Policy Futures for UK Health

*Discussion Paper and Review of Current and Proposed Public Health Policy*

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Introduction

Public health is broadly defined in terms of improving the health of populations, rather than treating the diseases of individual people1. Public health policy includes efforts to contain disease and provide sanitation but the use of term, and the focus policy, is increasingly on health improvement.

This discussion paper aims to provide a summary of current public health policy in order to provide a backdrop against which the implications for the future may be discussed. It provides the context for two further papers that review formal sociological and psychological literature relevant to future public health policy. In the interests of space discussion is focused on England unless significant deviations in policy between the home countries are observed.

Current public health policy in England is set out in the Choosing Health: Making Healthy Choices Easier White Paper (1). Delivering Choosing Health: Making Healthy Choices Easier (2) followed the White Paper. This discussion paper takes Delivering Choosing Health as its focus, and draws inter alia on interviews with staff from one Primary Care Trust (PCT) and one Strategic Health Authority (SHA). The document is in two parts. The main discussion paper provides a critical analysis of current public health policy, identifying some associated issues and controversies. It includes a commentary on current policy, designed to facilitate assessment of fitness-for-purpose. It also highlights some the broader issues relevant to future public health policy and health promotion policy. The second part of the document is the Appendix, which contains supplementary material for those less familiar with current policy. It provides a summary of Choosing Health; identifying current policy aims (‘Priorities’), interventions (‘Big wins’) and the evaluative framework. The Appendix also includes a brief explanation of the funding and organisation of the Choosing Health agenda. Details of strategies and policies identified as ‘supporting’ are included as endnotes.
Choosing Health: Policy Issues

This review of public health policy in England provides a critical analysis of policy, identifying outstanding issues and controversies. The hope is that by highlighting key issues now, and considering some of the implications and potential solutions, policy may be modified in ways that could better optimise the future of UK health. Several issues are raised. Some relate directly to the specific interventions associated with the priorities identified in Delivering Choosing Health\(^a\). A second set of issues concern funding and organisation of the Choosing Health, and the third highlight some major issues for the future relating to public health policy more broadly, including ethical and legal issues.

Choosing Health: Priorities and Big Wins

Inequality

The focus of the Choosing Health on inequality is welcome. It is important to recognise, however, that the emphasis is on health and not social-structural inequalities. This is further highlighted by the definition of the issue as ‘inequalities’ rather than ‘inequities’ (3). The main policy focus is on improving the health of the poorest; not at addressing health gradients (4). However, there is evidence of poorer health being associated with inequality as well as poverty (5) (6) (7). Current policy focuses downstream, which involves ‘working directly with poor individuals and communities to tackle their immediate problems’ (8). Many would argue that concentrating downstream will do little to shift inequalities (9). Bambra et al. (10) argue that no capitalist government will support the “full implementation of a radical equity agenda”. However, if they are committed to improving the health of the population, they will probably need to. Greater focus on health inequalities is to be welcomed, it is likely to prove insufficient for improving the health of all the population in the future, as this involves ‘tackling the fundamental causes on inequality through national social and economic policy’ (8). Placing the responsibility for health on individuals who occupy different social locations and different capacities for control (11), notions of the ‘fully-engaged’ patient, may exacerbate health inequalities could exacerbate inequalities (3).

The priority on health inequalities does give some recognition to the wider determinants of the health with supporting strategies relating to housing and environmental issues. These strategies belong to departments other than health. This shows potential for more comprehensive joined-up policy, but there is still greater scope to integrate and align policies that address the wider determinants of health than is currently the case. This implies more shared targets and incentives.

Smoking

Cancer is one of the biggest killers. Thirty percent of cancers are attributable to smoking, so reducing the prevalence of smoking seems an appropriate approach to improving population health. Moreover, as smoking prevalence is uneven across social groups, this should contribute to reducing inequalities in health outcomes. There is evidence that some existing strategies, most particularly cessation projects, are successful, although the specific processes that lead to success are unclear (12).

Current policy proposing a ban of smoking in public places is partial. Smoking restrictions will be phased in, with a ban on smoking in NHS and government buildings by 2006, in

\(^a\) The priorities relating to young people and older people do not have unique interventions associated with them, so are not discussed in this section.
enclosed public places by 2007 and with the restrictions on smoking in licensed premises introduced by the end of 2008. The current Health Bill is due to be in place fully by the end of 2006 ‘following consultation with the hospitality industry’. Those who support a total ban suggest that a partial will create confusion. Others are attempting to expand the ban – for example Liverpool City Council and the Welsh Assembly. Some hospitality companies have already banned smoking in their premises – e.g. Pizza Hut and Wetherspoons pubs. There are also concerns that the partial nature of the ban may not help address inequalities because premises that will be exempt from the ban are not evenly distributed across society (e.g. Leeds City Council estimate that most of their pubs do not serve food). Opponents of the ban, including the tobacco industry, refute the negative health effects of second-hand smoking. An economic argument is also made. According to politics.co.uk, the Restaurant Association suggest that banning smokers would cost £386million and 45,000 jobs (13). Others oppose the ban on the grounds of civil liberties. However, the same argument is used by those who do not want to breath others people’s smoke and therefore support a total ban.

A ban may be important for several reasons. First, a review of evidence undertaken by the Health Development Agency (HDA) suggests that there is a relationship between second hand smoking and health (12). Furthermore, a ban on smoking may help change the social and cultural context in which the activity takes place and thus reduce prevalence. The HDA report notes that evidence from the USA indicates that control of smoking in public places serves to ‘de-normalise’ it, rendering it less appealing, thereby contributing to declining prevalence. MacIntyre (14) also argues that an effective way reduce smoking amongst young people would be make it less socially acceptable and attractive through, for example, smoke-free policies.

MacIntyre goes on to argue that because young people associate smoking with adulthood and choice, laws prohibiting sales to minors have the potential to reinforce this notion and encourage smoking, as well as being unequal to the challenge of getting cigarettes. On the other hand, Naidoo et al. (12) cite evidence to suggest that better enforcement of regulations is an effective way of reducing smoking prevalence amongst young people.

Reducing availability and supply can be justified in terms of the evidence (12) as higher unit prices is associated with quitting (15). This is true across all social groups. This is significant as one issue around duty on cigarettes is that the effect is disproportionately born by the poorest. It is also argued that smoking is poor people’s only pleasure. McIntyre counters this with survey data showing that the same proportion of people on lower incomes wish to give up smoking, but are likely to need additional support. One way round this dilemma would be to ensure that revenue raised was spent on cessation programmes (14).

Duty on tobacco products, contributes around 2 percent of the Treasury’s annual revenue, but, as duty increases, so does smuggling. In 2004 it was estimated that 25 percent of cigarettes and 75 percent of rolled tobacco were non-UK duty paid - approximately £2.5 million in lost revenue. As a result, some countries, Denmark for example, have reduced duty levels in attempt to reduce smuggling (13).

The evidence to support the success of mass media campaigns is patchy (12). There is some evidence that media campaigns, when combined with other interventions, can reduce the uptake of smoking and encourage cessation, but pathways and effectiveness are not clear and conclusive.

Obesity

The 2002 Annual Report of the Chief Medical Officer (England) (16) described obesity as ‘a health time bomb’. The causes of obesity are complex, mostly attributed to behavioural
factors. Genetic factors are also important with some estimating the genetic contribution to weight gain as high as 70% (17). The Health Development Agency’s review of evidence notes that ‘data from the Health Surveys for England…revealed that age, education, social class and prosperity have an important influence on the risk of becoming obese (18). These wider factors are not sufficiently reflected in current policy that focuses on individual food choices and physical exercise.

Improved food labelling and a media campaign can be expected to have a limited effect. To date there is little evidence of the effectiveness of media campaigns on prevention or treatment (18) or industry’s desire to improve nutritional value voluntarily. Often pricing structures encourage people to purchase large portion sizes and once ordered these are more likely to be eaten. Taxes on unhealthy food are an option (19) (20) but not yet highly developed and likely to be open to the criticisms that they will disproportionately affect the poor. Individual choices are made in the wider social context, for example norms around eating patterns have changed, with people eating outside the home more.

The other driver of obesity is a decline in levels of physical exercise. Current policy is attempting to address the decline in physical exercise due to ‘changing patterns of transport, work, electronic communication, energy-saving devices such as escalators…as well as sedentary entertainment’ all occurring at the same time (21). A raft of data suggest a changing patterns of activity in children’s lives too – greater use of car, less playing out, more use of computers and television, for example (21), and considerable policy effort is being concentrated on children. Given also the evidence that exercise in youth in a not a strong predictor of exercise in adulthood, this raises questions about the long-term efficacy of school-based programmes – which is not to say that other benefits associated with such activities are not important.

Furthermore, there is a lack of conclusive data about levels of activity for health. Current official recommendations are set out in the report of the Chief Medical Officer, At Least 5 a Week (22), but they are not universally supported (21). Likewise, evidence so far suggests that whilst diet and physical exercise are both important to losing weight, diet is more important (18).

Existing evidence suggests a need to draw a distinction between prevention and treatment of obesity. Where an individual succeeds in losing weight, they will need support to maintain that loss and continued contact with a professional expert appears to aid this (18) (23). This represents a huge potential burden on the formal care system. Support will be needed for an estimated half of the population from professionals not trained to see obesity as their problem within a NHS that has not excelled at prevention.

Furthermore, changing individual behaviour within the constraints of prevailing structures and norms is a challenge – for example, trying to encourage active commuter options in the absence of adequate alternative infrastructure. Most policy focus is on increasing activity in leisure time, but most people’s time is spent at work, getting to and from work and in household chores, so interventions into these aspects of time use could be more effective. Environmental, as opposed to individual, approaches seem necessary therefore, but the challenges for policymakers are not trivial, requiring change to ‘structural, systems, policies, and socio-cultural norms’ (21).

**Sexual health**

The **Teenage Pregnancy Strategy** (24) attempts to be long-term and comprehensive. Given the poor UK record on teenage pregnancy and the ramifications for mother and child, the strategy is welcome. One proposed intervention, which is supported by available evidence,
is providing better information to teenagers and better access to services (25). A more controversial suggestion is to give contraceptives and offer abortions to young women aged below 16 without parental knowledge or consent. The rights of young women to privacy are being challenged in the High Court at present. Current guidance allows for under-16s to be given advice without their parents being informed. The Duty of Confidentiality is absolute. However, Channel 4 News, quoting the sexual health charity Brook, say that 'some local health authorities have already changed their guidance so that professionals are required to report all sexual activity among younger teenagers to social workers and police, regardless of the circumstances' (26). Supporters of the current privacy position consider confidentiality to be fundamental to young women seeking support and thereby essential to the protection of their sexual health.

Sex education in the UK tends to be poor (27). Some argue that providing sex education encourages sex, but evidence does not support this view. Current policy encourages better provision, but it is up to individual schools to consult parents and to decide on school-based advice and contraception. Sex education is not compulsory (28), and data from comparator countries suggests that there are reasons for making it so (29).

The second aspect of the sexual health strategy concerns sexually transmitted infection (STI), an area in which there is increasing need for and highly variable and often inadequate supply of service (30). Policy and services must respond to the huge increase in the prevalence of STI and increasing resistance to antimicrobial drugs, for example for Gonorrhoea (31). A recent Panorama programme for the BBC found that 27% of clinics could not treat a patient reporting serious symptoms of an STI within 48 hours (32). The Department of Health recognised that more needs doing and it is investing £300m over the next three years in addition to the £11 million invested in 2002 (32).

Also planned for Choosing Health is a media campaign. Evidence suggests that these need to be targeted at particular groups (33) and should include behavioural interventions that increase self-esteem, for example. Laverty and Pugh (30) identify a need for information about sex and relationships in general aimed at young people. In the context of STIs they also highlight an urgent need to focus information on women who have sex with women and also men who have sex with other men; fewer men who have sex with other men are using protection than was the case in 1995. One explanation is that current drug technologies have defined the disease from a ‘death sentence’ to a chronic condition (34), but changing sexual behaviour is not well understood. This highlights the importance of locating individual behaviour in wider social contexts.

Laverty and Pugh also note the rise in HIV in women mostly accounted for by women migrating from sub-Saharan Africa. Migrant and trafficked women typically have broad and complicated sexual health needs which are perhaps not yet adequately recognised or addressed (35). Current Home Office discussions around prostitution should add to the debate (36). Laverty and Pugh (30) worry that sexual health will not be a local delivery plan priority outside London, and given that LPDs are prepared on three-year cycles, the momentum will be lost.

Mental health and well-being

Three issues emerge strongly from the Choosing Health mental health agenda. These are a strong focus on illness rather than well-being, improving service provision and client satisfaction and addressing the extreme end of social inequality. Changes to service provision, which attempts to reduce stigma and increase equity, are to be welcomed in the light of the weaknesses acknowledged already by policymakers. The expansion of services also seems expedient in the context of anticipated increases in the level of mental illness in
society in future (37). However, these strategies would also seem to be insufficient given the range of factors outside health services associated with poor mental health (38).

Many potential levers are addressed in other areas of policy, but the links are not made in the White Paper. These relate to environmental and social community issues - school programmes designed to reduce bullying and increase self-esteem, for example, parenting support programmes, developing social networks, programmes designed to reduce isolation and increase social trust and cohesion are associated with improved mental health; as are participation in physical education and participation in education. Focusing this policy agenda so narrowly, therefore, could be a missed opportunity for wider health benefits, particularly as better mental health is also associated with better physical health. Given the close relationship with mental and physical health, more emphasis could be placed on wellness in future policy.

Controversy also surrounds the current Mental Health Bill² (39) (40) (41).

Alcohol

Despite the recognition of the economic and social cost of alcohol misuse to individuals and societies, the Alcohol Strategy (42) was only recently introduced in England. It has been widely welcomed in principle (43). There are, however, some omissions and it is not always clear where there is evidence to support particular interventions.

Omissions include strategies for harm reduction, support for families affected by alcohol misuse, and stronger attempts at controlling supply. Given the recognition of the complex multiplicity of factors seen to predict problem drinking laid out in the Strategy Unit’s National Harm Reduction Project’s Interim Analytical Report (44) - including heavy focus social norms and culture and the changing market, current policy appears thin. There is a lack of evidence that strategies such as labelling products with warnings helps to promote sensible drinking, and education programme around safe units have not been successful to date (45). The message that alcohol is harmful is placed alongside the message that alcohol is good for you and ‘safe limits’ are subject to change. This has the potential for adding confusion rather than encouraging individuals to change behaviour. There is not yet firm evidence that interventions aimed at young people are successful.

A recent report from the Academy of Medical Sciences (46), argues a strong link between general levels of alcohol consumption in the population and problems. Like the Institute of Alcohol Studies (IAS) and Alcohol Concern, the report warns against the current policy view that there are a small group of ‘problem drinkers’ and the rest of the population who drink sensibly. Some argue that denial of a correlation between average alcohol consumption and alcohol misuse is a result of too close a relationship with commercial interests (43)(Institute of Alcohol Studies, 2004 #1524)(46). However, the report from the Academy of Medical Sciences, makes a compelling case for reducing drinking. They argue for a range of measures to reduce drinking and increase harm reduction. These measures should address economic access, ease of access and social access, including increasing the cost and reducing travellers’ allowances.

As with tobacco, the Government faces a dilemma with regard to alcohol duties. Increasing duty is likely to stimulate duty evasion and revenue loss, but not doing it leaves the Government open to accusations of social irresponsibility. Already smuggling and evasion is a problem. In 2001-2002, Customs claimed that it had lost £600 million through alcohol duty evasion, compared to £450 million in 2000-2001 (47). Some argue the solution to this lies in matching UK duty levels with those in Europe and harmonisation of alcohol duty is a EU
objective (47). Others note that current travellers’ allowances are the equivalent of 272 days supply for a heavy drinker and support greater consumption therefore (46).

Two other policies are worth mentioning in the context of harm reduction. The first is the 2003 Licensing Act (48), which liberalizes opening hours. Designed to reduce binge drinking, some argue that it will simply allow more time for drinking. Its effect is still unknown. There is also debate about current thresholds for blood alcohol levels for drink driving. At present these are 80mg per 100 ml of blood. Only three other EU countries have such high rates (49). The Academy of Science proposes a reduction to 50mg and greater use of random traffic checks.

**Funding Choosing Health**

The *Choosing Health* White Paper (1) identifies £1 billion for supporting the agenda. Half of this has gone into Primary Care Trust (PCT) revenue accounts and it is not clear what is happening to the other half. One question here is whether the money should have been ring-fenced. The Department of Health would probably argue that ring-fencing money reduces flexibility ‘on the ground’, that it is administratively more complicated, time-consuming and more costly to arrange and monitor. There is, however, a trade-off if money for specific projects is simply being absorbed in PCTs’ deficits. Discussions with a PCT and a Strategic Health Authority (SHA) indicated an expectation that, given the SHAs are being told that their most important task is to break even, much of the money will be used by PCTs to address financial deficits. One issue then is what the Department’s real expectations are, and how they should manage how the money is to be spent if they are committed to these priorities. This is especially important given that the half the *Choosing Health* money has been kept back to fund ‘new modes of delivery’.

Another issue currently unresolved is the fact that Local Area Agreements (LAA) funding is meant to be additive - made available for innovative but evidence-based interventions. According to one PCT, some government offices have made it clear that they will not consider applications to support existing projects. This creates a tension, as new projects cannot be directly evidence-based. At the same time, it means that interventions with positive outcomes cannot be sustained because they are not new. In the specific context of the public health agenda, there is a further difficulty given that the Local Authority applies for the money and the PCT is responsible for the delivering *Choosing Health*.

**Organising Choosing Health**

The idea of a joint Local Delivery Plan seems in principle to be a good one, suggesting greater moves towards coherent policy. There remains, however, a question of how effective this will be, given that the different partners will have different overall priorities even when they share some specific targets (for example, teenage pregnancy). How much is the PCT going to worry about the Local Authority missing their targets? Given the acknowledgement of the wider issues and performance, should the *Choosing Health* agenda be NHS-led rather than Local Authority-led?

There are other issues related to targets and incentives that may have implications for the future public health. Some priorities do not have targets. In prioritising priorities, are PCTs likely to focus on those that relate directly to key targets, many of which relate to process and not outcome? The alcohol priority, for example, is likely to be difficult for the NHS to address and is seen are being more amenable to Local Authority policy action relating to licensing, community safety and so forth. Moreover, this target is a Home Office PSA.
Some measures are arguably poor measures of outcome, others are missing altogether. Is it reasonable to measure changes in smoking prevalence by the proportion of people in cessation programmes at 4 weeks? To date, there is no satisfactory measure for obesity or agreed baseline data and other measures have been deferred – for example, the number of people aged 15-24 accepting chlamydia screening. The PCT and SHA employees interviewed were also not sure what happened if the targets were not met. Is there a greater need for explicit incentives therefore? Is the absence of target dates against some measures and indication of their (lack of) importance? And is this acceptable?

What are the implications for the lack of evidence? Is it possible to engage the public sufficiently to change their behaviour or to potentially give up some of their own choice for the wider social good, when they have their own understanding of health and illness causation and receive mixed messages? What are the implications of lack of evidence of cost-effectiveness, so important in other areas of health policy? For example, there is not yet definitive evidence about optimal levels of physical activity and little evidence of physical activity referral programmes being cost-effective.

One justification for the seepage of the Choosing Health money into general budgets may be that it is not clear what is new activity anyway. Some of the big wins identified in the Delivery Plan had been delivered or met sufficiently prior for this to be indicated in the summary tables. Likewise, discussion with the PCT, when asked if they were doing anything new or additional as a result of the White Paper replied ‘not really’. It should be added, however, that they welcomed the White Paper nonetheless because it gave renewed attention on health inequalities, brought focus to public health, and gave a boost to some services that felt marginalized. However, given that a national and local level Choosing Health seems to be ‘more of the same’, future hopes for major outcomes should perhaps not be too high.

Also germane to future policy, are the implications for delivery within restructuring of primary care and the merger of PCTs, including implications of practice-based commissioning and payment by results.

**Major issues for the future**

Current policy emphasises health promotion. There are series of complicated issues related to this, which have implications for the future.

**The role of the state**

One ethical issue central to health promotion is the extent to which the state should intervene to change the behaviour of individuals with regard to having healthier lifestyles. Many people engaging in unhealthy behaviour know it is unhealthy (50). Whilst the right to life (contained in Article 2 of the Council of Europe Convention on Human Rights) has been interpreted as giving states a positive obligation to secure the lives of their citizens, it is not clear which interventions could be included without transgressing the acceptable boundaries between public and private (51).

There is also the question of whether it is ethical to neglect the wider determinants of health when there is evidence that they matter to health. Both individual and community health are predicted by issues that are collective. Can a case be made for policy not being moved upstream, to social, political and physical environments, away from a sole focus on individuals and behavioural change?
Whether the ultimate goal of the health service should be to maximise health (and minimise illness) overall or to reduce inequalities in health is also relevant to policy, given that the majority of healthcare is publicly funded in England. Zimmern and Hope (51) have argued that this has implications for how healthcare is created and distributed, as well as raising a question about the extent to which individuals may legitimately be expected to take responsibility for protecting and improving their own health and, as an extension of this, whether individuals who are deemed ‘irresponsible’ should be expected to pay for care. What are the limited of responsibility and entitlement? What are the implications of greater emphasis on self-care?

Individual choice and autonomy

The relative absence of the values of individual choice and autonomy in health promotion run counter to those increasingly underpinning clinical medicine. One of these is the right of an individual to refuse treatment, even if it is life-saving. The second is the paternalism inherent in health promotion practice, which negates the individual’s right to choose to behave in particular ways. A further issue is when it is ethical to curtail individual choice and behaviour if it affects the health of others. How are demands for individual autonomy and the perceived needs of the population to be reconciled?

The focus on lifestyle issues and the medicalisation of conditions, such as obesity, can be seen as part of a more general trend in surveillance medicine. Critiques of this kind highlight the expansion of the medical ‘gaze’ and the shifting role of the state away from welfare provision to the ‘conduct of conduct’ (52) and the associated ‘moral imperialism’ (53). Armstrong (54), for example, describes how health and illness have ceased to be binary conditions, but medical efforts are brought to bear on potential illness and risk. Activities designed to reduce risk are internalised by individuals who must take responsibility for monitoring and managing their exposure to risk. Inherent in surveillance medicine are issues of blame and potential stress as individuals powerless to produce health effects are still expected to do so.

There also a raft of issues around individuals making decisions. One theme that has emerged many times during the discussion of big wins, was the lack of evidence of effectiveness. Even where scientific evidence is available, it is important to recognise that behaviour is socially embedded. This implies a greater need for policymakers and practitioners to engage with lay understandings of health and illness (lay epidemiology), and health inequalities (55),(56). For instance, Davidson et al.’s recent paper (57), quotes a young woman who worries about smoking because she knows it is bad for her, but believes it helps her cope with her stressful environment and that she has no choice. Marmot (11) argues how adopting healthy behaviour is likely to be less appealing to those who know they will probably die early. These processes need to be understood if policy interventions are to be effective.

In Choosing Health, citizens and patients are defined as consumers. This brings in a range of other complex issues related to public and patient participation in health, rights, responsibilities and entitlements, for example.

Infrastructure

Systems critiques of public health policy (58) point out impossible mismatches between operations and the larger context partly because of sociostructural issues, and also incompatibilities in legislation and structures. One current example might be the provisions of confidential advice on contraceptives to minors, at the same time as allegations that some
Local Authorities are instructing advisers to inform parents. Systems critiques might also include those issues that relate to the implementation and management of a public health agenda. Yach (59), for one, has argued for a shift of focus from ‘a health system’ to ‘a system of health’, but policy effort and media attention, continue to prioritise healthcare and the NHS. A question for the future is whether there is a policy preference and how it can be achieved.

Moving away from a focus on public health as health promotion, a further gap is the exclusion of issues concerning health protection and the apparent inadequacies of the public health infrastructure in this regard, complicated further by devolution (60) (61) (62). Exploring a range of issues, the Partnership for the Health of the People found that, despite myriad legislation and regulation, significant gaps exist. These include the absence of any ministerial responsibility for public health, little formal or coordinated evaluation of public health policy and no single person having a responsibility to protect the public’s health or to take the lead in communicable disease control, or, more relevant to the future perhaps, bio-terrorism. The UK Partnership for Health of the People identified a series of measures designed to improve this situation. This was a UK body operating with a clear definition of the public health function, clear definitions of roles and responsibilities on and a new legal framework similar to that of the Regulatory Reform Act 2001 (61).

Summary:

This section has highlighted some the unresolved issues related to current public health policy. Key points with implications for the future are:

- Lack of evidence to support some interventions and a neglect of some factors for which there is evidence of a link.
- Lack of evidence around the economics of interventions.
- Too great an emphasis on individual and behavioural factors, and individual choice and a lack of recognition of the social and cultural ‘embeddedness’ of individuals. This implies a strong need to factor psychology and ordinary people’s understandings of illness (lay epidemiology) into policymaking.
- Failure to address the broader issues around inequality – which is exacerbated by shifting the policy focus upstream.
- Seepage in funding; poor or absent performance targets, and the potential for conflict or gaps between expectations of key stakeholders.
- A need for clarity on broader policy: What is the appropriate role of the state in public health, changing behaviour or changing structures? What changes should be sought on questions of individuals’ rights, responsibilities and entitlements in the publicly funded health system?
- Gaps in the legal and organisation public health infrastructure.
Appendix: The current and proposed policy framework: Delivering Choosing Health: making healthier choices easier (2)

This section provides a summary of current public policy aims (‘Priorities’), interventions (‘Big wins’) and the evaluative framework. Details of other relevant strategies and policies are included as endnotes. This section also includes a brief explanation of the funding and the organisation of the Choosing Health agenda, for those less familiar with the broader agenda.

Delivering Choosing Health: making healthier choices easier was published in March 2005, bringing together the White Paper, Department of Health Public Service Agreements (PSA)\(^3\) (i.e. main performance targets) and relevant aspects of the Cross Cutting Spending Review on Health Inequalities\(^4\).

The Delivery Plan identifies a shift in focus in policy away from healthcare to health: ‘Health improvement and health inequalities will become an integral part of NHS activities’. It is stated that government cannot make informed decisions for people but ‘can support them in making healthier choices’ and the overall aim is to engage the public in improving their own health. It identifies a renewed commitment to partnership working: ‘Helping people make healthy choices is...mainstream activity for government, the NHS and local authorities’, led by the NHS. Big wins are therefore broken down into national, regional and local levels responsibilities. All such activities are organised by priorities (A-H).

The Delivery Plan outlines the priorities for action and identifies policy interventions designed to address them. Most are 'based on advice rather than evidence'. Performance measurement and accountabilities are indicated.

Delivering Choosing Health sets out nine priorities as:

A. Tackling health inequalities
B. Reducing the numbers of people who smoke
C. Reducing obesity
D. Improving sexual health
E. Improving mental health and well-being
F. Reducing harm and encouraging sensible drinking
G. Helping children and young people to lead healthy lives
H. Promoting healthy and active life amongst older people.

Priority A: Health inequalities

The health inequality targets are:

- Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth:
  - Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole.
  - Starting with Local Authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the “worst health and deprivation indicators” and the population as a whole.

- Substantially reduce mortality rates by 2010 (from the 1995-97 baseline):
  - From heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the 20% of
areas with the worst health and deprivation indicators and the population as a whole.

- From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the 20% of areas with the worst health and deprivation indicators and the population as a whole.

In practice targets overlap and health inequality in embedded in many others. Thus, many of the big wins identified are also big wins for other targets. PCTs appear to have dealt with this issue by making inequality their headline priority, into which the others feed.

Big wins for tackling health inequalities are:

- **Reducing smoking**: especially in disadvantaged groups and among pregnant women.
- **Targeting disadvantaged groups**: for example focusing smoking cessation projects on manual workers and some minority ethnic communities.
- **Improving access to primary care and secondary prevention and care**, especially in disadvantaged groups.
- **Using health equity audit and ethnic monitoring**.
- **Responsive, accessible services and advice**: e.g. tailored provision, Health Trainers.
- **High quality family and early years support**: e.g. Sure Start, Home Start.
- **Healthy Schools**\(^5\), (key date: half of all schools by 2006 with the rest working towards Healthy School status by 2009 – targeting schools with >20% free school meals as a priority) including PE and sports targets, meal standards and the school fruit and vegetable scheme.\(^6\)

Supporting strategies from the Department of Health include:

- **Tackling Health Inequalities: a programme for action** (July 2003)
- **NHS Cancer Plan: a plan for investment, a plan for reform**\(^7\) (September 2000)
- **National Service Framework for Coronary Heart Disease**\(^8\) (March 2000)

Supporting strategies from other departments include:

- **ODPM Five Year Strategy: Sustainable Communities: Homes for All**\(^9\) (January 2005)
- **DWP Five Year Strategy: Opportunity and Security Throughout Life**\(^12\) (February 2005)
- **A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond – Health and Safety Commission**\(^13\) (February 2004)
- **UK Sustainable Development Strategy**\(^14\) (March 2005)

Monitoring lines for performance measurement include those relating to infant mortality, heart disease and cancer:

- Smoking during pregnancy (reduction in levels)
- Breastfeeding initiation rates (increase in levels)
- Teenage conception rates (reduction in level)
- Cardiovascular disease mortality rates among under 75s (reduction in levels)
• Practice-based registers of patients at risk of CHD (GP screening of high risk patients)
• Blood pressure readings (GP screening of high risk patients)
• Cholesterol levels (GP screening of high risk patients)
• Cancer mortality rates among under 75s (reduction in levels)
• Cancer (implementation of NICE Improving Outcomes Guidance)
• Bowel cancer screening (returning plans to DH is deferred)

Priority B: Reducing the numbers of people who smoke

The target for smoking is:

• Reduce adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine manual groups (from 31% in 2002) to 26% or less.

In addition the existing national target is to be maintained: 800,000 smokers from all groups successfully quitting at the four-week stage by 2005/06 (from 2003/04).

Big wins are:

• **Support for smoking cessation**: more accessible and responsive ‘stop smoking’ services, wider availability of nicotine replacement therapy, particularly to manual groups, use of new technology, for example, electronic booking, targeted support for NHS employees.
• **Reducing exposure to second-hand smoke**: a staged approach to ending smoking in public places; establishing smoke-free government, NHS and voluntary agreements (key date: by 2006); legislation on enclosed public spaces and workplaces (key date: by end 2007) and licensed premises (key date: by end 2008) following consultation with the hospitality industry.
• **Reducing tobacco advertising and promotion**: enforcing existing and new legislation banning or restricting advertising and promotion, stronger regulatory framework with new mandatory picture warnings on tobacco products.
• **National smoking, communication campaigns and education**: new campaigns on second-hand smoke and the health risks of tobacco products; motivating and helping people who want to quit, with a particular focus on manual groups.
• **Reducing availability and supply of tobacco including illicit and smuggled tobacco**: Her Majesty’s Treasury and Customs working together locally and nationally to reduce the market share of smuggled (including counterfeit) tobacco; new powers on underage sales and enforcement of existing regulations.

Supporting Strategies are:

• **Smoking Kills** (December 1998)
• **The Cancer Plan** (October 2004)
• **The NSF CHD** (March 2000)
• **Tackling Tobacco Smuggling** (March 2000)

Performance against this priority will be monitored by:

• Smoking quitters at four-week follow-up stage
• Smoking status among the population aged 15-75 years (reduction in levels)
Priority C: Reducing obesity

The obesity target is:

- Halt the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

Big wins are:

- **Simple labelling of packaged food**: a clear and simple set of food labels developed with the Food Standards Agency (FSA), retailers and industry; simplified and mandatory food labelling; action by industry to reduce fat, sugar and salt in foods and reverse the trend in increasing portion sizes.
- **National Obesity Awareness Campaign**: evidence-based promotional campaign to encourage parents to make healthy choices for themselves and their children, awareness raising in early years through Sure Start including promotion of breastfeeding.
- **Helping people who want to lose weight**: practical advice and support to promote healthy lifestyles, screening by GPs and referral through obesity care pathways for dietetic programmes and surgical interventions.
- **Food Promotion to Children**: restricting further advertising and food promotion to children of foods high in fat, sugar and salt; push to amend EU Directive to restrict advertising of infant follow-on formula, Healthy Schools.
- **Encouraging Activity**: community level interventions to promote physical activity, sport, cycling and use of green spaces; play projects; school PE, sport and club links; Specialist Sport Colleges; cycle training; action to promote cycling and walking to school.
- **Family and early years support**: such as Sure Start.

Supporting strategies include:

- *Food and Health Action Plan* (March 2005)

Relevant strategies from other departments include:

- *Game plan: a strategy for delivering government’s sport and physical activity objectives*
- *Sports England Delivery Plan*
- *ODPM’s 5 Year Strategy: People, Places and Prosperity* (January 2005)
- *Healthy Schools, Active Minds: A Healthy Living Blueprint* (September 2004)
- *Healthy Schools*
- *Food in Schools*

Performance monitoring of this target is not yet clear:

- Childhood obesity (returning plans to DH is deferred)
- Obesity status amongst the GP registered population aged 15-75 (GP screening)
Other relevant PSA are:

- By 2008, increase the take-up of cultural and sporting opportunities by adults and young people aged 16 and above from priority groups by:
  - increasing the number who participate in active sports at least 12 times a year, by 3%;
  - and increasing the number who engage in at least 30 minutes of moderate intensity levels sport at least three times a week, by 3% (Department of Culture, Media and Sport)

Priority D: Improving sexual health

The target for sexual health is:

- Reduce the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.

Big wins are:

- A new national media campaign: co-ordinated with the teenage pregnancy strategy and targeting younger men and women to ensure they understand the risks of unprotected sex and the benefits of using condoms; engaging support of local stakeholders and industry.
- The Teenage Pregnancy Strategy: strengthen delivery to reach vulnerable groups and target areas with high rates of under-18 conception as part of the broader programme to improve sexual health.
- Modernised sexual health services: investment in more accessible and effective contraceptive, abortion and sexually transmitted infection (STI) services; fully integrated care pathways and networks; working with the Health Protection Agency to identify needs; developing new service models; implementing standards for HIV services (and forthcoming standards on STIs).
- Faster access to services: annual progress towards targets; appointments offered within 48 hours of contacting a genito-urinary medicine (GUM) service (target date: 100% by 2008); national roll-out of screening for chlamydia (target date 2007), including screening in non-traditional sites (for example pharmacies).
- Advice and contraceptive services for young people: co-ordinated programmes through children’s trusts involving the NHS, local authorities and schools.
- Sexual Assault Referral Centres (SARCs): joint DH and Home Office initiative to develop nationally, including services for children and adolescents.

Supporting strategies are:

- National Teenage Pregnancy Strategy (June 1999)
- National Strategy for Sexual Health and HIV (July 2001)

Performance indicators are:

- Teenage conception rates (reduction in levels)
- Access to GUM clinics within 48 hours
- Decrease in rates of new diagnoses of gonorrhoea
- Percentage of people aged 15 to 24 accepting chlamydia screening (returning plans to DH is deferred)
‘Teenage conception rates’ is also a Local Authority Best Value Performance Indicator.

Priority E: Improving mental health and well-being

The target for mental health and well-being are:

- By 2010, reduce mortality rates from suicide and undetermined injury by at least 20%.

Existing national target to be maintained: Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005, and a comprehensive Child and Adolescent Mental Health service by 2006.

Big wins are:

- **Expanding help for people with mental illness**: improving access, care planning and referral arrangements (including referrals from the criminal justice system); well-being support programmes; physical and mental health promotion and illness prevention; supported employment and day services.
- **Targeted action to improve the quality of patient experience**: for example, patients from black and minority ethnic communities or victims of domestic violence (such as through the joint Department of Health, Home Office and National Institute of Mental Health in England 26 (NIMHE) violence and abuse programme).
- **Extended coverage of child and Expanding help for people with mental illness**: improving access, care planning and referral arrangements (including referrals from the criminal justice system); well-being support programmes; physical and mental health promotion and illness prevention; supported employment and day services.
- **New** services to improve mental and emotional well-being: for example, by supporting parents and carers and improving parent-child relationships; Sure Start, Healthy Schools and programmes for looked-after children, supporting carers and promoting social inclusion through initiatives to engage communities; local implementation teams to promote mental health and reduce stigma; materials to support self-help.
- **A healthy workplace programme**: encouraging employers, including the NHS, to adopt policies and guidelines to promote better mental health at work, tackle stress and support staff experiencing distress; supporting people with mental health problems back into the workplace through links with local partners, including JobCentre Plus.
- **NHS Health Trainers**: helping people who want to develop their own health guides; providing advice and practical support to stop smoking, practise safer sex, deal with stress and access local services; support people who lack basic skills (Key date: from 2007, 2006 in areas with highest need).

Supporting strategies are identified as:

- **National Framework for Mental Health** (September 1999)
- **Delivering Race Equality in Mental Health Care** (January 2005)
- **National Workforce Programme for Mental Health** (August 2004)
- **National Suicide Prevention Strategy** (September 2002)
- **Mental Health Promotion programme and ‘Shift’: the programme to reduce stigma** (June 2004)

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b New?
• **Social Inclusion Programme** (June 2004)

Not mentioned, but relevant is the Draft Mental Health Bill.

Performance measures are:

- Suicide rates (a reduction in levels – mortality rate from suicide and undetermined injury per 100,000 directly age standardised population).
- CPA 7-day follow-up (increase the percentage of people on enhanced CPA receiving follow-up by phone or face to face contact within 7 days of discharge from hospital).

A related measure for Local Government is ‘to assess the overall provision and effectiveness of local authority services designed to help victims of domestic violence and prevent further domestic violence’.

**Priority F: Reducing harm and encouraging sensible drinking**

The Target is a Home Office target and not a Department of Health PSA:

- Reduce crime by 15% and further in high-crime areas, by 2007-08.

Big wins under the reducing harm and encouraging sensible drinking priority are:

- **Placing information for the public on alcohol containers and in alcohol retail outlets**: providing clear and accessible information about sensible drinking, including reminders about responsible drinking on alcohol advertisements.
- **Raising awareness**: national communications campaign to reduce binge drinking: providing information for the public in healthcare and non-healthcare settings (for example retail outlets).
- **Local Authority enforcement**: for example checking retailers identify and refusing to sell alcohol to under-18s, and complying with codes of practice and legislation.
- **Increase access to and effectiveness of alcohol treatment**: using the national audit of alcohol services and the Models of Care guidance (spring 2005) to develop local services; training professionals to identify and target support at harmful and dependent drinkers; establishing referral protocols between primary and secondary healthcare settings and specialist alcohol services.
- **Screening and brief interventions**: piloting interventions in primary care and A&E, identifying ways to reduce alcohol intake in high-risk groups, linked to similar initiatives within criminal justice settings.
- **Planning local responses**: involving local authorities, PCTs, the police, licensing trade and other local statutory partners (for example through Crime and Disorder Reduction Partnerships).

The **Alcohol Harm Reduction Strategy for England** (March 2004) is the identified supporting strategy.

Department of Health monitoring data are not specified. The target relates to crime and is a Home Office target. At the same time, the Home Office Drug Strategy specifically states that it does not include alcohol because that is a Department of Health issue.

Since the publication of *Delivering Choosing Health*, the Department of Health have announced the **Programme of Improvement for Alcohol Misuse** (November 2005), designed
to help PCTs improve services. £3.2 million has been allocated to support early intervention (63).

Priority G: Helping children and young people to lead healthy lives.

This priority captures a range of existing targets, namely the obesity target and sexual health:

- Halt the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.
- Reduce the under-18 conception rate by 50% by 2010 (from the 1998 baseline) as part of a broader strategy to improve sexual health.

Big wins here are:

- **Healthy Schools**: implementing new healthy school standard; deliver PE and school sport target and implement school meals standards and school fruit and vegetable scheme.
- **School nurses**: every PCT resourced to have at least one full-time, year-round, qualified school nurse working with each cluster or group of primary schools and the related secondary school to identify and help children at risk (Key date: 2010).
- **Children’s Trusts**: integrating the planning, commissioning and delivery of health services across education and social care (key date: in all areas by 2008); implementing a single inspection framework (key dates: September 2005); improving core health skills and knowledge of professionals working with children, young people, families and carers; action to make health services more accessible to children and young people.
- **Children’s Centres**: (key dates: 2,500 centres including one in each of the 20% most disadvantaged areas by March 2008, 3,500 by 2010, one for every community in England).
- **Extended Schools**: all schools doing over time to deliver an integrated range of services to pupils, parents and the wider community.
- **Supporting healthier choices**: national campaigns, children’s health guides, digital media; targeting high-need children and their parents, for example carers of looked-after children, young people in contact with the criminal justice system; vouchers for milk, fresh food; improving youth work to support young people’s choices including sex and relationships, drugs, alcohol and opportunities for physical activity.

Supporting strategies include:

- *DFES Five Year Strategy for Children and Learners* (November 2004)
- *Updated Drugs Strategy* (November 2002) (Home Office)
- *Tackling Drugs to Build a Better Britain* (1998) (Cabinet Office)
- *Learning through PE and school sport* (March 2003)
- *Learning through PE and sport – an update on strategy* (October 2004)

The targets for this priority relate to obesity and sexual health. This is reflected in the data monitoring lines, which are:

- Childhood obesity (returning plans to DH is deferred).
• Obesity status among the GP-registered population aged 15 to 75 years (GP screening).
• Teenage conception rates (also a Local Authority Best Value measure).
• Access to GUM clinics within 48 hours.
• Decrease in rates of new diagnoses of gonorrhoea.
• Percentage of people aged 15 to 24 accepting chlamydia screening (returning plans to DH is deferred).

Priority H: Promoting healthy and active life amongst older people.

The final Choosing Health priority relates to the Department of Health’s PSA target addressing older people:

• Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:
  o Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008.
  o Increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

Big wins here are:

• Local physical activity programmes.
• Communications and education targeted at people in midlife: for example, physical exercise.
• Continuing piloting, promotion and good practice in new technologies and assistive technologies, for example Health Direct.
• Preventing falls and fractures through integrated falls services.
• Intermediate healthcare and intensive homecare as an alternative to hospital care.

Supporting strategies are:
• National Service Framework for Older People45 (May 2001)
• DWP Five Year Strategy: Opportunity and Security Throughout Life46 (February 2005)

Delivery Choosing Health does not specify performance measures.

Supporting Strategies

Achieving targets will depend on four ‘supporting strategies’, each with big wins and some with target dates:

Promoting personal health big wins are:

• NHS Health Trainers (key date: from 2007, 2006 in areas of highest need).
• Health Direct, internet and digital TV services (key date: mid 2007).
• **Stronger voluntary and statutory codes**, for example restricting advertising, supporting health living promotions (key date: 2007, legislation if necessary after this).
• **Using marketing to build public awareness and change behaviour** (key dates: campaigns from April 2005).
• **Healthier work places**, for examples introducing a health organisation model to Investors in People (key date: 2007) and advising on preventing illness and getting people back to work (key date: Workplace Health Direct pilots starting early 2006).
• **Skills for Health Programme** (key date: 2007), demonstration sites to include the business sector (key date: starting autumn 2005).

*Developing the workforce* big wins are:

• **Engaging the NHS workforces**, including implementing Essence of Care Benchmark, and focusing efforts on preventions.
• **Improving the health of the NHS workforce**.
• **A national workforce strategy and competency framework**.
• **Developing local capacity and capability through PCT Local Delivery and Workforce Plans**.
• **Supporting and development of new roles**, such as school nurses and personal trainers.

One supporting strategy is identified: *Delivering the NHS Improvement Plan: The Workforce Contribution (November 2004)*[^47].

*Building on research and development* big wins are:

• **Public health research initiative to provide a strong evidence case for intervention to be developed with the UK Clinical Research Collaboration** (key date: spring 2005).
• **Public health research consortium to strengthen the evidence base of national policy making**.
• **Increased funding** (key date: in April 2007/08).
• **National prevention research initiative**, providing money for research aimed at preventing heart disease, cancer and diabetes.

*Using information and intelligence* big wins are:

• **A Health information task force** (key date: March 2005).
• **Standard sets of local and regional health information** to be provided by Regional Public Health Observatories (key date: end 2005).
• **Six monthly progress reports** (key date: from early 2006).
• **New systems for recoding lifestyle measures**.
• **New guidance on data sharing, disclosure and confidentiality**.
• **Workforce development** – developing the capacity of the public health workforces to use knowledge management systems.
• **An Innovation fund for testing and disseminating new interventions** (£30 million in 2006/07; £40 million per annum from 2007/08).
• **Guidelines and review of evidence by NICE** and the public health research consortium (key date: 2007).
Funding

Delivery of the Choosing Health priorities will be funded largely from main PCT allocations. PCTs need to include spending in support of health improvement as part of their core business planning. Revenue allocations to PCTs, for the period 2006/07 – 2007/08, were announced on 9 February 2005 and were: £64billion to PCTs in 2006/07 and £70billion in 2007/08. Of this, £211million in 2006/07 and £131million in 2007/08 (£342m in total in 2007/08) has been allocated to support delivery of Choosing Health. This represents around half of the £1billion promised in the White Paper in November 2004. The remainder will fund national programmes or new models of delivery. The extra local funding will be targeted on the most deprived areas, including the Spearhead PCTs (64).

There is scope for PCTs to apply for additional monies as part of the Local Public Service Agreements (LPSAs) and stretch targets. Local Public Service Agreements are negotiated with (Office of the Deputy Prime Minister) ODPM but the Department of Health are consulted on social care and public health targets. There are 12 potential stretch targets. The additional money in LPSAs if of two sorts: Pump Priming grants and Performance Reward Grants. According to the Department of Health:

‘Pump Priming’ grants are sums of money made available to local authorities at the beginning of LPSA programmes to improve services. An example would be a grant for staff training to skill the workforce to deliver a programme. The need for a pump priming grant is assessed for each component of the LPSA and an overall Pump Priming Figure is agreed. This figure is assumed to be £750,000 plus £1 per head of population (subject to a maximum of one-third of their agreed PRG)’.

‘Performance Reward Grants’ are the main financial reward for achievement of the agreed outcomes, and are worth 2.5% of one year’s net revenue expenditure of the local authority. This reward is evenly distributed across all twelve agreed targets. Allocation of this final payment is based on the number of targets achieved. These are large sums and act as a significant incentive for local authorities to deliver’.48

(\[\text{http://www.dh.gov.uk/AboutUs/MinistersAndDepartmentLeaders/ChiefMedicalOfficer/Features/FeaturesArticle/fs/en?CONTENT_ID=4116435&chk=BmbaGN}\]

Organisation

Health improvement will be led by the NHS, but must involve with other stakeholders, such as the Local Authority. PCT Chief Executives are responsible for outcomes (targets). PCTs and partners identify means by which they will meet national and local targets. These plans are set out in Local Delivery Plans (LDPs). These are three-year plans put together with the PCT, the Local Authority and community stakeholders. LDPs are broader than the Choosing Health agenda, as they relate to all health and social care activity. LDPs must be ‘signed off’ (approved) and monitored by Strategic Health Authorities and address both national and local priorities. Over time Local Area Agreements (LAA) will become the main planning mechanism.

The Healthcare Commission will assess performance. Ultimate responsibility for delivery of Choosing Health, and meeting PSA targets, lies with the Department of Health.
Summary

The above section has reviewed current and proposed policy relating to health improvement, concentrating on England. Key points emerge as:

- Priorities (targets) for health improvement are set for 2010.
- Policy is focused on the individual and the changing behaviour.
- The need to address the wider determinants of health.
- Inequalities in health are given considerable attention, but the emphasis is on improving the health of the most disadvantaged - rather than addressing the social gradient – and on addressing health inequality ‘downstream’.
- Many of the proposed interventions are based on ‘advice’ rather than evidence. This should improve over time if interventions are properly evaluated and the results are fed back.
- Social and cultural context is given little focus.
- There are remaining issues around the funding, organisation and management of the agenda.

These issues are discussed more fully in the main part of this paper.
End notes

1 The official definition of public health is ‘the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society’, following the Acheson Report in 1988. (http://www.dh.gov.uk/AboutUs/MinistersAndDepartmentLeaders/ChiefMedicalOfficer/Features/FeaturesBrowsableDocument/fs/en?CONTENT_ID=4102835&MULTIPAGE_ID=5017805&chk=0d0WL6).


3 Department of Health objectives are set out in the Spending Review 2004 Public Service Agreement are as follows:

Objective 1: Improve the health of the population: by 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women

1. Substantially reduce mortality rates by 2010:

   • From heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
   • From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
   • From suicide and undetermined injury by at least 20%.

2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

3. Tackle the underlying determinants of health and health inequalities by:

   • Reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.
   • Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.…
   • Reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health.

Objective 2: Improve health outcomes for people with long-term conditions.

4. To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

Objective 3: Improve access to services

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.
6. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

**Objective 4:** Improve the patient and user experience

7. Secure sustained national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:

- Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008.
- Increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.


4 *Tackling health inequalities - 2002 cross-cutting review* (November 2002)

This long term strategy forms the basis of the cross government delivery plan for tackling health inequalities. It aims to address root causes of inequality and puts responsibility for tackling health inequalities at the heart of every key public service. It ‘empowers local communities to address the health inequalities in their areas, working in partnership with all agencies with a role to play locally’, requires a cross-government response and is associated with additional funding.

([http://www.hm-treasury.gov.uk/media/1F8/DC/Exec%20sum-Tackling%20Health.pdf](http://www.hm-treasury.gov.uk/media/1F8/DC/Exec%20sum-Tackling%20Health.pdf))

*Tackling health inequalities: A Programme for Action* (July 2003) sets out plans to tackle health inequalities over three years. It established the foundations required to achieve the national target for 2010 to reduce the gap in infant mortality across social groups, and raise life expectancy in the most disadvantaged areas faster than elsewhere.


See also *Tackling Health Inequalities: Status Report on a Programme for Action* (August 2005)


5 The *National Healthy Schools Programme* is jointly funded by the Department for Education and Skills (DfES) and the Department of Health (DH). It is part of the government’s drive to reduce health inequalities, promote social inclusion and raise educational standards. The overall aim is to help schools to become healthier and, in doing so, bring about school improvement and greater inclusion. The National Healthy Schools Programme takes a very holistic view of health, so activities in the Programme focus on emotional, social and community health – as well as the physical.

([http://www.foodinschools.org/schools_support/healthy_schools.php](http://www.foodinschools.org/schools_support/healthy_schools.php))

6 The *School Fruit and Vegetable Scheme* is part of the 5 A DAY programme to increase fruit and vegetable consumption. Under the Scheme, all four to six year old children in LEA maintained infant, primary and special schools will be entitled to a free piece of fruit or vegetable each school day.

([http://www.5aday.nhs.uk/sfvs/default.aspx](http://www.5aday.nhs.uk/sfvs/default.aspx))

7 The *Cancer Plan* provides a detailed account of the government’s programme for investment in and reform of cancer services in England, aimed at reducing death rates and improve prospects of survival and quality of life for cancer sufferers by improving prevention, promoting early detection and effective screening practice, and guaranteeing high quality treatment and care throughout the country. The *Cancer Plan* is committed to addressing health inequalities by setting new national and local targets for the reduction of smoking rates, the setting of new targets for the reduction of waiting times,
the establishment of national standards for cancer services, and investment in specialist palliative care, the expansion and development of the cancer workforce, cancer facilities, and cancer research. (http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/CoronaryHeartDisease/fs/en)

8 The National Service Framework for Coronary Heart Disease - modern standards and service models (NSF CHD), published in March 2000, set out a strategy to modernise CHD services over ten years. It details 12 standards for improved prevention, diagnosis, treatment and rehabilitation and goals to secure fair access to high quality services. (Chapter 8 was added 04/03/2005). (http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094275&chk=eTacxC)

9 ODPM Five Year Strategy: Sustainable Communities: Homes for All focuses on accessibility to housing for all that need it, including tackling housing supply and quality, increasing choice related to housing. Improving social cohesion (tackling inequalities and discrimination) is also a major aim. It is anticipated that health is an area that will benefit from the new strategy. (http://www.odpm.gov.uk/index.asp?id=1122851; http://www.odpm.gov.uk/index.asp?id=1122852)

A second part to this strategy - Sustainable Communities - People, Places and Prosperity - should be published to tackle the problems of disadvantaged neighbourhoods and set out to raise the economic performance of all English regions. (http://www.odpm.gov.uk/index.asp?id=1122898)

10 Fuel Poverty in England: The Government’s Plan for Action was published in November 2004 and reviewed in 2005. Reducing fuel poverty is seen as a major step towards reducing poverty. The target date to ‘end fuel poverty for vulnerable households’ is 2010. The core aim is to ensure that the “fuel poor” are adequately targeted. Vulnerable households (e.g. the elderly) are therefore a prime focus but this paper also recognises the needs of the private rented sector.

Aims of this plan include: improving the energy efficiency and thermal comfort of properties, social inclusion, developing schemes and grants (such as EEC grants and Warm Front) and ensuring that the schemes work together rather than in isolation. Although the situation has improved, the targets of the 2005 review document are still those stated in the original plan, i.e. not met. (http://www.defra.gov.uk/environment/energy/fuelpov/index.htm) (http://www.dti.gov.uk/energy/consumers/fuel_poverty/strategy_third_progress_report.pdf) (http://www.defra.gov.uk/environment/energy/hees/index.htm)

11 Improving Opportunity, Strengthening Society: The Government’s Strategy to Increase Race Equality and Community Cohesion (January 2005) recognises the importance of social cohesion on health and well-being. It emphasises Equal Opportunity as a practical issue that must be targeted and monitored across society, in health, education, housing, justice and the labour market. Within this plan, social participation and a ‘shared British identity’ are seen as paramount to strengthening society.

The government wants to promote ‘a sense of common belonging and cohesion among all groups’, targeting especially young people and new immigrants. Moreover, racism, extremism and hatred are to be fought. Providing focused, tailored support is seen as essential to continue achieving those goals. This includes the enforcement of discrimination legislation and a more effective immigration system. This paper insists on the need for others (‘employers, voluntary and community organisations and individuals themselves’) to help the government in its tasks. (http://www.homeoffice.gov.uk/documents/improving-opportunity-strat)

12 DWP Five Year Strategy: Opportunity and Security Throughout Life (February 2005) establishes the need to support certain groups within an ageing society, namely, children and families, disabled workers, ethnic minorities and those on benefits. This should allow them to find work, increase their income and gain independence whilst ‘achieving [their] long-term aspirations’.

This plan does not only concern the workplace itself, but also health, life-long education, rights and benefits, taxes and the legal framework. The DWP aims understand the needs of its ‘customers’ and tailor its support to their needs.
The key aim is ‘opportunity and independence for all’. The DPW seeks to create and ‘opportunity society’ where people will be able to live long, healthy and fulfilling lives. Targets have been set for completion between 2005 and 2010.

13 A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond (February 2004) has a vision ‘to gain recognition of health and safety as a cornerstone of a civilised society’. Health and Safety should be seen as an enabler, not a hindrance. The areas at the heart of this document are: law enforcement, public perception of health and safety and its institutions, communication (especially with small businesses), incident prevention, occupational health, education, sharing responsibility and strategically targeted programmes.

http://www.hse.gov.uk/aboutus/hsc/strategy.htm

14 UK Sustainable Development Strategy (March 2005) recognises the human impact on climate change, its negative consequences for the environment and for people’s quality of life and therefore urges for changes to take place. This paper warns about long-term potential dangers to humans if nothing changes: diseases, disruption in food supplies, skin cancers and deaths due to major ecological disasters. It also encourages change by explaining what existing dangers could be avoided: obesity and the over consumption of ‘unhealthy’ food, diseases (often in deprived areas) caused by bad air quality, pollution and diminishing green areas.

The government proposes to lead the way by establishing environmental policies providing ‘long-term social and economic benefits’ such as better environment, health, education, job prospects and housing. It also shows what is already in place. School programmes, for instance, promoting ‘healthier, greener and safer ways of travelling to school, and healthy living’ and the improvement of school food. All this is planned at a national level but also in cooperation with European and global initiatives.


15 Smoking Kills (1998) set out a package of measures intended to reduce smoking prevalence. Measures included banning tobacco advertising, use of taxation, support for smokers wanting to quit, smoke-free policies.

http://www.archive.official-documents.co.uk/document/cm41/4177/contents.htm

16 Tackling Tobacco Smoking (March 2000) identified measures to be taken to reduce smuggling.


17 The National PE and School Sport Club Links strategy (PESCCL) – ‘Learning through PE and School Sport’ (March 2003) aims to increase participation of all 5-16 years olds in high quality PE and School Sport to 85% by 2008. This will be achieved through a multifaceted approach to the provision of high quality PE and School Sport opportunities both within and beyond the PE curriculum. Related documents include Learning through PE and Sport – an update on strategy (October 2004) and the Swimming Charter.

(www.teachernet.gov.uk/_doc/7522/PESS%20and%20CLS.pdf)
(www.teachernet.gov.uk/_doc/5885/Swimming%20charter.pdf)

18 The Food and Health Action Plan sets out interventions to help improvement diets, including plans to label foods better and to encourage health eating. It also addresses issues of sustainability in farming and food production.

(http://www.renewal.net/Documents/RNET/Policy%20Guidance/Choosingbetterdiet.pdf)

19 Choosing Activity: a physical activity action plan sets out Government’s plans to encourage and co-ordinate the action of a range of departments and organisations to promote increased participation in physical activity across England. It brings together all the government’s commitments relating to physical activity in Choosing Health as well as other action across government, which will contribute to increasing levels of physical activity. These include school PE and sport and local action to encourage activity through sport, transport
plans, the use of green spaces and by the NHS providing advice to individuals on increasing activity through the use of pedometers.  
(http://195.33.102.76/assetRoot/04/08/17/12/04081712.pdf)

20 *The Game Plan* (2002) details the government’s vision and strategy for sport from both a mass participation and performance perspective up until 2020. It includes comparative participation and sports performance data, research statistics and theories underpinning the value of sport (such as they are). It details the government’s vision and strategy for sport from both a mass participation and performance perspective up until 2020.  
(http://www.sportdevelopment.org.uk/gameplan2002.pdf)

21 *Sustainable Communities: People, Places and Prosperity* sets out action to ‘revitalise neighbourhoods’. It aims to provide safer, cleaner environments, choice; changes which are to be locally led.  
(Contents: http://www.odpm.gov.uk/index.asp?id=1122899)  
(Complete document: http://www.odpm.gov.uk/pub/900/SustainableCommunitiesPeoplePlacesandProsperityPDF1179Kb_id1122900.pdf)

22 *Healthy Schools, Active Minds: A Healthy Living Blueprint* aims to support schools to do more to encourage children to eat sensibly, stay physically active and maintain good levels of personal health; to give children the knowledge, skills and understanding they need to lead healthy lives, not just through what is taught, but also the school’s organisation and ‘whole-school’ environment. Tools include teaching about healthier life styles, providing healthy food, providing better PE and PSHE opportunities.  
(http://www.dfes.gov.uk/pns/DisplayPN.cgi?pn_id=2004_0150)

23 *The Food in Schools Programme* aims to help schools implement a whole school approach to food education and healthy eating, for example healthier breakfast clubs, healthier cookery clubs, healthier lunch boxes, growing clubs, water provision, healthier tuck shops and healthy vending machines. See also http://www.foodinschools.org/policies_reports/index.php

24 The *National Teenage Pregnancy Strategy* aims to halve the under-18 conception rate in England by 2010 and increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long-term social exclusion.

The strategy focuses on:
- Coordinated multilevel action.
- A media campaign for young people and their parents designed to address myths and ignorance around sex.
- Improved sex and relationship education and access to contraception.
- Better support for teenage parents.

The Teenage Pregnancy Unit moved to DfES when they assumed overall responsibility for children’s and young people’s services. The Independent Advisory Group on Teenage Pregnancy is a non-statutory body established in 2000 as part of the Action Plan.

25 The *Sexual Health and HIV Strategy* was published for consultation in July 2001. It indicated government’s commitment to modernise and improve sexual health services.

It aims to:
- Reduce the transmission of HIV and STIs.
- Reduce the prevalence of undiagnosed HIV and STIs.
- Reduce unintended pregnancy rates.
- Improve health and social care for people living with HIV.
- Reduce the stigma associated with HIV and STIs.
This was followed by the National Strategy For Sexual Health And HIV Implementation Action Plan, published in June 2002; a 27-point action plan providing a framework for delivery, sets out detailed milestones and how interventions will be delivered. It also addresses key concerns raised in consultation.

26 NIMHE is the National Institute for Mental Health in England. It is responsible for supporting the implementation of positive change in mental health and mental health services. It is responsible for the Care Services Improvement Partnership (CSIP, ShiFT programme, the Choice Agenda in mental health services and the social inclusion programme.

27 The National Service Framework for Mental Health sets national standards and defines service models for promoting mental health and treating mental illness in the five following areas: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about carers; and preventing suicide. The Framework also clarifies expectations about the future configuration of mental health services; sets out arrangements for local implementation; puts in place national underpinning programmes to support local delivery. It establishes milestones and a specific group of high-level performance indicators against which progress within agreed timescales will be measured. It reflects the findings of recent consultations with people who use mental health services and their carers, including the work of the Mental Health Taskforce in the Building on the Best: Choice, Responsiveness and Equity consultation (December 2003).

28 Delivering Race Equality: a framework for action for consultation was issued in response to the concerns that mental health services are not being delivered to people from Black and minority ethnic (BME) communities experiencing mental illness and distress in a way that is appropriate to their needs. Delivering Race Equality is intended to set out what those planning, delivering and monitoring local primary care and mental health services need to do to improve services for users, relatives and carers from Black and minority ethnic communities.

29 The National Mental Health Workforce Strategy sets out six key aims for developed the mental health workforce:
• To improve workforce design and planning so as to root it in local service planning and delivery.
• To identify and use creative means of to recruit and retain people in the workforce.
• To facilitate new ways of working across professional boundaries.
• To create new roles to tap into a new recruitment pool and so complement existing staff types.
• To develop the workforce through revised education and training at both pre- and post-qualification levels.
• To develop leadership and change management skills.

(http://www.skillsforhealth.org.uk/mentalhealth/nwp.php)

30 The National Suicide Prevention Strategy aims to support the target of reducing the death rate from suicide by at least 20% by 2010. It will be delivered as one of the core programmes of the National Institute for Mental Health in England (NIMHE).

The Strategy has 6 goals:

• To reduce risk in key high-risk groups.
• To promote mental well being in the wider population.
• To reduce the availability and lethality of suicide methods.
• To improve reporting of suicidal behaviour in the media.
• To promote research on suicide and suicide prevention.
• To improve monitoring of progress towards the Saving Lives: Our Healthier Nation target for reducing suicide [now the Choosing Health target].

(http://nimhe.org.uk/downloads/suicide-prevention-sep02.pdf)

31 The Mental Health Choice Programme has developed a ‘Choice Checklist’ to engage and encourage local mental health services to improve and extend choice they provide to people who use their services. Our Choices in Mental Health – The Checklist (due for publication 31 July 2005) identifies key ‘choice points’ along the care pathway where offering the ability to choose will add the most value to people using services.

In the autumn of 2005, local services will be asked to show how they are providing, or planning to provide, choices as part of the Choice Themed Review report. The national submissions will be analysed and a summary report will be available at the end of the year at www.mhchoice.org.uk.

32 Shift is a five-year initiative (2004-2009) in England to tackle stigma and discrimination surrounding mental health issues. The programme of work is set out in a plan called From Here to Equality. It aims to create a society where people who experience mental health problems enjoy the same rights as other people. This means working in partnership to redesign and evaluate services. Shift builds on the mind out for mental health campaign, which ran from 2001 to April 2004.

(http://www.shift.org.uk/Home)
(http://nimhc.csip.org.uk/index.cfm?fuseaction=main.viewItem&intItemID=13871)

33 NIMHE’s Social Inclusion Programme will drive forward the implementation of the ‘Mental Health and Social Exclusion’ Report, published in June 2004 by the Office of the Deputy Prime Minister (ODPM). The 27-point action plan brings together the work of government departments and other organisations in a concerted effort to challenge attitudes, enable people to fulfil their aspirations and significantly improve opportunities and outcomes for people with mental health problems.

(http://kc.nimhe.org.uk/upload/Natl%20SI%20Prog%201st%20AnnualReport%2020051.pdf)

The implementation process will divide into 8 key project areas:

• Stigma and Discrimination
• Employment
• Income and Benefits
• Education
• Housing
• Social Networks
• Community Participation
• Direct Payments

For each project area, current baseline evidence will be established, action undertaken to meet immediate deliverables and work put in place to define and disseminate medium and long term goals and action.

34 Care Programme Approach.

35 The 1998 Crime and Disorder Act established partnerships between the police, local authorities, probation service, health authorities, the voluntary sector, and local residents and businesses to reduce crime and disorder. The Home Office’s 5-year Strategic Plan has outlined 7 new Public Service Agreements (PSAs) that set their priorities to 2007/08 (December 2004). One relates to health:

• PSA4 - to reduce the harm caused by illegal drugs including substantially increasing the number of drug misusing offenders entering treatment through the Criminal Justice System

(http://www.crimereduction.gov.uk/partnerships62guide.doc)

See: http://www.crimereduction.gov.uk/partnerships62.htm

36 The Alcohol Harm Reduction Strategy for England aims to:

• Tackle alcohol-related disorder in town and city centres.
• Improve treatment and support for people with alcohol problems.
• Clamp down on irresponsible promotions by the industry.
• Provide better information to consumers about the dangers of alcohol misuse.

The strategy includes a series of measures aimed at achieving a long term change in attitudes to irresponsible drinking and behaviour, including:

• Making the "sensible drinking" message easier to understand and apply.
• Targeting messages at those most at risk, including binge- and chronic drinkers.
• Providing better information for consumers, both on products and at the point of sale.
• Providing alcohol education in schools that can change attitudes and behaviour.
• Providing more support and advice for employers.
• Reviewing the code of practice for TV advertising to ensure that it does not target young drinkers or glamourise irresponsible behaviour.
• Improving health and treatment services.

(http://www.strategy.gov.uk/downloads/su/alcohol/pdf/CabOffice%20AlcoholHar.pdf)

37 Children’s Trusts bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to cooperate, to focus on improving outcomes for all children and young people. Children's Trusts are a response to Lord Laming’s report of the inquiry into the death of Victoria Climbié.

This highlighted the need for better partnership working and communication. Good examples of existing multi-agency work include: Sure Start, the Children's Fund, Connexions, behaviour and education support teams, children and young people's strategic partnerships, and youth offending teams.

(http://www.everychildmatters.gov.uk/aims/childrentrusts/faq/)
(http://society.guardian.co.uk/children/story/0,1074,540386,00.html)
Children’s Centres are one-stop shops joining up services for young children and their families, including childcare integrated with early learning. Children’s centres form a key part of the Government’s services which aims to tackle the broader Government objectives of: Giving children the best start

- Improving social/emotional strategy for children’s development.
- Helping families move from welfare to work.
- Enabling family friendly work / life balance.
- Neighbourhood renewal and community development.

In the Government’s Ten Year Childcare Strategy 2004, there is a target to create 3,500 children’s centre by 2010. Local authorities have been given strategic responsibility for the delivery of children’s centres and are planning the location and development of centres to meet targets set by the Government.

In the Chancellor’s Spending Review speech in July 2004, he announced that an additional £100 million would be made available to create 2,500 children’s centres by 2008. They will be expected to offer:

- Early education and childcare places that fit with families’ needs, whether in group settings, with childminders, or at home.
- Parenting and family support.
- Health advice, including health visiting and midwifery.
- Preventative services to support children with additional needs early in a child’s life, including outreach to communities.
- Support and help for parents to move into training and work.

Extended School provides a range of services and activities, often beyond the school day, to help meet the needs of children, their families and the wider including:

- High quality childcare available 8am-6pm all year round.
- Parenting support including family learning sessions.
- Swift and easy referral to a wide range of specialist support services.
- Wider community access to ICT, sports and arts facilities, including adult learning.

The Children’s NSF is a 10-year programme intended to stimulate long-term and sustained improvement in children’s health, published in October 2004 and updated in January 2005. The NSF sets standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy to adulthood.

Relevant standards include:

- **Standard 1**: Promoting Health and Well-being, Identifying Needs and Intervening Early the health and well being of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS in partnership with local authorities.
- **Standard 2**: Supporting Parenting
  Parents or carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.
- **Standard 3**: Child, Young Person and Family-Centred Services
  Children and young people and families receive high quality services that are coordinated around their individual and family needs and take account of their views.

**DfES Five Year Strategy** focuses on choice and personalisation of services. ([http://www.dfes.gov.uk/publications/5yearstrategy/docs/DfESSYearstrategy1.rtf](http://www.dfes.gov.uk/publications/5yearstrategy/docs/DfESSYearstrategy1.rtf))
The Updated Strategy 2002 builds upon the findings of the 10-year strategy Tackling Drugs to Build a Better Britain (1998) and is designed to provide an integrated approach. The Updated Strategy arose from a review conducted by the Home Affairs Select Committee, which found that while the Government's drug policy covered the right areas, a stronger emphasis was needed on preventing and stopping problematic drug use, reducing the harms from drug misuse and more focused and measurable targets. (http://www.drugs.gov.uk/publication-search/communications-campaigns/Updated_Drug_Strategy_2002.pdf?view=Binary)

Tackling Drugs to Build a Better Britain (1998) set out a ten-year programme. Overall, the UK-wide drugs strategy aims to:

- Prevent young people from becoming drug misuses.
- Reduce the supply of illegal drugs.
- Reduce drug-related crime.
- Reduce the use of drugs through increased participation in treatment programmes.

Current PSA targets are:

- Reduce the harm caused by illegal drugs (as measured by the Drug Harm Index encompassing measures of the availability of Class A drugs and drug related crime) including substantially increasing the number of drug misusing offenders entering treatment through the Criminal Justice System.
- Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
- Reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people. (http://www.archive.official-documents.co.uk/document/cm39/3945/3945.htm)

Choice for parents, the best start for children: a ten year strategy for childcare sets out the Government's aims for providing better choice, availability, quality and affordability in childcare. Specific policies include:

- Extending paid maternity leave to nine months from April 2007 with a goal of 12 months by the end of the next Parliament.
- A new right for mothers to transfer some their maternity pay and leave to fathers.
- Extending the right to request flexible working arrangement…to parents with older children.
- By 2010, affordable before and after school care all year round for children aged between three and four.
- By 2010 a Sure Start children’s centre in every community…
- More hours of free early education and care for three to four year olds…
- Investment to ensure quality, sustainable, affordable, quality provision…
- Improvements to childcare part of the Working Tax Credit. (http://www.hm-treasury.gov.uk/media/D94/AE/cfp_leaflet_020205.pdf)

National Service Framework for Older People addresses problems older people face in receiving care in order to deliver higher quality services. The key standards are plans to eradicate age discrimination and to support person-centred care with newly integrated services. A new layer of intermediate care is being developed at home or in care settings, while in general hospitals, care should be delivered by the appropriate hospital staff.
The NHS is also to take action on stroke prevention, in the promotion of health and active life and a reduction in the number of falls for older people. Integrated mental health services are to be provided for older people. The process of translating these nationally supported standards into local delivery is outlined.

Standard 8 relates to the promotion of health: ‘The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils’…

Action can be taken by the NHS and councils to:

- Prevent or delay the onset of ill health and disability.
- Reduce the impact of illness and disability on health and well-being.
- Identify barriers to healthy living (for example cultural appropriateness of services).
- Develop healthy communities that support older people to live lives that are as fulfilling as possible. This will include working with council services such as leisure and lifelong learning.

(DWP Five Year Strategy: Opportunity and Security Throughout Life sets out the long-term aspiration of increasing the overall employment rate from 75% to 80% by tackling inactivity while still supporting those who are unable to work, including:

- Reform of incapacity benefits to help more people who are able to work, get back to and stay in work. This is part of a six-step strategy designed to ensure more people with health conditions and disabilities, are helped back to work. The strategy includes a £20 million trial to improve workplace health and measures to support GPs in providing fitness for work advice, including placing employment advisers in GP’s surgeries.
- A package of help for lone parents, together with the extension of childcare.
- Increased opportunity to work longer and save more for retirement.

The strategy also sets out how the welfare state is being reformed so that services are now tailored to the individual.

(www.dwp.gov.uk/publications/dwp/2005/5_yr_strat/index.asp)
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