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**REPORT:02**

**White paper on Healthy Life.**

Course title:Documentation of Software Engineering

Course code: SWE-131

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Semester:Fall-2018 Date:22/12/2018

**Contents**

**Executive Summary:**

1.Our strategy for public health in England.

2.Seizing opportunities for better health.

3.A radical new approach.

4.Health and wellbeing throughout life.

5.A new public health system with strong local and national leadership.

6.Making it happen.

7.A vision for the role of Director of Public Health.

8.Conclusion.

Our strategy for public health in England:

The Government produced a white paper entitled Healthy Lives, Healthy People – Our strategy for public health in England. In brief, the White Paper outlines plans for much greater localisation in the delivery of public health services. ... strengthened focus on public health issues in the education and training of GPs.

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.

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:

1.

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.

2.

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.

3.

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.

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.

5.

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:

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:

1.

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

strong system to the frontline;

2.

empower local leadership and encourage wide responsibility across society

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

influence it;

3.

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;

4.

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

5.

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.

6.

This approach will:

reach across and reach outaddressing 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;

rigorousprofessionally-led, focused on evidence, efficient and effective; and

resilientstrengthening protection against current and future threats to health.

Health and wellbeing throughout life:

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:

1.

empowering local government and communities, which will have new

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

problems;

2.

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;

3.

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;

4.

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;

5.

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

6.

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:

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:

1.

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.

2.

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.

3.

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.

4.

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.

5.

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.

6.

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.

7.

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:

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:

1.

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);

2.

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

fenced funding allocated to local government from April 2013; and

3.

give local government new functions to increase local accountability and

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

public health.

4.

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.

5.

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.

6.

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

of this White Paper. We would welcome views on this report.

7.

Forthcoming consultation documents will set out the proposed public health

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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.

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 cancersand over 30% of deaths

from circulatory diseasecould 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.

Conclusion:

The realisation is growing that changing our diet can have an enormous impact on health – for better or worse. But what constitutes healthy food – and unhealthy – is not universally agreed and seems to change on a weekly basis. Cow’s milk is vigorously defended by the dairy industry and they have managed to turn it into a national icon. Woe-betide anyone who challenges their sacred cow. Not surprisingly, the resulting controversy is confusing. On the one hand consumers are told that milk is essential for good bone health while on the other, that it causes allergies, illness and disease.

Of course we need calcium for bones and teeth as well as blood clotting, muscle function and regulating the heart’s rhythm. But no matter how loudly the dairy industry shouts, an increasing body of evidence begs the question: is cow’s milk really the best source of calcium? It certainly is not for most of the world’s people. Claims that dairy is best carry strong overtones of cultural imperialism and simply ignore the 70 per cent of the global population who obtain their calcium from other sources – people such as the Japanese who traditionally have consumed no dairy yet have far better health than British people and live considerably longer.

Milk has been part of the human diet for less than 8,000 years – this is very recent in evolutionary terms. It is not just that most people don’t drink it – they cannot because their bodies will not tolerate it. Up to 100 per cent of some ethnic groups are lactose intolerant. It’s obvious that the claims made for milk ignore the research and owe more to marketing hype than science.

The dairy industry has spent many years and many millions promoting the notion that cow’s milk is good for us through expensive advertising campaigns such as the ‘White Stuff’ – fronted by the milk-moustachioed celebrity, Nell McAndrew. Now, because of an increasing body of evidence, there are signs of a growing realisation that milk is neither natural nor healthy.

The very people who are most aggressively targeted by the dairy industry – the young – are those most at risk of being damaged by milk. It is not just the few per cent under the age of one who will develop allergies but those likely to develop type 1 diabetes from cow’s milk infant formula. The evidence is convincing even though the mechanism may not yet be fully understood. This is not the time to be withdrawing support from the midwives and infant feeding coordinators, who encourage breastfeeding in parts of the country with the lowest uptake.