

Securing Good Health for the Whole Population

Final Report

Derek Wanless

February 2004

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"We are not tinkers who merely patch and mend what is broken... we must be watchmen, guardians of the life and the health of our generation, so that stronger and more able generations may come after"

Dr Elizabeth Blackwell (1821-1910), The First Woman Doctor

CONTENTS

	Page
Summary	3
Chapter 1 Introduction	11
Chapter 2 Public Health Policy in England: Lessons to be Learnt	23
Chapter 3 Delivery of Public Health	39
Chapter 4 Case Studies	77
Chapter 5 Public Health Evidence	107
Chapter 6 Investing in Public Health	123
Chapter 7 Roles and Responsibilities	149
Chapter 8 Government Levers	167
Chapter 9 Recommendations	183
Annex A Consultation	187
Annex B The Department of Health's Public Service Agreement	195
Annex C PSAs contributing to Health Inequalities Targets	197
Annex D Population Surveys	199
Annex E The Economics of Externalities	201
Annex F Glossary	205
Annex G Abbreviations	211

SUMMARY

REPORT TO THE PRIME MINISTER, THE SECRETARY OF STATE FOR HEALTH AND THE CHANCELLOR OF THE EXCHEQUER

BACKGROUND TO THE REVIEW

The 2002 report “Securing Our Future Health: Taking A Long-Term View” set out an assessment of the resources required to provide high-quality health services in the future. It was based on first catching up, and then keeping up with other developed countries, which had moved ahead of us over recent decades.

That report illustrated the considerable difference in expected cost depending upon how well our health services became more productive and how well people became fully engaged with their own health. Resources were needed not only to satisfy short-term objectives, particularly access to service, but also to invest in improving supply, by building the capacity of the workforce, improving information technology support and renewing premises, and to invest in reducing demand by enhancing the promotion of good health and disease prevention.

Many of the benefits of engaging people in living healthier lives occur in the long term but there are also immediate and short-term benefits when demand for health services can be reduced, especially in those areas such as acute services where capacity is seriously constrained.

This further review has been focused particularly on prevention and the wider determinants of health in England and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities. It was asked to consider consistency of current policy with the public health aspects of the “fully engaged” scenario outlined in the 2002 report. The definition of public health for this review has been drawn very widely; essentially it considers public health to 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.”

THE RECENT HISTORY OF PUBLIC HEALTH

This review commissioned a study looking at examples of approaches to public health in other countries. By and large, the key barriers to success overseas are similar to those identified in this report. Chapter 2 looks at the history of public health policy in recent decades. What is striking is that there has been so much written often covering similar ground and apparently sound, setting out the well-known major determinants of health, but rigorous implementation of identified solutions has often been sadly lacking.

There has also been limited assessment of the long-term impact on population health, and inequalities, of key policies such as agriculture or the built environment and this has led to situations difficult to resolve even in the longer term.

That said there have been considerable successes too. Protection against infectious diseases, often major killers in the past, has generally been very effective and remains a vital and successful part of public health. The initial HIV/AIDS campaign was a

powerful and positive case study and changes in behaviour such as seatbelt wearing have been effectively introduced and gained widespread acceptance.

The growing public concern about 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 first step towards public engagement. The announcement of the forthcoming consultation period and of a White Paper on Public Health suggests that the conclusions and recommendations of this Review will be addressed by Government. It is vital that they are and the Review therefore concentrates on the frameworks and processes, which are likely to encourage sustained action. If they are not, yet another opportunity to act will have been missed and the health care services will continue to run faster and faster to stand still.

WHO IS RESPONSIBLE AND WHAT SUPPORT IS NEEDED?

Individuals are ultimately responsible for their own and their children's health and it is the aggregate actions of individuals, which will ultimately be responsible for whether or not such an optimistic scenario as "fully engaged" unfolds. People need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make.

These failures include a lack of full information, the difficulty individuals have in considering fully the wider social costs of particular behaviours, engrained social attitudes not conducive to individuals pursuing healthy lifestyles and addictions. There are also significant inequalities related to individuals' poor lifestyles and they tend to be related to socio-economic and sometimes ethnic differences.

These failures need to be recognised. They can be tackled not only by individuals but by wide ranging action by health and care services, government – national and local, media, businesses, society at large, families and the voluntary and community sector. Collective action must however respect the individual's right to choose whether or not to be "fully engaged".

Shifting social norms is a legitimate activity for Government where it has set for the nation objectives for behaviour change. This may take time to achieve, may require careful judgement and it may at some stage be appropriately underpinned by regulation, for example the wearing of seatbelts. The main levers for Government action: taxes, subsidies, service provision, regulation and information are considered in detail in Chapter 8.

Actions should be based on sound principles and good practices such as those suggested in Chapter 7. A framework for assessing priorities is vital and it should help identify which economic instrument seems the most appropriate in each case. Interventions should tackle failures as directly as possible and should ensure total costs are kept to a minimum and are less than the expected discounted benefits. The overall distribution of the impacts of all interventions to address a particular failure should be considered. Individual programmes might worsen inequalities but still be very beneficial at the whole population level; they should be accompanied by campaigns adequately addressing the resulting inequalities. Individuals should balance their right to choose their own lifestyle against any adverse impacts their choices have on others.

To assist the full engagement of the population, advice should be available freely and in formats all find accessible, including the development of internet and telephone

services. The developing NHS Direct brand should be considered for expanded use in this way.

Annual communication about the state of the population's health and of the main determinants of health should be made available at national and local authority levels to encourage understanding. As would be standard practice in marketing any product or service to the public, part of the regular management process should be to obtain feedback from the population and important sub-groups about whether the messages being communicated about public health were being received and understood. Information should also be routinely collected about the acceptability to them of possibly controversial state interventions.

INFORMATION AND RESEARCH

The very poor information base has been a major disappointment as it was when writing the 2002 report. There is a need for significant and continuous improvement if evidence is going to be used to drive decisions. The lack of conclusive evidence for action should not, where there is serious risk to the nation's health, block action proportionate to that risk and, for example for infectious diseases and terrorist threats, a good deal of subjective and experienced judgement is needed.

But generally evidence-based principles still need to be established for public health expenditure decisions. Although there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation. Research in this area can be technically difficult and there is a lack of depth and expertise in the core disciplines. This, coupled with a lack of funding of public health intervention research and slower acceptance of economic perspectives within public health, all contribute to the dearth of evidence of cost-effectiveness. This has led to the introduction of a very wide range of initiatives, often with unclear objectives and little quantification of outcomes and it has meant it is difficult to sustain support for initiatives, even those which are successful. It is evident that a great deal more discipline is needed to ensure problems are clearly identified and tackled, that the multiple solutions frequently needed are sensibly co-ordinated and that lessons are learnt which feed back directly into policy.

The Review has considered (in Chapter 6) the appropriateness of different methods of economic evaluation. The economic evaluation of interventions in public health does not differ conceptually from the evaluation of other health care interventions. Nevertheless, the body of economic evidence relating to public health interventions is small in comparison to that related to health care. There are practical difficulties but they should be capable of being overcome to produce high quality, convincing evaluations of public health interventions. To achieve the objective of allocating funding more efficiently between health care and public health, it is vital that similar analytic methods are used for both. The National Institute for Clinical Excellence (NICE) has developed its methodology soundly since its establishment and use of its framework for rigorous evaluation of all interventions, covering health care and public health, offers a practical way forward.

Diabetes (Type 2) was investigated in detail to assist the search for conclusions about the management of chronic diseases and to suggest a framework for analysing their cost-effective management. Utilising a framework based on the NICE methodology, a number of interventions can be shown to be cost-effective, at less than £20,000 per quality adjusted life year (QALY), particularly around screening and secondary

prevention, many of which have already been implemented through National Service Frameworks and NICE recommendations. However, the weaker cost-effectiveness evidence base for primary prevention and self-care meant that comparisons with other interventions along the disease pathway were difficult to make.

Health data are essential for monitoring the health of the population and for evaluating the effects of health interventions. Yet the information collected nationally is often poor and there is no regular mechanism by which a Primary Care Trust (PCT) or local authority can gather reliable information on its own population. The information held about individual patients is not yet adequate to provide such local population information comprehensively.

However, there are opportunities to generate evidence from current public health practice, which has much potential for use as natural experiments. If evaluation became an explicit component of their implementation, it would inform the evidence base for public health. To improve understanding of prevalence of disease and to enable proactive management of personal risk factors, much greater use needs to be made of primary care data systems. The potential of the Electronic Patient Record and new General Medical Services (GMS) contract to begin to collect this type of information and use it to guide both national understanding and local activity must be fully realised. The Public Health White Paper should address the possible threat to public health research, which arises from the difficulty of obtaining access to data to assist the formulation of public policy.

TARGETS AND THEIR ACHIEVEMENT

In recent years, governments have set targets for many determinants of health where behaviour change has been considered desirable and of benefit as well as for the reduction of health inequalities. But those targets do not have comprehensive coverage and have not always met the requirements of stretching ambition and realism. The philosophies behind them have been inconsistent. So, the smoking targets set in 1998 could be considered unambitious while the obesity targets (1992) and the physical activity target (2002) seem highly aspirational. In none of these cases does the target setting process encourage a belief that resource management to achieve improvement will be optimal.

In spite of numerous policy initiatives being directed towards public health they have not succeeded in rebalancing health policy away from the short-term imperatives of health care. So it is not surprising to hear the view regularly expressed that we have a “National Sickness Service”, dealing, as a priority, indeed almost an exclusive focus, with an urgent need to improve short-term access and quality. As a result, public health practitioners generally seem to feel undervalued.

For such a complex organisation, seeking to achieve so many competing objectives, the focus of the NHS on narrowly based access targets has been a very blunt instrument. Unfortunately the same narrow use of targeting has been introduced to public health delivery with the setting of a target for the number of people quitting smoking for four weeks with the help of smoking cessation services. This has been followed up with targets for four week quitters centrally imposed on PCTs with a real danger of distorting local activity.

That is not, of course, to say that reducing smoking levels in England is not very important; it and obesity remain the most important lifestyle determinants of future health. “Fully engaged” was illustrated in the 2002 report by a reduction in smoking

levels significantly higher than the Government's existing target. In addition to an advertising ban and changes in warnings on cigarette packets, resources have been directed at advertising, at prescribing smoking patches and in appointing many local smoking cessation officers but it is impossible to judge if the resource committed is in any sense optimal. The evidence base has not kept pace with the effort and there are weaknesses in the monitoring of performance, the understanding of how much can justifiably be spent, where it should be directed, what workforce is needed to achieve the best possible results and how all the efforts should be co-ordinated. A commitment of adequate resource for monitoring and feedback should be an integral part of the planning of any national programmes to achieve change. If that had been done in the past, it is likely that the imbalance of expenditure on reducing smoking prevalence against the burden of disease associated with it would be less dramatic.

The forthcoming consultation period, ahead of the White Paper, should be used, *inter alia*, to seek the public's views about the acceptability of different ways of tackling smoking. There are a number of major areas for consideration; a workplace/public place ban, the need to take firmer action over smuggling and counterfeiting cigarettes and the possibility of allowing nicotine substitutes to be more widely available. It is evident from our recent lack of reasonable progress in reducing smoking and the damaging impact that this may have on achieving reductions in inequalities, that the benefits, which success from these firmer actions might produce, would be expensive to achieve by more conventional techniques of education and advice.

Chapter 4 also considers case studies on health inequalities, salt, obesity, falls and physical activity. They are not a comprehensive list of the key public health determinants, but illustrate important general points concerning the implementation of public health policy and practice. A comprehensive view would also consider the role of broader economic factors and other environmental determinants and would deal with issues of health protection including sexual behaviour and infections generally. But the examples considered already show that the Government does not currently have a comprehensive set of objectives for key lifestyle risk factors at the national and local level, and that there is often little evidence on how to reduce their burden.

With respect to health inequalities, targets were set for life expectancy and infant mortality. Although the life expectancy target is stretching, it could be achieved if the promising trend in reductions of coronary heart disease (CHD) and cancer continues but it also requires substantial progress to be made in the most disadvantaged areas. A limit to progress may be encountered if actions fail to target the hardest groups to reach. This is a real danger given that there is so little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities, such as smoking, or about the differential impact of interventions across the socio-economic gradient. In contrast, prospects for achieving the infant mortality target are less easy to assess: although key interventions have been identified, the target is difficult to measure, monitor and tackle at local level where numbers of deaths are often in single figures.

OBJECTIVE SETTING IN FUTURE

The setting of quantified national objectives for changing the prevalence of all the important determinants of health status for the medium and long term would help inform future resource planning projections and immediate decisions. A great deal of research, analytic thinking and consensus building is required to ensure these

objectives are carefully defined and the responsibilities for delivery are understood. They would also be a major input into local decisions. And it is locally that much of the activity needs to be planned and implemented by networks of local authorities, health organisations and community and voluntary groups.

It is recommended that the Government should seek advice about what the objectives for all major determinants of health should be and that these should be subdivided where appropriate to cover important groups within the population, for example by age, ethnicity or social class, particularly those key to achieving the inequality objectives. It is suggested that, for these determinants, it may be appropriate to set three year and seven year objectives and that they should be reassessed regularly, say a year before the three year period is up, in the light of their importance for future health care demands, performance being achieved at home and abroad, evidence of what is working and its cost-effectiveness. It is to be expected that some objectives would be reassessed upwards and others down but that all should be kept close to a trend which represents the best that we can do.

For example, smoking, obesity and physical activity objectives should all be reassessed immediately after the consultation period which is about to begin and the consultation should be used to gauge opinion as well as the desire of the public to tackle the issues. To represent steps towards full engagement, smoking prevalence objectives should be more ambitious than at present, an objective should be set to halt the rise in obesity now with a gathering pace of reductions planned for the medium-term while ambitious but realistic short and medium-term physical activity targets should replace the current aspiration. The new objectives should be fixed for 2007 and 2011. The White Paper should propose the plans to achieve them, detailed costings and research programmes and a structure for periodic reassessment of the objectives for all of the major determinants.

DELIVERY

While recent policy and activity has been directed at strengthening the public health role of the NHS and local government and facilitating partnership working to improve population health, difficulties remain in some areas due to capacity problems, the impact of recent organisational changes and the lack of alignment of performance management mechanisms between partners.

Much of the workload in the health services in achieving local objectives will fall on PCTs. They are relatively new and small bodies and they have a crucial role in ensuring the NHS delivers, particularly in commissioning and in driving behaviour changes in primary care. Each has a Director of Public Health and this is spreading existing resources very thinly, although there is a welcome move to broaden the skill base by introducing non-medical Specialists. PCTs will be vital in making the new primary care contracts work to best effect, including in public health. Given the newness of the structure and that repeated restructuring has tended to weaken the NHS over decades, structural change is not recommended but where it seems locally that the best way forward is to combine PCTs' forces to tackle public health that should not be discouraged. Similar considerations may well apply to their commissioning role but the need to drive behavioural change is an argument for their current size.

Where local authorities and PCTs are co-terminus and have begun pooling resources, for example making joint appointments in public health, the prospects for mobilising resources to tackle issues more forcibly seem better but the structure is too new for this

to be proven. Evidence should be collected quickly to show whether the expected benefits are materialising.

Recent years have seen significant growth in the number of “arm’s length bodies” established by Government to tackle particular issues. A review has been instigated by the Secretary of State to consider their future; that review extends beyond public health but the opportunity should be taken in the review to ensure that gaps in activity identified in this report are tackled. Responsibilities should be assigned for:

- developing the cost-effectiveness evidence base on public health;
- researching the practical effectiveness of current activities and interpreting findings for future implementation;
- the educational role, previously played by the Health Education Authority, which has not been picked up by any other body at a time when full engagement requires the public and the health workforce to have more support. There is no single easily accessible source of advice for interested or confused individuals;
- reassessing periodically our national objectives for all major determinants of health and health inequalities; and
- the regulation of nicotine and tobacco.

In addition, the efforts of arm’s length bodies should be co-ordinated at a local level (for example, the Health Development Agency, Public Health Observatories and Health Protection Agency) and their relationship with PCTs should be examined by the review.

One of the most important components of the “fully engaged” scenario was the assumption of increasing productivity gains. High productivity must also be a feature of public health activity and measures of productivity will be required in public health, as they are in health care services. Adequate workforce capacity will need to be created with appropriately broad skill mixes. Because more of the activity will be concerned with monitoring, interpreting data, identifying risk, educating people and motivating them to change behaviour, the required mix of skills will change. The role of self-care, the development of “the expert patient”, possibly playing a much greater role in assisting other patients, and the role of community pharmacists will also need to be developed to expand overall capacity in the increasingly important management of chronic conditions and take pressure off traditionally skilled people.

In the future, knowledge of genetics and of individual risk factors could have an increasing influence in successfully creating a “fully engaged” population through individualised health promotion and disease prevention. It is assumed that much of this development will take place in primary care, which will change greatly over the next decade if the health services are to move away from dealing predominantly with the sick. Information Management and Technology (IM&T) will be a massive driver of change and the big commitment which is being made to improved technology in the NHS will have, as part of its justification, the possibility of helping the identification of personalised risks from the information stored about the individual. In order to discover how quickly these changes might happen and to help find the evidence about the effectiveness of enhanced risk management, it is recommended that an experiment should be established across a range of primary care units to assess the benefits of additional resource in information systems, in monitoring risk, in varying degrees of

attention and in advisory services. The experiment should be directed towards areas of inequity, given that access to services there is a crucial issue, which must be resolved.

Primary care will not be the only support for individuals. Many organisations will play a part in engaging individuals in thinking about their future health. Employers may for example be able to create business cases for encouraging their employees to consider the mental and physical health risks they face. Some interesting examples were drawn to our attention. None were in the public sector. The NHS clearly should be thinking more about the health of its employees and should pilot exercises to see what benefits it can obtain from taking action to improve their health. Reduced absenteeism and better productivity and staff morale would all be valuable for an organisation under continuing pressure. In keeping with the need to devolve activity to local level, PCTs and Strategic Health Authorities (SHAs) should be encouraged to experiment and lessons should be learnt and disseminated.

Our health services must evolve from dealing with acute problems through more effective control of chronic conditions to promoting the maintenance of good health. This will need to be fully taken into account when resource allocation formulae are revised. The implications for total government spending of these significant shifts in emphasis, which will be reinforced by this Review, cannot be estimated at this stage. My 2002 Report illustrated the potential long-term benefits. While there are areas in which more resources will be required, for example in research and in experimenting with new ways of working, it is also expected that there will be areas where better information will show that adequate value is not being achieved by current spending. In 2002, I recommended a full review after five years incorporating both health and social care. That recommendation remains appropriate as the benefits of a fuller information base and further research become clearer. There is an important role for social care in minimising demand for health care.

I have concluded that all the activity underway could well put us on course for the solid progress scenario but the efficiency of the spending being incurred needs to be kept under close review. A step change will be required to move us on to a fully engaged path. In practice, full engagement will mean achieving the best outcomes that individuals in aggregate are willing to achieve with strong leadership and sound organisation of all the many efforts being made to help them. The main recommendations of this Review are brought together in Chapter 9. They are designed to ensure that, in future, the necessary and justifiable support will be there. They set out the work needed to learn how support can be better provided, and to help find the answers to the many practical questions still unanswered.



Derek Wanless
February 2004