Freeing the Dragon
New Opportunities to Improve the Health of the Welsh People

Dr Stephen Monaghan
Consultant in Public Health Medicine
Bro Taf Health Authority

Jane Davidson
Assembly Member, and
Former Head of Social Affairs,
Welsh Local Government Association

Dr David Bainton
Senior Lecturer in Public Health Medicine,
University of Wales College of Medicine

Foreword by:
John Wyn Owen CB

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New Opportunities to Improve
the Health of the Welsh People

Dr S. Monaghan
J. Davidson AM
Dr D. Bainton

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Correspondence to

Dr Stephen Monaghan
Consultant in Public Health Medicine
Public Health Department
Bro Taf Health Authority
Temple of Peace and Health
Cathays Park
Cardiff
CF10 3NW

Telephone: 01222-402514

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This publication is dedicated to our families, Breege, Mark and Paul, Guy, Joe, Lewis and Hannah, and Carolyn without whose support it would not have been possible.

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All views expressed and any errors within the document are those of the authors alone and should not be taken to represent the positions of their employing organisations.

CONTENTS

		PAGE
	FOREWORD BY JOHN WYN OWEN	vii
1	INTRODUCTION	1
2	THE HEALTH OF THE WELSH PEOPLE	5
3	TOWARDS EXPLAINING AND IMPROVING WALES' POOR HEALTH	11
4	CURRENT HEALTH POLICY	23
5	IMPROVING HEALTH THROUGH THE EUROPEAN UNION	35
6	IMPROVING HEALTH THROUGH THE WELSH ASSEMBLY	47
7	IMPROVING HEALTH THROUGH LOCAL GOVERNMENT	55
8	IMPROVING HEALTH THROUGH THE NHS	63
9	IMPROVING HEALTH THROUGH THE PUBLIC HEALTH FUNCTION AND INTERSECTORAL COLLABORATION	79
10	CONCLUSIONS: TAKING THE HEALTH AGENDA FORWARD	87
	APPENDIX	97
	A BIBLIOGRAPHY	101

FOREWORD

Better Health, Better Wales[1] describes the legacy of health and inequalities in health status within Wales and between Wales and other countries. The health service in Wales has made a significant contribution to improving the health of the people, though too many of the policy levers to make a difference are outside health - notably housing, environment, and employment. The health service in Wales also has a long tradition of innovation, not least the concept of health gain. In the National Audit Office report *Improving Health in Wales*[2] the general conclusion was that the Welsh Office's Strategic Intent and Direction "was a pioneering response to the WHO Strategy for Health For All by the Year 2000 and therefore lacked models to follow

> *...The initiative has had a substantial effect on the way in which the NHS in Wales plans service developments.*

In the WHO Annual Report Dr Gro Harlem Brundtland, Director-General of WHO, said that human health and its influence on other aspects of life is central.

> ....*Research has begun to provide clearer evidence of the economic benefits of improving health ... Economists should never forget the intrinsic value of health ...But neither should health professionals forget an important message for presidents and finance ministers: investing in health accelerates economic growth and is one of the very few viable approaches to rolling back poverty* .

These WHO messages are important for the newly-established Assembly in Wales and also for the Parliaments in Edinburgh and Westminster. As they contemplate their economic policies, politicians need to bear in mind that

> *the relationship between health improvement variables and economic growth is sufficiently significant in the long term to justify sustained national commitment to investing in health*[4]

Freeing the Dragon forms part of the Trust's interest in devolution and health in the UK and is a contribution to the development of policy villages, the need for which was highlighted in *Devolution and Health*[5]. The expectation is that with tight political and professional networks it is possible to reach quicker and easier agreement over policy and strategy.

The assessments and advice contained in this publication have wider implications and could be of interest to regional administrations as they strive to achieve Health 21[6],

[1] Better Health Better Wales. Welsh Office. May 1998
[2] Improving Health in Wales. NAO. 1996.
[3] Making a Difference. The World Health Report 1999. WHO. Geneva
[4] ibid. Pan American Health Organisation
[5] Robert Hazell and Paul Jervis. Devolution and Health. Nuffield Trust. 1998
[6] Health 21. An introduction to the health for all policy framework for the WHO European Region. European Health for All Series No. 5. WHO. Copenhagen. 1998.

through attaining scientific, economic, social and political sustainability and action covering:

- multisectoral strategies to tackle the determinants of health

- a health gain programme and investments for health development and clinical care

- integrated family - community oriented primary health care supported by a flexible and responsive hospital system.

- A participatory health development process that involves relevant partners in health at home, school and work at local, community and country levels and that promotes joint decision making, implementation and accountability.

Despite recent improvements the health of the people of Wales is poor compared with the majority of the European countries and other parts of the UK. A fresh approach is needed. The Assembly offers an opportunity for this but it will be important to ensure that lessons are collated and Welsh efforts benchmarked against OECD achievements and tested against the principles of the Ljubljana Charter[7]. In summary, these propose that health care reforms should be:

- driven by values of human dignity, equity, solidarity and professional ethics

- targeted on protecting and promoting health

- centred on people, allowing citizens to influence health services and take responsibility for their own health

- focused on quality, including cost-effectiveness

- based on sustainable finances, to allow universal coverage and equitable access

- oriented towards primary care

John Wyn Owen CB
Secretary, The Nuffield Trust
August 1999

[7] World Health Organisation (1996) The Ljubljana Charter on Reforming Health Care.

CHAPTER 1

INTRODUCTION

Inequalities in health are the most fundamental inequalities of all, there is no greater inequality than the difference between being dead and being alive.

Frank Dobson 1997.

premature death is the ultimate social exclusion

Tessa Jowell 1999

The state of health in Wales leaves much to be desired. National research has identified the existence of inequalities in health and quality of life between local authority areas. Locally, there are extreme differences in mortality and health experience between communities, at its worst highlighted by a five year difference in life expectancy within a mile.

For fifty years the NHS has helped people who fall sick, and health in Wales has primarily been seen as the responsibility of the NHS. Good health is however more than about the absence of disease. It has to do with the way we live, the quality of our life and our environment.

A fresh approach is therefore required - which addresses the root causes of local health problems.

Improving health means not just addressing lifestyle but taking action on the life circumstances which give rise to poor health. A job, a decent home, good education and an attractive environment are all key determinants of health and a strong framework is required to focus on the underlying social, economic and environmental circumstances which affect health. Such an approach coupled with access to good local health care services will lay a good foundation for improving health. Such an approach in Wales is enhanced by the establishment of the new National Assembly for Wales.

The preliminary result of the Nuffield Trust report on devolution and health commissioned from the Constitution Unit (Hazell and Jervis 1998) is that devolution offers the health service in Scotland and Wales few new freedoms. Scotland has a stronger political will for devolution, while Wales has a clearer reforming agenda, particularly with local government involvement. This book now looks at the opportunities for developing a Wales-specific reform agenda to tackle health gain issues.

Wales is entering an exciting period in its constitutional history. Over the last year, there has been a focus on a new style of partnership politics in preparation for the Assembly. The former Welsh Office set up numerous cross-sector groups to advise government in the delivery of policy development in Wales. Now, these partnerships are enshrined in legislation - the Partnership Council with local government, the

compact with business and the voluntary sector, and the regional advisory committees. There is a potential new focus in Wales for consultative and participatory politics through the National Assembly for Wales.

How the Assembly will develop a specific Welsh agenda, what its relations with Whitehall will be and how it will relate to Europe are all unanswered questions. This book explores how an effective public health agenda can be delivered in Wales within local, national and international contexts. The government in Wales has made a commitment to transparent processes and the development of joint working and we look to ways of realising these aims, while recognising the limitations.

We anticipate the Assembly starting cautiously. It will inherit a series of constraints on its activity. Tighter political accountability locally will make unpopular decisions more difficult; its funding capacity will be constrained by current investment commitments.

Nevertheless, the creation of the Assembly presents real political opportunities: Assembly politicians will be able to develop a strategic view through closer access to health professionals; a dedicated Secretary and subject committee will have more legitimacy to introduce change; more vigorous democratic scrutiny should lead to improved performance.

It will be easier to operationalise co-ordinated health gain policies in Wales because of its smaller size of administration and ease of communication

With Labour in minority government, the Assembly has to take on board government priorities related to health, education and the economy. Early positive indicators from the new Health Secretary indicate a commitment endorsed by the authors to tackling inequalities.

The Government has recently consulted on its spending priorities through its Comprehensive Spending Review. Its objectives went out to wide consultation leading to a three-year framework of Welsh priorities to be inherited by the Assembly. The most relevant objective in respect of health was:

> Objective 5: To promote the health and well being of everyone living in Wales and provide effective and efficient health and social services:
>
> - to improve the health and well being of the population of Wales and reduce inequalities in health status
> - to reduce inequity in access to health services and treat people suffering from illness or injury effectively
> - to improve the standards of support and care provided in the community to the socially disadvantaged or those requiring continuing care;
> - to promote the welfare of children and protect them from abuse and neglect

This has been followed up by the Assembly's consultation document, "A Better Wales" published on 16 July 1999. Social inclusion and tackling health inequalities are identified as key strategic challenges; partnership is the paramount value and principle, and tackling the causes of ill health a proposed priority for the Assembly.

The commitment to improving the health and wellbeing of the population of Wales is very welcome. But, where do you invest to get health gain? Wales already has 12% higher spending on health services; 9% higher on personal social services and has a 10% lower GDP than other parts of the UK. Public services in Wales constantly complain of under-investment, yet the NHS and local government already account for nearly 80% of the Welsh purse. This book will make proposals for consideration by new Assembly members as to the mechanisms required for the delivery of an effective public health agenda, within the identified constraints.

One of the ways in which the Assembly will be able to become more effective is to learn lessons from elsewhere. Wales already has good international links through the World Health Organisation's (WHO) European Regional Offices. The Welsh Local Government Association is currently working with the WHO on its investigation into the role of local government in the delivery of primary care. Wales is part of the Regions for Health network - in fact a founder member, and has a number of WHO collaborating centres and health promoting hospitals. Health Promotion Wales, prior to its incorporation into the National Assembly for Wales, had established an international profile with its work on healthy communities. Wales has an office in Brussels, the Wales European Centre, supported by the Assembly, WDA and local government. Much of Wales has qualified for Objective 1 Status. This all needs enhancing. The Assembly should monitor and evaluate Wales' performance against the best in the world whilst developing a Wales-specific agenda.

An immediate challenge for new Members of the Assembly is to clarify its role in terms of existing structures and relationships. Wales has been subject to a great deal of structural re-organisation over the last few years, and there is now a good deal of resistance to the idea of further change. Key structural changes have included the re-organisation of local government in 1996 into 22 unitary, all purpose authorities at the same time as health authorities were re-organised from eight reflecting the old county structures, down to five. NHS trusts, only established following the introduction of the 1990 NHS and Community Care Act, have been halved in number in the last year at the same time as their acute and community functions have been combined. Local Health Groups, led by the NHS, have been based on local authority boundaries as have the proposed Local Health Alliances to be led by local government.

In light of the number of structural changes, "Putting Patients First" in January 1998 recommended the retention of the current five health authority boundaries to create stability in a service already undergoing re-organisation. However, their boundaries are increasingly at odds with other relevant organisations in Wales which are either based on unitary authorities or which divide Wales into four, e.g., the new Assembly regional advisory committees, the new economic regions, the Training and Enterprise Councils, the police and the probation service. The Assembly has the power under the Act to change health authority boundaries or to transfer to itself the functions of the health authorities, and will need to consider whether and how this power should be used to maximise the opportunities for inter-sectoral collaboration.

"Putting Patients First" lays the framework for NHS reforms and there has been a corresponding Government-led agenda to modernise local government. Joint working between the NHS, local government and the voluntary sector is seen as essential in carrying out the government's aims to tackle health inequalities and create a seamless service in health and social care. Future collaborative arrangements are underpinned by a statutory duty of partnership between health authorities and NHS trusts, and between health authorities and local government. These arrangements are being facilitated by the increasing use of local government boundaries for the delivery of all public services, as these are unlikely to change.

This swiftly-changing context provides a framework for the development of our thinking in analysing the potential for a specific agenda to improve the health of the public in Wales. We hope that our analysis of current policies, the opportunities available through the development of the Assembly and the corresponding new relationships with other institutions, plus our proposals for further action will contribute towards Wales being at the forefront of the development of a radical health improvement agenda.

CHAPTER 2

THE HEALTH OF THE WELSH PEOPLE

FINDING OUT WHERE WE ARE IN HEALTH TERMS

In order to tackle health problems in Wales, it is essential to establish a baseline, to assess the relative disadvantage of the people in Wales, both between local authority areas and against other European countries. For a fuller account the reader is directed to An Atlas of Health Inequalities between Welsh Local Authorities (Monaghan 1998).

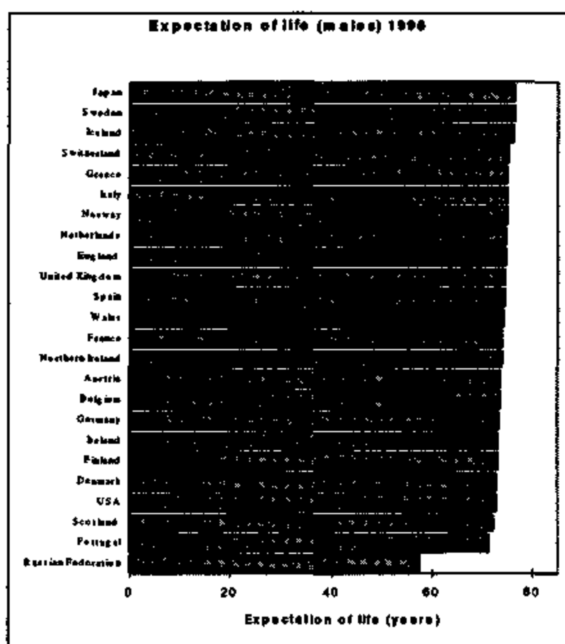
INTERNATIONAL HEALTH COMPARISONS

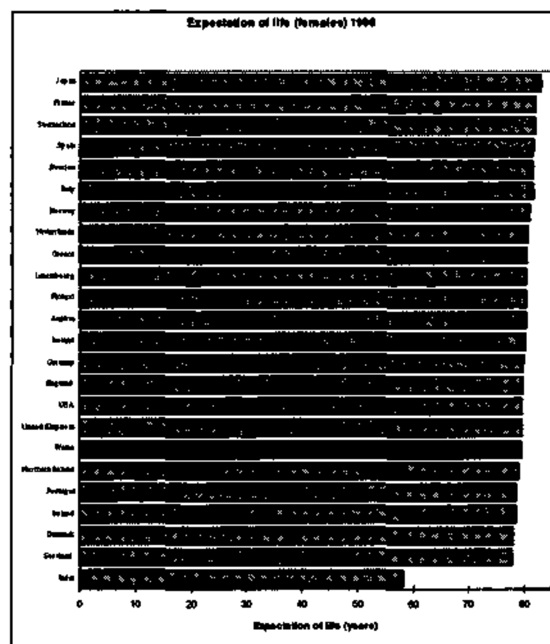
DEMOGRAPHY AND DEPENDENCY

Dependency and health needs are greatest in between 0-14 and over 65. Wales has the 6th highest percentage of population aged 0-14 years and the 2nd highest aged 65 and over of the European countries. This high dependency ratio is a particular concern for Wales because it has a relatively poor economic base from which to support these people.

LIFE EXPECTANCY

Males and females have lower life expectancies at birth than those in England and three to four years less than in the best European countries.





ALL CAUSE MORTALITY

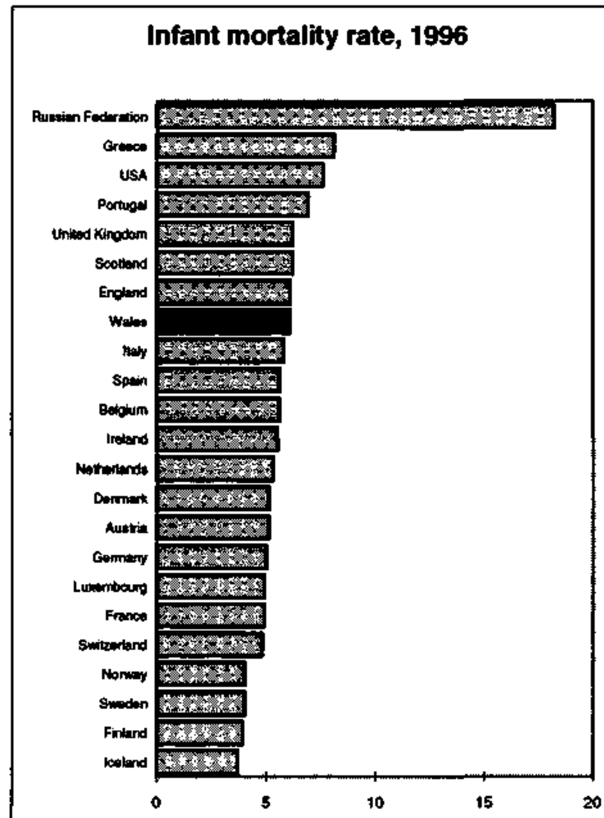
Mortality from all causes is probably the most important summary health index because it is usually unambiguous. The Infant Mortality Rate and the All-cause Standardised Mortality Rate (SMR) are two forms.

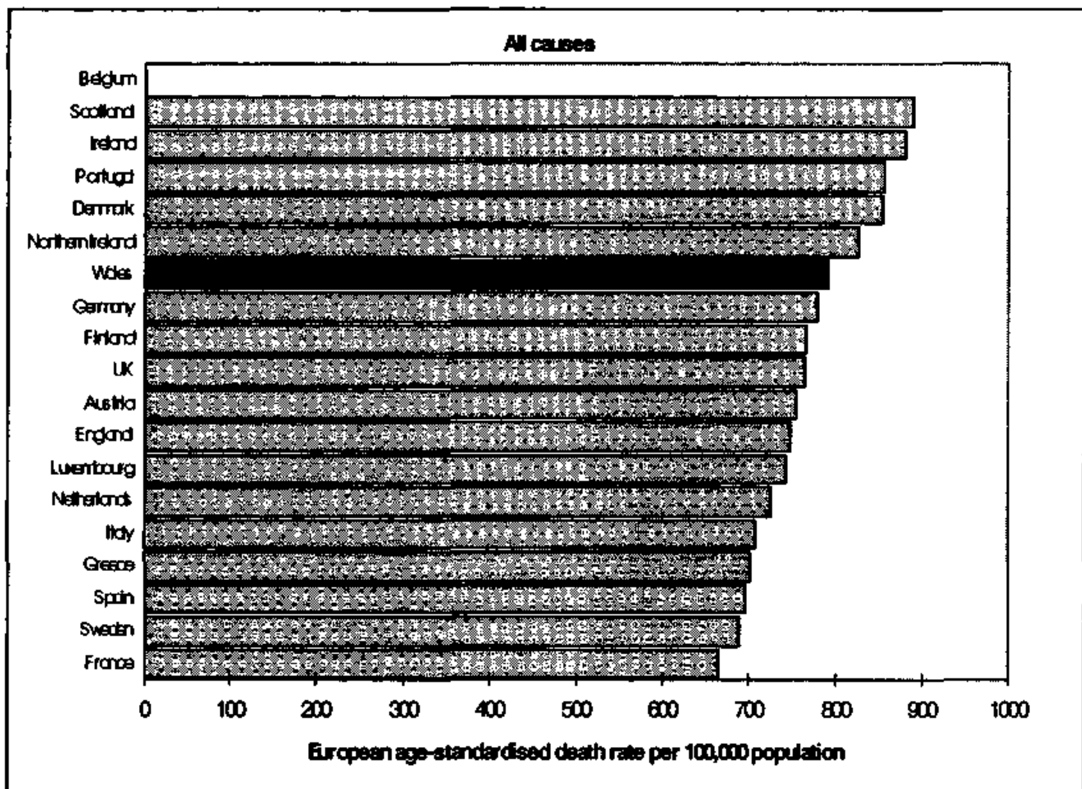
INFANT MORTALITY RATE[8]

Wales has an infant mortality rate above the European average.

ALL-CAUSE SMR[9]

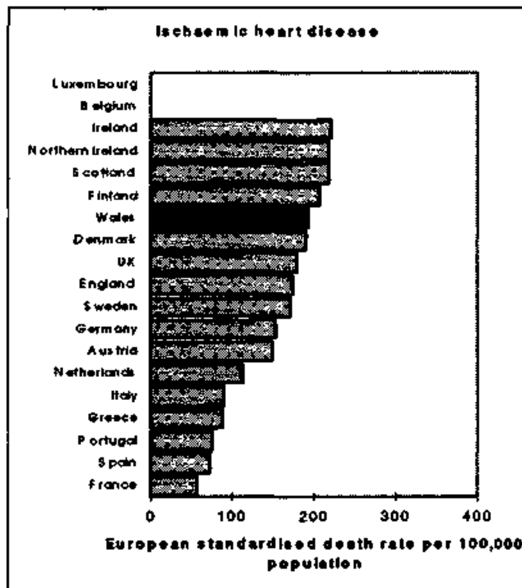
Wales has the 6th highest European standardised death rate per 100,000 population in the European Union for all causes with Scotland being the highest and France the lowest.

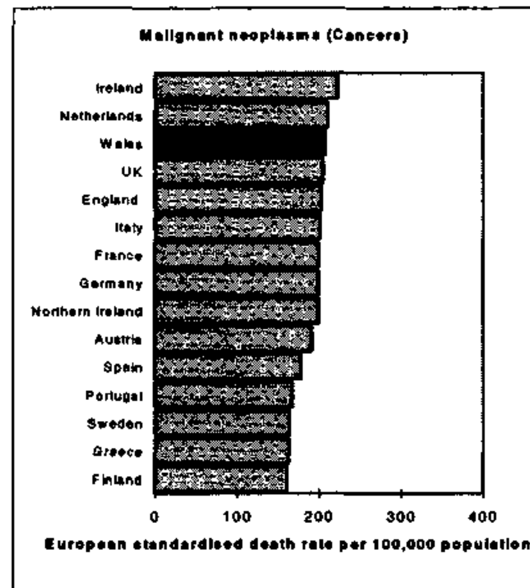


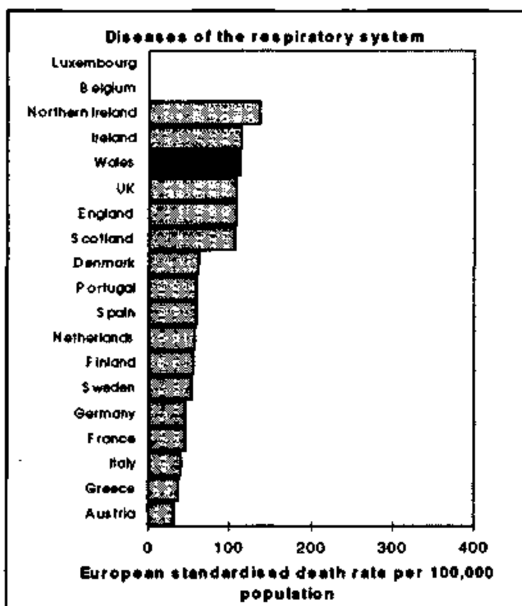


8 This is the "all-cause" death rate in the first year of life.
9 This is an "all-cause" death rate for all ages, adjusted to a population of standard age structure.

DISEASE FREQUENCY





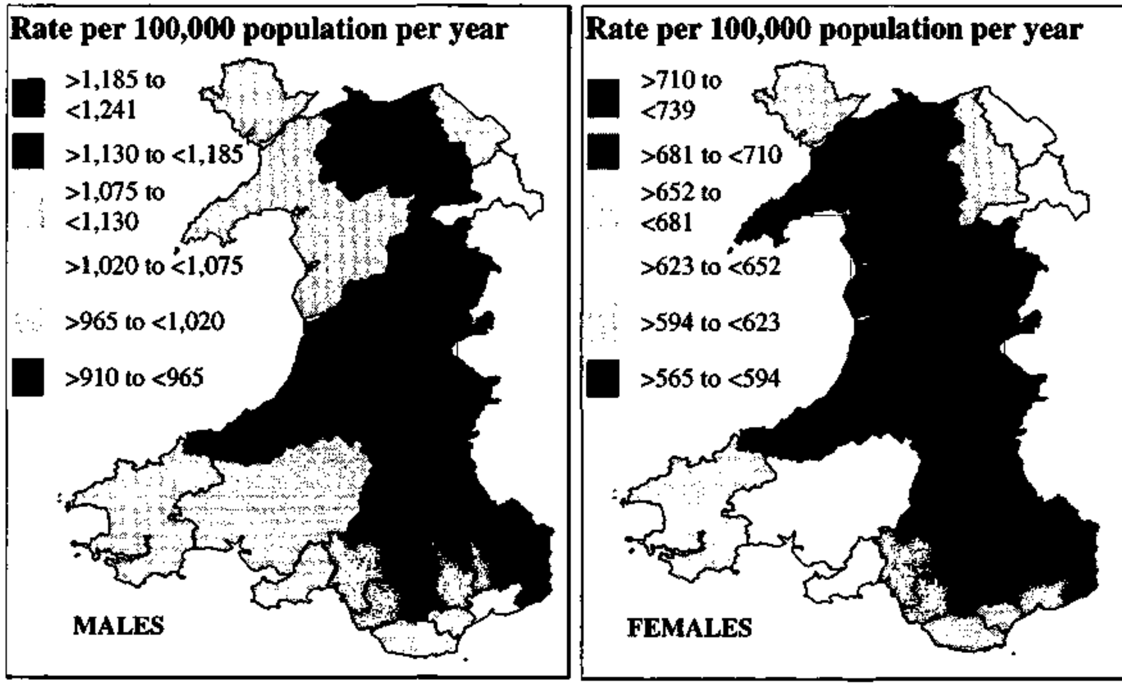


Ischaemic heart disease (MD) is the largest cause of death in Wales, which has one of the highest mortality rates in Europe, 20 percent higher than in England, and three times the rate in France. The second largest cause of death in Wales is cancer, of which lung cancer is the greatest contributor. Wales again has one of the highest mortality rates due to cancer in Europe. Respiratory diseases are also an important cause of death in Wales, particularly in the old mining areas of the South Wales valleys, and once more, Wales has one of Europe's highest mortality rates.

HEALTH COMPARISONS WITHIN WALES

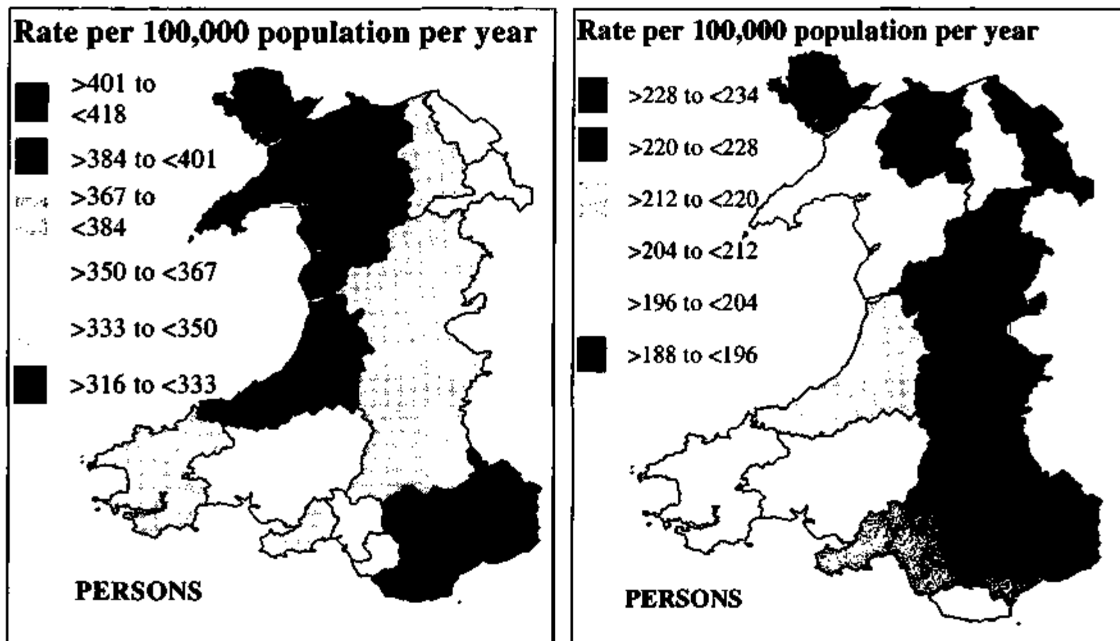
A consistent pattern of inequality is also seen between Welsh local authorities, with the South Wales valleys faring particularly badly, especially Blaenau Gwent, Merthyr Tydfil, and Rhondda Cynon Taff. However, it is important to remember that there are much larger inequalities *within* all local authorities than between them. Despite recent improvements in health, the harsh reality is that a substantial proportion of the population remains deeply disadvantaged in health and life expectancy. The fact that death rates in a substantial minority of the Welsh population are not declining as fast as those in the majority should be a matter of public concern and debate. Instead of achieving the WHO's 1995 target of reducing health inequality by 25% by the year 2000, it is likely that there will have been an increase of 25% in health inequality.

GENERAL MORTALITY RATES (ALL CAUSES)



AVERAGE ANNUAL EUROPEAN AGE-STANDARDISED MORTALITY RATES FOR ALL CAUSES OF DEATH FOR MALES AND FEMALES OF ALL AGES BY LOCAL AUTHORITY AREA OVER THE SIX YEAR PERIOD 1990-1995

DISEASE FREQUENCY

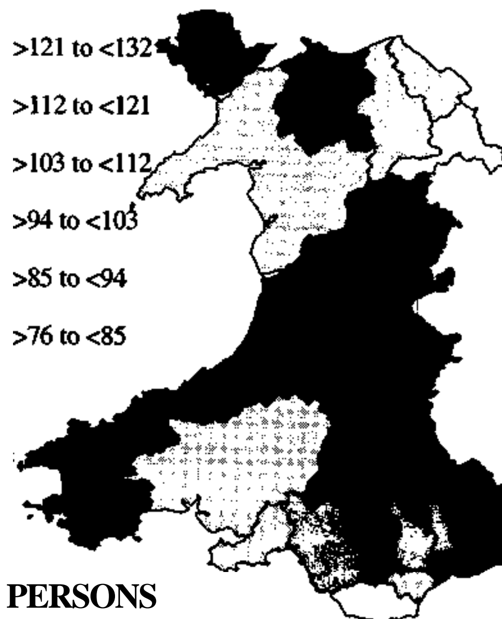


AVERAGE ANNUAL EUROPEAN AGE STANDARDISED MORTALITY RATES FOR CIRCULATORY DISEASES (LEFT) AND CANCERS (RIGHT) FOR PERSONS OF ALL AGES BY LOCAL AUTHORITY AREA OVER THE SIX YEAR PERIOD 1990-1995

The major diseases show marked variation across Wales. Circulatory diseases are the most important cause of death in Wales. They are caused by diets rich in saturated fats, smoking and high blood pressure. Cancer is the second largest cause of death in Wales after circulatory diseases. The lung cancer death rate for men under 75 years in Blaenau Gwent is around twice that in Powys.

Respiratory diseases appear particularly concentrated in the old mining areas of the south Wales valleys. However, the fact that this is true in females as well as males suggests that this is not entirely occupationally related and is likely to be partly smoking dependent.

Rate per 100,000 population per year

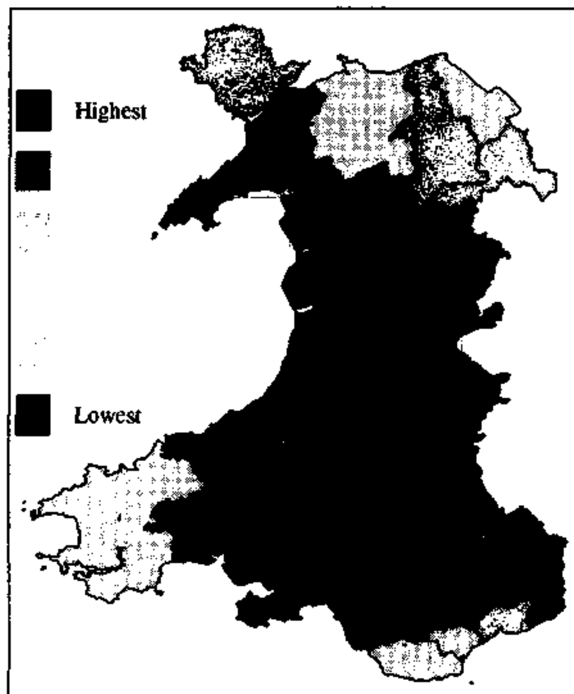


AVERAGE ANNUAL EUROPEAN AGE-STANDARDISED MORTALITY RATES FOR RESPIRATORY DISEASES (RIGHT) (EXCLUDING LUNG CANCER) FOR PERSONS OF ALL AGES BY LOCAL AUTHORITY AREA OVER THE PERIOD 1990-1995

PERCEIVED HEALTH / QUALITY OF LIFE

LIMITING LONG TERM ILLNESS

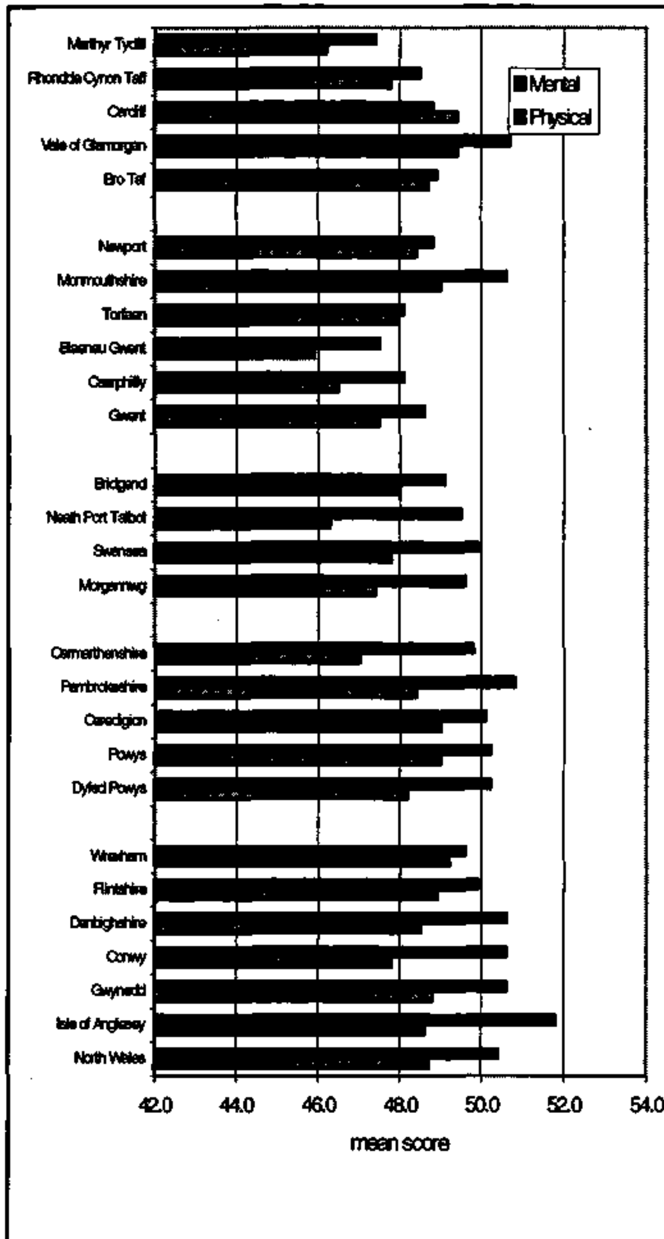
This is an important index gathered from the 1991 census, recording lay reported long term disabling illness. Limiting long-term illness rates are considerably higher in Wales than England.



PREVALENCE OF LIMITING LONG TERM ILLNESS BY LOCAL AUTHORITY AREA

(1991 Census)

SF-36 GENERAL HEALTH PERCEPTION SCORES



When people were asked in the Welsh Health Survey about their own perception of their health using the SF-36 health measurement instrument, some marked differences were apparent between local authority areas for both physical and mental health.

MENTAL AND PHYSICAL HEALTH SUMMARY SCORES BY LOCAL AUTHORITY AND HEALTH AUTHORITY AREAS

Source: 1999 Welsh Health Survey

NB: High scores equal better health

CHAPTER 3

TOWARDS EXPLAINING AND IMPROVING WALES' POOR HEALTH RECORD

The Government recognises the complex causes of ill health and the part that economic and social factors have to play. It also recognises the fundamental inequalities in health; that the worst off in our society are more ill and die earlier.

Department of Health 1998

If we are to generate policy options to improve the health of the population, we need to understand the reasons for Wales' poor health record. This understanding of the determinants of health will suggest where policies should be directed.

EXPLAINING LEVELS OF POPULATION ILL HEALTH

CONCEPTUAL FRAMEWORK: THE DETERMINANTS OF HEALTH

The title of a recently pubUshed book (Evans et al 1994) asks "Why are some people healthy and others not?" As a first step towards improving the population's health, it is clearly important to understand what factors lead to our current pattern of ill-health and health inequality.

With the increase in chronic disease in the developed world as a major contributor to both mortality (death) and morbidity (presence of disease), it becomes difficult to talk of *any single cause.*

The medical concept of a necessary and sufficient cause is also too narrow. If we are to improve the peoples' health we need to look at the wider determining factors, recognising that causative factors logically cannot be limited to biological, chemical and physical agents as usually, other psychological and socio-economic factors are just as strongly related.

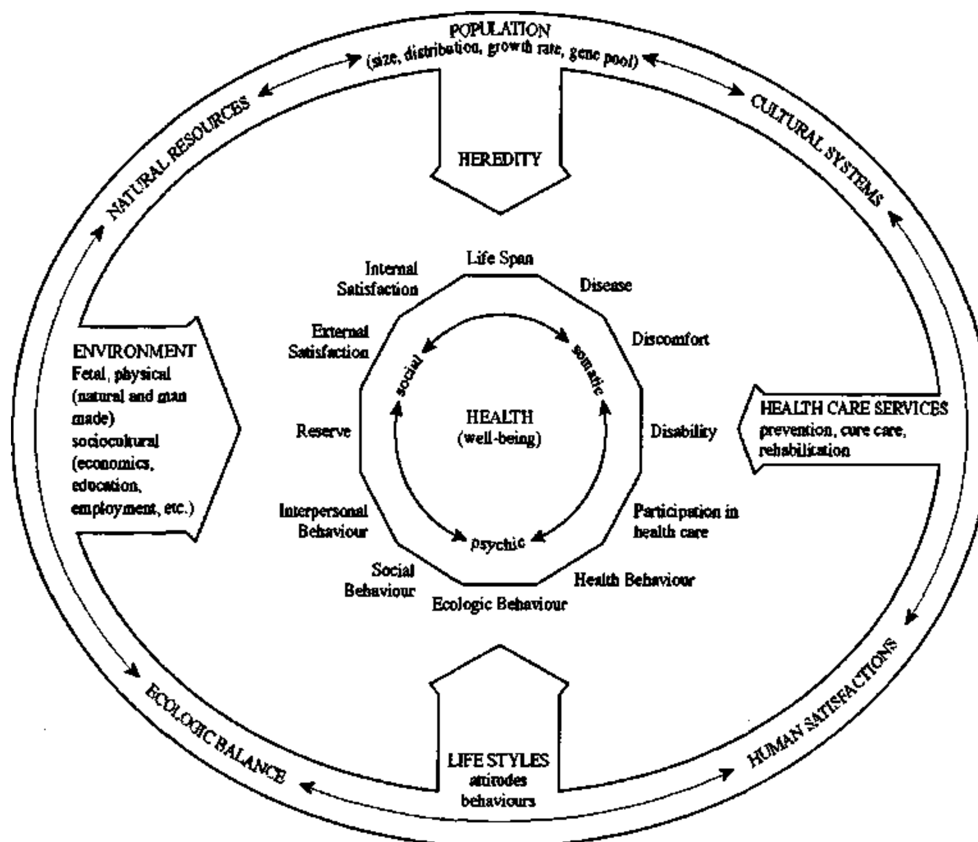
Epidemiology, the study of the health and ill-health in human populations, is a crucial tool for the development of public health policy, as it can be used both to research determinants and monitor improvements in health.

It is by tackling these determinants of health that one might begin to promote health and prevent ill health. It is, therefore, clear that we must address a complex range of issues if we are to achieve real improvements in the health and wellbeing of the Welsh population.

WHICH DETERMINANTS ARE IMPORTANT?

What factors determine health status and therefore also inequalities in health status? The model developed by Blum (1981) comprises the four fields of:

- heredity (Genetics)
- environment (Physico-chemico-biological and Psycho-socio-economic)
- lifestyle
- healthcare services



Blum 1981 - reproduced with permission

THE ENVIRONMENT

The environment can usefully be sub-divided into the pre-natal environment - before birth and within the womb; and the post-natal environment to which we are exposed following birth during childhood and adult life.

THE PRE-NATAL ENVIRONMENT

There is a growing body of evidence (Barker 1992) which supports the importance of the pre-natal environment within the womb as a determinant of subsequent adult

health and mortaUty. Key factors include: maternal illness, medication and poor nutrition, smoking or high blood pressure which result in low birthweight babies, and diabetes which can result in overweight babies. The adult mortality rate from stroke and ischaemic heart disease also appears to be powerfully determined by adverse maternal factors acting before and during pregnancy.

THE POST-NATAL ENVIRONMENT

Improvements in the health experienced by all societies as they undergo economic development can be attributed more to improvements in wider environmental conditions rather than advances in medical care. (McKeown 1979). These include access to sufficient nutritious food, the provision of potable drinking water, the disposal of sewage separated from water supplies, improvements in working conditions and in housing, and a voluntary reduction in the birth rate. The term environment is broad and can be usefully considered as comprising both the physical, chemical and biological environment as well as the social, psychological and economic environment. However, these factors do not exist in isolation and there are multiple and varied interactions between them.

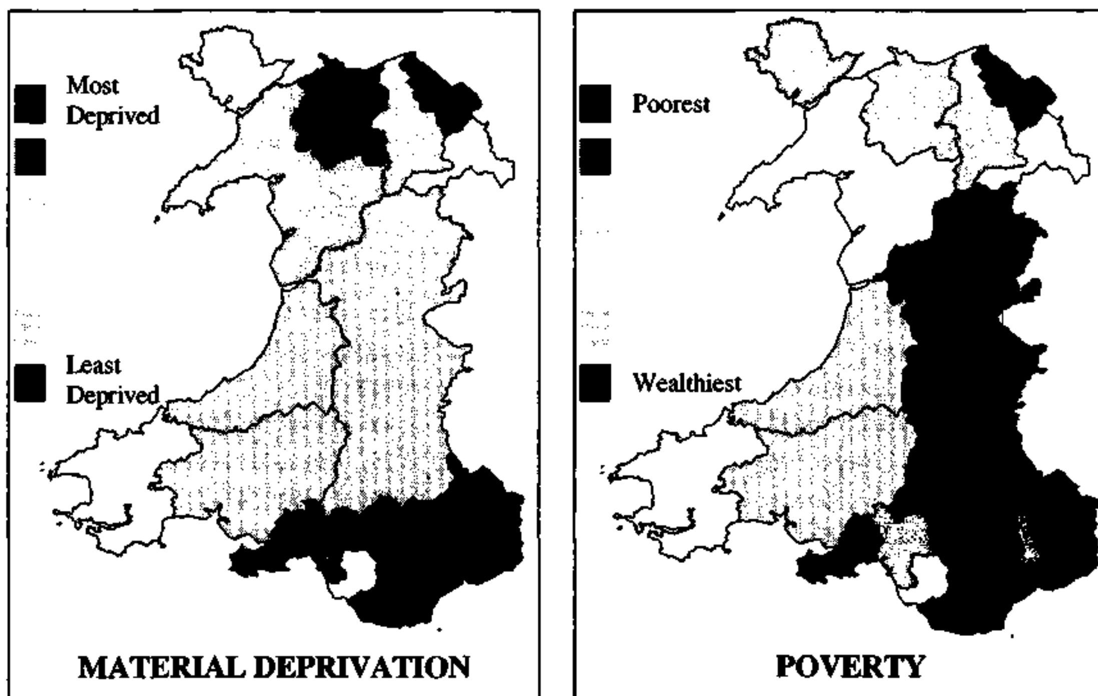
The social, psychological and economic environment

In Wales there is a five year difference in life expectancy at birth between males in social class I and in social classes IV and V. The corresponding figure for females is 3 years. Both of these differentials are wider than they were 15 years ago. Long standing limiting illness is 40 percent more common in social class V than social class I, while no such differential exists in acute illness.

Infant mortality in Wales is 70 percent higher in social class V than in social class I and again this is a differential that has widened in the last decade and a half. Children in the manual social classes are more likely to suffer from chronic illness and tooth decay than those in non-manual classes.

Evidence suggests that the socio-economic environment remains the primary determinant of current social inequalities in health status within populations and between areas. It is particularly important to recognise there is persuasive evidence demonstrating that it is not just absolute poverty but *relative* poverty and social position which act to determine health (Wilkinson 1996). In addition to powerfully determining health directly, the socio-economic environment also considerably determines the physical, environmental and lifestyle determinants of health, because it influences the level of exposure to physical environmental hazards[10] and the ability of individuals to make "healthy" choices. Influencing the socio-economic environment through policy action must be a primary objective to improve health.

[10] The wealthy are able to buy their way out of living in hazardous physical environments.



There is a close correlation between poverty, deprivation and ill health both geographically and at the social group level indicating large inequalities in health. According to the 1995 Welsh Health Survey, people doing unskilled work have higher rates of obesity, heart disease, respiratory disease, mental illness, arthritis and back pain, accidents or injuries needing hospital treatment, uncorrected eyesight and hearing problems. However, they are less likely to visit the dentist and optician, or to take exercise. Those who report limiting long term illness tend to be men over 45 years old who live in households dependent on benefit.

The physical, chemical and biological environment

The physical, chemical and biological environmental influences are also extremely important determinants of health, noting also that exposure to environmental hazards is strongly correlated with social class. Key issues include:

Shelter, housing and homelessness

The most significant health risks from housing are associated with cold and damp. Wales has the highest proportion of owner occupiers living in pre 1919 houses, and the lowest income per head of household. This means that there are many parts of Wales where householders are not able to afford to renovate or maintain their homes. In the recent Welsh House Conditions Survey (1999) a large proportion of homes still do not meet fitness standards despite a considerable injection of money through the renovation grants system. There is also a significant problem with homelessness in Wales. According to a snapshot survey by Shelter Cymru and the former Special Needs Housing Advisory Service, 77% of those sleeping rough were under the age of 35, and 44% said they had physical or mental health problems, including drug and alcohol misuse. Further work in this area is crucial.

Air Pollution

Poor air quality contributes to ill health. Particulate air pollution from motor vehicles is a potent contributor to asthma, and is an increasing problem in urban areas and near transport corridors. Small particles produced by diesel engines are the most dangerous. Industrial air pollution is also a concern and the area around Port Talbot has some of the highest levels of sulphur dioxide air pollution in the UK. Radon is the second most important cause of lung cancer deaths after smoking and is a naturally occurring gas in many parts of Wales and is present in high levels in some dwellings.

Water and sanitation

A fundamental determinant of health is the separation of sewage and drinking water. Beyond this basic requirement are considerations of the level and nature of bacterial and chemical contamination within drinking water supplies and bathing waters.

Climate

Climate influences the type of shelter required and the time spent indoors - and, thereby, the spread of airborne pathogens from person to person. It also determines which other species share the local environment, the foodstuffs that can be grown and thereby the cultural dietary patterns. Climate also influences the economic productivity levels likely to be achievable in outdoor manual labour.

Food hygiene and quality

Food poisoning appears to be increasing as a result of intensification of agriculture, processing and preparation of food creating new ecological niches for bacteria and increased risks of exposure of large numbers of people to contaminated food resulting from a single failure in the production or distribution of food.

LIFESTYLE

Another important factor which influences health is the lifestyle of each individual; whether a person chooses to smoke, exercise frequently, or limit the amount of fatty foods they eat. Whilst at times lifestyle has been seen as an active choice made by the individual it is in large part pre-determined by wider factors related to local and personal situations including education level, peer pressure, social norms, advertising and the availability of options. This has been neatly summarised by Dusenberry:

> *economics is all about how people make choices, sociology is all about why they don't have any choices to make.*

DIET AND NUTRITION

There is increasing evidence on the importance of diet and nutrition in promoting health and wellbeing. For example, evidence suggests that poor nutrition in early childhood can increase subsequent susceptibility to death from heart disease and stroke in adulthood. Foods high in refined sugar lead to obesity and dental caries[11].

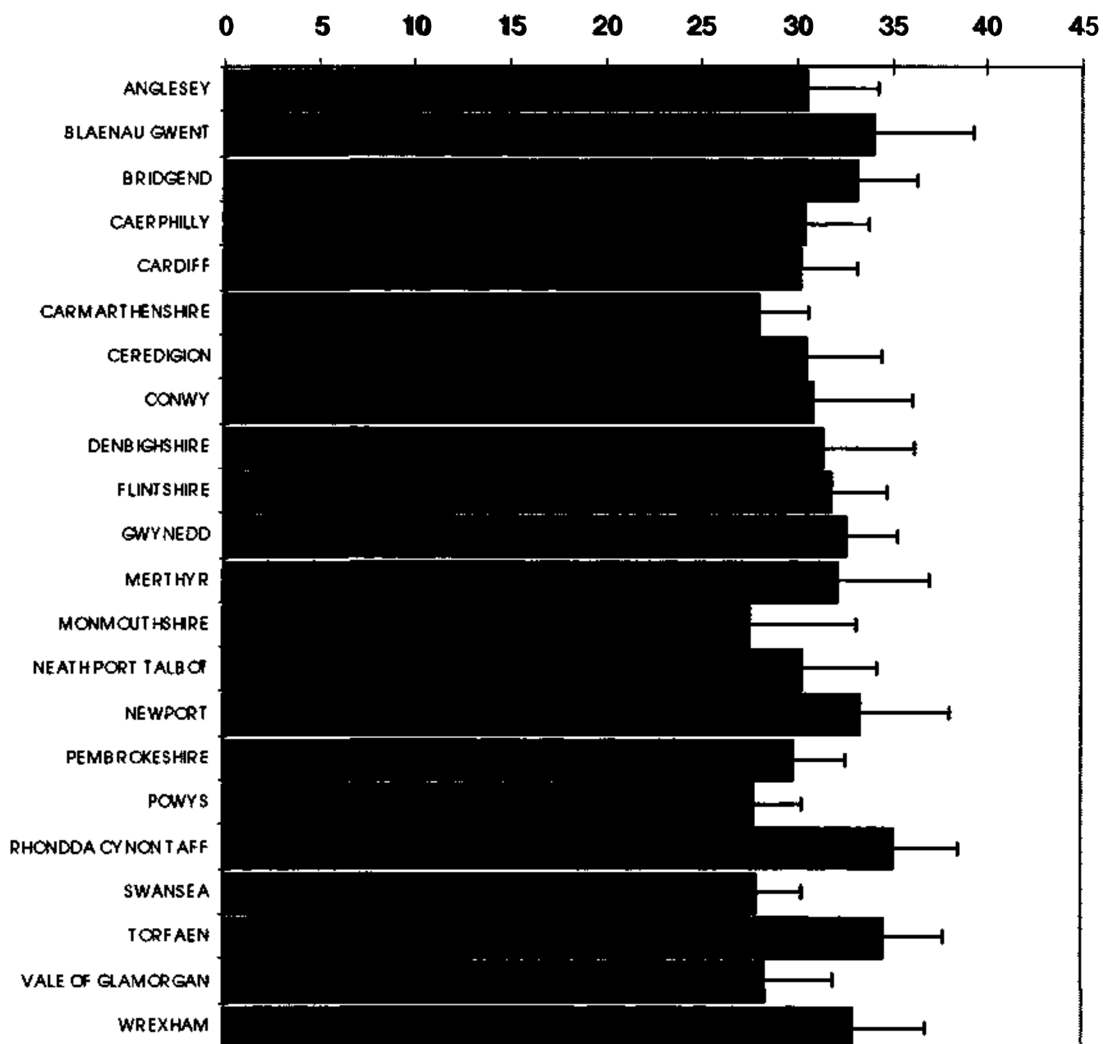
[11] There are widely varying rates of tooth decay in Wales, with rates among 5-year olds having risen by 168% in Anglesey since Welsh Water unilaterally stopped water fluoridation in 1991.

Evidence from the Health in Wales Survey (HPW 1986) indicated that people in the South Wales valleys ate less fresh fruit and vegetables and cooked with more lard than other parts of Wales.

SUBSTANCE MISUSE

Smoking tobacco and the misuse of alcohol and drugs has major implications for health. The most important of these in public health terms is smoking. Smoking increases the risk of having a small baby, and of suffering heart disease, lung cancer, bronchitis and emphysema, limb amputation and various other problems. A major concern is the large and increasing proportion of teenage girls who smoke. The Welsh Youth Surveys conducted by HPW have shown that the proportion of boys aged 15 who smoke was 16% in 1986. This fell to 12% in 1988 and then rose to 23% in 1996. The pattern has been similar among girls. In 1996, 29% in this age group were smokers. The geographical distribution of smoking in all age groups is shown below.

PERCENTAGE OF ADULTS SMOKING BY UA (with 95%CIs)
Source: 1990,1993 and 1996 Health in Wales Surveys (HPW)



In excess, alcohol causes cirrhosis of the liver, high blood pressure, and social problems. In moderation, alcohol may be beneficial to health. There are rising levels of drinking among Welsh under-16s who already have one of the highest intakes in Europe.

An increasing proportion of Welsh 15-16 year olds report that they use illicit drugs. In 1996, 40% of girls and 50% of boys experimented with at least one drug.

SEXUAL BEHAVIOUR

Rates of conception among Welsh under 16-year old girls are among the highest in Europe, are showing no marked decline and are even rising in some parts of Wales.

EXERCISE AND OBESITY

Both exercise and obesity are strong risk factors for coronary heart disease, which is the biggest killer in Wales. According to the Health in Wales Survey (HPW). Overweight and obesity levels in Wales are increasing - 51% of females and 53% of males are classified as overweight or obese in 1996 according to the Health in Wales Survey (HPW). Over 70% of the Welsh population are not taking enough exercise

HEREDITY (GENETICS) AND OTHER INTRINSIC FACTORS

Almost all human diseases are at least partially genetically determined, the only obvious exceptions being a small number of diseases due to infectious agents or chemical poisons, where susceptibility is universal. Some diseases, which are due to single gene or chromosomal deficits, appear to be completely genetically determined, but they are the exception.

Gene therapy is thus potentially the most powerful arena for medical intervention to improve the health of individuals. However, currently, clinical genetics is limited for technological and ethical reasons to screening and attendant counselling for genetic predisposition to certain diseases and conditions.

HEALTH AND SOCIAL CARE SERVICES

A person's health can clearly be influenced by access to good quality health and social care, and whatever contributions the other determinants of health may make, it will always be necessary to offer care for those who become ill or dependent - most of us will require the support of the formal care services at some time in our lives. We believe that health and social care, at the end of the day, is a humanitarian activity. The point we make here is that in quantifying the relative contributions of the broad determinants of health, health and social care themselves, at a population level, are probably not the most important.

Within a hospital setting, the process of becoming a patient usually means that, as a natural corollary, the health care system determines the activities that take place in, what is, a closed setting, and is naturally a significant contributor to outcomes, at least in the short term. However, most contacts with the formal health and social care system in the UK take place in a primary care setting outside a hospital where it is

much more difficult to influence the role of those factors which are likely to exert effects on (often) mutually desired longer term outcomes.

THE DETERMINANTS OF HEALTH - CONCLUSIONS

Health and ill-health are largely determined rather than freely chosen.

The most powerful determinants of health which operate at the population level and differ by geographical area and social groups are socio-economic such as deprivation, and lifestyle factors such as smoking, which in Wales closely correlate by geographical area with poor health status.

Socio-economic determinants are the main explanation for inequalities in health status. The continuing socio-economic differences in Wales suggest that the mortality divide between poor and wealthy areas may continue to increase unless decisive public policy action is taken.

IMPROVING HEALTH - QUESTIONS FOR POLICYMAKERS

Arguably, it is the central task of a democratically elected government to improve the condition of the people it serves. Health - particularly in its widest conception as well-being - is the most fundamental measure of the condition of the people. Population health should thus be promoted as a social good in its own right, and is a more relevant overarching objective for government policy than national economic prosperity expressed as GDP per head.

In fact, economic prosperity and health are closely related, and in both directions. From an economic perspective it is essential to sustain an efficient and healthy workforce. The economic cost of hours lost at work due to health is substantial, reduces the GDP, and renders Wales less competitive compared to other countries.

Developing a health gain agenda in Wales will require key decisions from politicians at all levels based on their analysis of the problem. In a resource-neutral climate with policy direction on social security and taxation remaining in Whitehall, the Assembly will also need to become an effective lobby to central government over its welfare reform proposals. Wales, particularly in the South Wales valleys, does have a disproportionately high number of people who are disabled or who suffer a long term limiting illness, coupled with a low number of work opportunities. The Assembly will need to address this through the Objective 1 funding, but this begs a fundamental question for politicians:

> Should public policy aim to improve the health of the population or simply to provide care and treatment to patients?

Population health gain from public policy is clearly possible as has been demonstrated continually throughout the last 150 years in terms of life expectancy. In the last two decades health gain has continued to be achieved but alongside widening inequalities in health status between social groups.

How can improvement in average population health (Health Gain) be achieved and is the reduction in health inequalities between social groups possible?

Inequalities in health are inevitable at the individual level as genetically people are not born equal. However, social inequalities in health defined by population group or geographical area are not inevitable and could theoretically be reduced by social manipulation (social engineering).

Can public health policy achieve anything regarding health inequalities or are they inevitable?

Given that it is desirable for public policy to attempt to achieve health gain and to reduce health inequalities, and that both are theoretically possible, what policy pointers are there about how best these objectives can be achieved?

PUBLIC POLICY TO TACKLE ENVIRONMENTAL DETERMINANTS

As already discussed, the weight of evidence suggests that healthcare has been and remains the least important of the four categories of health determinants at a population level (McKeown 1979)[12]. To the individual, the determinants of health appear fixed and therefore only healthcare seems relevant to their needs.

Genetics and environment are the most important population health determinants. However, genetics offers almost no effective interventions at present although it could offer great potential in the future. Environment is therefore the key field for intervention to improve population health, particularly the psycho-socio-economic environment.

Public policies to tackle the environmental determinants of health, both physical and social, are the most powerful means of achieving population health gain and reduction in health inequalities. This applies to all categories of health outcome - whether the objective is increasing life expectancy and saving lives or reducing disease frequency or improving quality of life and wellbeing.

Economic Policy, Sustainable Development, and Wealth

On the whole, wealth is good for health providing its distribution is relatively fair. International trade and free markets have been capable of producing economic growth and thereby wealth creation. However, to produce maximum health gain in the long run, economic activity must be sustainable within the confines of our global natural resources. The National Assembly for Wales has a statutory duty to develop a sustainability scheme to influence all its policy development. The process is led by the First Secretary and will be reviewed annually.

[12] "Medicine" is not the reason for this poor performance, rather it is the narrow role that clinical medicine has adopted that is at fault. Rudolf Virchow, one of the giants of medicine, and an architect of the biomedical model, who observed that medicine was a social science and that physicians are the natural attorneys of the poor and the social problems should largely be solved by them. The problem is that physicians and most other groups in health care and society have been conceiving the solutions to health problems too narrowly - within the biomedical model and centred largely upon the individual.

Inequality in Wealth Distribution and Inequality in Health

In order to minimise inequalities in health outcomes, both the benefits - wealth, and the dis-benefits - including pollution, should be spread reasonably evenly within the population either by the market itself (which is unlikely) or alternatively by governmental re-distributive policies and public services to ameliorate these effects. Free markets alone, based as they must be upon economic incentives, do not spread their benefits (and their dis-benefits) evenly.

Economic growth has also been the traditional economists' response to dealing with inequality. If all slices of the economic pie are not distributed equitably to begin with, if the pie gets bigger, based on present proportional distributions, then each individual share will get larger, too - the so-called trickle-down effect. But if economic growth cannot be sustained or trickle down fails to operate sufficiently (as in Wales in the 1980s), then the distribution of goods and services, or those resources that they represent, becomes increasingly the focus of concern.

What is fair or just requires political action and will follow from polices relating to welfare, wages and the environment - the very policies threatened by global free-trade - by undermining the ability of individual governments to adopt "uncompetitive" social policies.

PUBLIC POLICY TO PROVIDE HEALTH AND SOCIAL CARE

As already indicated, quality comprehensive health and social care, accessible to all who need those services is vital as a safety net in providing the support, care and appropriate interventions beyond the resources and capabilities of the individual person or family.

Public health and clinical health care and personal social services are clearly in different, though overlapping businesses with both roles being crucial. The first is more in the realm of prevention at the population level and the second more in the realm of cure, relief and care of the individual. The NHS and social services are principally in the business of providing effective care and support, relief or cure to benefit individuals, especially those who are already ill or dependent, while wider public health policies are likely to be more effective in reducing health inequalities and achieving population health gain. However, there are a number of pragmatic and principled reasons why health and social care services are very useful sites for intervention to improve the health of populations:

- firstly, clinical medical, health and social care services already exist and are already paid for from public monies because society is not willing to do without services to treat and care for sick individuals - fulfilling the so-called "rule of rescue". The population health gain and /or reduction in health inequalities achieved in the process of fulfilling its main role is, in a sense, a bonus of the NHS and social services and is available at little or no additional cost.

- secondly, the NHS in particular enjoys consensus political support across the political spectrum and initiatives mounted by it, to achieve health gain and to tackle inequality in health status, are likely to be politically acceptable so

long as the costs are not excessive. The NHS is more of a risk-free environment for politicians than wider social policy.

- thirdly, although less powerful than preventive policy interventions targeted at the determinants of health, the NHS and social services do offer proven effective interventions which do improve the public health and reduce inequalities through the sum total of these individual interventions.

In terms of specific medical and healthcare interventions, immunisation and preventive maternal and child health services have historically been (and are likely to continue to be) of particular value in advancing population health and also in reducing health inequalities. Certain surgical interventions including orthopaedic surgery and cataract surgery are also of particularly high health gain.

Access to high quality primary healthcare is also a basic requirement, particularly in those areas where health need is greatest, and is fundamental within any effective (and cost-effective) response to health inequality. This is because primary healthcare provides a substantial proportion of essential healthcare services while also forming the gateway of referral to specialist hospital services, acting as the patient's advocate, especially for the otherwise dis-empowered.

ARE INEQUALITIES IN ACCESS TO HEALTHCARE INEVITABLE?

In principle, inequities in healthcare delivery are neither inevitable nor desirable.

Inequities in access to health care services need not occur in a NHS free at the point of use. However, they do occur, and most notably in geographical areas, such as the South Wales valleys where the local residents are already more unhealthy and poorer than other parts of Wales. This "inverse care law" is as true today as when Dr Julian Tudor Hart first described it in the early 1970s. Many parts of the valleys do not have adequate primary care services, and potentially this situation could worsen considerably over the next five years as current GPs retire and are only replaced with difficulty.

Healthcare can be provided more equitably (on the basis of need if):

- there is political will,
- the service remains free at the point of use,
- resource allocation is adequately needs weighted,
- there are incentives for high quality staff to go to poor areas,
- there are intensive efforts to recruit people to preventive programmes in poor areas.

TAKING THE AGENDA FORWARD

Taking this agenda forward will require a redistribution of resources in Wales. However, part of the current difficulty is related to the inadequacy of the information

base on which to develop evidence based decisions. The recent publication by the WLGA of Steve Monaghan's "An Atlas of Health Inequalities Between Welsh Local Authorities" urgently needs a sister volume looking at the access to healthcare services by local authority boundary (i.e Local Health Group areas) in order to improve the opportunities for those whose access is currently poor, to good local healthcare services.

The Assembly does have the capacity to make a substantial response to the challenges set by this agenda, bearing in mind its responsibilities for health and local government. However, it can only achieve a certain amount within its own powers and structures, bearing in mind the importance of social policies related to social security and taxation which are reserved to Westminster. There will also be a need for the Assembly to relate to both Westminster and Europe to encourage agreement in policy development at all levels.

CHAPTER 4

CURRENT HEALTH POLICY

UNITED KINGDOM GOVERNMENT POLICY THEMES

Key themes of this government are related to social justice - and draw much of their heritage from the work of the Commission on Social Justice established by John Smith and published in 1994. Four imperatives ran through its work:

- the transformation of the welfare state from a safety net in times of trouble to a springboard for economic opportunity.
- the radical improvement of access to education and training and to invest in the talent of all our people.
- the promotion of real choices across the life-cycle for men and women in the balance of employment, family, education, leisure and retirement.
- the reconstruction of the social wealth of the country and the nurturing of social institutions from the family to local government, to provide a dependable social environment in which people can live their lives.

This focus on empowerment (work and income), community (particularly with reference to social support) and family, particularly with a focus on children, are key drivers of the Government's social agenda.

THE WELSH NHS WHITE PAPER "PUTTING PATIENTS FIRST

This was issued in early 1998 and has now been enacted into law as The Health Act 1999. The philosophy and policy themes can be summarised as integration, planning, a focus upon primary care and local partnerships, and an emphasis on quality. Taking these in turn.

INTEGRATION -THE MAIN THRUST FOR THE NEW NHS

There are some important differences in detail between the Welsh and English NHS White Papers - notably the Welsh version is the more inclusive - but no important differences in thrust. The principal thrust of both White Paper documents is:

"replacing the internal market with integrated care "

Tony Blair - preface to English White Paper

However, there remains confusion about whether the approach is to integrate commissioning of specialist services or to integrate provision of care through LHGs. If integration of provision of care is the main focus, this probably largely relates to horizontal integration of care outside hospital (primary and community care and, perhaps later - social services). However, some vertical integration or co-ordination of

care between community and hospital settings is probably also intended, particularly centred around disease-management programmes.

PLANNING - THE NEW MANAGEMENT MODE FOR THE NHS

The purchaser / provider split is retained - though purchasing is re-labelled as "planning". Planning is the new health and health care agenda and planning, not purchasing appears to be the language of the new NHS. With the internal market, the NHS became fragmented, overexpanded, insolvent, and unsustainable. As a reaction to this, we appear to be back to unified planning across the NHS family including social services, moving from confrontation and competition to collaboration.

In fact, the new focus is upon programme planning. An all-inclusive local medium term plan for health and health care, the **Health Improvement Programme (HIP)** will be co-ordinated by health authorities. The HIP is a 3 -5 year local strategic plan to improve the people's health and their health care services, in partnership with local interests. It builds upon previous planning initiatives including *Strategic Intent and Direction* with its attendant *Local Strategies for Health.*

The HIP starts with a population focus, and although the HIP will be the local health and health care strategy, it will also detail how national targets and priorities will be met. The distribution of funds will follow the implementation of the HIP, including joint plans with social services for continuing and community care. Children's services could also be the subject of such joint plans at a later date.

A FOCUS UPON PRIMARY CARE AND LOCAL PARTNERSHIPS

The White Paper proposed the abolition of General Practitioner Fundholding and its replacement by new inclusive locality health organisations called **Local Health Groups** (LHGs), which were introduced on the 1st April 1999. The LHG is an aggregation of contiguous general medical practices, for which membership is automatic and universal - unlike fundholding. Their boundaries match those of local authorities so as to .... "take account of the benefits of co-terminosity with social services"....

LHGs exist initially as health authority sub-committees but can potentially evolve into free-standing primary care trusts (PCTs) with the veto held by the health authority. They are more like mini-health authorities than any of the previous primary care commissioning models. They represent the first UK application of strategy and co-ordination to primary care with a joint working focus across health and social care.

The health authority, in the medium term, is to be strategic and will not directly purchase care. The LHGs will have the budget and in theory will therefore do the secondary care commissioning. However, in practice the role of the LHG is likely to be more about horizontally integrating the delivery of primary health care / community services and social services.

The new arrangements will be dominated by collective planning and by the performance framework. LHGs will have to act within the HIP and their commissioning plans (and the business plans of the NHS trusts) must be in line with it. In practice, the new **Long Term Agreements** (replacing contracts) which LHGs

will put into place for secondary care, may be more like a return to block contract funding with a focus on quality and effectiveness.

The performance of health authorities, LHGs, and NHS trusts will all be judged according to the performance framework[13] and associated high level indicators and benchmarking of costs and quality assurance. Because of all these trends, purchasing will probably decline in importance.

The White Paper was followed by a further consultation paper "Partnerships for Improvement" in late 1998, which proposed a range of mechanisms to enable money to move, not only from the NHS to local government as has previously been possible through the JCC, but also from local government to the NHS. This provision is contained in the Health Act 1999. The Assembly will need to create its own legislation to implement these new proposals in Wales.

AN EMPHASIS UPON QUALITY

The other very strong, ambitious, interesting and probably enduring theme of the NHS White Paper is in the pursuit of effective clinical care and accountability for doctors referred to under the title of Clinical Governance. This emphasis is likely to be stronger still following the recent events in Bristol concerning the safety of children's cardiac surgery.

Health Authorities have been given a new role in ensuring the clinical effectiveness of the health care services that are provided to its residents. This is a strategic and facilitatory role with the operational functions largely being carried out at NHS trust and Local Health Group level. New management accountabilities for 'Clinical Governance' have been placed with Health Authority Chief Executives, NHS trust Chief Executives and Local Health Groups.

Clinical Governance is part of a multi-level government quality initiative for the NHS whose aim is

fair access to consistently high quality health care for all

This quality agenda has the following main components:

- national quality standards - these include National Service Frameworks (NSFs) and other standards set by the National Institute for Chnical Excellence (NICE).
- local delivery of quality services - through **clinical governance**
- monitoring of service quality - through performance management and by the Commission for Health improvement (CHI).

[13]The new National Performance Framework contains 6 dimensions, which are Health Improvement, Fair Access, Effective delivery of appropriate care, Efficiency, Patient/carer experience, Health Outcomes of NHS care. All of the new high-level performance indicators relate to one of these dimensions and majority of these high-level indicators being used to judge the performance the NHS are public health, clinical effectiveness and clinical indicators.

CUnical Governance will be professionally led and is probably the last chance for self-regulation given the events of Bristol. There is a great incentive for the medical profession in particular to get its act right both centrally (the GMC) and locally - potentially partially through the clinical / public health interface.

THE BETTER HEALTH, BETTER WALES GREEN PAPER

AIMS AND THEMES

With this public health Green Paper, issued in Wales in the first half of 1998, the Government set out a new approach to public health through tackling the underlying causes of ill health. The key aims of this consultation paper and its follow-up Strategic Framework were:

- setting a strategy to be taken forward by the National Assembly for Wales
- preventing disease and substantially improving the health and well-being of people in Wales;
- bringing the level of those with the poorest health up to that of those with the best
- improving the health and well-being of children
- encouraging individual responsibility for health
- improving the health and safety of people at work.

The Green Paper's main approaches were:

- a strong focus upon the determinants of health.
- the need for "sustainable health and well-being".
- policies on the environment, employment, housing, leisure, health, social care and education being considered together rather than separately.
- collaboration between voluntary agencies, local government and the NHS.

The Strategic Framework for the Welsh Public Health Green Paper (Welsh Office 1998) was published in October 1998. The objective was to provide a comprehensive, multi-disciplinary framework for national and local action.

ACTION ON HEALTH DETERMINANTS AND PRIORITY GROUPS

This was focussed particularly upon the socio-economic and physical environmental and lifestyle determinants of health and one priority group - children and young people.

COMMUNITIES - THE SOCIO-ECONOMIC ENVIRONMENT

The aim is to improve economic and social well-being and reduce inequaUty in all sectors of the community in all parts of Wales. The drivers for action are:

- employment and the economy
- local government action for health
- NHS action for health
- voluntary sector partnerships
- social inclusion
- workplace health

Specific levers for action are the New Deal, Employment Zones, EU funds, local government community leadership, local government formula, community safety audits, NHS allocations, screening strategy, Local Health Groups, NAW Voluntary Sector Schemes, People in Communities, and occupational health strategy.

THE PHYSICAL ENVIRONMENT

The aim is to ensure that environmental factors have minimal detriment to health. The drivers for action are:

- sustainable development
- pollution control
- planning and land use
- healthy homes
- integrated transport strategy

Specific levers for Action are the NAW sustainable development scheme, National Environmental Health Plan, Capital Challenge, UK Air Quality Strategy, environmental and drinking water improvements, contaminated land regime, hazardous incident plans, Waste Management Strategy, revised planning guidance, sustainable development plans, review of housing standards, Capital Receipts Initiative, integrated transport plans, Road Safety Strategy, National Cycle Strategy, and green transport plans.

LIFESTYLE

The aim is to encourage everyone to make choices which optimise their health and avoid ill-health. The drivers for action for lifestyle change are:

- Healthy Living Centres
- tobacco control

- food safety, standards and nutrition
- activity, sport and recreation
- accidents
- drugs and alcohol strategy
- sexual health, oral health and mental health strategies
- screening
- infectious disease control

The specific levers for action are Healthy Living Centres, Tobacco White Paper, Food Standards Agency, Sports Council schemes, Drugs and Alcohol Strategy, Sexual Health Strategy, Protocol for Oral Health, revised Mental Health Strategy, National Strategy for Infectious Disease Control.

CHILDREN

The aim: is to ensure children and young people reach their potential for achieving healthy satisfying lives. The drivers for action are:

- children's services
- schools and colleges
- youth services

Specific levers for action are the Children's Strategy, Sure Start, review of Health Visitors, National Child Care Strategy, standards for social care, Healthy Schools, instituting nutritional standards, special needs, school health services, safe routes to school, school exclusion initiative, review of the curriculum, and healthy colleges.

PARTNERSHIPS FOR HEALTH

The Green Paper called for action across a broad front to tackle inequalities in health. This, it said would require effective partnerships between central and local government, the NHS, commerce, industry and voluntary organisations.

LOCAL AUTHORITIES

Local authorities are expected to be "significant partners" in the development and delivery of Health Improvement Programmes - the local plans to improve health and health care introduced by the NHS White Paper.

The Government announced that it was to review the allocation of functions between health authorities and local authorities for the control of communicable disease.

It is also considering introducing a requirement for Health Impact Assessments for all major new developments, including local authority developments. The Assembly is to

consider changes necessary to planning guidance so health impact can be taken into account in local development plans.

Other forms of inter-agency collaboration with the local authority which are to be considered include:

- voluntary sector representatives on formal joint bodies,
- more effective joint working to deliver statutory social care plans,
- involvement of local people in developing the plans of local and health authorities,
- local authority environmental health officers to advise health authorities and LHGs,
- Directors of Public Health to develop their role in providing independent advice to health authorities and local authorities.
- joint appointments of public health professionals to be considered by HAs and LAs.

LOCAL HEALTH ALLIANCES

To be effective in raising the level of health and in tackling health inequalities, the new national structure will need to be supported by a local delivery structure. It is proposed that local authorities should lead the establishment of Local Health Alliances, in each local authority area, to bring together multi-sector agencies to protect and improve health. These are already in place in some parts of Wales with a range of other partners such as GPs, voluntary and community groups and businesses. The Assembly, in conjunction with the Welsh Local Government Association and the Welsh Collaboration for Health and the Environment, has now launched a best practice framework for Local Health Alliances.

In principle, Local Health Alhances should broadly engage local partners to:

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

The partners in each Local Health Alliance will be for local determination in the light of the issues to be addressed under the wider public health agenda. The recommendation is that an Alliance should be led by the local authority taking

corporate responsibility for cohesion of its own services such as public protection, environmental health, education, leisure and recreation, housing and personal social services and drawing upon the contributions of the NHS and others, including community and school nursing services, local Drug and Alcohol Teams, community regeneration partnerships, local County Voluntary Councils and members of local crime prevention/community safety schemes, in support of coherent and comprehensive programmes of health-improving activity. Local Health Alliances should facilitate local multi-disciplinary working across all public health functions.

THE NHS

The Green Paper laid out a new focus of NHS Wales - on collaboration rather than competition, and on improving health as well as treating sickness. To facilitate this, the public health role is to be strengthened to ensure all parts of the NHS become more focused on preventing ill health, and the government exempted public health professionals from NHS management costs.

STRUCTURES AND PROCESSES

The Strategic Framework proposes a range of structures and processes to support sustainable health and well-being in Wales. These include the Welsh Assembly's internal support structures, The Wales Centre for Health, health network, Local Health Alliances, health promotion review and Strategy, Research and Development, Health Impact Assessment, Sustainable Action Research Programmes (SHARPS), Health Improvement Programmes, DPP / DPH plans, health gain, multi-sector training plans.

THE WELSH ASSEMBLY'S INTERNAL SUPPORT STRUCTURE

There are new directorates for the NHS and for health promotion and protection. There is also a crosscutting departmental network within the Assembly's executive to co-ordinate and monitor the public health aspects of Assembly policies.

THE WALES CENTRE FOR HEALTH AND THE HEALTH NETWORK

The Strategic Framework proposes that a Wales Centre for Health be established in conjunction with academic and public sector partners. The Centre will be a focus for multi-disciplinary advice, debate and professional development. Its functions will include providing a forum for multi-disciplinary advice on health hazards; risk assessment of threats to health; disseminating research and other evidence to support decision-making; support for multi-professional training in sustainable health; and liaison with national and international multi-professional groups.

It also proposed to estabhsh a National Network for Health principally across the NHS and local government sectors to incorporate and strengthen the existing informal Public Health Network. The new Network is expected to meet as a standing conference at least twice a year. Its principal functions would be to support the functions of the Wales Centre for Health; share expertise and facilitate multi-disciplinary action; promulgate best practice, based on evidence and research; advise the Chief Medical Officer on multi-disciplinary health issues, as required; and be a source for training initiatives and professional development.

The establishment of the Wales Centre for Health, supported by the National Network for Health, will provide the national focus for strategic co-ordination of public health skills such as epidemiology, microbiology, environmental health and personal social services.

HEALTH PROMOTION REVIEW AND STRATEGY

During 1998 an expert group reviewed the arrangements for health promotion in Wales and brought forward recommendations for a National Strategy for Health Promotion to be taken forward by Health Promotion Wales within the National Assembly. The proposals include:

- a 10 year national strategy for national and local implementation;
- greater use of information technology to improve the quality of, and access to, information for the public and professionals;
- strengthening the local specialist units to improve the delivery of health promotion services and support across Wales;
- an audit of expenditure on health promotion resources and programmes;
- a new performance framework;
- programmes of research and evaluation to underpin action based on evidence;
- a multi-disciplinary, multi-sector expert committee to advise the National Assembly on health promotion issues; and continued national and international links and collaboration with the World Health Organisation and the European Commission.

A National Strategy for Health Promotion will be prepared for adoption by the National Assembly, taking account of responses to the consultation.

RESEARCH AND DEVELOPMENT

The Welsh Office for Research and Development has produced a strategic framework to promote evidence-based approaches to health improvement. In support of this aim, the health related R&D programme will be developed under three areas:

- *Best Care for Patients* - addressing the effectiveness of health care delivery;
- *Sustainable Health and Well-being* - covering issues around determinants of health; and
- *Accessing and Using Research* - ensuring that the research findings, both positive and negative, are integrated into service planning and practice.

Sustainable Health Action Research Programmes (SHARPs)

The Green Paper proposed to set up a 5-year action research project designed to identify the most effective ways of breaking the cycle of poor health in Wales. This will focus on communities with the highest incidence of ill-health and premature death, social exclusion and poor life chances. Areas will be chosen to reflect urban and rural issues. It is intended that SHARPS will be used to underpin LHGs' planning and decision-making powers.

HEALTH IMPACT ASSESSMENT

A Health Impact Assessment is the evaluation of the impact of policies, programmes and proposed developments on the health of the population at all levels; individuals, the community and the nation. A steering group has been established to further develop the concept of Health Impact Assessments. However, initially the Assembly will adopt the requirement that the impact of all policy proposals will be considered so that, at the very least, they are not harmful to health and, if possible and appropriate, they produce the maximum benefit to health.

INFORMATION

The Assembly's intended functions will include monitoring the health and well-being of the Welsh population. To do this job, it will need:

- information about health status
- guidance on setting standards for housing, transport, environmental controls, health care and health promotion
- and feedback on health gains achieved.

Similarly, if the public health strategy is to be successful, it will depend on access to accurate information. The right information base is needed to:

- enable people to make a more informed choice about health,
- to help bring about health improvements for the people of Wales,
- to inform debate about public health issues.

In response to these needs work is being undertaken on the development of an All Wales Information Strategy, including the further development of the Health of Wales Information System (HOWIS). Encouragement will also be given to public bodies to work in collaboration using existing available information.

MEASURING PROGRESS

The Welsh Assembly has decided to continue to focus on the fifteen health gain targets that the former Welsh Office established in June 1997 with the addition of new targets for children's health. All of these focus on *average* population health gain rather than reduction in health inequalities. It is imperative that policies are guided by targets for the reduction in health inequalities as well as for health gain. In this regard,

the Assembly has asked an expert advisory group to produce indicators for health inequalities. The current health targets are described in full in the Appendix.

Health authorities are expected to work with other local agencies to develop Health Improvement Programmes that cover the national targets and address health inequalities. There is also flexibility to set local targets in the Health Improvement Programmes.

REFLECTIONS UPON THE GREEN PAPER

The *Better Health Better Wales* Green Paper is welcome in that it appears to accept the importance of tackling the determinants of health, and of sustainable development, if one is to achieve lasting population health gain and reduction in health inequalities.

In the follow up *Strategic Framework,* we welcome the wish to improve health - particularly via those determinants of heath, other than healthcare - and we actively endorse the proposal that "joined-up" responses are needed for "joined-up" problems. However, it is a concern that the proposals offered to deal with inequalities in health in the document are too often symptomatic in their treatment of the problem, rather than addressing the underlying causes.

Of course, treating symptoms rather than root causes avoids the difficulty in confronting some difficult political and ethical issues. More fundamentally, the fact that the *Strategic Framework* did not follow through with the radical policies suggested by the logic of the Green Paper probably illustrates less a lack of will than the lack of power. Neither the devolved region nor the nation state is free to make policy alone in the face of the pressures of a global economy - a theme that will be returned to later in discussions on the European Union.

THE ACHESON REPORT ON INEQUALITIES IN HEALTH

In July 1997, soon after being elected, the government asked Sir Donald Acheson to lead an inquiry to review the evidence on health inequalities and to identify priorities for policies to reduce them. The inquiry had a scientific advisory group and consulted with, and commissioned papers from, a range of experts. It also drew upon Sir Douglas Black's 1980 report on the same subject.

The Inquiry reported at the end of 1998. It found that although the last twenty years have brought a marked increase in prosperity and substantial reductions in mortality, the health gap between those at the top and those at the bottom of the social scale has widened, with the causes lying in the social environment (see Wilkinson 1996). It concludes that many health inequalities can be tackled, but that the range of factors influencing them extends far beyond the Department of Health's remit. "It acknowledges that the policy solutions to ill-health and health inequality he in areas such as tax and benefits, education, employment, housing, transport, and nutrition. The report also focuses upon tackling health inequality among particular groups including mothers, children and families, young people and adults of working age, and ethnic minority communities.

The report makes a large number of recommendations across a wide range of policy areas. There are three main recommendations that:

- all policies likely to have an impact upon health should be evaluated for their impact on health inequality and should favour the less well off.
- priority should be given to improving health and reducing inequality for women of child bearing age, pregnant women and young children.
- further steps should be taken to reduce income inequalities and improve the living standards of poor households.

The Inquiry gives scientific analysis and says that the Government must decide whether the recommendations are affordable and when and how to implement them.

The report also looks into the role of the NHS in addressing health inequalities and sets out its responsibilities as follows:

- to provide equity of access to effective healthcare.
- to work in partnership with other agencies to improve health and to tackle health inequalities.
- to provide professional leadership and to stimulate the development of health policies beyond the NHS.

It suggests that providing equitable access to effective care in relation to need should be the governing principle of all policies in the NHS. Priority should be given to the achievement of equity in the planning, implementation and delivery of services. Specifically it recommends:

- extending the focus of clinical governance (and related national clinical effectiveness initiatives) and performance management to give equal prominence to equality of access.
- health authorities (working with local health groups) agree priorities and objectives for reducing inequalities, as part of the Health Improvement Programme.
- various moves towards more equitable resource allocation.
- Directors of Public Health, working on behalf of health authorites and local authorities, produce an equity profile for their areas and undertake triennial audits of progress towards achieving objectives to reduce health inequalities.
- a duty of partnership between health authorities, local authorities and other agencies so that joint programmes to address health inequalities are put in place.

CHAPTER 5

IMPROVING THE HEALTH OF THE PEOPLE THROUGH THE EUROPEAN UNION (EU)

> *Many of our health problems are of a global nature and are closely linked to economic development, the environment and other challenges. They can therefore only be overcome by intensified global co-operation, where strong efficient and forward looking international institutions must underpin our common efforts.*
>
> *Dr Gro Bruntland, Director General WHO 1998*

The EU has recently moved rapidly from a situation in which it had little involvement in health to one in which it has become a major influence in public health. In future, it is also likely to become increasingly important in relation to healthcare. The EU will therefore have a growing influence upon national and devolved regional health policies and upon the health of the people. This influence will be exerted not only through EU public health programmes and strategies, but also across all EU policy impinging upon the determinants of health - particularly environment, health and safety, and trade and competition policy. It is therefore important to pay close attention to the European dimension and to understand how EU institutions and legislation can influence public policies in the UK and in Wales.

UNDERSTANDING THE STRUCTURES AND PROCESSES OF THE EU

THE INSTITUTIONS OF THE EUROPEAN UNION

The European "government" is not made up of Members of the European Parliament. Instead, there is a triangle of institutions in which (roughly), the Commission proposes, the Parliament scrutinises, and the Council of Ministers (increasingly jointly with the Parliament) disposes. There is a fourth member in the centre of this triangle - The Court of Justice, for it is the guardian and ultimate interpreter and arbiter of the Treaties. Running through these bodies individually.

THE EUROPEAN COMMISSION (BRUSSELS / LUXEMBOURG)

The Commission is the most powerful of the EU institutions. It is the civil service of the EU, and is headed up by the 20 EU Commissioners, including Commission President Romano Prodi, who are appointed by the member states.

The Commission is charged with implementing the Treaties, which means:

- running detailed policy where this exists (e.g. The Common Agricultural Policy)

- implementing Directives and Regulations and Decisions, and if necessary bringing legal action through the Court of Justice against member states that do not comply.
- issuing regulations of its own accord, developing policy and drawing up draft legislation where the Treaties grant the power to do so (e.g. re. the European Single Market). Draft legislation is then put before the Council and Parliament for co-decision and laws are issued in the form of Directives, Regulations or Decisions.

The Commission's bureaucracy is sub-divided into 23 different Directorates General or DGs, each headed by a Director General.

The Organisation of the Health Function of the Commission

Prior to the current Commission headed by Romano Prodi, the health function was fragmented throughout the bureaucracy, and this remained the case even though public health had become a formal competency.

Now, for the first time, and as an illustration its increasing profile, health is to have its own specific Directorate-General within the Commission. The new Directorate General for Public Health and Consumer Protection will be headed by Commissioner David Byrne (Ireland).

THE EUROPEAN PARLIAMENT (STRASBURG)

The Parliament is the only directly elected European body. Direct elections first took place in 1979, and initially the Parliament had largely an advisory role. Its powers have since been strengthened and it now has legislative power and is able to approve some of the EU's expenditure.

The main role of the Parliament is to scrutinise the executive - the Commission and the Council - which it does through its 20 subject committees, each covering a policy area. Health comes under the powerful Committee on Environment, Consumer Protection and Health. Health and Safety at Work is dealt with by the Committee for Social Affairs and Employment. A separate committee for health has been suggested and seems attractive on the surface, but health probably benefits with the weight and power of the Environment Committee behind it.

THE COUNCIL OF MINISTERS (BRUSSELS / LUXEMBOURG)

The composition of the Council of Ministers varies according to the policy area, so there is a Social Affairs Council, an Agriculture Council and now a Health Council, composed of the health ministers of each of the member states. The Council of Ministers represents the governments of the 12 member states and is able to amend, accept or reject draft legislation. The Council has its own secretariat in Brussels.

THE COURT OF JUSTICE (LUXEMBOURG)

The Court of Justice draws its judiciary from all the member states. European law takes precedence over national law, and individuals, companies, governments or the Commission can bring cases before the court.

OTHER EU BODIES

These include the *Court of Auditors* which scrutinises EU expenditure, the *Economic and Social Committee* and the new *Committee of the Regions.* The last two have a health mandate, but are consultative committees without legislative or executive power.

THE "EUROSPHERE"

The "Eurosphere" is the informal name given to the large lobbying network that has built up in Brussels around the EU. There are health pressure groups, not least the European Public Health Alliance though these are vastly over-shadowed in funding terms by industry lobbies for the like of Philip Morris tobacco.

THE EU POLICY MAKING AND LEGISLATIVE PROCESS

EU legislative processes are transparent compared to Westminster. The Commission, initiates a legislative proposal, encouraged sometimes by the Parliament or a member state, prepared in the appropriate Directorate-General, usually after consulting with a wide range of bodies, including the Committee of the Regions and the Economic and Social Committee.

The path for legislation then proceeds through consultation involving iterative discussion between the Commission, the member states, Parliament and Pressure Groups. The forum for this discussion is known as CO-REPER. The draft legislation, then passes through either "Co-operation" with the final decision to adopt into law being taken by the Council of Ministers, or "Co-decision" where the legislative proposal finally succeeds unless it is voted down by the European Parliament. Both "Co-decision" and "Co-operation" are convoluted procedures, and the draft legislation can fail or be amended at any stage. The choice of procedure followed depends upon the legal basis for the proposal. Public Health legislation is subject to "Co-decision" and Qualified Majority Voting.

THE EU PUBLIC HEALTH COMPETENCE

HISTORICAL DEVELOPMENT

Before the Maastricht treaty, which was signed in February 1992, the European Community (renamed the European Union by that treaty) had no specific legal basis or competence to act on health, although the previous treaties did contain provisions of direct relevance, particularly in health and safety at work. Other policies such as agriculture, freedom of movement, research programmes, internal market provisions for medicinal products, mutual recognition of medical qualifications, free movement of services and environmental and transport measures have a considerable impact on health services and upon the health of the public.

However, because many of the major determinants of health had been strongly under its influence, the European Community was already important in public health terms prior to Maastricht. This remains the case today, to an even greater extent (as will be

described later), especially as a result of the EU's influence on the economy and on workplace and wider environmental regulation.

THE LEGAL BASIS OF THE EU PUBLIC HEALTH COMPETENCE

As a part of a move to counterbalance the prior predominance of the European Single Market with the improvement of social conditions for ordinary people, Article 129 of the Maastricht Treaty on European Union (1992) set up a formal competence (and legal jurisdiction) on public health.

Although the health competence established by the Maastricht treaty was limited to co-ordinating the Commission's existing activities on the health front and establishing more public health promotion programmes for specific important diseases and health problems its adoption was a turning point. For the first time decisions on health could be divorced from the considerations of the single market and a coherent strategy for health developed.

The wording of Article 129 was quite vague. However, it was clear when it stipulated that health protection requirements shall form a constituent part of the EU's other policies. To this end, the commission set up an inter-service group on health composed of representatives from different Directorates-General. It also set up specific EU public health strategies and programmes on *Europe against Cancer, Europe against AIDS, Drug Misuse, and Health Promotion. A* potential future programme is *Europe against Cardiovascular Disease.* Similarly, a specific EU health research programme (BIOMED) was founded, split between research on: disease prevention, care and health systems; major disease (AIDS, cancer, cardiovascular disease etc); human genome analysis; and biomedical ethics.

However, partly as a result of perceived EU failures in relation to controlling human risks from the bovine spongiform encephalopathy (BSE) epidemic in cattle, the EU public health provisions have now been strengthened in Article 152 of the Treaty of Amsterdam (1997) which has now been ratified into community law. This states:

1) A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.

   Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such actions shall cover the fight against major health scourges by promoting research into their causes, their transmission and their prevention, as well as health information and aducation.

   The Community shall complement the member states' action in reducing drugs and related health damage, including information and prevention.

2) The Community shall encourage cooperation between the member states in the areas referred to in this article and, if necessary, lend support to their action.

3) Member states shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the member states, take any useful initiative to promote such co-ordination.

   The Community and the member states shall foster co-operation with third countries and the

competent international organisations in the sphere of public health.

4) The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the regions, shall contribute to the achievement of the objectives referred to in this Article through adopting:

a) Measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any member state from maintaining or introducing more stringent measures.

b) By way of derogation from Article 37, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

c) Incentive measures designed to protect and improve human health, excluding any harmonisation of the laws of member states.

The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

5) Community action in the field of public health shall fully respect the responsibilities of the member states for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

CURRENT FOCUS OF EU PUBLIC HEALTH POLICY

The specific public health competence embodied in Article 152 of the Amsterdam Treaty enables the EU to take action to co-ordinate national policies on the prevention of major diseases as well as health information and health education.

Following on from the Amsterdam Intergovernmental Conference, the European Commission (1998) has outlined a possible new EU public health policy, which is based on three strands of action:

- improving information for the development of public health
- reacting rapidly to threats to health
- tackling health determinants through health promotion and disease prevention.

While Article 129 of the Maastricht Treaty stressed the prevention of disease, Article 152 of the Amsterdam Treaty emphasises that EU action will be directed towards improving the health of the people, preventing illness and disease, and attending to sources of danger to health. This requires a shift in focus towards the determinants of health in addition to tackling disease prevention.

Tessa Jowell, the English Minister for PubUc Health wishes to estabhsh a set of priorities for joint action by the EU and the member states on key determinants of health. She has indicated that these might include:

- environment and health
- safeguarding the safety and quality of food, medicines and medical devices

- monitoring and surveillance of rare and emerging communicable diseases

  ensuring that high levels of health protection are retained through the effective regulation of the free movement of health professionals.

CURRENT EU ACTION ON THE DETERMINANTS OF HEALTH

The EU already exerts a significant influence on the determinants of health through its laws and directives and through the activities of its specialised agencies such as the European Medicines Evaluation Agency, the European Environment Agency and the European Agency for Health and Safety at Work.

THE SOCIO-ECONOMIC ENVIRONMENT

DEPRIVATION, UNEMPLOYMENT, AND ECONOMIC DEVELOPMENT

Regional policy, and EU structural funding - which is very large in scale - have been influential throughout the poorer parts of Europe (including Wales) in promoting economic development and structural regeneration with potentially large effects upon economic deprivation and unemployment.

OCCUPATIONAL HEALTH AND SAFETY

There are EU Directives on safety in the workplace, working time, personal protective equipment, manual handling of loads, use of visual display units (VDUs), exposure to hazardous chemicals, asbestos, and biological agents, and on the protection of pregnant women and young people.

CONSUMER PROTECTION

There are Directives on the liability of suppliers of services, the safety of children's toys and equipment and a rapid alert system for dangerous consumer products.

THE PHYSICAL ENVIRONMENT

FOOD QUALITY

Probably the most visible example of how Europe is influencing public health practice in the UK has been the European Commission's (EC) worldwide ban on the export of British beef.

There are directives on additives, food irradiation, radio-nucleotide limits (post-Chernobyl), growth promoters in meat, standards in food hygiene, and labelling foodstuff nutrient values.

GENERAL ENVIRONMENT

There are powerful directives on air pollution and water quality and on exposure to chemical products, lead, cadmium, pesticides etc. The European Environment Agency has been set up in Copenhagen. There are potential moves towards sustainable development e.g. through carbon taxes but also through greater regulation of business.

RURAL ENVIRONMENT AND AGRICULTURE

The Common Agricultural Policy has an enormous influence upon the sustainability of the rural environment as well as upon the food-stuffs produced and thereby upon nutrition patterns.

LIFESTYLE

SMOKING TOBACCO

There are directives on tar yield and strengthening the warning labels on tobacco products. EU health ministers have recently agreed a ban on tobacco advertising and sponsorship. It will take some years to be fully implemented, but once it is, it will be an example of European policy making preventing thousands of premature deaths.

HEALTH AND SOCIAL CARE SERVICES

In theory, the EU health remit is limited to public health and it is explicitly precluded from jurisdiction in healthcare services with this arena being reserved to the national governments of member states. However, this may not always be the case and over time there are a number of reasons why EU legal competence may gradually extend to include health care services. Even in the absence of this, the EU still has influence upon health and social care.

Some established EU legislation affects healthcare services for example, regarding:

- mutual recognition of diplomas - Doctors Directive (1975), dentists, vets, midwives (1980), nurses (1977), pharmacists (1980).
- harmonising training - Directive on Vocational Training for GPs (1986), Directive on Harmonising Specialist Training.
- reciprocal arrangements for Acute Medical Care - Form E111

  pharmaceuticals - directives on assessing the safety and efficacy of drugs (medical equipment), directives on distribution, advertising and packet leaflets. The European Medicines Agency has been set up in London to evaluate and license medicines. The Euro is also making the differential pricing of pharmaceuticals more transparent.

  the Working Time Directive

Future increased EU influence upon healthcare will result from Single European Market legislation, which regards such services as a tradable commodity, and therefore subject to rules upon the free movement of goods and services. Judgements of the European Court of Justice have supremacy over the courts of member states and a crucial precedence is potentially being set currently upon the freedom of EU citizens to obtain treatment in other member states with the cost borne by their own national government. Court rulings have recently been made supporting these rights in two cases brought by individual EU citizens *(Kohl* and *Dekker).* The rulings are being appealed against by the member states. If sustained, the implications would be

profound as they would remove much of the sovereignty of member states in deciding their own healthcare policies and systems, and might also make cost containment difficult and threaten planning and equity policies, while prioritising choice, markets, health tourism and centres of excellence.

There are also moves to greater European integration, and a gradual process towards equivalent rights for European Citizens across different member states. These may gradually make EU citizens rights to healthcare more uniform and exert greater conformity on healthcare systems. In this regard, it is noteworthy that the prevailing healthcare systems in mainland Europe more often follow the Bismarckian social insurance model than the state provided socialised model exemplified by the British NHS and the Scandinavian systems. Bismarkian Health Insurance Systems and National Health Systems are in any case moving closer together throughout the world, in order to contain increasing costs and demand, towards American Health Maintenance Organisation (HMO) type models.

Furthermore, as a prelude towards the expansion of the EU eastward, the former communist block countries are receiving EU assistance to develop their economies, including their healthcare systems - along Bismarckian lines, and there are developments towards pan-European health insurance organisations - most being "mutual" or "not for profit" operations.

FUTURE EU INFLUENCE ON THE DETERMINANTS OF HEALTH.

The EU influence upon the determinants of health is likely to continue to grow as the EU's range of jurisdiction expands. Furthermore, Article 152 also commits the EU to consider the health consequences of all its policies - presumably via some form of health impact assessment. Potentially this will bring further powerful positive influence to bear upon the determinants of health.

In addition there are global economic forces at work which are likely to increase the imperative towards European integration and increase the EU's importance both in terms of public health and across the whole of what is possible in social policy terms including healthcare services.

EUROPEAN INTEGRATION AND HEALTH IMPROVEMENT

LIMITATIONS OF THE DEVOLVED REGION AND NATION STATE

In the modern world, neither the nation state (the UK), nor the devolved region (Wales) are free to set a policy course independent of the global market place. A global economy based on free trade threatens the ability of any government to carry out policies of its own making in respect of welfare, wages, environmental protection and conservation and public health.

The nation state is no longer a large enough entity to act effectively upon its own for the maximal benefit of its people. To govern effectively in a global market economy, the nation state must do so in alliance with other nation states or alternatively fuse with them to form a larger "superstate". This is the prime imperative towards European Integration. Because of its size, the EU is in a position to withstand global

economic forces in order to regulate many of the determinants of health, while the nation state is unable to do so.

THE GLOBAL ECONOMY AND THE EUROPEAN UNION

In its trade and competition policy, the EU is potentially large enough to counter the full blooded laissez-faire influence of the USA in negotiations of the (1994) General Agreement on Tariffs and Trade (GATT) which governs world trade and is administered by the World Trade Organisation (WTO).

The EU could increase duties for goods and services sold within the Single European market which were not manufactured or provided from bases within the EU. This would create an economic incentive to companies to locate within the EU and provide employment to its citizens.

TRANS-NATIONAL COMPANIES AND CORPORATE TAXATION

Similarly, within Europe, only the EU is large enough, as a single trading block, to stand up to the trans-national corporations and impose minimum levels of corporate taxation. It could do this (were it not precluded by the current GATT), because it is the world's largest single market and trans-national corporations cannot afford not to trade within its boundaries.

Furthermore, the EU could require companies setting up within its area to pay a minimum level of corporate taxation and social costs, instead of being able to play off different member states (or regions) against each other in an auction of lowest bidders for the employment which these companies provide.

TAX HARMONISATION AND THE SOCIAL MARKET ECONOMY

Such corporate tax harmonisation is currently on the EU agenda though progress is likely to be vetoed by a number of member states including Britain for short term political reasons. However, harmonisation of corporate taxation and later on of personal taxation (including income tax) and benefits (including access to health care) are natural and logical further developments of the Single Market, Economic and Monetary Union and a degree of political union which is ultimately likely to ensue.

All this is heinous to those who believe in the sovereignty of the nation state or in the free market ideologies which are currently in the ascendancy. Contrary to the prevailing logic, re-distributive and welfare policies are possible where an individual country cannot be held to ransom by trans-national business because the state is part of a unified trading block - the EU. In this situation, a social market economy is possible, taxes need not be minimal and public services need not be starved of resources nor privatised by necessity. The EU countries are in a better position to guarantee a social safety net and welfare policies for their citizens.

IMPROVING WELSH HEALTH THROUGH THE EU

Wales has previously been aided by Objective 2 status structural funding, but now two thirds of Wales, comprising the South Wales Valleys and West Wales (from the

Irish Sea coast down to the Bristol Channel) qualifies for the more lucrative Objective 1 status. This qualification is on account of the GDP per head of these areas being less than 75% of the EU average. The objectives of structural funding all concern economic development, and through these, substantial health improvement is also likely to result. Although improved population health outcomes are not a direct objective, there is considerable utility in Wales adopting a health impact assessment approach to the programmes financed by this structural funding. This would be in keeping with paragraph 1 of Article 152 of the Amsterdam Treaty, requiring the health effects of all EU policies to be considered, and would help to ensure that maximum health improvement is achieved.

After all, although improving the health of the Welsh population is a social good in its own right, from an economic perspective a healthy workforce is a pre-requisite for economic development. This economic development, so long as it is sustainable, will then in turn generate further health improvement in a virtuous cycle. Wales has poor health and a weak economic base, which are very much related, and it needs to find a way out of this vicious circle. Structural funding provides this opportunity if carefully used.

In Wales, the high prevalence of poor health (particularly long term sickness) has far reaching consequences for the economy, social structure and well-being of communities. It produces high levels of economic inactivity, which contribute markedly to the low GDP. The Assembly needs to therefore ensure that health improvement is a clear and central theme in the document submitted to the EU and that community based and other health initiatives should be an essential part of later funding applications. There is sufficient provision in Article 152 of the Amsterdam Treaty to encourage this dimension, which will widen the opportunities for tackling health inequalities in Wales. There is a major danger that if health improvement is not a major theme, then we will limit ourselves in the use of structural funds.

As previously discussed, a long-term focus on the determinants of health is required to achieve health improvement, and economic development through structural funding will be a central tenet within this approach. In the short term, a small proportion of the Structural Funding should also be used directly for population health improvement as an investment likely to create economic development. In England there are examples of "Exercise on Prescription" schemes funded through Objective 1. This needs to happen in Wales. If possible, consideration should also be given to funding some relevant healthcare programmes, including for example rehabilitation services - to enable some of those who are economically inactive due to ill-health to return to work, occupational health services and also specific transport programmes designed to improve access to healthcare services. The Assembly should link with those with relevant policy, management and professional expertise in the Welsh NHS to develop some of these proposals.

More broadly, regions within Europe, such as Wales, can perform many domestic policy roles just as well as or in some cases better than the larger nation state. In the case of global policy roles the regional level is little worse off than the current larger nation state so long as it acts within a larger federation such as the European Union. This can already be seen in the case of the Republic of Ireland which is a small nation state, no larger in population terms than a British region, but which has been

influential and has prospered economically as part of the larger European Union. The potential parallels for Wales are obvious and the opportunities large.

To maximise the benefits for Wales, liaison between the National Assembly for Wales and the EU will need to be close. In theory, this liaison is supposed to operate through a lead UK government department, in the case of health - the Department of Health in Whitehall, working through the UK Permanent Representation to the European Union (a kind of Embassy to the EU). In practice, this arrangement - which does provide for Britain speaking to Europe with a single voice - is unlikely to be adequate from a Welsh perspective and holds the potential for considerable tension. It brings into sharp relief the need for a proper federal UK government to complement UK regional assemblies and parliaments.

In the interim, there will inevitably be pressure for the Assembly to form its own informal liaison with the EU probably through the Wales European Centre in Brussels. The EU Committee of the Regions, upon which the Assembly will have one seat and the WLGA another, provides one potential platform, though this is weak compared to the power of the Council of Ministers. One potential short term solution is for the relevant minister from each of the devolved governments in the UK to accompany the British Government ministers as part of the delegation to the Council of Ministers, though this may be unwieldy especially in a future scenario including English Regional Assemblies.

The Assembly needs to press for healthy European Union policies, and for the Health Impact of all European Union policies to be examined, through:

- the Welsh MEPs,
- the Wales European Centre lobbying the Parliament and the Commission,
- the International Section of the Department of Health in Whitehall which relates to the Permanent UK Representation to the EU.
- the UK Minister for Health, the Minister for Public Health and the Prime Minister in order to influence the Council of Ministers.

CHAPTER 6

IMPROVING THE HEALTH OF THE PEOPLE THROUGH THE NATIONAL ASSEMBLY FOR WALES

POWERS AND STRUCTURES OF THE WELSH ASSEMBLY

Of necessity, with 60 new members, and powers that were only transferred on 1 July 1999, it will take the Assembly some time to settle down, and for its 8 cabinet members to gain control of their specific subject briefs. The creation of Secretaries with focused portfolios is an extremely important change as hitherto, Welsh Office ministers - of whom there were only three - have had very large briefs which encompass areas covered by up to seven different Ministers in Whitehall. This has presented practical problems in the past that can now be addressed.

All functions previously exercised by the Secretary of State through Welsh Office departments have transferred to the Assembly. The Assembly itself has decided how those portfolios are divided between its subject committees.

In funding terms, the Assembly has inherited the three-year framework already announced by the Secretary of State for Wales following the Government's Comprehensive Spending Review. Although it will be able to develop its own priorities over time, and after consultation, the Government's commitment to three year funding programmes rather than annual funding has been much welcomed by public services in Wales and will need to be supported by the Assembly. It is likely that it will also be strongly influenced by the government's manifesto commitments in the public domain based on national priorities of health and education.

The development of the Assembly has already necessitated a new way of working for the civil service and other agencies. Historically, government policy is developed almost exclusively by civil servants. Speaking in November 1997, the Permanent Secretary, in her speech to the Institute of Welsh Affairs said:

> *A department that answers to 60 politicians, who in turn answer to people from all over Wales is going to respond very differently from one that answers to one Cabinet Minister. We are going to have to get used to explaining ourselves in public. Our business will be conducted more openly than in the past and we will almost certainly find ourselves much more actively engaged with other bodies in Wales... We will have to listen more actively and respond more fully. We may increasingly become organisers of advice and expertise rather than monopoly suppliers... We will have to shed the mindset - still rather ingrained in civil servants everywhere - which says that the only advice worth having comes from the civil service.*

Rachel Lomax - speech to IWA, 7 November 1997

The structures, which enable the Assembly to engage fully in a new era of participative and consultative democracy, are spelt out within the Government of Wales Act. The Assembly is required by statute to have a range of new partnership mechanisms in Wales. Section 113 of the Act requires the Assembly to make a scheme setting out how it proposes to sustain and promote local government and to establish partnership with local government through a Partnership Council; Section 114 requires the Assembly to make a scheme setting out how it proposes to promote the interests of voluntary organisations; Section 115 requires the Assembly to carry out consultation with business and other interests, having regard to the impact of the exercising of its functions on the interests of business. The size of Wales and the degree of coterminosity between the geographic boundaries of public services give the Assembly a particular opportunity for "joined-up government" in Wales.

All the Assembly's powers are vested in the Assembly as a whole, and they are exercised by the full Assembly unless they are delegated by the Assembly. In the interests of effective decision making, the National Assembly Advisory Group proposed that most decisions would be delegated to the First Secretary and the Assembly Cabinet and that there should be an effective scrutiny role for subject committees, together with opportunities for questioning by individual members in the plenary sessions.

The policy business of the Assembly is delivered through the Assembly Secretaries whose actions are scrutinised by six subject committees. Each subject committee has nine or eleven members on which each party in the Assembly is represented proportionately. The subject committees match the policy portfolios of all cabinet members other than the Business Secretary and the Finance Secretary. In addition, the Assembly has standing committees on equal opportunities, Europe and four regional committees reflecting the economic regions in Wales.

Subject committees are currently developing annual forward work programmes which need to be agreed by the Assembly. The committees will work in different modes to achieve their objectives, e.g.,

- evidence taking
- scrutiny of the Assembly Secretary
- scrutiny of external organisations funded by the Assembly
- policy development
- consideration of legislation,
- formal resolutions to the full plenary

Standing Orders require the National Assembly to debate the following matters at least once a year. These proposals are major cornerstones of the new participatory democracy as the debates will clarify the Assembly's relationships with all its partners.

- the First Secretary's Annual Report
- the budget allocation between spending programmes
- the Secretary of State for Wales' consultation with the Assembly on the Government's legislative programme
- the Assembly's equal opportunity arrangements and report, including race, disability and gender
- the local government scheme
- the sustainable development scheme
- the voluntary sector scheme
- a matter proposed by each of the subject committees
- an annual report of the Audit Committee's work
- the Assembly's handling of matters related to the European Union

The Government of Wales Act (section 70) also requires that Assembly documents relating to committee or sub-committee proceedings should be open to public inspection, except in circumstances set out in Standing Orders. The Assembly will be covered by the proposed freedom of information legislation which allows public access to Government documents except in revised categories. Its meetings will be generally held in public

Although the Government of Wales Act does not provide for formal co-option onto committees, the Assembly has accepted the advice of the National Assembly Advisory Group which strongly promoted the value of the Assembly seeking expert advice from around Wales, including the use of external advisers to committees. Arrangements are now in place to seek expert advice on a short term contract basis. This is a major move away from the traditional use of civil servants alone for the provision of advice.

The Government of Wales Act sets out some minimum requirements in relation to the Assembly general subordinate legislation. Subordinate, or secondary legislation has the same force as primary legislation. A Government with a radical reform agenda will often use this mechanism to increase its legislative capacity by the development of framework bills which are then filled out through the use of statutory instruments. Across the UK there are some 1,500 - 2,000 statutory instruments annually. The Secretary of State for Wales, last year created 50 on his own; 400 with other Ministers. The power of the Secretary of State to make secondary legislation, which will now pass to the Assembly, is contained within primary legislation.

Section 44 of the Government of Wales Act removes any need for secondary legislation made by the Assembly to be subject to any additional parliamentary scrutiny, but freedom of legislative action will be more dependent on parliament than Scotland or Northern Ireland. A hostile Government could therefore limit the

Assembly's legislative activities considerably, restricting its capacity to create secondary legislation.

However, the capacity to make secondary legislation is one of the real opportunities of the new Assembly. There are a number of ways in which the Assembly can make subordinate legislation, Many statutory instruments just need uprating, and it would be a waste of members' time to give them too detailed consideration. These will tend to go straight to a plenary session, either for information or discussion. Others will require detailed consideration by subject committees, particularly once the Assembly uses its devolved powers to create legislation different from England. The usual route will be for the Business Secretary to advise the Deputy Presiding Officer and other party Business managers, through the Business Committee, of the need for a piece of legislation. Following discussion in Business Committee, the Deputy Presiding Officer will make a formal determination as to whether the proposed legislation should go through a subject committee or straight to an Assembly plenary session. Once the determination is made, the proposed legislation is referred to the Legislation Committee for detailed consideration. As this process could take a considerable period of time, there is a facility which can be used by the Cabinet to bypass the usual process under "urgency procedures." Under the urgency procedure, legislation is made without prior discussion by members. The Legislation Committee and the Assembly then consider such legislation after it is made, and the Assembly has the power of revocation.

The National Assembly Advisory Group makes particular recommendations regarding principles that should underpin the Assembly's budget setting process.

- the process should be as transparent and consultative as possible
- the budget should be allocated in accordance with the needs and priorities of the Assembly
- the budget allocations should normally provide firm budgets for the following financial year, and indicative budgets for the following two financial years
- the budget should be related to objectives and targets
- the Assembly should take account of the previous years' achievement when setting budgets
- there should be a proper and transparent process for making in-year changes to the budget

The Assembly will normally set the allocation of the budget between expenditure programmes on a rolling three year basis and ensure that definitive annual allocations will be notified a proper time in advance. Public bodies funded by the Assembly, and other interests, will be able to make representations on the forthcoming budget round through the appropriate subject committee(s).

The Assembly's relationship with Whitehall and Westminster cannot be prescribed by Standing Orders. With individual departments, protocols are currently being

developed between Whitehall and the Assembly to faciUtate communication. Some of the key elements of the relationship are

- the Secretary of State is required by the Government of Wales Act to consult the Assembly on the Government's legislative programme and to attend and participate in proceedings of the Assembly on at least one occasion
- the First Secretary and the Assembly Cabinet will need to liaise with the Secretary of State for Wales and Whitehall more generally on policy and draft legislation relevant to Wales
- the Assembly will be a participant in the British - Irish Council
- a conduit for Assembly opinion to Westminster could be through the Welsh Affairs Select Committee.

Relations between the Assembly and both the Government and Parliament will be of great importance to the Assembly's operation. Welsh interests will need to be represented in Parliament's consideration of the primary legislation which sets the framework for the Assembly's powers. Following devolution, the Prime Minister has appointed two ministers for Wales.

Europe will have a much higher profile in Wales than previously. Its bid for Objective 1 status has aroused a great deal of interest throughout Wales of the workings of European Structural Funds. The Assembly's Standing Orders provide for:

- the establishment of a Standing European Issues Programme Committee
- a plenary session annually to be set aside for a debate on the Assembly's handling of matters related to the European Union.

Further recommendations regarding the subject committees include each having a specific European co-ordinator who will report monthly to the committee; delegating the administration of the Structural Funds to one subject committee in accordance with the First Secretary's allocation of responsibilities to Assembly secretaries and having a representative on the Committee of the Regions. The Government has repeatedly stressed that Assembly Secretaries could, with the agreement of the lead UK Minister, form part of UK delegations to the Council of Ministers.

Key questions which will need to be resolved in the early stages of the Assembly's operation are how the Assembly will:

- influence the content of primary legislation
- ensure legislative capacity to develop its own policies
- maintain and develop access to Whitehall departments
- ensure that Wales receives its fair share of public funds
- ensure that Wales has a voice in Europe

THE ASSEMBLY WORKING WITH THE UK GOVERNMENT

The previous Nuffield publication, "Devolution and Health" described the NHS functions which will be reserved by Whitehall. The Civil Service Year Book says "The Department of Health represents UK health policy interests in the European Union and through relevant international organisations, including the World Health Organisation, and supports UK-based healthcare and pharmaceutical industries." The Secretary of State for Health retains current powers on matters related to abortion, human fertilisation and embryology; the control and safety of medicines and the regulation of the main health professions. The challenge for Wales is to ensure that the arrangements previously described between Whitehall and Cardiff are subject to agreed protocols to ensure clarification of each other's role.

It is important to remember that although the Assembly will make decisions for Wales, in Wales, it will do it in the context of the UK Government agenda, and the UK Government's traditional role in making primary legislation. The Assembly has a specified duty to inform Government of the effect of its policies in Wales, and has an opportunity to influence policy development prior to legislation. This means that for the first time in Wales, there is a focused opportunity for the Assembly to influence primary legislation. Similar opportunities exist to influence European policy development through Commission and Council of Ministers.

Wales will keep two Ministers working to Whitehall; the Secretary of State and one junior Minister who will have the job of sitting on Bill committees and representing the interests of Wales. It will be important for the Assembly to have regular dialogue with both these Ministers to look for legislative opportunities at both UK and the Wales level. In addition, Welsh MPs will sit on select committees on specific issues.

To make the Cardiff - London relationship work effectively, there will need to be effective protocols established between Whitehall departments and the Assembly executive to ensure that responsibilities are clear and that Wales' bids for new resources in government priority areas can be properly considered. It is also intended that the First Secretary and his opposite numbers in Scotland and Northern Ireland will also meet regularly with the UK Prime Minister in the new Joint Ministerial Committee in order to co-ordinate policy. The participation of the Northern Ireland First Minister is dependent upon the D'Hont procedures being triggered in order to form an inclusive Executive Committee (Cabinet) of the Northern Ireland Assembly.

JOINT WORKING WITH OTHER DEVOLVED ADMINISTRATIONS

Also contingent upon the successful implementation of the Good Friday 1998 Belfast Agreement is the Strand 3 structure "The British - Irish Council" originally referred to as "The Council of the Isles". This proposed structure brings together representation from each of the UK Government, the Irish Government, the Northern Irish Assembly, the Scottish Parliament, the Welsh Assembly and the administrations in the Isle of Man and the Channel Islands. Furthermore, this structure, if triggered, also provides for bilateral or multilateral arrangements between any of the participants - for instance the Welsh Assembly and the Scottish Parliament. Herein lies a statutory structure for collaboration with other administrations within the United Kingdom and

the Republic of Ireland. This is a potentially important link for the Assembly, dependent as it is however, upon success in the Northern Ireland peace process in which prospects seem recently to have become less rosy. Notwithstanding the delay in the implementation of the formal structure, we would strongly encourage informal links between the devolved administrations.

RELATIONS WITH THE NATIONAL LOTTERY FUNDS

Until this year, there were five Lottery distributors, each spending a fifth of the pot - Arts, Sports, Heritage, Millennium and the National Lottery Charities Board. The Government has now developed a new lottery fund, the New Opportunities Fund which will fund a range of health care initiatives, and most importantly Healthy Living Centres. This fund will in fact have a third of all Lottery proceeds to spend, once the Millennium expenditure is over. It will be distributed from London, although there will be a Wales advisory committee and a Welsh member. This will provide substantial extra expenditure, particularly in the development of Healthy Living Centres.

MAKING THE MOST OF DEVOLUTION

Collaboration and partnership extending well beyond the NHS will be required to tackle inequalities in health and poorer health across Wales. At an all Wales level, regional and local level inter-sectoral co-ordination will be essential to develop and implement policy to improve health. The key recommendation to the new Assembly members is to use this opportunity, and to ensure through its partnership mechanisms with local government, the voluntary sector and business that there is a coherent co-ordinated approach to the development of an effective agenda to improve the nation's health in Wales. The Partnership Council, the formal mechanism for engagement between local government and the Assembly, will be an important new opportunity to discuss issues relevant to both sectors and to focus upon joint strategic policy development. The Partnership Council should be strongly encouraged to look at the development of a national health improvement strategy for Wales.

Devolution will enhance the government's capacity to marshal and target its policies and resources in a way, which reflects Wales' health needs. The National Assembly for Wales will introduce for the first time democratic control of the management and control of the NHS and its partner bodies, and control over the resources for health and other public services, The NHS White Paper 'Putting Patients First' has outlined how the Assembly will set central goals for the NHS which reflect the commitment to improve the health of the population and provide care as locally as possible. These will be set within the three strategic themes -health gain focussed, people centred and resource effective. The Assembly will monitor the health and well being of the Welsh population and respond with policies to promote health and tackle ill health.

At the Assembly level, robust collaboration must take place to give the opportunity to all professional organisations and local government to input to a Welsh health strategy. The "Better Health, Better Wales" strategic framework proposes the establishment of a Wales Centre for Health and a network to advise the Health Secretary and open up a proper debate on health in Wales.

One overriding goal of the Assembly will be to promote co-operation both within the NHS family and locally between the NHS and its partner organisations, through the new statutory duties of partnership. The Assembly will have an unprecedented opportunity to build on the *Better Health, Better Wales* strategic framework looking at the public health implications of all its policies using a programme approach.

The Assembly has made an explicit commitment to tackling health inequalities in Wales and the development of a public health action plan to achieve this.

In addition, some of the following ideas may be useful to deliberate:

- there are real opportunities for a specific Welsh agenda through the creation of the Assembly.
- coterminosity between local government, Local Health Groups, Local Health Alliances and other strategic structures including local compacts with the voluntary sector represent particular opportunities for closer geographical and organisational structures.
- the Assembly could introduce a cross-cutting committee on health and well-being, working closely with the Centre for Health and the Network to monitor the implementation of the *Strategic Framework.*
- the Assembly could use opportunities for secondary legislation to enhance the agenda.
- in the context of the broader aim of social inclusion, the Assembly could ensure that its policies for tackling inequalities were based on a strong information base.
- public health is a key component of developing programmes under the Objective 1 criteria. This could be used to ensure that public health is a key priority for the Assembly.
- the Assembly could ensure that it has the widest possible base for expert advice, e.g from external advisers of national repute.
- health care reform should take place as a coherent part of an overall policy for health.
- major policy, including operational policy, should be evidence based - and transparent to the public. Any changes must be monitored and evaluated.
- the Assembly must lead a debate on values, focusing on equitable distribution of resources and how to ensure access to health services for the entire population, perhaps incorporating these agendas with issues of sustainability and equal opportunities.

CHAPTER 7

IMPROVING THE HEALTH OF THE PEOPLE THROUGH LOCAL GOVERNMENT

THE FORMAL HEALTH ROLES OF LOCAL AUTHORITIES

Local authorities have statutory functions directly related to health which are mostly delivered through Environmental Health and Social Services departments.

The basic functions of Environmental Health Officers employed in local government are summarised by the *U.K. National Environmental Health Action Plan* as:

- improving human health and protecting it from environmental hazards
- maintaining public health, including the control of communicable diseases, food poisoning and infestation
- initiating and implementing health education programmes to promote an understanding of environmental principles

Such responsibilities demonstrate the importance of environmental health to the role of local government in health. However, whilst there is a clear substantial overlap between public health medicine and environmental health functions, organisational changes have broken the link between health and environment at its most critical point without leaving any formal requirement for partnership. This is an unacceptable situation.

The principal interface between local government and the NHS has centred on social care and the development of community-based alternatives to institutional care. The relationship between local authority social services departments and the NHS is crucial to both in the delivery of their services and to the people they serve. A pattern of care exists in which each has a share of responsibility and a complementary role in both the assessment and provision of services and their proper regulation. In some places, professional carers are already working jointly in multi-disciplinary teams such as Community Mental Health Teams or being seconded to operate from bases in other agencies e.g. hospital social work.

As more vulnerable people remain at home in the community or in residential settings, and with the public interest in children's services provision, there is a need for a joint approach to care in order to meet all the needs of the individual. The health and social services inter-relationship is one which is critical to public confidence in public services and its effectiveness or otherwise can set the tone for other relationships in the wider hnks between the authorities. The Government addressed this in the *Health Act 1999,* which legislated for the pooling of NHS and local government resources.

Since April 1996, the 22 Welsh unitary authorities have been charged with the planning, purchasing and delivery of the full range of local government services,

including responsibilities for environmental health, trading standards, housing, education, leisure and transport, as well as social services.

The previous Government's English *Health of the Nation* document recognised that:

> *...any of the responsibilities on their own would make the impact of local authorities significant. Taken together the contribution is vital.*

As all-purpose organisations, local authorities in Wales are able to set a range of corporate agendas to tackle issues with an holistic approach. They can integrate the range of services they provide, and bring together different services to the furtherance of common corporate goals. This opportunity, under-pinned by the concepts of "best value" and the modernising local government agenda, is resulting in local authorities re-assessing services, objectives and relationships. The "best value" requirements will ensure that local authorities drive up standards on a year on year basis, reduce costs, encourage partnerships between local authorities, the private and voluntary sectors and local people, and improve local accountability so that council services meet defined need

Health and well-being is a major unrecognised and under acknowledged aim of all local government services and provides direction to many services including housing and leisure. The provision of good quality housing and surrounding environment can be the building block on which community involvement in improving health can be based. Measures such as exercise on prescription schemes can be a useful way of increasing physical exercise. The factors which impact on good health require specific interventions in schools, workplaces and at a local community level, as it is here that they impact on the every day life of individuals, families and communities.

The opportunity is there for a council working corporately and involving all departments and services to improve the health of its local communities. By using its influence and combining its role as a regulator/enforcer, service provider, enabler, educator, developer, major employer, purchaser, community advocate and supporter of the voluntary sector, local government can make a significant impact on a community's health. One major opportunity is for the council to ensure that its residents have access to effective welfare rights services, and run benefit take-up schemes, perhaps through the LHG or LHA. Wales has the highest level of unclaimed benefit in Britain, so positive action needs to be taken.

The Welsh Local Government Association, (WLGA) in partnership with Local Government Management Board (LGMB) Wales and the Health Promotion Authority for Wales (HPAW) undertook research, *"Picturing a Healthy Wales" (1997)* to establish the then current levels of health promotion in Welsh local authorities. The results illustrate the fact that there is much innovative health promotion work being undertaken, and that collaboration at a strategic and informal level already exists between local authorities and health authorities, trusts and the voluntary sector. Several health alliances are in place. However, a key finding of the research was that the non statutory nature of the function puts initiatives regularly at risk during budget planning - risks that do not just affect the authority's activity, but impact on other partnership arrangements. The Government is introducing a statutory duty of partnership between health authorities and local authorities. This duty needs to be

defined in relation to the public health agenda as well as health and social care services to ensure maximum co-operation.

Local authorities have always exercised a major role in improving their local communities by community leadership. The Government intends to place on them a new statutory duty to promote the economic, social and environmental wellbeing of their areas and to promote community safety. Such duties will require and enable local authorities to work in an integrated way across departmental and organisational boundaries. A new power of community governance in relation to tackling the determinants of health was signalled in the Better Health, Better Wales Strategic Framework. Local Health Alliances, led by local authorities and complementing the role of Local Health Groups will provide a focus for authorities enabling them to link the local health, community safety, regeneration and sustainability agendas.

Wales has specific advantages which should enable it to develop an effective partnership agenda between local government and other services. There are good working arrangements between the public health professions through the Multidisciplinary Public Health Network (MPHN) and the Welsh Collaboration on Health and Environment (WCHE). The unitary authority area is increasingly becoming the geographical focus for public service delivery; viz Local Health Groups and Crime and Disorder Reduction Strategies. The democratic legitimacy of local authorities and the National Assembly, in regular dialogue through the Partnership Council, will assist in developing members' strategic commitment to tackling the health improvement agenda in Wales.

A particular opportunity to develop joint work at the national and local level has been taken by the five Welsh health authorities and the Welsh Local Government Association acting on behalf of its members. Earlier this year the organisations signed a Memorandum of Understanding, which lays down expectations about delivery of services at the local level between individual local authorities and individual health authorities, and also identifies those areas which are best dealt with by a pan-Wales approach. Local plans to support the Memorandum are currently being developed across Wales.

IMPROVING HEALTH THROUGH LOCAL AUTHORITIES

In October 1998, the Welsh Local Government Association (WLGA) published the outcome of its health strategy group, "Working for a Healthy Wales; the Local Government Role". This laid out a strong case for local government having an increased involvement in the development of health policies, and argued for new relationships between local government and the health sector in Wales to achieve these aims. This case has been accepted by Government in its developing thinking.

Modern local government in Wales wields a significant influence on health right across the range of its functions. Environmental health, community safety, housing, economic and community development, consumer protection, social work, education, transport, planning, sports, leisure and recreational facilities can all contribute substantially to the creation of prosperous and safer communities in which good physical and mental health can flourish. Local government's experience in community leadership and collaboration with local groups, particularly voluntary

organisations will be essential in involving and empowering local communities. Underpinning the delivery of all local government services, including those which impact on health, 'Best Value' will ensure quality in approach.

Maximising local government's potential to improve health is fundamental. There are specific advantages in Wales to do this as all local authorities have unitary status, the five health authorities are each co-terminous with a group of local authorities, and Local Health Groups have been established on local authority boundaries.

Local authorities should adopt a positive definition of health, acknowledging health as a positive state of well being, rather than the mere absence of disease and recognising the primary factors which impact on the health of local communities. In so doing, local authorities can focus on improving those communities that are in greatest need and where the levels of health are worst.

Recent audits have shown that local government in Wales is already undertaking much useful collaborative work in areas such as sustainable development (LA Agenda 21) and health promotion and has set up innovative partnerships to address health.

Involving local government fully will therefore bring added value as well as democratic accountability to the public health agenda.

Politically there is a need to develop clear reporting mechanisms to ensure that members view health in a holistic way. This should not preclude the roles of individual committees, but by centralising health issues, possibly under a, central policy committee or specific health sub-committee authorities can provide a framework for decision making in relation to health issues which considers all aspects of the local health agenda. Such mechanisms will need to draw on the experience of senior elected members and include a member of the cabinet.

Local government in Wales has committed itself through the WLGA to the development of corporate health strategies to make its commitment to the health and well-being of its local population more explicit. Such strategies must identify and acknowledge the action that each of its service areas undertakes and integrate health improvement into its corporate processes including those for sustainable development, community regeneration, area based housing renewal, anti-poverty and community safety.

A COMMUNITY FOCUS

The focus for good health should be centred on local communities. Much of the worst health is seen in many of the poorest parts of Wales where social, economic and environmental deprivation combines to create communities which are physically unattractive and do not help to foster healthy living. It is at the local community level that the complex personal, socio-economic and environmental factors combine with individuals, families and whole communities.

A key factor for success will be to engage local communities, empowering them to improve and sustain a healthy community environment and lifestyle. There are many imaginative projects in Wales, which bring together health and local government professionals assisting local communities with the development of their agenda.

The new local authority led community plans, which will embrace a statutory duty for local government to promote the socio-economic and environmental well-being of its residents, will be an essential tool of local regeneration. Local authorities are required to prepare an overarching strategy for promoting the well-being of their areas. The community strategy will provide the backdrop to locally based bids for resources.

The Local Government White Paper, "Local Voices" states that government intends to ensure that councils are at the centre of public services locally. The important role of local government services to influencing the local determinants of health, their potential influence in focusing combined local effort and the need to engage other sectors in health improvement activity, leads us to conclude that for the Better Health, Better Wales Strategic Framework, public health improvement will need to be the central focus of all local authority community plans.

NEW PUBLIC HEALTH AGENDA

The Government's acknowledgement of the complex determinants of health and the effects of life circumstances and lifestyle on health are important. Tackling such issues is vital both in health terms and more broadly, in support of social cohesion and community safety. Local government in Wales has welcomed the key role for local authorities in the establishment of the new public health agenda outlined in "Better Health, Better Wales ," particularly in relation to the development of Local Health Alliances.

Tackling the causes of ill health clearly involves a range of linked programmes including measures on employment, crime, housing and education, as well as on health itself, and local government, through its services and community leadership role, has a vital part to play.

Public health policies require collective action to improve how people live tackling those issues, which single individuals are not in a position to control. This will require action to improve quality of life, protect the environment, tackle social exclusion, improve housing, community safety and education standards, address poverty and unemployment and provide good quality local health and social care. This provides a real opportunity for local authorities. Within the new partnership arrangements, the whole local authority clearly has a vital role to play in both improving and promoting health and tackling local health determinants.

Authorities have the capacity to integrate health into many of their existing priorities and seek to direct resources to tackle the areas with the highest need and worst health experience. Key areas for interaction will include community safety, social exclusion and, of vital importance, area-based regeneration aimed at tackling deprivation. A holistic approach to regeneration, which incorporates health improvement, will enable key socio-economic and environmental improvements to be combined with longer-term lifestyle and health benefits.

Working in partnership with the NHS, voluntary sector and others improved health care facilities and healthy living centres can be incorporated into wider proposals for area-based improvement.

The challenge to central and local government alike, is to place health at the centre of its agenda, assessing the **impact on health** of each of its services and policies and then linking the broad agendas which impact on health and **corporately** seeking to improve health and well-being within local communities.

PROMOTING HEALTH

In addition to tackling issues surrounding the socio-economic and environmental influences on those life circumstances that individuals alone are unable to control eg deprivation, local authorities also have key roles to play in influencing healthy lifestyles. There are several arenas where action can take place. Local authorities have the opportunity to help people gain access to health promoting resources where they live, learn, work, spend leisure time and seek assistance.

- the key setting where local government can assist in providing a new direction for health promotion is in the **local communities** themselves. In seeking to foster community cohesion and reduce social exclusion it will be vital for community based approaches to promoting health across a broad front to be put on a sustainable footing, with local action underpinned by policy and strategy at a higher level. The community approach to health demands that individuals and communities are active in expressing and addressing their needs and requires providers to work together to assess and help meet those needs.

- as a major employer, local authorities have duties to promote health within their own workforce and as such by taking a positive attitude to health improvement can seek both to develop their own comprehensive **healthy workplace** policies and influence local businesses to follow their example. A safe and healthy working environment can have a real bearing on health improvement on the workforce employees and the general public who visit.

- by building health into education policies, not only can authorities assist with the delivery of appropriate health education but they can also foster the concept of **healthy schools** where through policies on smoking, eating, physical activity, drugs and alcohol a 'healthy' school environment can start to influence the lifestyle choices of young people. In working in partnership with further education to maximise access to adult and community education opportunities, authorities can also seek to build health improvement into its policies, which seek to develop 'Education for Life.'

The potential is there, but for it to be successful will require a change in the way in which services including health promotion are planned, commissioned and delivered at the local and national level. Local authorities have expressed a wish to have greater involvement in the local commissioning of health promotion and there is real merit in considering the siting of locality-based health promotion units within local authorities where access to the key arenas for health promotion e.g., schools, would be facilitated.

LOCAL HEALTH ALLIANCES

Designating the local authority as the lead agency to create Local Health Alliances creates a real opportunity for local government to work in partnership to achieve improvements in the local population's health; to reduce inequalities a local level between communities, areas and groups and to lobby jointly for policies and resources to improve local health choices including greater equity in access to health services. Inter-agency co-operation, planned activity and a locally co-ordinated approach are features of the existing local health alliances in Wales.

The Welsh Local Government Association is working corporately with all Welsh authorities to develop the "Better Health, Better Wales " Strategic Framework. A standing conference including those members and officers with the lead role in developing the Strategic Framework meets quarterly. The WLGA has strongly encouraged the development of individual local government health strategies across Wales and is now offering particular support to authorities establishing Local Health Alliances. The Assembly should aim to work with the WLGA and local government to ensure that Local Health Alliances are in place throughout Wales within a specified timescale.

EFFECTIVE RELATIONSHIPS WITH SOCIAL SERVICES DEPTS

The recent report of the Chief Inspector of Social Services in Wales, highlighted the following concerns which will need to be taken up by the Assembly:

- budgets have not kept pace with inflation
- the need to improve the strategic planning framework
- the need to improve qualifications for residential childcare staff
- the reduction in home care because of budget pressures
- inadequate inspection capacity within local authorities

The new Government White Paper on Social Services in Wales proposes;

- new arrangements for regulating services and the workforce
- new arrangements for promoting and regulating training
- effective patterns of working with the reshaped health services in order to promote and support normal patterns of hfe for vulnerable adults and children
- assuring quality and integration in services for children
- securing effective mechanisms to support the management and monitoring of personal social services as part of the general reform of local government

This re-emphasises the commitment of Government to creating policies focused on children's health. The Government, through "Better Health, Better Wales" has

responded to the call from the WLGA and Children in Wales for the development of a children's strategy for Wales. This will need to include key public health recommendations, focusing on tackling social exclusion, joint working and consultation. There are currently serious practical difficulties in local authorities making sufficient investment in family support and preventive work. The Assembly may wish to review current priorities to ensure that this deficit can be tackled.

COMMUNITY CARE

Relationships between health and social services are greatly influenced by issues of resourcing. The Government is understandably concerned to achieve its target of reduced waiting lists, but this has overshadowed the need for parallel funding of social care.

There is no indication of further funding of community care and this will have far reaching implications for the capacity for local authorities to meet needs in the community and deal with the discharge of vulnerable patients from hospital.

The continuing care agenda remains an important policy interface. The importance of improving rehabilitative services, developing creative approaches to minimising the need for hospital care and establishing a sound basis for monitoring performance jointly in the areas of discharge planning will be crucial to the development of effective and efficient services.

There has been a great deal of legislation and a number of influential reports which impact on the delivery of community care: The Carers (Recognition and Services) Act 1995; the Community Care (Direct payments) Act 1996; the Disability Discrimination Act 1995; Community Care charters; and guidance on continuing care agreements. The Royal Commission on Long Term Care reported in March this year and a Disability Rights Commission with a Welsh commissioner will be established shortly.

Community care plans need to be improved and linked effectively with other processes in health and local government now being planned. Care for older people is running at approximately 50% of the budget of Social Services Departments, although the reality is that home care services are reducing, with a more intensive service to fewer people.

Financial pressures on authorities, caused not least by an estimated cumulative £95 million shortfall following the introduction of the NHS and Community Care Act, (identified in research undertaken for the former Welsh Office, Association of Directors of Social Services and the WLGA by the Nuffield Institute for Health) has led to increasingly tight criteria for assessment of need and subsequent provision of services, with different criteria being used in different authorities. Eligibility criteria, have, of necessity, been ratcheted up to use budgets effectively with the result that the majority of the budget is spent on high cost residential care. This will need to be addressed by the Assembly, in the public health context of improved prevention before such acute needs are expressed, with more opportunities for people to receive the range of services to enable them to remain in their own homes.

CHAPTER 8

IMPROVING THE HEALTH OF THE PEOPLE THROUGH THE NATIONAL HEALTH SERVICE

ROLES AND RESPONSIBILITIES OF NHS ORGANISATIONS

HEALTH AUTHORITIES

In a recent joint health authorities submission to the Assembly, *The Future Role of Health Authorities,* the health authority of the future is seen as a leader and shaper, strategically leading on both health and health care improvement, in order to overcome the fragmentation of previous NHS reforms. In keeping with this, the health authority will devolve responsibility for managing primary care and commissioning secondary care to LHGs, but will retain overall strategic control and accountability.

The idea is to combine both the innovation of primary health care and the strategic view of health authorities. Health authorities will still be responsible for tertiary services commissioning though this might be top-sliced by the Welsh Assembly to the newly created Specialist Services Commission for Wales.

The roles and responsibilities of the new health authorities can be separated into statutory responsibilities, strategic planning, the clinical governance of LHGs, and the provision of public health services.

Statutory responsibilities

- improving the health of the population
- working in partnership with other organisations, including engaging local authorities in the new planning and public health approach.
- for the quality of healthcare services through clinical governance

Strategic planning - including the following elements:

- assessing health needs of the local population
- drawing up the Health Improvement Programme (HIP)
- deciding upon the range and location of health care services for the authority's residents (and recording these decisions in the HIP). Health authorities will have reserve powers over NHS trusts for example on consultant appointments which would have to be consistent with the HIP.

Leading on assuring clinical effectiveness (Clinical Governance)

- partnership and mutual benefit rather than sanctions and threats

- although given the responsibility to see that this happens, the health authorities' role is largely facilitatory.
- setting local targets to drive quality and efficiency and ensuring their delivery

Relating to LHGs

- supporting the development of LHGs
- allocating resources to LHGs
- holding LHGs to account

Providing public health services

- communicable disease control
- disease cluster investigation
- major incident / chemical incident planning and management

Health authorities have been given the leadership on the improvement of the health of the people in addition to the improvement of health care services. Health authorities are expected to provide a holistic overview of policies and programmes from a health gain and health inequalities perspective, and this would be expressed via the HIP.

However, health authorities cannot deliver this wider health improvement agenda alone; they must do this in partnership with others, particularly local authorities.

Public health is the lead-off point for health authorities, and this is enshrined in their new statutory duty to improve the health of their populations. The report of the Director of Pubhc Health will be the starting point for the HIP.

Health authorities will also work with local authorities (LAs) and others to identify local action. Public health action will include communicable disease control, health needs assessment, health inequaUties, monitoring health outcomes and evaluating the health impact of local plans and developments.

LOCAL HEALTH GROUPS (LHGs)

LHGs have the following formal roles and responsibilities;

- they have a statutory duty to promote the health of the population.
- they have a statutory duty of partnership to work with other agencies.
- they have a statutory duty to improve the quality of primary health care services through clinical governance

- they must contribute to the Health Improvement Programme (MP), reflecting the perspective of the local community, and then act within this plan to improve health and health services.

- they should provide improved primary care for their patients by developing and managing primary health care:

  > developing primary health care by joint working across practices; sharing skills; providing a forum for professional development, audit and peer review, as important components of clinical governance.

  > integrating primary and community health services and work more closely with social services on planning and delivery.

- they should commission secondary health care services from relevant trusts, in line with the HIP, and monitor the performance of the trust against service agreements.

- they should consult the local community - LHGs are required to represent and to consult with the local population.

- they may hold the budget for hospital, community health services, GP prescribing, GP staff, premises and computers. (The budget will be cash limited at LHG level, and net of any top slicing e.g. risk management, health authority level commissioned services).

The health improvement role of LHGs has subsequently been downplayed by Welsh Office guidance. The former Welsh Office was clearly nervous about combining health services and health improvement within the LHGs.

Similarly, purchasing secondary health care may not be the main agenda of LHGs partly because they are too small and partly because purchasing will be largely replaced by planning.

In reality, LHGs may be more about the management of primary health care and die integration of care - particularly primary health care, community services and possibly social care. The size of LHGs is appropriate for this.

NHS TRUSTS

NHS trusts will remain corporate organisations providing health care. However, in future they will have a statutory duty to work in local partnership with the health authority (who will have new reserve powers over them - including the establishment of new consultant posts) and with LHGs. They must also contribute to, and provide services in line with, the Health Improvement Programme, which the business plans of the NHS trusts must follow. Clinical staff must be involved in designing the Long Term Service Agreements (LTAs) and in the production of the Health Improvement Programme (HIP), through the mechanisms to achieve this are not stated or prescribed in the White Paper. For NHS trusts, there is a major new accent on clinical governance involving a statutory duty for the clinical quality of the services they provide.

NHS PROCESSES

HEALTH IMPROVEMENT PROGRAMMES (HIPs)

HOW DOES THE HIP FIT IN?

As the embodiment of their more strategic role, the drawing up of the HIP will be led and co-ordinated by the health authorities working in partnership with LHGs, local authorities and NHS trusts. The role of the health authority, acting through the HIP, will be to integrate the inter-related system of the LHG / NHS trust / health authority / local authority in order to improve the health of the people and their health care services. This will require familiarity with die total system - including other agencies, and the larger picture of population health improvement, rather than just health care services. The HIP must therefore be developed in collaboration with all these bodies and other interests.

The HIP will record the decisions which have been reached regarding the health policies to be adopted to achieve improvement in people's health, and the range and location of health care services to be provided for the Health Authority's resident population. Through its action plan, the HIP will also programme all the changes to services and policies which need to take place and the timetable for implementation.

Health authorities and their partner organisations produced interim framework Health Improvement Programmes by the end of March 1999. The first definitive HIPs are to be produced by the end of March 2000.

MAKING THE HIP ABOUT HEALTH IMPROVEMENT

We have already established in Wales, in common with countries at all levels of development, that the major influences upon the health of the population he outside the health care system. Hence, planning for health improvement needs to involve all sectors, local government and communities, in addition to the NHS.

A distinction therefore clearly needs to be made between planning for health in its broadest sense and planning health services. They are separate though partially overlapping activities. Both are needed and the Health Improvement Programme is intended to cover both.

Because they are not synonymous, there is potential for tension between health services planning and planning for wider population health improvement. The definitive HIP Guidance from the former Welsh Office noticeably reduces the emphasis upon the wider health improvement role of the HIP, compared to the final draft guidance which was particularly strong on this point.

SOME CONCLUSIONS ON MOVING THE HIP FORWARD

HIPs should fully cover the wider health improvement agenda in addition to the improvement of health care services and the HIP should be about changing the context from health services to health.

Therefore the overall goals of the HIP should be reduction of health inequalities and achieving (average) population health gain, though the HIP should also aim to build seamless services (between agencies) for patients - but planned from a population health improvement perspective.

If the health of the people is to be improved then the HIP must be based upon a full understanding of the determinants of health. Because the main levers upon the determinants of health lie outside the NHS; the HIP must be developed in full partnership with local government.

LONG TERM AGREEMENTS (LTAs)

Long term agreements lasting three years are replacing the annual round of contracts between NHS purchasers and providers. At first sight this appears a cosmetic change; in practice, it represents a dismantling of the internal market.

The link between contracts and (population) health improvement was never effectively made because contracts only really dealt with cost and quantity.

The total size of the market was fixed by the total exchequer funding available to the NHS. Providers were not free to close "unprofitable services" and market exit was not permitted as NHS trusts were not allowed to fail or hospitals to close, partly because there would often be no alternative local service. Health Authorities were therefore required to manage the market strategically, particularly to ensure that any distortions caused by GP fundholders (the only part of die system allowed to act freely) were not allowed to destabilise trusts' financial viability. For this reason health authorities were not free to move contracts to other providers - which, in any case, did not exist for many services throughout much of the country.

The market, therefore, existed in name only. Hence the contracting process and the internal market was largely a bureaucratic exercise, which itself consumed considerable resources, with little tangible benefit to show for it. Some increased efficiency may have resulted, but there were incentives encouraging re-categorisation and re-counting of existing activity in different ways which means that a definitive judgement is hard to reach.

The NHS has historically rationed services by waiting lists, and by the gatekeeper function of general practice. The empowerment of primary care was in many ways welcome, but the changed power relationships with secondary care as a result of fundholding opened the gate, gradually increasing referrals and waiting lists. However, because waiting lists are publicly available statistics and because of the rise of consumerism, waiting list reduction itself became a major political imperative. The major alternative rationing mechanism of explicit rationing through contracts was politically difficult given its extreme transparency and difficulties in making this needs-based, meant that the only way to deliver waiting list reduction was to gradually increase total funding to the NHS. Thus, the internal market, designed to constrain costs, tended to have the opposite effect.

The current government has decided therefore to return to planning rather than the internal market and to replace contracts with Long Term Agreements. These three year concordats between health authorities and NHS trusts simply commit the latter to

provide services of particular types to patients with greater emphasis upon quality rather than quantity, and in return for a guaranteed financial allocation each year.

Service developments will be planned through the HIP - and if they are not in the HIP they are not happening - and the necessary finances and resulting service change will be agreed via the LTA.

The HIP and LTA processes spread responsibility for rationing (once again implicit rather than explicit) and maximising population health improvement from the resources available back across the NHS, rather than vesting this with Health Authorities alone. Responsibility for quality is also shared across the NHS organisations through clinical governance.

CLINICAL GOVERNANCE

NATURE AND ELEMENTS

Clinical governance is the framework organisations work within to improve and assure the quality of services. It is both a systems and a systematic approach which brings together all current quality activities, and it must also be integrated with the Health improvement Programme (HIP).

In simple terms clinical governance can be regarded as a system that ensures that we are:

> *Doing the right things right, at the right time and by the right people,.... and demonstrating that we are doing them right.*

Clinical policy can be regarded as an organisational statement of what the "right things" are. In the minority of instances, where explicit (clinical) policies have been set and adopted, clinical governance could function as a monitoring system that demonstrates the extent to which the policy was followed. However the overall scope of clinical governance is much wider and can be said to include three elements:

- continuous clinical quality improvement
- clinical risk management
- assuring minimum quality standards and managing poor performance.

ROLES AND RESPONSIBILITIES

A statutory duty for clinical governance has been placed upon the Chief Executives of Health Authorities and NHS trusts and upon the General Manager of Local Health Groups. Each organisation also has to identify a "lead clinician" to carry delegated responsibility, to establish clear lines of accountability, to set up reporting mechanisms usually through a board level clinical governance sub-committee.

The roles and responsibilities of clinical directors, medical directors and the director of public health are to bridge the gap between individual clinician and corporate levels, striking the necessary balance to achieve functioning healthcare systems which deliver high quality care.

GETTING THE CULTURE RIGHT

Clinical governance is the means to an end (of quality healthcare and thereby health improvement) not the end in itself. We must guard against the practice of clinical governance defeating the aim. A possible parallel would be the adoption of the NHS internal market with the aim of controlling finances, with precisely the opposite outcome. It is important that culture of Clinical Governance is **not** dominated by the negative aspects of either the detection and management of poor clinical performance or risk management and quality assurance, with little emphasis being given to the more positive aspects of continuous clinical quality improvement. A learning culture is fundamental, and is not going to be easy to achieve, partly because much of the prevailing atmosphere is one of blame, the so called "name and shame" approach.

MINIMUM REQUIREMENTS AND NEXT STEPS

The White Paper and ensuing guidance lay down four minimum requirements of clinical governance (across the health care system):

- the establishment of clear lines of accountability for the overall quality of clinical care.
- a comprehensive programme of quality improvement activities
- clear policies aimed at managing risk
- procedures for all professional groups to identify and remedy poor performance

For each NHS organisation, the following four key steps are expected to be carried out in year one:

- establish leadership, accountability and working arrangements.
- carry out a baseline assessment on capacity and capability - where are the deficiencies in the clinical governance processes and the clinical services themselves - in the health authority's case, the services it commissions - as well as provide.
- formulate and agree a development plan.
- clarify reporting arrangements for clinical governance within boards and Annual Reports - including reporting arrangements of complaints.

MAXIMISING THE HEALTH BENEFITS OF THE WELSH NHS

INTRODUCTION

The NHS in Wales exhibits a number of distinguishing features which separate it from that in England: its poorer population health status, with some of the most deprived communities in the UK. Yet the funding of the NHS in Wales is 12% greater per capita than for England. Using a 'normative' approach it has a larger number of

hospital beds in too many and inappropriately sited DGHs. We have already referred to the difficulty of providing primary care in parts of South Wales.

One may reasonably ask if the stream of papers emanating from the former Welsh Office will adequately address the needs for health and social care of the Welsh population. It is far too easy for the recommendations included in these documents to be treated with a considerable degree of cynicism by those in the front line, who feel almost battle-fatigued by what appears to have been one long series of reorganisations since 1974. And we have to express some sympathy and understanding for this weariness when some of the root causes of the difficulties faced by a service which has universal eligibility and free at the time of use, are not addressed. We, therefore, question how far the guidance in its various forms will address the 'problems' of the NHS. The rising demand and need for healthcare, a greater push for transparency and decision-making, particularly in the public sector, and exhortation to improve the quality of public services seems, to us, to be increasingly unsustainable without some additional and fundamental changes at all levels of the NHS.

We have assumed that the NHS will continue to include, as an integral and major feature of the service, primary care where general practitioners will determine, in most instances, access to specialist secondary sector care. Also, that access to healthcare is free at the time of use and paid for out of general taxation.

At a more detailed level, there are various drivers for change:

- an expansion in the body of scientific knowledge, at a human level this has been a powerful factor in producing sub-(or super-) specialisation so that there are doctors, within the same speciality, with different areas of interest and expertise. This pattern is now being extended to dentistry, nurses and for those belonging to the professions allied to medicine (PAMs)

- an increasingly innovative profession and medical/healthcare industry leading to new technologies and, at the same time, creating new needs

- rising public expectations in respect of healthcare

- an rise in the number of elderly with a consequent increase in the need for healthcare and a correspondingly smaller proportion of the population to generate the tax revenues to pay for the NHS

- the introduction of clinical governance in a formal and systematic way

- that it is referrals from primary care - both emergency and elective - that drive the secondary sector. There is a primary component to all hospital services, since this is where patients usually start their journey and most return to it.

In addition, there are other factors that need to be taken into consideration:

- that the needs and priorities of staff change over their working lives, for example, at the risk of being anecdotal, surgeons in their fifties and sixties - it is said - cannot operate with the same degree of resilience or capacity that they could in their thirties or forties, if this is true, then there is a need to

address this issue and encourage more senior doctors to take on other roles that need to be carried out and, at the same time, allowing their accumulated experience and wisdom to be recognised and used.

- there is a general presumption that services will be delivered "locally" although the issue of sub-specialisation, or access to technology, which is expensive in capital terms, may limit the extent to which this aspiration is achievable. Moreover, what evidence there is suggests that patients (and families) are prepared to travel some distance for one-off procedures (such as operations) or courses of treatment, when they consider the underlying problem is sufficiently important

- that in pursuit of an effective and efficient organisational structure for delivery of quality healthcare, it is necessary to put in place work structures and processes that allow job satisfaction for staff to be an integral feature of their design.

EDUCATING THE DEMAND AND SETTING LIMITS

We approach the difficulties facing the NHS in Wales with the wish to continue supporting, as far as possible, the founding principles of the NHS described above. What has been shed is the belief that all interventions, from cradle to grave, that could be offered as part of healthcare, are available "on the NHS". The NHS is, in effect, one very large insurance scheme but most private insurance schemes set limits on the benefits provided. Since the NHS is charged with living within its budget, then surely it would not be illogical for the NHS to set some limits, too. Just because one has paid contributions from income tax as a citizen does not mean that one is entitled to benefits without limits. We would quickly add that the coverage provided by the NHS should be relatively generous i.e. it should have a relatively high ceiling. Setting some explicit limits would make clear that everything is not available and would introduce a sense of reality for everyone and avoid the necessity by civil servants and those in the NHS to constantly square the circle. Otherwise, difficulties continue for everyone. The cost of P-interferon might be just affordable given the (relatively) low prevalence of multiple sclerosis, but the impending licensing of anti-TNF drugs for rheumatoid arthritis, with a year's treatment projected to cost £7,250, is another story again.

MANAGING THE SUPPLY - MANAGEMENT CULTURE AND STYLE

We have already recognised that providing healthcare is very different from the time when the NHS was set up and, if anything, the rate of change is Ukely to increase. The services provided by the public sector have, perhaps understandably, had a strong pervading theme of accountability and the need for probity in the way decisions are arrived at. Clearly, these are important checks on a bureaucracy spending public monies, but it leads to time-scales for decisions that are almost geological and an organisational structure that is hierarchical in nature with a strong command and control approach. Furthermore, when the decisions made have been arrived at with probity, one can question the wisdom and the content of some of those centrally-made decisions. Yet, at the same time, there are expectations for the public sector to be more efficient, innovative and responsive which may require an element of risk taking. We are clearly in a situation of trade-offs. As with other dimensions of quality,

we need to ask how much accountability do we want? How much innovation? Or how much efficiency?

We recognise the tension between the centre and more local organisations, but suggest that an organisation based on a traditional authoritarian and hierarchical approach may inadvertently contribute to its own failure. In fact, we said that in large complex organisations the notion of the centre being in control, in any detailed way is largely illusory[14].

The general pattern should be one of sufficient concordance between control and responsibility. Much of the frustration and discontent at the moment amongst those delivering care is the feeling of being responsible without a corresponding degree of control[15]. Equally, there is a sense that we have lost sight of the core business - healthcare - as financial control has become paramount.

The introduction of clinical governance has firmly and squarely put the responsibility upon all clinical professions for improving the quality of care they provide. But this is an active process, requiring the culture of the NHS to become that of a 'learning organisation'. Learning takes place best when individuals take responsibility for the process themselves. It cannot be mandated - it requires a personal change upon the part of the individual that he/she wishes to improve their performance. So, we would encourage a devolvement in decision making and the corresponding resources to make those decisions happen, to a lower level than is currently the case.

This would encourage a greater degree of (acceptable) risk taking as a way of ensuring a better use of finite resources and also, at the same time, ensuring that the organisation, as a whole, remains adaptive and flexible and in a Darwinian sense, 'fit'.

EMPOWERING AND DEVELOPING PRIMARY CARE THROUGH LHGs

DELIVERING A LARGE AGENDA FROM AN UNCERTAIN FOUNDATION

The aspirations for Local Health Groups (LHGs) are far reaching and ambitious particularly in the context of the current state of services. They will require widespread changes within primary care and social services to realise these ambitions. We, therefore, must be realistic in the pace of change.

GPs are first and foremost practitioners and not strategic players. Their skills in personnel and financial management vary widely. In particular, GPs have not been

[14] Peter Senge, in his book *The Fifth Discipline,* suggests the way the centre ensures that more distant or satellite parts of the organisation function with an acceptable level of uniformity of service or production is by having and communicating a very clear philosophy and set of values about the business and its functions.

[15] The book *Maverick!* is an intoxicating account of what can be achieved by empowering the workforce in a manufacturing company. And if those who find it difficult to let go and see such ideas as tantamount to the lunatics taking over the asylum, then the reassurance is that once people are made 'stakeholders' in the organisation, it is in their interest to consider its longer term well-being. Also, emerging ideas about how professionals and other knowledge workers might be managed do not include the traditional notions of control, co-ordination and direction, usually associated with the term 'management'. More appropriate themes include the sharing of information (knowledge) and developing a sense of common purpose through inspiration.

used to working collaboratively between practices. The independent contractor status of GPs raises fundamental questions of accountability and brings to a head the issue of salaried GPs.

To be effective, Local Health Groups need to build on a solid foundation of good joint working between health and social services at local level. In practice this is variable and has moved little over the years. There is considerable scope for reviewing joint assessment and access to services and in aligning devolved management arrangements with the Local Authority to help focus planning and service delivery more closely on natural communities. In the absence of additional funding to assist in the development of more collaborative arrangements, progress in these areas will inevitably be slow.

Nevertheless, LHGs have considerable potential for both population health improvement and better healthcare delivery because of their geographic co-terminosity, cross-sector base, and perhaps most importantly because of their scale of activity.

STRENGTHENING THE RESOURCE AND CAPACITY WITHIN LHGs

Local Authority participation in the developing LHGs

The authors endorse the decision that Local Health Groups should be coterminous with local authority boundaries, reflecting the principle that local government and health services should be commissioned at the same local community level.

However, if LHGs are to fulfil their objectives, it will be essential that they develop an important role in health improvement as well as the delivery of local health care services. This will require both the LHG and its Board to have appropriate corporate representation from each local authority and from NHS public health professionals. We therefore acknowledge the roles identified for Social Services and Environmental Health Officers in the White and Green Papers. The role of these local government professionals is recognised to be key in taking forward local health care and health improvement policies. In addition, a clear role should be established for each local authority Chief Executive to ensure that health authorities engage corporately with local government.

It will be important for the local authority, as lead organisation on Local Health Alliances to liaise closely with the health authority through its members on the Local Health Group. Ideally, there should be cross representation and Alliances should provide assistance to the LHG in drawing up the component parts of the HIP.

To ensure that LHGs are made accountable to the local communities in which they operate it is essential that the benefit of local government accountability is secured through the participation of local elected members.

LHGs and NHS Public Health Professionals

In all the guidance offered on LHGs, public health disciplines have hardly received a mention. The guidance could be seen as permissive or enabling, but given the population (that is, the LHG population) approach to the planning, delivery and evaluation of healthcare, it is perhaps surprising that more explicit mention of the

discipline, a characteristic of which is to include a population approach, has not been made.

We would like to argue that as LHGs develop, public health practitioners should be considered for a central role within them[16]. Firstly, public health brings a population perspective to the thinking and decisions of the LHG. Secondly, public health would hopefully be seen as disinterested and impartial in its contribution to decision making with respect to individual practices within the LHG. Particularly by having a public health physician at the heart of the LHG, certain functions would also be strengthened, namely the assessment of the need for healthcare within a strategic context, and the public health link within the developing standards of care / clinical effectiveness / clinical governance arena. These are the starting points for a strategy for primary care development and for the commissioning of secondary care.

Clearly, there are other public health roles, probably best carried out at (present) health authority level, and there would need to be a discussion as to how those responsibilities, often of a statutory nature, best carried out at the half million population level or so, can be combined with the new roles at the level of the LHG.

TAKING LHGs FORWARD TO ACHIEVE THEIR POTENTIAL

As the White Paper says, the present government wishes to build on the strengths of fundholding and other initiatives, over the last few years, involving the greater involvement of primary care, which have been largely to do with the purchasing of elective care provided by the secondary sector. For the earlier initiatives, involvement was voluntary, involving self-selected practices. In contrast, all practices will, *de facto,* be part of a LHG and, to have any chance of carrying out the functions set for the LHGs, will require that all practices are involved. Moreover, a token response is not sufficient; it really is a case of capturing the hearts and minds of doctors, and other healthcare professionals, who might reasonably be a little wary of yet another re-organisation. Any new proposals are likely to be greeted with a certain amount of cynicism.

Equally, it requires the 'letting go' of a certain amount of control from the centre, something that is difficult enough for senior managers in the private sector and perhaps, particularly so in the public sector where accountability for public monies is a dominant factor or theme in decision making. Clearly, we are not suggesting that anyone should be irresponsible with public monies, but that the caution, that this issue of accountability induces, may well inhibit innovation and experimentation. The corollary of creating LHGs is that the 'centre' needs to redefine its role and be prepared to live with diversity, resulting from the autonomy granted to LHGs.

The White Paper imphcitly and explicitly acknowledges the importance of "localness" in assessing the needs of a population served and the ability to respond to

[16] We are aware that not all public health professionals would wish to be involved in "a hands on" way with an LHGs, and indeed the Faculty of Public Health Medicine has, in the past we feel, been somewhat ambivalent about the place of "management" within the role of public health medicine.

those needs, and multi-agency / multidisciplinary input able to provide the different views in order to deal with the divergent problems which will be encountered[17].

If we wish to improve the way health care is provided and take on board various themes, like public participation in identifying and prioritising needs for healthcare, then the scale of activity is crucial. The scale of activity of LHGs will allow the type of management styles and behaviour to collect the relevant data about local needs and priorities and influence the providers of primary and community health care. LHGs are large enough to have impact and yet small enough to build the relationships and trust (co-operation) crucial to making it work.

The concern with quality of care is a particular theme for White Paper. There is almost certainly likely to be variation between general practices within an LHG. But we would suggest that the most effective route to improving care - by all professionals - is through the processes of reflection and learning. And so, an LHG needs to become what the business world would describe as a "learning organisation." The creation of (relatively) small units of organisation with a sufficient degree of autonomy could, indeed, allow this to happen.

The NHS is a cash-limited service, and the reality of this is an everyday experience for commissioners and providers of healthcare. In large organisations, it is only too easy to blame some more distant part of the organisation for any failures - the failures to deliver or the failure to keep within the budget. By creating small units with their own budgetary control, we believe there is a better chance of recognising the tensions resulting from pursuing the course of action which is, from the point of view of an individual practitioner or practice, sensible and appropriate, but if all parties behaved in that way that would spell disaster - financial or otherwise[18] It clearly requires the acceptance of a "common good" and what that might represent for a particular LHG. In turn, that agreement is only Ukely to follow if there is a reasonable degree of consensus about vision, philosophy and values underpinning the LHG.

The development of LHG's in the medium term into primary care trusts may appear to carry with it the seeds of the potential transfer of significant social service functions into these new trusts. If this is the underlying logic then it is essential for some of the implications to be addressed through dialogue at an early stage.

[17] E F Schumacher (of "Small is Beautiful" fame) in his "Guide for the Perplexed" argued that there were fundamentally two types of problem - convergent and divergent. Convergent problems have *a* solution; in contrast, divergent problems have no "right" or single answer. We would suggest that the complexities of both health, and health care often resulting in trade - offs, means that many of the issues and decisions met by a LHG will be of a divergent kind.

[18] This phenomenon has been described as the tragedy of the commons. The phrase is derived from the metaphor where a number of individuals have grazing rights on common land. It is in the interest of each person to put as many of his animals to graze on the common land. If everybody behaved in this way, then the commons are unable to sustain that number of animals, the land may well suffer permanent damage and lead to sub-optimal health of the animals. For the original reference see Garrett Hardin "The Tragedy of the Commons." (Science 1968 ; 168:1243 - 48) and for the same theme translated to a medical setting, see Howard Hiatt "Protecting the Medical Commons: who is responsible? (New England Journal of Medicine 1975; 293:235-41)

SECONDARY CARE FROM MANAGED CLINICAL NETWORKS

A PROPOSAL TO INTRODUCE MANAGED CLINICAL NETWORKS

We would encourage that thought be given as to how we might reconfigure hospital services. Some medical and surgical specialities require larger catchment populations than others to justify the critical mass of staff and facilities necessary for providing the service. This has traditionally been addressed by locating such services in regional centres or by a 'hub and spoke' arrangement where the hub is the regional centre and the spokes connect the centre to (usually several) DGHs.

The managed clinical network, a term we associate with the recent Scottish Office review of acute services, is different in several important respects from the hub and spoke approach. The hub is clearly at the centre and all that that implies, including *centralisation.* The spokes lead to local DGHs and in the language of the model, might be described as the periphery or *even peripheral.* The network is a much looser, fluid concept. It also recognises implicitly that most hospital care is delivered in non-teaching DGHs and, moreover, often provides the entry point to specialist care. All consultants are part of the network. Most consultants have a responsibility for "general" care within their speciality, but would also be encouraged to develop a sub-speciality interest. Thus, by enlarging the population base for the service, a critical mass of consultants can be justified for that speciality to allow sub-specialisation to occur and, at the same time, be able to offer a service that could be regarded as being comprehensive.

The eponymous Calman-Hine report on cancer services, as published, described what was, in effect, a hub and spoke approach with cancer centre and cancer unit (DGH). However, it seems to us that as translated into practice, the service for cancer is moving towards a managed clinical network, where services are not determined by particular buildings, but hospitals are used as bases for delivering care (viz. Velindre consultants holding joint clinics with the DGH consultants in the cancer unit and specialist nurses providing chemotherapy locally). The knack is to identify the appropriate paths that patients should follow for diagnosis and treatment within the network.

A recent Royal College of Surgeons of England report suggested a major reorganisation of emergency surgical services where the approach would require a population base of 500,000. Many smaller DGHs in Wales do not serve a population of this size. As part of the network though, smaller DGHs need not automatically close, but services could be reconfigured across a network of hospitals. It could also offer an improved base for training.

It also provides a structure for research activities e.g randomised controlled trials where patients are entered into such trials (subject to the usual safeguards), who previously might not have been included, and at the same time, extending the generalisability of any findings. Such arrangements recognise the contribution of all staff (teaching and non-teaching) in providing care; it is a genuinely inclusive approach. It clearly supports the functions of clinical governance by improving the chances of shared learning and a greater degree of uninformity of standards of care. A possible list of functions for the managed clinical network is reproduced in the box.

Devolved Responsibilities of a Managed Clinical Network

Functions of a managed network could include:

- speciality-specific population needs assessment
- sizing the service to meet need and reconciling this with population access
- defining service standards
- undertaking workforce planning (especially succession planning)
- defining capital investment requirements
- proposing capital investment priorities
- securing capital investment
- securing revenue funding flows
- reconciling service support with research and training priorities
- clinical audit and quality assurance
- continuing professional development
- managing the interface with primary care

Based on *Acute Services Review Report.* Scottish Office 1998.

Mr Dobson has described the NHS as a huge supertanker. He was, of course not the first to use this metaphor, at least implicitly, to describe the difficulties in changing direction in the NHS, and particularly if change is required quickly. By embracing all healthcare including the 'hotel' activities associated with running large hospitals, it is virtually impossible to make a decision without it having some adverse consequences, for some other department, if not downstream, then in some more distant part of the organisation. In fact, these consequences secure an organisational gridlock or paralysis. We would suggest the concept of a managed clinical network be extended in two ways that are not addressed in the Scottish report.

Firstly, we envisage the present hospital trusts being split into two in order to separate their clinical and hotel functions. This would allow a clinical directorate or managed clinical network to concentrate on what is its core service function - to provide healthcare. Indeed, the concept of a trust in respect of its clinical functions becomes a "virtual" trust, made up of a number of managed clinical networks. There is an important co-ordinating role for the trust in ensuring that the mix of services provided in any given hospital is coherent, so that specialities which do have lateral links to each other in respect of their clinical activities, are co-ordinated in time and place. Each managed clinical network will have its own business manager who, on behalf of the network, would negotiate contracts or service level agreements with hospitals for beds, use of operating theatres and day and out patient suites and the usual ancillary functions of catering, cleaning and other domestic services. Just as there is a clinical

network, the 'hotel' activities could be linked across existing hospitals mirroring the locations of clinical activity.

Secondly, we suggest that individual managed clinical networks should have their own budgets to discharge their roles and functions. We see the clinical network formulating strategic and operational plans for its chnical services in the context of the needs of the catchment population that the network serves. Indeed, public health could be part of the network, contributing to the estimation of the size and nature of the need for services. Also, the introduction of clinical governance, the initiative of clinical effectiveness, guidelines produced by august bodies, and utterances of the GMC have made it increasingly difficult for doctors to ignore how their clinical behaviour is perceived by others. In respect of the financial implication of doctors' clinical decisions there is much more awareness of the financial realities of working in a cash-limited system. Almost a generation ago, the pioneering work of Wickings included an experiment of giving doctors budgets, and allowing them, with the support of an administrator, to reconcile the needs of patients under their care, the clinical management of those patients and the budget. Moreover, the experiment included a parallel control group, and quasi-random allocation to experimental or control group, although 'blinding' was clearly difficult. Furthermore, the outcomes - effectively process measures in the main - moved in a favourable direction in the experimental group. The study included incentives for those taking part to use any 'savings' made for clinical equipment, personnel or other clinical activities that would have been foregone previously.

We see our suggestions as building on and extending developments that are already taking place in the NHS in different parts of the UK. Attention is directed at the core activity instead of the financial bottom line, so that potential synergy between clinical staff is released and allowed to flourish through appropriate structures, with devolvement of decision-making and budgets. Clearly, mechanisms of accountability will still be necessary. Once the population perspective is incorporated into a chnical framework - both at a strategic or service level - then the 'management' issues force themselves to be addressed.

The NHS in Wales is currently overdrawn to the tune of £70 - 80million. Without apportioning any blame, one could say that the present system has not coped particularly well. Our proposals attempt to address the difficulties at several levels in the organisation. Individually, our proposals, we believe, make sense. We would welcome the creation of pilot studies, involving various specialities in different parts of Wales, as a way of testing these proposals. If they worked then we might have an effective health care organisation that was lean and fit, and was still true in large measure to the founding principles of the NHS.

CHAPTER 9

IMPROVING THE HEALTH OF THE PEOPLE THROUGH THE PUBLIC HEALTH FUNCTION AND INTERSECTORAL COLLABORATION

THROUGH THE PUBLIC HEALTH FUNCTION

A critical requirement for the advancement of an agenda to advance the health of the population is the public health function itself. This urgently needs to be strengthened.

The Acheson Report (1989) defined public health as:

> *...the art and science of promoting Health, preventing disease and prolonging life through the organised efforts of society.*

Public health is therefore not just what professional public health practitioners do to improve the population's health, it is what we all do as members of society.

In its widest sense public health is therefore a political activity. However, there is also a professional academic and service discipline of public health, and a specific set of public health competencies - knowledge, skills and attitudes - possessed by a relatively small cadre of public health professionals who play a key role and together constitute the "public health function". At local level this spans both local government and health authorities.

The core knowledge, skills and attitudes of public health practitioners relate particularly to epidemiology, disease prevention and health promotion, health information and statistical methods; to a lesser degree they also relate to medical sociology and health psychology, social policy and health economics, and the organisation and strategic management of health care.

THE PERSPECTIVE OF PUBLIC HEALTH

The perspective of public health as a professional discipline is population based, largely strategic and objective led. The aim of public health is to improve the health of the population. This goal can be achieved in two ways:

- by structural / environmental and population based interventions each influencing the health of large numbers of people
- through the sum total of interventions directed at individual people through clinical health care.

NEW OPPORTUNITIES AND PROSPECTS FOR PUBLIC HEALTH

Public health professionals require an organisational platform that enables them to retain a balance between the two arenas. Arguably, this may be on offer from the

current reform proposals, which emphasise partnership[19] between sectors and seek to join up the wider health improvement and the health service agendas including planning the latter from a population perspective. This is an exciting opportunity for public health professionals of all disciplines.

Continuing statutory tasks, such as communicable disease control, environmental hazard investigation, disease cluster analysis, emergency planning for disasters, major incidents - including chemical and radiation incidents, Section 47 work and the Annual Public Health Report, remain and will require the present critical mass of public health skills.

A major new opportunity is the Health Improvement Programme. Public health skills and personnel will be essential to this process both at health authority and LHG level. Public health will need to make an input throughout the entire planning cycle. The public health skills and experience that are needed will include:

- accessing appropriate information
- health needs assessment (see below)
- familiarity with the total system (including other agencies) and the larger picture (health authority population and above)
- population rather than service focus
- prioritisation
- experience of working with a range of professionals/organisations, etc.

INFORMATION

The essential nature of high quality information to the successful introduction of the White Paper changes runs throughout the White Paper. Timely and accurate information is essential for:

- needs assessment
- commissioning
- integration of services
- evaluation and monitoring.

Information systems are currently inadequate. Secondary care data is unavailable in forms usable for comparative analysis at general practice level. Primary care data is not systematically collected and not available at LHG level.

[19] A new statutory duty (in the Health Act 1999) was placed on all NHS bodies to work together - with health authorities having the task of ensuring that this occurs.

Information will be essential to the effective delivery of the planned developments and to the public health role. There is a need for a considered and adequately resourced information network across all relevant sectors.

MULTI-SECTORAL PUBLIC HEALTH PROMOTION

In addition to planning to improve the average health of the population (health gain) and to reduce health inequalities through the Health Improvement Programme (HIP), public health skills will also be required in developing and implementing public health promotion initiatives. This will involve forging partnerships or alliances and joint working with other agencies and bodies particularly local authorities. The departmental structure of local government will make this quite tricky, but it is a very important public health role.

INVOLVEMENT OF PUBLIC HEALTH PRACTITIONERS WITH LHGs

To fulfil the vision of the White and Green Papers, the NHS in Wales must become a more public health orientated body, and should be staffed with appropriately skilled people. There will be a need for training programmes to develop appropriate skills in LHG staff - e.g. Practice Managers, particularly those with Fundholding experience, can be trained in aspects of needs assessment, clinical information management and audit. Similarly, Health Visitors have been an under-utilised group whose public health skills should be developed and tapped. The settings in which public health practitioners operate will determine to a large degree their success in applying their skills in the activities and processes described above. An outstanding and key question is the nature and degree of their involvement in Local Health Groups (LHGs).

There are strong arguments for public health to be involved in LHGs through health authority and local authority representation, not least because the role of the LHGs as described in the White Paper encompasses the broad definition of public health described by Acheson. Disappointingly, former Welsh Office guidance has not included public health practitioners in the formal board or executive membership of LHGs. This needs remedying to ensure public health representative on the executive. This should be endorsed by the Assembly as guidance develops.

WORK PRIORITIES FOR PUBLIC HEALTH PRACTITIONERS

In addition to the statutory public protection roles, public health should concentrate on the planning role. It should also actively seek involvement in the evolving standards of care and clinical governance arena.

Over a period of time, particularly with the specific endorsement of a political agenda to tackle health inequalities and poverty, it will be important to look at new opportunities for training and employing an increasing number of individuals with a public health background, in order to ensure that the delivery of health and social care services as well as environmental health action takes place within a public health context.

THROUGH INTERSECTORAL COLLABORATION

The Government has made a commitment to breaking down barriers between organisations in the interests of improved service. Across the public sector, the Government is facilitating new partnerships, many of which have not bedded down yet, so it is impossible at this stage to evaluate whether the effect will be the desired outcome of improved service delivery. Police and local authorities are required to work together on Crime and Disorder Reduction Strategies; health and social care services are being brought closer together; social housing providers are being required to bid jointly for funding with local government; new arrangements are being set in place for partnerships to tackle youth offending. Increased inter-sectoral collaboration presents particular opportunities for developing a public health agenda.

HEALTH AUTHORITIES AND LOCAL AUTHORITIES

Health authorities and local authorities are increasingly inter-dependent. The relationship is based on separate statutory duties in respect of the communities for which they share the responsibility of providing services. Both health authorities and local authorities carry obligations in respect of areas such as:

- communicable disease control;
- child protection and welfare;
- community care;
- regulation; and
- emergency planning.

These responsibilities require joint action at a strategic level to plan and commission services. Key areas of operational activity between the organisations and other stakeholders include:

- promoting healthy lifestyle, e.g. through education and training, provision of resource information;
- community care e.g. for older people and those with learning disabilities, physical and sensory impairment, palliative care needs, mental or sexual health problems or in relation to alcohol and substance misuse;
- children's services e.g. those for young children, mental health, youth justice, children with disabilities, young carers, looked after children and child protection;
- public protection e.g. communicable disease surveillance and control, emergency planning, environmental control;
- community and supported housing e.g. renovation grants, sheltered housing, special needs housing.

The legal basis behind partnership already exists and in some areas health and social services are required by law to co-operate with each other (e.g. Section 27 of the Children Act 1989 and Section 48 of the NHS and Community Care Act 1990). In relation to infectious disease control, the statutory duty rests with local authorities but following recommendation it is usual for the 'proper officer' appointed and authorised by each local authority to be the Consultant in Communicable Disease Control (CCDC) employed by the local health authority.

THE VOLUNTARY SECTOR

The voluntary sector plays a crucial role in many thousands of projects across Wales supporting people with special interests and needs. The Government of Wales Act is unique in Britain for formalising a relationship between the voluntary sector and the Assembly through a voluntary sector scheme. The Welsh Local Government Association has been working with individual local authorities to ensure that by autumn 1999 there will be individual compacts between each local authority and their local voluntary sector councils. Wales Council for Voluntary Action has established an office close to the Assembly and has appointed an Assembly liaison officer. Expectations within voluntary sector organisations, many of whom have no paid staff, are very high. It will be a major challenge for the Assembly to respond to this new agenda.

However, there is also an important new opportunity using the statutory nature of the relationship between the Assembly and the voluntary sector, to use community based skills and involvement to contribute towards health authority led Health Improvement Programmes and local authority led Local Health Alliances. At a local level working with the voluntary sector will be vital in improving health. Voluntary action is often the basis for successful local communities and the role of local groups will continue to become more important as we strive to develop community-based health improvement. The voluntary sector will have a crucial role as lead organisations in developing Healthy Living Centres in partnership with other organisations able to access funding available through the New Opportunities Fund

JOINT CONSULTATIVE COMMITTEES

Prior to the establishment of Local Health Groups through the Health Act 1999, the Joint Consultative Committee (JCC) was the only generic statutory partnership between local authorities and health authorities. The JCC enables money to be moved from the NHS to local government under Section 28 of the old NHS Act, but not vice versa. The new Act now enables reciprocity which is an important new opportunity for both organisations to look at joint working.

Until the Assembly agrees the Statutory Instrument to commence the enactment of Section 32 of the new Act, JCCs will run alongside Local Health Groups and operate as usual. It is anticipated that the commencement of the Order will be in March 2000. Generally, it is assumed that the JCC mechanism should remain in place until other co-ordinated funding opportunities, e.g., pooled budgets come into place with the commencement of the Order, and until the Health Improvement Programmes are fully operational.

DRUGS AND ALCOHOL

The former Welsh Office strategy, *'Forward Together'* introduced under the last government, contained the framework for tackling the drugs and alcohol agenda at a Wales policy level through the Welsh Advisory Committee on Drug and Alcohol Misuse (WACDAM) and locally through drug and alcohol action teams (DAATs) at health authority level and local action teams (LATs) at unitary authority level. At present DAAT's in Wales do not have executive capabilities, have no statutory basis and are presently being run under a range of mechanisms. DAAT chairs are appointed by the constituency of the organisations identified by *'Forward Together'* and then become directly accountable to the Secretary of State. WACDAM members were also appointed by the Secretary of State, but did not include DAAT chairs.

This approach was increasingly at odds with the democratisation of Wales through the Assembly. Following a review of the strategy, the First Secretary of the Assembly disbanded the previous arrangements and established a new Substance Misuse Advisory Panel which includes the chairs of the five DAATs. This met for the first time in July, to develop an action-orientated approach, focusing on service delivery and treatment. The Panel's members include experts covering the key areas - crime and disorder, health, pharmaceutical matters, social services, the voluntary sector and youth. The Panel will develop a new Welsh Substance Misuse Strategy which will be similar to the framework of the UK Anti-Drugs Stratgey, "Tackling Drugs to Build a Better Britain."

COMMUNITY HEALTH COUNCILS

Government has accepted the need for Community Health Councils strategic capability to be strengthened, to represent the public interest in the planning and commissioning functions of health authorities, coupled with a recasting of local activities in line with those of Local Health Groups. Their new roles include a duty to represent the public in relation to improving the health of the population, to add to their traditional role concerning health services.

In March 1999 the Secretary of State announced the future configuration of CHCs in Wales, a network of 28 CHCs based on 9 federations. The new model aims to enable CHCs to become more able to reflect local views, and at the same time, exert greater influence and leverage at health authority and trust level. The pattern aims to encourage co-operation on key local issues that bear on more than one CHC, and by centralising support functions into 9 offices, will use existing resources to maximum effect. This does represent a new opportunity for CHCs to co-ordinate activity and influence all levels of government in Wales.

OTHER PARTNERSHIPS

There are a range of other partnerships in which health authorities and local authorities are involved alongside other agencies. Each of these, e.g., youth justice plans, community safety audits and action plans, children's services plans etc. offers opportunities to work within a context of overall health improvement. The challenge for those developing the health improvement agenda is to integrate this thinking across all public planning mechanisms.

STRENGTHENING INTERSECTORAL COLLABORATION

LOCAL PARTNERSHIPS

To implement a broad based health strategy for all at a local level it will be essential for new partnerships to be formed between many agencies including the voluntary and private sector in order to develop joint agendas for collaborative working.

An essential central foundation to the collaborative approach will be the local partnership between the local authority and the health authority. Underpinned by the new statutory duty of partnership, such partnerships must explicitly recognise the issues surrounding local accountability and foster a corporate agenda to improve health, not concentrating merely on the better provision of health or social care services. Such collaboration must be enhanced recognising and improving those barriers, which currently impede more effective joint working.

New partnerships must however be based upon a framework, which recognises and facilitates a better understanding of the organisational initiatives, values and constraints of each organisation. They must seek to take account of the key interfaces that exist - primarily policy, commissioning and service provision - and must reflect the new legislative framework and be built around the policy commitment to commission services at a local community level and reduce local inequalities in health. The Welsh Local Government Association and the five Welsh health authorities have signed up to a "Memorandum of Understanding" which will provide a framework for joint working at the local and national level.

Translating the new agenda into local practice will require close collaboration and working in each local authority area. It will be essential to develop a robust framework to take the public health agenda forward locally and to provide a network to advise the Assembly. This should involve the establishment locally of joint public health planning teams; analogous to joint care planning teams, which should report to both local authorities and health authorities. Key to such partnerships will be the relationship between health authority Directors of Public Health and their teams and local authorities To support such collaboration, joint appointment and secondment of staff on a reciprocal basis between central government, local and health authorities should be undertaken.

Whilst partnerships between local authorities and health authorities will be a prerequisite to effective health improvement there are many other local partners with whom both will need to engage when addressing the local health agenda.

GENERAL PRACTITIONERS

Partnerships between general practitioners and other agencies are not well developed across Wales. With the advent of Local Health Groups, this will undoubtedly improve, but it is essential for local authorities to develop local partnerships with local GPs. Involving G.Ps and local primary care teams in wider public health and community regeneration alliances will facilitate the inclusion of issues including health promotion, social care and the improvement of local health care facilities in the wider regeneration agenda.

COLLABORATIVE NETWORKS

There is a need to strengthen the public health function in Wales and in particular to develop local public health partnerships to address comprehensively health improvement. Good examples of such working already exist at the all Wales level. These include the Collaboration for Health and Environment (WCHE) which provides a focus and draws together professional groups into a multi-professional body aimed at facilitating and promoting combined public health initiatives and training opportunities, the Welsh Combined Centres for Public Health which links academic centres to provide multidisciplinary public health education and research, the Welsh Public Health Network and Welsh Forums including food microbiology and air quality. In endorsing this approach, we would seek to see such a model strengthened, and the partnerships which they represent, replicated at a local level.

RESEARCH AND DEVELOPMENT

The creation of the Wales Office of Research and Development (WORD) has created an opportunity to establish a strategic approach to health and social care in Wales. We welcome the development of the strategy designed to develop work in relation to social care and would particularly seek to increase the commissioning of research on the health and social care interface. Building on the need for evidence based policy, we also consider it essential to improve the evidence base for public health action. This will require the refocussing of existing research and associated funding to examine more closely the factors, which cause ill-health. We, therefore, particularly welcome the new WORD strategy with a specific section on public health and the recent public health research programme which follows on from it. We also look forward to the completion of the WORD funded systematic review of effective intersectoral collaboration.

There is a particular opportunity to pull together action based research from the new SHARPS proposals and the current People in Communities programme. These programmes should be monitored with a performance indicator to measure health improvement.

CHAPTER 10

CONCLUSIONS

TAKING THE HEALTH AGENDA FORWARD

The preventive health services of modern society fight the battle over a wider front than is the case for personal medicine. Yet the victories won by preventive medicine are much the most important for mankind. This is not so only because it is obviously preferable to prevent suffering rather than alleviate it. Preventive medicine, which is simply another way of saying collective action, builds up a system of social habits that constitute an indispensable part of what we mean by civilisation.

Nye Bevan

THE MAIN HEALTH IMPROVEMENT ISSUES

Our current health care system focuses on ill health. A debate which the Assembly will need to tackle early on is whether investment in a public health agenda will lead to less support being needed for the large, often impoverished, social group whose health is damaged by their lifestyles and living conditions. The balance of expenditure between investing in health care and investing in more broadly based measures to improve health will need to be reviewed within the Assembly's priorities. If we are to limit the trend of health care consuming an ever larger proportion of the Welsh budget, it will be necessary that we invest in policies that diminish the inequity and deprivation that causes high levels of ill health and demand for health care in particular social groups and particular geographic areas. This will require effective local programmes for economic development, housing, transport and the environment as well as specific health and social policies. These policies need to be evidence-based. There are major policy areas where very little research has been done, e.g. the links between poor housing and poor health deserves further exploration. Wales has the highest level of home-ownership in Britain, mostly in pre 1919 stock. When area renovation schemes are carried out, they should incorporate a longitudinal study into the health of the local population.

There are dramatic health inequalities in Wales, and only an agenda, where health improvement is a key thread underpinning all Welsh policy direction, will be successful. We have many residualised industrial areas in valleys which have not succeeded in attracting new industry; new inner-city urban slums; and large, increasingly unpopular, peripheral housing estates. These are areas with a high proportion of young families; with high levels of teenage pregnancy and lone parenthood and where unemployment can be found through four generations. The valleys in particular have the left-behind elderly with a legacy of poverty and industrial disease and poor housing. High levels of long-term limiting illness and mental health problems and poor access to health services is a shared feature.

This does mean that we will need to develop a Wales-specific agenda to tackle these problems. The Assembly, with its secondary legislative function, provides us with one new major opportunity, but there are other opportunities created by the development of new relationships between sectors, e.g. local government and the NHS and also the Assembly with statutory partnerships with local government through the Partnership Council, the voluntary sector and business. When you add this to the new relationship with Europe as an Objective 1 recipient, and the commitment of the Assembly to have a meaningful relationship with Europe, then there is an entirely new context for the development of health improvement policies for Wales.

This section will briefly draw together the conclusions reached within the book on the way forward and make some suggestions for policy makers in all sectors.

KEY HEALTH AND SOCIAL CARE ISSUES

In terms of developing a health and social policy agenda, two key issues need to be addressed - how to develop a joint health care and social care programme that enables individuals requiring access to both services to move easily and efficiently between one and the other; and secondly, how to ensure that health and social care services are delivered within a context of improving the population's health.

Bringing the locus of service planning down to unitary authority level offers a real opportunity to tackle the diversity of needs at an identified "local" level. However, if this agenda is to be fully developed, then the Assembly will have to play a clear strategic role in developing and stimulating new models for delivering health and social care and looking at new relationships between sectors focused on both the "health" and the "illness" agendas. The "Partnership for Improvement" agenda will make this possible and encourages voluntary participation in schemes. We need to ensure that there is active participation in models designed to achieve seamless care for the user across the whole of Wales.

The role of local government will need to change to play its full part. Its role is already changing through the Government's modernising agenda from being a provider of services to community governance in the context of best value. It needs to be enabled to support the new health agenda positively. Its contribution to the new Local Health Groups (LHGs) will assist them in finding a balance between the medical perspective and a social policy dimension and its leadership of Local Health Alliances must play a complementary role.

A key component will be the government's commitment to a "primary care -led NHS" led by GPs when we are, in Wales, potentially faced with a crisis in basic GP provision in the valleys areas over the next decade. Dr Julian Tudor Hart has strongly advocated salaried GPs, a view supported by the multi-disciplinary "Going for Gold" group which he established, and by the WLGA. If GPs are to lead primary care in areas based on local government boundaries, within multi-sector environments viz Local Health Groups, this will require a substantial change in their working practices. They will need to be willing to work in new ways with local social workers as well as community nurses, midwives and others.

DIFFERENT STRATEGIES FOR DIFFERENT WELSH REGIONS?

The differential distribution across Wales of ill health described already requires different local strategies for the provision of patient care services (preventive, treatment and care). The differential distribution of the determinants of health also requires different population based preventive strategies locally.

For public policy to achieve maximum health gain and / or reduction in health inequalities, it should probably be directed particularly towards those geographical areas and social groups with worst health status where there is most potential for improvement.

Different areas experience differing degrees of ill health because they experience the determinants of health to differing degrees and in differing balance. There is therefore an argument not only for targeting certain geographical areas for policy intervention but also for different policies in different places. Already substantial work has been done on establishing the "People in Communities" programme, which aims to tackle social exclusion in eight communities in different parts of Wales. These programmes are led by local authorities, and match funded by the Assembly. We believe that they should be expanded to each local authority in Wales, and that a performance indicator related to improved health should be introduced as part of their monitoring and evaluation. The potential for the development of local policies for reduction in health inequalities has been enhanced by the government's reforms which set up Local Health Groups (LHGs) and require local Health Improvement Programmes to be drawn up.

Although there are considerable arguments for a geographically targeted approach, there are also some generic problems which are pertinent throughout Wales and which would probably be best tackled centrally by government social and economic policy.

Preventive policy action directed at the psycho-socio-economic determinants would probably be the most fruitful. We have already demonstrated that in so far as these health determinants are within public control, they are within the arena of central and local government, not the NHS. However, radical social and economic policy may not be an option in a economy which must operate within the global marketplace dominated by trans-national corporations and given the presence of a contented majority (JK Galbraith 1996) within the electorate along with worries about the fostering of a dependency culture.

A STRATEGIC APPROACH TO HEALTH IMPROVEMENT

The remit of the HIP is to develop policy and services to improve health locally. Much can be done in joint working between the NHS and Local Government at this level. In order to ensure that the HIPs complement each other, a national strategic overview is also essential. Many of the necessary policies can only be set at a Welsh Assembly, UK Government or European Union Level. It is important that relevant policy options at all levels are considered if the health of the population of Wales is to be maximised.

If we are going to achieve an improvement in the health of our population it helps if we have an explicit aspiration to achieve this, a realistic vision of a different future. These aspirations are usually expressed in terms of goals, aims, objectives and targets.

Overall health improvement aims to be achieved within the resources available should be:

- health gain, which is the improvement of the average state of health in the Welsh population.
- reduction of inequalities in health status; that is closing the health status differences which are apparent between social groups within our population. In technical terms to narrow the population distribution of health status.

The goal is to achieve both of these aims, and in an ideal world to do this simultaneously. It is however, important to remember that either of these objectives can be achieved in isolation of the other and that in some cases successful efforts to achieve one of these objectives may actually set back progress towards the other. In the 1980s for example, health gain was achieved while inequalities in health widened. For this reason, differently designed programmes may be required to address these two objectives individually. Furthermore, in order to achieve both goals simultaneously, we need to improve the health of the worst off fastest.

HEALTH OBJECTIVES AND TARGETS

In line with the Strategic Intent and Direction of the Health Service in Wales, a reasonable but ambitious objective might be to improve the health of the Welsh people to that of the best in Europe (already described). Currently we are a long way short of this objective and in fact to improve health to the European average or even the UK average would be progress.

A motivation to improve and a sense of priorities are most effectively instilled if objectives are set in the form of time dependent quantitative targets (McGinnis et al 1997). Such targets also have the advantage of allowing progress against the objectives to be tracked. Targets must be challenging but should be achievable and furthermore there should not be too many or a sense of priority will be lost.

The current health targets (see Appendix) largely relate to health outcomes and the lifestyle determinants. All of these focus on average population health gain rather than reduction in health inequalities. It is imperative that policies are guided by targets for the reduction in health inequalities as well as for health gain; in this regard the Assembly has asked an expert advisory group to produce indicators for health inequalities.

In addition, progress towards improvements in the physical environment can be tracked using the Agenda 21 Targets for a sustainable environment, and the Local Environmental Health Action Plan (LEHAP) and National Environmental Health Action Plan (NEHAP) targets. There are no formal targets for improvements in the social environment as yet, however, the Assembly has committed itself to developing targets for the reduction of poverty and social exclusion.

Similarly, for health services determinants, there are targets for childhood immunisation coverage, child surveillance, and breast and cervical cytology screening uptake[20]. All other NHS process targets are about efficiency rather than effectiveness and include targets for waiting lists and waiting times, patient centred services and good communication. A number of targets for clinical processes and clinical outcomes need to be adopted to demonstrate that the highest priority for health care services is health improvement.

GENERATING POLICY OPTIONS

If we are to generate policy options to improve the health of the population, we need to understand the determinants of health (again already described), which will suggest where policies should be directed. The conceptual framework for a health improvement strategy should probably contain four categories:

- social and economic environment
- physical environment
- lifestyle
- public health, clinical health care and personal social care services".

Improved population health outcomes only occur through improvements in the determinants of health. These can be brought about through processes - policies and services. Therefore, if a strategy is to stay true to its goal of improving the people's health, then it must be concerned with both the determinants of health and with the partnerships which the Assembly must have with the NHS and local government to deliver change through policies or / and services. The determinants that are likely to be most relevant to health improvement in Wales lie within the socio-economic environment, and must be cross-referenced to policies in other areas, including access to European funding.

WHAT POLICIES SHOULD BE ADOPTED IN THE STRATEGY?

According to the Ottawa Charter for Health Promotion (WHO 1986), public health improvement is in general terms likely to be achieved through:

- healthy public policy to:
- create supportive environments and
- strengthen community action and to
- develop personal skills and
- re-orient health care services (towards primary health care)

[20] Performance is tracked against uptake targets which are applied to General Practice and Health Authority populations.

FORMS OF POLICY INTERVENTION

There are several forms of such policy intervention including:

- fiscal/monetary (incentives/subsidies)
- regulation (economic, environmental)
- direct provision (goods, services)
- participatory guarantees
- research / development / information / education

DIRECTING POLICIES TO IMPROVE HEALTH

Effective public policies depend fundamentally upon political will and public support. However, in an ideal world, and in order to achieve greatest public health impact, policies should be directed towards those population groups facing the most serious health hazards, and those most deprived. We have endorsed this view in highlighting possible policy options for the different contributory sectors. However, in reality they are likely to rely upon considerable inter-sectoral working (Dahlgren 1994) for successful outputs.

KEY RECOMMENDATIONS FOR HEALTH IMPROVEMENT

THROUGH INFLUENCING EUROPE

The EU is likely to have an increasing role in both public health and health care. This role is still developing in conjunction with member states. The Assembly and the Government will need to lobby the Commission directly if possible and use the opportunities provided by consular links to the member states and an enhanced presence in Brussels through the Wales European Centre. Wales, as a new Objective 1 region will need to create its own momentum and add a voice to the debate about the role of health improvement in Objective 1 allocations

Key recommendations include:

- Wales European Centre lobbying Parliament and the Commission
- using Article 152 of the Amsterdam Treaty to support the introduction of Health Impact Assessments for Objective 1 bids
- utilising Welsh MEPs to scrutinise healthy European policies and develop a dialogue with the Assembly
- using the Assembly's standing committee on Europe to further dialogue with other sectors from an agreed Welsh position.

THROUGH WESTMINSTER ACTION

The Government retains the power for the creation of primary legislation in England and Wales. The annual programme is set out in the Queen's speech. The Government has stated that it will consider, in drafting each Bill that it introduces into Parliament, which of the new powers in each Bill should be exercised in the Assembly. In practice, this means that primary legislation following devolution will give greater discretion in terms of its implementation in Wales. The Secretary of State is also required to consult with the Assembly. The retention of two Ministers is helpful, and close relationships will need to be developed between the Ministerial team and the Assembly Cabinet to ensure that Assembly views can be taken into account in Westminster. It is likely that there will need to be particular dialogue around welfare reform as Wales has such a large number of claimants with a long term limiting illness or disability.

Key recommendations include:

- creating opportunities for dialogue with the Assembly about the development of primary legislation
- ensuring that primary legislation is not counter-productive to Wales
- ensuring that the protocols developed between Whitehall departments and the Assembly are properly monitored
- promoting a UK Health Consultative Committee where ministers from all four countries can come together
- ensuring representation from Wales in UK delegations to the Council of Ministers when appropriate

THROUGH NATIONAL LEADERSHIP IN WALES: THE ASSEMBLY

The National Assembly for Wales provides an excellent opportunity for leadership focussed upon health gain, where health is seen within its social context, and where value judgements about priorities are made with democratic legitimacy. However, it is also important that the Assembly operates inclusively, is focussed on communities, achieves optimum use of resources and aspires to evidence based policies. The Assembly must remain outward looking throughout, and above all it must remember that its role is "to steer and not to row". This presents a huge opportunity to be taken and will only be successful if we are able to influence Assembly membership and potential leaders of importance of public health agenda, and support a political debate about policy and practice rather than resources.

The Assembly is in a unique position in Wales to take a firm grip on the health improvement agenda because of its statutory obligations for partnership with local authorities, the voluntary sector and business. Also, it is committed to equal opportunities, sustainability and Europe. The fact that the cabinet secretary responsible for health and social care is also the person responsible for drawing together the Assembly's social inclusion programme is a very positive step forward.

Because social exclusion, deprivation and poverty are really the common denominators that link most social determinants of health, interdepartmental "joined - up" policies are required, particularly if inequalities in health are to be reduced. A central unit, co-ordinating policy development between different departments, is, therefore, sensible. The British Government now has its "Social Exclusion Unit" performing this function and reporting directly to the Prime Minister. The Welsh Assembly should consider setting up a similar unit with a close relationship with Whitehall in order to ensure that expertise from the larger unit is brought to Wales. Until the establishment of the Assembly, there has been no real co-ordination of the social inclusion agenda, and urgent action is needed to ensure that action under this agenda is co-ordinated with action to tackle health inequalities.

Section 121 of the Government of Wales Act requires the Assembly to promote sustainable development which should provide "outcomes, currently desired, without compromising the entitlement of either present or future populations ... to a healthy and productive life." Section 108 of the Act requires the Assembly to honour the UK's commitments to international conventions. It would therefore be possible for Wales to honour such conventions, e.g. the UN Convention on the Rights of the Child, to a level agreed, but not yet implemented by national government.

The policy development and analysis function will be crucial towards advancing a public health agenda post devolution. Currently this function is small in size in Wales both within government and outside in independent or academic policy forums, think tanks etc. This is a major deficit in Wales and needs to be strengthened. One proposal would be the fostering of a number of "policy villages" a concept which would suit the relatively small scale of Wales and the advantage that so many of the key players across different sectors know each other.

We have suggested in the relevant chapters how we feel that the formal health care system could be modified to deliver services which are more appropriate, more effective or more efficient. But for those responsible for the delivery of care to do this is predicated on a greater degree of autonomy in the way decisions are made and implemented than is currently the case. Thus we would support the evolution of LHGs to Primary Care Trusts (PCTs), as appropriate for local delivery. Equally, we see managed clinical networks - with devolved budgets - as a way of ensuring that activities remain clinically focussed and responsive in a way that is difficult, if not impossible, in a large DGH. We also feel that the purpose of these changes would be aided by separating the 'hotel' and clinical functions associated with hospital-based care.

Public Health - or that part of it that relates to identifying the need for health care and the nature of the response to that need - could contribute by working closely with LHGs/PCTs in the primary sector and managed clinical networks in the hospital sector.

Some of the other roles of public health, - for example, the investigation of outbreaks of communicable disease or the threat to health by (say) chemical pollution - could be addressed by a network model, comparable to the managed clinical network, referred to above, so that practitioners with varying degrees of sub-specialisation, work in a collaborative and mutually supporting way.

Some of the lessons from the private sector of industry might be of relevance to the health sector. Here, collaboration between partners (companies) has produced far larger efficiency and quality improvements than concentrating on attempting to improve performance within each separately.

Key recommendations to the Assembly include:

- development of information infrastructure to facilitate surveillance, investigation and monitoring
- data collection at LHG level and below of health inequalities allied to collection of poverty data
- commissioning an atlas to plot healthcare services at LHG level and below; to include levels of service utilisation, and access by public transport
- expanding the People in Communities programme across Wales and ensure that health improvement is a key performance indicator
- endorsing the use of Health Impact Assessments on new policy initiatives, including applications for Objective 1 funding
- piloting the managed clinical network proposal in a number of sites
- taking an active lobbying role with Government in Westminster and Europe to facilitate the development of a Welsh Strategy
- using its partnership mechanisms, specifically the Partnership Council with local government and the Voluntary Sector Scheme to promote health improvement across all sectors
- recreate the Welsh Health Planning Forum at the earliest opportunity with a cross-departmental remit so as to address all the determinants of health
- establishing the Wales Centre for Health at the earliest opportunity; ensuring multi-disciplinary skills and capacity
- implementing fully the UN Convention on the Rights of the Child

THROUGH LOCAL NHS AND LOCAL GOVERNMENT ACTION

Much health improvement can be achieved at local level between the NHS and local government. Local authorities have most influence over determinants of health, but it is also important to ensure that health services are planned within a public health perspective.

Key recommendations include:

- ensuring full partnership and ownership of the HIP
- using the new flexibilities offered by the Partnership for Improvement agenda

- encouraging the strategic involvement of local elected members in LHGs and Local Health Alliances (LHAs)
- focusing on individual communities for targeted action
- ensuring that the public health function, both from the local government and health perspectives is represented on the executive of each LHG in Wales
- creating opportunities for joint appointments and secondments between the NHS and local government
- encouraging benefit take up campaigns through LHGs or LHAs
- health improvement should be the central focus of the local authority Community Plan.
- when area renovation schemes are carried out, they should incorporate a longitudinal study into the health of the local population.

THROUGH INTERSECTORAL COLLABORATION

A key message throughout this publication has been about the value of working in partnership within and between organisations with a relevant interest in developing the health improvement agenda in Wales. We have made recommendations throughout the book to each sector, within the context of an agenda which can only be adequately seized if all the potential partners look actively at what contribution they can make. A number of legislative changes and new statutory duties to bring the health and local government sectors closer together are very welcome, but will take some time to work through the system. In the meantime all partners involved in partnerships at Assembly level, and the strategic local partnerships of Local Health Groups and Local Health Alliances need to be pushing in the same direction. There is a major role for representative national bodies such as the NHS Confederation, the NHS Staff College, the Welsh Collaboration on Health and Environment, the Welsh Combined Centres for Public Health and the Welsh Local Government Association to develop training programmes to ensure that their members are able to drive this essential agenda forward.

APPENDIX

THE CURRENT HEALTH TARGETS

The Welsh Assembly has established a set of these high-level health targets. The targets are health outcome based, or intermediate outcome or process based. The highest level targets are those which focus upon population health status / health outcome.

HEALTH OUTCOME TARGETS

All of these focus on average population health gain rather than reduction in health inequalities. They are as follows:

INFANT MORTALITY

- infant mortality - reduce the infant mortality rate (deaths up to 1 year) from 5.9 (1994/1996 - 3 year average) to 5.5 (2003/2005 - 3 year average).

CIRCULATORY DISEASE

The Welsh targets for circulatory diseases relate to coronary heart disease (CHD) (ICD9: 410-414) and stroke (ICD9: 430-438). The targets take the baseline from 1995 and are expected to be met by 2002.

CORONARY HEART DISEASE

- reduce mortality for people aged under 65 years by at least 50% (to no more than 25.2 per 100,000 European standard population)
- reduce mortality for people aged 65 to 74 by at least 25% (to no more than 615 per 100,000 European standard population).

STROKE

- reduce mortality for people under 65 years of age by at least 20% (to no more than 9.2 per 100,000 European standard population)
- reduce mortality for people aged 65 to 74 by at least 25% (to no more than 163.8 per 100,000 European standard population).

CANCER

There are four Welsh targets for cancer: one for cancer of female breast (ICD 9: 174), two for cancer of trachea, bronchus and lung (ICD 9: 162) and one for cervical cancer (ICD 9: 180). The targets are to:

- reduce lung cancer mortality in men under the age of 75 by at least 54% by 2010 (from 49.2 per 100,000 European standard population in 1995 to no more than 22.6 in 2010)

- reduce lung cancer mortality in women under the age of 75 by at least 21% by 2010 (from 23.0 per 100,000 European standard population in 1995 to no more than 18.2 in 2010)

- reduce breast cancer mortality in women aged 50-74 by at least 30% by 2002 (from 83.9 per 100,000 European standard population in 1995 to no more than 58.7)

- reduce invasive cervical cancer registration in women by at least 50% by 2002 (from 21.9 per 100,000 European standard population in 1990 to no more than 11.0)

ACCIDENTS

The targets set for Wales are to:

- reduce accident mortality by at least 15% by 2002 (from 20.7 per 100,000 European standard population in 1995 to 17.6, ICD9: E800-949)

- reduce the rate of injury to children aged 0-16 caused by accidents. (Subject to the All Wales Injury Surveillance System providing data on an all-Wales basis).

A proxy target on road accident deaths and injuries is under consideration.

MENTAL HEALTH

The two target areas for mental health are suicide and health status:

- reduce suicide mortality by at least 10% by 2002 (from 12.3 per 100,000 European standard population in 1995 to no more than 11.1, ICD 9 codes E950-959, E980-989 include undetermined causes)

- increase the SF-36 mean mental component summary score to 50 by 2002 (from 49.5 in 1995 to USA mean score)

LOW BIRTH WEIGHT

The Welsh target for maternal and child health is based on low birth weight (LBW). Data on this indicator are available from the All Wales Perinatal Survey, and the target is to:

- reduce the proportion of low birth weight babies to below 6% by 2002 (births of below 2500g as a proportion of live and stillbirths)

UNDERAGE CONCEPTIONS

- reduce the conception rate for 13-15 year olds from 10.2 (1994/1996 - 3 year average) per 1000 to 9.5 per 1000 by 2003.

PHYSICAL DISABILITY

There are two target areas for physical disability - arthritis and back pain. Both were included as questions in the Welsh Health Survey, and it is from the results of this survey that the health targets for these disorders have been derived.

BACK PAIN

- reduce the proportion of people aged under 65 years with back pain by at least 10% by 2002 (from 27.4% in 1995 to no more than 24.7%, treated by a doctor)

ARTHRITIS

- increase the mean SF-36 score in people aged 65 and over who have arthritis to 34.9 by 2002 (from 32.4 in 1995 in those treated by a doctor)

The former Welsh Office Health Outcome Targets which still pertain were carried over from the previous government's agenda and unfortunately only focus upon health gain, and do not focus upon the inequalities in health outcomes. There is an urgent need to adopt targets for reduction in inequalities in health outcome.

INTERMEDIATE OUTCOME TARGETS AND PROCESS TARGETS

Improvement in health outcomes can only be achieved through changes in the determinants of health. The former Welsh Office therefore also decided upon a number of health promotion targets for unhealthy lifestyles. They cover smoking reduction, healthy eating and alcohol consumption.

SMOKING REDUCTION

- reduce the proportion of adults aged 18 to 64 who smoke to no more than 20% by 2002 (from 31.5% in men and 28.1% in women in 1993, daily or occasionally smokers)

- reduce the proportion of 15 year old children who smoke to no more than 16% for boys and 20% girls (from 23% in boys and 29% in girls in 1996, at least weekly smokers)

- increase the proportion of women who give up smoking during their pregnancy to a least 33%

NUTRITION

- increase by 5%, the number of 11-16 year olds eating fresh fruit every day from 46% of boys and 55% of girls in 1996, to 51% and 60% respectively, in 2002;
- increase by 5%, the number of 11-16 year olds eating either raw or cooked vegetables every day from 27% of boys and 33% of girls in 1998, to 32% and 38% respectively, in 2002.
- increase the proportion of adults aged 18 to 64 who eat green vegetables or salads most days to at least 40% by 2002 (from 32.8% in 1993)
- increase the proportion of adults aged 18 to 64 who eat fresh fruit most days to at least 55% by 2002 (from 44.3% in 1993)

DRUGS AND ALCOHOL

- reduce the percentage of 15-16 year olds reporting drinking alcohol at least weekly from 60% in 1996 to 50% by 2002.
- reduce the percentage of men aged 18 to 64 consuming more than 21 units of alcohol per week to 18% by 2002 (from 26.4% in 1993)
- reduce the percentage of women aged 18 to 64 consuming more than 14 units per week to 7% by 2002 (from 8.5% in 1993)

A target (or targets) for drug misuse will be provided at a later date and will draw on those developed as part of the UK Anti-Drugs Strategy.

BREASTFEEDING

- increase the percentage of mothers breastfeeding at 6 weeks by 5% by 2003. (Current level from ONS infant feeding survey in 1995 is 46% for Wales and South West England).

VACCINATION/IMMUNISATION

- increase the percentage of children aged 2 years who have taken up childhood immunisations and vaccinations, to 95% by 2003.

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