Executive Summary

The Health of the Nation – a policy assessed

Two reports commissioned for the Department of Health from the Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine
1.0 BACKGROUND

1.1 From 1992 to 1997, the Health of the Nation (HOTN) strategy was the central plank of health policy in England and formed the context for the planning of services provided by the NHS. Its importance lay in the fact that it represented the first explicit attempt by government to provide a strategic approach to improving the overall health of the population.

1.2 The HOTN focused on five key areas: coronary heart disease and stroke; cancer; mental illness; HIV/AIDS and sexual health; and accidents. Each had a statement of main objectives attached to it, together with twenty-seven targets across the areas.

1.3 This review of the HOTN, commissioned by the Department of Health, is designed to identify its achievements, failures, limitations and those elements that appeared to be working well and those where there was demonstrable room for improvement.

1.4 The fieldwork, conducted between September 1997 and March 1998, was undertaken by two teams, one working jointly between the Nuffield Institute for Health at Leeds University and the Welsh Institute for Health and Social Care at the University of Glamorgan, and the other from the London School of Hygiene and Tropical Medicine. The disciplinary skills available ranged across health policy, public health, finance, health economics and management.

1.5 Sixteen health authorities and related agencies were chosen at random, representative of all levels of population deprivation and NHS health regions, with some examples also being selected by the Leeds/Glamorgan group, using “soft” intelligence of authorities with different degrees of established joint working.

1.6 Over 250 semi-structured interviews on an individual and group basis were undertaken, and in excess of 400 relevant documents scrutinised.

2.0 PRINCIPAL FINDINGS

General

2.1 The HOTN was widely welcomed - it was the first attempt to put in place a national health strategy based on WHO’s Health for All. It had an important symbolic role. Many of those interviewed were committed to intersectoral work and recognised its potential benefit in bringing about health improvements. The HOTN was perceived as increasing prevention activity overall particularly in relation to the key areas and alliance work.

2.2 The HOTN failed over its five year lifespan to realise its full potential and was handicapped from the outset by numerous flaws of both a conceptual and process-type nature. Its impact on policy documents peaked as early as 1993; and, by 1997, its impact on local policymaking was negligible. It wasn’t seen to count while other priorities, for example waiting lists and balancing the books, took precedence.

2.3 The HOTN was regarded as a Department of Health initiative which lacked cross-departmental commitment and ownership. At local level, it was seen as principally a health service document and lacked local government ownership. Interviewees would have liked central government to take a stronger role in improving health and to avoid conflicts between policies of different government departments. Shared ownership, therefore, at all levels, both horizontally and vertically, was stressed as essential for success.

Within the NHS

2.4 The HOTN did not change significantly the perspective and behaviour of health authorities, and did not fundamentally alter the context within which dialogue between health purchasers and providers and other partners took place.
2.5 The HOTN did not cause a major readjustment in investment priorities by health authorities. But per capita and health promotion expenditure as a proportion of total NHS spend for both “narrow” and “broad” measures of health promotion showed a slight increase over the study period to a peak in 1994/5, with a gradual tailing off. However, the HOTN was perceived as enabling health promotion efforts to be prioritised and helping to improve co-ordination. Overall, no relationship could be seen between resource use and outcomes, and there was no evidence of a cost benefit approach having been adopted.

2.6 The HOTN reinforced the changing role of health authorities, providing a framework within which the commissioning role was to be judged.

2.7 Where attempts were made to drive progress via the contracting process the results were minimal. The impact upon Trust and primary care teams’ performance was slight.

2.8 The HOTN did not seriously impact upon primary care practitioners, either as commissioners or providers. General Practitioners tended to focus on the health promotion aspects of their contracts alone, and gave little priority to strategic action for health beyond this.

2.9 Community Trusts appear to have been most engaged via involvement in community development activities and health promotion programmes, focusing on the key areas and involving alliances outside the NHS. Acute Trusts were largely untouched by the health strategy. The HOTN was seen as relevant only where it enabled pre-existing agendas to be furthered and/or as a source of new funds.

2.10 Continual organisational turbulence and resulting staff turnover were perceived as frequently disrupting management teams, working alliances and HOTN implementation. It also contributed to lapses of corporate memory which hindered consistent data collection and recollection of events by interviewees.

Joint Working

2.11 Pre-existing structures and challenges heavily influenced the starting point for joint working. For example, where local government had responded to WHO’s Health for All initiative and had formed relationships with health authorities, there was already joint machinery upon which to build. In these circumstances, the HOTN had been possibly unhelpful. Where no such activity existed, the HOTN provided a suitable spur to joint action. The amount of money invested by health authorities to create alliances ranged from £2,000 to £200,000, most normally in the lower part of the range.

2.12 The different agendas/drivers and cultures of health services and local government were complicating factors. Health authority respondents found it difficult to develop relations with local authorities where they contained strong, independent directorates; and the more political nature of local government and its different complexions made for inconsistent alliances for health promotion activities. Deprivation within an area, however, was often perceived as a mobilizing factor.

2.13 Local authorities, in general, perceived the HOTN to be dominated by a disease-based approach and heavily “medically led”. This was a cause for concern among those local authorities which believed that they contributed more to a health agenda, in its broadest sense, than health authorities.

Targeting and Performance Management

2.14 National targets were a useful rallying point, but the encouragement to develop local targets would have been welcomed within the national framework as a reflection of local needs.

2.15 Approaches to the translation of national targets to local level varied considerably. There was a general wish for greater freedom both to add target areas to the menu and to adjust
targets in the light of local circumstances. There was criticism of the targets on technical grounds, particularly the one on suicide reduction.

2.16 The performance management process was heavily geared to short-term outputs, largely driven by the Efficiency Index/Patient's Charter/financial management agendas, and there was no extant performance management for strategic development and achievements for health as opposed to health services.

2.17 Lack of management guidance and incentives at local level were seen to be major failings of the HOTN. Local agencies did not have their roles, tasks and responsibilities clearly spelt out, with a timetable to ensure that agreed targets or milestones were met.

2.18 Strengthening the institutional capacity to deliver on the health strategy was seen to be an unmet priority.

3.0 POINTERS FOR THE NEW PUBLIC HEALTH STRATEGY

Greater success is likely with integrated central leadership and committed local ownership.

Government needs to:

1. send out clear, consistent "corporate" signals and ensure cross-departmental ownership

1. develop an integrated framework for new initiatives, eg HAZs, HIPs, HLCs, SRB, Agenda 21 etc, thereby addressing effectively the underlying determinants of ill-health

1. establish shared ownership, horizontally and vertically, with a statutory framework and accountability, and widen ownership outside the NHS

1. spell out agency expectations, tasks and responsibilities

1. give consideration to a joint lead role locally between health and local authorities

1. encourage a wide range of programme approaches at the local level

Building and sustaining local intersectoral partnerships and alliances will be important.

There is need:

1. to develop and use a matrix approach involving diseases, population groups and community settings

1. for a development strategy to equip managers and practitioners with the requisite skills and competences

1. to acknowledge and take into account the different cultures in health and local authorities
Without the requirement for substantial performance management, particularly at local level, a new public health programme’s chances of success will be reduced significantly.

There is need to:

1. require the development of local strategies and targets, together with a timetable, involving health and local authorities and the voluntary sector
2. hold each group responsible for its contributions - both process and outcomes
3. make public health part of the core business, by embedding it in the organisational culture
4. consider instituting regular and independent policy audit, to include a cost-benefit approach
5. consider a new role for the HEA in strengthening the performance infrastructure
6. keep the public health function under regular review
7. include Our Healthier Nation in the new Performance Management Framework, with measures of process as well as outcomes.

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<th>to use existing evidence on alliance-building</th>
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<td>to involve all key stakeholders and to include the public through the voluntary sector and other means</td>
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Developing the evidence base for both target setting and other implementation activities should be a key priority.

There is need to consider:

1. the further development of evidence-based targets
2. mechanisms for the dissemination of evidence in respect of public health interventions to the NHS, local government and the voluntary sector
3. local target setting using the evidence base
4. re-examination of the inclusion of the suicide target, or the addition of items stressing measures of well-being
5. new approaches to implementation which combine individual lifestyle change and community development
6. strengthening the public health information and intelligence function to operate widely across health and local authorities
7. setting up new data capture mechanisms, including relating resource use to outcome, for future evaluation purposes
The reference details for the full report are:
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