From “Health of the Nation” to “Our Healthier Nation”

David J. Hunter, Naomi Fulop, Morton Warner

Policy Learning Curve Series, Number 2
August, 2000
EUROPEAN HEALTH21 TARGET 2

EQUITY IN HEALTH

By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 21

POLICIES AND STRATEGIES FOR HEALTH FOR ALL

By the year 2010, all Member States should have and be implementing policies for health for all at country, regional and local levels, supported by appropriate institutional infrastructures, managerial processes and innovative leadership

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

Keywords

HEALTH PLANNING
STRATEGIC PLANNING
PUBLIC HEALTH
HEALTH POLICY
FORECASTING
UNITED KINGDOM

Cover design: Manfred Frank

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As far as possible, these developments are described by those who were active participants in the process. This will allow readers to gain insight into the policy environment in which they took place, the motivation behind such processes, and the experiences of some of the major stakeholders.

We believe that, in this way, policy-makers and students of policy development across Europe will have easy access to emerging developments, or thoughtful analyses of past events that have shaped policies for health. By sharing this experience, we trust that the capacity to assess what might work or not work in other countries or regions will be strengthened.

The aim is to go beyond the rather narrow circle of people who read scientific articles on policy development, to reach those who actually take the decisions to make policy happen. Authors have therefore been requested to present up-to-date information on and insight into health policy development processes based on available evidence and experience, without the formal demands of a scientific article, but to provide core references to potential further reading.

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David J. Hunter ¹, Naomi Fulop², and Morton Warner³

Introduction

Many governments around the world, including the United Kingdom government, are turning their attention from an exclusive focus on health care systems to the wider social and economic determinants of health. They are beginning to realise that simply concentrating on downstream acute interventions through health care systems is insufficient as an effective policy response to mounting evidence of a growing ‘health gap’ between rich and poor. According to the OECD, the gap is perhaps widest in the UK with around 20 per cent of the population having experienced long term poverty over the last 17 years or so. The gap is still growing despite the election of a Labour government in 1997 committed to narrowing it (1). Indeed, the government has embarked on one of the most ambitious social engineering programmes witnessed in recent times by any government anywhere. It claims it is serious about tackling deep-seated inequalities through a variety of mechanisms that go far beyond simply throwing money at the problem.

Some of the approaches being adopted, like Health Action Zones (HAZs), are of a structural type. There are 26 HAZs in England which are intended to promote partnership working and provide innovative solutions to health problems. Health Improvement Programmes are another mechanism aimed at devising local strategies which combine a focus on population health with improvements in health care services and bring together health service

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organisations and local authorities whose activities contribute significantly to the health of local populations.

Part of the government’s social exclusion agenda involves getting to grips with health inequalities. Central to this task is the government’s health strategy unveiled in July 1999 following the production of a consultation document in February 1998. Before it launched its new strategy, the work primarily of the first ever Minister for Public Health, the government commissioned two studies to assist it. First, it funded an independent evaluation of the impact of the previous health strategy, *The Health of the Nation (HOTN)*, produced in 1992 (2). *HOTN* had run into problems and had been criticised by the National Audit Office, the body charged by Parliament to scrutinise government spending, among others. Before embarking on its own strategy, the government wanted to learn the lessons from the experience of implementing the first health strategy in England (3). The second study involved inviting a former Chief Medical Officer, Sir Donald Acheson, to review the scientific evidence in reducing inequalities in health in order to inform future policy and recommend priority areas for action (4).

The successor health strategy to *HOTN*, entitled *Saving Lives: Our Healthier Nation* (5), acknowledged the contribution of the evaluation of the first health strategy and shows evidence of having absorbed at least some of the lessons. It also acknowledged the role of social, economic, and environmental factors in influencing population health and inequalities in health and confirmed the government’s commitment to ‘improve the health of everyone, and the health of the worst off in particular’ (6).

In this policy case study, we review the assessment of *HOTN* and present the main findings. We then compare what we found in respect of the *HOTN* with the new strategy and the initial steps being taken to implement it. We comment on the improvements over the first strategy and also on remaining problems or challenges. Finally, we look ahead to what future policy may hold.

Events are moving swiftly. Following the government’s commitment in its March budget to allocating significant additional resources for the NHS, six modernisation action teams were established to consider how the resources might best be used. One of the teams covered prevention and inequalities although, given the considerable policy work already completed on the public’s health and on health inequalities, it was difficult to see what this team could do that had not already been done (7). The work of these teams culminated in a national plan for the NHS published in late July (8).

The plan is principally concerned with problems concerning the delivery of health care services and secondary care interventions but it includes a chapter on improving health and reducing inequality. The plan notes that the life expectancy of a boy born into the bottom social class is over nine years less than a boy born into the most affluent social class. While emphasising the
importance of dealing with the fundamental causes of health inequalities, the plan is concerned with the NHS’s role in prevention and in working in partnership with other agencies to tackle the causes of ill health so as to reduce health inequalities. Where the plan extends rather than simply rehearses existing policy, is in the area of target-setting. Whereas the health strategy had resisted setting a national inequalities target, encouraging instead the formulation of local targets, the NHS plan will develop national inequalities targets.

1. History of Health of the Nation evaluation

The Health of the Nation strategy (HOTN) launched in 1992 was the first attempt by a British government to develop a strategy explicitly to improve the health of the population of England. Based on the WHO's Health For All strategy and similar developments in the US, its overall aim was ‘to add life to years and add years to life’ (9), (10). The strategy focused on five key areas: coronary heart disease and stroke, cancers, mental health, sexual health, and the prevention of accidents. These areas were selected following publication of a consultation paper in 1991 (11). The five key areas were chosen for the following reasons: they are major causes of premature death or avoidable ill health; effective interventions were thought possible; and it was possible to set objectives and targets in the areas and monitor progress towards them. Twenty-seven targets were set across these key areas. Examples of targets are shown in Box 1.

Box 1: Examples of Health of the Nation targets

- To reduce the rates of CHD and stroke in under 65s by at least 40% by year 2000
- To reduce death rate for lung cancer by 75 by at least 30% in men & 15% in women by 2010
- To reduce overall suicide rate by at least 15% by year 2000
- To reduce rate of conceptions amongst under 16s by at least 50% by year 2000
- To reduce death rate for accidents for under 15s by at least 33% by 2005

The HOTN strategy sought to widen the responsibility for health, and this emphasis was reflected in the Ministerial Committee set up to oversee the development, implementation and monitoring of the strategy. The Committee, chaired by a senior cabinet minister (Lord President of the Council), was comprised of ministers or junior ministers from 12 government departments, including health, social security, employment, and the environment (those from home affairs, transport and education were to receive papers and invited to attend as appropriate). There is no evidence that this Committee ever met (12).
The Committee was supported by three Working Groups which focused on the public health dimensions of HOTN; the monitoring and review of progress towards the achievement of targets; and the contribution of the NHS to the implementation of HOTN. At the local level, health authorities were given the responsibility for co-ordination and implementation of the strategy through alliances with other organisations such as local authorities, voluntary agencies, and the private sector.

The strategy was broadly welcomed on the grounds that the emergence of an explicit national health strategy marked a significant turning point in shifting the emphasis in health policy from health care to health. However, it was criticised for not taking into account the socio-economic determinants of health, and the strategy and targets were criticised for following mainly a disease-based model. The different views have been summarised as follows:

‘for some it was a bold initiative, setting out specific health targets for cutting mortality from the major causes of death and reducing risk factors across a range of illnesses and diseases. For others, [it] side-stepped issues such as the need to tackle poverty and deal effectively with equity’ (13).

The UK Faculty of Public Health Medicine was reported as wanting the targets and activities to focus on the factors that lead to ill-health – smoking, poverty, and inadequate housing, for example, rather than on the disease and conditions that resulted (14).

There was also some controversy about how the targets had been set. Some argued that targets such as those for CHD and stroke were set too low as rates were already decreasing in line with the target set. Progress towards targets has been mixed – three targets have gone in the opposite direction: obesity, teenage pregnancies and smoking among young people.

Following the election of a Labour Government in May 1997 and the appointment of the first ever Minister for Public Health, the government announced its intention in a speech by the new Minister to launch a new strategy, Our Healthier Nation (15). This new strategy was to be based on a very different philosophy from the previous one, that is, it would explicitly accept and aim to address the underlying causes of health and disease, and the inequalities in health which result. Whereas under the previous government the term ‘inequalities’ was not used in official publications – the term ‘variations’ was reluctantly adopted later on (16) – under the new Labour government inequalities in health were to be specifically addressed.

Proposals for the new strategy were set out in a ‘green’ (consultation paper) in February 1998 (17). During this time the Department of Health commissioned a review of the existing HOTN strategy. While progress towards the targets had been assessed, the HOTN strategy as a means by which central government could influence national and local policy had not yet been evaluated. Two university research teams were separately commissioned to
review the HOTN strategy – one from the London School of Hygiene and Tropical Medicine, and the other a joint team from the Nuffield Institute for Health at the University of Leeds and the Welsh Institute for Health and Social Care at the University of Glamorgan. The purpose of the review was to assess the implementation of HOTN locally and draw out lessons for the development of the new strategy, Our Healthier Nation.

The results of the two studies were presented to the Minister for Public Health and civil servants writing the new strategy, and were published in a single volume by the Department of Health (18). An accompanying summary identified the key findings from the two studies. In this briefing paper, the methods, findings and implications of the two studies for future policy are presented jointly.

1.1 Methods for assessing Health of the Nation

The two research studies between them conducted 16 case studies, two from each health region in England. Over 250 interviews were conducted on an individual and group basis with key actors in health authorities, local authorities, providers, general practices, patient representatives, the voluntary and private sectors, and the police. Over 400 documents were analysed, including annual public health reports and purchasing plans. In eight health authorities, an analysis of expenditure was also carried out to determine what impact, if any, HOTN had on resource allocation. Fieldwork was carried out between September 1997 and March 1998. The final report was submitted in July 1998 and was subsequently published in November 1998.

2. Lessons from Health of the Nation for Our Healthier Nation

Both research studies found that the HOTN strategy was widely welcomed and that it had an important symbolic role. The lessons for the new strategy - presented to the Minister for Public Health and civil servants during the consultation period - can be summarised as follows:

2.1 Role of central government

Central government has a key role in ensuring that there is a consistent message across government in support of the health strategy and in fostering the development and dissemination of an evidence-base for public health.

The research found that those implementing the strategy at local level need to feel supported by central government in terms of national policies that are consistent with the strategy. It is difficult to maintain momentum and enthusiasm for the strategy at local level if national policies are in conflict with it. For example, at the time the research was conducted it was felt that the
government was not taking a sufficiently firm line on tobacco advertising and sponsorship.

2.2 Underlying philosophy

The new strategy needs to address directly the underlying social and structural determinants of health and health inequalities. A major criticism of HOTN, confirmed by the two studies, was that it failed to address these. This acted as a barrier to implementation at the local level because the strategy had less credibility, particularly with some local authority and voluntary sector partners. Using a matrix model, such as that proposed by the European Commission (see Figure 1), has many advantages and enables consideration of both disease and population-based models of health.

Figure 1. Matrix working

![Matrix working diagram]

Source: European Commission

2.3 Responsibility for the strategy

The studies found that there is an unresolved issue about where responsibility for a national public health strategy should rest. There is a powerful argument, expressed by the Local Government Association – a national body
representing the views of local authorities - among others, that the Department of Health and health authorities should not be the lead agencies as they have a strong tendency to focus on health care rather than longer-term health concerns (19). Some respondents in the research studies, including those from the health, local government and voluntary sectors, suggested that responsibility for public health should rest with local authorities.

2.4 Targets

Both studies found widespread support for targets as a helpful way to prioritise and focus efforts. However, there are a number of lessons to be drawn from the review of the implementation of HOTN:

- National targets must be credible, i.e. based on sound and convincing evidence
- The development of local targets needs to be encouraged
- Process targets should supplement outcomes locally and nationally.

As mentioned above, a key lesson is that the new strategy should not adopt a purely disease-based model as a basis for setting targets.

2.5 Ownership and communication

The new strategy needs to be communicated widely – to broaden ownership outside the National Health Service, and include the public. The research studies found that in many areas there was a lack of ownership of HOTN amongst agencies other than district health authorities.

2.6 Sustaining the strategy

To sustain momentum and ensure effective implementation, the strategy must be embedded in the performance management framework for health and local authorities. Health authority chief executives and other senior managers should be judged on their performance on implementing the new health strategy as well as on their ability to manage the performance of a hospital or health care facility. Further, consideration should be given to the provision of earmarked funding (that is, funding allocated to this specific purpose) for the implementation of the new strategy in order to give priority to this activity.

2.7 Encouraging partnerships

There is a need for a statutory framework to encourage key local agencies, particularly local government, to work in partnerships for health. Other incentives for partnerships should be considered to support the commitment
of individuals and both statutory and non-statutory sector organisations necessary for implementation.

It will be important to increase the role of key stakeholders, in particular the public, the private sector and those working in primary care. General Practitioners’ lack of involvement with HOTN raises important concerns about their ability to fulfil their responsibilities for population health promotion in Primary Care Groups and, increasingly, Primary Care Trusts.

3. The New Health Strategy - Saving Lives: Our Healthier Nation

The new health strategy, Saving Lives: Our Healthier Nation, was published in July 1999 (20), some 14 fourteen months after publication of the consultation document. During the long period between publication of the two documents, there was speculation concerning the government’s commitment to the new strategy. However, when it was finally published the prime minister had contributed the foreword and 12 ministers had signed the preface – important symbols of the relative significance of the health strategy and a measure of the importance the government attached to cross-departmental working, or ‘joined up’ government. In the period between the publication of the consultation document and the final policy statement, a number of changes were made to the strategy, not least the addition of Saving Lives in the title. This, and the headline target to prevent 300,000 deaths and the proposal to introduce defibrillators in public places appeared to some to emphasise downstream, disease-based health care over wider, upstream public health concerns (21).

The new strategy has two key aims: to increase length of life and number of years free from illness; and to improve the health of the worst off in society at a faster rate than for other groups, and narrow the health gap. Like the previous strategy, Our Healthier Nation focuses mainly on disease-based areas, despite criticism from many quarters and the findings of the review of the HOTN strategy. Our Healthier Nation focuses on four key areas: CHD/stroke, cancer, mental health, and accidents. Justification for these areas is that they are the ‘four main killers’ which ‘play the greatest part in causing preventable deaths and ill health’. These four key areas are the same as those in the HOTN strategy – the key area of sexual health has been removed from the health strategy and tackled in a different way4.(22)

3.1 Targets

In the new strategy, the government has moved away from the previous approach of what it describes as ‘too many, poorly focused priorities’.

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4 Following a report by the Social Exclusion Unit (based in the Cabinet Office) on teenage pregnancies, a separate strategy has been developed, including a target to halve conception rates among the under 18s in England by 2010. The strategy is being implemented under the direction of a newly-appointed senior civil servant working with the Minister for Public Health.
Whereas the *HOTN* strategy included 27 targets the new one has just four. They are:

By 2010:
- To reduce the death rate in cancer in people under 75 by at least one-fifth (saving 100,000 lives)
- To reduce the death rates from CHD and stroke and related diseases in people under 75 by at least two-fifths (saving 200,000 lives)
- To reduce the death rate from accidents by at least one fifth and to reduce the rate of serious injury from accidents by at least one tenth (saving 12,000 lives)
- To reduce the death rate from suicide and undetermined injury by at least one fifth (saving 4,000 lives).

These targets were made more challenging between publication of the consultation document and final policy statement. For example, reductions to serious injury as well as deaths were added to the targets for accidents, and targets for cancer and CHD/stroke now included those under 75 not just those under 65 years of age.

The strategy sets out a ‘national contract’ by which these targets are to be achieved. This three-way partnership between individuals, communities and government is needed, the government argues, to improve health and tackle health inequalities. For each target, the responsibilities of each partner are set out. Under the national contract for cancer, for example, individuals can ‘give [people] help to give up smoking’; communities can ‘through local employers, make smoke-free environments the norm’; and the government and national players can ‘end advertising and the promotion of cigarettes’. To some extent, this indicates a move away from the sole emphasis on individual responsibility for health which characterised the philosophy behind the *HOTN* strategy.

### 3.2 Inequalities, *Our Healthier Nation*, and the Acheson Inquiry

In contrast to the previous health strategy there is a significant emphasis on reducing inequalities in health and the underlying social and economic causes of these inequalities. However, the government backed off including a national target to reduce inequalities fearing that this would be too much of a hostage to, particularly economic, fortune. The government argues in the strategy that ‘many of the underlying causes will take a generation or more to work through’. The absence of a target to reduce health inequalities has been criticised by those who argue it has important symbolic significance and other health strategies, notably the WHO European Region’s *Health 21* targets, to which the UK is a signatory, has included such a target (23).
At the same time as it commissioned the two research studies on the HOTN strategy reported above, the government also invited Sir Donald Acheson, a former Chief Medical Officer for England, to conduct an independent inquiry into inequalities in health ‘to review the position and identify the most critical areas to tackle’. The report from the inquiry, published in November 1998 (24) echoed findings from the 1980 Black Report ‘that the gap in inequalities in health has been steadily increasing and that differences in material deprivation are a major cause of the increase’ (25). The report contained 39 wide-ranging recommendations covering tax and benefits, education, employment, housing, the environment, and transport. As the inquiry was expected to keep ‘within the broad framework of the government’s overall financial strategy’ (26), policies, particularly those concerning benefits, were not specified or costed (27).

The government published its response to the Acheson Inquiry on the same day it published Saving Lives: Our Healthier Nation (28). The response describes in detail government policies which address each of Acheson’s recommendations including, for example, increase to benefits for families with children, funds for regeneration of deprived neighbourhoods, funds to reduce homelessness, and public health policies such as the development of Health Action Zones (see section 5 below). While those campaigning on health inequalities welcome many of these policies, many argue that they do not go far enough. Furthermore, it remains to be seen whether the cross-government action, to which the government is committed at all levels, will reduce health inequalities (29).

As mentioned in the introduction, the government’s 10 year National Health Service plan goes further than the health strategy and promises the creation of national health inequalities targets. These will seek to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country. Specific targets are to be devised in consultation with the key interest groups. They will be delivered by a combination of specific NHS policies and broader government policies, including abolishing child poverty, and action on cancer and coronary heart disease.

The plan also mentions the development by 2002 of a new health poverty index that will combine data about health status, access to health services, uptake of preventive services and the opportunities to pursue and maintain good health.

3.3 Other public health initiatives

The health strategy, Saving Lives: Our Healthier Nation, proposed several major new public health initiatives to strengthen the public health function. The Health Education Authority (HEA) has been replaced by a Health Development Agency which will review the evidence on public health interventions to determine their effectiveness (see further section 5 below).
The government decided to replace the HEA because it wanted an organisation more closely aligned with its policy stance and equipped with the skills both to assess the evidence concerning public health interventions and to ensure that the evidence was applied in practice.

In addition, a public health development fund and regional public health observatories to monitor progress on reducing health inequalities have been introduced. The specialty of public health is to be opened up to those without medical training, and there will be a national development plan for public health staff such as health visitors, midwives and school nurses.

The NHS plan states that by 2002 there will be new single, integrated public health groups across the various regional organisations to enable the regeneration of regions to embrace health as well as environment, transport and inward investment.

3.4 Learning the lessons

There is much to be welcomed in the health strategy and in the references to health in the NHS plan. Some of the views expressed during the preceding consultation period have been taken on board, and some account taken of the findings of the two studies reported earlier which reviewed the previous strategy. In particular, the focus on the underlying causes of ill health and reducing health inequalities marks a substantial change in direction. The new targets have taken into account the calls for greater emphasis on health in later life. But the priority areas and targets remain primarily disease-based. Our review of the HOTN strategy found that the predominance of the medical model underlying the strategy was a major barrier to its ownership by agencies outside the health sector, notably local government and voluntary agencies. However, the new specialist in public health post, equivalent to a senior doctor and open to a range of disciplines, rightly recognises the multi-disciplinary nature of public health.

The proposals to strengthen research and development in public health are an important advance – the new Health Development Agency will provide a much-needed evidence base for the new strategy by producing guidelines for health promotion programmes and evaluating and disseminating research on public health (see further section 5 below).

The strategy has not, however, challenged the basic premise that the responsibility for public health should lie with the Department of Health and local health authorities. There is an argument that local government rather than health authorities should have the lead role for the local implementation of a national public health strategy. But the government wishes to retain a lead role for the NHS with, for instance, responsibility for Health Improvement Programmes (see section 5 below) remaining with health authorities. Implementation of Saving Lives will be monitored through separate performance assessment arrangements for the NHS and local government.
Though welcome, it leaves open the question of how joint action is to be monitored. The lack of effective monitoring of the HOTN was one of the principal weaknesses uncovered by the evaluation of the strategy.

Further, the new strategy has not taken on board the lessons from the review of the previous strategy that specific funds need to be made available to ‘oil the wheels’ of implementation, particularly to allow the voluntary (not-for-profit) sector to participate in partnership working.

If the new strategy is to succeed, central government must provide a clear lead across the whole range of policies which affect health. In this respect, the development of health impact assessments at national and local levels is particularly welcome. Most important, as the evaluation of the HOTN demonstrated, the strategy needs to be communicated imaginatively to a wide range of agencies – both governmental and non-governmental – and the public, to ensure broad ownership among those who must contribute to improvement of the population’s health.

4. New Context, New People

Since the government’s health strategy was published, there have been further developments both in health policy, notably the NHS plan already mentioned, and in the composition and portfolios of the ministerial team at the Department of Health together with other changes involving senior officials. It is not possible to judge the significance of these since their impact is unlikely to be immediate or easily isolated from other factors and influences. However, just as it would be inappropriate to place too much emphasis on them nor can they be completely ignored as having no significance whatsoever. The politics of policy, and its implementation, is as much about people in key positions, and their values and concerns, as it is about the more technical and structural aspects.

Changes in the team of ministers at the Department of Health which occurred in late 1999 could have implications for the fate of the health strategy. Of particular importance for public health was the arrival of a new Secretary of State for Health and a replacement of the first ever Minister for Public Health and, in the process, awarding her a different title within the ministerial hierarchy, which implied to outsiders a lower status. The government has denied this but it is the public perception that the post has been downgraded that is important. The Secretary of State for Health, while not unsympathetic to notions of health improvement, has placed top priority on modernising the NHS as an efficient and effective health care delivery system.

The public health portfolio must surely be one of the most complex in government. Though located in the Department of Health, the Minister is expected to operate across government in pursuit of a joined up approach to implementing the health strategy. The strategy was endorsed by all 12 of the key ministers and their support needs to be ensured. This is no easy task.
especially when the Minister has no resources at her disposal pour encourager les autres. She must convince and cajole by persuasion. Her task is made more difficult by a lack of joined up policy at the centre, a conclusion reached in a report produced by the Cabinet Office’s Performance and Innovation Unit (30). Particularly problematic is that the health effort at the centre is already awkwardly split between the Department of Health, the Cabinet Office (where the Social Exclusion Unit resides), and the Treasury (which has led on the campaign to eradicate child poverty and claims that the Chancellor’s working families tax credit scheme has already lifted 1.2 million children out of poverty).

In the midst of such fragmentation and divided responsibilities, it is not at all clear who is leading on health. There is a perception externally that, encouraged by the lead minister, the Secretary of State for Health, the Minister for Public Health is being sucked into a narrower conception of the public’s health which centres on the NHS’s contribution. There is no disputing the NHS’s important contribution to improving the public’s health but, on past showing, the NHS may not be the natural vehicle for leading on this agenda and may fail to deliver. As the NHS plan makes clear, the primary focus of health ministers in the months and years ahead is to modernise the health service and while primary prevention and health concerns are an important part of this agenda, the wider public health might receive less attention.

For now ministers insist that public health within the NHS has become trapped in a ghetto. They want public health to come out of the ghetto and transform the framework within which the NHS operates so that it takes health much more seriously (31) There is merit in such a view but it requires more than releasing public health from the trap in which it finds itself. If managers and others were offered incentives or performance-managed to refocus their efforts and mindsets so that taking a population health approach became mainstream business for them then a real shift in favour of public health might be discernible. Historically, the NHS has only succeeded in repeatedly marginalising public health while it gets on with the serious business of delivering health care. This entails managing waiting lists and times, balancing budgets, reconfiguring acute services, enabling fledgling primary care groups and trusts to acquire the necessary skills and resources to operate successfully and so on. There is little room left in such a crowded agenda to take public health seriously. Perhaps the NHS plan may succeed in shifting the focus. However, with the development of Primary Care Groups and Primary Care Trusts at local level, there is concern that population-based health concerns will become even more marginalised as the new primary care organisations focus on becoming new organisations and the challenges of both commissioning and providing health care (32).

There have been other important changes among the ranks of senior officials in the Department of Health although their impact on the public health strategy is yet to be felt. The most significant of these was the appointment of a new
Chief Medical Officer (CMO) towards the end of 1998. He inherited from his predecessor a major review of the public health function initiated by the then Minister for Public Health. To date, a final report is awaited although it was expected in September 1999. There is no disputing the CMO’s commitment to public health. He was heavily involved in finalising the health strategy and chaired the modernisation action team on prevention and inequalities which fed into the NHS plan. But he also has a long-standing interest in clinical governance and the problems presented by malfunctioning clinicians. Much of his attention since becoming CMO has been devoted to the issue of bad doctors following a stream of celebrated cases which have attracted wide media attention and public concern. There is a risk in the midst of such pressures and such a broad portfolio of the ‘urgent driving out the important’.

The breadth of the public health agenda at all levels in the UK may itself be part of the capacity problem whereby there are too few public health specialists focusing exclusively on the core business of public health and its wide determinants. Many public health specialists, because of their location, get diverted into NHS management concerns around clinical effectiveness, clinical governance and rationing.

5. Outstanding Issues and Further Developments

In speculating on what the impact of the new health strategy, the NHS plan and related developments might be, it is useful to review a number of influences which will determine whatever outcome emerges. The following are singled out for particular comment: regionalism and intra-UK devolution; Health Action Zones; Health Improvement Programmes; Public Health Observatories; Health Development Agency; the importance of partnerships, networks and network governance. The last is of particular importance to a government committed to joined-up policy.

5.1 Regionalism and intra-UK devolution

The face of politics and public policy in the UK has been irrevocably changed by the devolution of power to Wales, Scotland and (though faltering) Northern Ireland. It has significant, though yet to be realised, implications for health policy. For those involved in providing or receiving health care, the test of devolution will be its effect on the health of people in the four countries making up the UK. Whether the new governance arrangements will enable the specific problems of the three countries, including their poorer health status when compared to England, to be addressed effectively remains to be seen. The changes in outcomes will take many years to work their way through.

Within England, there does not appear to be a regional agenda as far as the governance of the NHS is concerned. Regionalism is taking route slowly through the Regional Development Agencies and Regional Assemblies but the NHS is unaffected by these. It is possible that the public health agenda
could serve as a driver for closer partnership working at a regional level. Certainly the proposal in the NHS plan for single, integrated public health groups across the regions is consistent with such a view. The NHS will come under pressure to engage more fully in the regional development agenda. This has been most evident in London where the NHS region matches the boundaries of the Greater London Authority with the first elected City Mayor at its head.

5.2 Health Action Zones

In setting up Health Action Zones (HAZs), Ministers saw them as being in the frontline on the war on health inequalities. They were seen, too, as having both the opportunity and responsibility to pioneer new ways of driving up local standards of health. HAZs are in the vanguard of promoting new ways of working locally between health and social services. Although afforded freedoms and resources separate from the usual NHS hierarchy, HAZs remain firmly accountable to Ministers. Two rounds of HAZs have been approved resulting in 26 zones helping 13 million people. Designed specifically to tackle health inequalities, HAZs tend to be located in inner cities, coalfield communities, struggling rural areas and places where wealth and poverty co-exist.

HAZs are engaged in a variety of activities, including tackling the root causes of inequalities through regeneration, access to healthy lifestyles, employment and education; community empowerment through information, consultation and development; and process – e.g. strategy development, capacity building, evaluation and learning.

Ministers’ expectations of HAZs have been high – possibly unrealistically so – and there is a growing sense of disappointment at the highest levels that more has not been achieved. Perhaps the fixation on structural solutions to problems whose roots lie elsewhere is at least in part responsible. After all, partnerships cannot be made to happen and tend to emerge from long-term stable, high trust relations. Many HAZs are extremely complex organisations involving multiple health authorities and local authorities. Their governance arrangements are similarly complex especially when those high trust relations are not in place.

Or perhaps HAZs have not been given sufficient time to prove themselves or show results. These cannot be achieved within a year or two. Yet Ministers have made constant demands on HAZs and they have had to justify every decision made. Paradoxically, for bodies intended to be flexible and innovative they have been subjected to bureaucratic scrutiny of an intensity which goes beyond that accorded to already existing bodies.
5.3 Health Improvement Programmes

Health Improvement Programmes (HImPs) are regarded as the strategic glue holding many of the changes in health policy together. Designed to ensure that the health needs of communities are assessed as well as their health care needs, HImPs were introduced in late 1998. They are expected to mature over a three-year period and be updated annually. They are co-ordinated by health authorities acting as the lead agencies, but the intention is to be inclusive and involve all the key partners with an influence on health.

The agenda facing HImPs is a huge and complex one. There are many organisations to include, not least the new organisations developing in primary care. The public must also be consulted. The HImPs can only succeed if the partners genuinely sign up to the agreed priorities and if resource flows support the direction of policy. This is not always evident, with HImPs all too often being aspirational and wish lists of desirable developments and targets. Meanwhile, the real decisions on where resources are to go are made elsewhere.

5.4 Public Health Observatories

The new health strategy recommended the creation of 8 Public Health Observatories (PHOs) – one per region – to assist in the achievement of the government’s policies to tackle health inequalities and narrow the widening health gap. The Chief Medical Officer launched these in February. The models vary across the regions although most have links with Universities or are even based in them. The remit of the PHOs also varies but tends to embrace the following:

- identifying gaps in health information
- bringing together existing data and presenting them in accessible, attractive ways to a variety of audiences, including the public
- facilitating the use of data by those agencies whose activities impact on the health of local communities.

A key requirement is that PHOs will work with a wide range of bodies, including the NHS, local authorities, regional organisations, the voluntary sector and the private sector in a combined effort to ensure that interventions to improve the public’s health are not only informed by sound data analysis and interpretation, but are acted upon in practice. Nationally, there is a governing body chaired by the CMO with representation from different government departments, the regional directors of public health, the Health Development Agency. In addition, the 8 PHOs have formed an Association of PHOs to share good practice and develop common standards and systems across the country.
The resources available to the PHOs are modest and therefore it will be necessary for them to agree clear priorities and identify realistic goals. Having just started, it is too soon to pass judgement on PHOs. All are acutely aware of the need to produce early outputs and to demonstrate added value. They could serve as an important catalyst for change. Or they could simply become part of the information generating capacity of the health system adding little of value to the more difficult matter of getting that information acted upon.

5.5 Health Development Agency

Another new institution is the Health Development Agency (HDA) which began work in April. It has its roots in the Health Education Authority which it has replaced through extensive re-engineering of its role and staffing. The HDA has three functions:

- research and evidence
- advising on standards
- capability and capacity development.

The HDA will perform a major role in establishing what works and does not work in public health by assessing the evidence and where necessary providing modest support to closing gaps in the evidence. In assessing the evidence, there will be a move away from a biomedical approach and a belief that randomised control trials constitute the only evidence that matters. Extending the range of methods that may legitimately offer useful ways of evaluating interventions designed to modify health status will be a key responsibility. Interdisciplinary approaches will be encouraged.

The HDA will have an advisory role in setting standards for policy, strategy, implementation, evaluation and review. These standards will be embedded in the performance management framework to ensure that they are being observed. But, importantly, the HDA will not be an inspectorate. Rather its approach will be developmental and supportive, assisting health organisations with access to the appropriate evidence (where available) and with its subsequent application.

Capability and capacity development are therefore important features of the HDA’s remit. It will seek to encourage partnership working, community-based models of health improvement, development of best practice in particular settings – eg schools, workplaces, the NHS.

Some early examples of the HDA’s work include disseminating evidence through the development of ‘toolkits’, expert reviews, regional training and dissemination; raising standards through helping 50 local partnerships reach Healthy School standards by 2001; developing national health at work standards; and developing capability and capacity through a public health skills audit, guidelines on health authority/local authority partnerships.
5.6 Partnership Working: Network Development and Governance

Across Europe, and certainly no less in the UK, working across the boundaries that exist between public sector agencies and with the vital resources available in the voluntary or civil society sector, has proved very difficult. Gareth Morgan, using language from individual psychology, has said the ‘forms of the organisation itself often becomes a psychic prison: the actions its members pursue are constantly trapped by ancient memories of the organisation’s real or believed history’ (33).

Earlier, we presented the difficulties faced in implementing The Health of the Nation, at the core of which was how to establish shared ownership both at all levels within an organisation and also horizontally between organisations. The new strategy responded by addressing directly the issue of developing partnership: ‘Successful partnership working’, it said, ‘is built on organisations moving together to address common goals; on developing in their staff the skills necessary to work in an entirely new way – across boundaries, in multidisciplinary teams, and in a culture in which learning and good practice are shared. It also means:

- clarifying the common purpose of the partnership
- recognising and resolving potential areas of conflict
- agreeing a shared approach to partnership
- strong leadership based on a clear vision and drive, with well-developed influencing and networking skills
- continuously adapting to reflect the lessons learned from experience promoting awareness and understanding of partner organisations through joint training programmes and incentives to reward effective working across organisational boundaries’ (34).

Ensuring effective partnership working is a major implementation challenge. It has been analysed endlessly for at least the past 25 years in the UK. The factors which contribute to successful partnerships are well known but they have met with partial success at best. Even with a government enthusiastically committed to partnerships progress has been less than impressive. A danger with new instruments like HAZs is that they risk adding further fragmentation and division instead of reducing them. A report from the Cabinet Office’s Performance and Innovation Unit reported the confusion experienced by those trying to make the new initiatives work (35). Apart from the large number of new initiatives, they are being run separately even where they target the same people. Most important, the problem is worse at the centre where departmentalism survives and there has been a failure to cross boundaries. There is no central government function responsible for bringing together health issues. It is a task for the Minister for Public Health but as the position is located within the Department of Health it is easy for the occupant of this post to become preoccupied with the NHS.
In Wales there has been the explicit development of public health based Health Alliances which broadly set out to attempt to engage local partners to:

- gain a wider understanding of how health gain can be achieved;
- ensure better co-ordination between local health and environment services;
- increase local capacity in conjunction with local health promotion specialists;
- facilitate a network for sharing health and environment information; and support communities in action to improve health, living conditions and life chances (36)

Scotland’s health is poor when compared with the rest of the United Kingdom and Western Europe. It has some of the worst oral health in the UK, a high proportion of smokers, and poor nutrition. The Scottish Executive believes that its health policy, set out in a white paper Towards a Healthier Scotland (37), provides an outstanding opportunity to improve the public’s health. The strategy sets out a framework for a co-ordinated approach to health improvement based on

- *Life circumstances*: including poverty, unemployment, adverse social structures, poor housing and a polluted environment
- *Lifestyles*: including smoking, diet, exercise and alcohol and drug misuse
- *Health topics*: including cardiovascular disease, cancer, mental health, sexual health, accidents, child health and dental and oral health.

In order to deliver on its policy intentions, the Executive, through the Chief Medical Officer for Scotland, launched a review of the public health function in Scotland (38). Tackling the underlying causes of poor health and disease requires a robust infrastructure. To secure such an outcome, the review put forward a number of recommendations including the following:

- The establishment of a Public Health Institute for Scotland
- The development of public health networks at national and supra-regional levels
- The enhancement of public health training and multidisciplinary team working
- The development of models to deploy public health expertise in local authorities and NHS organisations.

### 5.7 Public Health and Primary Care

With the development of a primary care-led NHS, responsible for the health of local populations as well as individuals, the links between public health and primary care are assuming greater significance. The precise arrangements for primary care vary across the UK but the thrust of policy is essentially the same. It is accepted, however, that primary care and public health
respectively have both different tasks and perspectives as well as pursue common themes. Figure 2 summarises the position.

Figure 2. Public Health and Primary Care: The Conjoint Agenda

<table>
<thead>
<tr>
<th>Public Health</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longer term, strategic view</td>
<td>Short term, operational view</td>
</tr>
<tr>
<td>Population focus</td>
<td>Individual patient focus</td>
</tr>
<tr>
<td>Larger populations (geographical)</td>
<td>Practice population</td>
</tr>
<tr>
<td>Prevention orientated</td>
<td>Treatment orientated</td>
</tr>
<tr>
<td>Needs assessment of groups and populations</td>
<td>Needs assessment of individuals</td>
</tr>
<tr>
<td>Work through others (manage change)</td>
<td>Direct work with patients</td>
</tr>
</tbody>
</table>

**Common Themes**

- Multidisciplinary and generalist approach
- Holistic and concerned with health
- Consider people not just as ‘patients’
- Clinical standards and quality
- Longer term relationships and concerns
- Whole spectrum of health and disease issues
- Concerned with health/social care interface
- Achieving value for money


There is a consistency of language; and much of it is concentrated around ‘working across boundaries,’ ‘improving networking,’ ‘constructing partnerships’ and ‘empowering communities’, very much the challenges illustrated by Goran Dahlgren, and contained in his now famous model (see Figure 3) which summarises the main factors that, in combination, determine the level of health of individuals and communities (39).
5.8 Formalised Networking – A Potential Solution

The need for conjoint activities is now generally accepted and the UK government has strengthened the potential for joint working through a number of initiatives especially Partnership in Action (40). In addition, the Health Act 1999 allows pooling of funds and requires explicit joint planning, leadership and commissioning of services. But there is a limit to tolerance which is exceeded when reorganisation of the NHS and local government is mooted: the tendency is to suggest that in the quest for greater democracy local authorities (which are elected, whilst NHS Boards are not) should be supreme. The issue, then, is how arrangements are to be orchestrated which cause joined up activity to happen.

Here, the role of health and social gain targets is important and these now appear within National Service Frameworks (two such frameworks have been produced so far – covering mental health and coronary heart disease respectively; others for diabetes and elderly care are in production). One practical option is for all organisations at locality level to agree what contribution they can make (or most often would normally be making anyway) to national target achievement, and to form a virtual organisation, on a limited time basis, to co-ordinate activities. Importantly, managerial accountability would remain within each of the participating bodies who would have signed up to the agreed conjoint activities. Figure 4 represents the arrangement.

The government, anxious to ensure that partnership working becomes the norm between health and social care, is making incentive payments to
encourage and reward joint working (41). The NHS Plan also proposes establishing a new level of primary care trusts which will provide for even closer integration of health and social services. New single multi-purpose legal bodies, known as Care Trusts, will commission and be responsible for all local health and social care. These organisations will be based on Primary Care Trusts and represent a new level of operation. They will be able to commission and deliver primary and community health care as well as social care for older people and other client groups. Social care is to be delivered under delegated authority from local authorities.

Figure 4. Virtual re-organization by design, to improve the public’s health

Virtual Reorganisation by Design (VRD) has the potential to reduce inter-organisation tensions; and if there are purchasers involved ‘leaves no blood on their head’5 because any reorganisation that might occur does so over time, is organic in nature, and results from local perceptions of utility, not external pressure. New forms of social contracts and partnerships between organisations, communities and individuals will emerge. But important issues will remain to be resolved which relate to organisational self-autonomy within networks, and the development of network governance.

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5 We are grateful to Arne Johansson, Chief Executive of Ostergotland County Council, for this phrase.
The individual organisations that are required to come together for joint working to raise the public’s health are all currently hierarchical in nature; and self-autonomy is a critical component of hierarchies. Therefore, changes in the environment that threaten autonomy by requiring different work patterns and some degree of external accountability – in this case the network – will, in turn, have an impact on the nature of both inter and intra-organisational exchanges, and could result in dissonance.

However, one important source concludes that inter-organisational networks will become the dominant institutional form, increasingly replacing both markets and hierarchies as a governance mechanism. The authors conclude that:

‘... conflict is most closely associated with loss of autonomy and the structural characteristics of networks and, contrary to popular wisdom, has surprisingly little to do with either administrative co-ordination or task integration’ (42).

Given this, the idea of ‘contribution to achievement of health and social gain targets’ would appear to be one likely in itself to engender co-operation. And, indeed, government policy in the UK, which enables ‘joined up working’ to occur more easily, may reduce problems concerned with structure, although not entirely.

5.9 Network Governance

This is an important building block. There are many examples in recent government policy documents where networking is the suggested remedy to existing deficits in inter-organisational co-operation. However, the fields of networking and network governance are ones little applied in the public sector; and hence their ability to support the development of VRD is not well understood. There is, though, a considerable body of research and this has been summarised to develop a general theory of network governance (43).

Here, these authors suggest that network governance

‘involves a select, persistent and structured set of autonomous firms or non-profit agencies engaged in treating products or services based on implicit open-ended contracts to co-ordinate and safeguard exchanges. These contracts are social – not legally binding’.

Specific sub-definitions are important:

‘Select’ network members do not contribute to all activities, at least in the first instance
‘Persistent’ network members work repeatedly with each other over time (i.e. a need for projects to develop/engineer in some intensity)

‘Structured’ exchanges are neither random nor uniform, reflecting a division of labour

‘Autonomous’ potential for each organisation to remain legally separate

‘Implicit and open-ended contracts’ the means of adapting, co-ordinating and safeguarding exchanges that are not derived from authority structures or from legal contracts.

In recognising these items as comprising the factors, which make for successful network development and governance – leading to VRD – they must be taken into account and used as the evidence base implicit for the creation of successful intersectoral action in public health.

One recently developed tool has the potential to assist cross boundary working (44) and VRD. This involves rapid appraisal of current inter-agency working and a developmental approach through structured action. In part, its aim is to expose, through discussion, the potential challenges to organisational autonomy and to develop networking arrangements and governance.

Networking through which virtual reorganisations are developed can only lead to the more efficient use of resources – by reducing duplication and closing gaps in provision – and in turn result in better services for communities in the UK.

6. Conclusion

The government’s policy stance is clear – but only up to a point. Tensions between competing policies persist. There exists a health strategy with a clear commitment to tackling health inequalities and to improve the state of health of the poorest sections of society at a faster pace than the rest. Only by adopting a policy of affirmative action in respect of the poorest groups does the health gap stand any chance of being narrowed. So far, government policy in the shape of a new health strategy and related initiatives aimed at tackling the structural determinants of health inequalities has had a negligible impact on the health gap. But it is early days and far too soon to prejudge the outcome. The government has stated that it will take at least 10 years for results to emerge. This is not unreasonable so an interim verdict must be that the jury is still out.
Encouragingly, much of the current health strategy’s content, and the issues concerning its implementation, draw on the research studies reported earlier which sought to identify the impact of the first health strategy in England, *Health of the Nation*, on practice. The new strategy, *Saving Lives: Our Healthier Nation*, has incorporated many of the lessons and insights provided by the assessment of *HOTN* though how far it will succeed where its predecessor failed must await further assessment.

There remains a tension between the government’s determination to modernise the NHS on the one hand, as demonstrated most recently with the arrival of the NHS plan, and to tackle the wider public health agenda on the other. There is clearly an overlap between the two but many commentators believe that only by being separated from the NHS can the broader ‘upstream’ assault on public health begin to succeed and not be constantly diverted by pledges on waiting lists, faster access to care, and so on. The government has steadfastly resisted any relocation of the public health dimension of its work. But if it is to remain within the Department of Health, then surely it will have to be restructured to pursue a different set of priorities. Otherwise the NHS agenda will continue to be the only one that is ever really seen to matter. It is worth recalling that of the 39 policy recommendations put forward by the Acheson inquiry into health inequalities only three related to the NHS.

References


(6) Ibid.


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