HEALTHY PUBLIC POLICY

a role for the HEA

King's Fund Institute

ADVISORY GROUP

Healthy Public Policy: A role for the HEA is a King's Fund Institute briefing paper which aims to inform members of the new Health Education Authority about key issues in British public health policy, and to suggest areas on which the Authority should concentrate its attention. The briefing paper was prepared in consultation with the Advisory Group listed above, and the Institute is very grateful for their help and advice. We acknowledge with thanks the work of the King's Fund/London School of Hygiene/HEC Independent Steering Committee, whose forthcoming report *The Nation's Health: A strategy for the 1990s* we have drawn on for the briefing paper.

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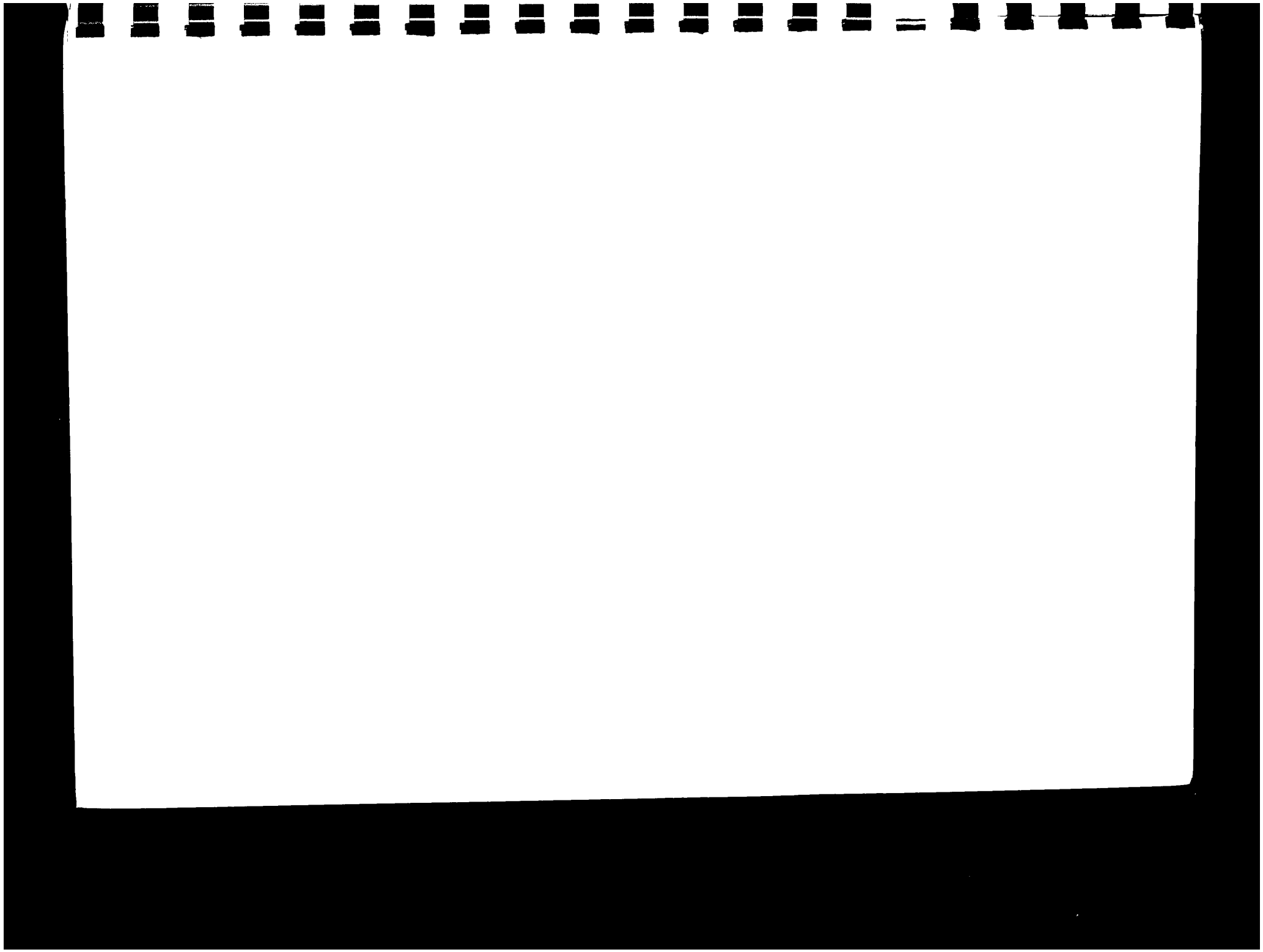
SUMMARY

Ministers have stated that the new Health Education Authority's aim is *'the promotion of good health, not merely health education'*. This goal is consonant with the government's intention to shift health policy towards preventive health services and active health promotion. But British health promotion policy has been hampered by the absence of a coherent national strategy, and activity at all levels remains unfocussed and haphazard. *Healthy Public Policy* argues for a revitalised public health policy, in which the HEA should play a major role.

The paper's main contention is that the HEA must help give health promotion greater national prominence by becoming an active advocate for the public health. A central task for the new Authority will be to press for a national health promotion policy based on the World Health Organisation's 'Health for All' principles. The paper goes on to highlight seven key areas where the HEA should play a major role in developing sustained long-term health promotion programmes: smoking control, coronary heart disease, alcohol abuse, diet, ageing well, preventive medicine and AIDS.

These areas relate closely to Britain's major public health problems. Our coronary heart disease rate is the highest in the world. It and diseases like lung, breast and bowel cancer pose problems that can only be addressed by effective, well-targetted preventive measures and active health promotion. Reducing alcohol and tobacco-related harm are major public health objectives, and developing strategies to enhance and promote health among elderly people must become one. In designing its programmes, the Authority must take account of the social and regional inequalities in health that remain one of the UK's most persistent national health problems, and target its advocacy and health education work accordingly.

Effective health promotion is an essential part of any national campaign to improve public health. The key to successful health promotion lies in well-coordinated long-term programmes directed at achieving defined targets. By pressing for a national health promotion policy, and contributing to sustained strategies to address our major public health problems the HEA should become a potent force for positive change.



THE PUBLIC HEALTH CONTEXT

British people in every age group can expect to live longer in 1987 than they could a decade ago. In 1984 infant mortality rates reached an all time national low. British adolescents and young adults have one of the lowest death rates in the affluent world. Deaths from road traffic accidents are lower than any of our EEC partners. Perinatal mortality rates have fallen by 50 per cent or more across the UK over the last ten years, and the incidence of some birth defects has reduced very significantly. There has also been a dramatic improvement in children's dental health.

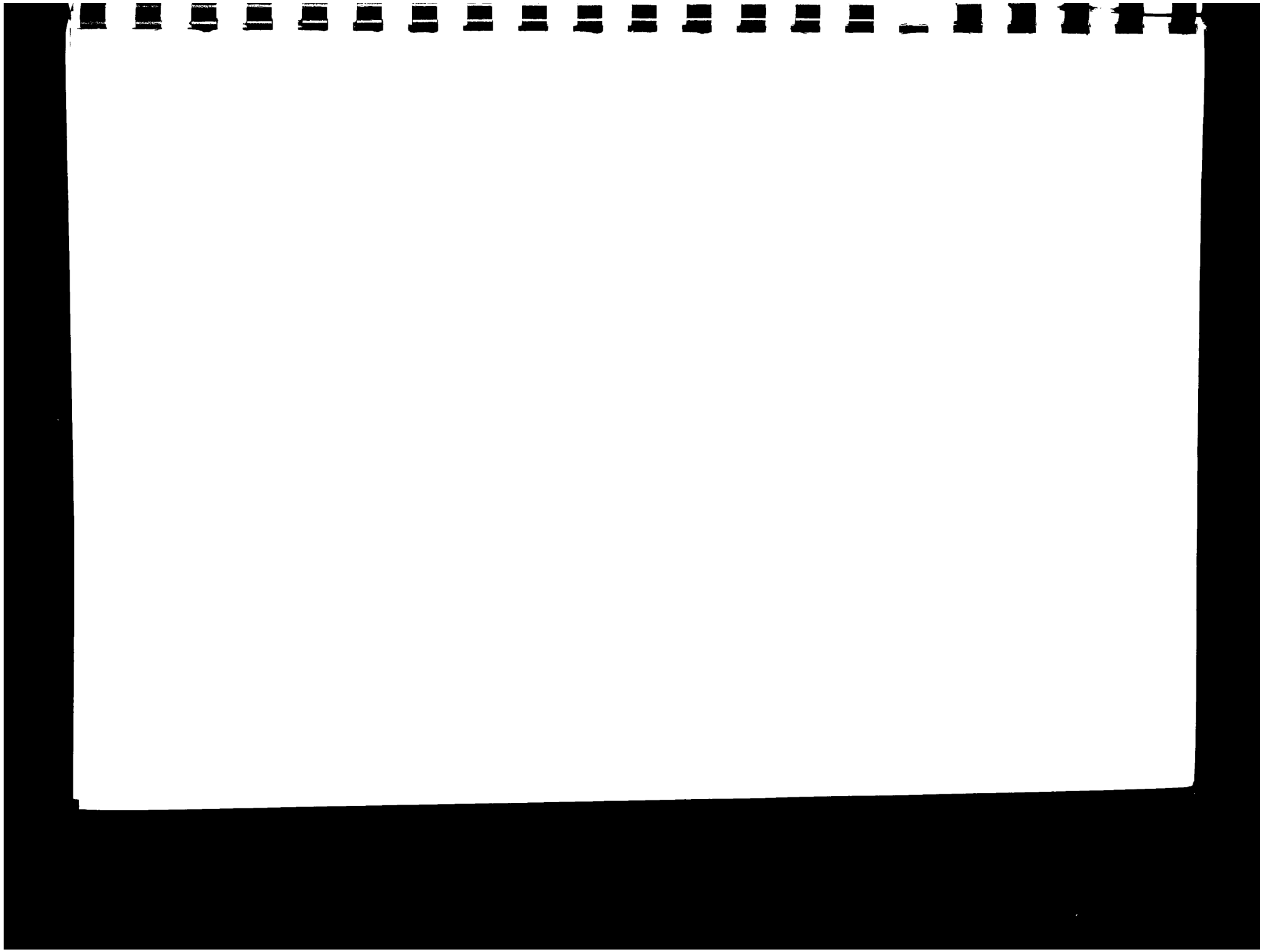
But these achievements mask real and stubborn problems. The UK has the world's highest death rate from coronary heart disease, and these deaths are not falling at the same rate as they are in countries like the USA, Australia and New Zealand. While male death rates from lung cancer have halved between 1960 and 1983, death rates among women have doubled and the UK continues to have the highest lung cancer death rate in the world. Britain also has the highest incidence of breast cancer in Western Europe. These high cancer and heart disease rates help to explain why - despite an overall increase in life expectancy - our expectation of life at 45 remains one of the lowest in the developed world. And although infant mortality has improved in the last ten years, most other European countries have done better than we have. Serious inequalities in health persist across the social spectrum - and between regions. People at the bottom of the social scale have much higher death rates than those at the top at every stage of their lives, and for most causes of death.

Coronary heart disease is a modern epidemic. It kills 160,000 people in England and Wales each year. Heart disease and lung, breast and bowel cancers pose public health problems as pressing for us today as infectious diseases were a hundred years ago. We do not know all their precise causes. But we know enough to be certain that they can only be addressed by a combination of improved treatment and active health promotion measures that reach the whole population.

The infectious and deficiency diseases endemic in the nineteenth and early twentieth centuries - cholera, tuberculosis, scarlet fever, rickets - were arrested by a combination of public health measures and an increase in the whole population's standard of living. Their incidence had declined significantly well before medical science introduced effective preventive or curative treatments for them, and before their causes were fully understood. A combination of factors including better nutrition, clean water, improved housing and sanitation, smaller families, better working conditions and personal hygiene was responsible.

The Victorian public health movement used sanitary engineering and a series of legislative measures to help bring about a major improvement in the health of the whole nation. This involved the creation of a new government department and very considerable local government expenditure on (among other things) sewers and reservoirs, as well as changes in individual behaviour made possible by greater prosperity and new technologies.

We need to revitalise the public health approach developed in the last century to create a strategy for dealing with the major health problems of our own time, and of the century to come. The need to do this is made more urgent by the emergence



of a new infectious disease - AIDS - for which a public health approach is, at the moment at least, our only defence. The success of nineteenth century public health was the result of a range of interconnected activities - some legislative, some regulatory, some concerned with housing, some with the workplace, some at local level, some at national level, but very few of them narrowly medical or focussed on the individual. The implications for public health in our own time are clear.

The Health Education Authority (HEA) has a central part to play in the development of a new national public health policy, since good information on health and how to achieve it is as important to us as good sanitary engineering was to the Victorians. But as the senior body responsible for health education in England, the HEA must do more than simply prepare good information and educational material for individuals. Its role must encompass education for policy makers on the legislative, administrative and fiscal measures needed to reduce ill health. It must support a wide range of professionals, including non-health ones like caterers, farmers, and food suppliers, in efforts to encourage sensible changes in our diet. It must enable local communities to develop strategies appropriate for tackling their own health problems, and help make sure that they have the information they need to do this effectively. Finally, it must use its new position within the National Health Service (NHS) to inform and educate health professionals and managers about the importance of improved preventive health measures and wider health promotion strategies for the public health. It should encourage them to collaborate with Local Authorities and the voluntary sector on public health policy development and action.

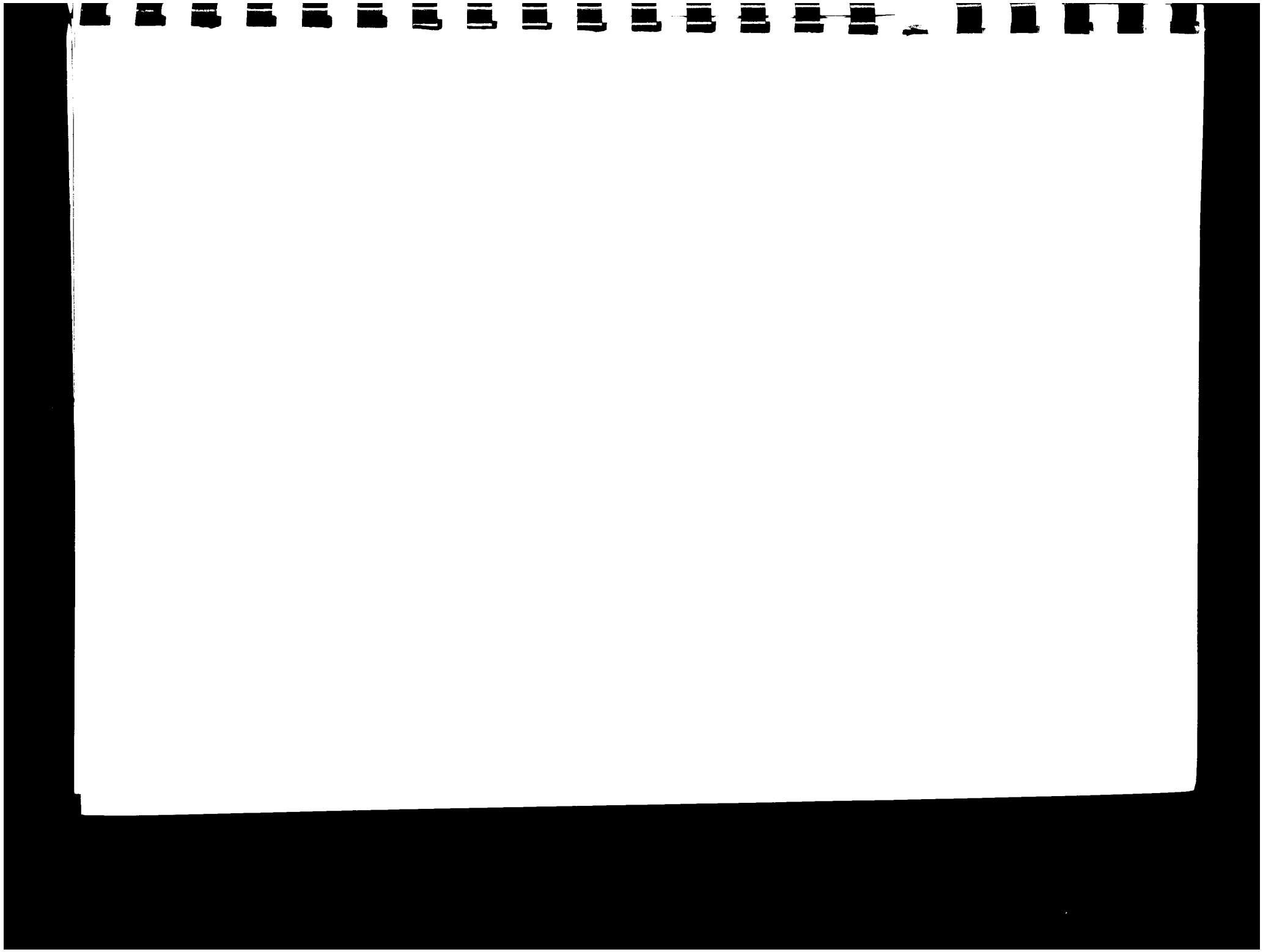
In short, the HEA must be an advocate for public health and work for the development of healthy policies at national and local level.

THE POLICY CONTEXT

Over the last decade there has been increasing emphasis on the importance of prevention of ill health, as the high costs and limited effectiveness of postwar curative medicine on chronic degenerative conditions like coronary heart disease have become apparent. At government level, the shift began in 1976 with the publication of *Prevention and Health: everybody's business* which stressed the responsibility of the individual for his or her own health. *Care in Action*, the government's 1981 handbook setting out priorities for health and social services, continued this theme by underlining the need for health and education authorities, local government and other organisations to develop coordinated strategies to discourage smoking, reduce the incidence of heart disease and stroke, and improve preventive medical services like immunisation and screening.

More recently, the government has endorsed the World Health Organisation (WHO)'s 'Health for All' strategy and the European targets set for achieving it. The Annual Reports for the National Health Service stress a commitment to health promotion, despite the fact that expenditure on preventive medicine and health education remains low at an estimated 5 per cent of all NHS spending.

This reorientation of policy at national level has borne some fruit. All English Health Regions now include health promotion objectives in their Strategic Plans, although there are enormous differences of approach between them. Just over half



have Regional Health Promotion Groups. Certain RHAs, for example North Western and Mersey, have officers specifically responsible for prevention and health promotion activities. The number of health education officers has nearly doubled since 1979. Most district health authorities now have health education or health promotion units which act as focal points for local activity. Some have begun to compile information on patterns of disease and death in their district as a basis for action.

The Royal College of General Practitioners has affirmed its commitment to health promotion, and has produced reports pointing out opportunities for GPs to promote health in the fields of mental health, family planning, ante-natal care, immunisation, mother-child relationships, smoking control, bereavement counselling and the detection and management of high blood pressure. Experiments such as Oxford RHA's project to pinpoint individuals at high risk from heart disease seek to involve the primary health care team in more effective activity.

Outside the NHS some twenty Local Authorities have begun to renew their traditional commitment to public health by developing comprehensive local government health strategies to inform activity in fields as diverse as housing, leisure facilities, occupational health, and food health. Within schools, health education has assumed a much more important place on the curriculum, and more than half of all secondary schools now have a senior member of staff designated as a health education coordinator. Two-thirds of secondary schools and one-third of primary schools now have written health education programmes.

While commitment to health promotion has deepened and spread across a wide range of agencies, and more staff time has been devoted to it, a good deal of this activity has been unfocussed and haphazard. In particular, there has been no development of a comprehensive *national* public health policy, with detailed targets and strategies for achieving them. Instead, policy at central government level has centred on the need to convince individuals to change or avoid high risk behaviours like smoking or drug misuse.

Accordingly, action to promote public health remains disjointed in the UK, despite official commitment to reorient resources as part of what central government has termed 'an unequivocal change in policy', and a general awakening to the possibilities of the approach within health authorities, education and local government. In the absence of a set of national targets, or a strategy to which local health promotion activities both within and outside the NHS can relate, support remains tokenistic and action fragmented. The combined budgets of the Health Education Council and the Scottish Health Education Group were £13 million for 1985-86 - or 23p per head of the UK population. Preventive health services like immunisation and cervical cytology are poorly organised and have not reached their potential. In contrast to countries like Denmark, Finland and Sweden, where a significant decline in deaths from cervical cancer has taken place, the British cervical screening programme has had no appreciable effect on deaths. Immunisation rates for rubella, measles and whooping cough remain well below WHO targets, and there are important variations between districts.

Commitment to health promotion varies widely across the country. In October 1985 only six of the fourteen English regions earmarked funds for health promo-

tion, and of these only two - Mersey and North Western - have budget allocations of £150,000 or more. At that time, regional strategies for health promotion displayed enormous diversity of approach and emphasis, and ranged over more than twenty separate topics. Two regions did not include action on smoking - the single most important preventable cause of ill health in Britain - in their health promotion strategies, although there was a 'core' content of subjects - smoking control, healthy eating, alcohol education - which most other plans included. Less than half of all regions collaborated with districts on specific public health activities, and only eight had considered how they might support district health promotion initiatives with data collection, training and increases in posts.

A ROLE FOR THE HEA

The Health Education Authority is the only national organisation with responsibility for health promotion in England. As such, it and its sister organisations in Wales and Scotland should be among the principal advocates for public health in this country. Its status within the health service is comparable to a regional health authority. In the debates surrounding the establishment of the HEA, ministers stated that their intention in establishing the HEA as a special health authority was *'to ensure that the prevention of ill health and the promotion of good health play a more central role in the National Health Service'* and that the aim of the new authority should be *the promotion of good health, and not merely health education.*

For this aim to be fulfilled, the HEA should ensure that health promotion and wider public health objectives play a larger part in the determination of national policy than they have done up to now. Health promotion is about creating a healthy environment as well as encouraging individuals to adopt healthier ways of living. The World Health Organisation describes it as a process which enables people to increase control over and improve their health, with health embracing physical and social capacities as well as physical ones. Successful health promotion must take account of people's cultural approaches to and beliefs about health.

By definition, both public health and health promotion cut across policy boundaries, and cannot be confined to the health service alone. Health promotion implies social, political, economic, educational, organisational, community and individual action. The Clean Air Acts of the 1950s were placed on the statute book as a direct result of more than 2,000 deaths from the great fog which blanketed London for a fortnight in 1952. They are legislative measures, which were drafted, enacted and enforced entirely outside the health service. They remain one of the most important single postwar public health initiatives.

Health promotion, therefore:

- Involves the whole population instead of focussing on people at risk from specific diseases;
- Is directed towards action on the causes of health;
- Combines a variety of complementary approaches and policy instruments, including legal, fiscal, regulatory, structural, organisational, educational and economic measures;

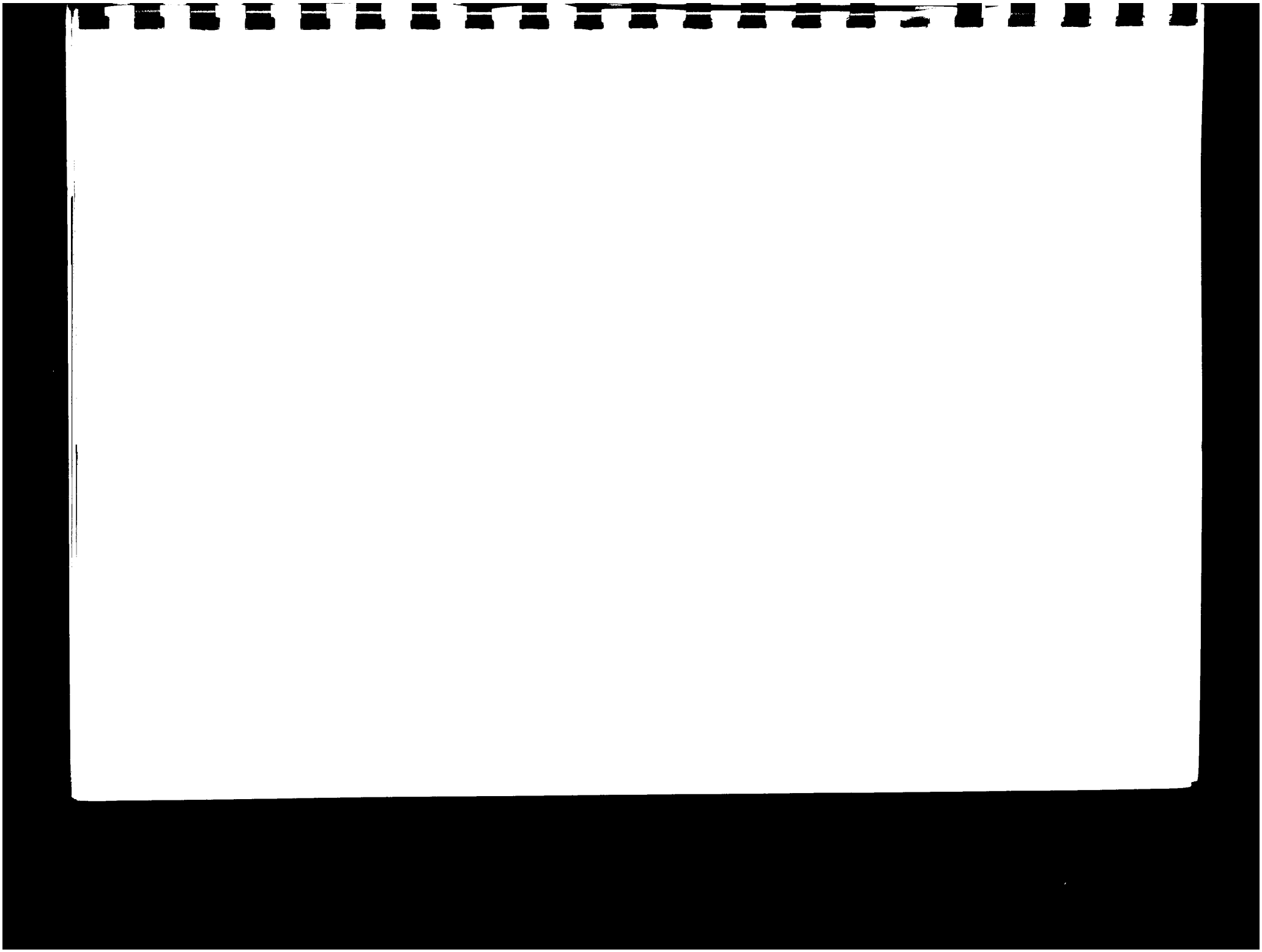
- Encourages effective and concrete public participation;
- Involves health, education, community development, and social work professionals - particularly those concerned with primary care.

This is a broad and challenging remit. If the Health Education Authority is to pursue it effectively it must develop and improve on the Health Education Council's existing programmes, particularly when they involve collaboration with organisations outside the formal health sphere such as the Sports Council, community and voluntary organisations and Local Authorities. It should use its new position within the health service to encourage health authorities to work with local government in developing joint approaches to health promotion, as some are beginning to do already. These should go well beyond traditional health education to influence the places where health is determined - the worlds of work, leisure, home, and city life. In doing so, they must take particular account of the way in which social and economic conditions affect individuals' ability to adopt healthy life-styles.

The new Authority should help make local health promotion strategies more effective and realistic by providing information and materials upon which action can be based. It must expand its training function, experiment with different ways of organising health promotion within the NHS and continue to develop new ways of involving primary health care workers in effective health promotion. It should examine existing preventive medicine within the NHS, and consider how these services could be integrated into a wider health promotion strategy for the health service as a whole. At the same time, it should continue to experiment with ways of working with local community and special interest groups to develop approaches to health promotion which involve them in defining and meeting their real health needs. It must then ensure that these new approaches and ways of working are evaluated and that their implications are integrated in planning and action at all levels.

At the same time, the Health Education Authority should advocate the development of a national health promotion policy for England. An explicit policy would be an important focus for the legislative, fiscal, and regulatory public health measures that must be enacted at national level. It would also help coordinate the piecemeal approaches to public health and health promotion that are evolving at different rates and at different levels in a wide range of organisations around the country.

Independence will be crucial to the Authority's success. Effective health policy development means that the implications of scientific evidence for action must be debated openly, and decisions taken without undue influence from those with conflicting vested interests. It is already abundantly clear that major changes in our national diet and smoking habits must take place if the modern scourges of coronary heart disease and lung, breast and bowel cancer are to be checked. These changes will involve short-term costs which must be balanced against the potential for longer-term improvements in the public health. In discussions with government, industry, and the health professions about policy development and possible action the HEA must be seen to have both the freedom and the authority to be an effective advocate for public health.



KEY ISSUES

A national health policy

The UK has endorsed WHO's 'Health for All' policy internationally and at the European level, and has recognised its applicability for national policy. This policy, WHO's concept and principles of health promotion, and the 'Health for All' targets developed by WHO Europe should be used as the basis for the development of an explicit health policy for the UK which will be appropriate to national health priorities and determine objectives for action.

Britain has lagged behind countries like the United States, Canada, Australia, Sweden and Finland in developing a national strategy to promote health. Canada pioneered a national approach to health promotion with the publication of *A New Perspective on the Health of Canadians* in 1974. This stressed the need to influence the entire field within which health choices are made in any effort to create a comprehensive health policy. The Canadian initiative has just been renewed and aligned to WHO targets in the strategy document *Achieving Health for All: A Framework for Health Promotion.*

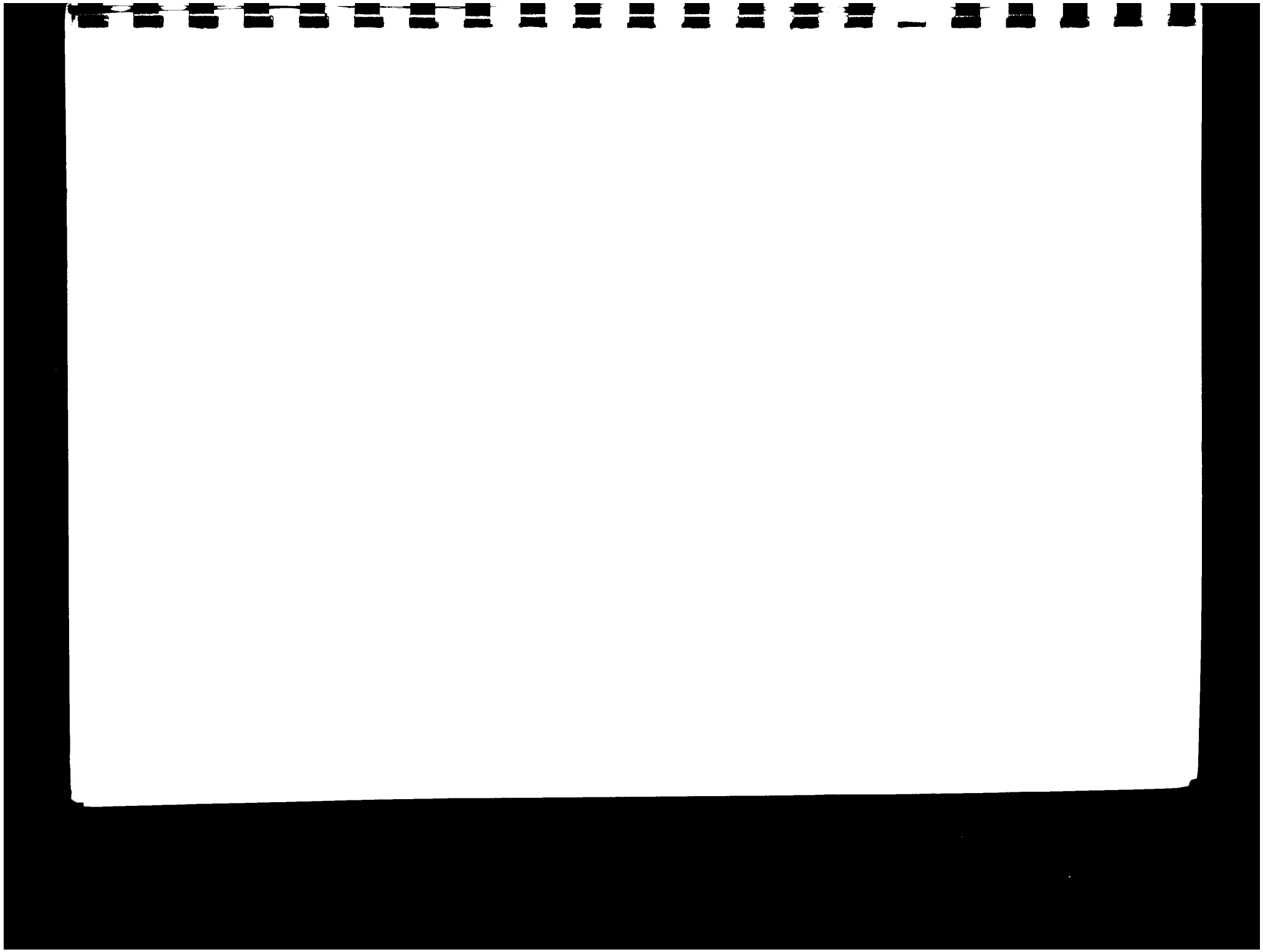
The first national goals for health promotion in the US were established in 1979 in the Surgeon General's review of the nation's health *Healthy People*, and elaborated a year later in the policy document *Promoting Health, Preventing Disease: Objectives for the Nation.* Other countries have followed, making use of the North American examples and the 'Health for All' strategy.

A national health promotion strategy for Britain would both legitimise and galvanise action to achieve public health objectives across the country. It would help coordinate existing programmes to promote health and prevent disease, and provide inspiration for new ones. In the United States, *Promoting Health, Preventing Disease* has stimulated a vast flowering of health promotion initiatives by federal, state, municipal and voluntary bodies across the country. In Canada, the amalgamation of four disparate preventive departments into the Health Promotion Directorate in 1978 gave a new impetus to public health.

The overall goal of WHO's 'Health for All' strategy is to give people a positive sense of health which will allow them to make full use of their physical, mental and emotional capacities. The strategy has four aims: to ensure equity in health; to improve the quality of life by ensuring the full development of people's physical and mental capacity; to increase the number of years that people live free of major diseases and disabilities; and to increase life expectancy by reducing the number of premature deaths.

'Health for All' rests on an understanding that individual health depends on the context for health created by the political, social, cultural, economic and physical environment. Ideally, the entire field of national policy should be consistent with health promotion objectives in order to, as WHO puts it, 'make healthy choices the easy choices'. For this to happen the interest of individuals, groups and communities in actively promoting their own health must be solicited and enlisted.

The 'Health for All' strategy is not a blueprint for a national health policy. Instead, it is a framework which can act as a basis for setting a national health agenda appropriate to the particular health needs of individual countries. The debate sur-



rounding the drafting of a national health policy would in itself provide an effective spur for action, and should be encouraged as such. An outstanding advantage of the 'Health for All' approach is that it should stimulate cooperation between health authorities and local government in developing policies for particular areas. In Britain, cooperation on developing local 'Health for All' strategies has begun in a few places, and a number of metropolitan authorities are translating 'health for all' targets into local action plans as part of WHO's 'Healthy Cities' initiative. A national commitment to 'Health for All' would strengthen these tentative beginnings.

A national health policy must have a mandate at the highest government level. Its success will rest on effective cooperation between a wide range of government departments and related bodies as well as local government and outside groups. Health promotion and disease prevention work by government currently spans some fifteen government departments and agencies, including bodies as diverse as the Department of Transport, the Medical Research Council, British Standards Institute, HM Customs and Excise and the Health and Safety Executive. This fragmentation greatly weakens any coherent presentation of a public health perspective when national policy is made. This problem has been exacerbated by the fact that the HEC, as a quango, had no direct formal relationship with NHS health education officers or local authority education departments. Although the HEA's position as part of the health service should improve links with HEOs, there is a danger that this will further attenuate communication with local government and industry.

There is a strong case for establishing a national body with responsibility for developing a national public health policy and the objectives and targets related to it. The new organisation should include representatives from central and local government, the health service, voluntary bodies and consumers, as well as the HEA itself. In order to underline the national health policy's status as a priority for the country as a whole, the new organisation should be directly responsible to the Prime Minister's Office. As such it would build on existing initiatives to coordinate inter-departmental and inter-sectoral policy such as the Cabinet sub-committee on AIDS, the inter-departmental ministerial group on the misuse of drugs, and the National Economic Development Office.

The new organisation's first aim should be to develop a coherent long-term strategy for public health policy, based on 'Health for All' principles, and to encourage political, professional and public support for it. The HEA should recommend the establishment of such an organisation as an essential prerequisite to the development of a national public health policy.

Priorities for Action

In the absence of a coherent national policy for health promotion and disease prevention the Health Education Authority must marshal its resources to address the country's health priorities. In doing so, it must recognise that social and regional disparities in health are one of Britain's most persistent health problems. Although the overall health of the population has improved over the past decade, those at the bottom of the social scale have much higher rates of death and illness from almost all causes than those at the top. This gap is widening for adults.

The HEA should bear this point firmly in mind when acting as an advocate for public health, and when designing its programmes of work. When considering the need for changes in life-style, the Authority should be conscious that individuals' abilities to make healthy choices are heavily constrained by their social and economic circumstances. This perception should influence the design and content of the HEA's own educational campaigns and materials, and its stance on national policy issues which affect the public health.

1. AIDS

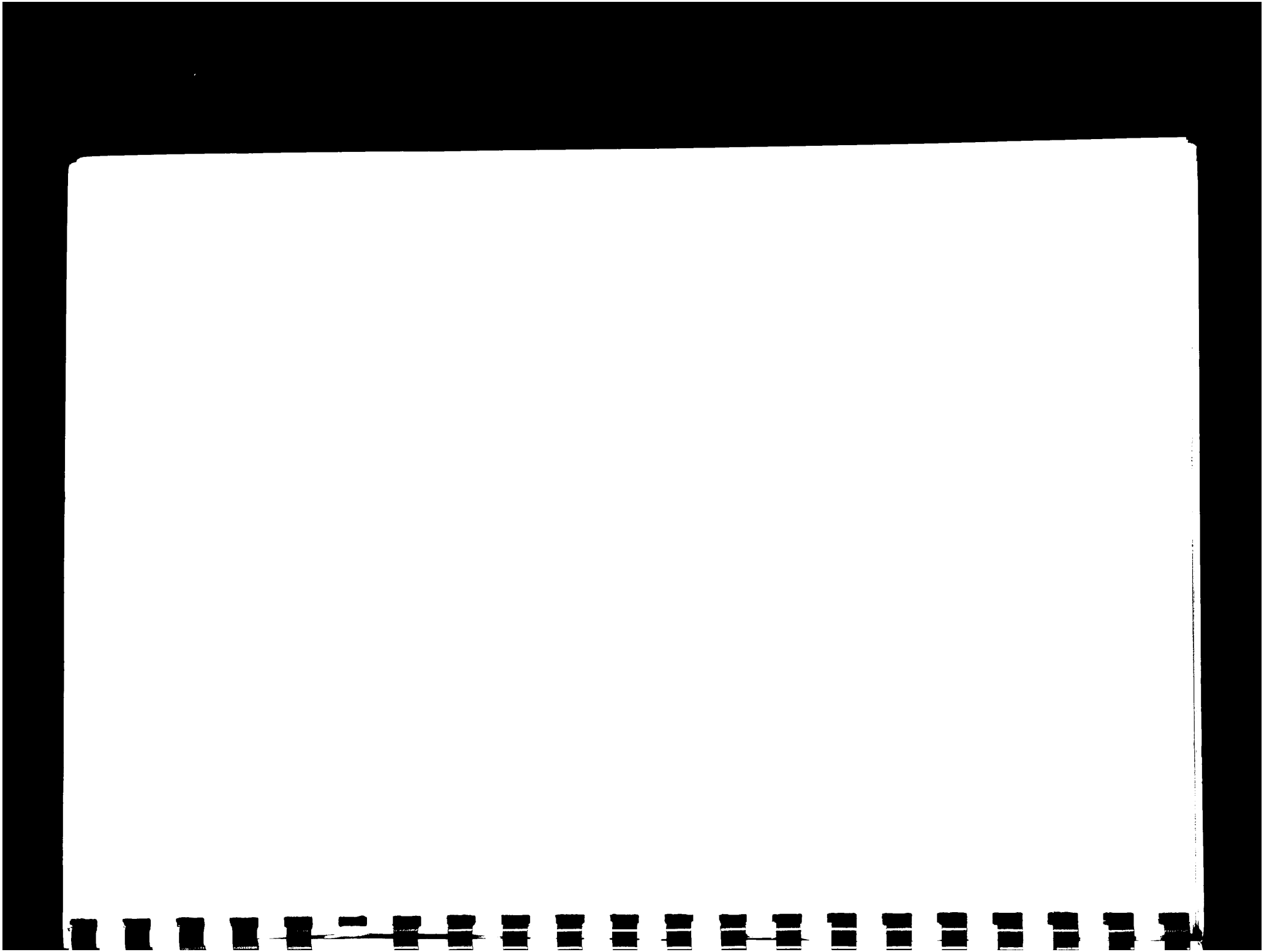
The HEA will soon be largely responsible for the government's campaign on AIDS, with a budget of some £20 million. The HEC's combined budget for its smoking, alcohol and diet programmes is £3.9 million for 1987-88. One of the most important challenges for the new Authority will be in finding the right balance between its AIDS work and older-established programmes. AIDS is undeniably a very significant threat to public health. The full extent of its potential to harm remains unknown, but will be added to coronary heart disease and cancers - Britain's leading causes of premature death and disability. In its efforts to come to grips with the threat of AIDS, the HEA runs the risk of swamping its limited resources of staff time and expertise at the expense of other programmes.

This could be avoided by integrating AIDS work as far as possible into expanded programmes on family and personal health and health education for young people. Family and personal health already contains an important element concerned with contraception and the prevention of sexually transmitted diseases. The programme on health education for young people is based in schools, and has considerable expertise in curriculum development. Concentrating the major part of AIDS-prevention work for young people here would allow the subject to be addressed as one part of an integrated approach to healthy human sexuality. The design of appropriate training packages on AIDS for health and other professionals should become an important part of the Authority's professional development work.

2. Smoking control

The HEA should strengthen the HEC's work on smoking by linking it with smoking and health advocacy at national level, and by increasing its efforts to cooperate with organisations like the Sports Council to discredit the image of smoking. It should promote increased taxation of cigarettes, and a ban on tobacco advertising and sponsorship. It should continue to coordinate its work on smoking prevention with its programmes on coronary heart disease, 'Look After Yourself!', 'Look After Your Heart' and health education in schools. The Authority's position within the NHS will give it important new opportunities to increase its support for smoking control policies by regional and district health authorities and primary care workers through the supply of materials, and pooling of ideas and experience. It should also continue to encourage the provision of 'smoke free' zones in public places..

When developing materials directed at individual smokers, the HEA should angle its message to take account of the social and emotional reasons why people smoke - for example, coping with stress, depression, loneliness or boredom - and attempt to suggest positive alternatives. The aim must be to minimise personal feelings of guilt and maximise positive action for change.



In developing its advocacy role, the HEA should work with ASH, the British Medical Association and other interested bodies to pioneer new approaches to smoking control for the next decade.

3. Diet

The high fat, sugar and salt content of the British diet, and its low dietary fibre, has been strongly linked with our unenviable place at or near the top of the world league tables for premature deaths from coronary heart disease, and breast and bowel cancers. Unhealthy eating is a contributory factor to stroke and diabetes, and other non-lethal but irksome health problems of epidemic proportions like obesity, dental caries and constipation.

A series of authoritative national and international scientific reports have made recommendations for dietary changes — which include an increase in consumption of dietary fibre, reductions in total fat intake, and decreases in sugar and salt consumption — on health grounds. These recommendations will be reinforced by nutritional guidelines to be published by WHO's European Office later this year.

However, despite encouraging public interest in food and health, there remains a great deal of confusion about the implications of these recommendations for individuals. In addition, there is very little clear, accessible advice on how to feed children to decrease the risk of heart disease in later life or on how heart disease sufferers should change their eating habits. There is also a need for structural changes along the entire food chain — in farming, processing, retailing, purchasing and catering — which will result in a healthier diet.

The HEA must develop a priority programme designed both to stimulate structural improvements in the British diet, and to provide clear information for individuals and special interest groups on desirable dietary changes, and how to make them. In doing so, the Authority should place particular emphasis on reaching caterers in health authorities, schools, the armed forces, and industry in an effort to improve the nutritional quality of the food we eat outside the home. The HEA should foster existing efforts to develop food health policies within the NHS and other public and private sector organisations. In particular, the HEA might examine DHA food health policies, and consider how they could be strengthened, their impact improved, and their implications applied to other sectors. At the same time, the Authority should consider devising a nutrition education programme for health professionals. This could be coupled with educational materials for the general public on nutrition, its relationship to the full range of diet-related diseases, and clear recommendations for dietary changes by individuals.

The HEA should also work with the food and farming industries on the development of healthier products. Recent negotiations with the National Federation of Bakers which resulted in an official HEC endorsement for the fibre content of certain types of bread in exchange for a reduction in its salt were a very welcome innovation in the food health field. The HEA should encourage other initiatives of this type.

4. Alcohol Abuse

The Royal College of Psychiatrists estimate that alcohol is responsible for some 25,000 premature deaths a year. The Home Office calculates that 45 per cent of all violent crimes are committed by people who have been drinking — 60,000 crimes a year. One in six accident and emergency cases are thought to be alcohol-related. The cost of male alcohol-related sickness absence and absenteeism from work has been estimated at £632 million. The total cost to British industry of alcohol-related accidents, inefficiency and lost hours has been put at around £2 billion.

However, the full extent of alcohol-related harm is extremely difficult to quantify exactly, mainly because alcohol use is so firmly knit into the fabric of British social and cultural life. We still know disturbingly little about when enjoyable social drinking becomes a hazard, and who is most at risk.

What is clear is that between 1950 and 1979 alcohol consumption in the UK doubled, and while there was an 11 per cent fall between 1979 and 1982, consumption is rising once again. There is general agreement among experts in the alcohol field that while the 3-4 million-strong group of heavy drinkers are at most risk of alcohol-related harm, the biggest burden of alcohol-related ill-health comes from moderate to light drinkers, simply because they are much more numerous. The most effective strategy to adopt, therefore, is one that will reduce alcohol consumption throughout society, rather than one which attempts to target a small, high-risk minority. Once again, such a population-based approach will involve a combination of structural measures, such as increases in tax on alcohol and changes in licensing laws, with efforts to educate the public as a whole about safer drinking.

The HEA should become involved in both structural and educational approaches to our national alcohol problem. It should consistently and coherently articulate the case for structural measures to encourage a general decrease in alcohol consumption, while at the same time educating all sections of the community on safer drinking. In particular, the HEA should expand the HEC's alcohol education programme to take account of the lessons learnt from its experimental community-based project on drinking in the North East, which are presently being applied in South West England. It should cooperate with trade unions and employers to greatly increase the current HEC programme on alcohol education in the workplace. It should place a high priority on the development of authoritative guidelines on safer drinking aimed at the whole population, and work with the media, health and education authorities, voluntary bodies, the alcohol industry and others on disseminating them as widely as possible. The Authority should work closely with Alcohol Concern and other expert groups when designing this campaign. It should also encourage the establishment of local alcohol forums in which health and local authorities, community and special interest groups, licensing authorities, the alcohol industry and others can develop appropriate alcohol policies.

When developing its materials on drinking, the Authority should concentrate on providing clear information on what 'safer drinking' amounts to for the main groups within the general population, bearing in mind that there will be circumstances - like driving and work - in which the concept of 'safer drinking' is inappropriate.

5. Coronary heart disease

In 1985, 160,000 people died from coronary heart disease (CHD) in England and Wales. Heart disease kills four people prematurely every hour, and treating it cost the NHS an estimated £390 million in 1985. Coronaries account for 40 per cent of deaths in middle-aged men, with some 25 per cent of all men between 40 and 59 showing signs of heart disease. The UK's CHD mortality rate is the highest in the world and heart disease is our primary killer disease.

The HEC's heart disease programme centred on increasing knowledge about the disease, encouraging positive behaviours like good nutrition and exercise, and improving provision and uptake of preventive health measures such as hypertension measurement. In 1987, this approach is being augmented by 'Look After Your Heart', a major HEA-DHSS campaign to encourage a healthier life-style through a decline in smoking, adoption of healthier eating habits, increased exercise, and better coping with stress. 'Look After Your Heart' will centre on a major mass-media educational campaign directed at consumers, with a parallel campaign directed at improved risk-factor detection by doctors.

The HEA should build on these programmes and work with the Coronary Prevention Group, the UK National Coordinating Committee, and the Sports Council in planning and carrying out a sustained, long-term national CHD prevention policy. At the same time it should continue the HEC's efforts to stimulate the primary health care team to screen for CHD risk factors and undertake preventive work.

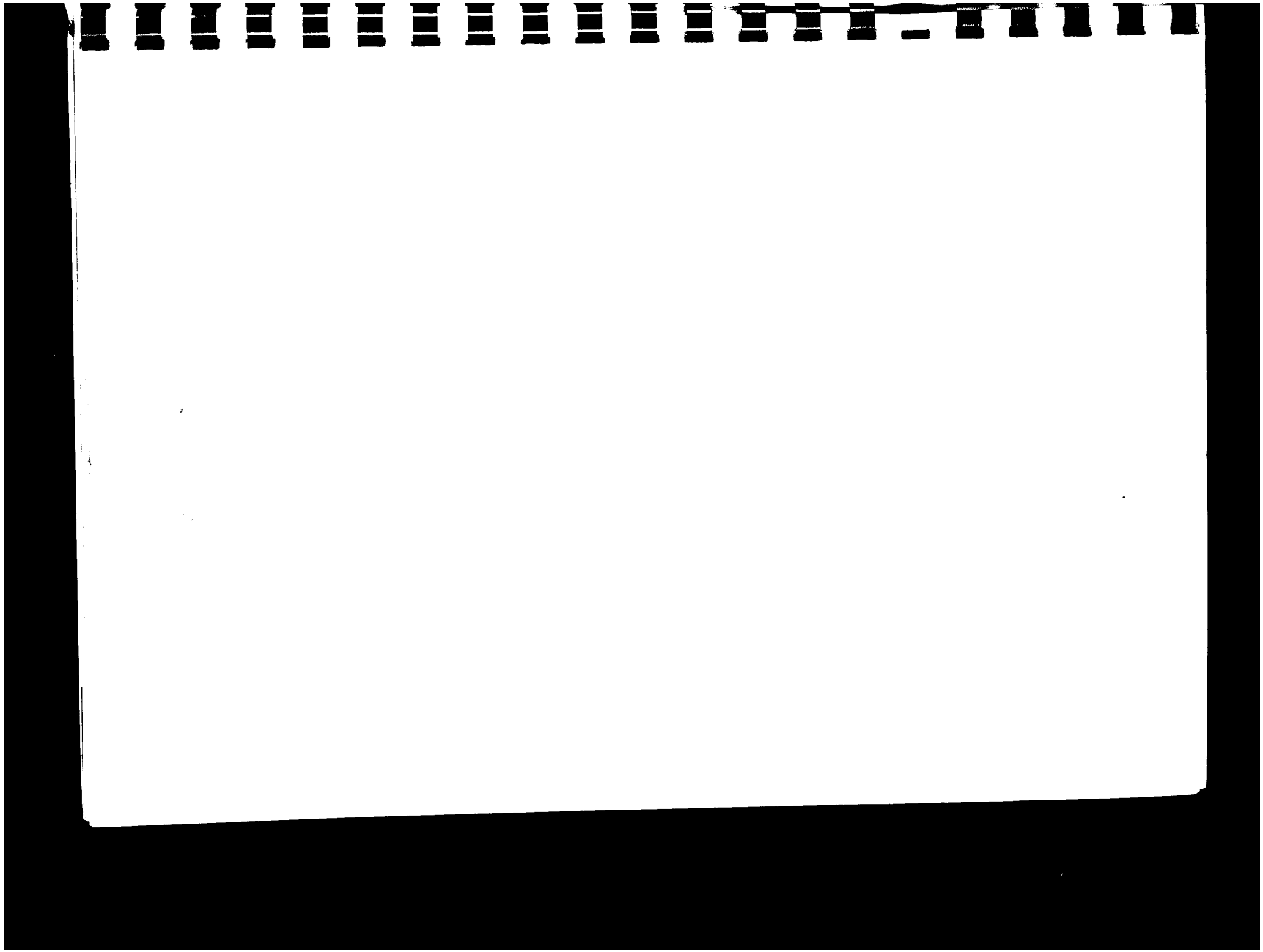
The HEA's work on heart disease should be complemented and strengthened by its advocacy of fiscal, legislative and regulatory measures designed to reduce smoking and improve nutrition. In addition, it should consciously apply the lessons learnt from the HEC's Welsh Heart Programme — which has pioneered a community-based approach to CHD — when developing its programme for England. Enlisting the help of farmers, food processors and retailers to develop and promote healthier food products has been central to 'Heart Beat Wales'. This approach should be applied and developed further in the HEA's CHD programme for England.

6. Ageing well

Negative images of ageing remain entrenched in our society, and are reflected in the actions of professionals and service agencies. Attention is focused on a minority of 'problematic' elderly people, and their interlocking health and social difficulties, rather than the majority of well elderly people and the resources they need to continue independent living.

Significant improvements in the health of older people can be achieved, but only through the development of an integrated strategy which takes account of the varied needs, preferences and interests of older people themselves. The challenge is to raise the general standard of health by reducing the prevalence and severity of health problems for older people today and for the elderly population of the 1990s and beyond. This requires action in — for example — employment, tax and income maintenance policies, as well as the formal health sphere.

The Health Education Authority should capitalise on the joint HEC-Age Concern 'Ageing Well' campaign, and work with the voluntary sector, the Royal College of



General Practitioners, health authorities and older people themselves in taking it forward. In developing an expanded campaign, the HEA should encourage the primary health care team to promote health actively to older people, and to design improved preventive programmes for them. As part of this initiative, it is important to acknowledge the positive contribution that elderly people themselves can make to the promotion of their own health. Very often older people are excluded from the dissemination of information about what constitutes good physical and mental health. If the HEA could assist in redressing the balance it might be possible to enhance self-care, increase active involvement in decision-making and thereby enable individuals to have a greater impact on service provision and policy-making.

7. Preventive Health Services

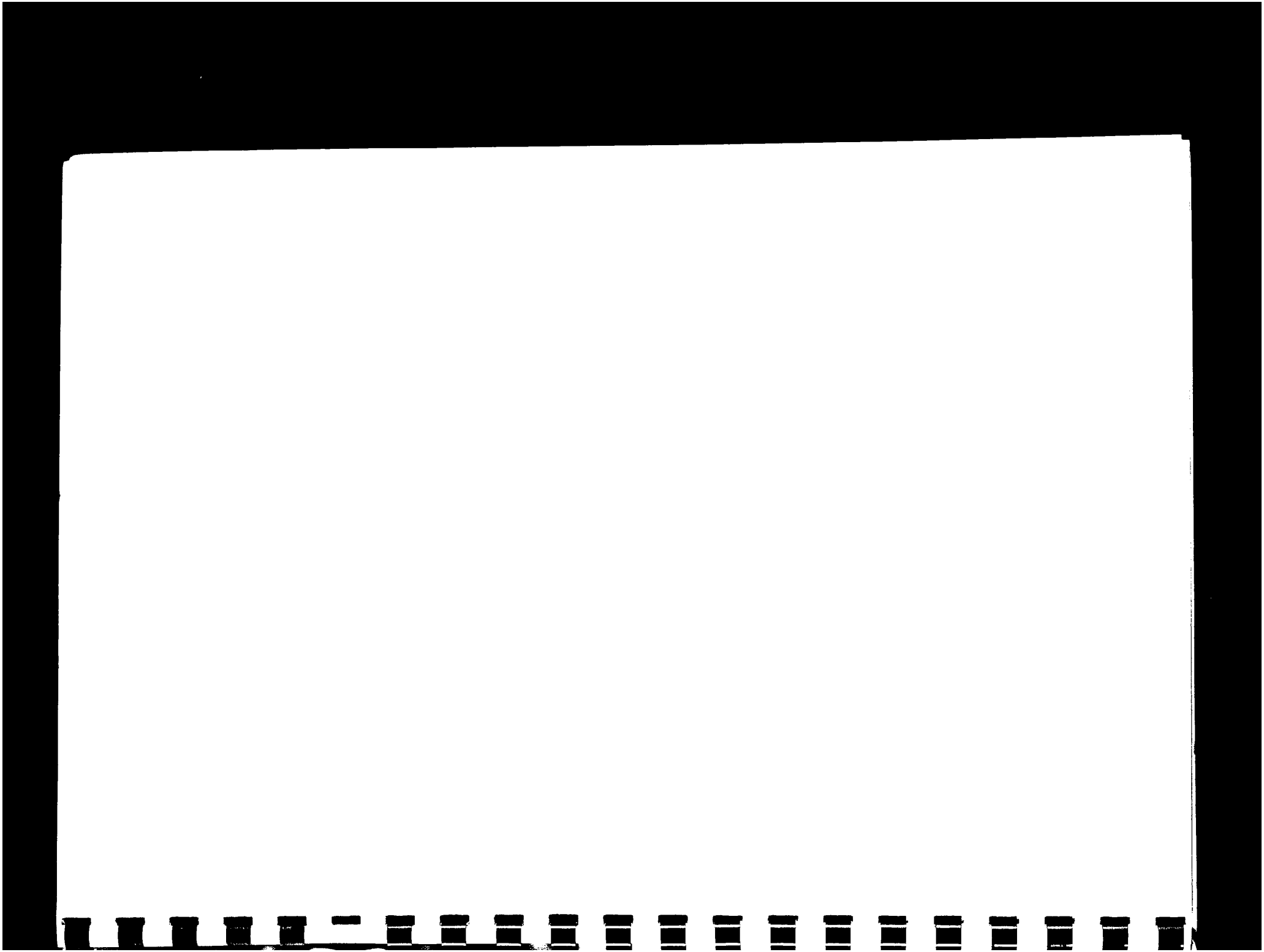
Within the NHS, preventive medicine remains a poor relation of acute medical care. Preventive services are underfunded and poorly organised. There is a conspicuous lack of 'product champions' to galvanise them in a way that would result in more productive and consumer-sensitive provision. Unfortunately, community physicians do not appear able to assume this role.

While there can be no question of the HEA taking on the responsibility of reorganising preventive medicine, the Authority should do all it can to encourage the development of a coherent and rational preventive health service within the NHS. Expertise and resources from within the Authority's existing research and professional development programmes might be devoted to this end. There is a particular immediate need to ensure that the new national breast screening programme avoids the organisational and other problems that have so seriously limited the effectiveness of cervical cytology. The Authority could usefully develop information materials for the providers and users of the new service.

Ways of Working

The style and method of working that the new Authority adopts will be almost as important to its success as the programme of health priorities around which it structures its work. When developing a way of working, the HEA should bear the following points in mind.

- Advertising on television, the radio, on hoardings and in the press is by no means always the most effective or sole way of of conveying information about health, although it is certainly one of the most expensive. Messages that seek to inform people about health or to alter their behaviour in a healthy way are often complex, and cannot always be reduced to simple advertising slogans. The HEA should therefore continue the HEC's tradition of working in a wide variety of media and at a number of different levels. The HEC's 1985 'Great British Fun Run' was a good example of this kind of synergy, uniting as it did Local Authorities, the Sports Council, and the HEC in a programme that promoted healthy physical exercise and information about fitness, and stimulated a great deal of media coverage.
- The Authority should maximise its impact by working with and through other agencies to promote health. Coordination is essential to the success of sus-



tained national programmes to reduce smoking and alcohol abuse, improve nutrition, and lower death rates from heart disease and cancers.

- The new Authority should make sure that its health promotion and education materials are realistic in terms of the lives, experiences and beliefs of the people who will use them.
- The HEA should examine the needs of individual health and local authorities and voluntary groups for specific information to promote health in their localities. The HEC's 'Big Kill' statistics package, which gave figures for smoking-related deaths in different local areas, is an approach which could be adapted and applied to many other health promotion programmes.
- The HEA should continue its predecessor's policy of supporting research on health promotion and education. It should pay particular attention to the development of appropriate evaluation and monitoring techniques for health promotion programmes.
- Self-help and other community groups have been shown to be an effective way of approaching the interlocking problems of poverty, depression and alcohol, tranquilliser, and hard drug abuse in multiply deprived areas. The HEA should support experiments in this field, and investigate their potential for health promotion.
- When health promotion policy development is discussed there is predictable tension between those who advocate a 'bottom up', community-based approach where health promotion priorities are determined in terms of needs expressed by local people and groups, and those who maintain that action for structural change at the centre is essential. In fact, both approaches are necessary and must reinforce each other. In the family planning field, enabling legislation in the early 1970s paved the way for a marked increase in contraceptive use, such that by 1983 nearly 90 per cent of sexually active people were using some form of contraception. The legislation was enacted as a result of representations by family planning and women's organisations, who in turn helped ensure increased take-up of free contraceptives. The HEA must solicit and foster the views of local communities and special interest groups to inform its role as a public health advocate at national level.

CONCLUSIONS

Effective health promotion is an essential part of any national campaign to improve public health. The key to successful health promotion lies in well-coordinated, long-term programmes directed at achieving defined targets. This work depends on a political will to change and improve the social and economic conditions which determine the public health. The development of this political will in its turn depends on the quality of information and public debate on public health issues. By pressing for a national public health policy based on 'Health for All' principles, and by drawing public attention to the action needed to address our major health

problems, the Health Education Authority has the potential to be a crucial force for positive change in British health policy.

SELECT BIBLIOGRAPHY

Judy Allsop: *Health Policy and the National Health Service*, Longman, London, 1984.

John Ashton et al: 'Healthy Cities - WHO's New Public Health initiative', *Health Promotion*, 1:3, 1986, 319-324.

John Ashton, et al: 'Promoting the new public health in Mersey', *Health Education Journal*, 45:3, 1986, 174-179.

Judy Berry: *Health Promotion Planning: An Information Guide for Regional and District Plans*, North Western RHA, Manchester, 1985.

Bloomsbury Health Authority: *Health For All in Bloomsbury - Annual Report No 1*, Bloomsbury Health Authority, London, 1987.

J R Butler: *An Apple a Day?: A study of lifestyles and health in Canterbury and Thanet*, University of Kent, Canterbury, 1987.

J R Butler: *An Apple a Day?: A study of lifestyles and health in Maidstone*, University of Kent, Canterbury, 1987.

Paul Castle and Bobbie Jacobson: *The Health of Our Regions: An analysis of the strategies and policies of regional health authorities for promoting health and preventing disease*, HEA, London, forthcoming.

DHSS: *Care in Action: A handbook of Policies and Priorities for the Health and Personal Social Services in England*, HMSO, London, 1981.

DHSS: *The Health Service in England*, Annual Reports 1984, 1985, 1986, HMSO, London.

DHSS: *Prevention and health: everybody's business: A reassessment of public and personal health*, HMSO, London, 1976.

DHSS: *The Way Forward: Priorities in the Health and Social Services*, HMSO, London, 1977.

DHSS and HEC: *Look after your Heart: A campaign on healthier lifestyles - strategy document*, DHSS, London, 1986.

Directorate of the Welsh Heart Programme: *Take Heart: A consultative document on the development of community based heart health initiatives within Wales*, Heartbeat Report No 1, Welsh Heart Programme, Cardiff, 1985.

Faculty of Community Medicine: *The Year 2000: Charter for Action*, Faculty of Community Medicine, London, 1986.

Wendy Farrant: 'Health for WHO by the year 2000? Choices for district health promotion strategies', *Radical Community Medicine*, Winter 1986/7.

Wendy Farrant: *Health for All in the Inner City: Proposed framework for a community development approach to health promotion policy and planning at district level*, Paddington and North Kensington Health Authority, London, 1987.

Wendy Farrant and Jill Russell: *The Politics of Health Information: Beating Heart Disease as a case study of Health Education Council publications*, Bedford Way Papers 28, University of London Institute of Education, London, 1987.

Phil Fryer: 'Oxford's Aim of Health for All', *Health Services Journal*, 5.3.87, 274-275.

Hilary Graham: 'Prevention and Health: Every Mother's Business'. A Comment on Child Health Policies in the 1970s in Chris Harris (ed): *The Sociology of the Family: New Directions for Britain* Monograph 28, University of Keele, Keele, 1979, pp 160-185.

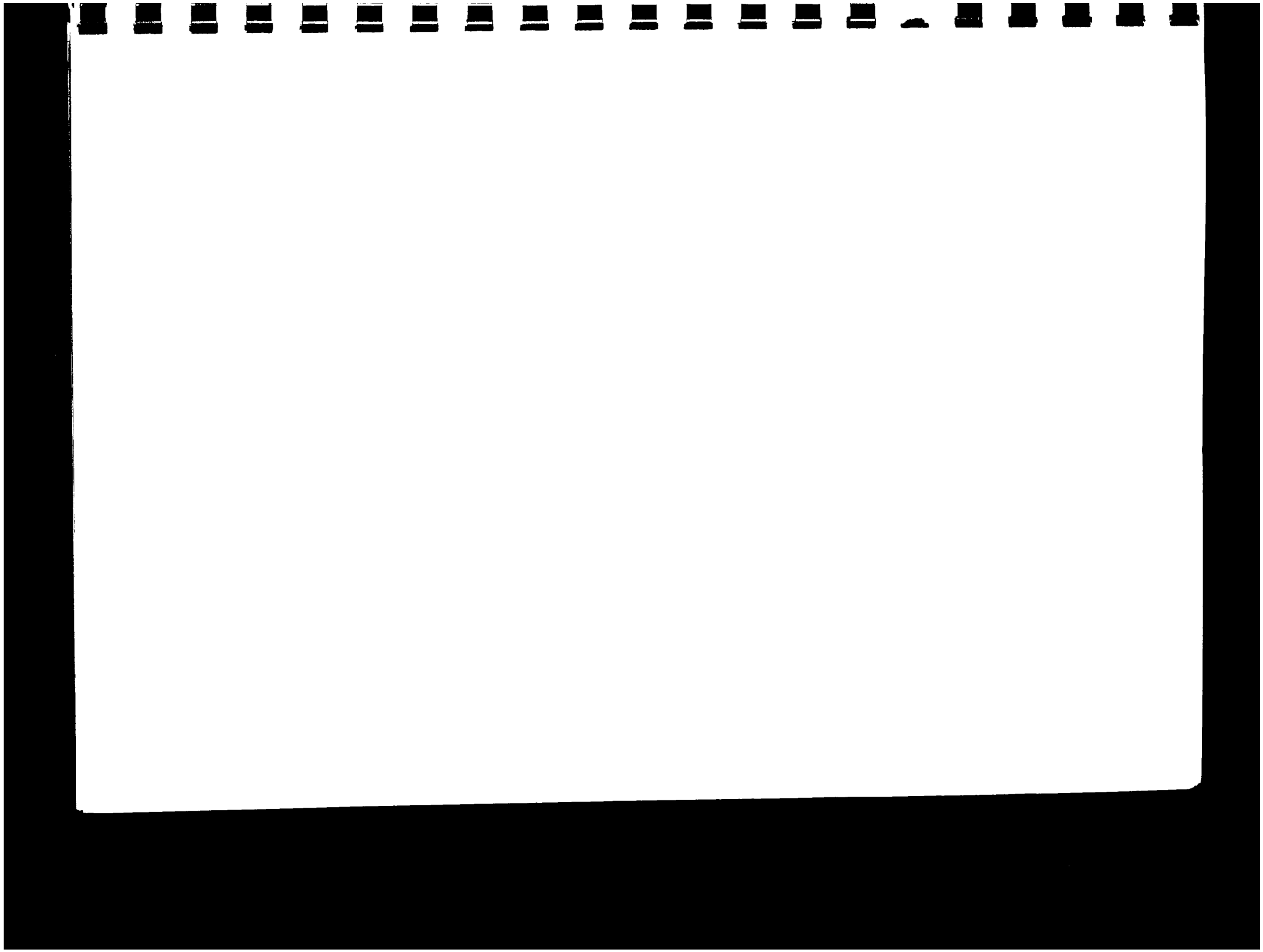
Health Education Council: *Annual Report 1984-5*, HEC, London, 1985.

Health Education Council: *Coronary Heart Disease Prevention: Plans for Action*, Pitman, London, 1984.

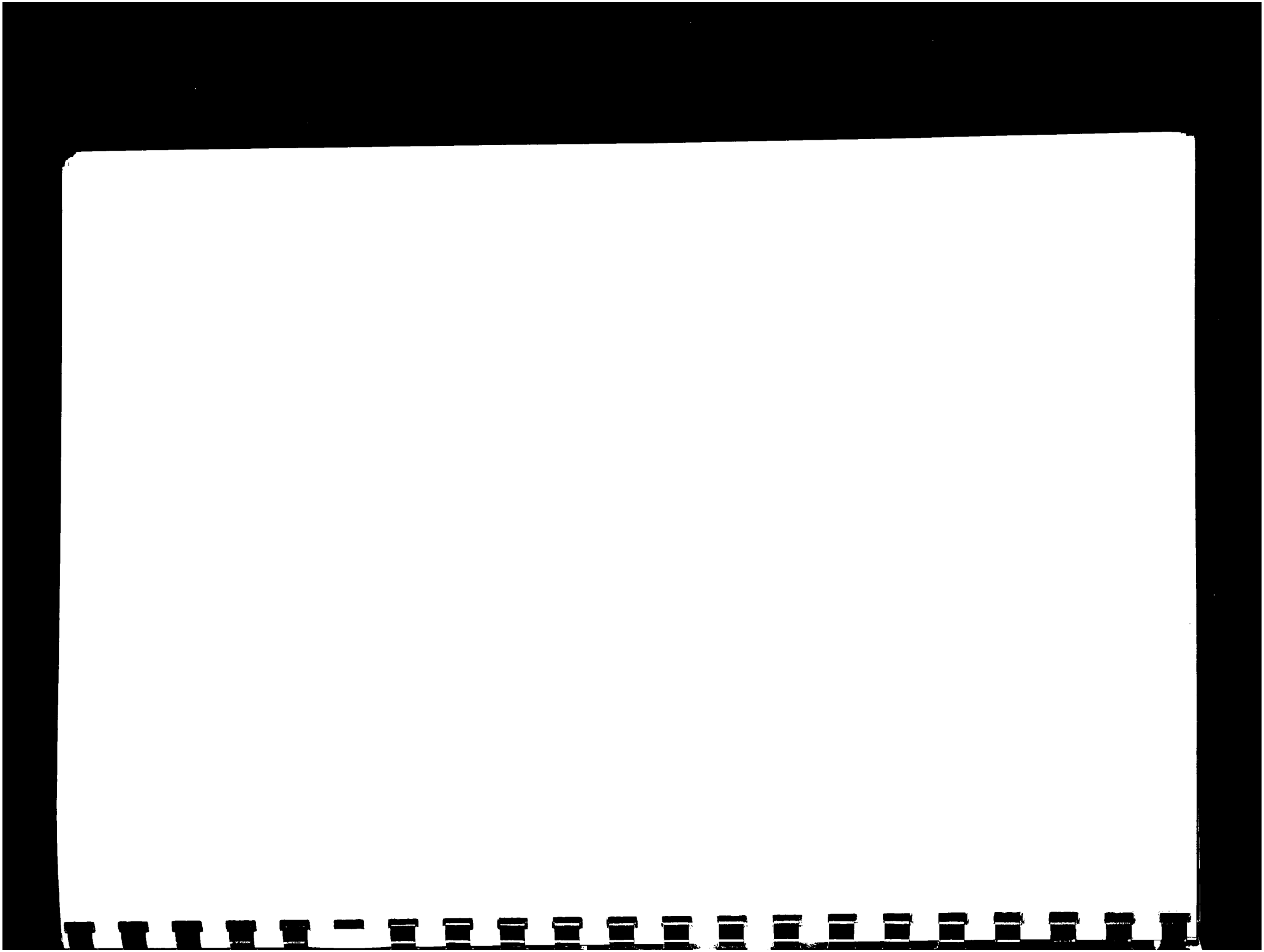
Sarah Harvey and Ken Judge: *Community Medicine and the NHS in England: a survey report*, King's Fund Institute, London, 1987.

Health Education Council: *Healthy Living: Towards a National Strategy for Health Education and Health Promotion*, HEC, London, 1983.

Health Education Council: *Programmes for 1983-4*, HEC, London, 1984.



House of Commons: *Forty-Fourth Report from the Committee of Public Accounts: Session 1985-86: Preventive Medicine*, HMSO, London, 1986.
House of Commons: *Weekly Hansard*, No 1399, 1-5 December, HMSO, London, 1986.
House of Commons: *Report of the First Standing Committee on Statutory Instruments - Meeting on the Health Education Authority - 18 February, 1987*, HMSO, London, columns 3-26.
David Ingledew: *A Review of the Health Promotion Activities of the District Health Authorities of Mersey Region*, Mersey RHA, Liverpool, 1986.
Marc Lalonde: *A New Perspective on the Health of Canadians: A working document*, Government of Canada, Ottawa, 1974.
OECD: *Living Conditions in OECD Countries: A compendium of social indicators*, OECD Social Policy Studies No 3, OECD, Paris, 1986.
Office of Health Economics: *Coronary Heart Disease. the need for Action*, OHE, London, 1987
National Audit Office: *Report by the Comptroller and Auditor General: National Health Service Preventive Medicine*, HMSO, London, 1986.
Christopher Robbins (ed): *Health Promotion in North America: Implications for the UK*, Health Education Council and King Edward's Hospital Fund for London, London, 1987.
Royal College of General Practioners: *Health and Prevention in Primary Care: Report of a Working Party appointed by the Council of the Royal College of General Practioners*, RCGP London, 1981
Royal College of General Practioners: *Promoting Prevention: A discussion document prepared by a Working Party of the Royal College of General Practioners*, RCGP, London, 1983
Royal College of Psychiatrists: *Alcohol: our favourite drug*, Tavistock, London, 1986.
Scottish Health Education Co-ordinating Committee: *Health Education in the Prevention of Alcohol-related Problems*, SHECC, Edinburgh, 1985.
Scottish Health Education Co-ordinating Committee: *Health Education in Areas of Multiple Deprivation*, SHECC, Edinburgh, 1984.
Scottish Health Education Co-ordinating Committee: *Health Education in the prevention of smoking-related diseases*, SHECC, Edinburgh, 1983.
Alwyn Smith (Chair), *The Nation's Health: A Strategy for the 1990s*, Report of an Independent Steering Committee, King's Fund/London School of Hygiene/Health Education Council, forthcoming.
Peter Townsend and Nick Davidson (eds): *Inequalities in Health: the Black Report*, Penguin Books. Harmondsworth, 1982
Jill Turner: 'Bloomsbury consults on Health for All'. *THS Health Summary*, 4:2, 1987. 8.
Margaret Whitehead: *The Health Divide: Inequalities in Health in the 1980s*, HEC, London, 1987
World Health Organisation: *Ottawa Charter for Health Promotion*, WHO with Health and Welfare Canada and the Canadian Public Health Association, Ottawa, 1987
World Health Organisation: *Global Strategy for Health for All by the Year 2000*. WHO. Geneva. 1981
World Health Organisation Regional Office for Europe: *Targets for Health for All: Targets in support of a European regional strategy for health for all*, WHO, Copenhagen, 1985

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