Editors’ introduction

Government policy on public health, along with related policy on issues which affect health such as education, employment, food and transport, provide the broad framework for action to improve the health of the population; policies can facilitate new opportunities for health improvement but they may also hinder progress.

It is therefore crucial that public health workers develop a critical understanding of current public health policy and programmes at both national and local level. In this chapter, the author provides a refreshing insight and critique into the important area of public health policy development and implementation, which should prove useful for everyone working in the field of public health, in whatever capacity.

The government’s commitment to public health is evidenced by a range of policy initiatives since 1997. The author takes a critical look at current policy developments and examines how they have been put into action. He questions whether the current and developing policy and administrative framework are ‘fit for purpose’ and appropriate for the problems and challenges posed by the development of multidisciplinary public health in the 21st century. He identifies and discusses barriers and difficulties posed by the breadth of policy development.

The chapter is in three sections. The first section reviews the present state of public health policy and its recent history since 1997. In particular, it assesses the tension in health policy between a ‘downstream’ agenda fixated on acute health care and an ‘upstream’ agenda centred on public health interventions designed to maintain and improve health, and avoid or delay contact with the NHS.

The second section examines the constraints on implementing public health policies and the bias in public health towards the NHS and health care. It questions how far this can be influenced and changed.

The final section and conclusion consider the future of public health policy and make suggestions for what needs to happen if there is to be a sustained shift in policy towards health as distinct from health care.
Introduction

This chapter takes a critical look at current public health policy and its implementation. It questions whether the current and developing policy and administrative framework are ‘fit for purpose’ and appropriate for the problems and challenges posed by the development of multidisciplinary public health and concludes that they pose major barriers and other difficulties which, if not addressed, will seriously impede implementation. Though centred on the position in England, the chapter briefly considers the differing policy contexts elsewhere in the UK post-devolution. The impact of devolution affords opportunities for policy learning.

The chapter is in three sections. The first section reviews the present state of public health policy and its recent history since 1997. In particular, it assesses the deep rooted tension in health policy between an ‘upstream’ agenda centred on public health interventions, and a ‘downstream’ agenda fixated on acute health care. The second section examines the constraints on implementing public health policies and the bias in public health towards the NHS and health care; it questions whether this is inevitable. The third section considers the future of public health policy and makes suggestions for what needs to happen if there is to be a sustained shift in policy towards health as distinct from health care.

The state of public health policy

The new Labour government May 1997: public health renaissance

Public health underwent something of a renaissance following the election of the Labour government in May 1997. The new government acted quickly to appoint the first ever minister for public health as a member of the ministerial team in the Department of Health. Her remit only extended to England as plans for devolution to Scotland, Wales and Northern Ireland were already well advanced. The new minister was anxious to map out a new approach to health policy to demonstrate the government’s commitment to a more socially equitable and cohesive society.

There was a recognition that improving health and narrowing the widening ‘health gap’ between social groups were policy challenges that transcended any single department’s responsibilities. They were cross-cutting issues and therefore key features of the government’s concern that there should be ‘joined up’ solutions to ‘joined up’ social problems. The minister for public health immediately set in progress three initiatives:

- the development of a new health strategy to replace The Health of the Nation, the first ever health strategy for England which existed from 1992 to 1997 (Secretary of State for Health 1992);
- an evaluation of the impact of The Health of the Nation at local level, the findings from which would inform the new strategy (Department of Health 1998b); and
- an inquiry into inequalities chaired by a former chief medical officer, Sir Donald Acheson, to demonstrate where the scientific evidence showed interventions to be effective in tackling inequalities (Acheson 1998).
The Acheson inquiry made 39 recommendations only three of which directly concerned the NHS. This only confirmed the government in its view that improving the public’s health and tackling inequalities had to be part of concerted action across government. (See Chapter 10 for a detailed discussion of tackling inequalities in health.)

Table 1.1 lists key policies, reports and initiatives in public health since the Labour government came to power in 1997.

Table 1.1 Key policies, reports and initiatives in public health 1997–2002

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>1997</td>
<td>Election of new Labour government; commitment to public health action to reduce health inequalities.</td>
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<tr>
<td>1998</td>
<td>Acheson Independent Inquiry into Inequalities in Health published.</td>
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<td>1999</td>
<td>New national strategy for health in England published: Saving Lives: Our Healthier Nation. Initiatives such as health action zones, healthy living centres and Sure Start started to be launched to improve health and reduce inequalities in health.</td>
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<tr>
<td>2000</td>
<td>Health Development Agency set up; remit included strengthening the evidence base of public health. The NHS Plan published; signalled organizational change and attracted criticism about the lack of emphasis on public health.</td>
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<td>2001</td>
<td>National targets on health inequalities published. Shifting the Balance of Power published – devolving NHS responsibility to the ‘front line’. House of Commons Select Committee reports on public health published, which criticized the lack of government emphasis on public health. The Report of the Chief Medical Officer’s Project to Strengthen the Public Health Function also published. Two reports: Tackling Health Inequalities (consultation document) and Vision to Reality (progress report on tackling health inequalities) published.</td>
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<tr>
<td>2002</td>
<td>Wanless Report published on future health trends and resources required; it supported public health action to bring health and economic benefits. Tackling Health Inequalities report published on action needed. HM Treasury and Department of Health Tackling Health Inequalities: Summary of the 2002 Cross-Cutting Review published, which committed the government to placing tackling health inequalities at the heart of public service delivery.</td>
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New health strategy and other initiatives

A new health strategy finally appeared in 1999 after some delay (Secretary of State for Health 1999). Entitled Saving Lives: Our Healthier Nation, it attempted to take on board at least some of the lessons from the evaluation of its predecessor, The Health of the Nation. The strategy was widely welcomed although some commentators felt it remained rather too firmly wedded to a health care model which was less about supporting communities to remain healthy than about keeping individuals alive (Fulop and Hunter 1999). The strategy focused mainly on disease-based areas. To
this extent, therefore, there were limits on how far it represented a move ‘upstream’. A key finding from *The Health of the Nation* evaluation was that the dominance of the medical model underlying the strategy ‘was a major barrier to its ownership by agencies outside the health sector, notably local government and voluntary agencies’ (Department of Health 1998c). Commenting on the new health strategy, the Local Government Association and the UK Public Health Association in a joint report concluded that ‘the traditional concerns of public health medicine focused primarily on alleviating sickness and preventing premature death’ remained a ‘dominant and overly narrow perspective’ (Local Government Association and UK Public Health Association 2000: 2).

Almost simultaneously with these policy developments, the government launched a bewildering array of other new programmes and initiatives. These included health action zones (HAZs), healthy living centres (HLCs), Sure Start (with its pledge to end child poverty within a generation), New Deal for Communities and health improvement programmes. Judging by the sheer number of announcements and their scope and range there could be no doubting the government’s resolve and drive in respect of raising the priority attached to improving the public’s health and narrowing the gap between rich and poor.

At the same time, the Health Education Authority was replaced by a virtually new body, the Health Development Agency, charged with strengthening the evidence base for public health in line with similar developments that were already underway in respect of evidence-based medicine. The new Agency’s remit included a commitment to disseminate the evidence about what interventions worked and those that did not work, as well as to provide developmental support to those organizations struggling to apply the evidence in practice.

The government’s commitment to evidence-based public health reflected the ‘new scientism’ that had invaded government during the late 1980s and early 1990s (Klein 1996). There was a view that if only the evidence were available to point policy makers in the right direction then it would be possible to answer those critics who believed public health interventions were ineffective and based on rhetoric rather than solid evidence. Indeed, this is the opinion of the Minister for Public Health, Hazel Blears. In one of her first major speeches following her appointment, she stressed her enthusiasm for the evidence of what works. ‘Evidence is vital, not least because I am well aware that there are sceptics who suggest that none of this effort makes any difference to the health of the public’ (Blears 2002). But perhaps the sceptics simply choose to ignore the evidence that already exists. In any event, the evidence will always be imperfect and incomplete. In this respect the position is no different for public health than for any other area of policy.

While welcoming the government’s commitment to public health evident in the outpouring of policy statements, ministerial speeches and so on, critics accuse the government of suffering from ‘initiativitis’. This actually makes the job of ‘joining up’ policy and management more difficult because each initiative tends to operate in isolation and receives its own dedicated funding and its success is judged according to criteria specific to that particular initiative (Hunter 2003). Rather than simplifying partnership working, which the government claims it wants to do by, for instance, abolishing the NHS internal market, the plethora of initiatives only increases
fragmentation. It has introduced a new kind of market as agencies compete against each other in bidding for funds to become a HAZ, HLC and so on.

The NHS plan

It was the appearance of *The NHS Plan* in July 2000 that gave an indication that the government’s attention and energy were being progressively directed towards the NHS and its problems, the extent of which the government had underestimated during its initial years in office (Secretary of State for Health 2000). Aware that the NHS was a key electoral issue and that it must remain an asset for Labour rather than becoming a liability, ministers prepared for major changes in the system of delivering health care. Initially opposed to ‘big bang’ structural reform the type of which the NHS had become weary over decades of successive structural changes, the government embarked on the most comprehensive and complex organizational changes the NHS had witnessed (Department of Health 2001a). The NHS is still coming to terms with these changes but one of their effects has been to put at risk the government’s early focus on public health.

A slim chapter buried deep in *The NHS Plan* was devoted to improving health and reducing health inequalities. Rightly or wrongly, this signalled to those outside the Department of Health that the main business of health policy was sorting out the NHS, since success on this front would determine the government’s future at the next general election. Indeed, in an unprecedented move, the government and the prime minister personally, have staked their survival on the NHS being ‘modernized’. (See Chapter 2 for a comprehensive discussion of Labour’s ‘modernization’ agenda and what it means for public health.)

A debate on the merits of national health inequalities targets that was never resolved in *Saving Lives: Our Healthier Nation* was brought to an end with a promise in *The NHS Plan* to produce national targets. These duly appeared in March 2001. They are intended to complement the local targets called for in the health strategy and are to be delivered by a combination of specific health service policies, broader government policies, including abolishing child poverty through Sure Start, and action on cancer and coronary heart disease, to be taken through the appropriate national service frameworks. A problem with the targets was that while they were produced by the Department of Health and directed at the NHS for implementation, their realization actually depended on the activities of other bodies, especially local authorities. But these bodies were not engaged in the production of the targets and saw them as directed at the NHS rather than at them.

Public health – ‘off the boil’?

As the government became more embroiled in sorting out the NHS through its *Shifting the Balance of Power* initiative aimed at devolving responsibility to the front line and intervening less from the centre, there was a growing sense of despondency in the public health community that the government had reverted to form in being preoccupied with urgent ‘downstream’ issues affecting the NHS. It merely indulged in a lot of symbolic posturing around the important ‘upstream’ determinants of health
but was seemingly less committed to putting its own policies into action. Policy resembled what Bachrach and Baratz (1970) termed ‘decisionless decisions’.

Many of these sentiments around public health having gone ‘off the boil’ were given added impetus when expressed by the House of Commons Health Committee in a critical report on public health in March 2001 (House of Commons 2001a, b). The Committee was critical of the imbalance in government policy in favour of health care as distinct from health. Even in respect of those initiatives, like HAZs and health improvement plans, intended to promote health the Committee was critical of the way in which they had been implemented. The difficulties arose principally from the sheer number of initiatives and their lack of integration. Although welcoming the Plan’s commitment to health inequality targets, the Committee felt that ‘a great opportunity to give public health a real impetus has been lost by the lack of emphasis on this area in the Plan’ (House of Commons 2001a). The Committee noted the contrast with the equivalent plans in Wales and Scotland which both led with a strong commitment to the public’s health (see below).

Reviews and reports strengthening public health

As if sensing the change of mood about its commitment to public health, the government, in addition to producing the national targets, published a number of other policy documents and reports testifying to its determination to fulfil its public health objectives and possibly seeking to reassure its critics that its eye had not been taken off the health ball altogether. The much delayed final report of the chief medical officer’s review of the public health function appeared simultaneously with the Health Committee’s report in March 2001 (Department of Health 2001b). It restated the government’s wish to strengthen the public health workforce, although the report was light on the cost of such an exercise or where the resources would come from; consequently, action following the report has been limited.

Later the same year two further reports appeared from the centre. The first, Tackling Health Inequalities, was produced to consult on the action needed to achieve the two national health inequalities targets (Department of Health 2001c). To deliver the targets, six priority themes were proposed:

- providing a sure foundation through a healthy pregnancy and early childhood;
- improving opportunity for children and young people;
- improving NHS primary care services;
- tackling the major killer diseases: coronary heart disease and cancer;
- strengthening disadvantaged communities; and
- tackling the wider determinants of health inequalities.

The report made the point, yet again, that effective action required joined up working across government and across sectors at national, regional and local levels. A follow up report was published in June 2002 (Department of Health 2002a). It provided
feedback on the consultation exercise on the government’s six priority themes. They were generally supported, but those consulted were critical of the document’s largely NHS and medical focus. In particular, there was concern that the contribution to be made by local government had been given insufficient attention and weight and needed to be made more explicit. This should include its duty to develop strategies and its health scrutiny role. Local strategic partnerships (LSPs) were seen as key vehicles for involving both the NHS and local government. Again, in delivering the agenda the feedback was generally critical of the prominence given to the NHS to the virtual exclusion of other agencies. Finally, there was criticism of the heavy reliance on short-term projects and initiatives. They distracted staff and too often mainstream activities and services remained unaffected or unchallenged by any lessons the projects had to offer.

The second report to appear in 2001 (mentioned above), Vision to Reality, took the form of a progress report from the minister for public health and chief medical officer on developments since the Acheson inquiry on health inequalities, the Saving Lives: Our Healthier Nation strategy, The NHS Plan and the chief medical officer’s public health function review (Department of Health 2001d). As such, it did not contain any new policy thinking but served as a reaffirmation of the government’s commitment to a modernized health service and public health service that ‘will lay even greater emphasis on the protection and improvement of the population’s health, and which will at last start to reduce the gap between the best and worst off in society’. There was an acknowledgement that ‘for too long the NHS has been seen as a sickness service not a health service’. The intention was to see the NHS acting in partnership with others ‘to prevent sickness and ill health, as well as treating problems once they arise’ (Department of Health 2001d).

While health policy was traditionally the preserve of the Department of Health, the Chancellor of the Exchequer, Gordon Brown, announced a long-term review of the challenges facing the NHS over the next 20 years. He appointed the former chairman of the National Westminster Bank, Derek Wanless, to lead a review to examine future health trends and the resources required over the next 20 years to close gaps in performance and to deliver The NHS Plan. The review team published an interim report in late 2001 and a final report in April 2002 (Wanless 2001, 2002). Rather unexpectedly, it gave an important boost to public health and certainly acknowledged its importance.

The review team argued that ‘better public health measures could significantly affect the demand for health care’ (Wanless 2002: paragraph 1.27). On top of any health benefits, a focus on public health was also seen to bring wider benefits by increasing productivity and reducing inactivity in the working age population. The review team expressed concern that the poor evidence base in public health demonstrating the effectiveness of interventions made it difficult to conclude that investment in public health should be significantly increased. In its final report, it revised this conclusion and was more optimistic in its assessment of the potential for public health interventions. ‘Despite methodological difficulties and the length of time needed for research, there is evidence suggesting that some health promotion interventions are not only effective, but also cost-effective over both short and longer time periods’ (Wanless 2002). It quoted research findings showing that 25 percent of
all cancers and 30 percent of coronary heart disease are preventable through public health measures (McPherson 2001).

Most important, especially coming from a hard nosed banker, was a conviction that good health is good economics and that far from being a cost, investment in health is a benefit to individuals, employers and the government. Healthy communities attract investment, while unhealthy ones do not (Hunter 2002). What was required, according to Wanless, was a better balance between curing sickness on the one hand and preventing disease on the other. The review team expressed concern that perhaps too much effort and emphasis was being placed on ‘downstream’ acute care services in preference to ‘upstream’ interventions designed to maintain and improve health, and avoid or delay contact with the NHS. The Wanless review therefore gave an important and timely boost to those advocating a more assertive approach to public health interventions both inside and outside government.

The Treasury’s commitment to tackling health inequalities was reflected in the 2002 cross-cutting review published jointly by it and the Department of Health in November 2002 (HM Treasury and Department of Health 2002). Launching it in a speech to the Faculty of Public Health Medicine, the Secretary of State for Health, Alan Milburn, stated that the review committed the whole of government ‘to place tackling health inequalities at the very heart of public service delivery’ (Milburn 2002). Perhaps of greater significance given the health secretary’s preoccupation with the NHS and delivery of health care, he astonished his audience by conceding that ‘the health debate in our country has for too long been focused on the state of the nation’s health service and not enough on the state of the nation’s health’. It was time for ‘a sea change in attitudes’ and ‘to secure a better balance between prevention and treatment’.

This section has briefly reviewed the impressive volume of documentation establishing the case for rebalancing policy so that it gives proper attention and weight to health as distinct from health care. But, if there has been a common complaint running through the various policy pronouncements that have appeared since 1997 it has been that there remains an unhelpful bias in favour of the NHS and of avoiding ill health and disease rather than maintaining good health. The contribution other sectors and agencies can clearly make to the public health effort is too often overlooked or treated as an add on. It has been a recurring theme over many years and one that has been repeated ad nauseam in countless reports from numerous quarters. Hardly surprising, therefore, to find that other key stakeholders have not been engaged in ways that are essential if the wider public health agenda is to be addressed. The section below – Public health: constraints on implementation – probes a little further the implementation gap in respect of public health.

Devolution and public health policy

None of the policy documents reported above apply to Wales, Scotland and Northern Ireland. Nor is there a separate public health minister in these countries. Some documents, notably the health strategy, Saving Lives: Our Healthier Nation, and The NHS Plan have their equivalents in the other three countries. But it is still early days as far as devolution and its impact are concerned. Policy divergence is a slow process and
although some evidence for it can be seen in respect of the various policy statements produced, how far any differences will get translated into practice remains to be seen.

In contrast to England, the Welsh and Scottish Plans both open with a strong commitment to putting health first (Northern Ireland has been omitted from this discussion because its circumstances are rather different from elsewhere in the UK). But there is scepticism in some quarters over whether this really signals a break with the past. Greer, for instance, who has studied the progress of public health across the UK asserts that the English Plan is ‘primarily focused on health care services organisations’; Scotland is ‘speaking of public health but still focusing on health care services’; and Wales is ‘focusing on integrated public health activities and promotion’ (Greer 2001: 21). Both Wales and Scotland appear to be addressing the public health infrastructure deficit more directly having established new bodies dedicated to the strengthening of the public health function. Nothing comparable has emerged in England. However, as Greer also points out, it makes little sense to take England as a baseline for intra-UK comparative purposes, tempting though this may be. Including Northern Ireland, there are now four policy arenas with four health policies. Each of these arenas is likely to display a mix of convergence and divergence. Perhaps one of the more interesting developments will be the impact of devolution on English regionalism. The final section below – The future of public health – returns to this issue.

Public health: constraints on implementation

Reasons advanced for the lack of effective implementation of policies favouring public health are many and include:

- lack of clarity of the public health function especially as performed by public health medicine specialists;
- a policy stance that seems to be more symbolic and concerned with gesture politics rather than with real change;
- the absence of clear boundaries – improving health is everybody’s business (the risk being that it becomes nobody’s responsibility);
- the results of interventions to improve health take many years to take effect and it becomes difficult to establish cause and effect;
- giving the lead role for public health to the NHS which, many would claim, is preoccupied with ill health rather than health; health care services have an insatiable appetite for growth and expansion and they are where the powerful vested interests in health policy are located; and
- poor evidence about the effectiveness of public health interventions in contrast to the alleged acceptance of evidence-based medicine.

Public health: core purpose?

It is possible to contest some of these explanations, like the issue of the evidence base where comparisons with evidence-based medicine are not sensible or valid. But a key
factor in public health’s failure to deliver, it is suggested, has its roots in confusion about its core purpose and the multiple roles it is expected to perform. These are:

- health promotion, including the wider public health;
- improving the quality of clinical standards; and
- protection of public health and management of risk: communicable disease control and so on. (See Chapter 7 for more about health protection.)

The weakening of public health’s leading role in health improvement is not confined to the UK. Julio Frenk, Mexico’s Minister for Health and until recently a senior official in WHO, claims that ‘public health is experiencing a severe identity crisis, as well as a crisis of organisation and accomplishment’ (Frenk 1992: 68, my italics).

The US Institute of Medicine in 1988 claimed that ‘public health, as a profession, as a governmental activity, and as a commitment of society is neither clearly defined, adequately supported nor fully understood’ (Institute of Medicine 1988). The situation is little different throughout most of Europe.

Periodically, public health medicine has found itself at a crossroads in terms of the opportunities and challenges facing it. Yet, on each occasion, despite repeated attempts to refocus public health on its core business, the specialty has continued since the early 1970s to be buffeted by successive NHS reorganizations and has found itself more and more at the mercy of general managers who have strengthened their grip on the NHS and on its priorities. Few managers have been advocates for public health and have sought instead to use expensive clinically trained public health professionals to pursue their own agendas around evidence-based medicine, contracting, commissioning and clinical governance. For the most part, public health specialists appear to have been willing accomplices. Or, for whatever reason, they have felt unable to speak out.

Of course, all these essentially health care tasks are included in the mix of roles listed above and ascribed to public health practitioners but it is arguable whether such a complex and varied set of tasks can easily be vested in a single specialty or individual. Little wonder, then, that the practice of public health has ‘shifted uneasily between the analysis of health problems and the administration of health services’ (Berridge 1999: 45). While the commitment to tackling poor health and health inequalities may be genuine, the energy and resources appear to be directed to other more immediate and pressing concerns thereby dashing hopes of implementing national policy locally (Exworthy et al. 2002).

Too little emphasis on practice?

But there are other aspects of the public health function which have hampered implementation. There has always been a tension between public health science and public health practice. Both are essential to improving health but public health practice remains a much neglected area of the public health function. A similar conclusion is reached by Nutbeam and Wise (2002) when they assert that public health medicine has been more concerned with knowledge acquisition than with its application to
change practice. At issue here is the training available to public health trainees and
the balance between competencies and skills designed to equip them with an ability
to acquire and handle evidence on the one hand and manage change on the other.
Too little emphasis is placed on change management skills. The final section of this
chapter, on the future of public health, returns to this theme.

Insufficient joining up

Another impediment to implementation is the compartmentalization of policies
and structures mentioned earlier. The government has rightly argued that complex
problems demand complex solutions and that there is a premium on ensuring
that policy and management is joined up both horizontally across departments and
agencies, and vertically between levels of government.
The rhetoric has been impeccable, while the reality has been disappointing.
In practice, the government has approached policy and its implementation from
exactly the opposite, ‘reductionist’, point of view – breaking a problem down into
its component parts and then attempting to solve them in a linear fashion. The
accompanying preoccupation with endless targets, performance management
systems and all the other paraphernalia of modern managerialism has prevented the
very ‘joined upness’ that the government says it seeks. There is a curious mismatch
between ends and means with the chosen means almost certainly making the desired
ends less, rather than more, likely to be achieved.

Moreover, despite the mantra of ‘joined up’ policy emanating from the prime
minister’s office, the persistence of departmentalism is evident all around. Nor
is it denied within the Cabinet Office where reports from the Performance and
Innovation Unit pull few punches in their critique of the government’s approach to
implementation (Cabinet Office 2001a, b).

In particular, the Performance and Innovation Unit is critical of the linear model
of policy delivery which dominates thinking in central government (Cabinet Office
2001a). In important respects it does not describe the real world that governments
inhabit, and its application often leads to failure and frustration. The Performance
and Innovation Unit also notes that ‘too many new policies and initiatives can wreck
delivery by diverting management time – carrying out instructions gets in the way
of better outcomes’ (Cabinet Office 2001a: 6). In another report on leadership
the Performance and Innovation Unit commented on the need for ‘horizontal’ leader-
ship within and across sectors. There was a need for leaders ‘who are able to see the
whole picture, and create a common vision with other agencies’ (Cabinet Office
2001b). The emphasis on targets was criticized too, since it could ‘stifle innovation
and initiative with leaders concentrating on centrally-set targets’ to the exclusion of
more important issues affecting their organizations.

Politics and power

Finally, if there is genuine concern about implementation failure and its causes then
attention has to be given to the politics of change and the power plays that exist. It is
incorrect to allege that if only the evidence existed in regard to which interventions
worked then implementation would follow. Impediments to change often owe more to political than technical factors. ‘Unless and until we are willing to come to terms with organisational power and influence, and admit that the skills of getting things done are as important as the skills of figuring out what to do, our organisations will fall further and further behind’ (Pfeffer 1992: 12, my italics).

The future of public health

Given the present state of public health policy and the problems affecting its implementation, many of them, it has to be said, being far from new or of recent origin, this final section looks to the future and considers likely developments which will help guide and shape public health policy. Because the problems over lack of ‘joined up’ policy and organization, and the difficulties of establishing effective partnerships, are both long standing and deep seated, it is easy to be pessimistic about the future and to conclude that the government is practising a form of ‘decisionless decision making’ whereby the policy may be sound enough but fails to lead to real sustainable change. A continuation of such a style of policy making is indeed conceivable but would constitute a worst case scenario. There are many high risk elements evident in current health policy, notably the key role accorded primary care trusts (PCTs) to improve the health of their local populations. It is proving difficult for PCTs to take population health seriously when the pressures on them to deliver on the NHS acute health care agenda are so great and expectations of improved performance so high.

However, a more optimistic scenario may be envisaged, too. The Wanless Report, described earlier, may have an important bearing on future policy as it affects public health. The review developed three scenarios in order to identify the cost drivers and to help estimate the resources required to deliver a high quality health service. Of the three scenarios, the Treasury has accepted the ‘fully engaged scenario’. It contains the most significant implications for public health since it assumes it will improve dramatically with a sharp decline in key risk factors such as smoking and obesity, as people actively take ownership of their own health. ‘People have better diets and exercise much more . . . These reductions in risk factors are assumed to be largest where they are currently highest, among people in the most deprived areas. This contributes to further reductions in socio-economic inequalities in health’ (Wanless 2002: 39).

The scenario is the most optimistic of the three and therefore the most challenging. If all goes according to the model and effective public health measures are applied, then NHS spending in 2022–23 will be £154 billion. Under the least optimistic ‘slow progress’ scenario, spending will be £184 billion – a gap of £30 billion. In respect of the gain to be achieved in reduced spending on the NHS there is clearly an incentive to ensure the ‘fully engaged’ scenario becomes a reality.

Other developments might contribute to such an outcome and some of the key ones are considered briefly below.
Regionalism

The impact of regionalism in England, especially the creation of elected assemblies, could give a new focus to public health. The link between regionalism and public health is widely supported by those working in public health but has not hitherto developed particularly vigorously. There is limited evidence to suggest that regional bodies have finally discovered public health and its importance to economic regeneration. *The NHS Plan* began the process of strengthening the wider regional role. It stated

by 2002 there will be single, integrated public health groups across NHS regional offices and government offices of the regions. Accountable through the regional director of public health jointly to the director of the government office for the region and the NHS regional director, they will enable regeneration of regions to embrace health as well as environment, transport and inward investment.

(Secretary of State for Health 2000: paragraph 13.25)

The move was widely welcomed, especially by those concerned with the wider public health and keen to remove its sole locus from within the NHS. However, as was reported earlier, *The NHS Plan* unexpectedly got overtaken by *Shifting the Balance of Power* and the major restructuring of the NHS it heralded. Part of the move towards devolution was the demise of the eight NHS regions to be replaced by four directorates of health and social care that were arms of the centre, which is the Department of Health.

The regional public health function as articulated in *The NHS Plan* has survived the *Shifting the Balance of Power* changes. Regional directors of public health, relocated to each of the nine regional offices of government, are to provide the public health function. Their role is wide ranging. Among their tasks, they are to tackle the root causes of ill health and inequalities through the health component of cross-government policies in the regions (for example, transport, environment and urban regeneration). For the first time, regional directors of public health will be able to work with other government departments in the regions to build a strong health component into regional programmes.

The Minister for Public Health, Hazel Blears, told the Faculty of Public Health Medicine’s annual scientific meeting in June 2002 that the new regional arrangements ‘will help spread the influence of public health across the business of the regions . . . The co-location between public health and the other regional functions is a very exciting prospect’ (Blears 2002). Part of the appeal of the regional dimension is that it provides an opportunity to remove public health from the constant pressure on waiting lists that damages NHS public health.

A note of caution must be sounded. The remit of the regional directors of public health is very broad and, as was argued earlier, it may be asking too much of one person to perform such a range of tasks effectively. At least one senior public health practitioner now working in a regional government office has suggested that it might have been better to break down the regional role into its component parts, retaining the more medical health service elements within the NHS while confining
the new regional public health function, involving the work of the regional offices of government, to a dedicated senior post.

Finally, the future of regional government remains uncertain although the government has at last published proposals to introduce elected assemblies where there is public support for them (Department of Transport, Local Government and the Regions/Cabinet Office 2002). As in the case of the Greater London Authority, public health is not to be an executive function but an influencing one. Nevertheless, the White Paper, Your Region, Your Choice, notes that regional assembly responsibilities in the fields of housing, transport and economic development have important links with public health. It also emphasizes the need for a joined up approach to drive improvements in public health outcomes.

(See Chapters 2 and 3 for further discussion on regionalism.)

Local government

It has been a long standing complaint that local government’s significant contribution to public health – certainly greater overall than the NHS’s – has been ignored or marginalized. Despite all the talk of ‘joined up’ government local government has always played second fiddle to the NHS, which has retained its lead role on public health matters. Part of the blame lies with local government itself. The President of the Society of Local Authority Chief Executives admits that ‘local government is not very good at talking about health and the role it plays in achieving good health for its citizens’ (Duggan 2001: 4). The new policy context, especially the development of local strategic partnerships, provides ‘opportunities for local authorities to reclaim their original role as champions of the health of local communities’ (Duggan 2001).

In a significant, but little reported, development the cross-cutting spending review on health inequalities led by the Treasury and completed in July 2002 has given local authorities a lead role in achieving new targets designed to improve health and tackle inequalities (HM Treasury and Department of Health 2002).

There are also numerous examples of new joint arrangements in place where local authorities have taken the lead in exercising greater influence over public health. There are many joint directors of public health in post between the NHS and local government. In Manchester, a joint health unit has been established within the City Council by the Council and Greater Manchester Health Authority in a move to pass the lead role for public health to the local authority. These may be isolated examples but if they succeed they will point the way for others to follow.

Finally, the new local authority overview and scrutiny committees offer an opportunity for local government to assess the extent to which the NHS is concerned with improving the health of local populations rather than with treating ill health.

Europe

The concern in this chapter has principally been with developments in England although these are largely mirrored elsewhere in the UK. However, there is a European dimension which ought not to be overlooked. It is likely to become more significant in the years to come. The European Union was principally conceived to
develop a single economic market. Social policy, including health, issues have tended to receive little attention and have remained the strict preserve of member states. But recent public concern over food safety and other issues like the environment has raised the importance of public health on the EU agenda. For many years, the UK has been ‘in a state of active denial about the influence of Europe’ (Mossialos and McKee 2002: 991). This is no longer a tenable position to adopt.

Public health issues have never been accorded much prominence in the EU but the situation has begun to change for the reasons noted above and a new public health programme is close to being adopted. The proposed programme ‘takes a horizontal and policy-driven approach on the basis of a broad view of public health’ (Commission of the European Communities 2001: 2). It focuses on three strands of action:

- improving information and knowledge for the development of public health;
- responding rapidly to health threats such as those arising from communicable diseases; and
- addressing health determinants and tackling the underlying causes of ill health.

The new public health policy represents a significant departure from the EU’s approach to public health hitherto. No longer will public health be seen as a series of separate action programmes, largely disease orientated. In its place, a more structured approach linked to clearer policy objectives will be introduced (Merkel and Hubel 1999). The focus will be on health determinants, health status and health systems rather than specific diseases or conditions.

It remains to be seen how far the EU is really prepared to pursue a vigorous public health policy since to do so may conflict with the overriding aim of the EU which is the creation of a single market. Anything which could interfere with its smooth running has not been accorded priority. Yet, a change of climate about the importance of health in a well run economy does appear to have occurred. Only time will tell whether this is more than a rhetorical flourish.

(See also Chapter 3 for discussion about Europe in the future of public health.)

The management of change

Before concluding this section, there is a more general issue in regard to the success of public health which concerns the change management model the government has adopted. Its essentially mechanistic, reductionist nature is proving dysfunctional. As was suggested earlier, the transmission of policy into practice is more complex than perhaps the government appreciates or is even prepared to acknowledge. This is despite criticisms of its approach from no less an authority than the Cabinet Office, located at the heart of government. There are serious, and often neglected, issues about whether, and how, national policy can be effectively implemented locally and what needs to be in place for this to occur.

In a recent booklet from DEMOS (an independent think tank) on system failure, Chapman (2002) argues that a major impediment to ‘joined up’ management and
organization (in other words, implementation of ‘whole systems’ policy making) is the adherence to a linear rational model of policy making that is no longer a guide to the policy maker. He asserts that ‘a new intellectual underpinning for policy is required’ (Chapman 2002: 23). The complexity and breadth of the public health agenda is not in any doubt. It may therefore be more fruitful to start from this point and to view the various moves to tackle health, as distinct from ill health, as resembling a complex adaptive system (Plsek and Greenhalgh 2001). Such a system has been described as ‘a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent’s actions changes the context for other agents’ (Plsek and Greenhalgh 2001: 625). Complexity based organizational thinking is concerned with the whole system rather than with artificially viewing the system as comprising discrete parts or sectors. There is growing awareness that if sustainable progress is to be made in securing an ‘upstream’ change agenda, then moving away from current models of implementation is an essential prerequisite. However, the precise nature and shape of whatever might replace these models remains unclear.

(See also Chapter 3 on public health management and leadership.)

Conclusion

The problem in public health does not lie in the lack of sound policy but in its follow through and implementation, where progress has been less impressive. Contributing to the problem is a tendency in all health care systems for resources and effort to be concentrated on health care services. However, there is also a need for government to adopt a new model of policy and implementation if progress is to be made. Treating public health as a complex adaptive system would herald such a new approach and it would then be possible to devise new management systems and skills with which the public health workforce could then be equipped. But it is not simply a case of advocating a set of skills devoid of context. Context is all important, especially in a field like public health which transcends so many organizations and professional groups.

Unfortunately, we are some way from achieving such an outcome. But unless the capacity for public health practice is strengthened, policy in this area will for ever remain symbolic.