Our Healthier Nation

A Contract for Health

Presented to Parliament by the
Secretary of State for Health
by Command of Her Majesty,
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Foreword

Good health. It's not just a toast. It's what everybody wants for themselves, their family and friends. If you are a parent, it's the supreme gift you'd like to give your children. For the sake of every individual, for society and for the economy, it should be a top priority for any Government. It is a top priority for this Government.

While health generally has improved, far too many people are still
falling ill and dying sooner than they should. The NHS is there to provide treatment and care when people fall ill. Our recent White Paper - *The new NHS* - spells out our proposals for a modern and dependable health service. But it's not enough to treat people when they fall ill. We've got to do more to stop them falling ill in the first place.

That means tackling the root causes of the avoidable illnesses. In recent times the emphasis has been on trying to get people to live healthy lives, where necessary by changing their lifestyle. Now we want to see far more attention and Government action concentrated on the things which damage people's health which are beyond the control of the individual.

Poor people are ill more often and die sooner. To tackle these fundamental inequalities we must concentrate attention and resources on the areas most affected by air pollution, poverty, low wages, unemployment, poor housing, crime and disorder, which can make people ill in both body and mind.

The new Government is already taking action to tackle all these problems. That will improve the health of the worst off and least healthy people and neighbourhoods.

This Green Paper sets out our proposals for concerted action by the Government as a whole in partnership with local organisations, to improve people's living conditions and health. It recognises that there are limits to what Government can do and spells out what the individual can do, if the Government do their bit. That's why we are proposing a 'contract for health'.

We put forward specific targets for tackling some of the major killer diseases and proposals for local action. But the Government doesn't believe we have a monopoly of concern and knowledge. So we are inviting everyone who is interested to let us have their comments on what we are proposing and to put forward suggestions of their own.

Frank Dobson
Secretary of State for Health

Tessa Jowell
Secretary of State for Public Health

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comments

OUR HEALTHIER NATION

Summary

Good health is treasured. It is the foundation of a good life.
Better health for the nation is central to making a better country.

'have major opportunities to improve people's health'

We have major opportunities to improve people's health. Almost 90,000 people die every year before they reach their 65th birthday. Of these, nearly 32,000 die of cancer, and 25,000 die of heart disease, stroke and related illnesses. Many of these deaths could be prevented.

Health inequalities are widening. The poorest in our society are hit harder than the well off by most of the major causes of death. In improving the health of the whole nation, a key priority will be better health for those who are worst off.

There are sound economic reasons for improving our health. 187million working days are estimated by industry to be lost every year because of sickness - a £12 billion tax on business.

'sound economic reasons'

Treating ill health is expensive. Heart disease, stroke and related illnesses cost the National Health Service an estimated £3.8 billion every year. By preventing avoidable illness we can concentrate resources on treating conditions which cannot yet be prevented.

Poor health has complex causes. Some are fixed - ageing, for instance, or genetic factors. Our priority is to concentrate on the factors which affect people's health, and on which we can all make an impact.

These include a range of factors to do with how we all live our lives - diet, physical activity, sexual behaviour, smoking, alcohol and drugs.

Social and economic issues play a part too - poverty, unemployment and social exclusion. So too does our environment - air and water quality, and housing. And so does access to good services, like education, transport, social services and the NHS itself.

'a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the

other'

Tackling these health issues involves a range of linked programmes, including measures on welfare to work, crime, housing and education, as well as on health itself.

In the proposals put forward in this consultative Green Paper, *Our Healthier Nation*, the Government has two key aims:

- 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.
- To improve the health of the worst off in society and to narrow the health gap.

To achieve these aims, the Government is setting out a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other.

Good health is no longer about blame, but about opportunity and responsibility.

While people on their own can find it hard to make a difference, when individuals, families, local agencies and communities and the Government work together deep-seated problems can be tackled.

Our third way is a national contract for better health. Under this contract, the Government, local communities and individuals will join in partnership to improve all our health.

'Government, local communities and individuals will join in partnership to improve all our health'

For its part, the Government will help assess the risk to health by making sure that people are given information on health which is accurate, understandable and credible. Where there are real threats to health we will not hesitate to take tough action - though regulation and legislation will be the exception, not the rule.

Health Authorities will have a key role in leading local alliances to develop Health Improvement Programmes, which will identify local needs and translate the national contract into local action.

Local Authorities will have a new duty to promote the economic, social and environmental well-being of their areas.

Businesses can bring new skills to bear, including marketing and communications - as well as improving the health and safety of their own employees.

Voluntary bodies can act as advocates to give a powerful voice to local people.

'to make real progress, we will focus on four priority areas'

Individuals can take responsibility for their own health.

To help enact the contract, we have identified three settings for action:

- Healthy schools - focusing on children
- Healthy workplaces - focusing on adults
- Healthy neighbourhoods - focusing on older people

And to make real progress, we will focus on four priority areas, setting clear targets for improvement in each:

By the year 2010:

- **HEART DISEASE AND STROKE.target**: to reduce the death rate from heart disease and stroke and related illnesses amongst people aged under 65 years by at least **a further third**
- **ACCIDENTS[Ý].target**: to reduce accidents by at least **a fifth**
- **CANCER.target**: to reduce the death rate from cancer amongst people aged under 65 years by at least **a further fifth**

- **MENTAL HEALTH.target**: to reduce the death rate from suicide and undetermined injury by at least **a further sixth**.

These are tough targets. They are challenging targets. With this consultation paper, we want to know what you think of them. There are strong personal, social and economic arguments for making our health better. This Government intends to act on them.

'tough targets... challenging targets'

[Ý] An accident is defined here as one which involves a hospital visit or consultation with family doctor.

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comments

Chapter 1

Fit for the 21st Century

The Case for Health

1.1 There are strong personal, social and economic arguments for making our health better. The Government intends to act on them.
We know that progress has been made, but more needs doing. There are still major opportunities to improve our health.

'progress has been made, but more needs doing'

The Personal Case

1.2 Good health is the foundation of a good life. Our own health and the health of our families and friends underpin our ability to enjoy life to the full. When we are well we are able to make the most of the opportunities that life has to offer and to play a full part in family, community and working life. No matter what goes wrong in life - money, work or relationship problems - good health helps sustain us. How often have we all heard someone say that although things may not be going well - at least they have their health. Good health is treasured.

'good health is the foundation of a good life'

1.3 Good health also means not living in fear of illness, constantly worried about our health or the health of those closest to us. It means being confident and positive and able to cope with the ups and downs of life. Better health for the nation is central to making a better country.

1.4 It's good that people are generally living longer and living healthier lives. But the level of illness remains a cause for concern. Estimates based on Government statistics show there are over 250 million visits to GPs and 70 million visits to hospitals every year. Now, in the 1990s, nearly 90,000 people die each year before they reach their 65th birthday. Of these people, more than 25,000 die of heart disease, stroke and related illnesses and 32,000 die of cancer. Many of these deaths could be prevented.

'good health is about quality of life'

1.5 But good health is not just about how long people live. It is also about quality of life and how well people are during those extra years, so that they are not robbed of their dignity and independence in later life. Figure 1 shows that although both men and women are living longer, they spend many of those years in poor health. What we want is a healthier country where people spend as little time as possible burdened by sickness, pain and disability.

Figure 1

The Social Case

1.6 In a modern and strong society, united by core values of fairness and compassion, it is vital that everyone gains from a national drive for better health.

1.7 A healthy country would be one where health was not dictated by accident of birth and childhood experience. Everyone should have a fair chance of a long and healthy life.

'everyone should have a fair chance of a long and healthy life'

1.8 The general improvement in health stems largely from improved living standards. But not all have shared in growing prosperity. Surveys over the last few years have shown a growing gap in wealth between the best and worst off people and the best and worst off neighbourhoods. Predictably the most recent figures[1] from the Office for National Statistics show that the health gap is growing as well.

1.9 The poorest in our society are hit harder than the well off by most of the major causes of death. Poor people are ill more often and die sooner. The life expectancy of those higher up the social scale (in professional and managerial jobs) has improved more than those lower down (in manual and unskilled jobs). This inequality has widened since the early 1980s (see figure 2).

1.10 In the past this social dimension was frequently neglected. Poor health was put down to bad luck, unhealthy behaviour, or inadequate healthcare.

1.11 Yet it is clear that people's chances of a long and healthy life are basically influenced by how well off they are, where they live and by their ethnic background. A child's chance of surviving to its first birthday relates to the country of birth of its mother, as figure 3 shows. Figure 4 shows how men's social class can influence their chances of dying from lung cancer before the age of retirement. Figure 5 shows how some areas are hit harder by deaths before the age of 65. Parts of Tyne Tees, Greater Manchester, the West Midlands and London have some of the highest rates of early death, whilst most of East Anglia and the South West have the lowest.

Figure 2
Figure 3
Figure 4
Figure 5

1.12 The Government recognises that the social causes of ill health and the inequalities which stem from them must be acknowledged and acted on. **Connected problems require joined-up solutions.This means tackling inequality which stems from poverty, poor housing, pollution, low educational standards, joblessness and low pay. Tackling inequalities generally is the best means of tackling health inequalities in particular**.

'tackling inequalities generally is the best means of tackling health inequalities in particular'

1.13 Within our overall programme to improve the health of the whole population a key priority will be to improve the health of those who are marginalised and worst off. We will seek to improve the absolute and relative positions of those people and areas which are hit hardest by poor health and premature death. That will narrow the gap between them and the better off .

1.14 Moreover, social exclusion can be both a *cause* and an *effect* of ill health. If people are too ill to work or to participate in everyday social life, isolated from the mainstream opportunities by illness or disability, then they can become socially excluded. If they are not in society's mainstream, they are more likely to damage their health by smoking or they may seek comfort in activities like illegal drug-taking and so damage their health.

'to succeed in the modern world economy, the country's workforce must be healthy as well as highly skilled'

The Economic Case

1.15 A healthy population is a key factor in a prosperous and modern economy. There are sound and hard-headed business reasons for making our health better.

1.16 To succeed in the modern world economy, the country's workforce must be healthy as well as highly skilled. The Confederation of British Industry has estimated that 187 million working days are lost each year because of sickness[2]. That's a £12 billion social tax on business every year, damaging to competitiveness and a brake on prosperity.

1.17 Cancer treatments cost the NHS an estimated £1.3 billion each year, whilst heart disease, stroke and related illnesses cost £3.8 billion. Treating accidents and other injuries costs some £1.2 billion and treating poor mental health in excess of £5 billion a year[3]. Illnesses caused by smoking cost the NHS between £1.4 and £1.7 billion each year. By preventing avoidable illnesses we can enable the NHS to concentrate its resources on treating those conditions which cannot yet be prevented.

'by preventing avoidable illnesses we can enable the NHS to concentrate its resources on treating those conditions which cannot yet be prevented'

1.18 Investing in the country's health is partly about working for a fair and decent society. It is partly about using the resources of the health service to best effect. But, equally importantly, it is also part of the Government's determined drive to improve England's economic efficiency and performance.

Our Health Can Be Better

1.19 Our health today falls short of what we already know is possible. It is better here than in many other European countries. But it is hit harder than some countries by the big killer diseases. And, as figure 6 shows, people in England have less chance of a long life than people living in France, Italy or Sweden.

Figure 6

1.20 Compared with other countries, many people - particularly older people - still spend much of their lives in pain or discomfort, dependent on others for support. At a time when they should be free to make the very most of their lives too many spend their retirement unable to enjoy the independence that people who are well take for granted[4]. We want to ensure a more comfortable retirement which gives people the ability to live independently and to do things for themselves for as long as possible.

'we want to ensure a more comfortable retirement which gives people the ability to live independently'

Our Healthier Nation

1.21 So there is an overwhelming personal, social and economic case, based on common sense, for improving our health. The Government is determined to play its part in a concerted effort to make our health better.

1.22 It is obvious that problems that have persisted for decades will not be solved overnight. The results of our efforts may take years to show through in better health. Improvements in health will not be easy to secure. They will have to happen at a pace which people can accept and which the country can afford. There will be hard choices to be made by us all. But this is no excuse for inactivity and in time our efforts can and will make a real difference.

'the Government is determined to play its part in a concerted effort to make our health better'

1.23 The Government has two overriding aims for *Our Healthier Nation*.

Our Healthier Nation - Two Key Aims for improving the health of the population

- *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.*
- *To improve the health of the worst off in society and to narrow the health gap.*

1.24 The Government has identified four priority areas for action - heart disease and stroke, accidents, cancer and mental health - and proposes to set a national target for each of them. These targets will give purpose and direction to the strategy and help us to assess overall progress.

'this Green Paper asks for your views'

1.25 This Green Paper sets out the Government's proposals on how, together, we can achieve our two overriding aims, and asks for your views on them. When your views have been taken into account, we will publish later this year a White Paper setting out a strategy for action.

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comments

Chapter 2

The Causes of Ill Health

Understanding the Causes of Ill Health

2.1 Our understanding of how and why people become ill has advanced in leaps and bounds in the past century, with British science and know-how often at the forefront of international efforts. For example, it has played a key role in proving the link between smoking and cancer, in the development of life-saving vaccines and in understanding the factors, such as air pollution, which cause other diseases. British medical science has also played a leading role in developing such treatments as antibiotics, anaesthetics and key-hole surgery. The Government will continue to support this British research. We are determined that this proud history will continue.

'the causes of ill health are complex'

2.2 But the causes of ill health are complex. There are still many illnesses which we do not fully understand and which can strike unexpectedly. Some are caused by genetic factors fixed before our birth, some by factors beyond our individual control, and others by the way we live. Whatever the causes of ill health we need a health care system to treat and care for people who fall ill. The Government's renewal of the health service, set out in the White Paper, *The new NHS[5]*, will ensure a modern and dependable NHS. This is especially vital for those who are poor or vulnerable, who are likely to have the worst general health and so the greatest need to use the NHS.

'the Government's renewal of the health service, set out in the White Paper, The new NHS will ensure a modern and dependable NHS'

2.3 Some of the main factors which influence our health are shown in the table overleaf. This sets out a whole range of factors - those which are beyond the influence of individuals and so require wider national and local efforts to secure progress, alongside those which are determined by individual behaviour.

Factors affecting health

Fixed	Social and Economic	Environment	Lifestyle	Access to Services
Genes	Poverty	Air quality	Diet	Education
Sex	Employment	Housing	Physical activity	NHS
Ageing	Social exclusion	Water quality	Smoking	Social Services
		Social environment	Alcohol	Transport
			Sexual behaviour	Leisure
			Drugs	

Fixed factors

2.4 Although our age, sex and genetic make-up have a major influence on our health, for most people there is little we can do about them.
But we can try to modify some of their predictable consequences. Within a few years we can expect developments in genetic science to make it possible to do much more than we can now.

'people's health is affected by their circumstances'

Social and Economic Factors

Poverty

2.5 People's health is affected by their circumstances. Well-being, a sense of control over your life, and optimism about the future is good for health. For example:

- low income can make it hard to afford to keep your house warm or protect yourself and your family from fire and accidents in the home, such as by buying smoke alarms or replacing faulty wiring;
- low income, deprivation and social exclusion all influence smoking levels. It's harder to stop smoking when you're worrying about making ends meet. One study found that while a third of children in the United Kingdom lived with at least one adult smoker, for low income families, the figure rose to 57%[6].
- if the nearest supermarket is miles away or the bus doesn't go there when you can, it can be difficult to buy food which is cheap and healthy;
- if the street outside your home is busy with traffic or there are drug dealers in the park then it's safer to keep the kids in front of the TV than let them out to play.

Employment

2.6 Being in work is good for your health. Joblessness has been clearly linked to poor physical and mental health. Figure 7 shows how those in work tend to live longer lives than those without jobs. Unemployed men and women are more likely than people in work to die from cancer, heart disease, accidents and suicide. Losing his job doubles the chances of a middle-aged man dying within the next five years.

'being in work is good for your health'

Figure 7

Social Exclusion

2.7 When social problems - poor housing, unemployment or low pay, fear of crime and isolation - are combined, as they often are, then people's health can suffer disproportionately. Social exclusion involves not only social but also economic and psychological isolation. Although people may know what affects their health, their hardship and isolation mean that it is often difficult to act on what they know. The best way to make a start on helping them live healthier lives is to provide help and support to enable them to participate in society, and to help them improve their own economic and social circumstances. That will help to improve their health.

'when social problems are combined, people's health can suffer disproportionately'

Environment

2.8 A safe, secure and sustainable environment is a pre-requisite for a healthy nation. The way in which the environment affects our health is sometimes easily explicable but more often involves a complex mix of factors. Such things as clean air and water and good quality housing are important to our health and well-being.

'a safe, secure and sustainable environment is a pre-requisite for a healthy nation'

Air Quality

2.9 People need to know that if they don't smoke, or if they are giving up smoking, then the Government, Local Authorities and businesses are also taking action to ensure that general pollution is not harming their health and that the quality of the air they breathe is good. A recent study has suggested that high levels of ozone in the air in the summer months lead to increased hospital admissions for respiratory disorders[7][8].

Housing

2.10 Housing has an important impact on health. Research has shown that the most significant risks from poor housing are

associated with damp, which can contribute to diseases of the lungs and other parts of the respiratory system [9][10][11][12]. Cramped living in poor conditions leads to accidents, sleeplessness, stress and the rapid spread of infections.

2.11 Many deaths each year are due to cold conditions. Older people and the very young are particularly vulnerable to cold weather. About a million homes in the United Kingdom have inadequate standards of energy efficiency, putting the health of those who live in them at risk when it's cold.

2.12 100,000 houses in the United Kingdom have high levels of radon gas. People want to be confident that if they are acting responsibly and protecting themselves from cancer by eating well and not smoking, then the Government and Local Authorities are actively engaged in reducing the health risk in those areas where radon gas in homes can increase the chances of developing lung cancer [13][14].

'families with small children and older people need plentiful supplies of water'

Water Quality

2.13 The quality of the water we drink is an important influence on health. Some of the very earliest public health measures were about tackling water-borne diseases such as cholera. Moreover families with small children and older people need plentiful supplies of water for washing at prices they can afford. The Government will set a stringent standard of 10μg/l to reduce lead in drinking water, as supplied to homes, to be met within 15 years. The Government will also ensure that water suppliers will continue to treat water to reduce its ability to dissolve lead and for most properties this will ensure that levels at the tap - that is after any contamination by the property owner's pipes - do not exceed 25μg/l. The Government will be preparing advice for homeowners to help them take an informed decision on options for action if they have lead pipes within their homes.

2.14 There are many other environmental influences on our health, including noise pollution, global warming, ozone depletion, and carbon monoxide in the home. But there is also the important context of ensuring that particular environments, such as work and the community, are healthy ones.

Social Environment

2.15 The quality of life in the community and the extent to which people respect and support each other can also be important to our health. Social exclusion can have damaging health consequences.
One study found that, compared to people with lots of social ties, the socially isolated were over six times more likely to die from a stroke and more than three times more likely to commit suicide [15].

'tackling crime and fear of crime in the community can have a direct impact on our health'

2.16 Neighbourhoods where people know and trust each other and where they have a say in the way the community is run can be a powerful support in coping with the day to day stresses of life which affect health. And having a stake in the local community gives people self-respect and makes them feel better.

2.17 Tackling crime and fear of crime in the community can have a direct impact on our health. Sadly, many people may be afraid to go out for walks alone. They may suffer stress from being victims of crime or from living in an area where crime is commonplace and so they live in fear. Measures to tackle youth crime and develop local crime prevention strategies will help people feel secure in their homes, and reduce some of the stresses in their lives caused by the fear of crime.

Lifestyle

2.18 How people live has an important impact on health. Whether people smoke; whether they are physically active; what and

how much they eat and drink; their sexual behaviour and whether they take illicit drugs - all of these factors can have a dramatic and cumulative influence on how healthy people are and how long they will live.

'a good diet is an important way of protecting health'

Diet and Physical Activity

2.19 A good **diet** is an important way of protecting health. The amount of fruit and vegetables people eat is an important influence on health. Unhealthy diets, which tend to include too much sugar, salt and fatty foods, are linked to cancer, heart disease and stroke as well as tooth decay [16][17]. Research suggests that a third of all cancers are the result of a poor diet [18]. The amount of **physical activity** that people take is also an important factor in preventing heart disease, building healthy bones and helping to maintain good mental health.

Smoking

2.20 **Smoking** is the biggest cause of diseases which lead to early deaths in England. It is estimated to account for nearly a fifth of all deaths each year - 120,000 lives in the United Kingdom cut short or taken by tobacco [19]. Smoking is the main cause of lung cancer and is linked to heart disease, chronic bronchitis, asthma and cancers of the mouth, bladder, kidney, stomach and pancreas. Mothers who smoke increase the risk of cot deaths to their babies [20]. Figure 8 shows the range of risks that smokers face.

Figure 8

It has been estimated that for every 1,000 young smokers, one will be murdered, six will be killed in a road accident and 250 will die before their time because they smoke [21].

2.21 Some smokers do live long lives but the odds are still heavily stacked against smokers. In 1996 28% of boys aged 15 and 33% of girls aged 15 smoked regularly and these figures are rising.

Complementary Strategies

- smoking
- alcohol
- teenage
- conceptions
- HIV/AIDS
- drugs

2.22 And a recent study funded by the European Union estimated that passive smoking kills more than 20,000 people each year in Europe [22]. Because of the terrible toll that smoking takes on health, the Government is preparing a comprehensive

strategy on reducing smoking to support *Our Healthier Nation*. This will be published later this year.

Alcohol

2.23 Many people who drink **alcohol** enjoy it and cause no harm to themselves or to others. Whether people drink sensibly can dramatically affect their physical and mental health and that of others. Drinking too much is an important factor in accidents and domestic violence and can impair people's ability to cope with everyday life. It has been estimated that up to 40,000 deaths could be alcohol related and in 1996 15% of fatal road accidents involved alcohol. The Government is preparing a new strategy on alcohol to set out a practical framework for a responsible approach.

'death rates of babies born to teenage mothers are more than 50% higher than the national average'

Sexual Health

2.24 Girls who become pregnant in their early teenage years can harm their own health and their career chances as well as the health of their babies [23]. Teenage girls who have to look after their young babies find that their education suffers. Their ability to get a job is diminished. Poor living standards can result, which in turn lead to problems with their own health in the long term. The death rates of babies born to teenage mothers are more than 50% higher than the national average[24]. The prevention of early teenage conceptions is being addressed through a separate national programme.

2.25 A safe and responsible approach to sex is an important part of a healthy life. It prevents the spread of sexually transmitted diseases. HIV/AIDS poses particular challenges which continue to require special attention. The Government is preparing a separate strategy to combat the spread of HIV infection and to meet the challenge to services which HIV and AIDS present.

Drugs

2.26 Illegal **drugs** threaten the health of those who take them and are damaging to society and the community[25]. The Government's new Anti-Drugs Coordinator and his deputy are currently reviewing the existing drugs strategy and will advise Ministers in the spring about how it can be improved and strengthened in the future.

Access to High Quality Services

Education

2.27 The Government wants to make sure that children learn at school both the theory and practice of healthy living. And it goes much further than that - **a decent education** gives children the confidence and capacity to make healthier choices and the ability to better themselves and their future families. Poor educational achievement and pregnancy in the early teenage years are closely linked. A range of research studies have suggested that education and particularly nursery education could have an important impact on health in later life [26][27]. The Government has made clear that this means better education for all.

'a decent education gives children the confidence and capacity to make healthier choices'

Health

2.28 **Top quality health services** which genuinely meet people's needs mean that people seek help quickly and get the advice and treatment they need on time. In a fair society there must be fair access to these services for all, regardless of where people live, who they are and how much they earn. But fair access to services is not yet a reality everywhere. For example, some Health Authorities where we would expect to have the greatest need for heart bypasses actually have lower rates for these operations. There is a lower uptake of health checks and breast and cervical cancer screening among some disadvantaged groups. Areas of relatively high deprivation tend to have a relatively low uptake of immunisation. There are particular concerns about the quality of the family doctor service available in some deprived areas. All these aspects of health care bear

down hardest on the poorest in our society.

'in a fair society there must be fair access to top quality health services'

Social Services

2.29 **High quality social services** play a vital role in the health of the people that they serve. Decent support for older people, whether at home or in residential care; the protection and care of vulnerable children and young people; support for people with mental health problems; and helping people with disabilities to live more independent lives: health and social care are often one and the same. By protecting the vulnerable, caring for those with problems and supporting people back into independence and dignity, social services have a vital role in fostering better health.

Transport and Leisure

2.30 Finally, good **local transport** planning and affordable **leisure services** make it easier for individuals to be more physically active. Local Authorities in cities such as Leicester, York and Nottingham have been among the pioneers in integrated transport policies, combining measures such as city centre traffic calming and providing park and ride schemes with initiatives to encourage cycle use. As well as providing people with healthy transport choices, such schemes have shown reduced pedestrian casualty rates.

'leisure services have a real influence on health'

2.31 For example, the City of York has a strategic approach to transport policy, based on encouraging environmentally sustainable transport initiatives, including traffic calming and a cycling network. The city enjoys a relatively high cycling rate of around 20% of all journeys, while accidents to cyclists and pedestrians have fallen by 33% and 41% respectively from the mid 1980s to the mid 1990s. Leisure services which allow people to relax and take a break from the pressures of day to day life can also have a real influence on health. Having a place - a public park or gardens, where you can take a walk or sit, without fear of crime - is a real benefit to health. Sport, rambling and other leisure opportunities can be equally important.

Inequalities in Health

2.32 For many of these factors the extent to which your health is affected depends on how well off you are, whether you are a man or a woman, where you were born and brought up and your ethnic background [1].

'ill health is not spread evenly across our society'

2.33 Ill health is not spread evenly across our society. It is concentrated in particular groups and places. For example, figure 9 shows large differences in coronary heart disease deaths in people who lived in this country but who were born elsewhere. Figure 10 shows that children in the bottom social class are five times more likely to die from an accident than those in the top social class. Figure 11 shows how deaths from suicide amongst women have fallen through the 1980s and early 1990s whereas such deaths amongst young men rose substantially across the same period.

'the link between poverty and ill health is clear. In nearly every case the highest incidence of illness is experienced by the worst off social classes'

2.34 Figure 12 shows that, whereas death rates from lung cancer have been falling for many years in men, amongst women there was a steady rise until the beginning of the 1990s. Many diseases occur more commonly in particular parts of the country. For example, figure 13 shows that more people die of lung cancer in the north of England than in the south.

Figure 9
Figure 10
Figure 11
Figure 12
Figure 13

2.35 There are many factors that appear to contribute to the differences in health that people experience. However the link between poverty and ill health is clear. In nearly every case the highest incidence of illness is experienced by the worst off social classes. That is why the Government's overall determination to tackle inequality and create opportunity will reduce the health gap.

'Government's overall determination to tackle inequality and create opportunity will reduce the health gap''the causes of ill

health do not rest with individuals on their own or with Government on its own'

2.36 The causes of ill health do not, therefore, rest with individuals on their own or with Government on its own. They are shared by society. Chapter Three sets out a new way forward to pull together all who have a part to play in tackling poor health and health inequalities.

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comments

Chapter 3

A Contract for Health

New Public Health

3.1 In the past, efforts to improve health have been too much about blame. Individuals were to blame for failing to listen to well-intentioned but misdirected health advice. Or the Government was blamed for failing to embrace grand plans for social engineering which would make people healthier automatically.

'Our Healthier Nation sets out a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other'

3.2 In the past, arguments about health ranged between two extremes - individual victim blaming on the one hand and nanny state social engineering on the other. The broad majority who just wanted a normal healthy life for themselves and their families were ignored.

3.3 In a modern country these old positions must become obsolete. Health is not about blame, but about opportunity and responsibility. Everyone has a part to play - Government, national organisations, local services, communities, families and individuals. *Our Healthier Nation* sets out a third way of tackling the problems of ill health that our country faces.

3.4 Individuals on their own can find it hard to make a difference.
But with help from their families and support, when needed, from the community and local agencies they can make real changes. Local agencies need central Government to provide leadership and put in place the national building blocks and support. Without individuals, families and communities working together, Government achievements will be limited.

3.5 The new approach to public health also means finding more effective ways of using scarce resources, working together to maximise the impact of what we do and recognising the health benefits of investment in other areas. There are substantial additional resources for those elements of our strategy for health which are clearly associated with the promotion of good health - £300 million in the United Kingdom for Healthy Living Centres alone, and additional resources for the Healthy Schools Initiative. But it is the investment of time and resources such as the £5 billion Welfare to Work programme, the establishment of the National Minimum Wage and the reform of our welfare system to help support people back to independence which will be the most significant contributions to the strategy. The Government's Comprehensive Spending Review is considering the health implications of many Government policies and this work will be used to take forward the proposals in this Green Paper later this year.

'help support people back to independence'

A Contract for Health

3.6 To help bring the nation together in a concerted and coordinated drive against poor health, the Government proposes **a national contract for better health**. The contract sets out our mutual responsibilities for improving health in the areas where we can make most progress towards our overall aims of reducing the number of early deaths, increasing the length of our healthy lives and tackling inequalities in health.

3.7 The national contract recognises that the Government can create the climate for our health to be improved. It pledges to deliver key economic and social policies. It places requirements on local services to make progress in improving the public's health.

3.8 But for *Our Healthier Nation* to succeed it must engage everyone with a contribution to make to the national contract. The contract will only work if everyone plays their part, and if everyone is committed to fulfilling their responsibilities.

3.9 This is our new contract for health:

A Contract for Health

Government and National Players can:	**Local Players and Communities can:**	**People can:**
Provide national coordination and leadership.	Provide leadership for local health strategies by developing and implementing Health Improvement Programmes.	Take responsibility for their own health and make healthier choices about their lifestyle.
Ensure that policy making across Government takes full account of health and is well informed by research and the best expertise available.	Work in partnerships to improve the health of local people and tackle the root causes of ill health.	Ensure their own actions do not harm the health of others.
Work with other countries for international cooperation to improve health.	Plan and provide high quality services to everyone who needs them.	Take opportunities to better their lives and their families' lives, through education, training and employment.
Assess risks and communicate those risks clearly to the public.		
Ensure that the public and others have the information they need to improve their health.		
Regulate and legislate where necessary.		
Tackle the root causes of ill health.		

3.10 Provisional national contracts for each of the four national priority areas are set out in Chapter Four. So the proposed framework for the national strategy will be:

Our Healthier Nation - Two Key Aims

- 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.
- to improve the health of the worst off in society and to narrow the health gap.

A National Contract for Health

Four Priority Areas
- Heart Disease and Stroke
- Accidents
- Cancer
- Mental Health

A National Target for each of the Four Priority Areas

'coordination of health policy across Government'

What Government and National Organisations Can Do

Leadership and Coordinated Government

3.11 To deliver their part in each of the four national contracts, a range of Government Departments will need to work together. The Government has already taken two key steps to ensure that health is a central theme of Government policy.

- **First**, for the first time ever in England the Government has appointed a Minister for Public Health to ensure coordination of health policy across Government, not just in the Department of Health. The Government has set up a dedicated Cabinet Committee of Ministers from twelve different Departments, to drive the policy across Government.
- **Second**, the Government will apply health impact assessments to its relevant key policies, so that when they are being developed and implemented, the consequences of those policies for our health is considered. The Department of Health has already published guidance, called *Policy Appraisal and Health*, and if necessary this guidance will be revised in the light of experience.

'stronger role for Local Authorities'

3.12 The Chief Medical Officer is leading a project on public health at local, regional and national levels. One aim is to ensure that the public health function can play a full part in *Our Healthier Nation*. Emerging findings suggest that there is a wide range of expertise and enthusiasm in the public health function. But to build on this, we need:

- better partnership between Local and Health Authorities;
- greater impact from independent public health reports and a stronger role for Local Authorities in improving health;
- greater public involvement, in identifying health problems, developing local strategies to improve health and local community action;
- a stronger national network of experts and interested bodies.

3.13 Expertise in public health needs to be strengthened in all sectors. Developing education and training for the workforce must be a priority. Refocusing research and development on public health issues, rather than just health care, will also be important.

'public health needs to be strengthened'

3.14 As a signal of our commitment to the public health function the Government has decided to exempt public health professionals from the definition of Health Authority management costs, so that our efforts to curb bureaucracy in the NHS do not create a perverse incentive to weaken public health expertise at local level. Public health is a long term investment, not an administrative overhead.

3.15 The regional arms of Government will also have important roles in the strategy. Government Offices for the

3.15 The regional arms of Government will also have important roles in the strategy. Government Offices for the Regions coordinate the main Government programmes such as housing, planning, transport, training and investment in industry. The Regional Offices of the NHS Executive, with their Regional Directors of Public Health, oversee the work of the NHS locally. Working together these bodies should ensure that the potential of all Government programmes to support the health strategy is fully exploited.

International Role

3.16 The Government also has an important **international role** to play in delivering the national contracts. Just as we were able to play an important role in securing tougher environmental action at the Kyoto international Environment Summit, we will speak with a strong voice for the United Kingdom in the European Union, so that European policies are harnessed to the objective of protecting and improving our health. For example, we will continue to press for stronger international action to combat the depletion of the ozone layer. And we will continue to work with the World Health Organisation, at European and at global level, to play our part in international efforts to improve health, including the *Health for All* strategy.

'we will press for stronger international action'

Informed Government

3.17 Ministers and civil servants alone do not have the expertise and knowledge to make our strategy a success. *Our Healthier Nation* will need a great deal of expert advice to ensure that it makes maximum impact with the resources available. For example, the Government will need technical advice on monitoring progress and measuring improvements in health and the Chief Medical Officer's *Our Healthier Nation* group will bring together experts to assist in monitoring the national targets and to provide other expert advice. Government will also need advice on how best to involve the range of non-Government bodies who can play a part; and it will need support in making the most of the contribution of the NHS and Local Authorities.

'special task forces to accelerate action'

3.18 In the light of responses to this consultation document, the Government will consider whether to set up special task forces to accelerate action on these important issues. The Government will also need to consider what structures need to be established to ensure that all those involved in the national contracts have a voice in the implementation and development of the proposals.

3.19 Good information for policy making and for the public means we will continue to need high quality research and development and a way to ensure that research findings are widely disseminated and acted on. The Government will work across all Departments and with other funders to ensure that research to support *Our Healthier Nation* is put in place.

'the assessment and communication of health risks needs to be done better'

Assessing and Communicating Risk

3.20 Life is by its nature risky. It is the job of Government to identify risks to health, to assess them, and, where appropriate, either take action to reduce those risks or ensure that people who might be affected are aware of them. The Government believes that both the assessment and communication of health risks needs to be done better. This will require a more thoughtful approach.

3.21 It is important that scientific assessment and public perception do not get out of step. In the past, public concern has sometimes far outstripped the concern of the scientific and medical experts involved. On other occasions public response has been much less than the scientific and medical experts have felt to be appropriate. Neither situation is much help when it comes to trying to promote improvements in health.

'the public is entitled to know what the odds are so that individuals can make their own judgments'

3.22 To do this properly the Government must call on the best possible advice from people who command the respect of their professional colleagues. They must also be seen to have no axe to grind. But that isn't the end of the story.

3.23 The public is entitled to know what the odds are so that individuals can make their own judgments. If they feel that Government is telling them what to do that can actually be counterproductive. For people to be able to

make an informed judgment on risk they need to be able to understand and weigh up the evidence. They need to be able to use the information provided. It is very important to communicate the right information in the right way.

3.24 There is no one single way to communicate health information but the Government's strategy will include:

- **Publicity campaigns** The Government will continue to use publicity campaigns on issues such as occupational health, road safety, drink-driving, anti-drugs initiatives, safe sex, and smoking. The Government and the new Food Standards Agency will make sure that protection of the consumer is the first priority in food policy and ensure that we as individuals have the information we need to be able to make informed decisions about what we eat.

- **"*Wired for health*"** With all schools and colleges in the country being linked up electronically on the internet through the National Grid for Learning every young person in the country will have access to the information they need to make responsible decisions about their health. The Department of Health and the Department for Education and Employment will be working together to ensure that young people and their teachers are able to access relevant and appropriate health information at the touch of a button and reach a new web-site, *Wired for Health*, which will link to accurate, clear and credible web-sites on a variety of health issues.

- **Advisory group** The Department for Education and Employment is planning to set up an Advisory Group on Personal, Social and Health Education to advise on the place of this work in schools.

'a new web-site, Wired for Health will link to accurate, clear and credible web-sites on a variety of health issues'

Regulation and Legislation

3.25 Governments have always taken action to legislate or regulate where this was the only way of providing effective protection for the general public or particuler groups such as employees or children.
The 1956 Clean Air Act is one example which was necessary to reduce the toll of respiratory disease and death caused by the smogs of the 1950s. Laws to require the wearing of seat belts and to control drinking and driving are examples where changes in social attitudes took place so that public pressure augmented the input of the law.

'we will engage the active support of the people...
the contract for health is about partnership and mutual responsibility'

3.26 Where old threats to health continue or new threats arise we will not hesitate to legislate or regulate if this is judged to be necessary.
But we will seek to engage the active support of the people affected rather than resort to coercion or unwarranted intrusion. The contract for health is about partnership and mutual responsibility, about working together to make it easier to be healthy. Regulation and legislation should be the exception, not the rule - a step taken only where voluntary action will not sufficiently protect the public's health.

'regulation and legislation should be the exception, not the rule'

3.27 That is why the Government has already taken decisive action to secure an end to tobacco advertising and sponsorship, while providing time and help for all sports to allow them to find alternative sources of sponsorship. The Minister for Public Health secured agreement at the European Union Health Council on a framework for an historic Tobacco Advertising Directive, after years of United Kingdom opposition, banning tobacco advertising and sponsorship within the European Union. But even here legislation alone is not enough to reduce the prevalence of smoking. A whole range of other actions is needed against tobacco if the maximum impact is to be achieved from the advertising ban and if we are to achieve the objective of reducing the number of children who take up smoking. This will be outlined in the White Paper on Tobacco to be published later this year.

'the Government's main task under the national contracts for health is to tackle the root causes of ill health'

Tackling the Root Causes of Ill Health

3.28 The Government's main task under the national contracts for health is to tackle the root causes of ill health. Most of these are social, economic and environmental. Most of them will therefore be tackled through those overall Government policies which target help on the worst off. This means that they will automatically be

concentrating on those people who are ill the most often and who die the soonest, and on the places with the most deep-seated problems. The national contracts for health will ensure that we get the most out of the resources and effort being committed by Government Departments and their local partners.

3.29 The Government's programme is already well under way. The Welfare to Work Budget has set in hand an unprecedented programme to fight **joblessness** with a New Deal for young people, the long term unemployed and lone parents. Welfare to Work has also been extended to include people with a disability or a long standing illness. The worst excesses of **low pay** will be tackled through the National Minimum Wage. **Social exclusion** will be the subject of a long term, determined and coordinated Government effort, led by the Prime Minister's new Social Exclusion Unit. The Government is also working to foster **a new culture of partnership in business** between management and employees which will help impact on the problems of stress and insecurity in work.

3.30 Substantial additional resources - nearly £800 million over two years - for **decent housing** are being made available under the Government's Capital Receipts Initiative. This will help Local Authorities to meet priority housing needs and to improve existing housing. It will help to carry out repairs and improvements to Local Authority housing, housing association and private sector housing as well as build new homes.
The money will also be used to carry out energy efficiency improvements such as insulation, one of the most effective means of tackling health problems which are linked to cold homes. The Government is determined that older people should be able to keep warm and keep well in the winter. It has cut VAT on fuel to 5% and will be making a winter fuel payment of £20 to five million pensioner households and £50 to 1.7 million pensioner households on income support.

'a healthier environment for all'

3.31 An **Integrated National Transport Policy**, on which there will be a White Paper later this year, will ensure a healthier environment for all, as part of our commitment to sustainable development. The strategy will tackle congestion and pollution and their damaging consequences, promote cleaner and safer vehicles, and greater use of public transport, cycling and walking. The health benefits will include better air quality, improved levels of fitness, reduced levels of stress and fewer accidents. The Road Safety strategy and targets exercise announced by the Department of Environment, Transport and the Regions in October last year will complement the proposals on accidents in this Green Paper.

3.32 To ensure that initiatives on health and **the environment** have the maximum impact, the Government will ensure that the influence of the environment on health is fully recognised and integrated into major policy initiatives, particularly in the sustainable development strategy and the integrated transport strategy. To improve air quality more effectively and more rapidly, the Government is aiming to produce conclusions on its review of the National Air Quality Strategy by the end of 1998.

3.33 There is still unacceptably wide inequality in the levels of tooth decay in children. The evidence shows that **fluoridation** of the water supply to the optimum level of one part in a million can substantially reduce the amount of decay in children from similar backgrounds on this site.

Chapter 4

Targets for Health

Why Set Targets?

4.1 The national contracts for health will need to be clearly focused on areas where we need to make progress on our two key aims:

- 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
- to improve the health of the worst off in society and to narrow the health gap.

'to improve the health of the population as a whole and narrow the health gap'

4.2 No one should doubt the seriousness of our approach. In particular, our determination to narrow the health gap between the worst off in society and the better off represents a very substantial challenge. This is because, as our first aim shows, we also want the health of the majority of our people to get better year on year. We will not seek to narrow the health gap by slowing the drive for further progress in improved health amongst the many. So to achieve our vision of narrowing health inequalities we will need to improve the health of the poorest sections of our society very significantly indeed. This will not be easy, nor are there any "quick fix" solutions. We are in this for the long haul.

'we are in this for the long haul...the strategy must be focused and disciplined'

4.3 But operating on too broad a front risks dissipating our energies on too many goals - and achieving none. The strategy must be focused and disciplined. That is why the Government has identified four priority areas:

- **heart disease and stroke**,
- **accidents**,
- **cancer**,
- **mental health**.

4.4 These have been selected because they are significant causes of premature death and poor health, there are marked inequalities in who suffers from them, there is much that can be done to prevent them or to treat them more effectively and because they are real causes of public concern. **To drive the contracts and encourage everyone to take part we propose to set four national targets, one in each of these four priority areas**. By setting targets it is possible to give direction to the strategy, to help everyone involved understand the size of the task we face, to ensure that the right resources are in place and to allow the strategy to be monitored.

'contracts for health reflect the full range of social, economic and environmental factors'

4.5 These priority areas, as well as being important in their own right, will also be indicators of overall progress on our two key aims. They are not intended to be a comprehensive measure of all the important factors which contribute to health, but to give a spur to action and an overall indication of the direction and speed of travel.

4.6 Although the targets themselves will be focused on particular diseases and causes of ill health, the essence of the contracts for health is that they reflect the full range of social, economic and environmental factors which impact on these diseases. Action will be needed in all these areas and it is expected that other health benefits will be seen. For example better access to facilities for physical activity will give a health benefit not only in the area of heart disease but also in prevention of osteoporosis which can cause considerable disability in older people.

4.7 The suggested targets for each of the four priority areas are set out later in this chapter. We believe that they are both **realistic** - not simply wishful thinking with no hope of being reached - and **challenging** - they will require real effort from a wide range of players if they are to be reached.

Getting the Right Targets

4.8 There are two key reasons for setting a small number of targets. **First**, if everything is to be a priority then nothing will be a priority.
So there are tough choices to be made if we are to end stalemates in health and health inequalities that have persisted for many decades. While best efforts on all aspects of health must continue from everyone concerned, hard decisions have to be made if overall health is to improve.

'the rate of improvement for many illnesses can taper off as the easier ways of tackling that illness are implemented'

4.9 So while in consultation we will pay careful attention to arguments for adopting **different** priority areas, **additional** priorities which will dilute our efforts will need a very strong case for inclusion. We need nationally to take responsibility together for the priorities we adopt, so suggestions during consultation for new national priorities will also need to argue their merits against those which have been proposed by showing how they would deliver greater progress on the two key aims of *Our Healthier Nation*.

4.10 Our **second** key reason is that by keeping to a small number of national targets, we will ensure the maximum room for Health Improvement Programmes to set local targets reflecting local priorities.

Getting the Targets Right

4.11 Evidence shows that the rate of improvement for many illnesses can taper off as the easier ways of tackling that illness are implemented. For example, figure 14 shows that deaths from stroke in people under 65 declined at a fairly steady rate during the 1980s, but in recent years the rate of decline has levelled off.

'Health of the Nation was limited, because of its reluctance to acknowledge the social, economic and environmental causes of

ill health'

Figure 14

4.12 The previous health strategy - *Health of the Nation* - included targets. But its vision for health was limited, mainly because of its reluctance to acknowledge the social, economic and environmental causes of ill health. Health and Local Authorities and others achieved some progress on the ground and we recognise and applaud their efforts. But:

- many of the improvements in health over recent years were relatively easily and quickly secured because they related to those in professional and skilled groups who are often responsive to health promotion messages. We want to tackle the much harder task of improving the health of the unskilled and socially excluded as well;
- some of the crucial factors leading to a higher risk of heart disease and stroke, such as smoking and obesity, are currently worsening or not improving, making that task even harder. We need to turn these figures around before we can hope to see real health gains;
- it would be highly misleading to assume that even encouraging trends, such as declining numbers of deaths from accidents, are certain to continue. Indeed the evidence points to the need to redouble our combined efforts to reach those groups who have entrenched health problems.

'international comparisons give an idea of the scope for improvement but imply caution for many diseases'

4.13 When formulating our proposed targets, we looked at the experience of comparable countries and their rates of improvement in health. International comparisons give an idea of the scope for improvement, but also help to indicate the timescale over which improvements may be achieved. Those comparisons imply caution for many diseases.

4.14 A number of the suggested targets are for people aged under 65. Many such people are children, breadwinners or responsible for holding a family together. Preventable death and disease in such groups creates suffering well beyond the individual concerned. In addition, it is in these groups that improvements - for example those resulting from changes in lifestyle - are likely to show benefit first. Information about under 65s can act as a sensitive early indicator of progress overall and for all ages. Signs of improvement in targets for the under 65s should in due course reflect real improvements to the health of people who are over 65.

4.15 But the health of people of all ages is vital to overall success and will be centrally monitored as part of the strategy. We know that the policies and programmes set out in *Our Healthier Nation* are relevant to **all** age groups - giving up smoking, regular physical activity and eating healthily is good for everyone - regardless of age. The overall aims of the strategy are to improve health and to reduce inequalities in health for **all** ages. The final national and local contracts for health will reflect this.

'the policies and programmes set out in Our Healthier Nation are relevant to all age groups'

4.16 A target year of 2010 is proposed for each of the four targets, because the benefits of the initiatives and activities needed to tackle the determinants of ill health will take several years to be reflected in health improvements. We also intend, after consultation, to set intermediate targets for 2005 so that we can check our overall progress at the mid-point. We would welcome views on whether these time periods are the right ones.

4.17 The Department of Health will continue to fulfil its responsibilities to monitor national trends in health, covering all the main aspects of the country's health and looking at all age groups and sections of the population. We will publish regular updates on progress on *Our Healthier Nation* and progress through Health Improvement Programmes will be monitored on an

annual basis.

'achievement of our targets would prevent over 15,000 of the approximate 90,000 deaths under age 65 which occur each year'

Targeting Heart Disease and Stroke

4.18 **Heart disease and stroke**, (which, for the purposes of targets, will include all other circulatory diseases) have been selected as a priority area because:

- they are a major cause of early death, accounting for about 18,000 deaths (a third of all deaths) in men and 7,000 deaths (one fifth of all deaths) in women aged under 65 years [see figure 15];
- deaths from coronary heart disease alone account for more than a million years of life lost each year amongst those aged under 75 years;
- these illnesses accounted for an estimated 12% (£3.8 billion) of the total expenditure on health and social services in 1992/93[3]; they also accounted for almost a quarter of total days of certified incapacity in men and 10% in women in the early 1990s;
- they limit the ability of people who live with them to enjoy their lives to the full;
- heart disease and stroke can often be prevented;
- they show marked inequalities: for example, women born in West Africa or the Caribbean are over 50% more likely to die of a stroke than other women [see figure 16].
- similarly men of working age in the bottom social class are more than 50% more likely to die from coronary heart disease than men in the overall population [see figure 17]; and
- by making headway in tackling their causes we should make progress in other areas, such as cancer and mental health.

'Heart disease and stroke can often be prevented'

figure 15
figure 16
figure 17
figure 18

4.19 Death rates from heart disease and stroke have been decreasing for some years in both men and women. Nevertheless, there is considerable scope for further improvement. We, therefore, propose to set a target to **reduce the death rate from heart disease and stroke and related illnesses amongst people under 65 years by at least a further third (33%) by 2010 from a baseline at 1996** (see glossary).

'if we can achieve the proposed target it would bring us to the level which some of the best performing countries currently

experience'

4.20 A target based on the number of people developing heart disease, a stroke or a related condition focuses attention on steps we can all take to prevent such diseases. However, mortality data currently offer the most robust basis on which to set a numerical target. A reduction of this order would, if it had occurred in 1996, have resulted in nearly 8,500 deaths being avoided in this age group.

4.21 Figure 18 shows how this country compares with other European Union countries in respect of death from circulatory disease. The United Kingdom is at present clearly one of the worst performing countries. If we can achieve the proposed target it would bring us to the level which some of the best performing countries currently experience. This represents a major challenge and reflects the Government's determination to deal with the underlying causes of circulatory disease.

4.22 Further progress is not inevitable - in Australia marked reductions in coronary heart disease are now showing signs of slowing and, in this country the rate of reduction in stroke mortality has slowed in recent years. We would welcome views on whether the target suggested strikes the right balance.

'the contract shows that effective action to reduce heart disease and stroke will depend on public, voluntary and private sector players'

4.23 A draft national contract for tackling heart disease and stroke is set out in the table overleaf. It shows some of the key elements which may need to feature in the final contract in the White Paper. As with all the contracts in this Green Paper, they neither exhaustively cover all possible action to tackle heart disease and stroke nor prioritise such actions, as the local component of the contract will need to be agreed by local players in the light of local circumstances. In addition, the Government's role in the contracts will need to be refined in the light of its Comprehensive Spending Review and the responses received in the consultation period. But the contract does show that effective action to reduce the toll of heart disease and stroke will depend on the support and contribution of the range of public, voluntary and private sector players.

A National Contract on Heart Disease and Stroke	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	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.	Tackle social exclusion in the community which makes it harder to have a healthy lifestyle. Provide incentives to employees to cycle or walk to work, or leave their cars at home.	Take opportunities to better their lives and their families' lives, through education, training and employment.
Environmental	Encourage employers and others to provide a smoke-free environment for non-smokers.	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. Provide safe cycling and walking routes.	Protect others from second-hand smoke.
Lifestyle	End advertising and promotion of cigarettes. Enforce prohibition of sale of cigarettes to youngsters. Develop Healthy Living Centres. Ensure access to, and availability of, a wide range of foods for a healthy diet.	Encourage the development of healthy schools and healthy workplaces. Implement an integrated Transport Policy, including a national cycling strategy and measures to make walking more of an option. Target information about a healthy life on groups and areas where people are most at risk	Stop smoking or cut down, watch what they eat and take regular exercise.

	Provide sound information on the health risks of smoking, poor diet and lack of exercise.	are most at risk.	
Services	Encourage doctors and nurses and other health professionals to give advice on healthier living. Ensure catering and leisure professionals are trained in healthy eating and physical activity.	Provide help to people who want to stop smoking. Improve access to a variety of affordable food in deprived areas. Provide facilities for physical activity and relaxation and decent transport to help people get to them. Identify those at high risk of heart disease and stroke and provide high quality 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.

Targeting Accidents

4.24 The Government has chosen accidents as a national priority because:

- more than one person every hour died of accidental causes in England during 1996;
- the 1996 Health Survey for England estimated that the annual accident rate, (an "accident" being defined as one sufficiently severe to require medical attention either at hospital or from a family doctor) was 21 for every 100 adult men and 15 for every 100 adult women. Among children aged 2 to 15 it was 31 for every 100 boys and 22 for every 100 girls [32].
- treating injuries costs the NHS in the region of £1.2 billion each year[3];
- accidents are the greatest single threat to life for children and young people;
- accidents, and particularly falls, are a major cause of death and disability in older people;
- childhood injuries are closely linked with social deprivation. Children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off families - and that gap is widening [33];
- there are significant geographical inequalities in accidental deaths amongst young people mainly due to road accidents, and a particular problem in districts which have a significant rural population [35] (see figure 19);

  Figure 19
  Figure 19a
  Figure 19b

- there were nearly a quarter of a million road accident casualties in 1996 of whom more than 3,000 died.

'children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off

families'

4.25 Targeting accidents will allow us to focus on our key aims, increasing the number of years of life free from poor health, and tackling inequalities in health.

'many people suffer prolonged distress and poor quality of life as the result of a serious accident'

4.26 It is clearly important that we continue to reduce the number of deaths from accidents. However in addition many people suffer prolonged distress and poor quality of life as the result of a serious accident. We are able to measure the rate of accidents, through the Health Survey for England. We therefore propose to set a target **to reduce the rate of accidents -** here being defined as those which involve a hospital visit or consultation with a family doctor **- by at least a fifth (20%) by 2010, from a baseline at 1996** (see glossary). A reduction of this order, if it had occurred in 1996, when it is estimated that there were nearly ten million such accidents overall, would have resulted in nearly two million of these accidents being avoided.

4.27 The data on non-fatal accidents are not reliable enough to enable us to predict future trends accurately. There is some evidence that rates have slightly increased between the late 1980s and the mid 1990s, although data sources may not be directly comparable. Overall trends in accidents can sometimes mask more worrying trends specific to a particular age group or type of accident. The proposed target is based on the scientific information we have, but given its imprecise nature, we would welcome views on whether the proposed target is challenging but achievable.

4.28 The draft national contract below sets out some of the action needed to meet a national accident target. As with all the contracts, local contributions to the contract will need to be agreed in the light of local circumstances, and the national contribution reviewed in the light of the Government's Comprehensive Spending Review.

A National Contract on Accidents	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	Improve areas of deprivation through urban regeneration. Tackle social exclusion and joblessness.	Tackle social exclusion and joblessness in the community.	Take opportunities to combat poverty through education, training and employment.
Environmental	Improve safety of roads. Ensure compliance with seatbelt requirements and other road traffic laws. Help set standards for products and appliances. Promote higher standards of safety management.	Improve facilities for pedestrians and cycle paths. Develop safer routes for schools. Adopt traffic calming and other engineering measures and make roads safer. Work for healthier and safer workplaces. Make playgrounds safe. Provide child pedestrian and cycling training.	Check the safety of appliances and use them correctly. Install smoke alarms. Drive safely. Take part in safety management in the workplace.
Lifestyle	Provide information on how to avoid osteoporosis so that accidents don't lead to broken bones. Run public safety campaigns. Ensure strategies are coordinated across	Ensure those in need have aids to prevent accidents, like car seats for babies. Work for whole school approaches to health and safety.	Adopt safe behaviour for themselves and their children. Wear cycle helmets. Wear a seatbelt. Not drink and drive.

	coordinated across Government Departments and Agencies. Provide information on ways to avoid accidents.	Target accident prevention at those most at risk.	Keep physically fit. Eat a balanced diet which contains enough calcium and vitamin D, take regular exercise and stop smoking to protect themselves from osteoporosis.
Services	Encourage health professionals to give appropriate advice. Ensure professionals are trained in accident prevention.	Provide appropriate treatment to high-risk groups to prevent osteoporosis.	Have regular eye-tests. Know emergency routine.

Targeting Cancer Deaths

4.29 The Government has chosen cancer as a priority area, but recognises that a single target in this area will encompass a wide range of different cancers, with different trends, different causes and different scope for prevention, early detection and treatment.

'many cancer deaths are preventable either by tackling factors such as diet, smoking or the environment which cause them or by ensuring speedy diagnosis and treatment'

4.30 Not all cancer deaths are preventable. But many are, either by tackling factors such as diet, smoking or the environment which cause them or by ensuring speedy diagnosis and treatment. *The new NHS* White Paper has committed the health service to ensuring that everyone with suspected cancer will be able to see a specialist within two weeks of their family doctor deciding that they need to be seen urgently. These arrangements will be in place for everyone with suspected breast cancer by April 1999 and for all other cases of suspected cancer by 2000.

'cancers are amongst the commonest causes of death in this country, accounting for one out of every four deaths'

---

comments

Chapter 5

Your Views on Better Health

(vi) How should local priorities be determined? On what evidence and by what process?

'national contracts for each priority area will set out clearly who is responsible for delivering progress''your views will be taken into account'

5.1 The potential for improving health and preventing disease is enormous, but it will require a long term and concerted national effort. By focusing on four national priorities we will concentrate our effort. The national contracts for each priority area will set out clearly who is responsible for delivering progress. With targets to focus our action and indicate our progress, there are real opportunities open to improve our country's health and begin to narrow the gap between the health of the worst off and the best off.

5.2 We must encourage as many people as possible to support this approach and to play their part in achieving its ends. Your views will be taken into account when we finalise it later this year. Some of these questions are set out below but all comments on the strategy will be helpful in getting it right.

Chapter Three: A Contract for Health

(i) What are the obstacles to partnerships at local level and how can national Government and local players help to overcome them?
Are there good practice examples from which we can learn?

(ii) Is the overall contract for health comprehensive, or are there other elements which should be added to the national, local and individual roles?

(iii) How can public health research be strengthened?

(iv) What task forces might be required to aid implementation of the strategy? What sort of people should be involved in them?

(v) Have we omitted organisations with a role from this chapter? Are there good practice examples of their contribution?

(vi) How should opinion on fluoridation be tested in local areas?

(vii) What further action should Health Improvement Programmes require?

(viii) How can the Local Authority role in health be strengthened and supported?

(ix) How can we encourage and foster local community action to improve health? Are there examples of good practice?

(x) What structures are needed to ensure effective joint planning at local level?

(xi) What action is need to make healthy schools, healthy workplaces and healthy neighbourhoods a reality? Are there examples of good practice? What are the obstacles to success and how can these be overcome?

---

comments

Glossary and Technical Notes

Chapter Four: Targets for Health

(i) Are the priority areas, ie heart disease and stroke, accidents, cancer and mental health the right ones on which to focus the strategy?

(ii) Have the targets been set at the right level?

(iii) Is the approach that is suggested for intermediate targets (i.e. for 2005) appropriate?

(iv) What would you add to the draft national contracts on heart disease and stroke, accidents, cancers and mental health? A blank contract is attached.

(v) How should local inequality targets best be centrally monitored?

(vi) How should local priorities be determined? On what evidence and by what process?

5.3 You can send your responses by detaching and completing the form *Your Views on Better Health* at the end of this Paper, or write to:

The Health Strategy Unit

Room 535

Department of Health

Wellington House

133-155 Waterloo Road

London SE1 8UG

5.4 This Green Paper can be found on the internet at **http://www.open.gov.uk/doh/ohn/ohnhome.htm**

You can also send responses by e-mail to **ohn@doh.gov.uk**

5.5 A summary of this Green Paper is available in English, Hindi, Punjabi, Gujurati, Urdu, Bengali, Chinese, Vietnamese, Greek, Turkish, Somali and Arabic and a taped audio version are available from the **Health Literature Line, 0800 555 777**.

5.6 The closing date for responses to this Green Paper is 30 April 1998.

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comments

References

Proposed National Targets - to reduce mortality from: Heart Disease and Stroke and related illnesses; Cancer; Suicide; and to reduce 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. [NB 1997 data not available until mid-1998, i.e. White Paper stage].

Accident target: the average of the accident rates for the years 1995 and 1996.

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 WHO).

Accident target: Estimated "major" accident rates from the Health Survey for England.

Definitions:

Heart Disease and Stroke and related illnesses - includes all circulatory diseases - International Classification of Diseases (ICD) codes 390-459 inclusive.

Age group: under 65.

Target reduction by year 2010 - at least **a further third (33%)**.

Cancer - all malignant neoplasms - ICD codes 140-208 inclusive.

Age group: under 65.

Target reduction by year 2010 - at least **a further fifth (20%)**.

Suicide - suicide and undetermined injury - ICD codes (E950-E959) plus (E980-E989) minus E988.8

Age group: all ages.

Target reduction by year 2010 - at least **a further sixth (17%)**.

Accidents - defined as an accident which is sufficiently severe to require medical attention either at hospital or from a family doctor. Respondents to the Health Survey for England are asked if they had had one or more such accident in the 6 months prior to interview. For children aged 2-15, an adult is asked to respond on their behalf.

Age group: ages 2 and above.

Target reduction by year 2010 - at least **a fifth (20%)**.

Standardised Mortality Ratio (SMR)

The SMR is used to compare mortality rates in different population groupings because it takes account of differences in the age structure of the population. For example, in Figure 5, mortality in different geographical areas of the country is compared with a national standard (SMR for England = 100). If a Health Authority (HA) area has an SMR greater than 100, then the population of that HA has a mortality rate higher than the average for England (after taking account of differences in the age structure of the HA population and the national population).

The **SMR** is calculated as:
Observed number of deaths X 100
Expected number of deaths

The observed number of deaths is the actual number of deaths occurring in the geographical area or subgroup of the population. The expected number is calculated by applying the national age specific mortality rates to the population of the HA area or population subgroup.

Notes

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Back

1 Drever F and Whitehead M (eds). *Health Inequalities*. Office for National Statistics. London: The Stationery Office, 1997 (Series DS, No 15).
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comments

Your Views on Better Health

We want to hear your views on the plans in this document, and would be grateful if you could spare the time to complete this form and return it to us by **30 April 1998**. If you need more space please continue your comments on a separate piece of paper indicating which question you are answering. Please feel free to photocopy this form.

Please detach and send your completed questionnaire to:

The Health Strategy Unit

Room 535

Department of Health

Wellington House

133-155 Waterloo Road

London SE1 8UG

Alternatively, you can send your responses by e-mail to:
ohn@doh.gov.uk

Important Note: Under the code of practice of open government, any responses will be made available to the public on request, unless respondents indicate that they wish their response to remain confidential.

Please tick this box if you want your comments to remain confidential

Questions from Chapter Three

3 (i) What are the obstacles to partnerships at local level and how can national Government and local players help to overcome them? Are there good practice examples from which we can learn?

---

3 (ii) Is the overall contract for health comprehensive, or are there other elements which should be added to the national, local and individual roles?

---

3 (iii) How can public health research be strengthened?

3 (iv) What task forces might be required to aid implementation of the strategy? What sort of people should be involved in them?

3 (v) Have we omitted organisations with a role from this chapter? Are there good practice examples of their contribution?

3 (vi) How should opinion on fluoridation be tested in local areas?

3 (vii) What further action should Health Improvement Programmes require?

3 (viii) How can the Local Authority role in health be strengthened and supported?

3 (ix) How can we encourage and foster local community action to improve health? Are there examples of good practice?

3 (x) What structures are needed to ensure effective joint planning at local level?

3 (xi) What action is needed to make healthy schools, healthy workplaces and healthy neighbourhoods a reality? Are there examples of good practice? What are the obstacles to success and how can these be overcome?

Questions from Chapter Four

4 (i) Are the priority areas the right ones on which to focus the strategy?

4 (ii) Have the targets been set at the right level?

4 (iii) Is the approach that is suggested for intermediate targets (ie for 2005) appropriate?

4 (iv) What would you add to the draft national contracts on heart disease and stroke,

accidents, cancers and mental health? A blank contract is attached.

---

4 (v) How should local inequality targets best be centrally monitored?

---

4 (vi) How should local priorities be determined? On what evidence and by what process?

Q. (M) Personal Details

Title: Mr/Mrs/Ms/Other (please specify)

Surname

First name(s)

Which County/Metropolitan area do you live in?

Is your response a personal one, or are you responding on behalf of an organisation?

Personal Organisation

Organisational respondents only:

1) Please state your organisation's name

---

2) What type of organisation do you represent?

NHS:

Trust

Health Authority

Primary Care provider

Academic

Voluntary/Charity:

Charitable service provider

Other non-statutory group

Local Authority:

Education Department

Environmental Health Department

Social Services Department

Local Authority - Other (please specify department)

Commercial Organisation
(please specify nature of business)

Other (please specify)

Which version of the Green Paper do you have?

Full version

Summary version

Where did you obtain your copy of the Green Paper?

Department of Health mailing

Internet

Other source (please specify)

Unsure

Where did you learn about the Green Paper?

Newspaper/TV/Radio

Journal

Department of Health Communications

NHS Executive Communications

Internet

Other medium (please specify)

What is your overall opinion of the proposals in the Green Paper?

I/we mostly support the proposals

On balance, I/we support the proposals

I/we mostly disagree with the proposals

On balance, I/we disagree with the proposals

Thank you for taking the time to let us know you views. We're sorry that we cannot acknowledge individual responses.

Contract with England to tackle ...	**Government and National Players can:**	**Local Players and Communities can:**	**We all can:**
Social and Economic			
Environmental			
Lifestyle			
Services			

---

comments

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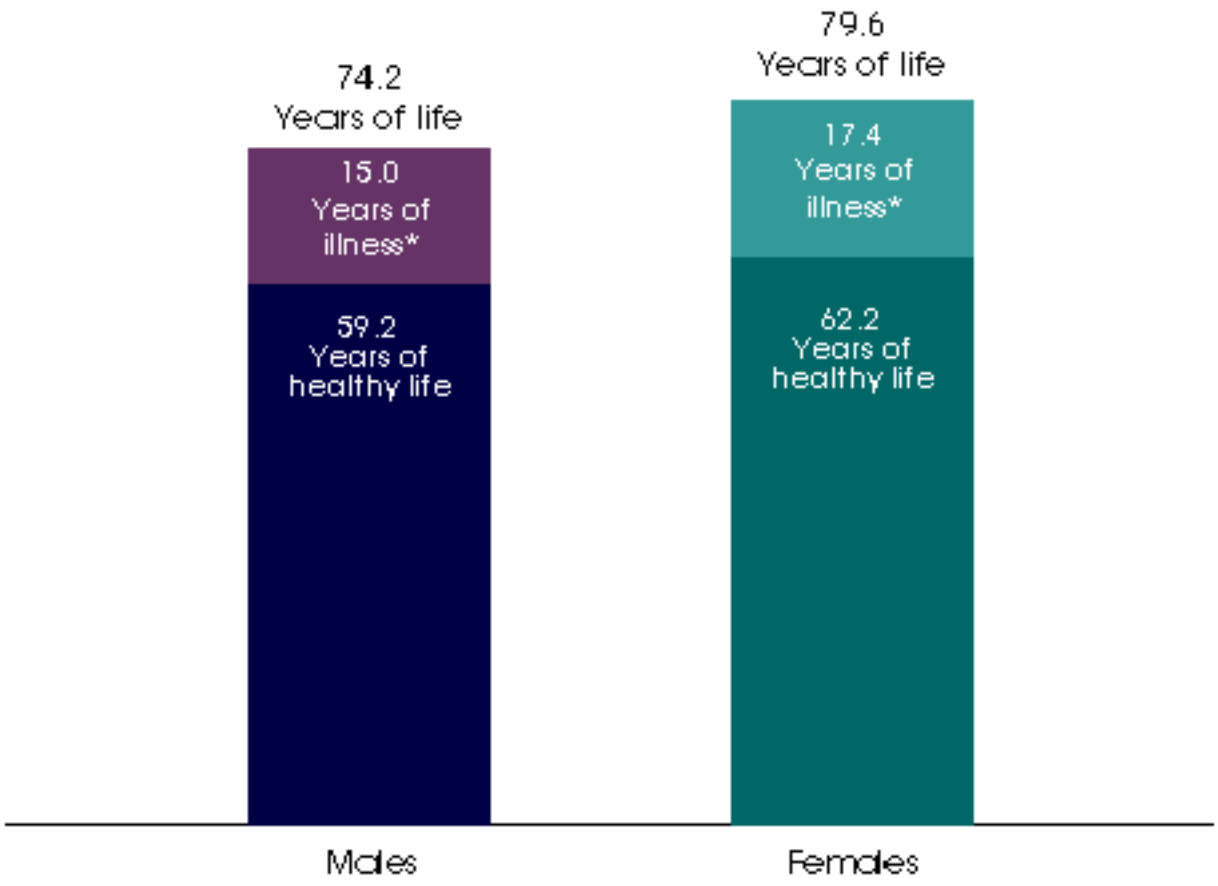
Chapter 1

Fit for the 21st Century

Figure 1.
Life expectancy and healthy life expectancy

At birth, Great Britain 1994

Source: Bebbington and Darton (1996),
from Office for National Statistics (ONS) data.



*Limiting long-standing illness - based on a positive response to the following questions in the General Household Survey:
(1) Do you have any long-standing illness, disability or infirmity?
(2) Does the illness or disability limit your activities in any way?

This chart presents Healthy Life Expectancy calculated on the basis of self-reported "limiting long-standing illness". Extra years of life gained over recent years have on the basis of this methodology, been years of mild to moderate disability. Other research however suggests that with respect to measures of more severe disability, healthy life expectancy at age 65 years has shown some improvements alongside total life expectancy. The extra years of life have not therefore been years of severe disability.

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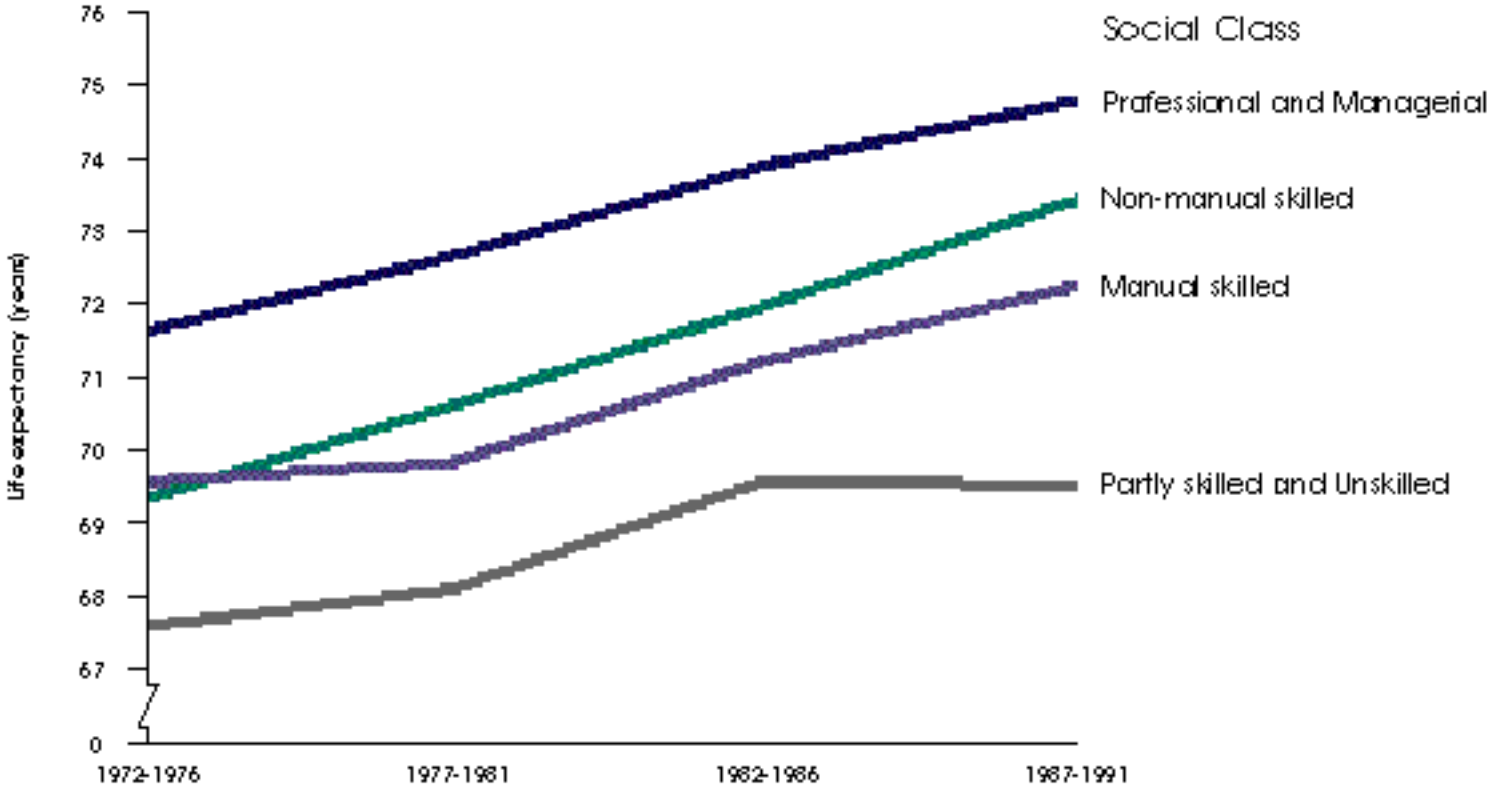
Chapter 1

Fit for the 21st Century

Figure 2.
Life expectancy by social class

Males at birth England and Wales 1972-1991

Source: adapted from Drever and Whitehead (eds), Health Inequalities,
ONS, (1997), using data from ONS Longitudinal Study



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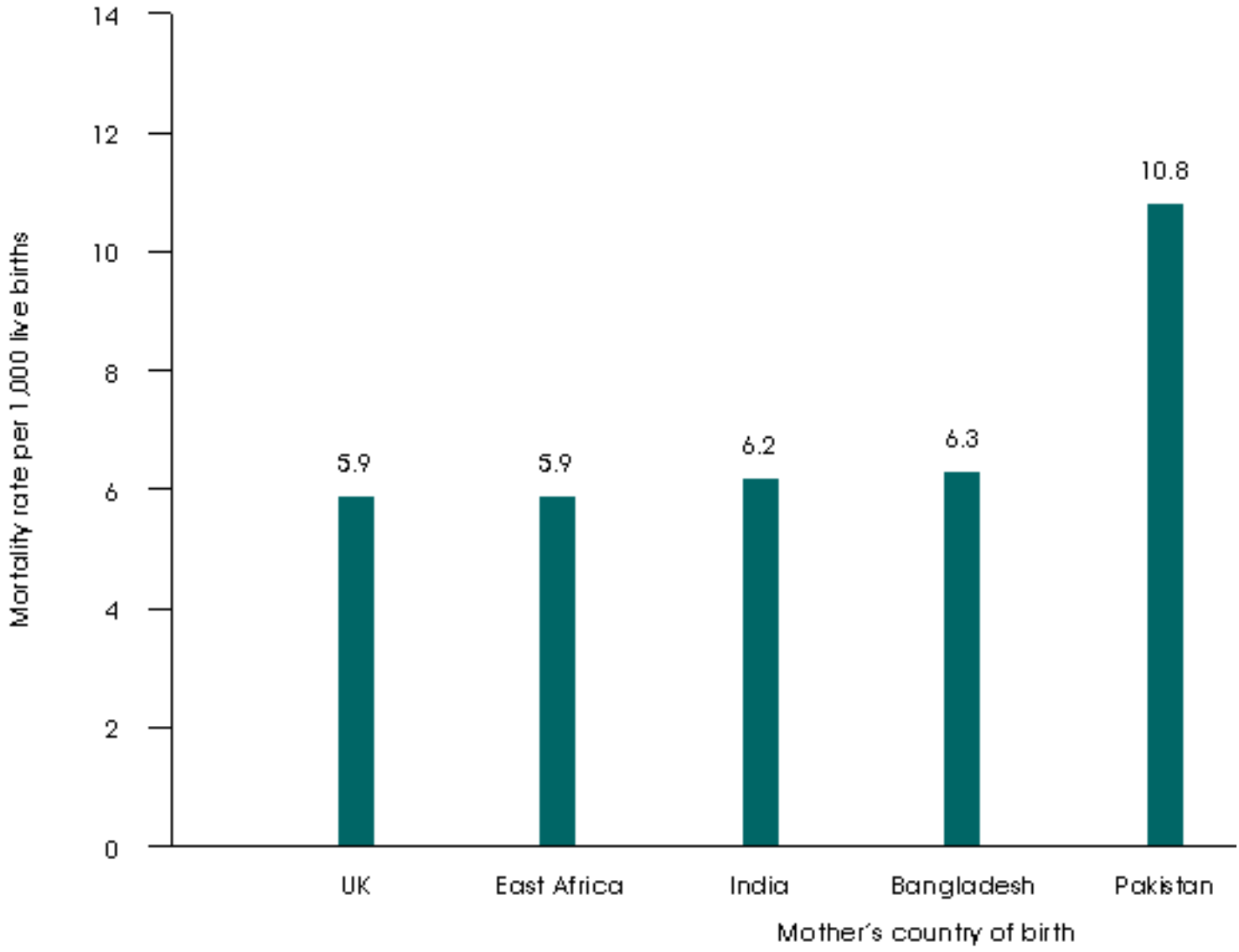
Fit for the 21st Century

Figure 3.
Infant mortality rate*

By mother's country of birth, deaths in England and Wales
1994-1996 combined

*Deaths before age 1 per 1,000 live births.

Source: ONS Monitors DH3 (1995, 1996, 1997).



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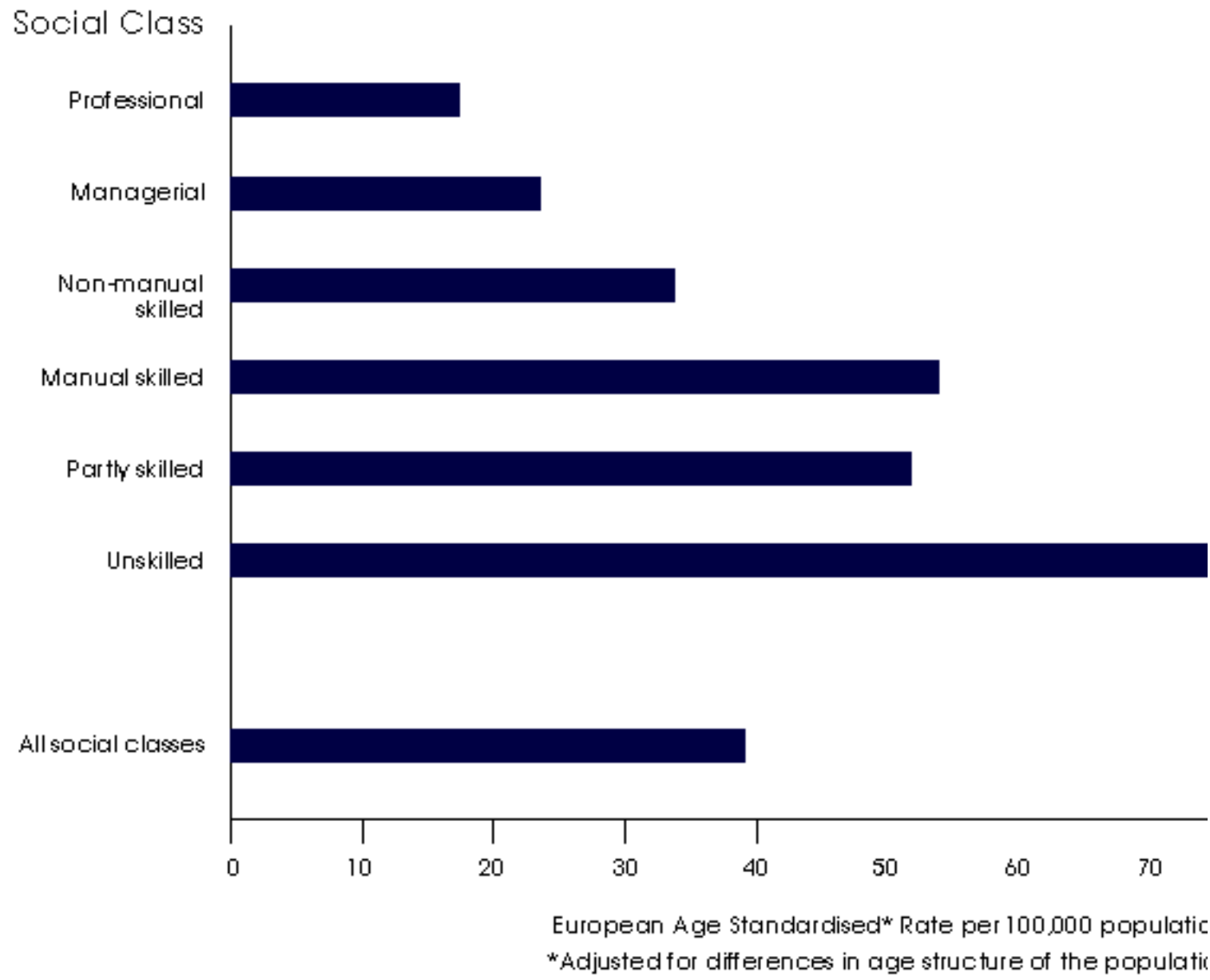
Chapter 1

Fit for the 21st Century

Figure 4.
Mortality from lung cancer by social class

Men, aged 20-64 England and Wales 1991-1993

Source: Drever and Whitehead (eds), Health Inequalities ONS, (1997) using data from death registrations and 1991 Census.



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Chapter 1

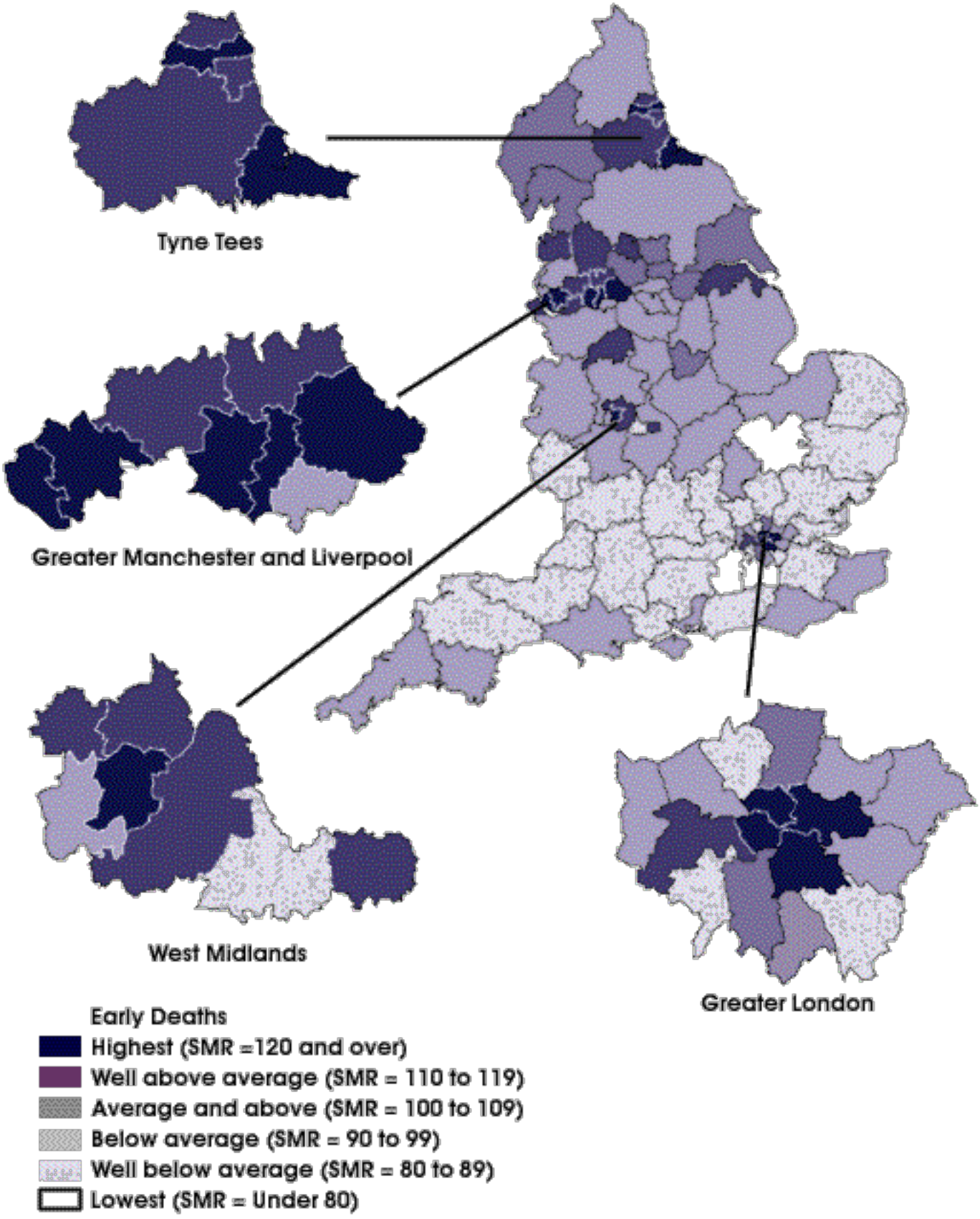
Fit for the 21st Century

Figure 5.
Geographical inequalities in mortality

By Health Authority, persons aged 15-64 1994-1996

Standardised Mortality Ratios (SMRs) from all causes.
(see glossary)

Source: Public Health Common Data Set 1997 (from ONS data)



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Fit for the 21st Century

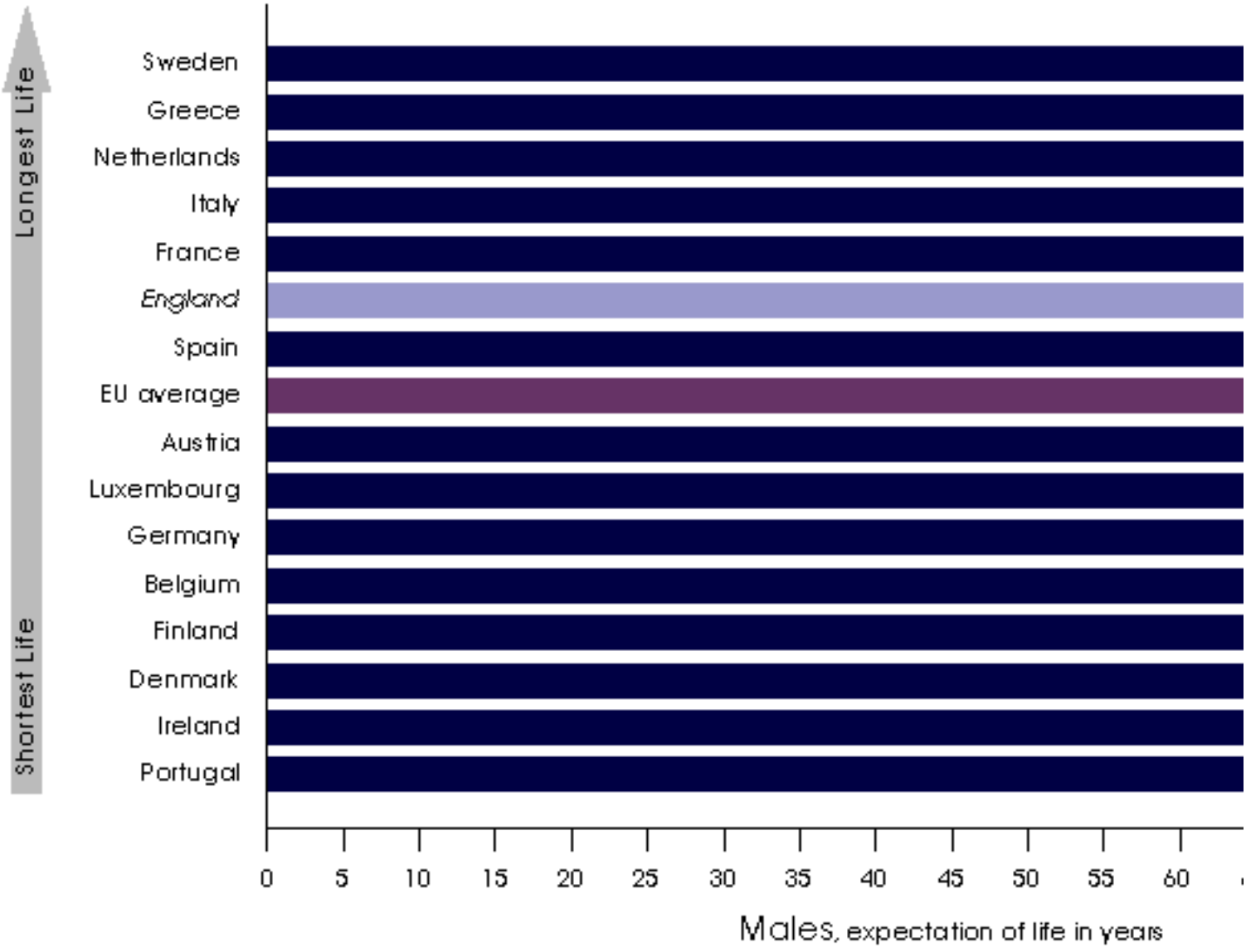
Figure 6.
Expectation of life at birth

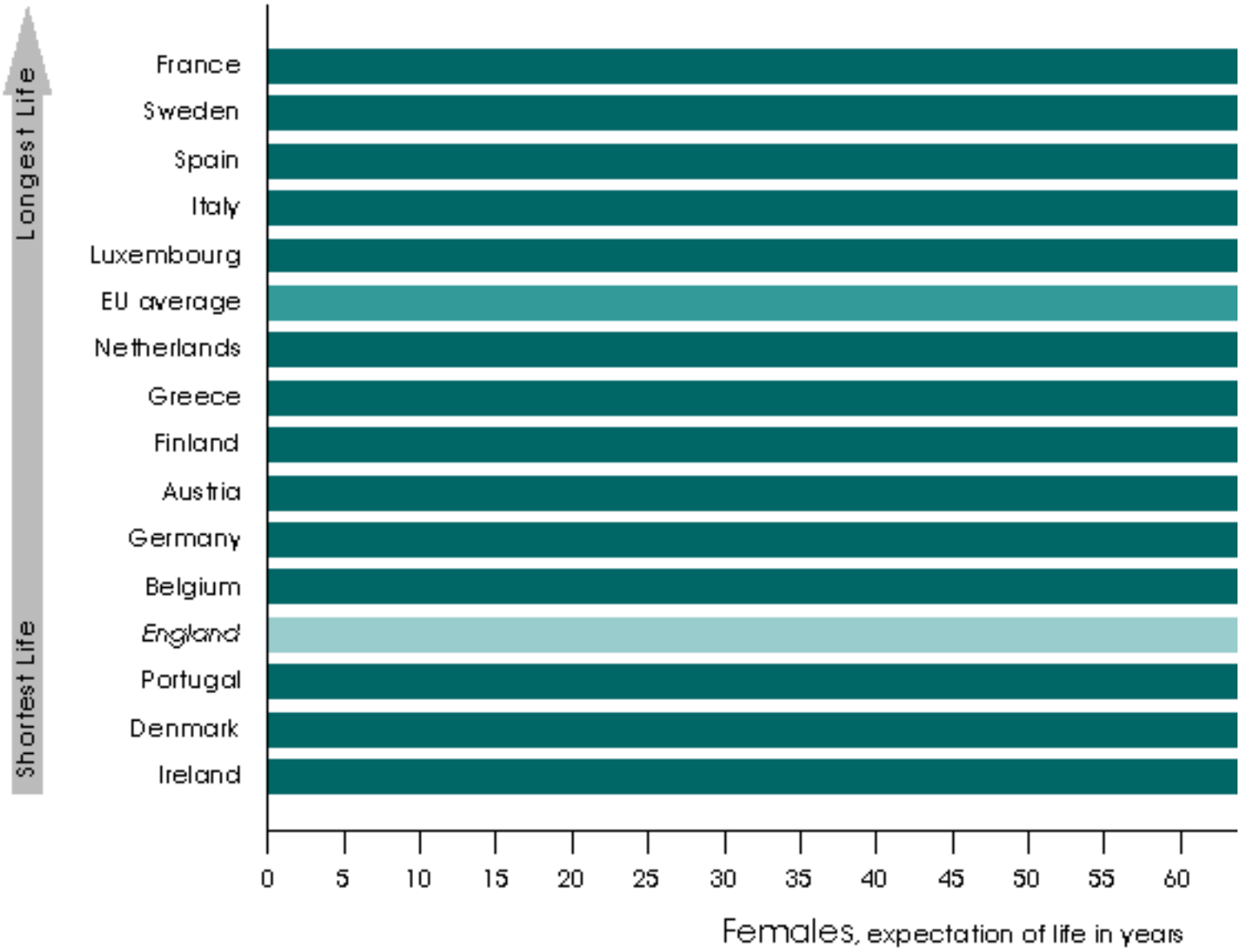
European Union circa 1995*

*Data for 1995 except for Austria 1996; Denmark and France 1994; Ireland, Italy and Spain 1993; Belgium 1992.

Figures for England calculated by Government Actuary's Department, by slightly different methodology to WHO figures, (however this does not affect the ranking of the countries).

Source: WHO Health For All statistical database and Government Actuary's Department.





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Chapter 2

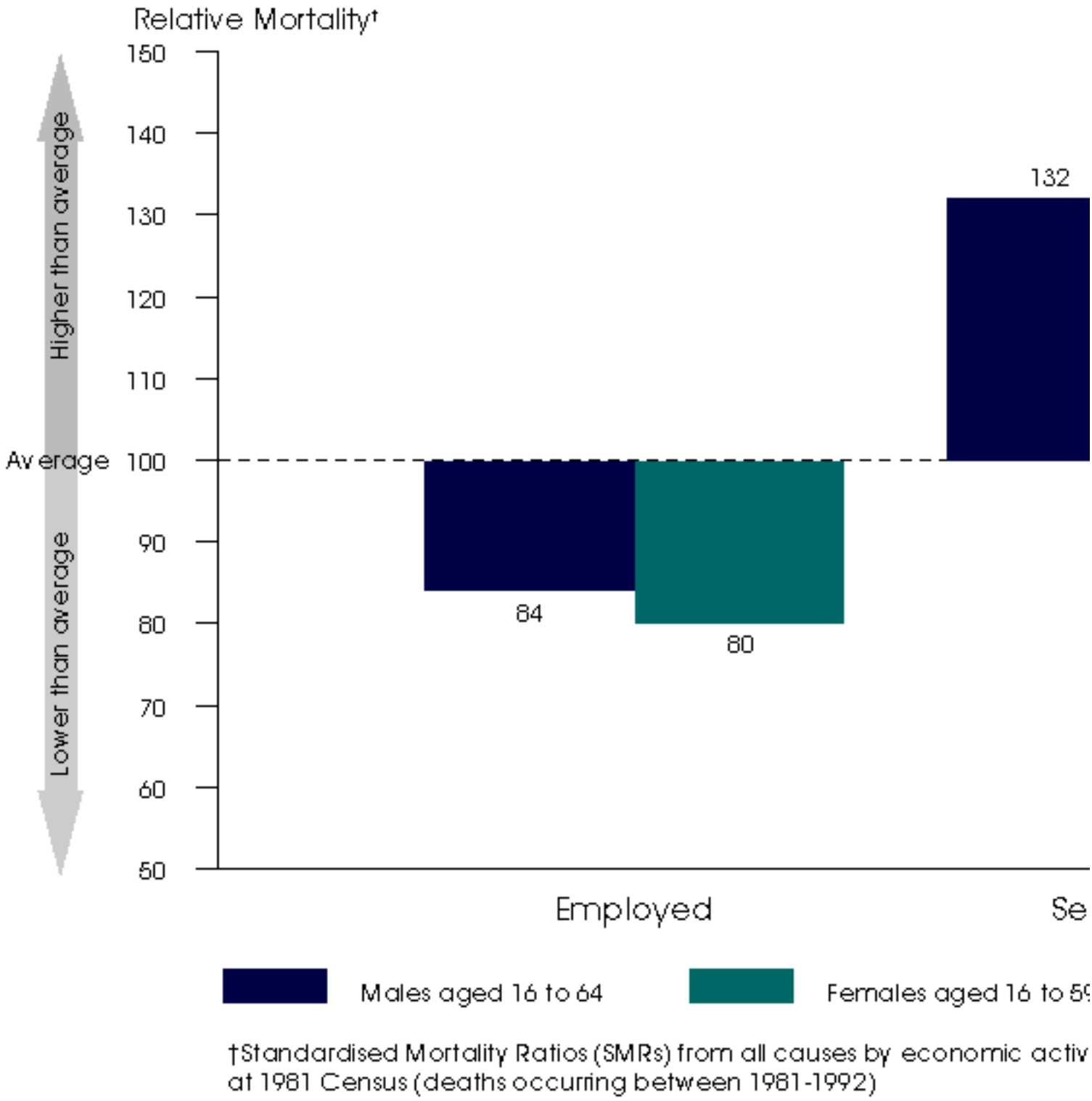
The Causes of Ill Health

Figure 7.
Employment, unemployment* and mortality

By sex, England and Wales 1981-1992

*Unemployment = People currently unemployed but seeking work. The chart does not include those who are permanently sick or disabled, or inactive for other reasons.

Source: Drever and Whitehead (eds), Health Inequalities ONS, (1997) using data from ONS Longitudinal Study.



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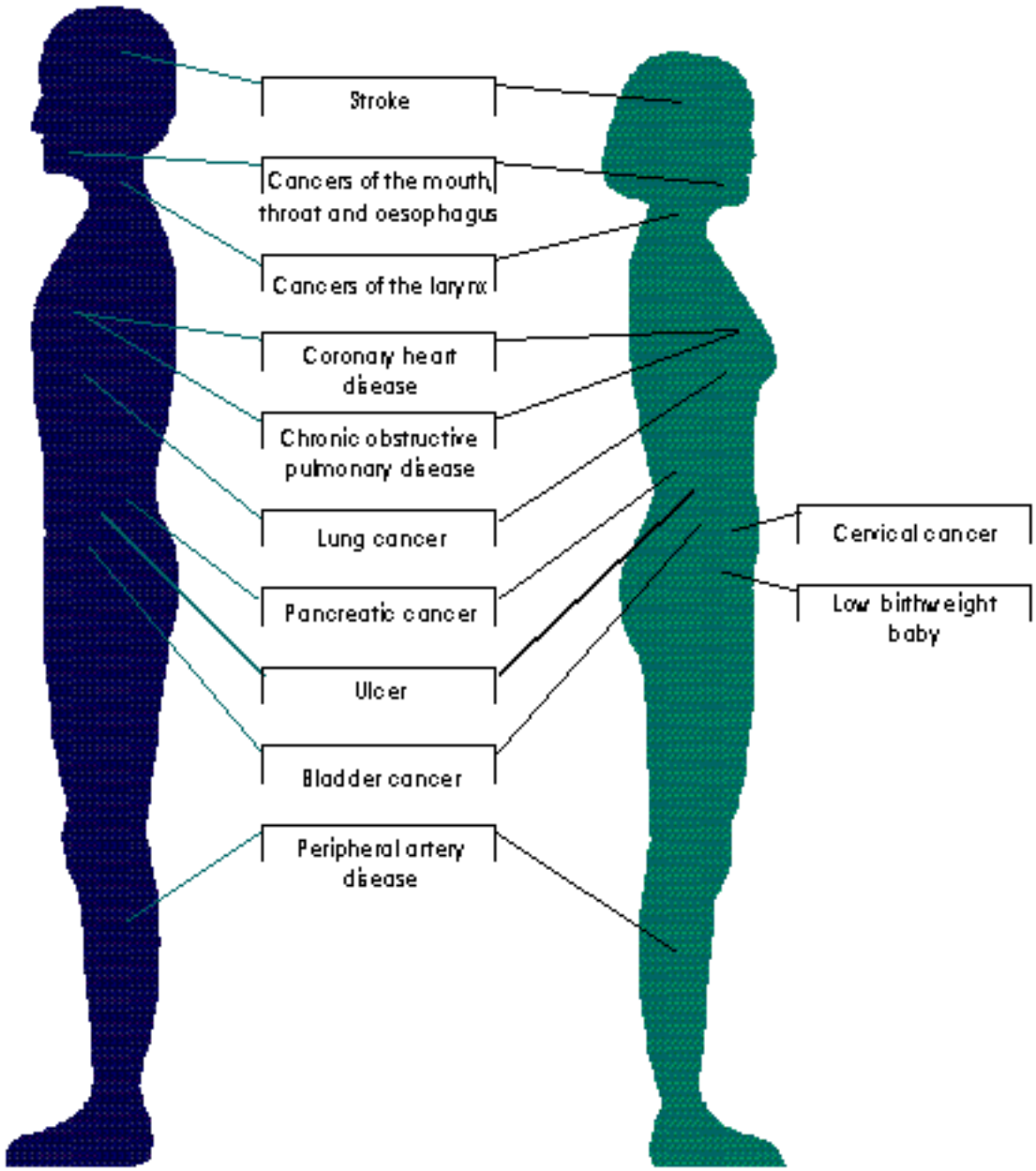
Chapter 2

The Causes of Ill Health

Figure 8.
The health risks of cigarette smoking

Source: based on Smoke-free for Health, DOH (1994), from US Office on Smoking and Health, Centers for Disease Control and Prevention Report, (1990).



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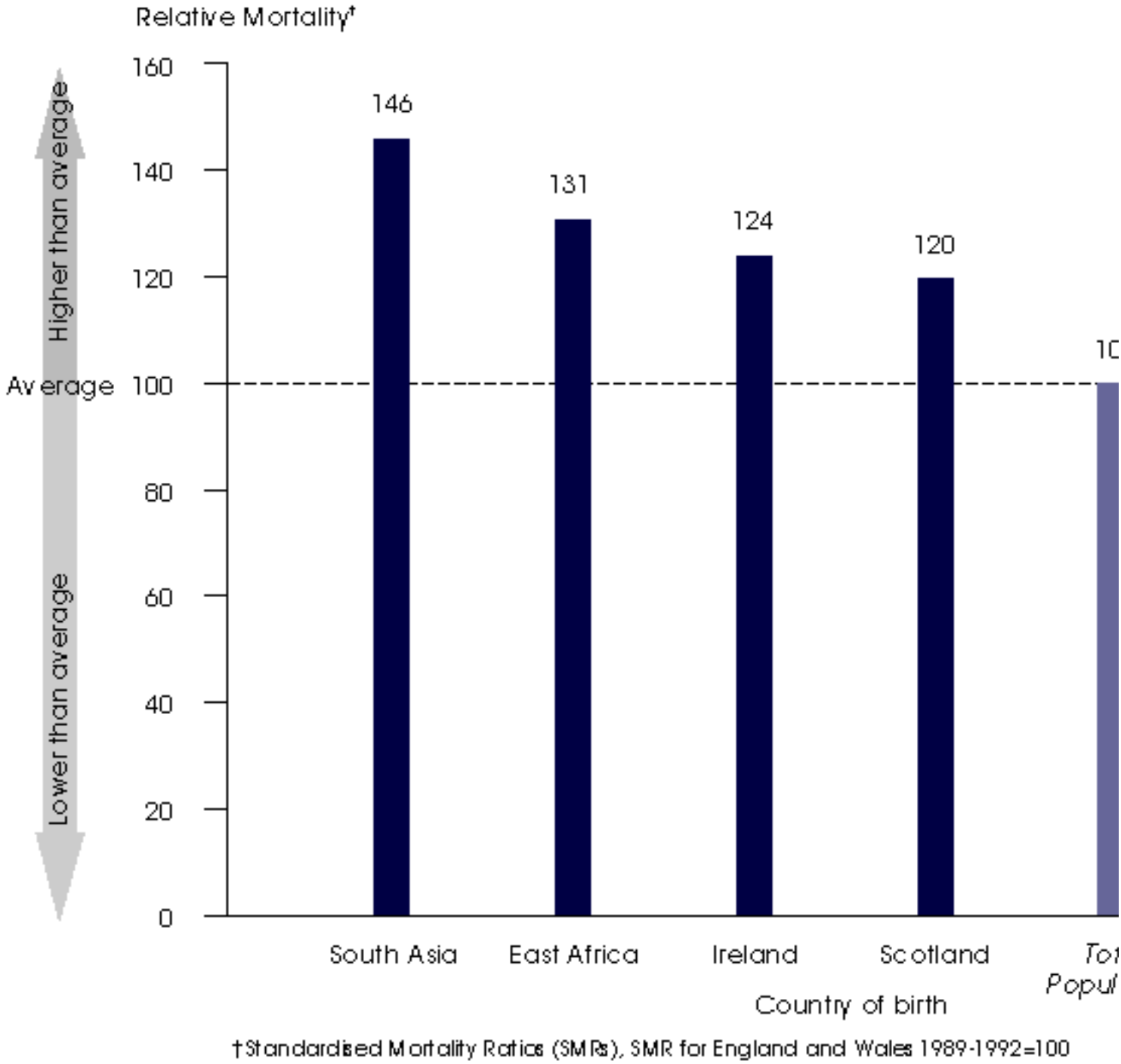
Chapter 2

The Causes of Ill Health

Figure 9.
Mortality from coronary heart disease

Males, aged 20-69 by selected country of birth,
deaths in England and Wales 1989-1992

Source: S Wild & P McKeigue (1997),
BMJ volume 314 (from ONS data).



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Chapter 2

The Causes of Ill Health

Figure 10.
Mortality from injury and poisoning in children aged 0-15 years

By social class England and Wales 1989-1992

Source: I Roberts & C Power (1996),
BMJ volume 313 (from ONS data).

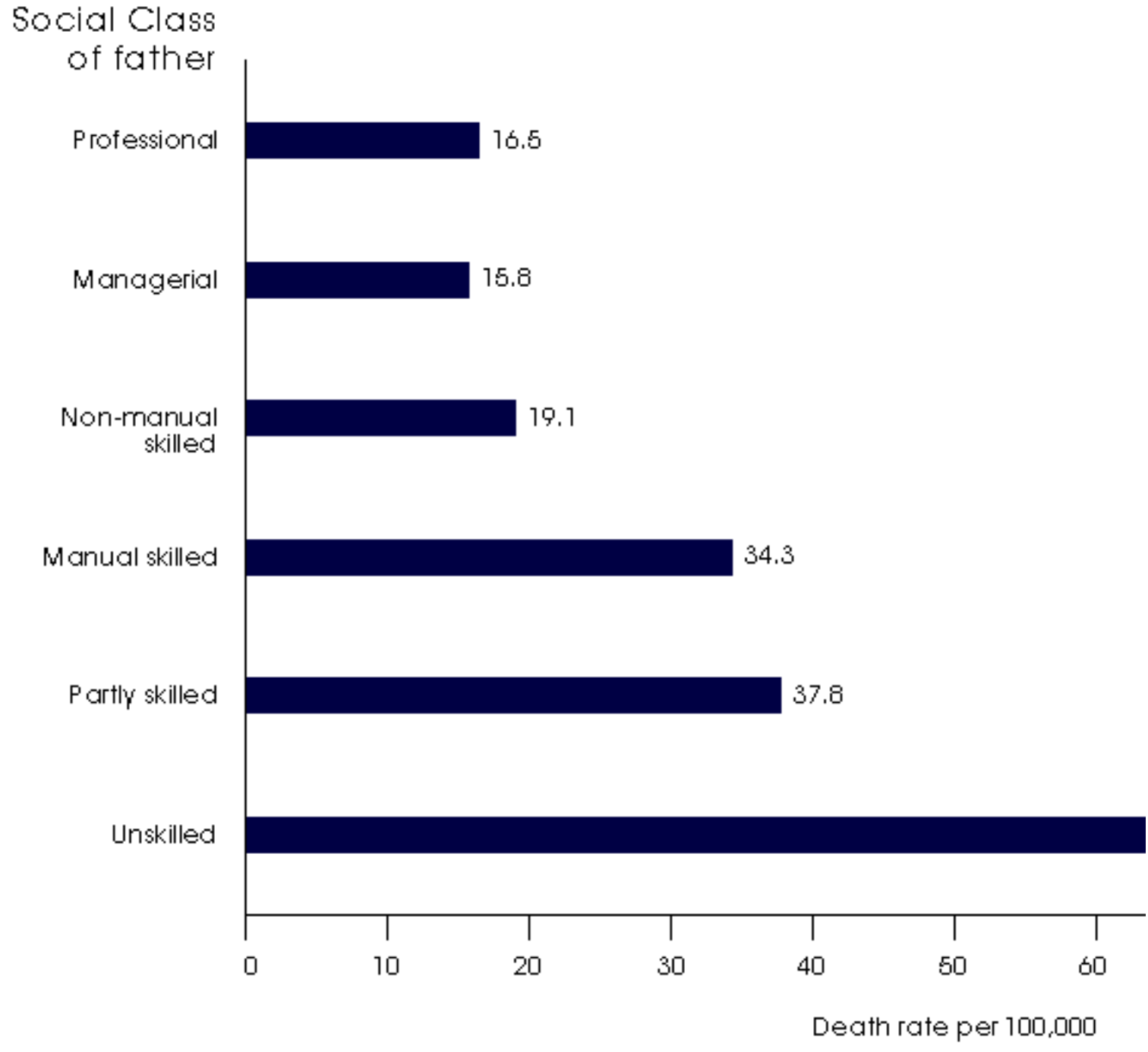

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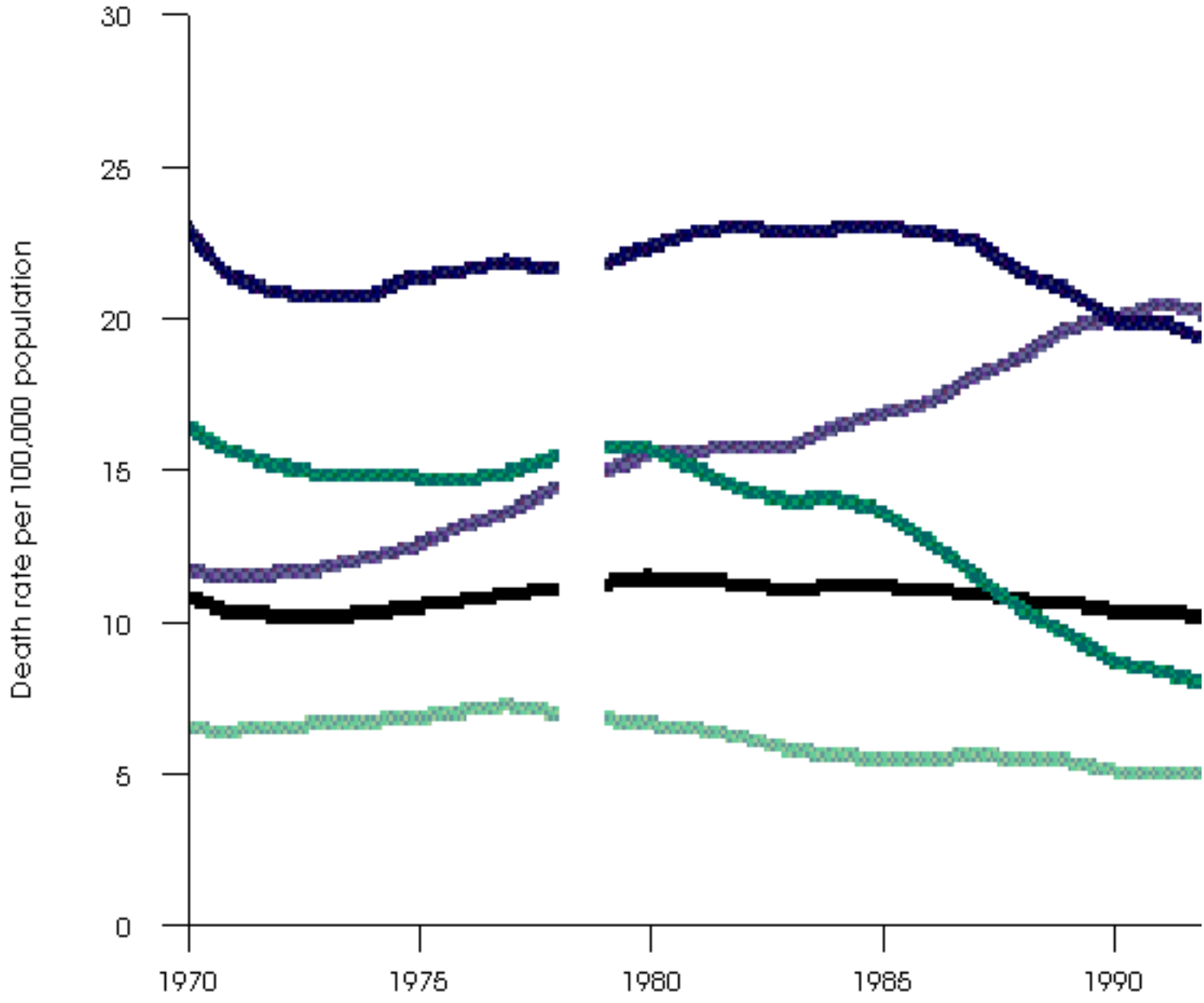
Figure 11.
Mortality rates*from suicide and undetermined injury

By age and sex, England1969-1996

3 year average rates

*Each age group has been separately age standardised, ie adjusted for differences in the age structure of the population.

Source: ONS Mortality Statistics (ICD E950-E959,E980-E989 less E988.8).



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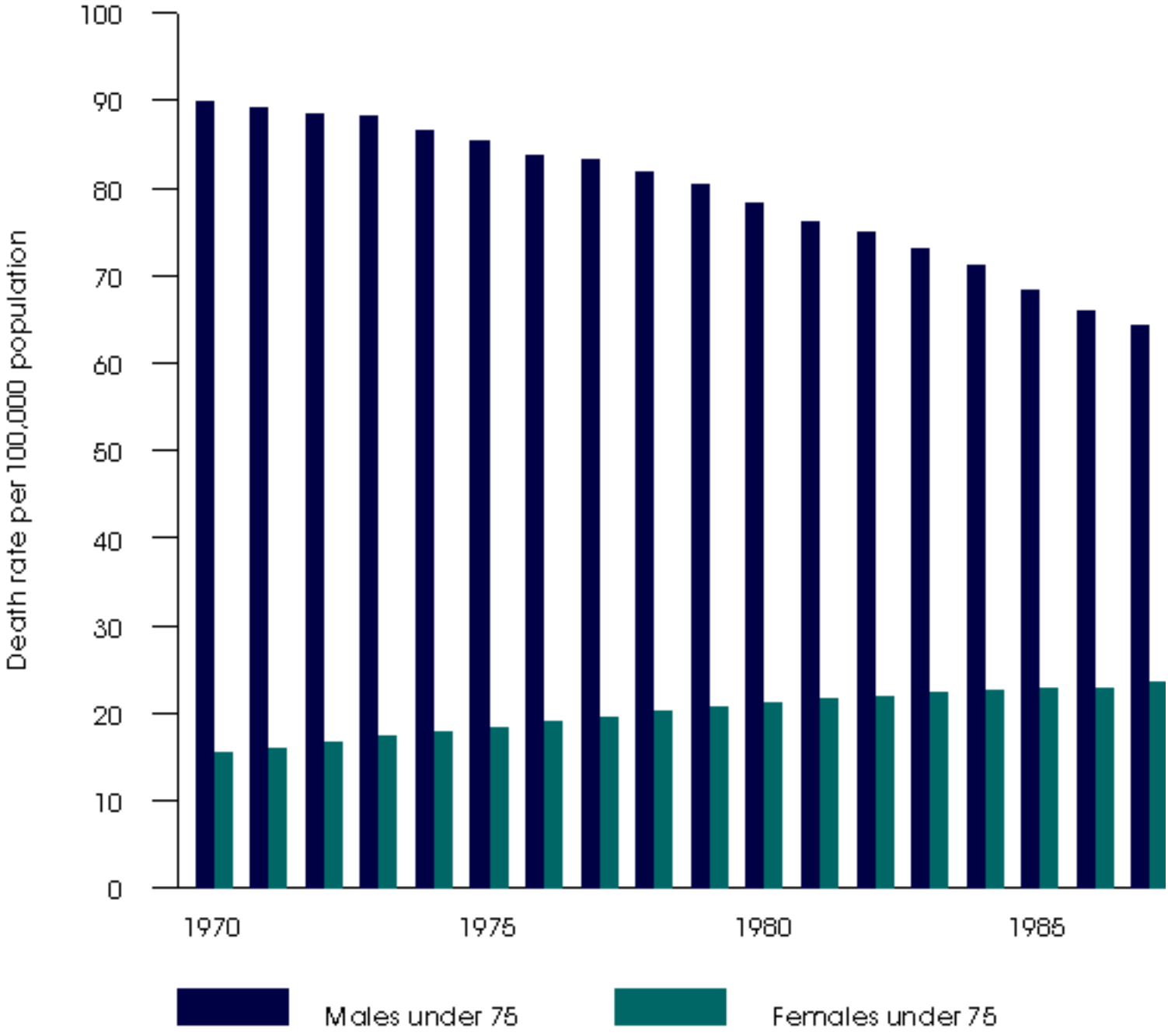
comments

Figure 12.
Mortality rates from lung cancer

By sex, England1969-19963 year average rates

3 year average rates

Source: ONS Mortality Statistics (ICD 162).



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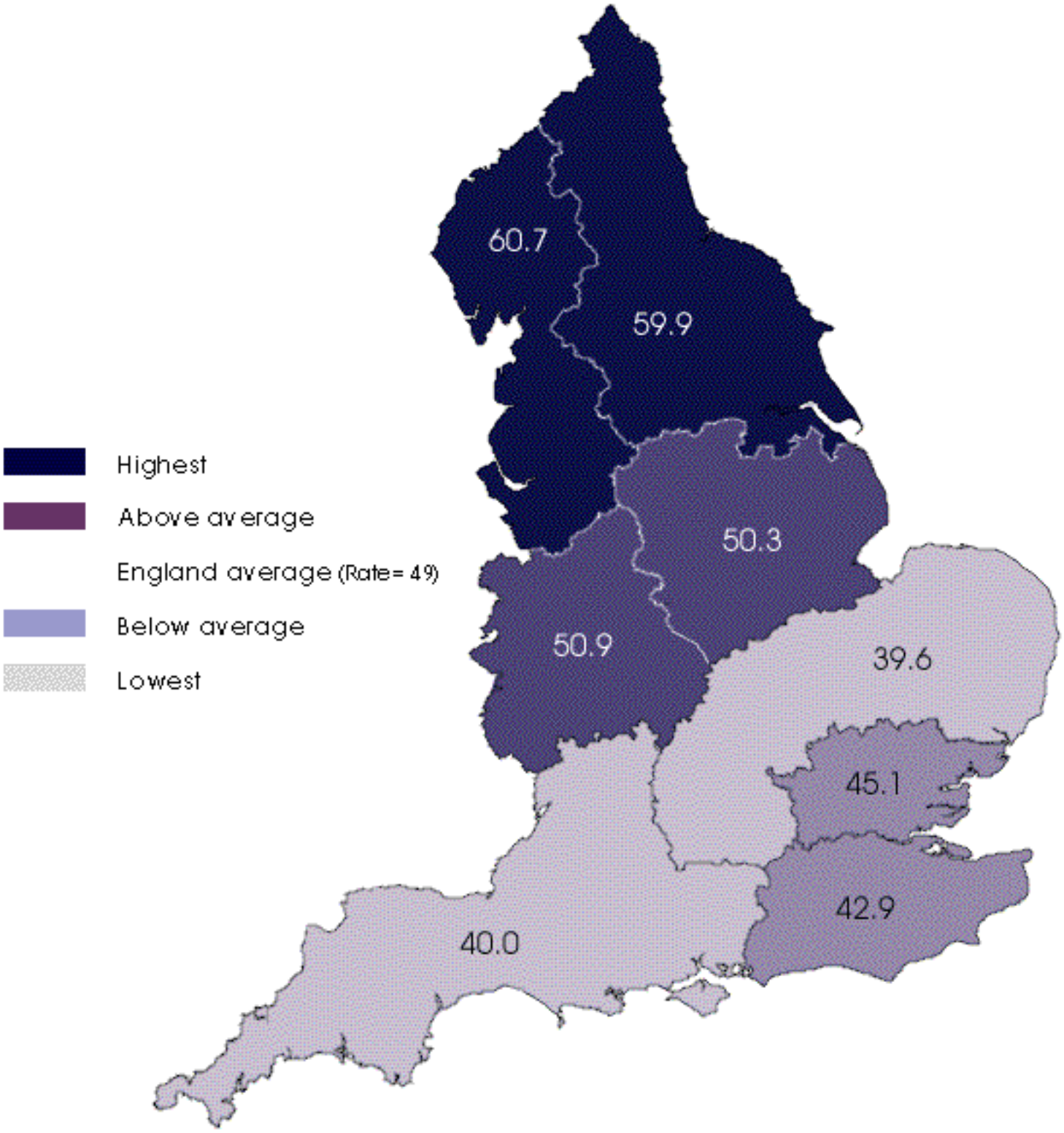
comments

Figure 13.
Mortality rates from lung cancer

By Regional Office Area, males aged under 75, England1996

Age Standardised Mortality Rate per 100,000.

Source: Public Health Common Data Set 1997(from ONS data).



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comments

A Contract for Health

on this site.

Figure 14.
Mortality rates[Ý] from Stroke

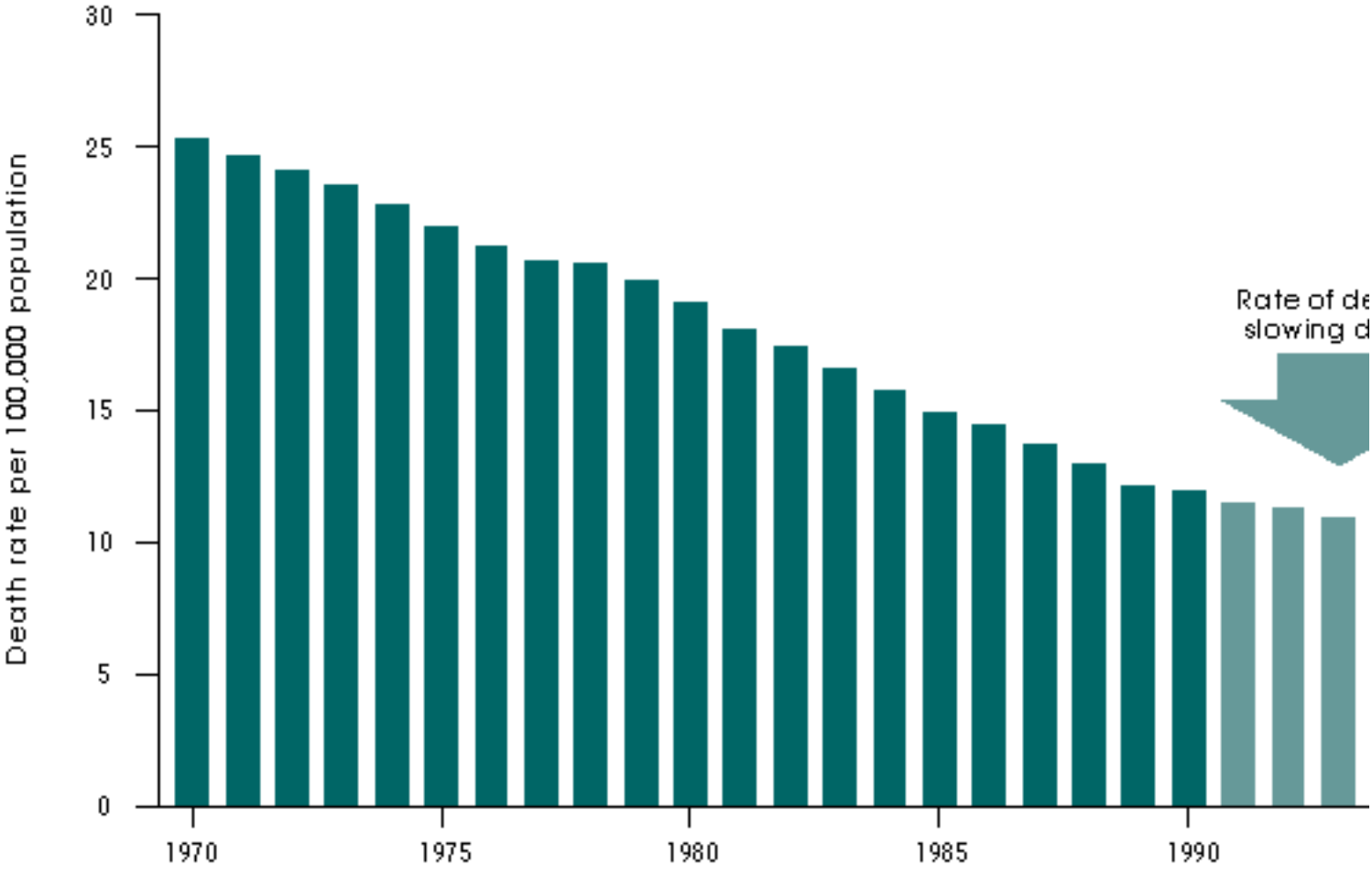
England 1969-1996
All persons aged under 65

3 year average adjusted rates*

ÝRates are calculated using the European Standard Population to take account of differences in age structure.

*The rates for 1984 to 1992 have been adjusted to be on broadly the same basis as those for 1969 to 1983 and 1993 to date, using factors provided by ONS. There is a small discontinuity between the years 1978 and 1979 due to a change in coding from ICD8 to ICD9 which slightly affects the comparability of data.

Source: ONS (ICD 430:438).



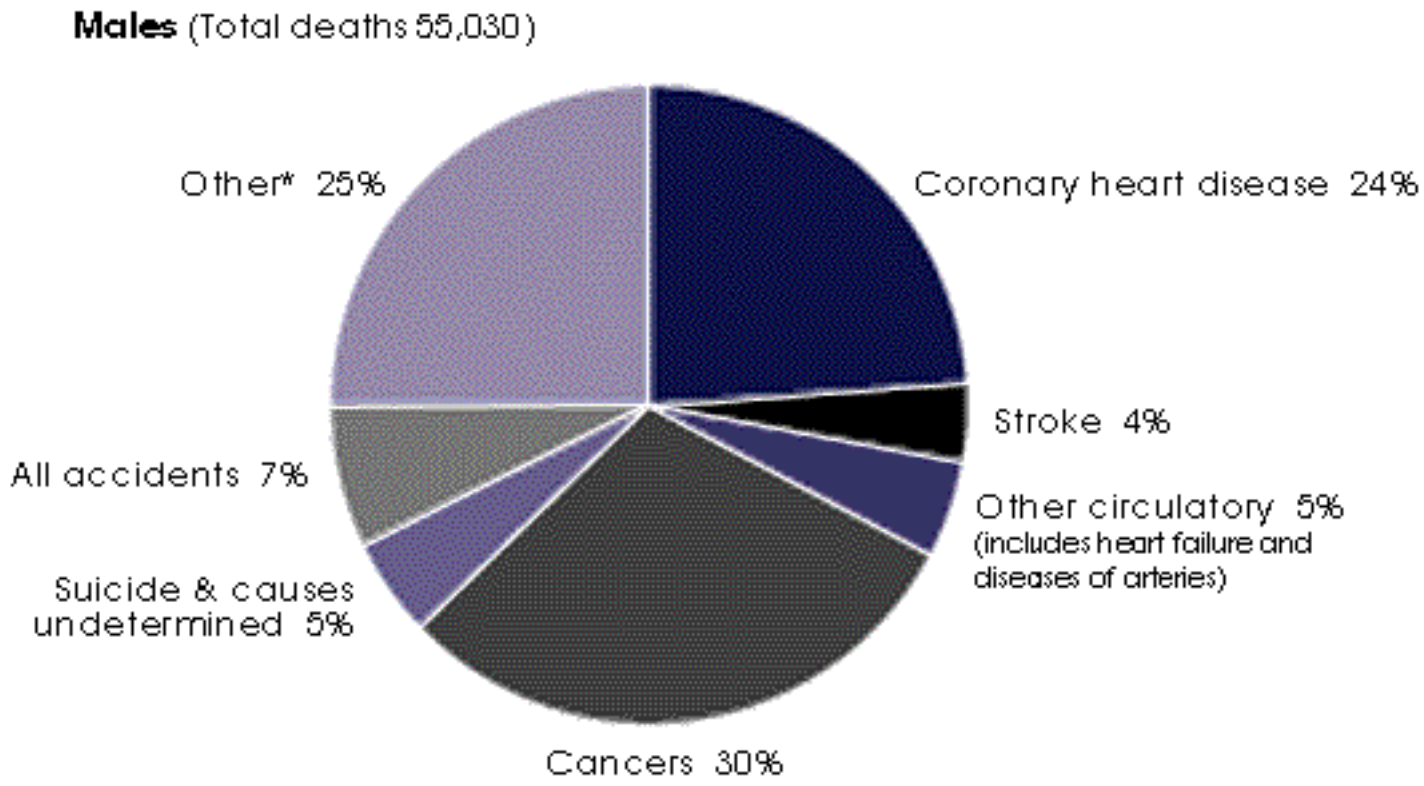
comments

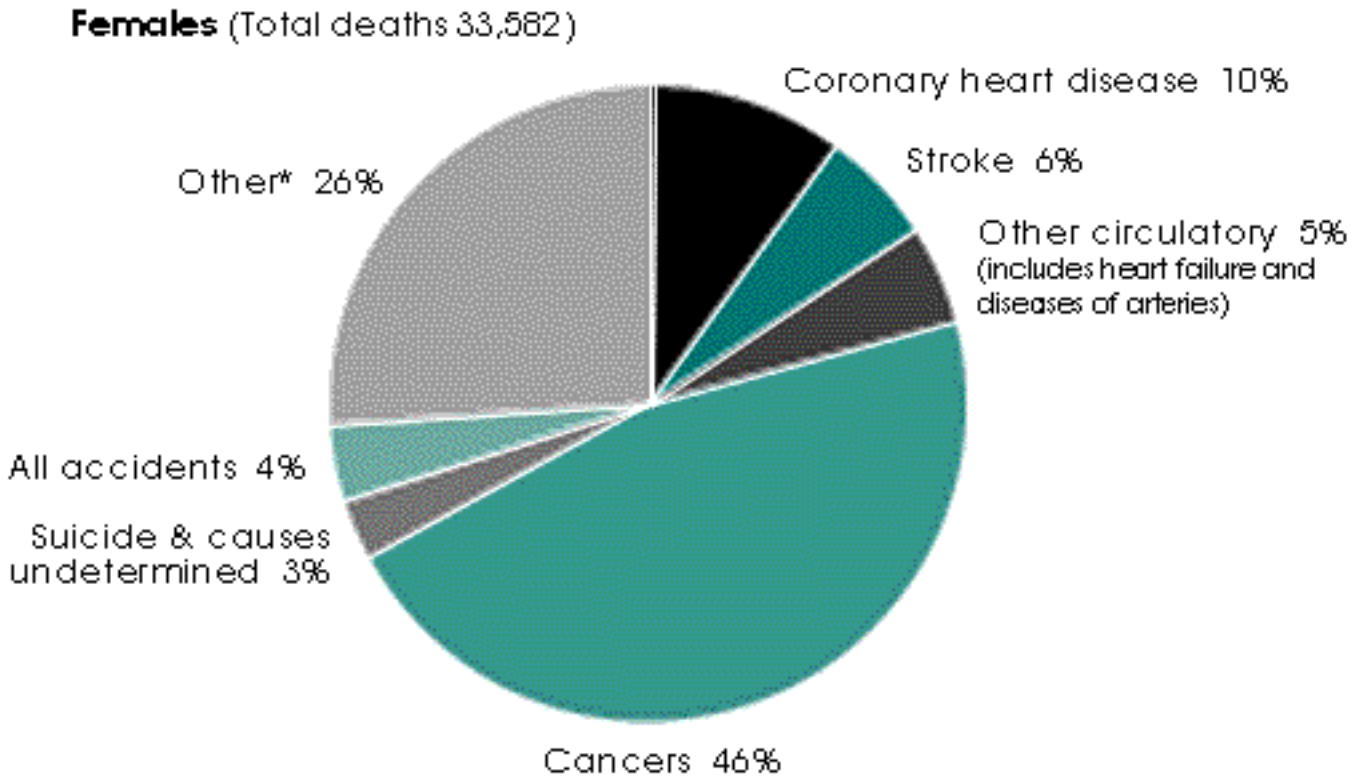
Figure 15.
Major causes of mortality

Under 65 years by sex, England1996

*Deaths occurring at ages under 28 days are included in the totals but are not allocated to a specific cause of death. These are therefore included in "Other". The major categories presented in this figure are those which have been identified as priority areas for *Our Healthier Nation*. All remaining causes of death have been assigned to the "Other" category.

Source: ONS Mortality Statistics.





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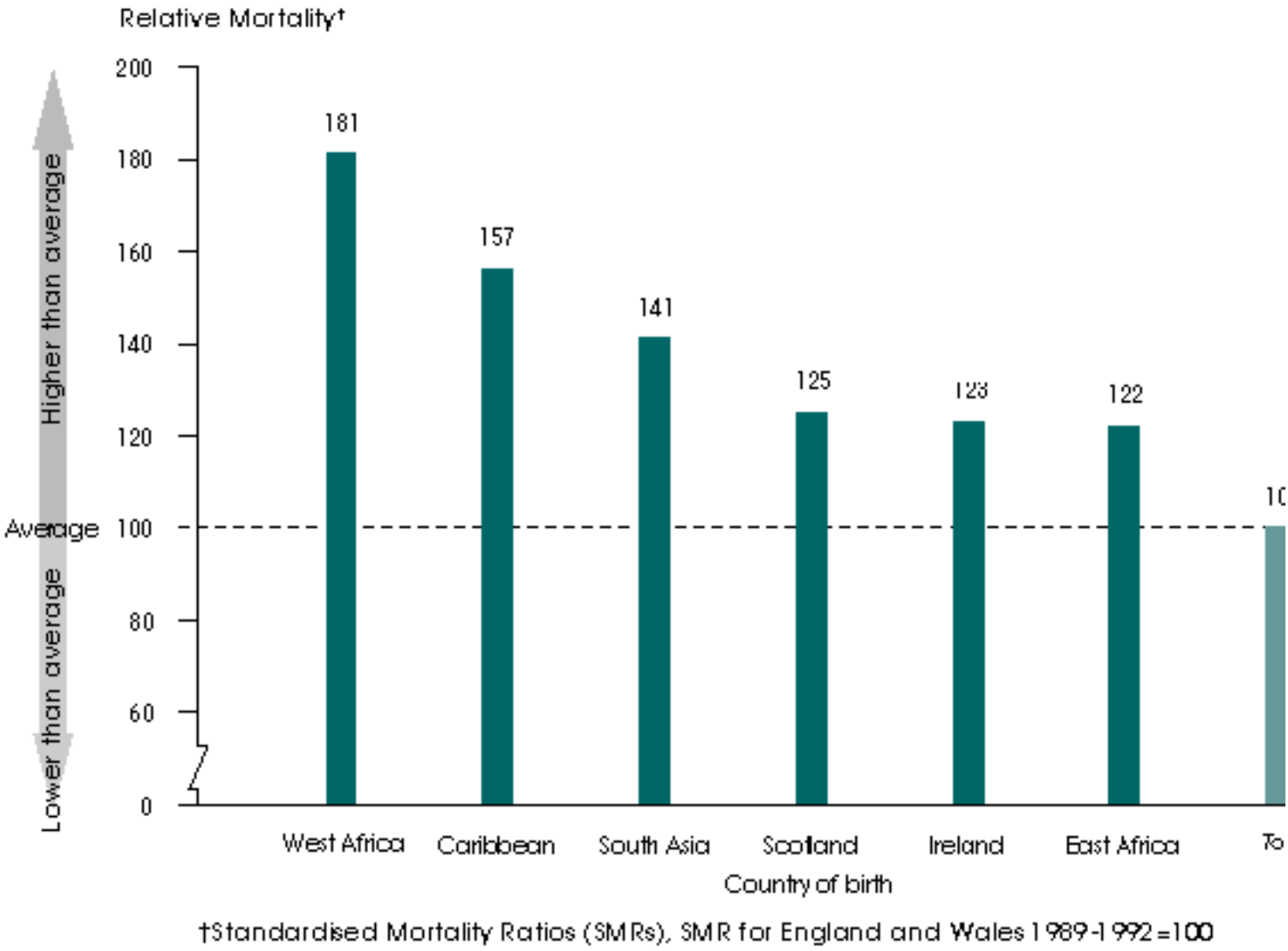
comments

Figure 16.
Mortality from stroke

Females, aged 20-69 by selected country of birth,
deaths in England and Wales 1989-1992

Source: S Wild & P McKeigue (1997),
BMJ volume 314 (from ONS data).



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comments

Figure 17.
Mortality from coronary heart disease by social class

Men, aged 20-64 England and Wales1991-1993

Source: Drever and Whitehead (eds), Health Inequalities, ONS, (1997) using data from ONS death registrations and 1991 Census.

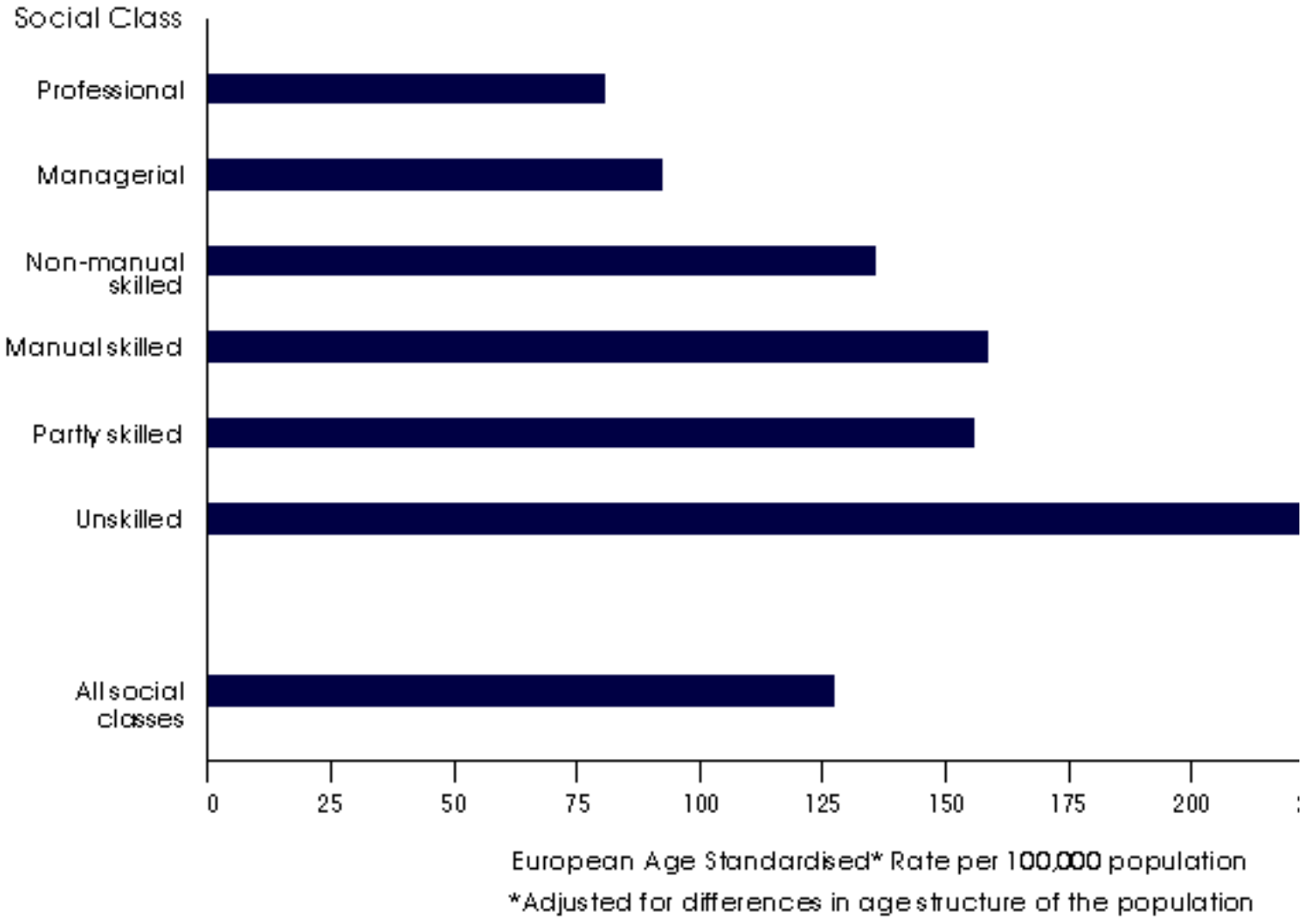

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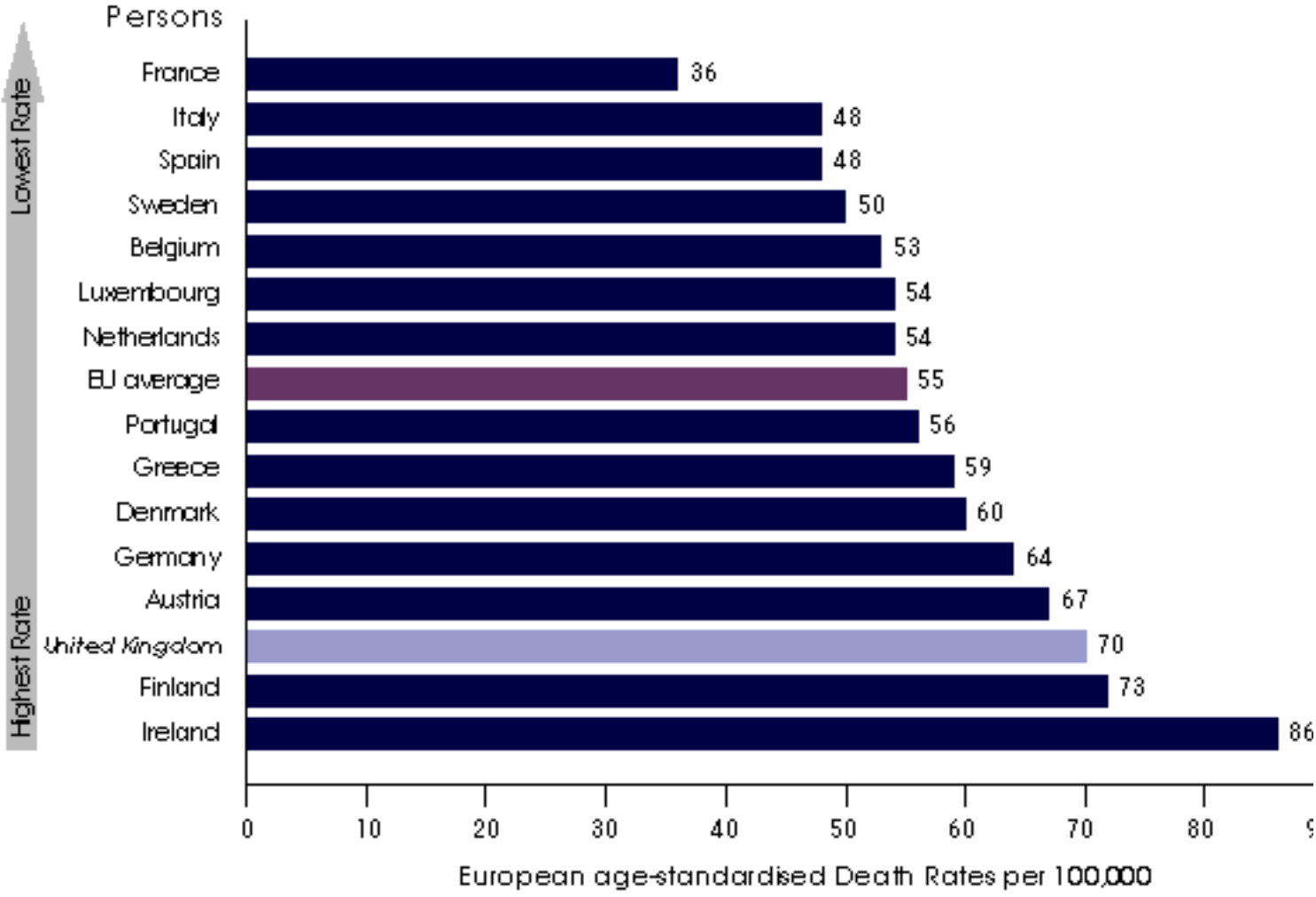
Figure 18.
Mortality from circulatory diseases

European Union aged under 65 circa 1995*

*Data for 1995 except for Austria 1996; Denmark and France 1994; Ireland, Italy and Spain 1993; Belgium 1992.

Source: WHO Health For Allstatistical database.



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comments

Figure 19.
Inequalities in mortality rates from accidents in young people aged 15-24

By Health Authority,1994-1996
10 highest and 10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

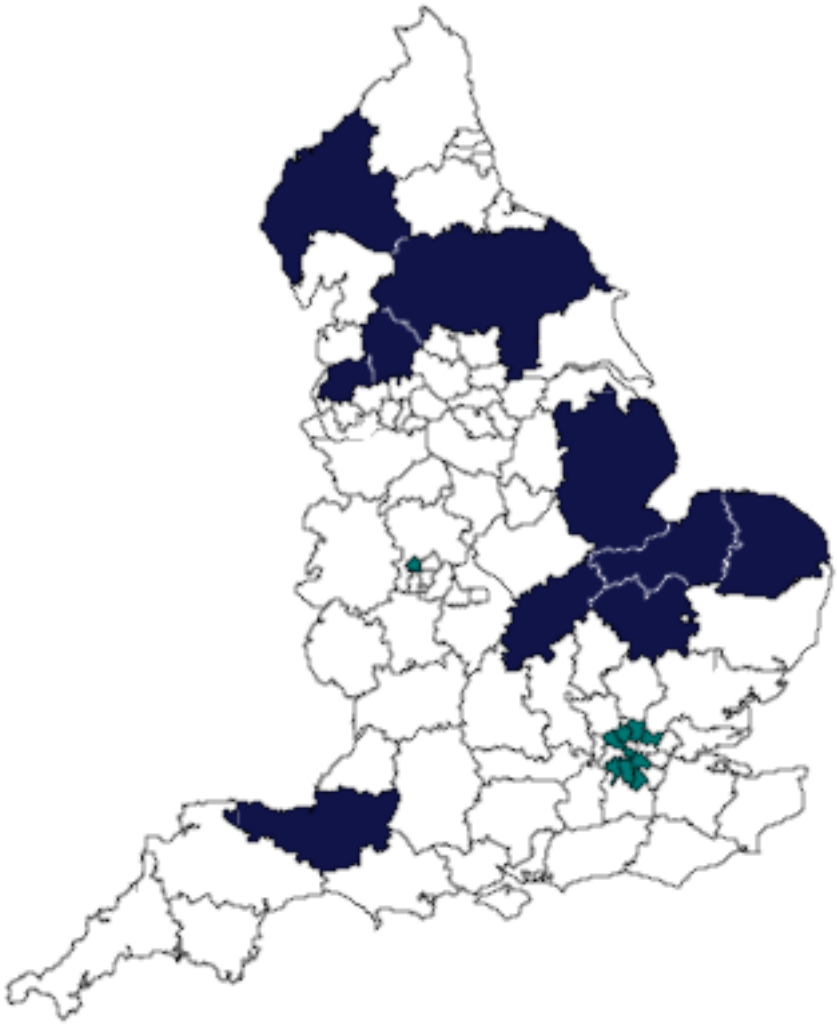

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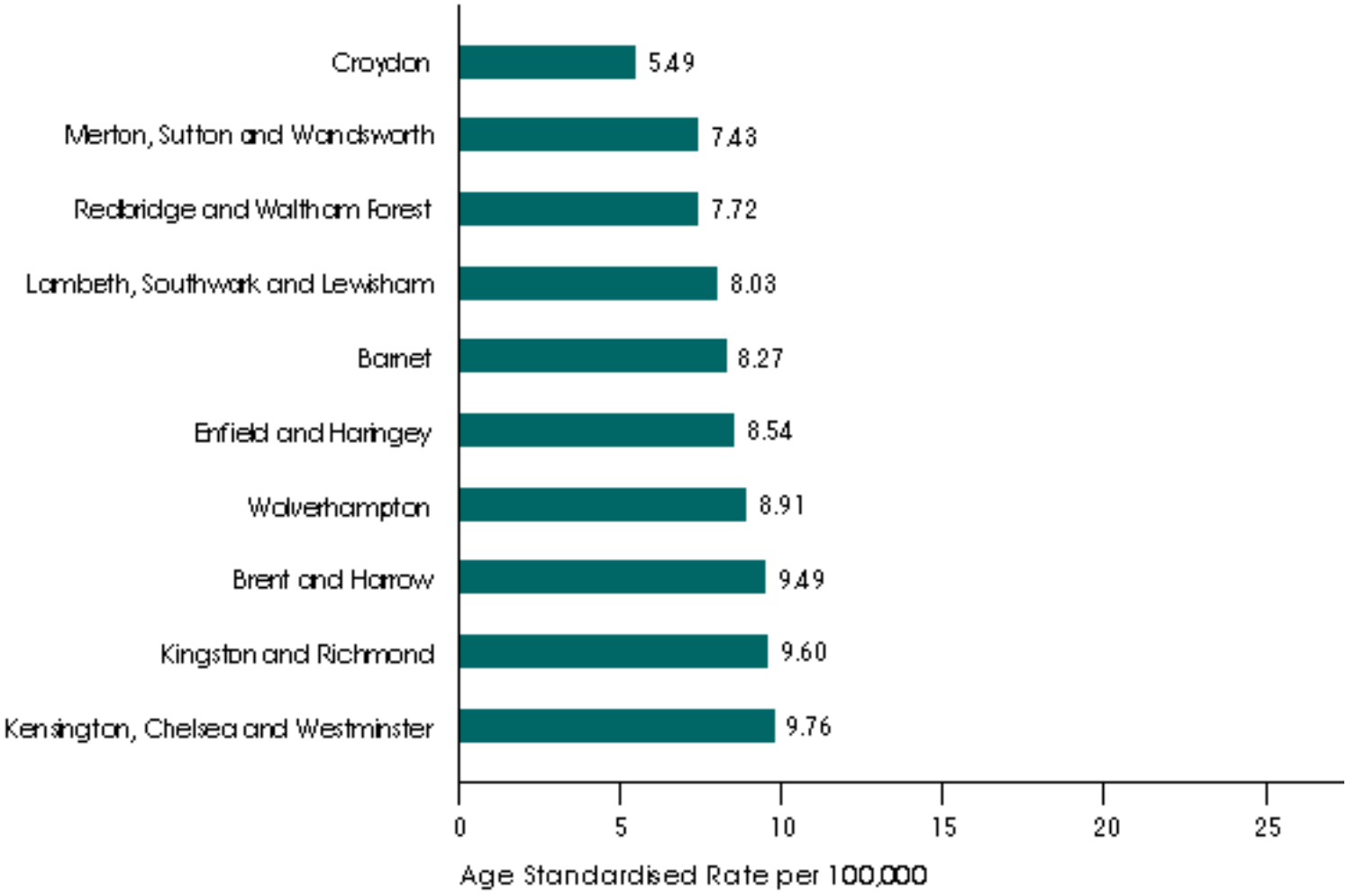
Figure 19 cont.
Inequalities in mortality rates from accidents in young people aged 15-24

By Health Authority,1994-1996
10 highest and 10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).



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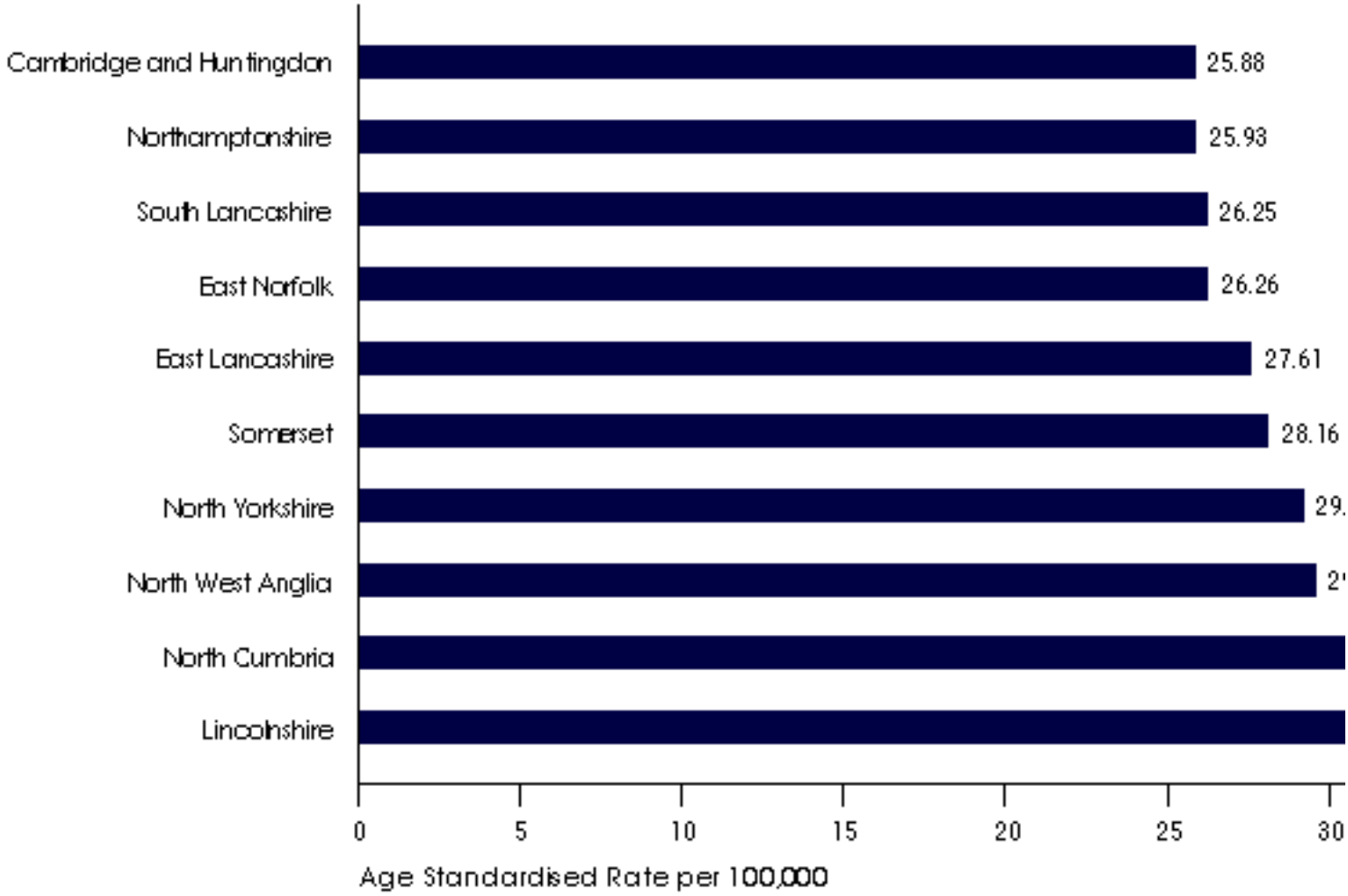
comments

Figure 19 cont.
Inequalities in mortality rates from accidents in young people aged 15-24

By Health Authority,1994-1996
10 highest and 10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).



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comments

Targets for Health

4.31 **Cancer deaths** have been chosen as a national target because:

- cancers are amongst the commonest causes of death in this country, accounting for one out of every four deaths - almost 130,000 each year. An even greater percentage of deaths occur at younger ages, one in three deaths under the age of 65 years - a total of nearly 32,000 deaths each year;
- the chance over a lifetime of being diagnosed as having cancer is almost 4 in 10 for men and only marginally less in women;
- cancer is the threat to our health which many of us fear most;
- there is much that can be done to reduce the death rate from cancers. The main causes of cancer deaths are illustrated in figure 20;
- there is very marked social class inequality in who dies from cancer. For example amongst men of working age the most recent figures show that the death rate for all cancers combined was twice as great in unskilled workers as in professionals. This inequality was worse for some types of cancers such as stomach cancer (three times as great in unskilled workers) and particularly lung cancer (four times as great);
- marked geographical inequalities also exist with, for example, death rates from lung cancer being about 20% higher in the north of the country than the national average. Death rates from cancer of the cervix follow a similar geographical pattern, but, by contrast, for malignant melanoma of the skin the highest rates occur in the southernmost parts of the country (see figure 21).

'there is very marked social class inequality in who dies from cancer'

- many of these cancer deaths could be avoided, either by preventing the disease (for example in lung cancer) or by early detection and treatment (for example in breast cancer). Prevention and early diagnosis which focuses particularly on cancers such as lung, breast, cervix, malignant melanoma of the skin, and colorectal cancer could have a major impact on reducing the overall burden from this disease;
- progress in tackling the factors which lead to preventable cancer deaths should help us to make progress in other areas which affect our health.

'progress in tackling the factors which lead to preventable cancer deaths should help us to make progress in other areas which affect our health'

Figure 20
Figure 21
Figure 21a
Figure 21b

4.32 We intend to set a single cancer target, **to reduce the death rate from cancer amongst people aged under 65 years by at least a further fifth (20%) by 2010 from a baseline at 1996** (see glossary). A reduction of this order, if it had occurred in 1996, would have resulted in some 6,000 deaths in this age group being avoided.

4.33 Figure 22 shows that Finland and Sweden are the best performing countries in the European Union. If we can achieve our target it would bring us to the levels currently experienced by these countries. The proposed target therefore represents a considerable challenge.

Figure 22

4.34 This is further illustrated by the fact that the target encompasses all cancers including those such as colorectal cancer

where opportunities for reducing incidence and mortality are not as clear cut as is the case with lung or breast cancer. There is also evidence that the incidence of cancer overall may have been increasing in recent years. Whilst reduction of risk factors such as smoking is of considerable importance in reversing this trend, progress remains challenging.

4.35 There remains, however, scope for improving the management and treatment of cancers, and this is being taken forward through the implementation of the Calman/Hine report in the context of the Government's strategy for cancer services and its overall commitment to improving the quality of care in the NHS. Thus prevention and better management both have a role to play in achieving the proposed target.

'if we can achieve our target it would bring us to the levels currently experienced by the best performaning countries in the European Union'

4.36 A draft national contract on cancers, which sets out some, but not all, of the action necessary, is set out opposite.

A National Contract on Cancer	**Government and National Players can:**	**Local Players and Communities can:**	**People can:**
Social and Economic	Continue to make smoking more costly through taxation. Tackle joblessness, social exclusion, low educational standards and other factors which make it harder to live a healthier life.	Tackle social exclusion in the community to make it easier for people to make healthy choices. Work with deprived communities and with businesses to ensure a more varied and affordable choice of food.	Take opportunities to better their lives and their families' lives through education, training and employment.
Environmental	Encourage employers and others to provide a smoke-free environment for non-smokers. Encourage local action to tackle radon in the home. Continue to press for international action to restore the ozone layer.	Through local employers and others, provide a smoke-free environment for non-smokers. Tackle radon in the home.	Protect others from second-hand smoke. Cover up in the sun.
Lifestyle	End advertising and promotion of cigarettes. Prohibit sale of cigarettes to youngsters and ensure enforcement. Support Healthy Living Centres. Provide reliable and objective information on the health risks of smoking, poor diet and too much sun.	Encourage the development of healthy workplaces and healthy schools Target health information on groups and areas where people are most at risk	Stop or cut down smoking and watch what they eat. Be careful when they are in the sun and ensure that young children are not exposed to too much sun. Follow sensible drinking advice.
Services	Encourage doctors and nurses and other health professionals to give advice on prevention. Ensure that healthy schools work with pupils and parents to improve health. Implement effective and high-quality cancer screening programmes. Ensure equal access to high-quality treatment and care.	Provide help in stopping smoking to people who want to stop. Improve access and availability to a variety of affordable food in deprived areas. Ensure hard-to-reach groups come forward for cancer screening services. Ensure rapid treatment for cancers when they are diagnosed.	Attend cancer screenings when invited. Seek medical advice promptly if they are worried.

'mental health is a key component of a healthy active life'

Targeting Mental Health

4.37 The Government proposes to adopt a national target for mental health because:

- the national strategy must reflect more than just the absence of physical disease and be a basis for efforts which acknowledge a more rounded idea of good health;
- mental health is a key component of a healthy active life and poor mental health is a risk factor for many physical health problems;
- mental health problems are a major cause of ill health: the 1995 Health Survey for England showed that 20% of women and 14% of men may have had a mental illness [35]; mental disorders accounted for an estimated 17% (more than £5 billion) of total expenditure on health and social services in 1992/93 (the largest single cause) [3] they also accounted for 15% and 26% of days of certified incapacity in the early 1990s in men and women respectively;
- there is evidence of an increase in poor mental health in children and young people over the last three decades, particularly in young people who are socially disadvantaged [36]. Early action in a child's life may improve their health and mental health in later life;
- there are marked inequalities in who suffers most from mental health problems; for example men of working age who are unskilled workers are more than twice as likely to commit suicide than men in the overall population (see figure 23) and women are more likely to suffer from anxiety, depression, phobias and panic attacks (see figure 24);
- similarly women born in Sri Lanka, India and the East African Commonwealth are approximately 50% more likely to commit suicide than women in the population as a whole (see figure 25);
- suicides are a significant cause of early death, and are responsible each year for nearly half a million years of life lost in those aged under 75 years.

Figure 23
Figure 24
Figure 25

4.38 The causes of poor mental health are complex and the Government would welcome views on how best to monitor progress with a single national target.

'to hit this target will require significant successes in suicide prevention among groups of people in which this is particularly difficult, such as the severely mentally ill'

4.39 Overall suicide rates have been falling in recent years (though the pattern is different in different population groups such as young men, or women from certain ethnic minority groups). Nevertheless, there is considerable scope for further improvement. A possible target in this area would be **to reduce the death rate from suicide and undetermined injury by at least a further sixth (17%) by 2010, from a baseline at 1996** (see glossary). A reduction of this order, if it had occurred in 1996, would have saved about 800 lives.

4.40 To hit this target will require significant successes in suicide prevention among groups of people in which this is particularly difficult, such as the severely mentally ill.

4.41 An alternative option would be to develop a target which tracked poor mental health rather than mortality and we would welcome views on whether this would be practicable.

4.42 A draft national contract is set out opposite, covering some of the measures that might be taken to meet the national target.

A National Contract on Mental Health	Government and National Players can:	Local Players and Communities can:	People can:
Social and Economic	Tackle joblessness, social exclusion and other factors	Develop local support networks, eg for recently widowed/bereaved, lone	Develop parenting skills.

	which make it harder to have a healthier lifestyle. Tackle alcohol and drug misuse.	parents, unemployed people and single people. Develop court diversion schemes. Develop job opportunities for people with mental illness. Develop local strategies to support the needs of mentally ill people from black and minority ethnic groups.	Support friends at times of stress - be a good listener. Participate in support networks. Take opportunities to better their lives and their families' lives through education, training and employment.
Environmental	Continue to invest in housing and reduce homelessness. Encourage employers to address workplace stress. Reduce isolation through transport policy. Promote healthy schools. Address levels of mental illness amongst prisoners.	Develop effective housing strategies. Reduce stress in workplace. Improve community safety.	Improve workload management.
Lifestyle	Increase public awareness and understanding of mental health. Reduce access to means of suicide. Support Healthy Living Centres.	Focus on particular high- risk groups, eg young men, people in isolated rural communities. Encourage positive local media reporting. Develop and encourage use of range of leisure facilities.	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.
Services	Develop standards and training for primary care and specialist mental health services. Improve recruitment/ retention of mental health professionals. Identify/advise on effective treatment and care. Develop protocols to guide best practice.	Promote high-quality pre-school education and good mental health in schools and promote educational achievement. Ensure mental health professionals are well trained and supported. Develop a range of comprehensive mental health services for all age groups and alcohol and drug services for young people and adults. Support carers of people with long-term disability and chronic illness. Provide advice on financial problems. Develop culturally sensitive services.	Contribute information to service planners and get involved. Contact services quickly when difficulties start. Increase knowledge about self-help.

'the broader nature of these national targets offers additional challenges and opportunities compared with the previous

strategy'

Continuity

4.43 The four national targets in *Our Healthier Nation* build on any success already achieved under *Health of the Nation*. The small number of national targets proposed for *Our Healthier Nation* will offer greater flexibility to focus on particular local health problems and on health inequality. And the broader nature of these national targets offers additional challenges and opportunities compared with the previous strategy. For example:

- the accidents target now addresses a much wider range of accidents, rather than focusing only on fatal accidents;
- the new cancer target includes all cancers, so cancers which were not covered in the earlier strategy will have to be addressed through improved prevention, diagnosis and treatment as part of *Our Healthier Nation*.

'health Improvement Programmes will identify additional priorities'

Local Priorities and Targets

4.44 One reason for limiting the number of national priority areas is to maximise the scope for local flexibility in setting additional local priorities which reflect the particular health problems of local communities.

4.45 In addition to local strategies and local targets for meeting the national targets, Health Improvement Programmes will identify a small number of additional priorities to tackle particular pressing local problems and to reduce health inequalities. For example, although nationally we are concerned that teenage conceptions are damaging the health and social well-being of young mothers and their babies, the incidence is not spread evenly across the country, so setting a national target in this area might be less relevant for some localities. For others it will be a high priority and they will want to target this problem locally.

4.46 The Government is considering how progress on these local targets can be monitored nationally and whether progress on similar problems in different localities can be aggregated nationally.

4.47 Some of the possible local priority areas are set out opposite.

Possible Local Priorities and Targets

Asthma and other respiratory problems -*Asthma is a common condition which can not only lead to death, with over 1,200 dying in 1996, but disrupts education, and is a medical condition often cited by adults as impairing their ability to play a full part in life. Better ways of managing this illness can reduce the health and social problems it can cause.*

Teenage Pregnancy -*Teenage conceptions (particularly for the under 16s) can harm both the health of the mother and the baby and we have high rates compared with the rest of Europe.*

Infant Mortality -*Although trends show improvement, the continuing inequalities in this area mean that it will be an important focus for action in many areas.*

Back Pain, Rheumatism and Arthritis -*In a survey of people over 65 in Great Britain in 1994, 18% said they had longstanding problems with arthritis, 7% said they had "problems with bones" and 4% had back problems.*

Environment -*In areas where housing, homelessness, pollution, or radon are of concern, Health Improvement Programmes may include targets to tackle these influences on health.*

Diabetes -*Diabetes affects more than one in fifty people in the population and can lead to blindness, kidney failure, amputations and heart disease. In addition to prevention efforts, better management of the disease can help to reduce these problems.*

Oral Health -*There are serious inequalities in the levels of tooth decay, both socially and geographically.*

Vulnerable Groups -*In order to address the health needs of specific groups of people whose health is of particular concern, local strategies might address the needs of different minority ethnic groups, homeless people, single parents, socially isolated people, people with learning disabilities, people on low income or refugees.*

4.48 To ensure some continuity, Health Improvement Programmes could, where possible, also include progress against the old health strategy's targets as indicators of progress on the health of the local population.

4.49 In localities where health is already better than suggested by the targets we must safeguard against complacency and ensure that further improvements are still achieved. Areas in this position may need to use benchmarks based on the standards achieved in other countries in order to seek further improvements to the health of their populations, or seek to target particular inequalities in health in their local populations.

Targeting Inequality

4.50 Inequalities in health have worsened in the past two decades. They are a consequence of the widening of social and economic inequalities. While inequalities can worsen in a matter of years, improvements can take much more time, even decades, to achieve. Whilst for some conditions it may be possible to close the gap more quickly, it must be recognised that the overall inequalities in health will only be resolved through long term, sustained and coordinated efforts and not through quick fixes. A sense of realism on the difficulties we face in addressing health inequalities is vital, because false optimism and unreasonable expectations in the short term will only sabotage the long term effort.

'for the first time ever the health strategy will require local policy makers to set targets for reducing health inequalities'

4.51 The NHS White Paper signalled that for the first time ever the health strategy will require local policy makers to set targets for reducing health inequalities. The groups and areas who suffer the most from ill health and early death must be a key focus of both local and national activity. Progress on the national targets must not be secured simply by targeting social or ethnic groups whose health problems are more easily tackled. This could have the effect of widening health inequalities. In addition to looking at the health of the whole population, each Health Improvement Programme will need to set out how progress is to be achieved by tackling the health problems of those local neighbourhoods or groups which suffer more from poor health than others. Taken together this will mean a pioneering concerted national effort to reduce health inequalities, fully monitored by the Regional Offices of the NHS Executive. We would welcome views on how local inequalities targets can best be monitored centrally.

The Independent Inquiry into Health Inequalities

The Government has asked Sir Donald Acheson, former Chief Medical Officer, to report on the main trends in health inequalities and to identify the areas of policy which evidence suggests are most likely to make a difference. His report will help the Government in developing the White Paper for *Our Healthier Nation* later this year. The terms of reference of the Inquiry are:

- "To moderate a Department of Health review of the latest available information on inequalities in health, using data from the Office for National Statistics, the Department of Health and elsewhere. The data review would summarise the evidence of inequalities of health and expectation of life in England and identify trends.

- In the light of that evidence, to conduct - within the broad framework of the Government's overall financial strategy - an independent review to identify priority areas for future policy development, which scientific and expert evidence indicates are likely to offer opportunities for Government to develop beneficial, cost effective and affordable interventions to reduce health inequalities.

- The review will report to the Secretary of State for Health. The report will be published and its conclusions, based on evidence, will contribute to the development of a new strategy for health."

4.52 The Government will consider the scope for national targets on inequalities in the light of consultation on the Green Paper and the Independent Inquiry into Health Inequalities.

'the Government will consider the scope for national targets on inequalities in the light of consultation on the Green Paper'

Monitoring Progress

4.53 Technical details on monitoring the targets will be published with the White Paper. We will also need to consider ways of monitoring and evaluating local processes to build and share knowledge on the effectiveness of different strategies, techniques and activities.

4.54 In monitoring progress, we will be able to draw on a range of sources of data, such as mortality statistics, cancer registration, hospital episode data, general practitioner data, and various national surveys, for example the Health Survey for England and National Food Survey. The new health strategy will be very broadly based. For the determinants of health, for instance, in addition to the data sources described above, national and local data from, for example, education, employment, transport and the environment will be relevant to the development of the strategy and the monitoring of progress and interpretation of change. We will make full use of sources of comparative information like the Public Health Common Data Set to assist in the presentation of health data in a consistent and comparable form at local level. Other local sources will need to be exploited.

Questions for Consultation

(i) Are the priority areas, ie heart disease and stroke, accidents, cancer and mental health the right ones on which to focus the strategy?

(ii) Have the targets been set at the right level?

(iii) Is the approach that is suggested for intermediate targets (ie for 2005) appropriate?

(iv) What would you add to the draft national contracts on heart disease and stroke, accidents, cancers and mental health? A blank contract is attached.

(v) How should local inequality targets best be centrally monitored?

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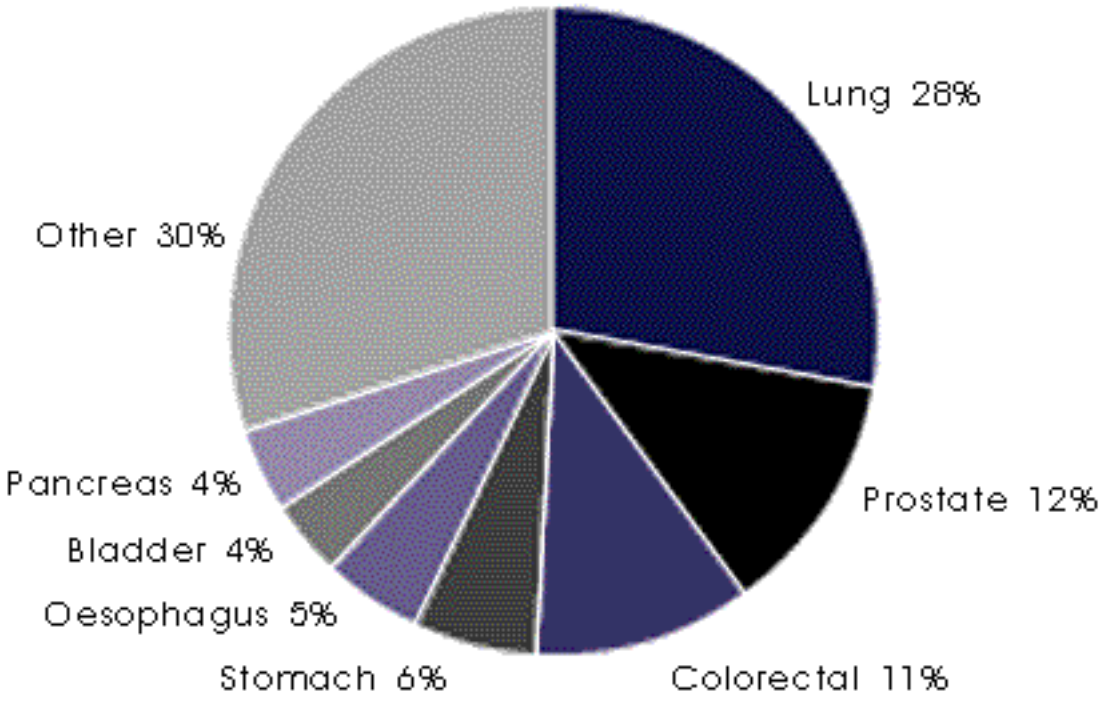
comments

Figure 20.
Main causes of cancer mortality

By sex, England 1996

Source: ONS Mortality Statistics.

Males (Total deaths 67,357)



Females (Total deaths 62,119)

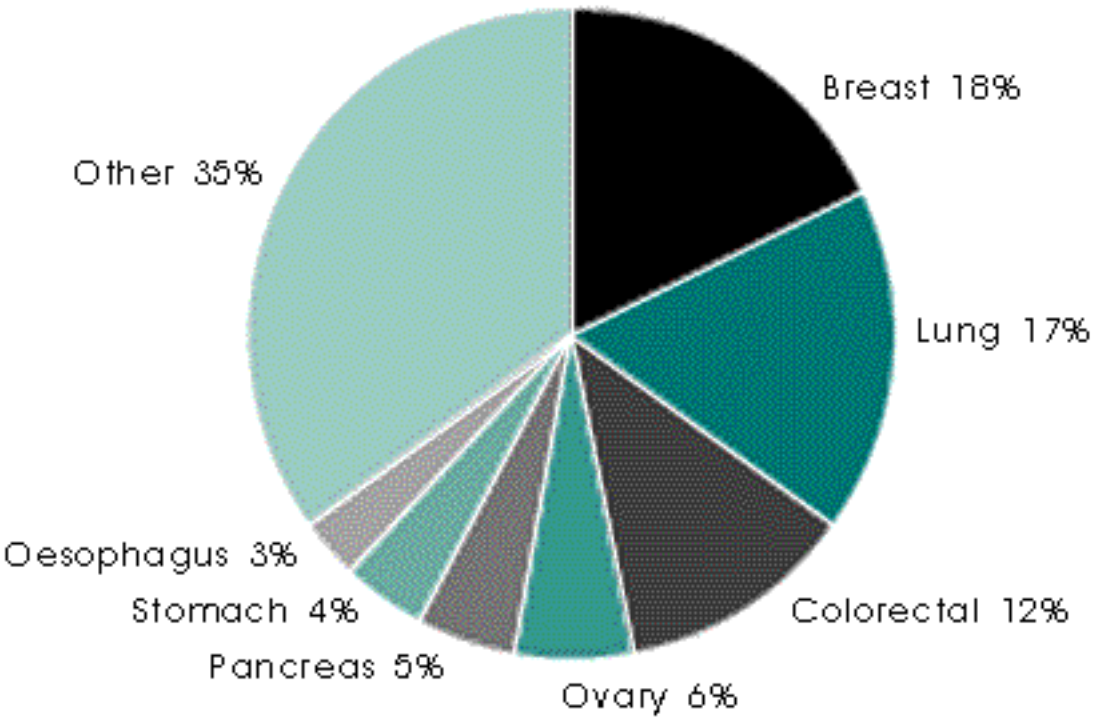


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Figure 21.
Inequalities in mortality rates from malignant melanoma

By Health Authority,1994-1996
10 highest and10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

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Figure 21 cont.
Inequalities in mortality rates from malignant melanoma

By Health Authority,1994-1996
10 highest and10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).

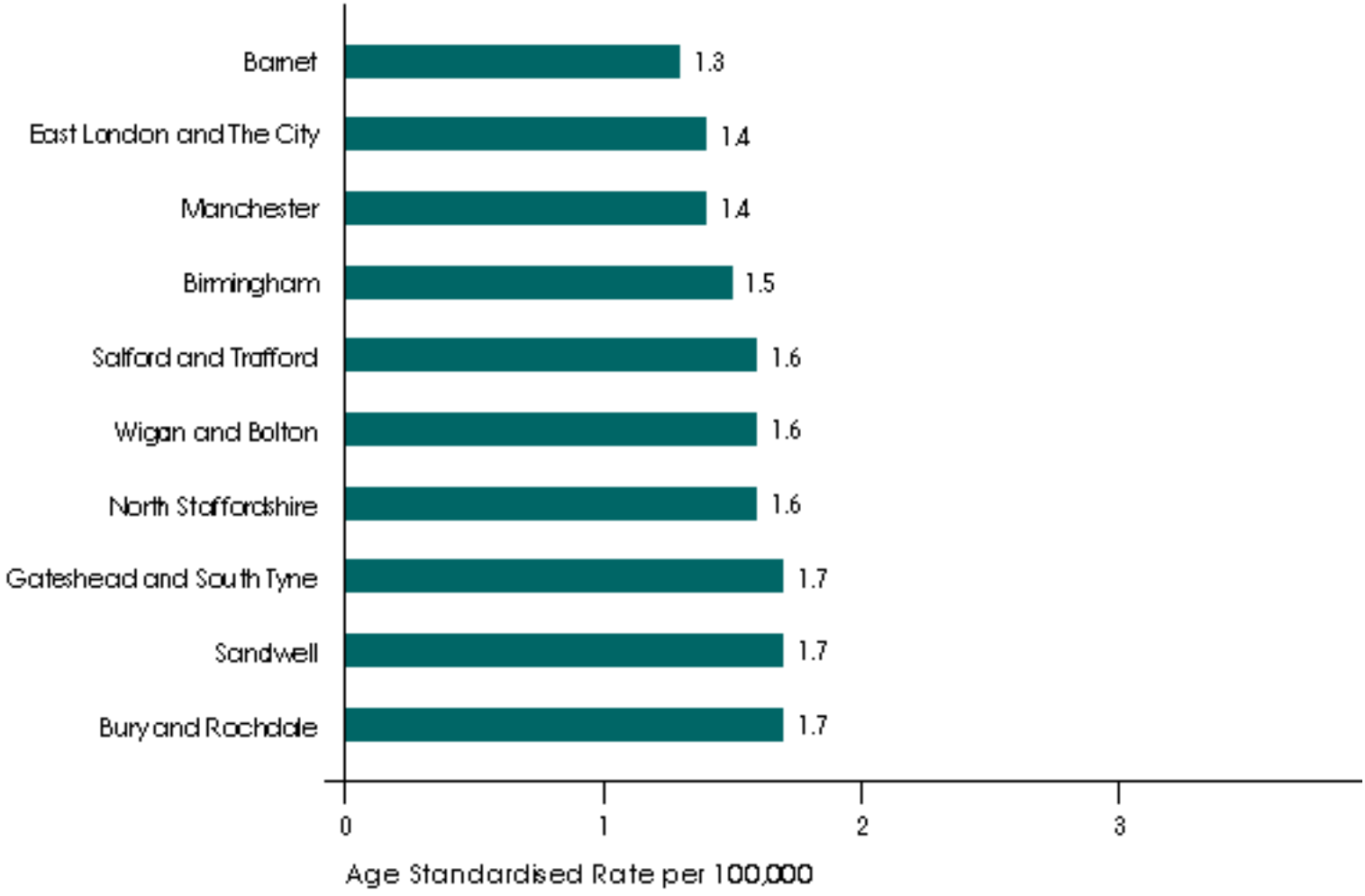

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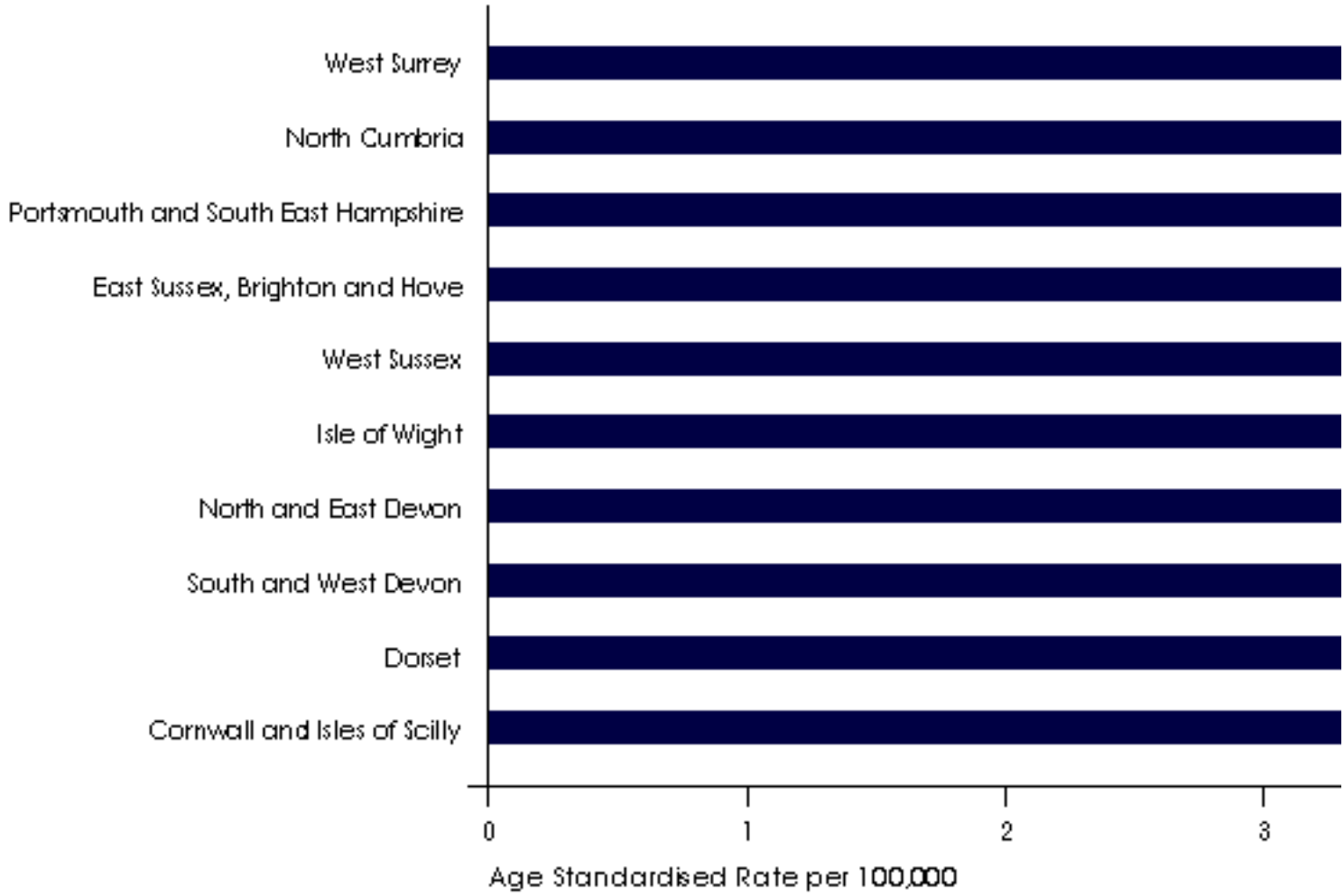
Figure 21 cont.
Inequalities in mortality rates from malignant melanoma

By Health Authority,1994-1996
10 highest and10 lowest HAs

Source: Public Health Common Data Set 1997 (from ONS data).



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comments

Figure 22.
Mortality from all cancers

European Union aged under 65 circa 1995*

*Data for 1995 except for Austria 1996; Denmark and France 1994; Ireland, Italy and Spain 1993; Belgium 1992.

Source: WHO Health For All statistical database.

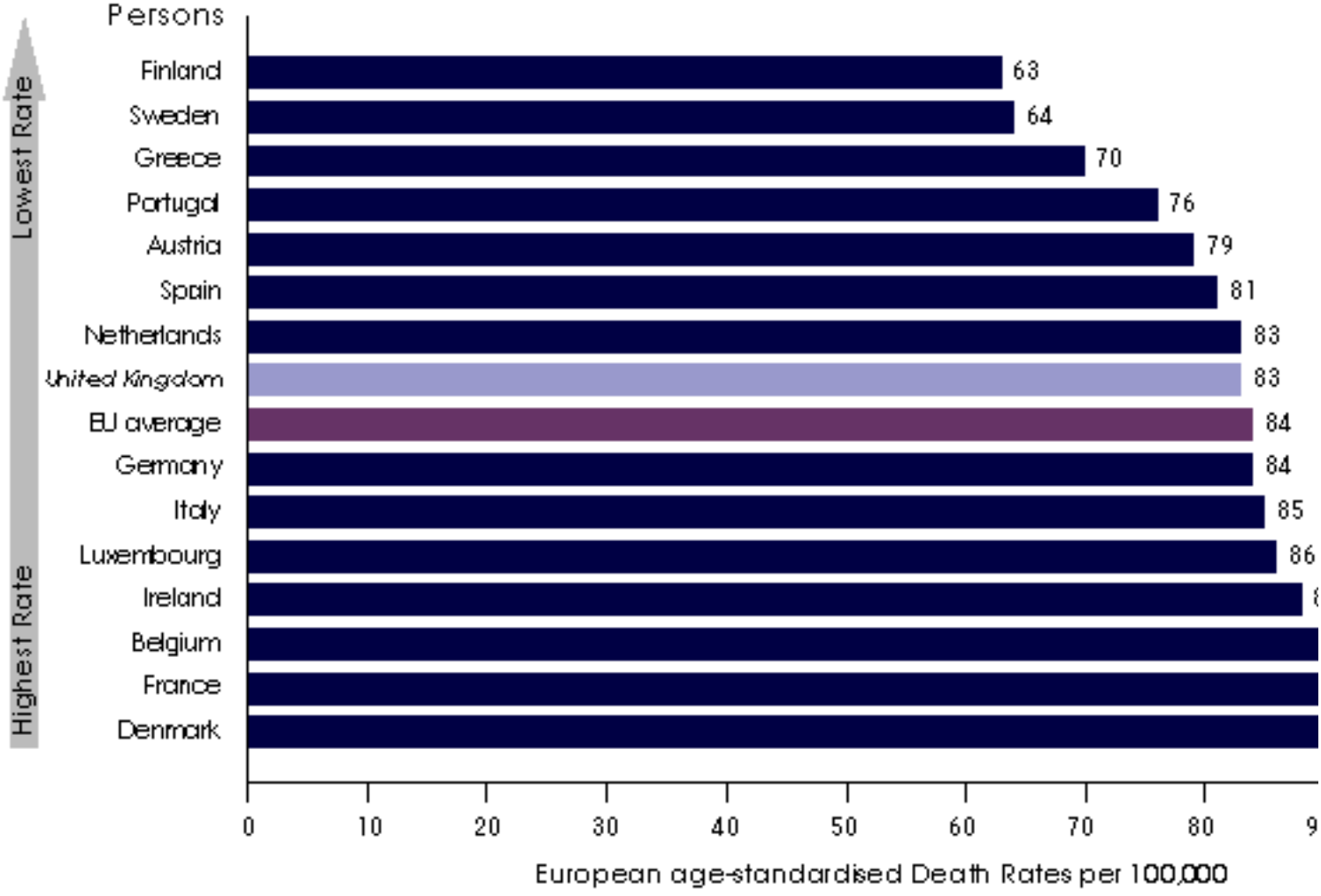

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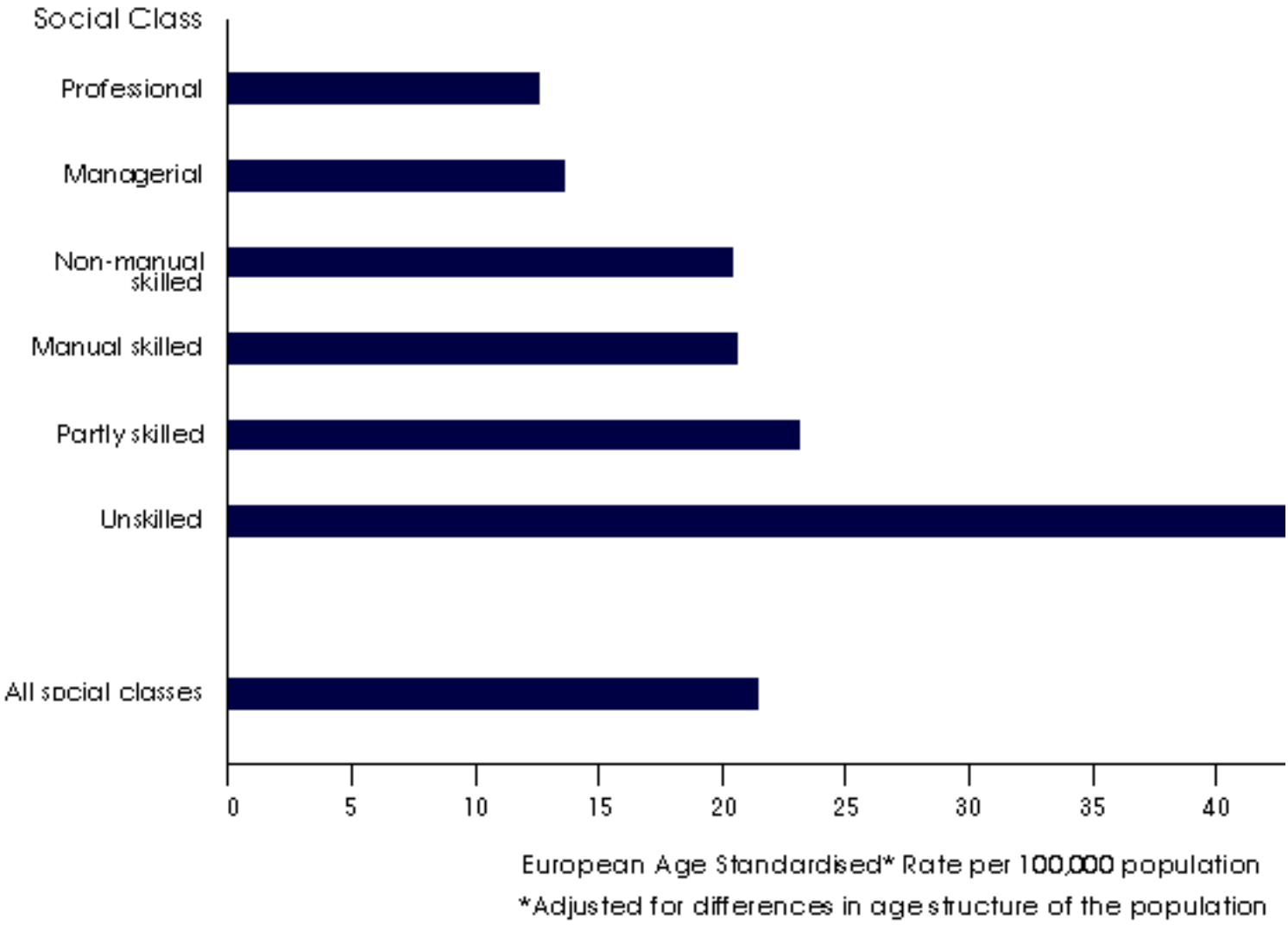
Figure 23.
Mortality from suicide by social class

Men, aged 20-64 England and Wales1991-1993

Source: Drever and Whitehead (eds), Health Inequalities, ONS, (1997) using data from ONS death registrations and 1991 Census.



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comments

Figure 24.
Prevalence of any neurotic disorder*

By sex and age, Great Britain 1993/1994

Adults aged 16-64

*Includes anxiety, depression, phobias, panic disorder

Source: ONS Psychiatric Morbidity Survey Report 1 (1995).

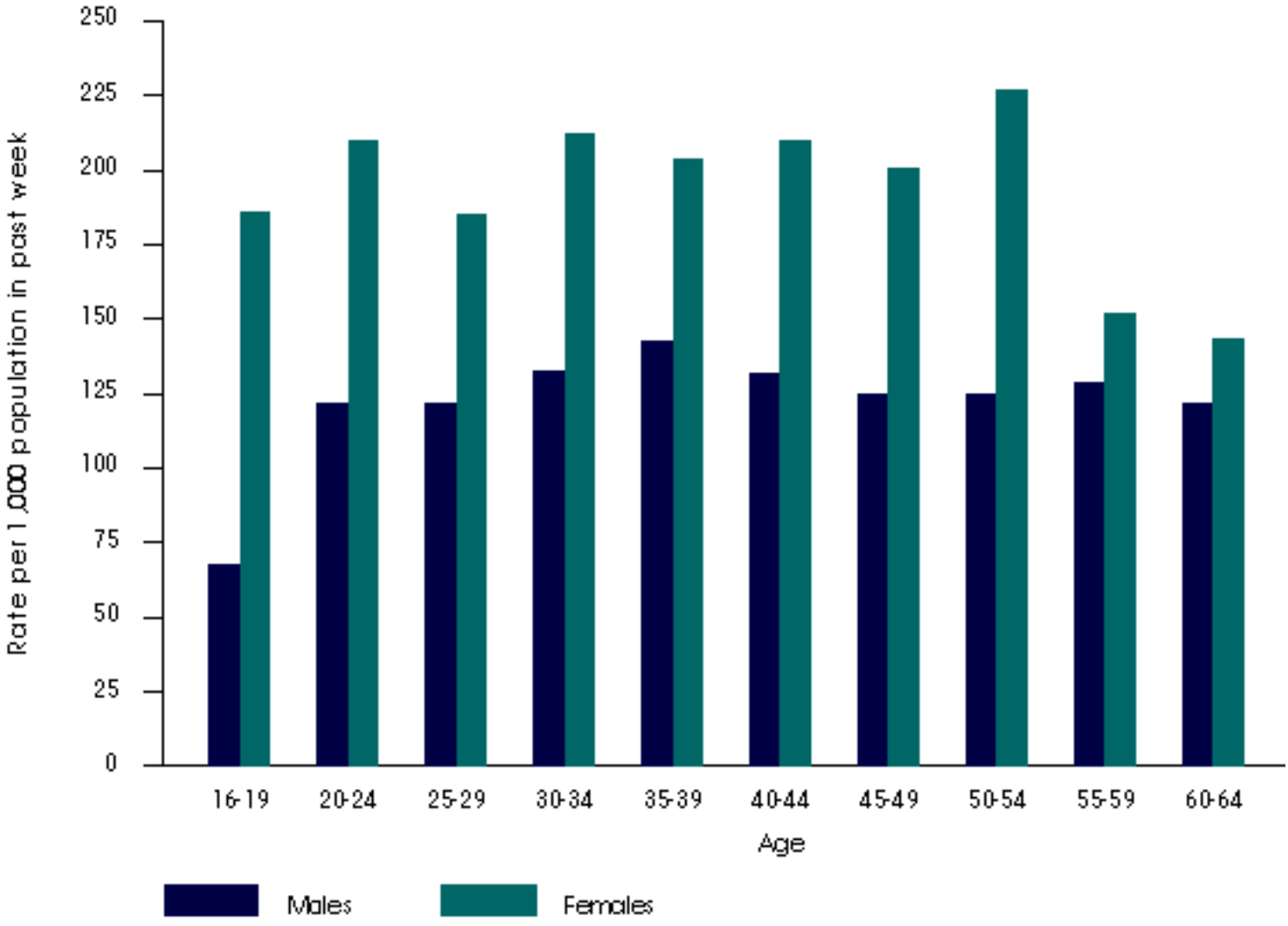

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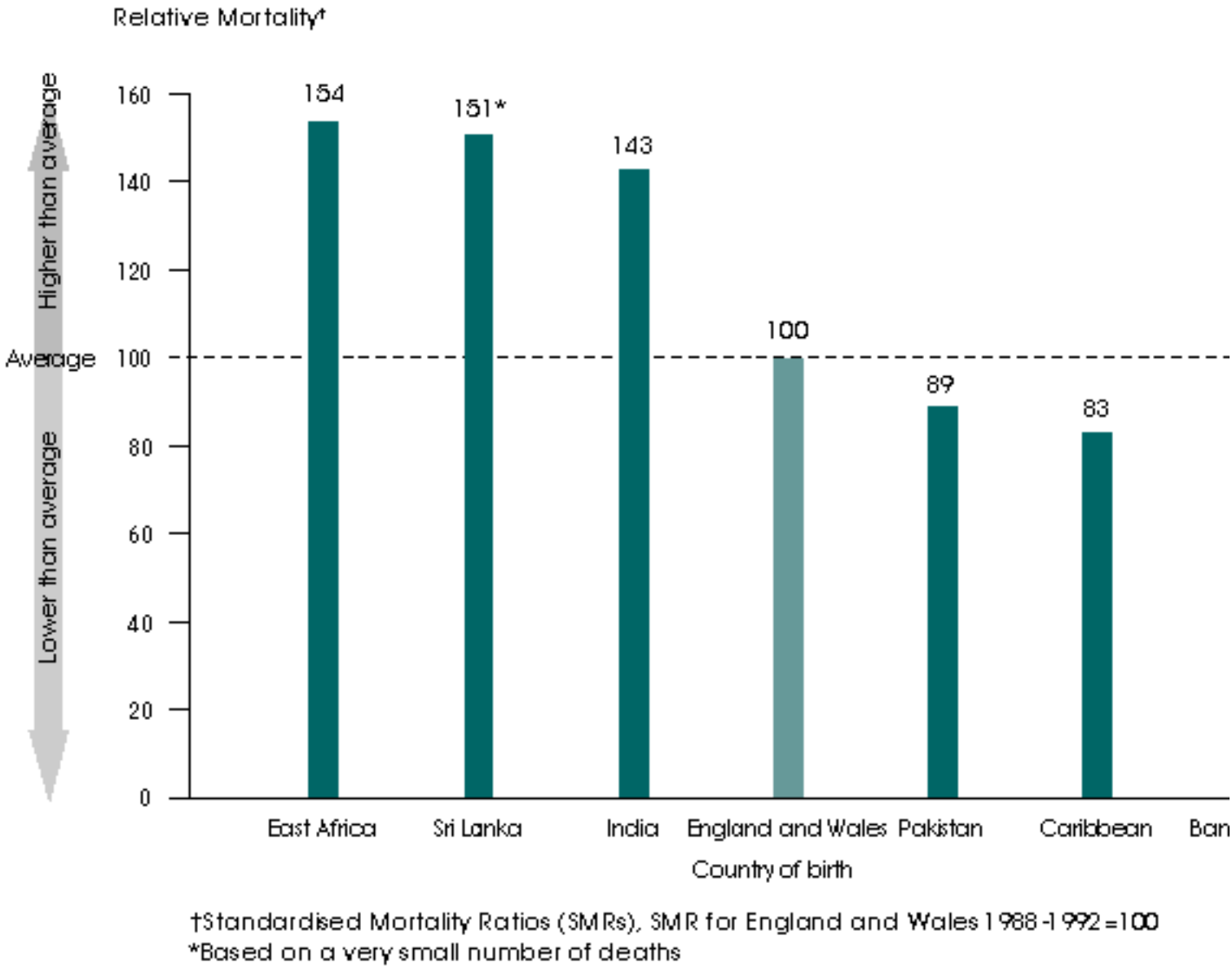
Figure 25.
Mortality from suicide

Females, aged 15-64 by selected country of birth, deaths in England and Wales 1988-199

Source: V Soni Raleigh (1996), Ethnicity and Health 1 (from ONS data).



†Standardised Mortality Ratios (SMRs), SMR for England and Wales 1988-1992=100
*Based on a very small number of deaths

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