical priorities. The National Institute for Clinical Excellence (NICE) and the Modernisation Agency were established.

2.42 Only the section on improving health and reducing inequality directly related to disease prevention and public health, focusing on children, smoking, diet and nutrition, drugs and alcohol, as well as developing partnerships with local authorities (LAs) and others. Measures outlined included expanding and reforming current programmes, fully implementing strategies, implementing and facilitating evidence-based interventions, and developing new partnerships with local services.

2.43 In addition, it set out as one of the main objectives of the Department of Health's Public Service Agreement (PSA):

Objective II: Improving health outcomes for everyone – Reduce substantially the mortality rates from major killers by 2010: from heart disease by at least 40 per cent in people under 75; from cancer by at least 20 per cent in people under 75; and from suicide and undetermined injury by at least 20 per cent.

2.44 However, in contrast with the specific and ambitious vision for the NHS, the NHS Plan offerings were scant for public health.

**National
Service
Frameworks
(since 1998)**

2.45 The *NHS Plan* announced that national standards should be set and matched with local inspections by an independent body. The National Service Frameworks (NSFs) would aim to set national standards and identify key interventions for a defined service or care group.

2.46 The NSFs examine the range of interventions shown to be effective, which might reasonably be expected to be achieved across the country, including public health measures. For example, in the CHD NSF⁴⁸, the first standard is that “the NHS and partner agencies should develop, implement and monitor policies that reduce the prevalence of coronary risk factors in the population, and reduce inequalities in risks of developing heart disease.” Effective policies are then listed (e.g. local smoking cessation services). The NSFs were costed, but this information was not published, and so there is no detailed information about the cost-effectiveness of interventions. Therefore, they do not allow for any prioritisation between primary prevention, secondary prevention, or care. Nor do they include comprehensive research programmes to enable them to be continually updated.

2.47 Since 1998, the areas covered by NSFs have included cancer, paediatric intensive care, mental health, coronary heart disease, older people and diabetes, while NSFs are being developed for children, renal services and long-term conditions focusing on neurological conditions.

⁴⁸ *National Service Framework for Coronary Heart Disease*, DH, 2000

Tackling Health Inequalities: Cross-Cutting Review (2002)

2.48 The cross-cutting review on health inequalities fed into the 2002 Spending Review (SR2002)⁴⁹. A summary of the Review *Tackling Health Inequalities: Summary of the 2002 Cross-Cutting Review* was published in November 2002. The Review aimed to develop the evidence base on health inequalities and to establish a strategy for delivery

2.49 As part of SR2002, a single target on health inequalities was announced: “By 2010 reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth”.

2.50 The interventions identified as most likely to have a major impact on the infant mortality component of the target were: Sure Start; reducing smoking in pregnancy; preventing teenage pregnancy; improving housing (for children in disadvantaged areas); and early intervention by the NHS (for example, immunisation; breastfeeding, improving diet etc). While for the life expectancy component of the target, interventions included: reducing smoking; prevention and effective management of other risks factors in primary care; environmental improvements; and targeting the over-50s.

2.51 No new funding was specifically allocated for reducing health inequalities, although health inequalities were reflected in the weighted capitation formula, which assessed need. However, the weighted capitation formula is heavily circumscribed by transitional arrangements, and submissions to the Review expressed concern that the formula does not adequately reflect population need for health care and preventative services.

A Programme for Action (2003)

2.52 The follow-up to the cross-cutting review was the delivery plan *Tackling Health Inequalities: A Programme for Action*⁵⁰ published in July 2003. This aimed to build on the *Acheson Report* and the *cross-cutting review* by setting out the policies being implemented that are designed to help to reduce health inequalities, as well as the indicators that can be used at a local level to monitor performance. The focus is on the broadest of public health measures – for example, preventing ill health, early interventions and addressing the underlying determinants of ill health. However, it is essentially a list of existing Government policies, rather than a strategic look at how best (and most cost-effectively) to reduce inequalities, see Chapter 4.

Wanless Report (2002)

2.53 The original Wanless Review *Securing our Future Health: Taking a Long-Term View* was published in April 2002. The main focus of the Review was to assess the financial and other resources that would be needed to provide a high quality health care system over the next twenty years, as set out in Chapter 1.

2.54 The Report suggested that success could not be ensured solely by spending additional resources but would be dependent on how resources are used. Perhaps for the first time, the Wanless Review illustrated and quantified, using scenario planning, the potential benefits of investing in a long-term public health strategy.

⁴⁹ *Tackling Health Inequalities: summary of the 2002 cross cutting review*. HM Treasury, DH, 2002

⁵⁰ *Tackling Health Inequalities: a programme for action*, DH, 2003

COMMON AND CURRENT THEMES OF PUBLIC HEALTH POLICY

Lifestyle Factors **2.55** Since the 1970s, and the *Lalonde Report*, lifestyle factors have been recognised as contributing to the major burdens on the health care service, as described in *Population Health Trends*. This recognition has been reflected in public health policy since the *Black Report*. It was viewed as a key element of the HON and *Our Healthier Nation* strategies, as well as being reflected in the *Acheson Report*, the NSFs, the *Cross-Cutting Review on health inequalities* and in a Department of Health initiative on 'Behavioural Epidemiology'⁵¹.

2.56 However, over time the view of the individual's relationship to these behavioural risk factors, such as smoking, diet, lack of exercise and alcohol consumption, has changed. The view in the 1970s and early 1980s was that individuals were responsible and to be blamed for their unhealthy behaviour; this has now evolved to consider the influence of socio-economic, environmental and cultural influences on behaviour, as well as individual responsibility, as discussed more fully in Chapter 7.

Life Course Approach **2.57** The life-course approach has come to encompass the theories that in utero and childhood experiences have a lifetime impact on health, and that habits and behaviours formed in childhood condition adult behaviour, such as eating patterns and exercise. The *Black Report* emphasised the need to give children a better start in life and the use of a life-course approach to public health has grown¹⁰. This was reflected in the *Acheson Report* and is one aspect involved in tackling health inequalities.

2.58 The life-course approach also allows policymakers and practitioners to articulate a framework for public health interventions concerned with the various settings (e.g. pre-school, school, work) and the transitions (e.g. leaving school, entering work, leaving work) individuals pass through⁵².

Health Inequalities **2.59** Health inequalities were brought to the fore in 1980 with the *Black Report*, but were largely ignored within the public policy arena until 1998 with the publication of the *Acheson Report*, during which time the UK had witnessed further widening in health inequalities. Tackling health inequalities is now seen as a key goal of Government, as *Our Healthier Nation*, the *NHS Plan*, the *Cross-Cutting Review*, the *Cancer Plan (NSF)* and the *Inequalities Programme for Action* all show.

Wider Determinants of Health **2.60** Public health policy has recognised the growing importance of the wider determinants of health and health inequalities, such as income, education, employment, housing, and the environment, as well as their effect on lifestyle. Highlighted in the *Black Report* and the *Acheson Report*, much of Government policy now seeks to address these issues that have traditionally been outside the health domain.

Targets **2.61** Target setting has become a key instrument of public health policy, stemming from WHO's targets. Public health related targets were introduced with the Health of the Nation strategy, then rationalised within the Our Health Nation and PSA targets, and are key to the current initiatives to tackle health inequalities. Targets have been used to focus current efforts to tackle specific issues and as a component of performance managing delivery, as well as articulating aspirational goals.

⁵¹ *Health Related Behaviour: an epidemiological overview*, DH, 1996

⁵² *Childhood Disadvantage and Adult Health: a life course framework*, H Graham and C Power, forthcoming

2.62 However, the use of targets has been criticised. They can result in priority being given to outcomes that can be easily measured, such as rates of illness and death, and not quality of life^{53,54}. In addition, they may skew local priorities, such as four-week smoking cessation targets, and may not lead to equity between different groups in society⁵⁴, when variations in health by geographical region, age, sex, socio-economic, or ethnic groups are not considered. Most importantly targets may be set at unattainable levels, and they can lead to inefficient use of resources when other important objectives are not explicitly targeted.

Evidence 2.63 Current Government policy has moved towards evidence-based policy with a philosophy of “what matters is what works”⁵⁵, confirming the central role of evidence in policymaking. Within the realm of public health, and partly echoing the evidence-based medicine agenda, *Our Healthier Nation* established the HDA. One of its roles was to build the evidence base in public health with a special emphasis on reducing inequalities in health, although not in terms of designing and applying a consistent cost-effectiveness framework to public health interventions. Such a framework is discussed in more detail in Chapter 6.

CONCLUSIONS

2.64 Since the 19th century, public health in England has evolved from being predominantly concerned with the prevention of communicable diseases to include the prevention of chronic diseases, although prevention of communicable diseases remains a vital part of public health and health protection has resurfaced as a major issue since September 11th 2001. With this evolution there has been a shift of emphasis towards the contribution of individual behaviour and lifestyle to disease, with programmes taking a population as well as an individual approach. This latter emphasis has also evolved to reflect the influence of socio-economic, environmental and cultural influences on behaviour.

2.65 Health inequalities have become increasingly important within public health, particularly since past and current public health approaches may have contributed to their widening across the socio-economic gradient, with higher rates of uptake and effectiveness in higher socio-economic groups, particular with interventions targeted at the individual level⁵⁶.

2.66 This evolution of the concept of public health has been reflected in health policy in England. Current health policy is articulated through the overarching *Our Healthier Nation White Paper* and the *NHS Plan*, which are underpinned by various public health strategies, such as *Smoking Kills*, and linked to specific NSFs (*the Cancer Plan*) and to cross-cutting issues, such as tackling health inequalities.

2.67 The major drivers of public health have been recognised since the 1970s. However, how to reduce the disease burden by prioritising and implementing effective public health interventions is not well articulated or understood, and needs to be strengthened and the existing evidence used more effectively, with agencies such as the HDA and NICE just beginning to build the evidence base for policy and practice.

⁵³ *What the Government Should Do?*, S Adams and S Hagard, 1991

⁵⁴ *The Use of Targets to Improve the Performance of Health Care Providers: a discussion of government policy*, R Elkan and J Robinson, 1998

⁵⁵ *Modernising Government Agenda*, TSO, 1999

⁵⁶ *Inequalities in Health, Cigarette smoking and inequalities in health*, H Graham, 1999

2.68 Numerous “upstream” and “downstream” public health strategies have been proposed. There have been some successes, but government has not always implemented fully much that has been proposed. Health policy has remained biased towards the “National Sickness Service”, and towards a medical model of avoiding ill health and disease, as reinforced by the *NHS Plan*, rather than maintaining and promoting good health and quality of life⁵⁷, as the case studies in Chapter 4 illustrate. Also, due to this NHS bias, the contribution of other sectors and agencies to the wider public health agenda has not been incorporated explicitly into health policy, and so policy has failed to engage fully these other stakeholders, although initiatives such as the Health Inequalities programme and the Food & Health Action Plan are beginning to engage them. So, in spite of numerous policy initiatives being directed toward public health, they have not resulted in a rebalancing of policy away from health care⁵⁷.

2.69 The House of Commons Select Committee on Health’s Second Report on Public Health⁵⁸ felt that a great opportunity to give public health a real impetus had been lost by the lack of emphasis on the area in the NHS Plan, meaning that in the race for resources, public health runs the risk of trailing well behind healthcare services. This seems to have been the case for a long time, with the failure to fully implement and prioritise many of the strategies promoted within the public health policy documents of the last 30 years.

2.70 There has been a continuing rise in demand for health related interventions, which has meant rising health care expenditure. This is projected to continue. Public health interventions need to be assessed as possibly the most effective means of reducing the future burden of mortality and morbidity. However, the evidence base for policymakers and practitioners is weak with respect to the differential effectiveness and relative cost-effectiveness of different interventions within and outside the remit of the NHS, particularly with respect to different populations groups or settings. The lack of an adequate cost-effectiveness framework for evaluating public health interventions and strategies has surely hindered the ability of public health professionals to raise public health’s profile within policy.

2.71 This Review has examined how investment decisions in public health are being made and then delivered through the current organisation of the public health function and through Government intervention, and by what mechanisms they could be made to maximise health outcomes for any given level of resources.

2.72 However, the growing public concern regarding issues such as obesity, children’s diet and smoking in public places seems to signal a change in the current climate for public health. This is a welcome and necessary step towards full engagement. In addition, the Department of Health’s forthcoming consultation period and Public Health White Paper indicates that the conclusions and recommendations of this Review will be addressed by government. It is vital that they are, and the Review therefore concentrates not on the multitude of specific proposals but rather on the frameworks and processes that are likely to encourage further action. If they are not, yet another opportunity to act will have been missed and the health services will continue to run faster and faster to stand still.

⁵⁷ *Public Health Policy*, D Hunter, 2003

⁵⁸ *Public Health, Second Report*, House of Commons Select Committee on Health, 2001