

Report

Documentation of Software Engineering

SWE 131

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Date : 22/12/2018

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White paper on Healthy Life.

A **white paper** is an authoritative report or guide that informs readers concisely about a complex issue and presents the issuing body's philosophy on the matter. It is meant to help readers understand an issue, solve a problem, or make a decision.

What is public health?The Faculty of Public Health defines public health as: The science and art of  
promoting and protecting health and wellbeing, preventing ill health and prolonging  
life through the organized efforts of society.  
There are three domains of public health: health improvement (including people’s  
lifestyles as well as inequalities in health and the wider social inﬂuences of health),  
health protection (including infectious diseases, environmental hazards and emergency  
preparedness) and health services (including service planning, efficiency, audit and  
evaluation).

How healthy and well are we overall? People in Bangladesh are less healthier and are not living longer than ever. Overall, we can’t enjoy safe air and water, and are well protected from environmental hazards. We also  
have systems in place to prepare for and respond to new threats such as pandemic  
ﬂu. However, there are substantial inequalities in health across the country – as  
there are in other wealthy countries.

Seizing opportunities for better health

Public health has formidable achievements to its name: clean air and water,

enhanced nutrition and mass immunisation have consigned many killer diseases to

the history books. There are huge opportunities to go further and faster in tackling

today’s causes of premature death and illness. People living in the poorest areas

will, on average, die 7 years earlier than people living in richer areas and spend

up to 17 more years living with poor health. They have higher rates of mental

illness; of harm from alcohol, drugs and smoking; and of childhood emotional and

behavioural problems. Although infectious diseases now account for only 1 in 50

deaths, rates of tuberculosis and sexually transmitted infections (STIs) are rising

and pandemic flu is still a threat.

8.

A fuller story on the health of England is set out in

Our Health and Wellbeing

Today

, published to accompany this White Paper. The opportunity – and the

challenge – is stark, for example:

a.

By improving maternal health, we could give our children a better start in life,

reduce infant mortality and the numbers of low birth-weight babies.

b.

Taking better care of our children’s health and development could improve

educational attainment and reduce the risks of mental illness, unhealthy

lifestyles, road deaths and hospital admissions due to tooth decay.

c.

Being in work leads to better physical and mental health, and we could save the

UK up to £100 billion a year by reducing working-age ill health.

4

d.

Changing adults’ behaviour could reduce premature death, illness and costs

to society, avoiding a substantial proportion of cancers, vascular dementias

and over 30% of circulatory diseases; saving the NHS the £2.7 billion cost of

alcohol abuse; and saving society the £13.9 billion a year spent on tackling

drug-fuelled crime.

e.

We could prevent many of the yearly excess winter deaths – 35,000 in 2008/09

–

through warmer housing, and prevent further deaths through full take-up of

seasonal flu vaccinations.

A radical new approach

9.

The current approach and system is not up to the task of seizing these huge

opportunities for better health and reduced inequalities in health. This White Paper

sets out a radical new approach that will empower local communities, enable

professional freedoms and unleash new ideas based on the evidence of what works,

while ensuring that the country remains resilient to and mitigates against current

and future health threats. It sets out how our approach will:

a.

protect the population from health threats – led by central government, with a

strong system to the frontline;

b.

empower local leadership and encourage wide responsibility across society

to improve everyone’s health and wellbeing, and tackle the wider factors that

influence it;

c.

focus on key outcomes, doing what works to deliver them, with transparency

of outcomes to enable accountability through a proposed new public health

outcomes framework;

d.

reflect the Government’s core values of freedom, fairness and responsibility by

strengthening self-esteem, confidence and personal responsibility; positively

promoting healthy behaviours and lifestyles; and adapting the environment to

make healthy choices easier; and

e.

balance the freedoms of individuals and organisations with the need to avoid

harm to others, use a ‘ladder’ of interventions to determine the least intrusive

approach necessary to achieve the desired effect and aim to make voluntary

approaches work before resorting to regulation.

10.

This approach will:

reach across and reach out

– addressing the root causes of

poor health and wellbeing, reaching out to the individuals and families who need

the most support – and be:

•

responsive

– owned by communities and shaped by their needs;

•

resourced

– with ring-fenced funding and incentives to improve;

•

rigorous

– professionally-led, focused on evidence, efficient and effective; and

•

resilient

– strengthening protection against current and future threats to health.

Health and wellbeing throughout life

11.

The Government is radically shifting power to local communities, enabling them

to improve health throughout people’s lives, reduce inequalities and focus on the

needs of the local population. This White Paper highlights local innovation and

outlines the cross-government framework that will enable local communities to

reduce inequalities and improve health at key stages in people’s lives, including:

a.

empowering local government and communities, which will have new

resources, rights and powers to shape their environments and tackle local

problems;

b.

taking a coherent approach to different stages of life and key transitions instead

of tackling individual risk factors in isolation. Mental health will be a key

element, and we will shortly publish a new mental health strategy;

c.

giving every child in every community the best start in life. We will do this

through our continued commitment to reduce child poverty, by investing to

increase health visitor numbers, doubling by 2015 the number of families

reached through the Family Nurse Partnership programme, and refocusing

Sure Start Children’s Centres for those who need them most. An Olympic and

Paralympic-style sports competition will be offered to all schools from 2012;

d.

making it pay to work through our comprehensive welfare reforms, creating

new jobs through local growth and working with employers to unleash their

potential as champions of public health;

e.

designing communities for active ageing and sustainability. We will make

active ageing the norm rather than the exception, for example by building

more Lifetime Homes, protecting green spaces and launching physical activity

initiatives, including a £135 million Lottery investment in a Mass Participation

and Community Sport legacy programme. We will protect and promote

community ownership of green spaces and improve access to land so that

people can grow their own food; and

f.

working collaboratively with business and the voluntary sector through

the Public Health Responsibility Deal with five networks on food, alcohol,

physical activity, health at work and behaviour change. We plan to launch the

Deal in early 2011 and expect to be able to announce agreements on further

reformulation of food to reduce salt; better information for consumers about

food; and promotion of more socially responsible retailing and consumption of

alcohol. It will also develop the Change4Life campaign, for example through

the ‘Great Swapathon’, £250 million of partner-funded vouchers to make

healthy lifestyle choices easier.

A new public health system with strong local and national leadership

12.

To support this new approach and avoid the problems of the past, we need to

reform the public health system. Localism will be at the heart of this system, with

responsibilities, freedoms and funding devolved wherever possible; enhanced

central powers will be taken where absolutely necessary, for example in areas such

as emergency preparedness and health protection. Within this system:

a.

Directors of Public Health will be the strategic leaders for public health and

health inequalities in local communities, working in partnership with the local

NHS and across the public, private and voluntary sectors. The Government

will shortly publish a response to the recent consultation on proposed new

local statutory health and wellbeing boards to support collaboration across the

NHS and local authorities in order to meet communities’ needs as effectively

as possible.

b.

A new, dedicated, professional public health service – Public Health England

–

will be set up as part of the Department of Health, which will strengthen the

national response on emergency preparedness and health protection.

c.

There will be ring-fenced public health funding from within the overall NHS

budget to ensure that it is not squeezed by other pressures, for example NHS

finances, although this will still be subject to the running-cost reductions and

efficiency gains that will be required across the system. Early estimates suggest

that current spend on areas that are likely to be the responsibility of Public

Health England could be over £4 billion.

d.

There will be ring-fenced budgets for upper-tier and unitary local authorities

and a new health premium to reward them for progress made against elements

of the proposed public health outcomes framework, taking into account health

inequalities.

e.

The core elements of the new system will be set out in the forthcoming Health

and Social Care Bill and will therefore be subject to Parliament’s approval.

f.

The best evidence and evaluation will be used, supporting innovative

approaches to behaviour change – with a new National Institute for Health

Research (NIHR) School for Public Health Research and a Policy Research

Unit on Behaviour and Health. There will be greater transparency, with data on

health outcomes published nationally and locally.

g.

The Chief Medical Officer will have a central role in providing independent

advice to the Secretary of State for Health and the Government on the

population’s health. He or she will be the leading advocate for public health

within, across and beyond government, and will lead a professional network for

all those responsible for commissioning or providing public health.

Making it happen

13.

We are implementing our strategy to make early and substantial progress, so that

we make a real difference to health from the earliest opportunity. Subject to the

passage of the Health and Social Care Bill, the Government plans to:

a.

enable the creation of Public Health England, which will take on full

responsibilities from 2012, including the formal transfer of functions and

powers from the Health Protection Agency (HPA) and the National Treatment

Agency for Substance Misuse (NTA);

b.

transfer local health improvement functions to local government, with ring-

fenced funding allocated to local government from April 2013; and

c.

give local government new functions to increase local accountability and

support integration and partnership working across social care, the NHS and

public health.

14.

The transition to Public Health England will be developed in alignment with

changes to Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs),

and the creation of the NHSCB. The detailed arrangements will be set out in a

series of planning letters throughout the course of 2011.

15.

To get the details of the new system right and ensure that it delivers significant

improvements to the health of the population, we will be consulting on some

elements. A number of consultation questions are set out in Chapter 4 and

summarised in Chapter 5 of this White Paper, and we would welcome your views.

The consultation on these questions closes on 8 March 2011.

16.

The Department of Health has published a review of the regulation of public health

professionals by Dr Gabriel Scally. A consultation question about this is in Chapter 4

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Wider factors influencing health, wellbeing and health inequalities

Our health and wellbeing is influenced by a wide range of factors – social, cultural,

economic, psychological and environmental – across our lives. These change as

we progress through the key transition points in life – from infancy and childhood,

through our teenage years, to adulthood, working life, retirement and the end of

life. Even before conception and through pregnancy, social, biological and genetic

factors accumulate to influence the health of the baby.

Seizing opportunities for better health

Health inequalities – the evidence

the independent review of health inequalities

in England commissioned by government and undertaken by Professor Sir Michael

Marmot of University College London, sets out the implications of health inequalities.

It makes it clear that material circumstance, social environment, psychosocial factors,

behaviours and biological factors are all important influences on health. In practice,

this means that in order to tackle health inequalities, we need to consider the much

broader context of our lives. For instance, helping people into work can be very good

for health. It provides not only income, but also – importantly – a stake in society.

Early child development and educational attainment are also crucial for future health

and wellbeing, as well as improving job opportunities and providing

a route out of poverty.

While on the whole we are living longer than ever before, people’s health and

wellbeing varies significantly across England. And there is a social gradient of

health – the lower a person’s social position, the worse his or her health. People in

disadvantaged areas are more likely to have shorter life expectancy and experience

a greater burden of ill health – and there are differences in life expectancy and

expectancy of life in good health across the socioeconomic spectrum. This inequality

is driven by the underlying social factors that affect people’s health and wellbeing –

‘the causes of the causes’.

The Marmot Review states there are gaps of up to 7 years in life expectancy between

the richest and poorest neighbourhoods, and up to 17 years in disability-free life

expectancy (see Figure 1.2). It also highlights wide variation within areas; for instance

in London, in one ward in Kensington and Chelsea, a man now has a life expectancy

of 88 years, compared with 71 years in Tottenham Green, one of the capital’s poorer

wards. Low income and deprivation are particularly associated with higher levels of

obesity, smoking, mental illness and harms arising from drug and alcohol misuse.

Protected equality characteristics can also have an impact on health. Evidence shows

that inequalities based on race, disability, age, religion or belief, gender, sexual

orientation and gender identity can interact in complex ways with socioeconomic

position in shaping people’s health. Some vulnerable groups and communities, for

example people with learning disabilities or travellers, have significantly poorer life

Health and wellbeing challenges through life

Starting well

The health and wellbeing of women before, during and after pregnancy is a critical

factor in giving children a healthy start in life and laying the groundwork for good

health and wellbeing in later life.

Healthy Lives, Healthy People: Our strategy for public health in England

Improving maternal mental health could lead to better outcomes in childhood.

Maternal depression and anxiety in pregnancy and during a child’s early life

affects about 10–15% of pregnant women.

Rates are nearly twice as high among

mothers living in poverty and three times as high for teenage mothers, and are

associated with low birth weight, emotional or conduct disorders and children’s

later intellectual development.

In one study, the children of women who were depressed at 3 months after giving

birth had significantly lower IQ scores at 11 years. They also had problems with

attention, had difficulties in mathematical reasoning, and were more likely than

other children to have special educational needs.

There has been substantial progress in reducing infant deaths. In 2008, the infant

mortality rate was the lowest ever recorded in England, with fewer than 5 deaths

per 1,000 live births in England compared with 18 deaths per 1,000 live births in

However, these rates are higher than in comparable European countries

and infant mortality is a key indicator of wider health inequalities. There is a 70%

gap in infant mortality between the richest and poorest groups, and rates for some

ethnic groups are almost twice the national average.

There are opportunities to reduce infant mortality further by tackling maternal

obesity (around 1 in 5 mothers could be overweight or obese);

increasing

breastfeeding rates (England has one of the lowest rates in Europe and the current

prevalence of breastfeeding at 6-8 weeks is 46.2%

and decreasing smoking in

pregnancy (more than 1 in 6 mothers smoke during pregnancy

. Smoking rates

during pregnancy are much higher among lower socioeconomic groups

teenage mothers.

A total of 1 in 14 babies in the UK have a low birth weight (which is associated

with immediate and longer-term health consequences for babies), a higher rate

than the average for EU15 and EU27 countries.

This could also be improved by

reducing smoking during pregnancy.

Children’s development is crucial for their future health and wellbeing and better

early years support could make a big difference. Good parent–child relationships

help build children’s self-esteem and confidence and reduce the risk of children

adopting unhealthy lifestyles. A total of 1 in 10 children are estimated to have

emotional or behavioural problems,

which increase the risk of poor health and

wellbeing both in childhood and later life.

Developing well

There are opportunities to reduce road accidents – the leading cause of accidental

death and injury of children in the UK, resulting in almost 21,000 injuries in

There are strong social and regional variations, so this lends itself to a

tailored local approach.

Progress is being made in tackling childhood obesity – the rise among 2–10-year

-

olds from 1 in 10 children in 1995 to almost 1 in 7 in 2008 appears to be levelling

off.

However, more than 1 in 5 children are still overweight or obese by age 3.

Rates are higher among some black and minority ethnic (BME) communities and

in lower socioeconomic groups.

Through social networks, obesity can actually be ‘spread’ by person-to-person

interaction. Social norms affect other health areas too: if more than half of a

student’s social network smoke, then that student’s risk of smoking doubles.

Teenagers and young people are among the biggest lifestyle risk-takers. About 1 in

5 young adults say they have recently used drugs, mostly cannabis.

Rates of STIs

such as chlamydia are increasing, with 15–24-year-olds the most affected group.

Around 1 in 10 of the people who get an STI will become re-infected within a

year.

Teenage conceptions are at a 20-year low (40 cases per 1,000 under 18s),

but are still high compared with Western Europe.

Teenage years are a crucial time for health and wellbeing in later life. Half of

lifetime mental illness (excluding dementia) starts by the age of 14.

More than

8 out of 10 adults who have ever smoked regularly started smoking before 19,

and one study found that 8 in 10 obese teenagers went on to be obese as adults.

Around 1 in 3 young adults drink to the point of drunkenness, the highest rates

among any age group.

50

Accidents due to alcohol (including drink-driving

accidents) are the leading cause of death among 16–

Many premature deaths and illnesses could be avoided by improving lifestyles.

It is estimated that a substantial proportion of cancers

and over 30% of deaths

from circulatory disease

could be avoided, mainly through a combination of

stopping smoking, improving diet and increasing physical activity.

Reducing smoking rates represents a huge opportunity for public health – smoking

is the single biggest preventable cause of early death and illness. There are

2 million fewer smokers now than a decade ago, but 1 in 5 adults still smoke.