

**Report**

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White Paper on Healthy Life

***Executive Summary***

This is a new era for public health, with a higher priority and dedicated resources. This White Paper outlines our commitment to protecting the population from serious health threats; helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest, fastest.

It responds to Professor Sir Michael Marmot's 'Fair Society, Healthy Lives' report and adopts its life course framework for tackling the wider social determinants of health. The new approach will aim to buid people's self-esteem, confidence and resilience right from infancy -with stronger support for early years. It complements 'A Vision for Adult Social Care: Capable Communities and Active Citizens' in emphasizing more personalized, preventive services that are focuses on delivering the best outcomes for citizens and that help to build the Big Society.

The goal is a public health service that achieves excellent results, unleashing innovation and liberating professional leadership. This White Paper builds on 'Equality and Excellence: Liberating the NHS' to set out the overall principles and framework for making this happen.

Subject to Parliament, local government and local communities will be at the heart of improving health and wellbeing for their populations and tackling inequalities. A new integrated public health service - Public Health England - will be created to ensure excellence, expertise and responsiveness, particularly on health protection, where a national response is vital.

During 2011, the Department of Health will publish documents that build on this new approach, including on mental health, tobacco control, obesity, sexual health, pandemic flu preparedness, health protection and emergency preparedness, together with documents from other government departments addressing many of the wider determinants of health.

The proposals in this White Paper apply to England but the Department of Health will work closely with the Devolved Administrations on shared areas of interest.

***COMMENTS ON DEPARTMENT OF HEALTH  
WHITE PAPER: HEALTHY LIVES, HEALTHY PEOPLE - OUR STRATEGY FOR PUBLIC HEALTH IN ENGLAND***

The Royal College of Physicians of Edinburgh welcomes the opportunity to respond to the White Paper on *Healthy Lives, Healthy People*– the strategy for Public Health in England.

This College has as many Fellows and members working in England as in Scotland, and its content will therefore be of interest to many. In addition, several public health measures contained in this strategy are reserved matters and therefore affect the whole of the UK. For this reason, the strategy relates to interests of this College across the Government’s remit for the UK in these respects. The strategy proposes a radical departure from previous approaches to public health strategy. It addresses many current public health challenges and shifts the balance of emphasis towards individuals and communities, a crucial element of any public health strategy. However, the strategy must recognise the leadership role of Government, and of political will, in facilitating change and improving health and the social determinants of health. Therefore, while the general direction of strategy is welcome, a number of questions are left unanswered.

***A welcome set of proposals:***

The RCP Edinburgh strongly welcomes the cross-Government, life-course approach to public health and the establishment of a Public Health Service with a ring-fenced budget.

It also welcomes the strong emphasis on public health. However, it would be reassuring to see the standard definition of public health stated early in the document:

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals".

It supports the commitment to improving the health of the poorest, fastest. This includes broad interventions to decrease poverty, because over 90% of ill health is attributable to factors outside the NHS. Furthermore, dedicated interventions and awareness campaigns are needed for those who suffer disproportionately from cardiovascular disease, including some black and minority ethnic groups

To protect population health, particularly children and young people, and to create an environment that supports and enables healthy choices, behaviour change approaches and voluntary action by industry must be part of a much wider government strategy that includes regulation and legislation.

While the College supports the commitment to empowering communities, national oversight and accountability are essential. Independent and open access to performance data, including the Public Health Outcomes Framework, will be crucial to enabling scrutiny and accountability and facilitating the sharing of best practice and effective innovation

Directors of Public Health (D.Ph.) must have the independence, authority and resources to be effective local leaders and to drive improvement in all policy areas that have a bearing on health and health inequalities

It agrees that close partnership working will be essential between Public Health England and the NHS Commissioning Board, and between DsPH in local authorities and GP Commissioning Consortia

Patients, the public and voluntary sector organisations should be involved in needs assessment and throughout the commissioning cycle.

***The College’s Concerns:***

To what extent is the Government diminishing its own role in leadership, regulation and legislation for health?

To what extent is it weakening the public health function by, once again, reorganizing, while simultaneously highlighting the need for a strong and integrated set of arrangements?

What is the relationship between the current strategic intentions and reduction of health and inequalities which still is a prime policy objective?

The strategy has not addressed these issues, while the whole breadth of Government action influences the public health of the country. This strategy does not bring together the Government’s commitment to fiscal and other legislative matters that could be vital ingredients, and that are so important in this area.

***Detailed comments on the Government’s Strategic Proposals:***

*Background:*Discussion of structural changes to public health organization in England inevitably follows the Government’s proposed reforms to the rest of the NHS in England. These will generate major disruption.

Some discussion of concerns regarding the wider NHS forms is therefore necessary.

*History is repeating earlier mistakes:*Early in the days of the last Labor Government, in the late 1990s, Primary Care Groups (PCGs) were established in England; these were commissioning bodies largely run by general practitioners (GPs). Very soon they were found to be too small to be able to commission effectively, as NHS hospitals were much larger and more powerful organizations. So these PCGs were amalgamated into larger PCTs in 2002, and employment of public health staff passed from health authorities (HAs) to these new PCTs. In turn, these PCTs were also shown to be still too small, and in 2006 were amalgamated into much larger PCTs, which looked rather similar to the original HAs of the 1990s! So public health departments had to reform themselves within new organizations twice within five years. Their performance was substantially impaired on each occasion.

Each previous NHS reorganization produced substantial disorganization and demotivation that lasted at least two years. The negative effects on the organization’s efficiency and morale of the NHS were therefore considerable. The NHS is one of the most effective and efficient health care systems in the world. The idea of simultaneously trying to extract £20billion savings while uplifting the biggest reform in three decades defies logic.

The current coalition government intends to abolish PCTs, and to devolve commissioning of most health services to consortia of GPs. These emerging consortia are already becoming recognizably similar to the PCGs of 12 years ago. We appear destined to be forced to tread the same path again, to re-learn that commissioning bodies have to be larger than is being proposed. An even earlier cycle of such reform was initiated by the Conservative Government of the early 1980s, when larger Area Health Authorities (AHAs) were abolished, to make way for very much smaller District Health Authorities (DHAs). These were in turn found to be much too small to be effective, and they were required to merge to form much larger HAs.

If it is now planned that PCTs should be abolished, public health departments will therefore need a new home, as “commissioning groups” will be too small to provide this (as were PCGs before them). So PCTs are to be transferred to local authorities (to the larger tier, where there are two tiers of local government), taking their budgets with them, supposedly “intact”. However, various PCT chief officers are concerned that PCTs, before they give up their public health departments, will have relieved them of responsibility for as many funding streams as possible, so that these can contribute to PCT “savings”. The Public Health White Paper describes how this should occur, and indicates some of the main public health challenges which the Government envisages will face the new local government-based departments, and how they might be structured to deal with these. It also indicates some of the public health solutions which the Government hopes may be adopted in the future.

***Pros and Cons of Locality based Public Health****:*There are both positive and negative aspects of the proposal to move public health to local government. The positive aspects are about the advantages of a local authority base – not a new idea for public health, as this is where public health was based until 1974. NHS PCT-based public health departments had to collaborate closely with matching local authorities, as so many public health and local government services interact with each other’s. Indeed, several directors of public health have, for some years past, been appointed to joint posts that straddle local authorities and PCTs. Such relationships should become much easier in the future proposed arrangements, and services may be able to collaborate more efficiently than hitherto.

The negative aspects surround the break-up of established PCT-based departments. These departments, operating since 2006, have just begun to function effectively, and with funding increases to support adequate public health data analysis and health promotion (or health improvement, as it is often called nowadays), have become able to achieve adequate critical mass to enable them to work really well. Their destruction will be a significant loss to effective health improvement in England.

However, the change will not “set public health free”. Public health departments in PCTs were often fairly criticized for too readily adopting NHS agendas. This was often at the expense of ignoring more major challenges outside the immediate reach of health services. If the proposals are enacted, Public health departments will now inevitably be dragged into the adoption of agendas that are set in the context of local government, its problems, perceptions, and services. It will probably be no easier for directors of public health to demonstrate independence of thought and action than it was within the NHS.

***The Public Health Function needs an Independent Voice****:*The White Paper proposes that they should share accountability to both the local authorities which employ them, and to the Department of Health (or perhaps to new “wholly-owned subsidiary” to be called “Public Health England”). Ironically, this is proposed by a Government supposedly supportive of the “devolution of power and authority” away from the centre! Furthermore, will DPHs (or D.Ph.?) be free to lead their departments in practicing genuinely science-based public health? There are inconsistencies and paradoxes in this approach.

The current Secretary of State has stated his opposition to what he calls “annoying legislation”. This is what others might call effective public health leadership. Previous impressive examples include clean drinking water, effective public sanitation, legislation to ban tobacco advertising, smoke-free indoor public areas, compulsory wearing of seatbelts, plus elimination of asbestos from workplaces, and arsenic from food etc. Health education itself was found to be largely ineffective over forty years ago (eg the people kept on smoking). It only became effective when supported by environmental changes (often legislative ones) which made healthy choices easier. However, the current Secretary of State opposes all such modifications of the physical and social environment in the interests of public health. His White Paper instead advises public health departments instead to “nudge” populations towards healthier lifestyles. On its own, this is a flawed and ineffective strategy, lacking supporting evidence and much criticized in recent papers in the BMJ and Lancet.

***Conflicts of Interest:***Another very worrying sign is the willingness of the Government to invite major food industry firms to work with the Health Department on “healthy nutrition initiatives” as part of the Responsibility Deals. There are clear worries about blatant conflicts of interest, based on past business loyalties.

***Evidence Based Policy:*** The recent NICE CVD Prevention report reviewed extensive evidence. The most effective policy levers are legislation, regulation tax and subsidies.

These have all been explicitly ruled out as “Departmental Diktats”. Instead, voluntary agreements are being developed. These were evidently ineffective during forty years of failed tobacco control. More recently voluntary agreements have been proven equally ineffective in promoting healthier diets in the USA and in Europe. Public health science runs a grave risk of being left outside the new public health service in England. This is reminiscent of the Conservative Government of the early 1980s and its suppression of the Black Report, that potently exposed social inequalities in health.

Recent events are worryingly similar. In December 2010, the Government cancelled over a dozen ongoing and planned NICE Public Health reviews. These covered key topics such as work on obesity.

The UK government has also told the National Institute for Health and Clinical Excellence (NICE) to suspend its work on the prevention of obesity using a ‘whole-systems’ approach at local and community level.

NICE has also been told not to start work on several programmes that were being prepared, including:

Increasing fruit and vegetable provision for disadvantaged communities

Identification and management of overweight and obese children in primary care

Developing transport policies that priorities walking and cycling

Using the media to promote healthy eating: guidance for policy makers, food retailers and the media

Identification and weight management for overweight and obese children: community based interventions

***Proposals for the Public Health Function****:*Service public health in UK has three main sub-specialties: health promotion, health protection, and planning and evaluation of health services. Consideration of each of these in the context of the reforms proposed:

***Health promotion****:* “health improvement” departments will move to local authority departments, and directors of public health will retain responsibility for these services; here the future seems reasonably clear.

*Health protection* *(mainly environmental health and communicable diseases control)*: most of the consultants (and other staff) working in this field are employed by the HPA. This however is to be disbanded; how services will be reorganised accordingly is far from clear.

*Health service planning and evaluation*: this will be the field of the new GP-led “commissioning consortia”. Will they invite the assistance of those individuals with a mass of experience and expertise: public health consultants, hospital consultants, and other stakeholders, into their work and discussions? Again, the future is far from clear.

***CONCLUSIONS***

This public health White Paper has some merits, but it does appear to preface:

Uncontrolled marketing and consumption of damaging amounts of junk food and sugary drinks;

Major disruption of currently effective public health departments and services;

Impoverishment of successor departments through pressure and erosion of their budgets;

Reduction of local accountability of public health departments and their directors;

Removal of parts of the scientific basis for public health practice from practical application;

Slowing the rate of improvement of health status in English communities;

Increasing inequalities in health.

In response to the Questions of the White Paper

This College welcomes the central engagement of primary health care as an influence in public health. The governance of GP commissioning and GP consortia will influence the extent of the real engagement with the public and services users, with patients as co-producers of health. This line of accountability for the performance of GP consortia, their priorities and delivery of care together with influence and determinants of health, is a crucial aspect of the strategic proposals. Additional ways, therefore, must include governance and accountability, harnessing all available skills for pollution-based health; secondary outcome-based objectives for GPs and GP practices in respect of public health; including the many objectives in the reduction of specific inequalities that are relevant to national policy and local circumstances; harnessing around GPs and GP practices core public health capacity and skills, with suitable expertise. Public health specialists should be at the core of primary care organisations, GP practices etc.

The best opportunities should be enshrined in clear strategy, sustained investment which bears the fruits of political courage and reasonable resources. Strategic leadership should be in touch with networks of many stakeholders including the academic and public health leadership communities, interested lay organisations and civil society. There are firm foundations and engage a vibrant capability across the UK with respect to public health research. It is always a challenge to shorten the distance between the knowledge creation, evidence, implementation, policy and then practice. The White Paper must respond to the challenge that public health science presents, and seek to apply it.

The pursuit of improved public health is not exclusively a matter for Government, or the individual or community. It is an integrated and sustained endeavour. The role of the individual in community could well be enhanced through this strategy. However, cultural change, empowerment and involvement at local levels are more important than structural change which, by itself, will not achieve the ambitions of this strategy. Public debate on evidence, and shifting consensus to take the UK into the environment of “pro-health culture” could be the vital contribution forward for public health at this stage. This will require concerted efforts of Government, the public health community, NHS leaders including those in general practice, and the wider society in order to achieve these gains. These are where the important current gaps lie, in our view.