Saving Lives: Our Healthier Nation

Presented to Parliament by the

Secretary of State for Health

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Contents

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Initiatives in this White Paper

on this site.

1 Better health: a new approach

1.1 England is a rich country - rich in its people, rich in its resources, rich in innovation, rich in its values, rich in its history, rich in its future. Yet in this rich country, not everyone has an equal chance of healthy life. Too many people suffer from poor health. Too many people are ill for much of their lives. Too many people die too young from preventable diseases.

'the opportunity of saving as many as 300,000 lives'

1.2 *Saving lives: Our Healthier Nation* is an action plan for tackling poor health and improving the health of everyone in England, especially the worst off.

1.3 We believe that if we can achieve the bold objectives we are setting we have the opportunity of saving as many as 300,000 lives over the next 10 years.

1.4 But to do that, we have to tackle the four main killers - the illnesses which, together with accidents, play the greatest part in causing preventable deaths and ill-health: cancer, coronary heart disease and stroke and mental illness. Together they account for more than 75 per cent of all the people who die before the age of 75 years. Combating these killers will not end them: they will still cut into people's lives and the lives of their families. But we can reduce their impact.

'We will achieve what no previous Government has achieved'

1.5 So we are setting new, tougher and challenging targets in each of these priority areas. By 2010:

- **Cancer**
  reduce the death rate from cancer in people under 75 by at least a fifth - saving 100,000 lives
- **Coronary heart disease and stroke**
  reduce the death rate from coronary heart disease and stroke and related diseases in people under 75 by at least two fifths - saving 200,000 lives
- **Accidents**
  reduce the death rate from accidents by at least a fifth and
  to reduce the rate of serious injury from accidents by at least
  a tenth - saving 12,000 lives
- **Mental health**
  reduce the death rate from suicide and undetermined injury by at least a fifth - saving 4,000 lives

1.6 These are ambitious targets. But they are achievable - and we
are committing ourselves to make steady progress towards achieving them.

1.7 We believe we can succeed in this ambition. We believe we can make a difference. We have the principles and programmes in place which will achieve what no previous Government has achieved:

'to attack the breeding ground of poor health - poverty and social exclusion'

- **Funding.** We are investing more money than ever before in encouraging a healthier population. Up to £110 million into helping people give up smoking. £300 million through the National Lottery into healthy living centres. £290 million into health action zones. £54 million into *NHS Direct*. And an extra £96 million to support the implementation of this White Paper through a new *Public Health Development Fund*. These specific areas of investment are underpinned by the extra £21 billion on health which we made available through the Comprehensive Spending Review.

- **Integration.** We believe in working across Government to attack the breeding ground of poor health - poverty and social exclusion - and we believe in creating strong local partnerships with local authorities, health authorities and other agencies to tackle the root causes of ill-health in places where people live.

- **Standards.** We believe in high standards for all, not just a privileged few. We believe that good health, like good education, should be within reach of all. Government should help people to achieve it and in turn individuals have a responsibility to do all they can to live a healthy life.

- **Health service.** We are re-activating a dormant duty of the NHS - to promote good health, not just treat people when they fall sick. That means a new role for primary care staff; improved screening services; better co-ordinated health research; a stronger public health workforce; new local initiatives - including the revolutionary *NHS Direct* which will provide rapid access to information and help for the entire population.

- **New public health.** We are establishing a Health Development Agency to ensure that organisations and individual practitioners build their work on the highest standards and raise the quality of public health in England.

- **Smoking.** Unlike previous Governments we believe in tackling head on the single biggest preventable cause of poor health.

'good health, like good education, should be within reach of all'

1.8 These are the building blocks for our new policy for improving the health of our population. They require individuals, communities, local organisations and Government to contribute to meeting the targets in a three-way partnership. Better health is the prize.

Better health

1.9 Good health is fundamental to all our lives. We all treasure our own health, and the health of our families and friends. Good health is the bedrock on which we build strong families, strong communities and a strong country.

'If people are healthier, their demands on the health service will be less than they would have been'

1.10 When we enjoy good health, we are able to make the most of the opportunities life has to offer. We can play a full part in our working lives, our family lives and our community lives. Nothing is more precious to most of us than our health.

1.11 Yet we tend to take health for granted - until something goes wrong. Then we look for help - to doctors, to nurses and to hospitals. In Government we are determined to make the modern NHS ready and able to respond to what people need from it.

1.12 But the better everyone's health is, the greater the ability of the NHS to use its resources to best effect. If people are healthier, their demands on the health service will be less than they would have been - leaving resources and facilities available for those who need them more.

1.13 Improving health is about more than just treating people when they become ill. Better health is vital in itself, leading directly to longer, more active and more fulfilled lives.

1.14 Many people are already taking the initiative to safeguard and improve their health. They are increasingly aware of the

importance of a better diet, of the value of physical activity, of the benefits of taking proper care of themselves and their families. The enthusiasm of many for improving their health is clearly reflected in the increased levels of informal physical activity such as walking and keeping fit, as well as the use of fitness and sports centres. Support for health is also reflected in the growth of complementary therapies and specialist products, including magazines, radio and television programmes and health websites, for people wanting to improving their health.

1.15 Better health is central to economic performance. A healthier workforce improves productivity and performance. In 1995 in Great Britain around 20 million working days were lost through work-related ill-health. Ill-health is expensive in both economic and human terms. Cutting the cost of sickness at work will help to decrease burdens on business. As we understand more about the causes of disease, such as coronary heart disease, so we can act to reduce preventable illness. And that has the potential to reduce welfare spending as we tackle health inequality and improve the health of the worst off.

'Cutting the cost of sickness at work will help to decrease burdens on business'

1.16 A modern and successful country needs more people in better health. We are engaged in a wide-ranging programme of modernisation: modernising education, modernising welfare, modernising social services and, in *The new NHS* White Paper, modernising the National Health Service. A modern approach to improving health and closing the health gap is a key part of this programme.

1.17 Our modern approach is reflected in the goals of this White Paper:

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness; and
- to improve the health of the worst off in society and to narrow the health gap.

1.18 Our twin goals are consistent with the health strategies being adopted by the other countries of the United Kingdom. They are also consistent with the World Health Organisation (Europe)'s new programme for the 21st Century *Health 21* and the European Community's developing strategy for public health.

1.19 We propose the first comprehensive Government plan focused on the main killers of people in our country. We are determined to succeed in our goals - and if we do, then by cutting needless early deaths from cancer, coronary heart disease and stroke, accidents and suicide, there is the real prospect of reducing the number of deaths from these causes by up to 300,000 by the year 2010.

1.20 This is a bold ambition. Improving health for all and tackling health inequality is a challenging objective - a crusade for health on a scale never undertaken by Government before. We will measure the success of our ambition by the numbers of lives saved, and by the improvement in the health of the people of our country. The task is clear: to give everyone in our nation, whatever their background, the chance to lead a long and healthy life.

The way to better health

1.21 Improving health means tackling the causes of poor health. We know that the causes of ill-health are many: a complex interaction between personal, social, economic and environmental factors.

1.22 In our new approach to better health, we want to break with the past. We want to move beyond the old arguments and tired debates which have characterised so much consideration of public health issues, including those who say that nothing can be done to improve the health of the poorest, and those who say that individuals are solely to blame for their own ill-health.

1.23 These arguments have focused not on what can be achieved, but on what role there is for those involved - including whether there is a role for Government, or whether these matters are solely issues of personal responsibility.

1.24 We reject the polarity of these positions. We refuse to accept that there is no role for anything other than the personal. Equally we refuse to accept that for some people poor health is inevitable.

'We refuse to accept that there is no role for anything other than the personal. Equally we refuse to accept that for some people poor health is inevitable'

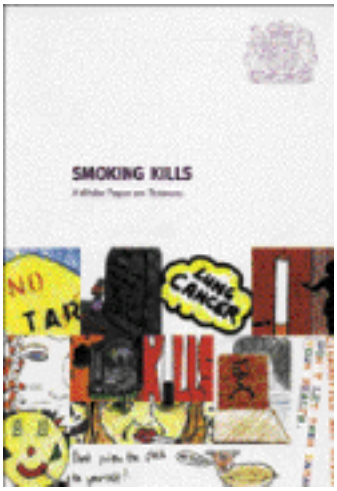
1.25 We reject that hopelessness. As with our policies on education and employment, we reject the inevitability of wasted lives and wasted generations - the belief that nothing can be done. As with education and employment, we believe that people can be instrumental in shaping their own futures, rather than being victims of them. And there is a clear role for local agencies acting together, offering help with the decisions that individuals make.

1.26 People are responsible for their own actions in health as in other areas. But the decisions people take over their health are more likely to result in better health and a healthier life if they have the opportunity to make informed decisions.

'a new balance - a third way - linking individual and wider action'

1.27 Our new approach is rooted in precisely that balance. We believe that individuals can, should and do affect how healthy they are. But we believe too that there are powerful factors beyond the control of the individual which can harm health. The Government has a clear responsibility to address these fundamental problems. Striking a new balance - a third way - linking individual and wider action is at the heart of our new approach.

1.28 Smoking provides a striking example of these various factors at work. We have set out our policy on smoking in our White Paper on tobacco, *Smoking Kills*. Smoking is the most powerful factor which determines whether people live beyond middle age. And smoking more than any other identifiable factor contributes to the gap in healthy life expectancy between the most deprived and the most advantaged. But it is at the same time a factor about which individuals can make a decision. For many people who smoke, the decision to give up is not an easy one. Nicotine is addictive. But there is a clear route to better health. It is a clear route too which those who are more fortunate tend to take more than those who are less fortunate. We want people to stop smoking. But we also want that policy to have a greater impact among the less fortunate, where the harm caused by smoking is greater. To do that we have to address the complex interactions of social, economic and personal factors. Tackling smoking achieves both our objectives - improved health for all, and especially better health for the worse off.



1.29 For people to make such decisions against the background of such powerful determinants, they need to make informed decisions. Such decisions must be based on information about the risks involved in a range of activities, practices and products. People cannot and should not be pressured into responsibility. We do not believe in the old nanny-state approach. But there is a powerful role for Government in making clear the nature and scale of risk, and in some cases, taking protective action in the light of it.

'Governments can set the preconditions for success in improving health. But Governments cannot

determine success'

1.30 We recognise that this is an unusual area for Government action. Governments can set the preconditions for success in improving health. But Governments alone cannot determine success. To do that, the Government needs to work in partnership with others.

A three-way partnership

1.31 Partnership is a key element of the Government's approach to a wide range of issues. Partnerships in areas such as business, education, crime prevention and many others are at the core of the way the Government carries out its work. Partnership is at the heart of our new approach to better health in *Saving lives: Our Healthier Nation*.

'a new three-way partnership, comprising:individuals, communities, and Government'

1.32 To improve health and to tackle health inequality, we need a new three-way partnership, comprising:

- individuals
- communities
- Government

1.33 Individuals are central to our new vision for better health. People need to take responsibility for their own health - and many are doing so. There is a new and clear realisation that individuals can improve their health, by what they do and the actions they take.

1.34 Better health information - and the means of applying that information - is the bedrock on which improvements to the health of individuals will be made. But better health opportunities and decisions are not easily available to everyone. For example, membership of a gym may not be an option for someone in a poor neighbourhood or a single mother.

1.35 Communities working in partnership through local organisations are the best means of delivering the better information, better services and better community-wide programmes which will lead to better health. The roles of the NHS and of local authorities are crucial. They must become organisations for health improvement, as well as for health care and service provision. We are underlining this joint responsibility by the new duty of partnership on NHS bodies and local government in the Health Act. All aspects of the way that the NHS works with other local bodies, from the reorganisation of primary care services to the development of healthy neighbourhoods, from the *NHS Direct* phone-line to the creation of a new Health Development Agency, will be geared not just to treatment of illness but to the prevention and early detection of ill-health.

1.36 Initiatives including the *Healthy Citizens* programme, health improvement programmes and health action zones will all provide a local focus for the delivery of information and programmes at local level aimed at helping individuals improve their health and the health of their families. The dynamic of health improvement will for the first time be integrated into the local delivery of health care.

'creating the right conditions for individuals to make healthy decisions'

1.37 Government will play its part by creating the right conditions for individuals to make healthy decisions. Across a range of Government policy, we are focusing on the factors that increase the likelihood of poor health - poor housing, poverty, unemployment, crime, poor education and family breakdown.

1.38 The Government is taking action to combat social exclusion, to make work pay, to support children and families, to promote community safety - all moves which will do much to improve people's health, and to improve especially the health of the least fortunate in our country.

An integrated approach

1.39 This is our new contract for health. Our new approach, based on our three-way partnership between people, local communities and the Government, adopts a new way of tackling poor health which is both inclusive and integrated, comprehensive and coherent.

1.40 It ensures that all involved in improving health play their part. Individuals have the responsibility to improve their health, and the health of their families. Local agencies, led by health and local authorities, have the responsibility for delivering local services and local programmes which will enable people to claim the right of better health. And the Government has the responsibility of giving everyone throughout our country the opportunity for better education, better housing, and better prospects of securing work.

'the whole will be greater than the sum of the parts'

1.41 Common sense suggests that this integrated approach to tackling poor health is best. It is supported by the scientific and medical evidence. Reducing the impact of cancer and heart disease, for example, can be done only if we tackle smoking effectively. In turn, tackling smoking depends on relieving the conditions - social stress, unemployment, poor education, crime, vandalism - which lead far more people in disadvantaged communities to smoke than in other sections of the community.

1.42 Our approach, based on partnership between individuals, communities and Government, is not one which ranks action by one above the other: by emphasising integration our strategy will ensure that the whole will be greater than the sum of the parts.

Targets

1.43 Previous efforts to try to address poor health have been marred both by the limited nature of their approach, resting on simplistic explanations of the causes of ill-health rather than the approach to root causes which we are adopting, and by an over-reliance on too many, poorly focused priorities.

1.44 We will not fall prey to these failings. We reject the checklist approach to improving public health. Instead, we are identifying tough but realistic targets which concentrate on the most important killers of people across our nation:

- cancer
- coronary heart disease and stroke
- accidents
- suicide

Listening and learning

1.45 Ten months after coming into office, we set out the scale of the challenge for improving health and tackling health inequality in England in our Green Paper, *Our Healthier Nation*. Over 5,500 responses were received. The response to consultation was overwhelmingly supportive with well over 90 per cent in favour of the proposed approach.

1.46 Individuals and organisations who responded particularly welcomed the emphasis on the fundamental social, economic and environmental causes of ill-health. They also approved of the much wider approach to accountability for improving health which identified the respective roles and responsibilities of individuals, local organisations and Government for improving health.

1.47 We commissioned Sir Donald Acheson to carry out an Independent Inquiry into Inequalities in Health to review the position and to identify the most critical areas to tackle.

1.48 We also commissioned an important study of the previous Government's health policy *The Health of the Nation*, carried out by specialists from the Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine. Its findings have helped to shape this strategy.

Our Healthier Nation

1.49 We believe that the country is united in an ambition for better health. The ambition to bring up children so that they grow up healthy is one that unites us all. The ambition of a long and healthy life for ourselves unites us all.

1.50 The three-way partnership we see as vital to improving our health is reflected in this White Paper:

- **Our Healthier Nation** - our approach to the causes of poor health (chapters 1-4)

- **saving lives** - the ways to tackle our priority areas of cancer, coronary heart disease and stroke, accidents and mental health
  (chapters 5-9)
- **making it work** - how we will ensure that our approach operates in practice (chapters 10-11)

1.51 This partnership approach underpins the contracts for health, set out in succeeding chapters, which summarise the action to be taken at each level - individual, local agencies, Government - to tackle each of the most important killers.

`action to tackle the four big killers`

1.52 We want to see healthier people in a healthier country. We want to see individuals striving to improve their own health, supported by local organisations working in partnership to deliver the information and services they need, against a backdrop of action by the Government. We want to see people deciding for themselves that they want to embrace better health - but doing so in the light of real and trusted information about the benefits, and about any risks. We will do so by providing the help which was so lacking in the past; and above all we will make it available to the least fortunate. We believe that this holds out the prospect of better health for everyone. We want to see everyone take the chance - and seize better health now, and for the future.

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6 Saving lives: coronary heart disease and stroke

Target: to reduce the death rate from coronary heart disease and stroke and related diseases in people under 75 years by at least two fifths by 2010 - saving up to 200,000 lives in total

6.1 One group of diseases kills more commonly than any other, can strike within minutes and singles out people in their prime as well as in later life. Coronary heart disease and stroke, along with other diseases of the circulatory system[1], account for over 200,000 of the half a million deaths which occur in this country each year. And while death rates are improving substantially for the best off in society, the worst off have not benefited to anything like the same extent, thus widening the health gap. Many families
in our country have experienced the tragedy that these diseases can bring.

In this White Paper all references to coronary heart disease and stroke should be understood to cover all diseases of the circulatory system

6.2 Many more people who survive acute heart attacks and strokes suffer long-term pain and disability. They and their families know how difficult it is to cope with these consequences. Never feeling completely well, unable to work, often confined to the house, constantly reliant on others - these are some of the worst features which many people must endure.

'England has one of the worst rates of coronary heart disease'

How do we compare?

6.3 Death rates for coronary heart disease and stroke fell during the 1970s and 1980s in most western countries and England was no exception. Deaths from coronary heart disease dropped by 38 per cent between the early 1970s and late 1990s and from stroke by 54 per cent over the same period. But across the European Union (EU), England has one of the worst rates of coronary heart disease - for people aged under 65 years, we are two and a half times worse than France (the country with the lowest rate in the EU) amongst men and over four times worse for women. For stroke, at least in those aged under 65 years, the picture is rather better with our death rates in men being better than for many other EU countries, but for women our rate is closer to the average and is more than 50 per cent higher than France, the best-performing EU country.

Fig 6.1 Death rates from circulatory disease: UK amongst the highest in Western Europe

Fig 6.2 Death rates from stroke: English women one of the worst records in Western Europe and men one of the best

Causes

6.4 Several of the major risk factors which increase the chances of people developing coronary heart disease or having a stroke are now well established. The key lifestyle risk factors, shared by coronary heart disease and stroke, are smoking, poor

nutrition, obesity, physical inactivity and high blood pressure. Excess alcohol intake is an important additional risk factor for stroke. Many of these risk factors are unevenly spread across society, with poorer people often exposed to the highest risks.

Fig 6.3 Levels of smoking have fallen more quickly in professional classes

Fig 6.4 Obesity in women: higher levels amongst manual social groups

'risk factors are unevenly spread across society'

6.5 Smoking is the most important modifiable risk factor for coronary heart disease in young and old. The fact that smokers of whatever age, sex or ethnic group have a higher risk of heart attacks than non-smokers has been known for a quarter of a century. All these effects have also been demonstrated in those exposed to other people's smoke (passive smoking). A lifetime non-smoker is 60 per cent less likely than a current smoker to have coronary heart disease and 30 per cent less likely to suffer a stroke.

6.6 While the proportion of young people starting to smoke is similar across social classes, by their 30s half of the better off young people have stopped smoking while three quarters of those in the lowest income group carry on. This is powerful evidence of how the cycle of social disadvantage contributes directly to the risk of premature death, avoidable illness and disability. About one third of smokers are concentrated in the bottom ten per cent of earners in this country. Smoking rates for those in professional social classes have fallen more rapidly than those for the unskilled. For example, in 1972, unskilled men were twice as likely to smoke as professional men; latest figures show that they are now three times as likely to smoke.

6.7 Poor diet - containing too much fat and salt and not enough fruit and vegetables - is another important cause of coronary heart disease and stroke. A diet high in fat, for example, raises cholesterol levels in the blood. A ten per cent reduction in cholesterol lowers the risk of coronary heart disease by 50 per cent at age 40 years falling to 20 per cent at age 70 years. Poor diet is a fact of life for many poorer families. They do not always enjoy easy access to shops selling a variety of affordable foods, which most of us take for granted.

'the cycle of social disadvantage contributes directly to the risk of premature death'

6.8 Keeping physically active provides strong protection against coronary heart disease and stroke. It also has beneficial effects on weight control, blood pressure and diabetes - all of which are risk factors in their own right; protects against brittle bones and maintains muscle power; and increases people's general sense of well-being. Levels of physical activity vary by social group and occupation. People in unskilled occupations are more physically active at work but less so in their leisure time than people in professional occupations. Even so, across all social groups we do too little exercise. Six out of ten men and seven out of ten women are not physically active enough to benefit their health.

6.9 High blood pressure raises significantly the chances of someone having a stroke or developing coronary heart disease. A modest reduction of salt in the diet, reduction in excess alcohol intake or an increase in physical activity could greatly reduce the risk of stroke and significantly reduce the risk of coronary heart disease. Many people with high blood pressure go unrecognised or are treated ineffectively. These people remain at increased risk.

Fig 6.5 Well under half of people with high blood pressure are treated successfully

6.10 There are influences in very early childhood, including while a baby is still in the womb, which determine a person's risk of developing coronary heart disease later in life. For example, small size at birth is an important risk factor for coronary heart disease in adult life. Some argue that these influences are related to nutrition.

'In countries with greater income inequality, health inequality

is greater too'

6.11 There is mounting evidence of the impact of the underlying causes of coronary heart disease such as income differences. In countries with greater income inequality, health inequality is greater too. And there is evidence that social stress, reflected in the extent to which an individual has low control over his or her job, increases the risk of coronary heart disease and of premature death. Similarly the degree of social cohesion, the strength of social networks in a community and the nature of people's
work may all affect their risk of dying from coronary heart disease.

Fig 6.6 Unequal risk of heart disease death at different employment levels in the public sector: even after allowing for risk factors

Action: reducing risk and staying healthy

6.12 A number of big changes would put people at much reduced risk of developing coronary heart disease or stroke in the future:

- major changes in diet, particularly among the worst off, with increased consumption of such foods as fruit, vegetables, and oily fish
- large reductions in tobacco smoking particularly among young people, women and people in disadvantaged communities
- people keeping much more physically active - by walking briskly or cycling, for example - on a regular basis
- people controlling their body weight so as to keep to the right level for their physique
- avoiding drinking alcohol to excess

6.13 Deciding not to smoke is choosing life against chronic ill-health and premature death. Giving up smoking produces benefits even in those who have smoked for many years. The White Paper *Smoking Kills* set out our policies for addressing this major cause of stroke and coronary heart disease. In addition to a new three-year public education campaign costing up to £50 million, a network of smoking cessation services will be established around the country, initially in deprived areas known as Health Action Zones. £60 million over three years has been set aside for this vital service. Addiction to nicotine underlies the smoking epidemic and is the reason why people find it so difficult to stop smoking. There is good scientific evidence that a combination of behavioural support and nicotine replacement therapy substantially increases the chances of an ex-smoker remaining free from this addiction. On 17 June we published regulations which set out our intention to ban tobacco advertising with effect from 10 December 1999.

'To ban tobacco advertising from December this year'

Action: more effective treatment

6.14 Early effective treatment of people who are in high risk groups or who have the initial signs of circulatory disease can prevent or delay them developing full blown heart attacks or strokes. Experience shows that people's access to effective treatment is
very variable across the country.

6.15 Although we want to prevent as many cases of coronary heart disease as possible, we want to ensure that people who could benefit from operations to relieve their symptoms are able to gain access to these specialist services. In the past we have also seen inequality in access to coronary bypass operations or angioplasty according to where someone happens to live. These operations do not always prolong life but they do improve quality of life, relieve the pain of angina and allow people to live free of disability.

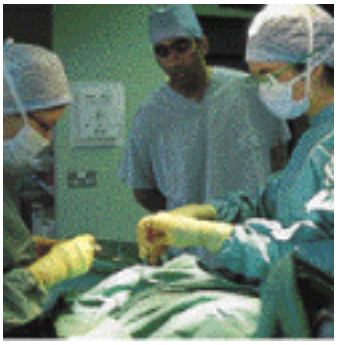


Fig 6.7 Differing rates of coronary bypass operations and angioplasties

6.16 Over time we want to ensure that the standards of the best services in the country apply to all parts of the country. That is why we are producing a *National Service Framework for Coronary Heart Disease*. The framework will set national standards and define service models for health promotion, disease prevention, diagnosis, treatment, rehabilitation and care. It will reduce variations in health care and improve service quality and will be published shortly.

'we want to ensure that the standards of the best services in the country apply to all parts of the country'

6.17 National service frameworks are also planned for older people and for those with diabetes. These will also help to reduce the impact of stroke as well as coronary heart disease. These national service frameworks will be published in April 2000 and April 2001 respectively.

6.18 We are also taking action to improve the control of high blood pressure in the population - too many people remain at risk of heart attack or stroke because their high blood pressure is undetected or treated inadequately.

6.19 To reduce high blood pressure we will:

- through publication of a review of the evidence, promote good practice in GP referrals
- develop an alcohol strategy for publication during 1999
- review the way that high blood pressure is detected and brought under control
- in partnership with the food industry explore the scope for reducing the salt content of processed foods.

'building social capital by increasing social cohesion and reducing social stress'

Integrated action

6.20 In our fight against coronary heart disease and stroke we can be successful only if everyone recognises that:

- A whole-generation approach is needed to reduce the impact of such factors as smoking, poor nutrition, obesity and physical inactivity by addressing the importance of influences that operate before birth through healthy pregnancy; laying the foundations for healthy values in early childhood; reinforcing knowledge about risks among young people and equipping them with the skills to take action; helping ensure that in middle and later life people's personal behaviour continues to promote their health and well-being
- Tackling underlying social, economic and environmental conditions is vital. Those factors operate independently as well as through the specific lifestyle factors. So health inequality can be reduced only by giving more people better education; creating employment so that people can achieve greater prosperity; building social capital by increasing social cohesion and reducing social stress by regenerating neighbourhoods and communities; and tackling those aspects of the workplace which are damaging to health
- More effective, high quality health services have an important part to play by providing support and advice to people who want to reduce the risks to their health; slowing disease progression in people with early signs and symptoms; limiting long-term incapacity for people who have been ill by well-targeted rehabilitation and follow-up care.

6.21 We will create an integrated strategy for action to reduce the burden of coronary heart disease and stroke through a contract for health. It will identify what the individual citizen must do, what local partnerships will do and what action we will take across Government.

'implementation of the contract by high-level Task Force'

6.22 Our *Healthy Citizens* initiative will help us in this task, through *NHS Direct*; through our *Health Skills* programme - including training for members of the public in the use of defibrillators; and through our *Expert Patients* programme which will enable people with vascular disease to manage their own condition.

6.23 We shall bring together the implementation of this contract for coronary heart disease and stroke with the implementation of the *National Service Framework for Coronary Heart Disease* by setting up a high-level Task Force, accountable to the Chief Medical Officer. The Task Force will ensure that the essential groundwork is laid to set us on course for achieving our target for saving lives which would otherwise be lost to coronary heart disease and stroke. We will identify someone of national prominence to act as its champion, whose function will be to build and maintain momentum for action, to communicate the purpose of the contract and to encourage individuals to commit themselves to it.

6.24 We will use the *Public Health Development Fund* to support the achievement of our target for coronary heart disease and stroke (see paragraphs 11.39 and 11.40).

Fig 6.8 Ways of beating heart disease and stroke: examples of how everyone can play their part

7 Saving lives: accidents

Target: to reduce the death rates from accidents by at least one fifth and to reduce the rate of serious injury from accidents by at least one tenth by 2010 - saving up to 12,000 lives in total

7.1 Accidents are responsible for 10,000 deaths a year across England. Accidental injury heads the league tables of causes of death among children and young people in England, Europe and America. It puts more children in hospital than any other cause. Accidental injury has in the past been one of the most neglected areas for preventive action, the commissioning of research and the education and training of health professionals.

'Accidental injury puts more children in hospital than any other cause'

How do we compare?

7.2 We have lower death rates from road accidents in this country than in most other European countries. We have seen substantial falls in the rate of children killed in accidents over the last 25 years. In our drive for a healthier nation, these and similar figures are encouraging.

Fig 7.1 Death from motor vehicle traffic accidents:England performs comparatively well

Fig 7.2 Death rates from all accidents in children

7.3 But in other areas the record is less good. Rates of death in childhood from pedestrian accidents in this country are amongst the highest in Europe. And, as children grow up, deaths from accidental injury account for a greater proportion of all childhood deaths. Among older people the rate of deaths from falls is not coming down. There are also substantial differences in deaths from accidents across the United Kingdom. For example, road accidents and serious injuries are more severe on our rural roads than in other areas.

Fig 7.3 Child pedestrian deaths: England one of the worst records in Europe

Fig 7.4 Accidents kill proportionately more children as they grow up

Fig 7.5 Deaths from accidental falls in older people are not reducing

'road accidents and serious injuries are more severe

on our rural roads'

Causes

7.4 Road traffic accidents are a principal cause of accidental death and injury. Across the whole population in 1997, 3,559 people were killed, 42,967 were seriously injured and 280,978 were slightly injured in road traffic accidents. Every year 1,500 car drivers and adult passengers die in road accidents and one hundred times that number are injured. And every year 1,000 or so adult pedestrians and cyclists are killed and 40,000 are injured. Motorcyclists are at the highest risk of all. In 1997 for every 100 million kilometres travelled, 150 motorcyclists were killed or seriously injured compared with 89 cyclists and 4 car drivers.

7.5 Families can be destroyed by the loss of parents and breadwinners. But children's deaths are the most tragic waste of life. Despite the improvements, road traffic accidents remain the biggest single cause of accidental death amongst children and young people. Each year in England nearly 180 children die and almost 4,800 are injured as pedestrians or cyclists. Many are killed when playing or walking close to their own homes. Added to this are the 215 deaths and 2,690 or more serious injuries to children riding as car passengers.

Fig 7.6 Childhood accident deaths involving head injury occur close to home

7.6 Older people are at particular risk of death and disability from falls. Osteoporosis (brittle bones) affects more people, especially women, as they grow older and can be a cause of accidents and contribute to the severity of those accidents. Broken wrists and hips become more likely and can mean lengthy hospital stays, creating long term health and social care needs for the individual.

'The younger the child, the greater the risk''give greater priority to pedestrians and cyclists'

7.7 One third of all accidents to adults occur in the home. Many are linked with people falling or stumbling in the home. Over 3,000 people aged over 65 years are killed annually in falls. The home is also the setting for many serious accidents to children from a variety of causes: fires, burns, drowning, choking, poisoning and cuts from sharp objects. The younger the child, the greater the risk. About half of all deaths among children under 5 happen in the home.

7.8 Some occupations expose employees to greater potential risks than others. Those risks may take different forms. Some may be linked to the work environment, such as mining or quarrying, or with work processes such as those involving poisonous substances. Others are associated with a failure to manage risk, such as falls from a height or from moving vehicles, in the construction industry, for example. Controls for risks are covered in legislation and enforced by the Health and Safety Executive and local authorities. Over decades the number of accidents in these areas has fallen markedly. But there were still nearly 140 fatal accidents in the construction industry and agriculture combined in 1997-8. The *Self-Reported Work-Related Illness Survey* for1995 concluded that about 2 million people suffered from ill-health either caused or made worse by their work.

7.9 People use their leisure time in a whole variety of ways. Many choose to be physically active, which helps them to reduce the risk of coronary heart disease. Yet these activities also bring some risk of accidental injury. Every year about 800,000 people are injured while playing sport, 215,000 of them children.

Action: reducing risk and staying healthy

7.10 We can all do a great deal to contain these risks of accidental injury. Sometimes it is a matter of taking simple precautions, such as remembering to wear a seatbelt. Sometimes it is a question of a better product design or the development of better controls.

7.11 We will reduce accidents by making the environment safer. We will reduce road traffic accidents through more careful planning of traffic flows; through traffic calming measures; by an effective speed management policy; and through encouraging the design of vehicles in ways which offer better protection not just to the occupants but also to others involved in collisions. We will do more to improve conditions and give greater priority to pedestrians and cyclists, including by designing safer routes to school through school travel plans. We will make sure our traffic management policies are best suited to their locations, whether urban or rural. The forthcoming *Road Safety Strategy* will set out in detail how we will make our roads safer.

Fig 7.7 Traffic calming can cut pedestrian raod accidents

7.12 Careful design is important to minimise the risk of accidents in the home. For new homes, Building Regulations set standards for the design of the main features associated with accidents. These include stairs, balconies and the use of safety glass in doors and low-level windows.

7.13 In the playground accidents could be reduced through more careful equipment design, the use of soft materials as flooring, and more supervision.

7.14 Drownings in canals, rivers, ponds and swimming pools could be reduced through the use of barriers which restrict access, through more teaching of swimming and through more adult supervision.

7.15 We can also reduce accidents through safer behaviour. Road safety training has long been a feature of childhood, and there is evidence that training parents and children together is particularly effective. We have introduced a practical training manual for children called *Kerbcraft*, based on a successful road safety education scheme run originally in Drumchapel in Glasgow.

7.16 All of us can play a role in improving safety for other road users by driving safely, following the Highway Code. Cyclists can reduce risks to themselves by using safe cycle routes where they exist, and by taking part in cycling skills training courses.

7.17 Many parents discourage their children from walking and cycling precisely because they are worried about the dangers from traffic. But in using private cars more we are restricting not only children's physical well-being but also their social development. Unless they have the chance to learn early on how to make decisions for themselves, children may eventually be at more risk on the roads and in other public places. Our *Safer Travel to School* initiative will encourage more children to walk or cycle to school.

7.18 Many accidents in the home can be prevented by taking simple precautions. The Department of Trade and Industry is conducting a three-year campaign targeted at older people, their families and carers setting out a few simple and practical steps which will help to prevent falls in the home - the biggest cause of accidental deaths in the home, and one which affects millions of people. The Department of Trade and Industry is also actively promoting safety advice on a range of other home safety topics, including gardening, carbon monoxide poisoning and burns
and scalds.

7.19 We can encourage people to adopt safer behaviour which makes injury less likely by increasing awareness of the causes of accidents in the home, in leisure, and in the workplace; and what can be done to make them safer. For example, when the Department of Trade and Industry ran its campaign on firework safety in 1998, focusing on sparkler safety, injuries from sparklers dropped by 36 per cent.

7.20 Safety protection is another effective way of preventing accidental injury. Seat belts and child restraints have been shown to be effective in reducing deaths and the severity of injuries to occupants of road vehicles. Cycle helmets have been shown to reduce the risk of head injuries among cyclists by as much as 85 per cent. Smoke alarms have been shown to reduce the number of deaths and injuries from fires significantly. One recent study estimated that an 80 per cent reduction was achieved in the incidence of injuries from residential fires. People can make their enjoyment of sport freer of injuries by taking simple precautions suitable to the sport.

Action: more effective treatment

7.21 To improve treatment for those who suffer accidental injury there must be fast, effective action at all levels from the time the injury occurs to the initial diagnosis and treatment and to the after-care. The physical and psychological injuries caused by accidents will be considered within the *National Service Framework for Older People*.

7.22 We have seen in the past the ways in which the sequence of events in response to accidental injury has been broken. Examples of ambulances failing to arrive in the critical time after a serious accident. Examples of children with serious injury lying too long in a local hospital whilst a bed is found in a specialist centre. Examples of failures to draw up good care plans leading to people with head injury not reaching their full recovery potential. These are the exceptions. But they must not be allowed to happen.

'frontline ambulances now have a fully qualified paramedic'

7.23 Frontline ambulances responding to 999 calls now have a fully qualified paramedic as well as a trained technician. Their training includes basic and advanced life support as well as a range of interventions which may be needed by people injured in accidents. Recent work indicates that patients cared for by paramedics recover better than patients who are not.

7.24 Following the 1997 Report *Paediatric Intensive Care: A Framework for the Future,* the Government has invested an additional £20 million in children's intensive care to ensure that critically ill children - for example, those suffering from head injury, burns or poisoning - can be swiftly transferred to a specialised centre accompanied by specially trained doctors and nurses. This aims to avoid past tragedies where staff and facilities were not available for such emergencies.

7.25 We are developing policies designed to ensure prompt and effective rehabilitation, treatment and care, to maximise people's recovery from accidental injury.

Integrated action

7.26 In our fight against accidental injury we can be successful only if everyone recognises that:

- There are key age groups that must be targeted. In particular, the greatest gain in lives saved and disability prevented would result from reducing injury (or its severity) in children up to 15 years (especially those from manual and unskilled households); in young people aged 16-24 years involved in road traffic accidents; and in older people who are at risk of stumbling or falling
- There are special factors associated with each different type of environment in which accidental injury occurs: the risks of death and injury can be reduced if the 'accident prone' features of roads, houses, workplaces, playgrounds and other settings are carefully analysed and measures designed specifically to reduce risk
- Single interventions will seldom be successful. A co-ordinated approach is needed. Individuals can take action for themselves and others. Transport, land use, housing, social and economic policies can all be harnessed together in ways which can reduce significantly the incidence of accidental injury.

7.27 Besides this, our *Healthy Citizens* programme will help to minimise the effects of accidents through our *Health Skills* programme for 14 –16 year-olds and for adults.

7.28 We will set up a high-level Task Force, accountable to the Chief Medical Officer, to oversee the first year of implementation of the contract to ensure that the essential groundwork is undertaken to set us on course for achieving the target. We will identify a person of national prominence to act as its champion, whose function will be to build and maintain momentum for action, to communicate the purpose of the contract and to engage people in it.

7.29 We will use the *Public Health Development Fund* to support the achievement of our target for accidental injury.

Fig 7.8 Ways of beating accidental injury: examples of how everyone can play their part

8.23 We will use the *Public Health Development Fund* to support the achievement of our target for mental health.

Fig 8.2 Ways of beating mental health problems: examples of how everyone can play their part on this site.

9 Public health: wider action

9.1 Our four priority areas address a wide range of public health issues, but there are further important threats to our health. We are tackling these as well, in a series of strategies complementary to *Saving lives: Our Healthier Nation* sharing its overall aims and focusing on specific problems. Like this strategy for health, they rely on Government-wide action and shared responsibility.

Sexual health

9.2 In March we announced our plans to draw up a national strategy for sexual health which will encourage the development of more comprehensive sex and relationships education, more coherent health promotion messages and more effective service interventions.

9.3 Sexual health is an important public health issue. England has one of the highest teenage conception rates in the developed world and the highest in Western Europe. Such rates vary in severity round the country, with some local authority areas such as Wear Valley having conception rates for girls under 16 as high as 22 in every 1,000. Babies born to teenage mothers have death rates 50 per cent higher than the national average. Many young girls who fall pregnant and choose to keep their baby are likely to experience poverty and poor health and pass such disadvantages onto the next generation.

Fig 9.1 Live births to teenage girls in Europe: UK has the highest rate in Western Europe

'clear goal to cut the rate of teenage conceptions by half in under-18s by 2010'

9.4 Action is already in hand on a number of fronts. The Prime Minister asked the Social Exclusion Unit to develop an integrated strategy to cut rates of teenage parenthood and propose better solutions to combat the risk of social exclusion for vulnerable teenage parents and their children. Its Report set out an action plan comprising:

- a national campaign to mobilise every section of the community to achieve its clear goal to cut the rate of teenage conceptions by half in under-18s by 2010
- better prevention by tackling the underlying causes of teenage pregnancy through better education about sex and relationships, clearer messages about contraception and special attention to high-risk groups including young men
- better support for young teenagers and teenage parents to ensure they finish their education and learn parenting skills; and changes to the housing rules so that young, 16–17 year-old teenagers will no longer be housed in independent tenancies but in supervised accommodation offering the support they need.

Fig 9.2 Under age pregnancies: a map of inequality

9.5 Sexually transmitted infections are increasing, particularly chlamydia and gonorrhoea (which can result in infertility), and

particularly among teenagers. For 16-19 year-olds there was a 53 per cent increase in cases of gonorrhoea between 1995 and 1997, and 45 per cent for chlamydia. In 1997 there were nearly half a million new diagnoses of sexually transmitted infections in genito-urinary medicine clinics alone.

'support for teenage parents to ensure they finish their education and learn parenting skills'

9.6 Chlamydia is the single most preventable cause of infertility in women, and screening pilots are underway. A national screening programme will be considered when results are available from these pilots. And there are a number of public health promotion campaigns for young people which aim to increase their understanding of sexually transmitted infections and how to prevent them.

9.7 HIV infection and AIDS remain serious threats to health. Because of early prevention efforts we have fared better than many other European countries. France, for example, has four times as many people with HIV as the UK. But we cannot be complacent. Last year saw the highest number of new HIV infections ever in the UK at nearly 3,000, almost twice the figure of a decade ago. So we must continue to promote messages about safer sex, both to the general public and those specific groups who are at particular risk of HIV infection. While new treatments are improving both the length and quality of life for HIV patients, there is still no vaccine or cure. And there are signs that some patients may not respond well to the new drugs, particularly over long periods. So our forthcoming HIV/AIDS strategy will cover issues of testing and treatment as well as prevention. It will be developed within the frameworks set out in *The new NHS* and *Modernising Social Services*.

'forthcoming HIV/AIDS strategy will cover testing and treatment as well as prevention'

Tackling Drugs to Build a Better Britain

9.8 Drug misuse is associated with poor health both directly, for example through the effect of overdoses and the spread of infection (specifically HIV/AIDS and hepatitis B and C); and indirectly, because of the link with social exclusion through homelessness, poverty, unemployment and criminal behaviour. And the problem is frighteningly widespread.

Fig 9.3 Percentage of young men and women who have taken illicit drugs

9.9 In *Tackling Drugs to Build a Better Britain*, published last year, we signalled our goal of shifting resources from dealing with the consequences of drug misuse to prevention and treatment. Our aims are to:

- help young people to resist drug misuse
- protect our communities from drug-related anti-social and criminal behaviour
- enable people with drug-related problems to overcome them and live healthy, crime-free lives
- stifle the availability of illegal drug

'shifting resources from dealing with the consequences of drug misuse to prevention and treatment'

9.10 Success will require concerted action at every level. At national level, the policies of different Government Departments are being brought together by the UK Anti-Drugs Co-ordinator, matched at local level by the Drug Action Teams on which a range of agencies are represented.

9.11 In May the UK Anti-Drugs Co-ordinator published his first Annual Report and Action Plan setting out his key performance targets for the next 10 years.

Alcohol

9.12 Moderate alcohol consumption is a part of everyday life for many, bringing enjoyment and relaxation. For older people, drinking small amounts of alcohol can give some protection against coronary heart disease. But heavy drinking is harmful not only to individuals, but also to their families and to society at large. As well as directly causing illness such as cirrhosis of the liver, alcohol contributes to certain cancers and to stroke. Its misuse places families under stress, sometimes resulting in domestic violence, mental illness, and family break-up. Alcohol-related disorder and violence affect the wider community. It is a factor in many accidents.

Figure 9.4

Some of the most common adverse health effects of heavy alcohol consumption

- liver cirrhosis and liver cancer
- mouth, throat, gullet and possibly breast cancer
- high blood pressure and related conditions such as heart and kidney disease, and stroke
- complications in pregnancy and infancy
- mental illness, suicide, epilepsy and damage to the nervous system
- accidents
- violence

Source: Department of Health (see Reference Section)

'An effective strategy to tackle alcohol misuse in the year 2000'

9.13 In the Green Paper *Our Healthier Nation* we undertook to develop a new strategy to tackle alcohol misuse. Our broad aims are:

- to encourage people who drink to do so sensibly in line with our guidance, so as to avoid alcohol-related problems
- to protect individuals and communities from anti-social and criminal behaviour related to alcohol misuse
- to provide services of proven effectiveness that enable people to overcome their alcohol misuse problems.

9.14 An effective strategy to tackle alcohol misuse needs the co-operation of all those concerned with alcohol: health and social services, schools, the alcohol industry, law enforcement agencies, Government and the general public. We shall carefully consider the views of all the above to ensure that our strategy provides a coherent and balanced framework for action to tackle alcohol misuse and its consequences. We intend to take this work forward, in partnership with health and industry interests.
We expect to publish our strategy after consultation early in the year 2000.

Food safety

9.15 People are now generally well aware of the risks to health which may be carried through the food chain. Communicable diseases like salmonella can cause severe illness and sometimes death. Outbreaks of food-borne diseases largely result from poor standards in the production, preparation or delivery of food. And numbers of reports of food poisoning have been rising. It is therefore important that high standards are set and monitored.

Fig 9.5 The rising trend of reports of food poisoning

'an independent Food Standards Agency, responsible for setting, maintaining and monitoring food standards and safety'

9.16 Last year we published a consultation document setting out in detail the commitment we made in our manifesto to set up an independent Food Standards Agency, responsible for setting, maintaining and, with local authorities, monitoring food standards and safety.

9.17 The Agency will provide independent and authoritative advice to the public on all food safety and standards issues, as well as on a balanced diet, and on the nutritional value of foods, to help people make informed decisions about what they eat. Following consultation on the draft legislation earlier this year, the Food Standards Bill to give effect to these proposals was introduced into Parliament on 10 June.

Water fluoridation

9.18 There are wide variations in dental health across the country. The Acheson Inquiry reinforced the fact that there is strong evidence that water fluoridation improves dental health and significantly reduces inequality in dental health. Children in deprived areas where the water supply is not fluoridated can have up to four times more tooth decay than children in affluent areas, or where water is fluoridated. Responses to the Green Paper were overwhelmingly in support of fluoridation in areas where the level of tooth decay was high.

'water fluoridation improves dental health and significantly reduces

inequality'

9.19 It is clear that the present legislation on fluoridation is not working. No new schemes have been implemented since 1985. Once a health authority has established that there is strong local support for doing so it may request a water company to fluoridate the water supply. Over 50 health authorities have made such requests to water companies, but to date none has been agreed. The companies are reluctant to take this step when a small but vocal minority are opposed to it. As a result there is deadlock.

'the present legislation on fluoridation is not working'

9.20 We are conscious that the extensive research linking water fluoridation to improved dental health was mostly undertaken a few years ago. So we have commissioned the Centre for Reviews and Dissemination at York University to carry out an up-to-date expert scientific review of fluoride and health. If it confirms that there are benefits to dental health from fluoridation and that there are no significant risks, we intend to introduce a legal obligation on water companies to fluoridate where there is strong local support for doing so. And to ensure that the extent and validity of that public support is beyond all doubt we envisage transferring from health authorities to local authorities the requirement to undertake public consultation on fluoridating the local water supply.

'we have commissioned an expert scientific review of fluoride and health'

Communicable disease

9.21 Communicable disease is one of the main causes of avoidable illness. In the past such diseases as polio, measles, whooping cough and diphtheria were the cause of many deaths in childhood.

Fig 9.6 Vaccination conquers disease:the trend for diphtheria

'transferring to local authorities the requirement to undertake public consultation'

9.22 Now the impact of those diseases in our country has almost completely disappeared as a direct result of the success of the childhood vaccination and immunisation programme. Vaccination programmes have completely eliminated smallpox worldwide. But we cannot afford to be complacent. Notifications of tuberculosis had dropped to a steady 5,000 a year in England and Wales but there has been a recent rise in notifications which must be countered.

Fig 9.7 An old adversary returning: the recent rise in turberculosis

9.23 In many cases the organisms which cause disease are evolving in ways which make our traditional defences ineffective. We are beginning to see old diseases return, this time resistant to antibiotics. And at the same time new diseases such as HIV/AIDS are emerging. To combat this threat we have asked the Government's Chief Medical Officer, Professor Liam Donaldson, to develop a strategy for tackling communicable disease to bring major reductions in the amount of illness, disease and death it causes.

'By 2003 the Human Genome Project will have mapped all 100,000 genes in the human body'

The genetics revolution

9.24 As we approach the new millennium we are on the brink of one of the most important scientific achievements in the history of humankind. By 2003, perhaps earlier, the *Human Genome Project* will have mapped all 100,000 genes in the human body. Genes provide a code for the structure and function of our bodies. They also determine our risks and susceptibility to disease. They are made up of strands of DNA - a single sequence of body chemicals, which has been described as "the secret of life". The structure of DNA was discovered by British and US scientists in 1953. Fifty years later the mapping of our entire genetic make-up will have profound implications for health, disease, diagnosis and treatment.

9.25 We already know about many particular genetic disorders which will cause serious disease - for example haemophilia

and cystic fibrosis. We know that some diseases can run in families - for example, breast cancer - and geneticists are gradually unravelling the genes which cause them.

9.26 At some time in the future it will be possible to map the genetic code of individuals and understand their risk of developing particular diseases through their whole lifetime. Most diseases are the result of a complex interaction between genes, environment, and lifestyle. So the opportunity will be there to provide an individual with detailed advice on how to reduce any health risks which might otherwise result from his or her genetic make-up.

9.27 This heralds a scientific and technological revolution. When it arrives, we will be ready to use the advances in ways which will enhance the opportunities for better health and prevention of disease, while taking account of the wider social, ethical and economic consequences. Effort will be targeted on those most in need. The new Human Genetics Commission, announced in May this year,will take on this task.

'a high level Task Force on Genetics and Disease Prevention'

9.28 We will also establish a high level Task Force on Genetics and Disease Prevention which will work to the new Human Genetics Commission.

Improving health for black and minority ethnic groups

9.29 In addressing the health of people from black and minority ethnic groups we need a new approach. It is now absolutely clear that some minority ethnic groups carry a higher burden of poor health, premature deaths and long-term disabilities than other groups in the population. We need to address these issues. But simply to tackle them as a list of problems is to fail to recognise the fundamental nature of the change of approach which is required. The report of the Inquiry into the death of black teenager Stephen Lawrence has reinforced our commitment to the root and branch reform we had already begun in the way in which services assess and meet the needs of those from minority ethnic groups. This is equally so not just for health services but for local partnerships and programmes of action aimed at improving the health of local communities. There must be genuine involvement of minority ethnic groups in these endeavours and programmes must be designed through their eyes, not on an assumption of what seems right.

'the death of black teenager Stephen Lawrence has reinforced our commitment to root and branch reform'

9.30 We are determined to tackle racism and racial discrimination wherever it occurs. Since taking office we have already more than doubled the proportion of black and minority ethnic people appointed to the boards of NHS bodies, so that they are more representative of the local people they serve. We have changed the arrangements for deciding on distinction and merit awards for consultants and the number of black and Asian doctors receiving such awards has increased by 50 per cent. We have published an action plan *Tackling racial harassment in the NHS* which sets targets for reducing incidents of racial harassment, and we are supporting it through a major public awareness campaign to highlight the impact of such harassment. And in December 1998 we held the first awards ceremony for the NHS Equality Awards, rewarding NHS bodies which have taken clear and effective action to combat discrimination, including on grounds of racial origin.

'effective action to combat discrimination'

9.31 Our strategy of targeting prevention, treatment and care of those most in need is particularly relevant to people from black and minority ethnic groups. They include some of the people with the worst health in this country. We need to make sure that our plans for achieving the twin goals of this strategy address the particular needs of these groups.

9.32 At present some people from minority ethnic groups have difficulty getting access to health services - health promotion as well as treatment. And when they fall ill their illnesses are diagnosed later and treatment starts later than for others.

Fig 9.8 Women in some ethnic groups have low uptake of potentially life-saving cervical cancer smears

9.33 There are also differences in the nature or incidence of illnesses which minority ethnic groups suffer. Some relate to the major killer diseases. For example people born in South Asia are at greater risk from heart disease than most other people in this country, while Afro-Caribbeans have high rates of stroke. Particular diseases such as sickle cell anaemia and thalassaemia occur mainly among specific groups. Taken together, this means not just that health workers need to be especially alert to spot early symptoms of disease among such people; but also that programmes must be tailored in ways which enable people in those groups to reduce their risk from the diseases.

Fig 9.9 Relative mortality from coronary heart disease by ethnic origin

9.34 Communication is sometimes a barrier between minority ethnic patients and health professionals. Certain health authorities have appointed linkworkers and patients' advocates to address this problem. This has helped patients to access and understand health services, particularly when they need specialist help. Patients are better able to discuss their anxieties with linkworkers.

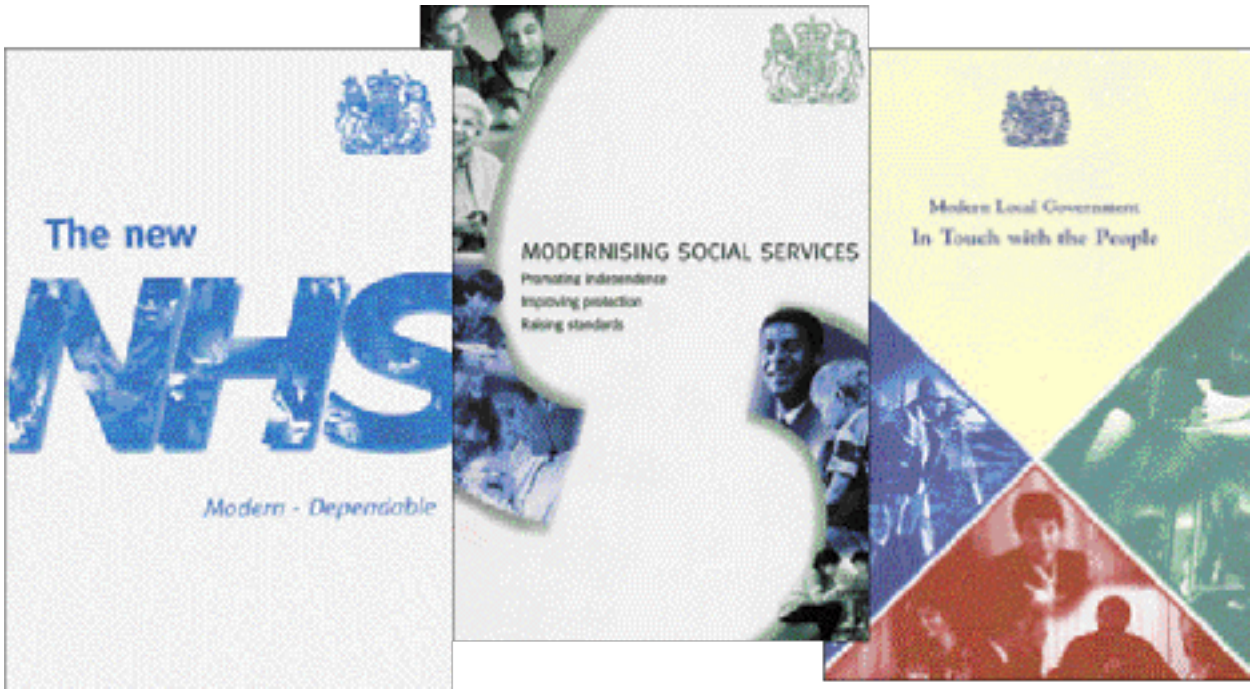
Fig 9.10 High rates of suicide amongst young women born in the indian sub-continent and living in this country

9.35 Black and minority ethnic groups have certain well-established health and cultural practices. Failure to recognise, understand and be sensitive to differing cultures has been an area in which services have failed in the past. We must match services to the needs of all people, for example by making ethnic diets available in hospitals; by providing appropriate spiritual care; and enabling those who would prefer to see a female doctor to do so - a measure which would encourage more Asian women, for example, to take up potentially life-saving screening programmes.

'We must match services to the needs of all people'

9.36 Statutory organisations are working increasingly with individuals, families and communities from black and minority ethnic groups to understand diversity, the different cultural traditions and the various ways in which people from those communities express themselves. For example, health authorities and community organisations are working in mosques, gurdwaras and temples to set up health services including screening services. In this way the local communities have more say in the organisation and delivery of such services.

10 Making it work: progress and partnerships



10.1 The goals of this health strategy will be achieved only by a joint effort. That means individuals taking steps to improve their own health, and on new directions and new more effective partnerships formed at local community level between the NHS, local authorities and other agencies.

10.2 Our new approach to better health comprises:

- reorienting local services - including the NHS - to give a high priority to health improvement
- local partnerships for health, where organisations and people work together to improve health overall.

REORIENTING AND EMPOWERING HEALTH SERVICES

10.3 Our determination to modernise the NHS, including ending the wasteful internal market, placing new duties on health authorities, and the creation of primary care groups which are close to patients, is not simply an agenda for improving the reliability and effectiveness of health care services. It is an agenda which will help to improve health overall and to tackle inequality. Health authorities have overall responsibility for improving health locally. Within the health authority the director of public health generally leads this work, accounting for it to the chief executive. In the past public health staff, including the director, had to spend too much time servicing the demands of the internal market. As a result a valuable public health resource was dissipated. The importance of the role of public health was not always clearly reflected through local priorities and too often public health was seen as something which someone else did.

'Health authorities have overall responsibility

10.4 We are modernising the NHS, and have abolished the internal market. In its place we have introduced a new structure based on partnership working linked to a new duty of co-operation between NHS bodies and local authorities.

10.5 As part of the modernisation process, we have placed a duty on health authorities to draw up health improvement programmes which tackle the health and health care needs of their area. This gives them a key role in improving the health of the local people they serve and we are encouraging them to develop public health expertise throughout their workforce and to apply it across the range of their activities. They must ensure that health problems are tackled and health inequality is addressed. This is reflected in the *National Priorities Guidance* we issued last autumn to health and local authorities, and again in the guidance we have issued for developing local health improvement programmes. NHS Trusts, too, will have a major part to play in the delivery of our health strategy, for example through their contribution to the National Service Frameworks, and in their role as large employers.

10.6 In particular health authorities will:

- identify local health and health care needs
- promote action to achieve demonstrable health improvements and reductions in health inequality
- at local level set the direction within the NHS for delivering service improvements
- provide support to the local health community and encourage opportunities for development
- fulfil their statutory functions in respect of regulating local NHS bodies
- enable, encourage and support the development of local partnerships for health.

New primary care organisations

10.7 We have placed primary care at the heart of our programme to modernise the health service. We are strengthening these services by introducing new primary care groups and the prospect of primary care trusts. These new organisations consist of broadly-based, multi-professional teams including family doctors, nurses, public health professionals, other practitioners and therapists.

10.8 Primary care groups began work in April 1999. Over time we expect them and, when established, primary care trusts, to play a leading role in improving health and cutting inequality, working closely with their local communities. They have strong links with local people and are well placed to do this. In some areas the best primary care teams have already taken on this wider public health role.

10.9 Primary care groups and primary care trusts will take on a range of important new responsibilities which were set out in guidance last December:

- to improve the health of, and address health inequality in, the local community
- to develop primary and community health services by improving the quality of those services, and dealing with poor performance in primary care service providers
- to commission services for their patients from NHS hospital trust

10.10 Primary care groups and primary care trusts must continue to ensure that preventive services - some cancer screening, immunisation and vaccination - are available as necessary. They will also continue, for example, to provide help to those wishing to give up smoking or to lose weight.

'we expect primary care groups to forge powerful local partnerships to deliver shared health goals'

10.11 However we expect primary care groups and primary care trusts to go beyond simply the provision of existing preventive services. Over time they too will forge powerful local partnerships with local bodies - schools, employers, housing departments - to deliver shared health goals. They will help shape the health improvement programme and draw up their own plans for implementing it and for hitting the targets in it.

Key features of core roles of health authorities and primary care groups and primary care trusts

Health authorities

- enabling
- gaining multi-sector commitment and co-ordination
- setting strategy (jointly with others)
- prioritising and investing in public health programmes
- developing public health organisational and people capability
- monitoring progress

Primary care groups and primary care trusts

- doing
- forging local partnerships
- planning action
- resourcing action plans
- building workforce capacity and public health infrastructure
- meeting objectives

LOCAL PARTNERSHIPS:

Leading health improvement

10.12 Tackling poor health and health inequality needs the NHS and local government to take joint responsibility. There are several parts of the country where NHS bodies, local authorities and others already work well together. But there are others where they work less well.

'a culture in which learning and good practice are shared'

10.13 Successful partnership working is built on organisations moving together to address common goals; on developing in their staff the skills necessary to work in an entirely new way - across boundaries, in multi-disciplinary teams, and in a culture in which learning and good practice are shared. It also means:

- clarifying the common purpose of the partnership
- recognising and resolving potential areas of conflict
- agreeing a shared approach to partnership
- strong leadership based on a clear vision and drive, with well-developed influencing and networking skills
- continuously adapting to reflect the lessons learned from experience
- promoting awareness and understanding of partner organisations through joint training programmes and incentives to reward effective working across organisational boundaries.

10.14 Through the Health Act 1999 we have extended the existing duty of partnership between health authorities and local authorities to NHS Trusts and primary care trusts (when established), reflecting the need for partnership in service commissioning and delivery as well as strategic planning. All this is underpinned by new financial flexibilities, including powers to operate pooled budgets. This will create the opportunity for the new style of partnership we want to promote.

Effective planning for health

10.15 Local health improvement programmes will reflect these new partnerships. They will be genuinely joint enterprises with local authorities and others. The role of local authorities in improving health locally will be clearly defined and reflected in their priorities and any community plans. Health improvement programmes will also show how the National Service Frameworks will be implemented at local level. So they will be effective vehicles for making a major and sustained impact on the health problems of every locality in the country. As well as looking at the overall health of the local population, they will also focus action on people who are socially excluded and need the most support.

10.16 The main responsibility for developing health improvement programmes rests with the health authority, drawing on the contributions of other NHS bodies, local authorities and others including local businesses, voluntary bodies, community groups and individuals. Universities and those responsible for the education and training of professional staff will also play a part.

'Local authorities will be key contributors to the health improvement programme'

10.17 Local authorities are at the centre of local public service provision. They will be key contributors to the health improvement programme through the best value initiative and any community plans which they develop in partnership with other local bodies to promote the economic, social and environmental well-being of their communities.

Health improvement programmes

10.18 Health improvement programmes will:

- give a clear description of how the national aims, contracts and targets will be tackled locally
- set out a range of locally-determined priorities and targets with particular emphasis on addressing areas of major health inequality
- specify agreed programmes of action to address these national and local health improvement priorities
- show that the action proposed is based on evidence of what is known to work (from research and best practice reports)
- show what measures of local progress will be used (including those required for national monitoring purposes)
- indicate which local organisations have been involved in drawing up the plan, what their contribution will be and how they will be held to account for delivering it
- ensure that the plan is easy to understand and accessible to the public
- also be a vehicle for setting strategies for the shaping of local health services.

10.19 Health improvement programmes are so central to achieving our aims that we want to recognise the success of those health authority areas which, working through NHS and local authority partners, are making a real difference in improving health and tackling health inequality locally. So we are setting up a *Health Improvement Programme Performance Scheme*. The Scheme will reward health authorities which have made the best progress in meeting their targets and objectives. In particular, it will recognise those health communities making progress from a low base, tackling entrenched problems of ill-health, deprivation and poor or fragmented services. In the first year we are investing at least an additional £10 million to drive forward implementation of the *National Service Framework on Coronary Heart Disease*.

'a Health Improvement Programme Performance Scheme

will recognise health communities making progress from a low base, tackling entrenched problems of ill-health, deprivation and poor or fragmented services'

10.20 We will also:

- invite NHS organisations to apply for beacon status where they have examples of good practice. The first 259 NHS Beacons were announced in May including 24 focused specifically on health improvement
- require health authorities to make available on the Internet an annual core health statement. These statements, drawn from local health improvement programmes, will enable experts from around the world to offer advice on the effectiveness of the approach taken.

Building local capability: regenerating health in communities

10.21 There is increasing evidence, including from the World Health Organisation, that having strong social networks benefits health. When people are involved in making the decisions which affect their lives their self-esteem and self-confidence rise, in turn improving their health and well-being. And, of course, many local people, including local workers such as health visitors, have a good understanding of the community's main health problems and of priorities for action.

'Real change can come only from the local community itself by harnessing the energy, skills and commitment of local people'

10.22 For most people these issues come together at the neighbourhood level. We will encourage local people to make their neighbourhoods healthier, for example by identifying and sharing good practice. Real change can come only from the local community itself by harnessing the energy, skills and commitment of local people in setting clear objectives for change and forming new partnerships for action. Sometimes certain individuals - "social entrepreneurs" - are particularly effective in focusing community action to secure change.

Health action zones

10.23 *Health action zones* are leading the way in breaking down organisational barriers. They are using imaginative new ways of providing services which cross boundaries between organisations. We established eleven health action zones from April 1998, and a further 15 started in April this year in some of the most deprived parts of the country. They cover both urban and rural areas.

Healthy living centres

10.24 The development of *healthy living centres* will help people struggling with health problems which may not need medical treatment. Healthy living centres will provide a way in which they can find help and support within their local community. Healthy living centres:

- will promote good health in its broadest sense
- may include a range of facilities, including health screening facilities, dietary advice, smoking cessation, employment, training and skills schemes, parenting classes, exercise classes and child care
- will involve the local community in the planning of the projects.

10.25 They will be funded throughout the UK with £300 million of Lottery money. The first Lottery applications for healthy living centre funding are likely to be agreed this autumn.

'there is a great deal of expertise within local communities, a

nd in non-Governmental organisations'

10.26 We recognise that there is a great deal of expertise within local communities, and in non-Governmental organisations. At local level we will encourage health authorities, local communities, primary care groups and primary care trusts to make use of non-Governmental organisations in delivering programmes. At a national level we will establish a National Forum of Non-Governmental Public Health Organisations to offer expertise and advice.

11 Making it work: standards and success

11.1 People, local communities through key organisations and the Government working together to improve the health of our nation will bring about a significant change in our overall health. But for that partnership to work, the quality of public health practice has to be of the highest possible standard. And in order to know how far and how quickly our drive for improved health is working, we have to be able to measure progress. So our programme for better health has to have both sensible standards and observable measures of success.

'the quality of public health practice is mixed'

Standards

11.2 In some local areas the quality of public health practice is excellent but across the country as a whole the picture is mixed. Many organisations want to do much more to improve the health of the populations they serve. Yet they are often unclear about what they should expect from the programmes they create or from the staff they employ to deliver public health goals.

11.3 Setting standards and measuring progress is now an integral part of the planning and delivery of services to patients in primary care and hospitals within the new NHS.

11.4 Standard setting for public health is not nearly so straightforward. Public heath is multi-disciplinary and multi-agency so standards need to be flexible enough to apply in different organisations and to staff with different backgrounds and training. In addition we do not yet have enough robust evidence in many fields of health on which to base standards. But that does not mean that standards do not have to be set. They do.

'the Government has decided to establish a Health Development Agency'

11.5 To help address these issues the Government has decided to establish a Health Development Agency. The Agency will ensure that organisations and individual practitioners base their work on the highest standards and over time raise the quality of the public health function in England.

'advising on the setting of standards for public

health and health promotion practice'

11.6 In advising and supporting the Secretary of State for Health the new Agency's key functions will include:

- maintaining an up-to-date map of the evidence base for public health and health improvement
- commissioning such research and evaluation as is necessary to support and strengthen the evidence base in areas where action programmes are required to improve health and tackle inequality, within an agreed framework governed by the Secretary of State's overall research strategy for health
- in the light of the evidence, advising on the setting of standards for public health and health promotion practice, and on the implementation of those standards by a range of organisations at national and local level
- in particular, providing advice on targeting health promotion most effectively on the worst off and narrowing the health gap
- through regular bulletins, guidance and advice, disseminating information on effectiveness and good practice in an authoritative, timely and effective manner to those working in the public health/health promotion field
- commissioning and carrying out evidence-based national health promotion programmes and campaigns which are integrated with the Department of Health's overall communications strategy and linked with regional and local activity
- advising on the capacity and capability of the public health workforce to deliver Ministers' strategy in these areas to the agreed standards, and on the education and training needs of the workforce, ensuring throughout that such advice is informed by research evidence and the appropriate quality standards.

Our Healthier Nation in Practice

To increase people's access to information about what is happening on the ground, especially on imaginative, innovative and successful ideas, we are also setting up a database of practice - Our Healthier Nation in Practice - as part of the Our Healthier Nation internet site on www.ohn.gov.uk. This will allow people to search the database for information and learning from a wide range of initiatives. The database will provide a direct contact name and number to encourage sharing of the detailed experience available.

11.7 The Agency will be a statutory body, with the status of a Special Health Authority. It will be established within existing public health resources. The resources of the Health Education Authority will be used to form the core of the new Agency and, consequently, subject to Parliamentary approval, the new Agency will supersede the Health Education Authority. The newly-appointed Chair of the Authority - and its new Board of Non-Executive Directors - will be invited to become the first Chair and Non-Executive Directors of the Agency. The intention is for the Agency to come into being on 1 January next year, subject to passage of necessary legislation through Parliament. The Agency will work closely with the Department of Health including the NHS Executive and its Regional Offices, Government Offices for the Regions, Regional Development Agencies, local authorities and other key players in the field, including the proposed Food Standards Agency.

EDUCATION AND TRAINING FOR HEALTH

11.8 We need to make sure that the public health workforce is skilled, staffed and resourced to deal with the major task of delivering our health strategy.

11.9 Medically-qualified public health staff have played a vital role in the development of the public health movement from the first Medical Officers of Health in Victorian England to the Directors of Public Health today. They must continue to do so in the future but as part of a modern public health workforce made up of people from a wide range of professional backgrounds.

'Those without medical backgrounds have had to put together "do it yourself" careers in public health'

We must ensure that all these diverse groups of professional staff can as necessary:

- manage strategic change
- act as leaders and champions of public health
- work in partnership with other agencies and individuals
- develop communities with a focus on health
- be familiar with public health concepts and use where appropriate evidence in guiding their work
- apply their professional skills and knowledge to play a part in securing the aims set out in this White Paper.

11.10 The challenge of achieving these goals is enormous but the potential benefit of ensuring that a diverse grouping of individual professionals becomes a true public health workforce is huge.

11.11 There are a number of barriers to achieving this. First is the absence of a true multi-disciplinary basis to public health practice. In the past the rhetoric has been strong but it has not always been followed through into practice. Those without medical backgrounds have had to put together "do it yourself" careers in public health. Even then they have often had relatively low status and recognition for their skills and expertise. Secondly, because public health has seemed a less pressing priority than financial and workload imperatives, many managers in the NHS have spent little of their skill and energy on implementing health strategy. Thirdly, there has been insufficient interdisciplinary working across organisational boundaries.

11.12 We intend to address these traditional deficits: to unlock the potential of the entire public health workforce. So we will produce a *Public Health Workforce National Development Plan*. In doing so we will work particularly with the professional bodies responsible for training and education of this diverse range of professional groups.

'to unlock the potential of the entire public health workforce'

11.13 To help with the plan we will also rapidly complete a *Public Health Skills Audit* to determine the current baseline of capacity and capability to deliver our goals through a skilled workforce. We will then expect local health organisations to decide whether they have the right mix of skills to prepare themselves for the shift to the new population- and health-focused agenda of the 21st Century.

Nurses and public health

11.14 Nurses, midwives and health visitors play a crucial part in promoting health and preventing illness. People have close contact with them at key points in their lives - in infancy, during adolescence, pregnancy and childbirth, and in sickness and old age - creating significant opportunities for health promoting interventions.

11.15 We are developing a strategy for nursing, midwifery and health visiting which will help strengthen the public health aspects of their roles. While recognising the potential of all nurses to contribute to public health it will include a focus on the roles of health visitors, school nurses, infection control and occupational health nurses as public health practitioners.

Health visitors as public health practitioners

11.16 We are modernising the role of health visitors to enable them to respond effectively to the challenge of the Government's new policies. So we are encouraging them to develop a family-centred public health role, working with individuals, families and communities to improve health and tackle health inequality.

'modernising the role of health visitors'

11.17 As a result of this modern role:

- parents will receive improved support including parenting education, health advice and information
- individuals and families will be able to have a tailored family health plan agreed in partnership with the health visitor to address their parenting and health needs
- the health needs of families and communities will be met by a team led by a health visitor including nurses, nursery nurses, and community workers
- health visitors will initiate and develop programmes for outreach, based on the experience of organisations such as *Homestart, New pin* and 'community mothers', where local parents use their experience to support others
- neighbourhoods or special groups such as homeless people within a practice or primary care group will have their health needs identified by health visitors, who will lead public health practice and agree local health plans
- local communities will be helped to identify and address their own health needs, for example accident prevention for older people.

'health visitors will lead public health practice and agree local health plans'

11.18 A team led by the health visitor will provide a range of health improvement activities including:

- child health programmes
- parenting support and education including support to *Sure Start*, parenting groups and home visits
- developing support networks in communities, for example tackling social isolation in older people
- support and advice for breastfeeding mothers and women at risk of post-natal depression
- health promotion programmes to target cancer, coronary heart disease and stroke, accidents and mental health
- advice on family relationships and support to vulnerable children and their families.

School nurses as public health practitioners

11.19 School nurses are ideally placed to help children, young people and their parents find the support and services they need. The potential to develop school nurses is a growing element within the *Healthy Schools* programme and their role is being increasingly considered within other Government initiatives, such as tackling teenage pregnancy. Responses to the Home Office document *Supporting Families* have highlighted the importance of the work of school nurses with families.

'The school nursing team will provide a range of health improvement activities'

11.20 School nurses can provide advice and help in areas such as personal relationships, managing stress and risk-taking behaviours. They can complement primary care services by providing a safety-net for children, particularly the most disadvantaged, who may not have had a full child health service before starting school. Their role needs to be developed and supported to enable them to:

- lead teams
- assess the health needs of individuals and school communities and agree individual and school health plans
- develop multi-disciplinary partnerships with teachers, general practitioners, health visitors and child and adolescent

mental health professionals to deliver agreed health plans.

11.21 The school nursing team will provide a range of health improvement activities including:

- immunisation and vaccination programmes
- support and advice to teachers and other school staff on a range of child health issues
- support to children with medical needs
- support and counselling to promote positive mental health in young people
- personal health and social education programmes and citizenship training
- identification of social care needs, including the need for protection from abuse
- providing advice on relationships and sex education by building on their clinical experience and pastoral role
- aiding liaison between, for example, schools, primary care groups, and special services in meeting the health and social care needs of children
- contribute to the identification of children's special educational needs
- working with parents and young people alongside health visitors to promote parenting.

'Midwives are uniquely placed to improve health and tackle inequality through services to women and their babies'

Midwives

11.22 Support for expectant mothers and families with very young children was identified as a high priority by the Acheson Inquiry. Midwives are uniquely placed to improve health and tackle inequality through the innovative services they provide to women and their babies at home and in hospital.

11.23 Midwives can:

- target vulnerable groups through, for example, pregnancy clubs for young single mothers or link workers for black and minority ethnic groups
- provide preconception counselling for prospective parents, targeting smoking cessation, alcohol intake and diet to reduce the risk of low birthweight and premature babies
- work with health visitors and others on post-natal depression, breastfeeding and best practice to avoid Sudden Infant Death Syndrome (cot deaths).

'creating the post of Specialist in Public Health of equivalent status to medically qualified Consultants'

Occupational health nurses

11.24 We are developing the public health role of occupational health nurses and communicable disease control nurses to enable them to use population approaches to assess and manage health needs. Occupational health nurses will be an important source of support for a range of action to improve health at work.

Specialists in public health

11.25 We want to develop future cadres of Consultants in Public Health Medicine in a way which recognises the multi-disciplinary basis of public health practice and removes the glass ceiling which limits their career paths at present. Thus, within the NHS we are creating the post of Specialist in Public Health which will be of equivalent status

in independent practice to medically qualified Consultants in Public Health Medicine and allow them to become Directors of Public Health. And their expertise would apply to other public sector bodies as well as the NHS.

Medical care epidemiologists

11.26 Public health is not just about the wider aspects of population health. For those with chronic and longstanding conditions, improving the outcome of care can mean reducing disabling complications and enhancing quality of life. Specialist skills are necessary in developing and using outcome measures at local level, in ensuring that information systems capture data and in evaluating clinical interventions and diagnostic tests. NHS Trusts and primary care groups will address these issues in different ways but we will be encouraging them to look at the results of a pilot scheme in the Northern and Yorkshire Region in which Medical Care Epidemiologists have been employed by NHS Trusts.

INFORMATION FOR HEALTH

11.27 We need a clearer national picture of health and health inequality so that we can track changes over time. Many agencies are involved in collecting and using information about health and disease in the population. Yet in some cases information may not be available, or may be unreliable.

11.28 At local level data may be even patchier. Data derived from national health surveys, for example, although offering an excellent national picture will often not be enough to provide the necessary level of information at a more local level.

'we will ensure that there is a Public Health Observatory in each NHS region of the country'

11.29 We will be carrying out a *Review of National Sources of Public Health Information* to see where they need to be strengthened to increase our ability to assess health and track progress in achieving the goals of this White Paper.

11.30 In order to strengthen the availability and use of information about health at local level we will ensure that there is a *Public Health Observatory* in each NHS region of the country. These observatories will be closely linked with universities to help bring an academic rigour to their work. Their main tasks will be to support local bodies by:

- monitoring health and disease trends and highlighting areas for action
- identifying gaps in health information
- advising on methods for health and health inequality impact assessments
- drawing together information from different sources in new ways to improve health
- carrying out projects to highlight particular health issues
- evaluating progress by local agencies in improving health and cutting inequality
- looking ahead to give early warning of future public health problems.

11.31 Public health observatories will work closely with NHS bodies, local authorities, NHS Executive Regional Offices, the Government Offices for the Regions and Regional Development Agencies as well as the new Health Development Agency. They will be linked together to form a national network of knowledge, information and surveillance in public health and will be a major new resource for local bodies working in public health.

11.32 The Liverpool Public Health Observatory was established in 1990, and provides some of the key elements which will be necessary in establishing the new network of observatories.

LIVERPOOL PUBLIC HEALTH OBSERVATORY

Examples of topics covered since 1990 include

- planned parenthood

- family planning, abortion and fertility
- coronary heart disease and stroke
- drug misuse and drug misuse services
- alcohol abuse; needs assessment and services review
- deafness
- asthma and environmental pollution
- environmental causes of death and disability
- tuberculosis and poverty
- cystic fibrosis and deprivation
- health impact assessment of the Merseyside Integrated Transport Strategy.

11.33 We will strengthen the information base on chronic diseases in the population by establishing a series of *Disease Registers* in different parts of the country. These registers will enable us to know, for example, how many people in a population are suffering from coronary heart disease, stroke, diabetes, asthma, high blood pressure. They will act as a base for investigation into disease causes, for evaluating new ways of delivering services as well as tracking changes in disease occurrence over time. These registers will draw on the work which we have already put in train through our *Information for Health* programme, and will complement the existing registers for cancer.

11.34 We will also use in a more systematic way the annual reports by Directors of Public Health, which are an important source of information on the main health problems and issues. We will ensure that they are used as a basis for the formulation of health improvement programmes and are fully relevant to local authorities as well as health authorities. We will ensure that they meet a common set of standards.

RESEARCH

11.35 Research plays a major role in helping us understand better the causes of ill-health, including the different ways our lifestyle and environment affect our health and our children's health. Public health research is also important in establishing the effectiveness of health programmes but we need to widen the scope of the methods used beyond the randomised controlled trial. In the past it has been the gold standard for research but it is no longer applicable to all the kinds of research questions which need to be answered.

11.36 We are carefully mapping all available research and will draw on it to develop a *Research and Development Strategy for Public Health*. In doing this we will make sure that the results of research are easily accessible to those who need to use them, that the programmes of work tackle our priority areas, that methods are appropriate and innovative and that there is a skilled research and development workforce in place.

'We want to create a climate in which academic

excellence can flourish'

11.37 The NHS spends around £420 million annually on research. Much of this investment covers the four priority areas for this health strategy - cancer, coronary heart disease and stroke, accidents and mental health. The Central Research and Development Committee for the NHS has established review groups in each of the four priority areas. These groups will report in the autumn, and recommend any necessary realignment of this research and development spending to ensure the most effective contribution to *Our Healthier Nation*.

11.38 Given the importance of a sound evidence base to underpin public health there needs also to be a strong and high-quality academic base to support both research and teaching. Unfortunately at present academic public health is not as rigorous as we would like to see it. Younger people are not opting for careers in the discipline and senior academic posts are becoming more difficult to fill. We want to create a climate in which academic excellence can flourish. So we are setting up a *Fast Track Development Programme* for young public health academics who will be the catalyst for the transformation we are seeking to achieve. As a first step we are setting up a pilot project in which research fellowships are jointly created between the Medical Research Council and the NHS Research and Development Directorate linked to a new initiative, *The Health of the Public*.

INVESTING FOR PROGRESS

11.39 We are creating a *Public Health Development Fund* as part of the Modernisation Fund for Health. It will be worth at least £96 million over three years. It will provide seed corn for new approaches in public health, to help and encourage the development of innovative ideas and to help tackle health inequality. The Fund will principally support action to save lives within the priority areas set out in this White Paper.

'We are creating a Public Health Development Fund'

11.40 Spending plans for the first year, amounting to £25 million, are already well advanced and cover a range of national, regional and local initiatives. The Fund will focus on four distinctive, though complementary, programmes, each designed to underpin the strategic framework in this White Paper. The first (£9 million in 1999/00) is directed primarily to the priority areas of cancer, coronary heart disease and stroke, accidents and mental health, but includes also work on infant feeding and the Health Visiting and School Nursing Innovation Fund. The second programme (£3.5 million) will help to develop the range of healthy settings. The third (£3.5 million) will fund key aspects of our *Healthy Citizens* programme that are not already being resourced in other ways. And the fourth (£9 million) will support the public health strategy as a whole in areas such as health impact assessment, the development of public health observatories and the improvement of infection control. This programme includes £4 million to be spent at regional level on a range of activities that, among other things, will help to develop the public health function.

'we have decided to set interim milestones in each of the four priority areas'

Success

11.41 We are setting out an ambitious programme to achieve our goals and targets for a long-term sustained improvement in health. They will take many years to deliver fully; and we need to be able to check our progress along the way. So we have decided to set interim milestones in each of the four priority areas for 2005. These milestones will tell us if we are on course to achieve our targets for the year 2010.

11.42 Our assessment of progress will cover:

- the targets themselves - reduction in mortality rates in our four priority areas of cancer, coronary heart disease and stroke, accidents and mental health
- improvements in the risk factors which have a direct bearing on our four targets
- movement in underlying factors which reflect social, environmental and economic change which the evidence shows to have an influence on health and inequality

- effectiveness of programmes - as part of assessing progress we need to know that action of the right kind is in place, supported by the development of capacity and capability in public health. We will monitor these aspects of progress through a range of mechanisms including health improvement programmes, local authorities' community plans and *Best Value* and the national service frameworks.

Fig 11.1 Cancer: how the strategy will save lives

Fig 11.2 Circulatory disease: how the strategy will save lives

Fig 11.3 Accident injury: how the strategy will save lives

Fig 11.4 Suicide: how the strategy will save lives

11.43 We shall support this process by publishing a Technical Supplement to this White Paper setting out the scientific basis for target setting and the indicators available for the assessment of progress across the whole range of influences on health - environmental and behavioural risk factors, as well as health outcomes.

11.44 To complement our continuous monitoring, every three years we will review and publish changes at national level to:

- expectation of life
- healthy life expectancy
- health inequality

Local targets for improving health

11.45 Much of the action that we are putting in place will be delivered at the level of local communities. We expect health authorities and their partner local authorities as well as other local agencies to set out in their health improvement programme how they plan to achieve the national priorities through targets at local level. Health improvement programmes will be required to include additional local targets to address particular local priorities and to cut health inequality.

Managing performance

11.46 We want the achievement of results in delivering *Saving lives: Our Healthier Nation* to matter as much to local agencies as hitting the targets in the other important programmes they deliver. A health organisation should take as much pride in reaching the targets set out here as in achieving its targets on waiting lists and times. The goals in this White Paper must be as rigorously pursued by performance managers as any other targets.

'We will hold NHS bodies to account through the new NHS performance assessment framework'

11.47 We will hold NHS bodies to account through the new NHS performance assessment framework. The NHS Executive Regional Offices will ensure that they set realistic but demanding targets for local achievement, and will monitor their performance. Where appropriate they will "benchmark" a body's objectives by comparing them with the plans of other bodies in broadly similar circumstances. A parallel performance assessment process applies to social services authorities, while local government overall is subject to the *Best Value* regime. External auditors will provide a rigorous check on the information provided by authorities in local performance plans, and on the management systems that underpin them. There will also be an objective and independent process of regular inspection for all local services.

'the new rigour and drive we are bringing

to public health'

11.48 To strengthen accountability the Audit Commission is developing ways of auditing areas of joint working between these agencies at local level, using its experience of carrying out local value for money studies.

CONCLUSION

11.49 This White Paper sets out our health strategy for England: the goals, the targets, and how we propose to reach them. Success will be built on the new rigour and drive we are bringing to public health. We expect everyone to play their part in making this strategy deliver its full potential. We shall ensure that public health is subject to the same concerted development and performance management as every other area of Government policy, so that we can secure real and rapid progress. We all stand to gain. This strategy will give us all longer lives, healthier lives, and make ours a fairer country.

'We shall ensure that public health is subject to concerted development and performance management'

Appendix 1

A National Contract on Cancer	People can:	Local Players and Communities can:	Government and National Players can:
Social & Economic	Take opportunities to better their lives and their families' lives through education, training and employment Participate in social networks and provide social support to others to reduce stress, and to give them help to give up smoking	Tackle social exclusion in the community to make it easier for people to make healthy decisions Work with deprived communities and with businesses to ensure a more varied and affordable choice of food (including fruit and vegetables)	Increase the tax on cigarettes by 5 per cent in real terms each year End advertising and promotion of cigarettes Prohibit sale of cigarettes to youngsters and ensure enforcement Seek to ensure cheaper supplies of fruit and vegetables Tackle joblessness, social exclusion, low educational standards and other factors which make it harder to live a healthier life
Environmental	Protect others from secondhand smoke and children from sunburn	Through local employers, make smoke-free environments the norm, with adequate separate provision for smokers and availability of smoke extractors where possible Tackle radon in the home (e.g. through direct advice from local authorities to affected householders)	Encourage employers and others to provide a smoke-free environment for non-smokers Encourage local action to tackle radon in the home and to eliminate risk factors in the workplace (e.g. enforcing regulations on asbestos and encouraging provision of non-smoking areas) and the environment (e.g. air pollutants) Continue to press for international action to restore the ozone layer

A National Contract on Cancer	People can:	Local Players and Communities can:	Government and National Players can:
Personal behaviour	Stop smoking, increase consumption of fruit, vegetables, and dietary fibre each day, avoid high consumption of red and processed meat, keep physically active, maintain a healthy body weight that does not increase during adult life Cover up in the sun Practise safer sex Follow Sensible Drinking advice	Encourage the development of healthy workplaces and healthy schools Target health information on groups and areas where people are most at risk	Develop healthy living centres Fund health education campaigns to provide reliable and objective information on the health risks of smoking, poor diet and too much sun Encourage research into ways to modify high risk behaviours (e.g. low consumption of fruit and vegetables)
Services	Attend cancer screenings when invited (i.e. for breast and cervical screening in women) Seek advice promptly if they notice danger signs Participate in managing their own illness and treatment	Provide effective help in stopping smoking to people who want to stop especially for disadvantaged groups Work with voluntary organisations to provide clear and consistent messages about early detection and uptake of screening Ensure that vulnerable groups have equitable access to screening services Ensure rapid specialist treatment for cancers when they are diagnosed	Encourage doctors, dentists, nurses and other health professionals to give advice on prevention Ensure smokers have access to high-quality smoking cessation services, particularly in health action zones Ensure that healthy schools work with pupils and parents to improve health Maintain effective, appropriate and high quality existing cancer screening programmes and consider possible extensions of these Ensure all patients with suspected cancer are seen by a specialist within 2 weeks of urgent referral by a GP Ensure equal access to high quality treatment and care, through

			implementation of the expert report on the organisation and management of NHS cancer services

A National Contract on Coronary Heart Disease and Stroke	**People can:**	**Local Players and Communities can:**	**Government and National Players can:**
Social & Economic	Take opportunities to better their lives and their families' lives, through education, training and employment Cycle or walk to work	Tackle social exclusion in the community which makes it harder to have a healthier lifestyle Provide incentives to employees to cycle or walk to work, or leave their cars at home	Continue to make smoking cost more through taxation Tackle joblessness, social exclusion, low educational standards and other factors which make it harder to live a healthier life
Environmental	Protect others from secondhand smoke	Through local employers and others, provide a smoke-free environment for non-smokers Through employers and staff, work in partnership to reduce stress at work Implement the Integrated Transport Policy - *A New Deal for Transport: Better for Everyone* - including a national cycling strategy and measures to make walking more attractive Provide safe cycling and walking routes	Encourage employers and others to provide a smoke-free environment for non-smokers

A National Contract on Coronary Heart Disease and Stroke	**People can:**	**Local Players and Communities can:**	**Government and National Players can:**
Personal behaviour	Stop smoking or cut down, watch what they eat and take regular physical activity	Encourage the development of healthy schools and healthy workplaces	Control advertising and promotion of cigarettes Develop healthy living

	physical activity	workplaces	centres
	Manage their blood pressure if they are at risk of or suffering from circulatory disease	Target information about a healthy life on groups and areas where people are most at risk	Ensure access to and availability of a wide range of foods for a healthy diet
		Enforce the ban on illegal sale of cigarettes to underage smokers	Provide sound information on the health risks of smoking, poor diet and lack of physical activity
Services	Learn how to recognise a heart attack and what to do, including resuscitation skills	Provide help to people who want to stop smoking	Encourage doctors and nurses and other health professionals to give advice on healthier living, and deliver effective and efficient services
	Have their blood pressure checked regularly	Reduce waiting times for coronary artery surgery and angioplasty	
	Take medicine as it is prescribed	Aim to reduce the incidence of second strokes	Develop National Service Frameworks and work towards their implementation
		Improve access to a variety of affordable food in deprived areas	
		Support those suffering from coronary heart disease and stroke, and their carers	
		Provide facilities for physical activity and reliable transport to help people get to them	
		Identify those at high risk of coronary heart disease and stroke and provide high quality services	
		Implement the National Service Frameworks	

A National Contract on Coronary Heart Disease and Stroke	**People can:**	**Local Players and Communities can:**	**Government and National Players can:**
Personal behaviour	Stop smoking or cut	Encourage the	Control advertising and

	down, watch what they eat and take regular physical activity Manage their blood pressure if they are at risk of or suffering from circulatory disease	development of healthy schools and healthy workplaces Target information about a healthy life on groups and areas where people are most at risk Enforce the ban on illegal sale of cigarettes to underage smokers	promotion of cigarettes Develop healthy living centres Ensure access to and availability of a wide range of foods for a healthy diet Provide sound information on the health risks of smoking, poor diet and lack of physical activity
Services	Learn how to recognise a heart attack and what to do, including resuscitation skills Have their blood pressure checked regularly Take medicine as it is prescribed	Provide help to people who want to stop smoking Reduce waiting times for coronary artery surgery and angioplasty Aim to reduce the incidence of second strokes Improve access to a variety of affordable food in deprived areas Support those suffering from coronary heart disease and stroke, and their carers Provide facilities for physical activity and reliable transport to help people get to them Identify those at high risk of coronary heart disease and stroke and provide high quality services Implement the National Service Frameworks	Encourage doctors and nurses and other health professionals to give advice on healthier living, and deliver effective and efficient services Develop National Service Frameworks and work towards their implementation
A National Contract on	**People can:**	**Local Players and**	**Government and**

Accidents		**Communities can:**	**National Players can:**
Social & Economic	Take opportunities to improve their education, training and employment	Monitor care homes for older people Promote safety practices at work Tackle social exclusion (*New Deal*, urban regeneration) Work within health improvement programmes on local partnership to improve local accident prevention initiatives, e.g. better identification of highest risks/priorities/targets Promote safety measures to community groups Raise public awareness of risks	Develop *New Deal for Communities* Remove obstacles to partnership Promote parental education *(Sure Start)* Improve provision of consistent monitoring data Co-ordinate Government strategy on accident prevention
Environmental	Install, check and maintain smoke alarms Maintain household appliances to reduce accidents in the home Wear seatbelts on car journeys Drive safely and within speed limits Ensure that they play an effective role in workplace safety procedures	Install smoke alarms in local and health authority properties Encourage private sector safety checks on appliances Develop traffic calming and other measures for local safety schemes as part of local transport plans Give greater priority to walking and cycling in local transport plans Adopt school travel and green transport plans Promote/maintain home safety checks for older people Develop safe play areas Maintain highways,	Ensure safety standards in new buildings Continue work on improving product standards Monitor standards for sports facilities and equipment Monitor water safety co-ordination at national level Promote *Design for Safety* Monitor vehicle safety standards Support for pilot schemes and voluntary bodies (e.g. Child Safety Week) Implement EC regulations on accident prevention

		pavements and playgrounds Identify/safeguard potentially hazardous sites (rivers, railways, dumps etc) Undertake community safety audits/risk assessment Ensure well-developed emergency planning	Develop road safety strategy
A National Contract on Accidents	**People can:**	**Local Players and Communities can:**	**Government and National Players can:**
Personal behaviour	Avoid drinking and driving Ensure that cyclists, especially children and young people, wear cycle helmets Undertake effective training to improve road safety skills Ensure that children and young people take up cycle / pedestrian training Take up physically active lifestyles (to improve bone density and prevent osteoporotic fractures) Ensure a healthy diet (with sufficient calcium and vitamin D intake for bone health)	Conduct local campaigns (LEAs) on accidental injury prevention Ensure more effective enforcement - fire, police, trading standards Put measures in place on prevention (e.g. stairgates, car seats) and rehabilitation (e.g. aids for older people) Ensure effective provision/loans of safety equipment to target groups Develop private sector promoting safety culture for occupational road use Promote swimming training	Provide education / publicity on drink-drive Provide education/publicity on speed management Promote accident prevention through schools programmes (Healthy Schools Award) Promote *Safer Routes to School* Set up Youth Networks, playgroup associations Target health action zones/education action zones/SRB/*New Deal for Communities*
Services	Have regular eye tests Learn basic resuscitation/emergency skills	Provide pedestrian training for children Continue reviews of medication, eyesight in older people (over 75 check) Promote safety awareness, with risk	Develop and implement *National Service Framework for Older People*

		assessment of fallers, on discharge from hospital Promote local initiatives on physical activity in older people Promote cycle proficiency schemes Promote family support - accident awareness, parenting skills Take part in *Healthy Schools* programmes Provide local alcohol services Ensure integrated service provision	
A National Contract for Mental health Social & Economic	**People can:** Take opportunities to improve their education, training and employment Develop parenting skills Support friends at times of stress - be a good listener Participate in support and self-help groups Work to understand the needs of people with mental illness	**Local Players and Communities can:** Tackle inequity and social exclusion Work within health improvement programmes to develop local mental health initiatives on prevention, better identification and treatment, including help for at-risk groups such as recently bereaved, lone parents, unemployed people, refugees Develop job and volunteeering opportunities for people with mental illness Develop strategies to support the needs of mentally ill people from black and minority ethnic groups	**Government and National Players can:** Consider the mental health impact when developing policy on employment, education, social welfare, child abuse, children in care and leaving care, refugees and substance misuse Develop *New Deal for Communities* Tackle joblessness, and social exclusion Improve provision of mental health systems and collection of information Tackle alcohol and drug misuse Ensure responsible media reporting of suicide and

		Encourage positive local media reporting to reduce stigma surrounding mental illness	homicides
Environmental	Improve workload management Support colleagues Visit elderly friends and family who are isolated Encourage children to read Encourage children to adopt a healthy diet and take physical activity Be alert to bullying at school Be alert to glue sniffing and substance misuse in schools Engage in regular parent-teacher dialogue Ensure children have safe access to public open space	Develop effective housing strategies which meet the needs of local communities Reduce stress in the workplace Develop local initiatives to reduce crime and violence and improve community safety Develop school programmes for mental health promotion including coping strategies, social supports and anti-bullying strategies, substance misuse detection and treatment Develop local programmes to tackle dyslexia in schools Encourage use of open spaces for leisure and social events	Continue to invest in housing, supported housing, to reduce discrimination and stigmatisation and reduce homelessness Encourage employers to develop workplace health policies which address mental health Reduce isolation through equitable transport policies Promote healthy schools and include mental as well as physical health education Promote healthy prisons and address mental illness in prisoners

A National Contract for Mental health	**People can:**	**Local Players and Communities can:**	**Government and National Players can:**
Personal behaviour	Use opportunities for relaxation and physical exercise and try to avoid using alcohol/smoking to reduce stress Increase understanding of what good mental health is Contribute to the creation of happy and healthy	Support people with severe mental illness and ensure their access to other mainstream services for physical health as well as the mental health care they need	Increase public awareness and understanding of mental health and mental illness Reduce access to means of suicide Develop healthy living centres

	work and school environments		
Services	Contribute information to service planners and get involved Contact services quickly when difficulties start Increase knowledge about self-help	Develop range of comprehensive and culturally sensitive mental health services in accordance with *Modernising Mental Health Services* Implement the *National Service Framework for Mental Health* Provide advice and practical help on financial, housing, day care, and work problems	Develop the *National Service Framework for Mental Health* Provide incentives to emphasise good mental health care Audit all suicides and learn the lessons for prevention (the Confidential Inquiry into Suicide and Homicide)

Appendix 2

Our Healthier Nation White Paper - Glossary and References

Glossary and Technical Notes

National Targets - to reduce mortality from: cancer; coronary heart disease and stroke and related conditions; suicide; and to reduce the rate of fatal and serious injury from accidents.

Target year: 2010 for all four targets.

Baseline year:

Mortality targets: the average of the European age standardised rates for the three years 1995, 1996 and 1997.
Serious injury from accidents target: the hospital admission rates for the year 1995/96.

Sources of data:

Mortality targets: Office for National Statistics (ONS) mortality statistics from death registrations. Mortality rates are age standardised to allow for changes in the age structure of the population (using the European standard population as defined by the World Health Organisation).
Serious injury target: Hospital Episode Statistics.

Definitions:

Cancer - all malignant neoplasms - ICD-9 codes 140-208 inclusive.
Age group: under 75.
Target reduction by year 2010 - at least **one fifth (20%).**

Coronary heart disease and stroke and related conditions - includes all circulatory diseases - International Classification of Diseases ICD-9 codes 390-459 inclusive.
Age group: under 75.
Target reduction by year 2010 - at least **two fifths (40%).**

Accidents - mortality from accidents and adverse effects - ICD-9 codes E800-E949 inclusive
Age group: all ages
Target reduction by year 2010 - at least **one fifth (20%).**

- serious accidental injury relating to hospital admissions defined by ICD-10 codes as below
Age group: all ages
Target reduction by year 2010 - at least **one tenth (10%).**

The injury must be sufficiently serious to require a hospital stay of four days or more

Accident morbidity

- Primary diagnosis must indicate an injury, ie is in range S00 through T98X

- External cause code must be in one of the following ranges:
- V01 - V99 Transport accidents
- W00 - X59 Other external causes of accidental injury (mostly falls)
- Y40 - Y8 Complications of medical and surgical care
- Length of stay must exceed 3 days.

As some records with a primary diagnosis indicating an injury do not contain a valid external cause code, these codes will be scaled out in proportion to the records with a valid cause code before applying the second rule above. Coding of external cause is consistently improving and this correction will decrease in importance as coding approaches 100%.

Suicide - suicide and undetermined injury - ICD-9 codes E950-E959 plus E980-E989 minus E988.8
Age group: all ages.
Target reduction by year 2010 - at least **one fifth (20%).**

International Classification of Diseases

The World Health Organisation maintains a statistical classification of diseases, injuries and causes of death, which is internationally recognised and used. Currently, the ninth revision of this classification (ICD-9) is used in England for differentiating causes of death, but the tenth revision (ICD-10) is used for classifying hospital episodes.

Suicide and undetermined injury

Official suicides are those in which the coroner or official recorder has decided there is clear evidence that the injury was self-inflicted and the deceased intended to kill himself. Unofficial suicides or open verdicts are those where there may be doubt about the deceased's intentions. Research studies show that most open verdicts are in fact suicides. For the purposes of comparisons with other countries, the figures quoted are for official suicides, but for the purpose of measuring overall suicides in England, official suicides and open verdicts are combined.

Social class

The Registrar General's Social Class groupings used in this document are as follows:

	Social class grouping	**Example occupations**
I	Professional	Doctors, engineers
II	Managerial/technical	Managers, teachers
IIIN	Non-manual skilled	Clerks, cashiers
IIIM	Manual skilled	Carpenters, van drivers
IV	Partly skilled	Warehousemen, security guards
V	Unskilled	Labourers

It should be noted that the proportion of the working population falling into these groups changes over time, and comparisons of social class groupings over time should therefore be interpreted with caution.

Chapter Two

Fig no. Description

2.1 A major decline in death from all infectious diseases in the 20th Century

Derived from: Office for National Statistics. Charlton J, Murphy M, eds. *The Health of Adult Britain*: *1841-1994*. London: The Stationery Office, 1997.

Additional data to 1997 from series DH2 nos 22,23,24. London: The Stationery Office, 1997, 1998, 1998.

2.2 Major improvements in expectation of life after centuries of early death

Office for National Statistics. Drever F, Whitehead M, eds. *Health Inequalities*. London: The Stationery Office, 1997.

2.3 Major fall in infant deaths in the 20th century

Office for National Statistics. *Mortality Statistics: Childhood, infant and perinatal (series DH1 no. 19 (1841-1985) and DH3)*. London: The Stationery Office, DH1 - 1989, and DH3 - 1990-1998.

2.4 Age at death at the start and end of the 20th century

1900 The Registrar General. *Sixty-Third Annual Report of the Registrar General of Births, Deaths and Marriages in England, 1900*. London: HMSO, 1902.

1997 Office for National Statistics. *Mortality Statistics Cause, England and Wales 1997 (DH2 no.24)*. London: The Stationery Office, 1998.

2.5 Selected causes of death at the start, middle and end of this century

1900 The Registrar General. *Sixty-Third Annual Report of the Registrar General of Births, Deaths and Marriages in England, 1900*. London: HMSO, 1902.

1950 Office for National Statistics. Charlton J, Murphy M, eds. *The Health of Adult Britain: 1841-1994*. London: The Stationery Office, 1997.

1997 Office for National Statistics. *Mortality Statistics Cause, England and Wales, 1997 (DH2 no.24)*. London: The Stationery Office, 1998.

2.6 Deaths before age 75 years in England annually: a major contribution from the four priority areas

Based on : Department of Health. *Public Health Common Data Set, 1998*.

(Derived from Office for National Statistics data). London: London School of Hygiene and Tropical Medicine, 1998.

2.7 Unhealthy years at the end of life

Bone M R, Bebbington A C, Jagger C, Morgan K, Nicolaas G. *Health Expectancy and Its Uses*. London: HMSO, 1995.

Chapter Three

Fig no. Description

3.1 Heart disease among public sector workers: higher rates associated with lack of control over job

Bosma H, Marmot M, Hemingway H, Nicholson A, Brunner E, Stansfield S.

Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study. *British Medical Journal* 1997; **314:** 558-565.

Chapter Four

Fig. no. Description

4.1 Death and disadvantage: excess death rates amongst men in non-professional classes

Office for National Statistics. Drever F, Whitehead M, eds. *Health Inequalities*. London: The Stationery Office, 1997.

4.2 The widening mortality gap between social classes

Office for National Statistics, Decennial Supplements, indexed by Department of Health Statistics Division 2.

4.3 Asthmatics are two to three times more likely to live in damp properties

Williamson I J, Martin C J, McGill G, Monie R D H, Fennerty A G. *Damp Housing and asthma: a case-control study. Thorax,* 1997; **52:** 229-234.

Chapter Five

Fig. no. Description

5.1 Change in annual death rates: some improving, some worsening

Analysed by Department of Health, Statistics Division 2, from Office for National Statistics data.

5.2 Death rates from all cancers - England in the middle of the Western Europe rankings

World Health Organisation, Copenhagen. Health For All indicators database (EU) England data analysed by Department of Health, Statistics Division 2 from Office for National Statistics data (ICD-9 140-208)

5.3 Death rates from breast cancer: UK amongst the worst in Western Europe

World Health Organisation, Copenhagen. Health For All indicators database (EU) England data analysed by Department of Health, Statistics Division 2, from Office for National Statistics data. (ICD-9 174)

5.4 Death rates from cervical cancer: English women amongst worst in Western Europe

World Health Organisation, Copenhagen. Health For All indicators database (EU) England data analysed by Department of Health, Statistics Division 2, from Office for National Statistics data. (ICD-9 180)

5.5 Cancer survival: England and Wales generally lag behind Europe and USA

Office for National Statistics. *Cancer Survival Trends in England and Wales 1971-1995. Deprivation and NHS Region*. London: The Stationery Office, 1999.
(Includes data from Eurocare II (EU) and Seer (USA))

5.6 Survival is better in affluent than in deprived areas

Office for National Statistics. *Cancer Survival Trends in England and Wales 1971-1995. Deprivation and NHS Region*. London: The Stationery Office, 1999.

5.7 Some spectacular breakthroughs: five year survival rates for acute lymphoblastic leukaemia in children.

Cancer Research Campaign Factsheet 23.2 1995 and Office for National Statistics. *Cancer Survival Trends in England and Wales 1971-1995. Deprivation and NHS Region*. London: The Stationery Office, 1999.

5.8 Ways of beating cancer: examples of how everyone can play their part

Chapter Six

Fig no. Description

6.1 Death rates from circulatory disease: UK amongst highest in Western Europe

World Health Organisation, Copenhagen. Health For All indicators database (EU). (ICD-9 390-459)

6.2 Death rates from stroke: English women one of the worst records in Western Europe

World Health Organisation, Copenhagen. Health For All indicators database (EU) England data analysed by Department of Health, Statistics Division 2, from Office for National Statistics data. (ICD-9 430-438)

6.3 Levels of smoking have fallen more quickly in professional classes

Office for National Statistics. Series *General Household Survey (1972-1996)*.
London: The Stationery Office 1974-1998.

6.4 Obesity in women: higher levels amongst manual social groups

Social and Community Planning Research (SCPR), Department of Epidemiology and Public Health. Prescott-Clarke P, Primatesta P eds. *Health Survey for England 1996*. London: The Stationery Office, 1998.

6.5 Well under half of people with high blood pressure are treated successfully

Social and Community Planning Research (SCPR), Department of Epidemiology and Public Health. Prescott-Clarke P, Primatesta P eds. 1991-96 data from *Health Survey for England 1996*. London: The Stationery Office, 1998. Data for *Health Survey for England 1997* published on Internet website: www.doh.gov.uk/stats/hstab97/intro.htm

6.6 Unequal risk of heart disease death at different employment levels in the public sector: even after allowing for risk factors

Marmot M, Shipley M J, Rose G. Inequalities in death - specific explanations of a general pattern? *The Lancet* 1984; **1;** 1003-1006.

6.7 Differing rates of coronary bypass operations and angioplasties

Department of Health, Hospital Episode Statistics data, calculated by Statistics Division 2. Figures are provisional, no adjustments have been made for shortfalls in data (i.e. the data are ungrossed).

6.8 Ways of beating coronary heart disease and stroke: examples of how everyone can play their part

Chapter Seven

Fig no. Description

7.1 Deaths from motor vehicle traffic accidents: England performs comparatively well

World Health Organisation, Copenhagen. Health For All indicators database (EU) England data analysed by Department of Health Statistics Division 2, from Office for National Statistics data. (ICD-9 E810-E819)

7.2 Death rates from all accidents in children

England data analysed by Department of Health, Statistics Division 2, from Office for National Statistics data.

7.3 Child pedestrian deaths: England one of the worst records in Europe

International Road Traffic and Accident database (OECD) via Department of the Environment, Transport and the Regions. From website - www.bast.de/indexeng.htm

7.4 Accidents kill proportionately more children as they grow up

Analysed by Department of Health, Statistics Division 2, from Office for National Statistics data

7.5 Deaths from accidental falls in older people are not reducing

Analysed by Department of Health, Statistics Division 2, from Office for National Statistics data.

7.6 Childhood accident deaths involving head injury occur close to home

Derived from Sharples P M, Storey A, Aynsley-Green A, Eyre J A. *British Medical Journal* 1990; **301:** 1193-7.

7.7 Traffic calming can cut pedestrian road accidents

Birmingham City Council via Birmingham Health Authority.

7.8 Ways of beating accidental injury: examples of how everyone can play their part

Chapter Eight

Fig no. Description

8.1 Death rates from suicide: England one of the best records in European Union

World Health Organisation, Copenhagen. Health For All indicators database (EU) England data analysed by Department of Health, Statistics Division 2, from Office for National Statistics data. (ICD-9 E950-E959).

8.2 Ways of beating mental health problems: examples of how everyone can play their part

Chapter Nine

Fig no. Description

9.1 Live births to teenage women in Europe: UK has the highest rate in Western Europe

Eurostat and United Nations Demographic Yearbook 1996, via Social Exclusion Unit.

9.2 Underage pregnancies: a map of inequalities

Based on: Department of Health. *Public Health Common Data Set, 1998*. (Derived from Office for National Statistics data). London: London School of Hygiene and Tropical Medicine, 1998.

9.3 Percentage of young males and females who have taken illicit drugs

Ramsay M, Spiller J, *Drug Misuse Declared in 1996: Latest Results from the British Crime Survey*. Home Office Research Study no 172. London: Home Office,
1997.

9.4 Some of the most common adverse health effects of heavy alcohol consumption

Department of Health. Based on *Sensible drinking. The report of an inter- departmental working group*. Department of Health, 1995

9.5 The rising trend of reports of food poisoning

Public Health Laboratory Service, website - www.phls.co.uk/facts/foodt1.ht

9.6 Vaccination conquers disease: the trend for diphtheria

Derived from: Office for National Statistics. Charlton J, Murphy M, eds. *The Health of Adult Britain: 1841-1994*. London: The Stationery Office, 1997. Additional data to 1997: Public Health Laboratory Service,

website - www.phls.co.uk/facts/dip.htm

9.7 An old adversary returning: the recent rise in tuberculosis

Public Health Laboratory Service, website - www.phls.co.uk/facts/tube-toi.htm

9.8 Women in some ethnic groups have a low uptake of potentially life-saving cervical cancer smears

Health Education Authority. Kai Rudat ed. of MORI Health Research Unit. *Black and Minority Ethnic Groups in England*. *Health and Lifestyles*. Great Britain: BPC Wheatons Ltd; 1994.

9.9 Relative mortality from coronary heart disease by ethnic origin

Wild S, McKeigue P: *British Medical Journal* **314,** (7082) 1997: 705-710, from Office for National Statistics data.

9.10 High rates of suicide amongst young women born in the Indian sub-continent and living in this country

Soni Raleigh V. Suicide patterns and trends in people of Indian Subcontinent and Caribbean origin in England and Wales. *Ethnicity and Health,* 1996:**1**(1): 55-63.

Chapter Eleven

Fig no. Description

11.1 Cancers: how the strategy will save lives

11.2 Circulatory disease: how the strategy will save lives

11.3 Accidental injury: how the strategy will save lives

11.4 Suicide: how the strategy will save lives

Estimates by Department of Health Economics and Operational Research Division, based on mortality data from Office for National Statistics.

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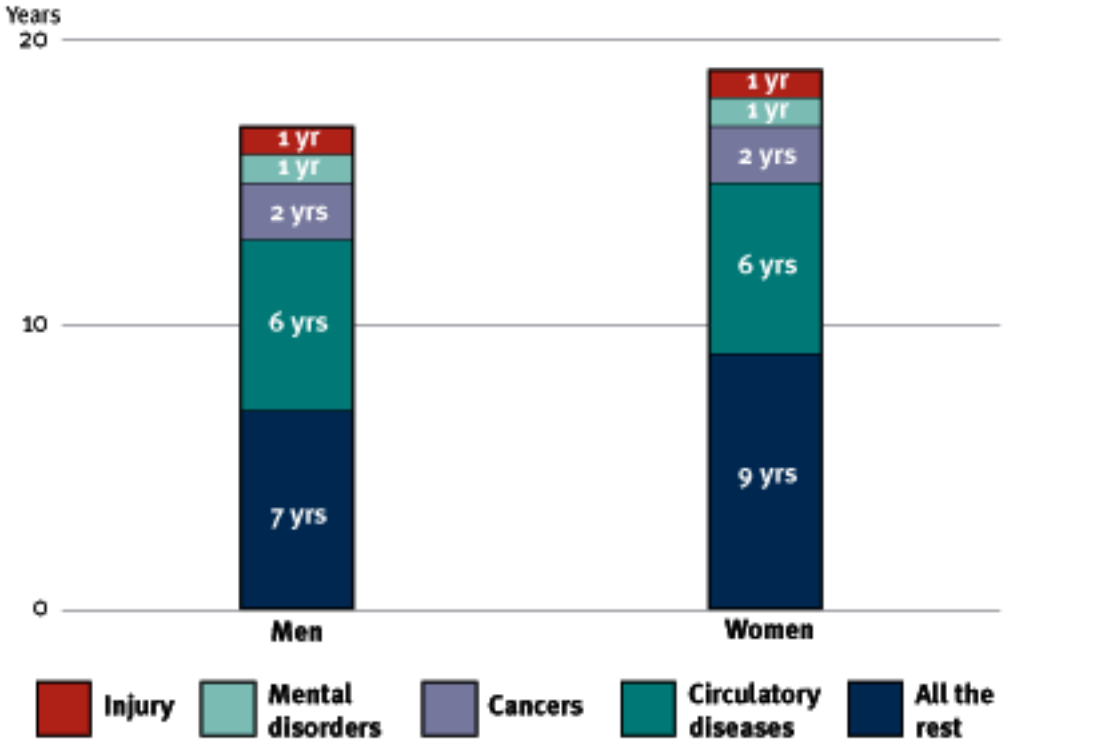
Fig 2.7 Unhealthy years at the end of life



Figures include some double-counting, as individuals may suffer from more than one condition

Source: Bone M, Bebbington A, Jagger C, et al. (see References Section)

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