IMPLEMENTING THE DEPARTMENT OF HEALTH’S CHOOSING HEALTH WHITE PAPER

Summary

In March 2005, the Government released its implementation plan for Choosing Health, its public health White Paper (November 2004). The sixth major public health policy document to be produced since New Labour came to power in 1997, the paper reflects a significant shift in government health policy.

It shows a new sense of urgency about the need to prevent illness, a reluctance to take action that might incur charges of ‘nanny statism’, a diminished enthusiasm for targets and a new focus on personal choice and changing individual lifestyles and behaviour.

This briefing analyses the White Paper and the challenges that will need to be tackled in implementing it.

What is in the White Paper?

Selected highlights include:

- **The Choosing Health philosophy.** Health problems result from individual choices. The right approach is to empower people, give support where it is wanted and foster environments that make healthy choices easier. Delivery is underpinned by three principles: supporting informed choice for all, personalisation of support to make healthy choices, and partnership working to make health everybody’s business.

- **Communications.** A new strategy to promote health information and health literacy. As part of this, a new service – Health Direct – is to run alongside NHS Direct and NHS Online, and efforts to improve information to the public on food, drink and tobacco. Ofcom is to consult on proposals for tightening rules for broadcast advertising of food and drink to children. The Government is to enforce change if voluntary action fails to produce satisfactory changes by 2007.

- **Child health.** A Child Health Promotion Programme is to be led by health visitors. New Children’s Health Guides are to be drawn up for individual visitors. Investment in more school nurses is planned. Ofsted inspections are to include an assessment of schools’ contribution to children’s health and well-being.

- **Community health.** New regulations to ban smoking from all enclosed public places and workplaces including restaurants, and pubs and bars that serve food. Public Health Observatories are to produce customised reports designed for Primary Care Trusts and local authorities. Primary Care Trusts are to develop local health targets. A Communities for Health scheme is to be launched in Spring 2005. A network of local health champions is to be developed. Use of pedometers by Primary Care Trusts and in schools is to be encouraged. The UK Sustainable Development Commission, with funding from the Department of Health, will develop the capacity of NHS organisations to act as good corporate citizens.
Supporting individual choice. Health trainers are to be made available ultimately to any individual who wants one, starting with those in disadvantaged neighbourhoods. Personal health guides will be developed by individuals who want to be healthier, setting out their current state of health, what changes they want to make and where they can get help. A stock-take of health will be offered to individuals at key life stages.

Turning the NHS into a health-improving service. Key points include general measures to improve NHS capacity to focus on prevention, managing chronic conditions and addressing major health risks. A National Health Competency Framework to improve skills and capacity of NHS staff is to promote health and prevent illness, including obesity prevention and treatment. Community matrons are to provide personalised care and health advice for those with chronic conditions. Definitive guidance from the National Institute for Clinical Excellence (NICE) on prevention, identification, management and treatment of obesity is to be available in 2007.

Promoting healthier working conditions. Evidence-based guidelines on occupational health. Investors in People (iIP), a framework for delivering business improvement, is to develop a new healthy business assessment. All government and NHS buildings are to be smoke free, with a new campaign to help nurses to stop smoking. The NHS is to lead by example.

Implementation. Health is to be a component of regulatory impact assessment of all future legislation. The Department of Health will publish six-monthly reports on progress towards health improvement targets. A Health Information and Intelligence Task Force will be set up to oversee information gathering and knowledge management. A Health Improvement Workforce Steering Group is to be established to develop strategy and to co-ordinate action needed to deliver the White Paper's objectives. The Modernisation Agency and its successor organisation will prioritise the implementation of the White Paper.

What is to be welcomed in the White Paper?

Scale and scope. It includes many changes and contains many more practical initiatives than earlier public health policy documents.

Embedding change. There are clear attempts to embed change in the operational processes of the NHS, as well as in other relevant organisations and relationships.

A strong local dimension. The White Paper recognises that locally focused activities by local organisations are essential to improving health and tackling health inequalities.

Focus on partnership working. The value of joint working between the NHS and local government, businesses and voluntary organisations is firmly acknowledged.

Support for disadvantaged groups and neighbourhoods. Many initiatives are to be targeted, with the initial focus on disadvantaged communities.

Engaging with the media. Support for a more proactive dialogue with regional and national media, and possibly also a national centre for media and health, along the lines of the Science Media Centre.

Healthier schools. Helpful moves include increasing numbers of school nurses, improving nutritional standards of school meals, encouraging healthy eating and physical activity and extending the scope of Ofsted inspections to schools' overall contribution to health and well-being. This will have a specific focus on healthy eating.

Curtailing food and drink promotion for children. The carrot-and-stick approach to broadcast advertising of food and drink for children is to be welcomed.

An obesity strategy. This outlines a strategy for preventing, identifying, managing and treating obesity, informed by guidance from the National Institute for Health and Clinical Excellence.
The NHS to lead by example. The NHS is to promote health through its corporate activities, such as food purchasing, capital development, providing a smoke-free environment, and healthy working conditions. The Sustainable Development Commission is to help develop good corporate citizenship.

Changing the relationship between the individual and primary health services. Proposals to introduce children’s health guides, personal health guides and periodic health checks or stock-takes merit further testing.

Community-based health advocates or ‘trainers’. These can help disadvantaged individuals and groups gain access to the knowledge and services they need to maintain and improve their health.

Employment as a determinant of health. Occupational health to be promoted in the NHS and other organisations, with help for people returning to work after illness or injury.

Action on smoking. The ban on smoking in enclosed public spaces including restaurants and bars that serve food is a step in the right direction.

Shortcomings and weaknesses

Lack of connectedness. The White Paper shows little sense of its own history. Showing how it connects with earlier health policy documents, such as the Acheson Report (1998) and Our Healthier Nation (1998) could help to give greater coherence to the vast array of initiatives in Choosing Health.

Reconciling choice and inequality. The ideology of choice is firmly imprinted on the White Paper. However, the task of reconciling individual choice with a commitment (also clearly stated) to reducing health inequalities will be a real challenge. The initiatives targeted on disadvantaged individuals and neighbourhoods are welcome, but it is still unclear whether the Government has committed itself to the radical agenda that will be required to ensure that everyone has a genuinely equal chance to enjoy a long and healthy life. If it does not do this, it will have been a missed opportunity.

Failure of nerve on smoking. The White Paper fails to follow Ireland, New York and others in banning smoking in all enclosed public spaces. There is evidence that a total ban would be popular with the public and this has worked well in other countries.

Too much dependence on voluntarism. It is doubtful whether discussions with the food industry will lead to prompt and effective action on food content and labelling, unless there is a promise of enforcement if voluntarism fails.

Shortage of detail on critical points. How will the Child Health Promotion Programme, the Communities for Health scheme and health champions operate, and how will the latter relate to the proposed health trainers? How, if at all, will health trainers relate to the large numbers of health advocates already operating at community level? Mental health and alcohol are dealt with at some length, but little is said about upstream prevention.

Too little attention to black and minority ethnic health. There are few substantive references to black and minority ethnic communities, in spite of significant inequalities and specific health needs relating to minority ethnic groups.

Questions and challenges

Can choice and equal opportunity be reconciled? The White Paper attempts to accommodate these two objectives. It will be a real challenge to make them work together, and this is not recognised in the document.

Is there enough money? The Department of Health plans to invest at least £1 billion in public health over the next three years to help implement the White Paper, but it is not clear whether this is all new money, where it comes from and what it is expected to cover.
How much of it will be implemented and by when? The Department of Health released its implementation plan in March 2005. Everything depends on the quality of implementation, and on how well the many component parts of the White Paper fit together and work in practice.

Will there be strong and sustained leadership for change? Will public health policy continue to have a high profile and be given priority at senior level across the Department of Health and the NHS? Strong and sustained national and local leadership will be essential, to continue well beyond the next election.

Is there a clear story that everyone can understand and support? Will all those required to act be able to share a view about what the objectives are and what can be achieved? Much will depend on how it is interpreted by those responsible for disseminating its messages and drawing up the implementation plan.

What are the incentives for the NHS to push the improvement of public health up the agenda? At present, the NHS is receiving unprecedented financial investment. Even so, many NHS organisations, in particular Primary Care Trusts, are hard pressed financially. Given the lack of strong evidence of the cost-saving effect of measures to improve public health, it is not clear what the incentives are for Primary Care Trusts in particular to focus seriously on some of the measures proposed in the White Paper. Unless this issue is addressed, there is a risk that the excellent measures proposed will not be implemented in a sustained way, especially in the future when resources for the NHS may be tighter.

What can be done to evaluate the cost effectiveness of a range of health-promoting interventions? There is an urgent need for a programme of research to assess the impact of both the more specific (yet complex) interventions to improve the health of people with chronic conditions and those designed to improve health more widely. Evaluation of such complex, and often multifaceted, interventions is difficult, but in the short term it will be critical to examine their impact specifically on the use of health care, to test the assumption that better health reduces use as asserted in the first Wanless Inquiry. There may be a role for the National Institute for Health and Clinical Excellence in this respect.
IMPLEMENTING THE DEPARTMENT OF HEALTH’S CHOOSING HEALTH WHITE PAPER

The Government issued Choosing Health, its new White Paper on public health, on 16 November 2004. It has now released its implementation plan to clarify how the initiatives will be carried out. The plan makes the new expectations and responsibilities clearer to public health professionals, but the impact of the initiatives on improving public health and reducing health inequalities will take longer to assess. The strengths and weaknesses of the White Paper will also influence the potential success of the new strategy.

Background and context

Choosing Health is the sixth major public health policy document to be produced since New Labour entered government in 1997. The first five were:

- **Independent inquiry into inequalities in health: The Acheson Report (1998).** This reviewed the causes of health inequalities and set out 39 recommendations for tackling them, with four overriding priorities. All policies likely to have a direct or indirect effect on health should, it said, be evaluated for their impact on health inequalities and should be formulated to favour less well-off people. Priority should be given to the health of women of child-bearing age, expectant mothers and young children. And further steps should be taken to reduce income inequalities and improve the living standards of poor households.

- **Our Healthier Nation: A contract for health (1998).** A Green Paper pledging to increase ‘the length of people’s lives and the number of years people spend free from illness’ and to ‘improve the health of the worst off in society and to narrow the health gap’. Targets to reduce premature deaths from cancer, coronary heart disease and stroke, accidents and mental health would be met though a ‘contract’ between individuals, local communities and national government, working in three settings – healthy workplaces, healthy schools and healthy neighbourhoods.

- **Saving Lives: Our Healthier Nation (1999).** A White Paper presenting a narrowly focused strategy of NHS-related measures intended to meet the four targets set out in the earlier Green Paper, with numbers of deaths to be avoided and dates specified.

- **Tackling Health Inequalities: A Programme of Action (2003).** This set out plans to achieve targets to reduce inequalities in health outcomes by 10 per cent by 2010, measured by infant mortality and life expectancy at birth. It claimed to be ‘the most comprehensive programme of work to tackle health inequalities ever undertaken in this country’, with a range of initiatives on education, welfare-to-work, housing, neighbourhoods, transport and the environment that will help improve health. In effect, it was a summary of most aspects of the social and economic policies being pursued across government.

- **Securing Good Health for the Whole Population (2004).** The second of two reviews commissioned by the Treasury from former banker Derek Wanless, this explored evidence-based ways of realising a ‘fully engaged scenario’ in which priority is given to preventing illness and individuals are committed to safeguarding their own health. In his first review, Wanless had calculated that failure to shift towards this scenario would cost some £20 billion extra in annual healthcare costs by 2020.

Early in 2004, just before the publication of the second Wanless review, Health Secretary John Reid announced a major consultation, entitled Choosing Health?, which he promised would lead to a public health White Paper later in the year.

When it arrived, the Choosing Health White Paper reflected a significant shift in government health policy. This can be characterised as follows:

- **A new sense of urgency about the need to prevent illness.** This is distinct from improving health care and was largely prompted by the Wanless reviews, which had begun to estimate the price of failing to take prevention seriously.
Implementing the Department of Health’s Choosing Health White Paper - briefing

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A new, official rationale for the sequencing of government priorities. Public health, it was said, had had to wait until the government had adequately addressed the shortcomings of the NHS. Only when issues such as waiting times had been tackled could the Department of Health justify giving fuller attention to managing chronic disease and preventing illness.

A clear reluctance to take action that might incur charges of ‘nanny statism’. This provoked a public debate about the limits of state intervention and seemed to signal an attempt to shape public opinion in favour of government taking less, rather than more direct action to promote population health.

A diminished enthusiasm for target culture. This has loomed large in Saving Lives and most health care policy since 1997.

A new focus on personal choice and changing individual lifestyles and behaviour. This reflected a cross-government emphasis on ‘personalisation’ of public services and a strong commitment in health care policy to ‘patient-centred care’ and ‘patient choice’. Personalisation and choice were envisaged as dominant themes in a general election campaign expected in 2005.

Tracing the journey taken by Labour’s health policy makers between 1997 and 2004, one can see that, with the first flush of victory, came a passionate interest in tackling health inequalities, echoing the Prime Minister’s commitment to ending social exclusion and child poverty.

Next came an attempt to carve out a ‘third way’ between traditional left and right approaches, with a strategy born of careful policy analysis, comprising a ‘contract’ between individual, community and state, for action in specified social settings. This was soon overshadowed by a desire to deliver measurable results, coupled with a pragmatic reversion to clinically defined objectives.

For several years thereafter, public health policy languished in the shadows of health care policy, which was almost entirely preoccupied with reorganising the NHS (yet again) and meeting stringent service-related targets. Not until the Treasury intervened with the Wanless reviews in 2002 and 2004, did public health emerge as a high-profile policy arena.

At this point, the social analysis of Our Healthier Nation and the disease-based targets of Saving Lives gave way to the new choice agenda that was being primed for the forthcoming election. This fitted quite comfortably with Wanless’ emphasis on the need for individuals to change their behaviour in order to restrain spiralling health care costs. It fitted less well with the continuing commitment to reduce health inequalities and (in the words of Health Secretary John Reid) ‘to refocus the NHS as a service for health’. The claim that more choice would bring greater health equity had not been thoroughly thought through.

What is in the White Paper?

Choosing Health is a substantial document, 207 pages in all. It covers a wide range of issues, and is not easy to navigate. In many respects, it is an ‘open text’ that can be given different meanings by different readers.

The chapter-by-chapter commentary that follows is offered as one of many possible interpretations. It is not definitive, but represents our best efforts to pick out the salient points. Some measures are fresh to the White Paper while others have already been introduced, although the distinction is not always clear. We have tried to focus on material that is new, or that has been given new significance by the White Paper.
Commentary

Chapter One: Time for action on health and health inequalities

This presents the rationale for the White Paper, as follows:

- There are serious and rising risks to health, especially in relation to smoking, sexually transmitted infections, mental health and alcohol.

- There is evidence of public enthusiasm for healthier living and for government action to support healthy choices.

- Some people find it harder than others to live healthily, for reasons beyond their control, for example disability, mental health problems, poverty, unemployment or living in disadvantaged neighbourhoods or temporary accommodation. They need more support than others to change their behaviour if inequalities are to be reduced.

- There must be a ‘step change’, not ‘more of the same’; old solutions have not provided the necessary impetus; too much time and energy has been given to analysing the problems and not enough to practical solutions that connect with real lives.

- Health problems – new and old – are the ‘cumulative results of thousands of choices by millions of people over decades’; the right approach is to empower people, give support where it is wanted and foster environments that make healthy choices easier.

- Delivery is underpinned by three principles. The first is supporting informed choice for all; the second is ‘personalisation’ of support to make healthy choices, to ensure equal access for all; and the third is working in partnership, with government in the lead, to make health ‘everybody’s business’.

Chapter Two: Health in the Consumer Society

This deals with how to get across messages that will encourage individuals to make healthy choices. It raises awareness about risks and provides information, in various ways, about what they can do to improve their health. The main new initiatives fall into two categories: general health education and promoting ‘health literacy’, and improving the quality of information to the public on food, drink and tobacco.

General health information and promoting ‘health literacy’

- A new communications strategy to be implemented by an independent body, appointed by the Department of Health.

- New health education campaigns on sexual health, obesity, smoking and alcohol, using creative social marketing techniques and new technology, and based on an understanding of the different needs of different groups in society.

- A new service – Health Direct – to provide information on health choices, alongside NHS Direct and NHS Online.

- New funding for Primary Care Trusts to run local Skilled for Health programmes, which combine the national adult basic skills programme, Skills for Life, with promoting ‘health literacy’, helping people gain a better understanding of their health needs. Each trust to run one such programme each year.

- More expert briefings from the Chief Medical Officer on a wider range of health-related topics.

- Possible development of a national centre for media and health to provide an independent forum for national and regional media to discuss major health issues.
Improving information to the public on food, drink and tobacco

- Efforts to encourage the food industry, working with the Food Standards Agency, to signpost the content of packaged food in ways that are simple, accessible and consistent.

- Discussions to encourage the food industry to make healthy food more accessible, reducing salt, sugar and fat content and portion size.

- A Food and Health Action Plan to be published early in 2005.

- Ofcom to consult on proposals for tightening rules for broadcast advertising of food and drink to children. If voluntary action fails to produce satisfactory changes by 2007, the Government plans to enforce change through existing powers or new legislation.

- New information campaigns on alcohol to be developed with the Portman Group, the industry-funded body that claims to promote responsible drinking.

- An end to tobacco internet advertising and ‘brand sharing’ (using a non-tobacco product as part of promotional activities) in 2005.

**Chapter Three: Children and young people – starting out on the right path**

This lists a great many initiatives introduced prior to the White Paper. These include the Public Service Agreement target to halt rising trends in child obesity, children’s trusts, children’s centres and locally integrated children’s services, extended schools, Sure Start, parental support measures, the extension of the school fruit and vegetable scheme for 4-6 year olds, support for cycling and walking to school, more school sport and measures to reduce teenage pregnancy and sexually transmitted infections among young people. Other initiatives include:

- A new Child Health Promotion Programme, led by health visitors, which will introduce Children’s Health Guides. These provide a record of the child’s health status and set out what is needed to maintain or improve their health. Developed and held in the early years by the parent or carer, the guides are intended to encourage children, as they grow older, to take responsibility for their own health goals, with help from health professionals and others. The guides can be reviewed at key life stages, such as entering secondary school and starting work, and may become the foundation for personal health guides that can be developed throughout an individual’s life.

- School nursing to be ‘modernised and promoted’, with new funding from 2006-7 to ensure that all Primary Care Trusts, starting with those in the most disadvantaged areas, can provide at least one full-time qualified school nurse for each ‘cluster’ of schools.

- The Healthy Schools Programme to be extended to all schools by 2009.

- Ofsted to inspect for schools’ contribution to children’s health and well-being, including healthy eating. Nutrient-based standards for school meals to be ‘strongly considered’. New guidance to encourage healthy eating and drinking throughout schools.

- A new ‘lad’s magazine’ called FIT to promote health information for young men aged 16-30.

- Legislation to strengthen controls on tobacco sales to under-age young people.
Chapter Four: Local communities leading for health

This deals with community-level action for health and, like the previous chapter, draws together a number of existing initiatives, including Local Area Agreements and measures to promote access to healthy food, sustainable transport and physical activity. It stresses the importance of partnership working between health trusts, local authorities and other local organisations, and sets out the following new or partly new initiatives. These fall into three main categories: community health, corporate citizenship and smoking bans.

Promoting community health

- Public Health Observatories are to produce reports designed for local authorities, using a standard set of local health information, linked to other data sets.

- Primary Care Trusts are to develop local health targets, agreed with partner organisations, to meet national targets and priorities set by the White Paper and the NHS Improvement Plan.

- The Healthy Communities Collaborative is to be extended to tackle obesity and other issues.

- A scheme called Communities for Health is to be launched in spring 2005, to promote action across local organisations on locally chosen priorities for health.

- A network of local ‘health champions’ is to be developed. These will include local authorities and other organisations and individuals who want to lead local action to improve health. They will be supported by ‘arrangements’ to share good practice and celebrate success through an annual award scheme.

- Pedometers are to be encouraged by Primary Care Trusts and in schools.

‘Good corporate citizenship’

- The UK Sustainable Development Commission is to be given funding by the Department of Health to develop the capacity of NHS organisations to act as ‘good corporate citizens’, namely, to use their corporate resources as employers, purchasers, landholders, managers of energy, waste and travel and commissioners of new buildings and refurbishments to promote health and sustainable development. This work will focus initially on food procurement and capital development.

- The Government will sponsor a debate on good corporate citizenship, leading to ‘firm recommendations’ for all public and independent bodies to organise their activities in ways most likely to improve the health of their employees and the wider community.

Smoking bans

- New regulations to ban smoking from all enclosed public places and workplaces including restaurants, pubs and bars that serve food. Clubs, pubs and bars that do not serve food can continue to allow smoking, but not in the bar area. All government departments and the NHS are to be smoke-free by the end of 2006. All other enclosed public places and workplaces are to be smoke-free by the end of 2007, except for licensed premises, where arrangements must be in place by the end of 2008.
Chapter Five: Health as a way of life

This is about supporting individual choice. It mainly consists of fresh material and makes three key proposals:

- ‘Health trainers’ to be available ultimately to any individual who wants one, starting with those in disadvantaged neighbourhoods. These trainers are themselves trained and accredited by the NHS and are expected to come mainly from the communities where they work. Their function is to help individuals be aware of health risks and how to change their behaviour to lead healthier lives. They can be accessed through health centres, NHS Direct and possibly through other local organisations.

- ‘Personal health guides’ can be developed by individuals who want to do so, with help from a health trainer. These are custom-made plans that set out, in the individuals’ own terms, their current state of health, what changes they want to make and where they can get help to do so. The guide may be electronically stored and linked to HealthSpace, a secure personal health organiser on the internet, as an ‘online personal health planning kit’. It can build on the Children’s Health Guide.

- A ‘stock-take’ of health will be offered to individuals at key life stages such as new employment, childbirth, entering a new relationship, and preparing for retirement. This provides an opportunity to review the personal health guide, with help and support from a ‘health trainer’ or other NHS personnel.

Chapter Six: A health-promoting NHS

This sets out plans for turning the NHS into a health-improving service. Key points fall in three categories:

General measures to improve NHS capacity to focus on prevention

- National Clinical Directors to work with clinicians across the NHS to find opportunities to extend primary and secondary prevention. They will work with the Chief Medical Officer to recommend a ‘comprehensive and integrated prevention framework, linking all areas covered by National Service Frameworks’.

- Primary Care Trusts will receive funding to enable them to give higher priority to areas of greatest health need, and become a ‘tool to assess local health and well-being’.

- A National Health Competency Framework is to improve the skills and capacity of NHS staff to promote health and prevent illness, including obesity prevention and treatment.

- A strategy for pharmaceutical public health, to be published in 2005, is to show how pharmacists can contribute to health improvement and reducing health inequalities.

- Dentists are to be given a new focus on prevention in contractual arrangements coming into force in October 2005.

 Managing long-term conditions

- Community matrons to provide personalised care and health advice for those with long-term conditions such as diabetes, asthma and arthritis, and to be responsible for case-managing patients with complex health problems. By 2008, there will be 3,000 community matrons and they will be supported by health trainers (see above).

- The Department of Health will bring in independent sector ‘partners’ to develop new approaches to managing chronic conditions, including personal health guides.
Addressing major health risks

- **Mental health.** New models of physical health care for people with mental health problems and new approaches to help people with mental illness to manage their own care.

- **Smoking.** A national taskforce to help improve NHS services to help stop smoking. The Healthcare Commission is to assess progress. (See also Smoking Bans above).

- **Obesity.** Definitive guidance from the National Institute for Clinical Excellence on prevention, identification, management and treatment of obesity is to be available in 2007. A ‘weight loss guide’ is to be produced and a ‘national partnership for obesity’ is to be established. A ‘patient activity questionnaire’, available by the end of 2005, is to help NHS staff improve patients’ physical exercise.

- **Sexual health.** New capital and revenue funding for tackling sexually transmitted illnesses. Improved chlamydia screening, possibly using independent partners such as retail pharmacists. Audit of contraceptive services and a target wait of a minimum of 48 hours by 2008 for those referred to a GUM (genito-urinary medicine) clinic.

- **Alcohol.** A programme to improve alcohol-treatment services, based on demand audits and ‘Models of Care’ guidance from the National Treatment Agency, with additional funding from Pooled Treatment Budget for Substance Misuse.

**Chapter Seven: Work and health**

This acknowledges the strong links between employment and both mental and physical health. It sets out proposals for healthier working conditions, and for encouraging the NHS and other public sectors to lead by example. These include:

- The production of evidence-based guidelines on occupational health.

- Sport England is to provide free consultancy to government departments on how they can encourage staff to be more active.

- There will be pilots to develop the evidence base for effective health promotion at work.

- Investors in People (IiP) are to develop a new ‘healthy business assessment’, to be incorporated in the new IiP standard when reviewed in 2007.

- All government and NHS buildings are to be smoke free and a campaign to help nurses to stop smoking is planned.

- The NHS is to become an exemplar, providing healthier workplaces and encouraging people back to work after injury, illness or impairment. Its progress will be assessed by the Healthcare Commission.

- Guidelines on managing mild to moderate mental ill-health in the workplace are to be published in 2005.
Chapter Eight and Annex B: Making it happen

These attempt to show how the ambitions of the White Paper can be realised. They describe at some length how different organisations will contribute and work together, nationally and locally. Key points not already mentioned include:

- Health will be a component of regulatory impact assessment of all future legislation.
- There will be new funding for health education campaigns, more school nurses, health trainers and obesity and sexual health services.
- The Department of Health is to publish six-monthly reports on progress towards health improvement targets.
- Extra government funding will be available for councils that achieve more ambitious local targets, for example, on tackling health inequalities.
- Funding for public health research is to reach £10 million by 2007-8; a public health research consortium and a National Prevention Research Initiative will be set up.
- An Executive Director for Health Improvement will be appointed within the National Institute for Health and Clinical Excellence (a merger of NICE and the Health Development Agency), to provide professional leadership.
- A Health Information and Intelligence Task Force will be set up to oversee information gathering and knowledge management. £10 million a year from 2006 will be made available for Public Health Observatories.
- Training for ‘health trainers’ and other frontline staff will be developed with partner organisations, possibly leading to a new national Health Trainer Certificate.
- The Department of Health and partners are to identify core skills and competencies needed for public health leadership.
- A Health Improvement Workforce Steering Group is to be established to develop strategy and co-ordinate action needed to deliver the White Paper’s objectives.
- Implementing the White Paper will be the priority of the Modernisation Agency and its successor organisation (when it has taken in the NHS University). A new Innovations Fund (£30 million in 2006-7 and £40 million thereafter) will support and evaluate new ways of working.

What is to be welcomed in the White Paper?

- **Scale and scope.** This is a wide-ranging, ambitious exercise that covers a great deal more ground than was ever suggested by the media reports that accompanied its launch. It claims to instigate a great many changes and contains many more practical initiatives than earlier public health policy documents.

- **Embedding change.** There are clear attempts to embed change in the operational processes of the NHS, as well as in other relevant organisations and relationships. Implicitly, the White Paper acknowledges the need not just to introduce new measures or pursue targets, but to change the culture and practice of the systems that deliver them.

- **A strong local dimension.** The White Paper recognises that locally focused activities by local organisations are essential to tackling health inequalities. Primary Care Trusts are to set local targets, informed by customised intelligence from Public Health Observatories, and the NHS is expected to work with local authorities and other organisations at that level.
Focus on partnership working. The value of joint working between the NHS and local government, businesses and voluntary organisations is firmly acknowledged as essential to effective implementation of the White Paper’s proposals. It sends out an unequivocal message that NHS organisations are expected to play a leading role in local partnerships for health.

Support for disadvantaged groups and neighbourhoods. A clear theme throughout the White Paper is that people who are poor, socially isolated or otherwise disadvantaged can find it harder than others to make ‘healthy choices’ and therefore need additional support. Many initiatives are targeted in the first instance on disadvantaged communities; these are quite obviously essential if inequalities are ever to be reduced.

Engaging with the media. Following consultations with media organisations conducted for the Department of Health by the King’s Fund, it has been suggested that there should be a more proactive dialogue with regional and national media, and possibly also a ‘national centre for media and health’ along the lines of the National Centre for Media and Science. We welcome the fact that these ideas are reflected in the White Paper; it will be essential to guarantee genuine independence for any such centre.

Serious about schools. The White Paper holds out a reasonable prospect of ensuring that schools create a healthier environment for children and play a stronger role in promoting child health. Helpful moves include increasing numbers of school nurses, improving nutritional standards of school meals, encouraging healthy eating and physical activity, and extending the scope of Ofsted inspections to schools’ overall contribution to health and well-being, including – specifically – healthy eating.

Curtailing food and drink promotion for children. The carrot-and-stick approach to broadcast advertising of food and drink for children is to be welcomed. The White Paper promises regulation backed up, if necessary, by legislation, if voluntary action by industry and advertisers has failed to produce satisfactory change in the nature and balance of food promotion by 2007.

An obesity strategy. The White Paper outlines a strategy for preventing, identifying, managing and treating obesity, informed by guidance from the National Institute for Health and Clinical Excellence. This is long overdue. It is well supported by strategies to encourage healthy eating and physical exercise for children and adults, and by a proposal to extend the healthy communities collaborative to address obesity at local level.

The NHS to lead by example. It is clearly stated that the NHS must lead by example, promoting health through its corporate activities such as food purchasing, capital development, providing a smoke-free environment and healthy working conditions. We welcome the decision to fund work with the Sustainable Development Commission to develop ‘good corporate citizenship’ within the NHS and to promote this model in other public sector bodies too. In 2002, the King’s Fund report Claiming the Health Dividend: Unlocking the benefits of NHS Spending vi made the case for using the corporate resources of the NHS to promote health and sustainable development.

Changing the relationship between the individual and primary health services. The proposal to introduce children’s health guides, personal health guides and periodic health checks or ‘stock-takes’ is welcome. The King’s Fund has argued for a change in the way individuals relate to the health system – from a passive doctor/patient relationship to one where individuals are seen as co-producers of their own health.vii We have suggested that individuals might have ‘health and lifestyle checks’ at key life stages and produce a ‘personal health plan’ that sets out their current state of health and what needs to be done to maintain and improve their health, with plans stored electronically and updated by the individual over the life course. Very similar ideas have been set out in the White Paper. We should welcome further testing of this approach, as one means of shifting the emphasis from treatment and cure towards health maintenance and improvement. There is a particular need to test whether this approach works for those at greatest risk of ill health – those in the most socially deprived groups and from minority ethnic groups.
Community-based health advocates or ‘trainers’. The King’s Fund has called for community-based advocates for health – already a well-established model for helping disadvantaged individuals and groups gain access to the knowledge and services they need to maintain and improve their health – to be further developed and brought into the mainstream of the health system. We welcome the proposal to introduce ‘health trainers’ (a concept that closely mirrors this idea), and for the NHS to invest in training and accrediting them. Given that people’s mental health is as important as their physical health, we believe mental health should be a core competency for all health trainers.

Employment as a determinant of health. We welcome the White Paper’s commitment to occupational health in the NHS and other organisations, and to helping people return to work after illness or injury. Addressing working conditions and other socio-economic causes of illness and well-being must be central to an effective strategy to improve population health and reduce health inequalities.

Action on smoking. The ban on smoking in enclosed public spaces including restaurants and bars that serve food is a step in the right direction. Yet the King’s Fund sees it as a missed opportunity.

Shortcomings and weaknesses

Lack of connectedness. The White Paper shows little sense of its own history, or how it connects with earlier health policy documents such as the Independent Inquiry into inequalities in health report chaired by Sir Donald Acheson and Our Healthier Nation. This suggests a desire to repudiate ‘old’ public health policies and start again. Yet earlier strategies have strengths that can be built upon. For example, the Acheson Report recommended giving priority to women of child-bearing age and children; Our Healthier Nation called for a three-way collaboration between individuals, local organisations in communities and national government, and for action in specific social settings – schools, communities and workplaces.

Reference to this kind of inheritance could help to give greater coherence and stronger meaning to the vast array of initiatives in Choosing Health. It could also be helpful for those who have to implement the White Paper if they could see more clearly how new initiatives relate to earlier ones, and if they were able to gain a stronger sense of a developing sequence of policies, one leading to another, bringing incremental change. There are real connections to be traced but Choosing Health largely ignores them.

Reconciling choice and inequality. The ideology of ‘choice’ is firmly imprinted on the White Paper. However, the task of reconciling individual choice with a commitment (also clearly stated) to reducing health inequalities will be a real challenge. The initiatives targeted on disadvantaged individuals and neighbourhoods are welcome, but it is still unclear whether the government has committed itself to the radical agenda that will be required to ensure that everyone has a genuinely equal chance to enjoy a long and healthy life. If it does not do this it will have been a missed opportunity.

Failure of nerve on smoking. The White Paper fails to follow the success of Ireland, New York and other places in banning smoking in all enclosed public spaces. Instead, it goes for a partial ban, excluding pubs and bars that do not serve food, as well as clubs. This is bound to cause confusion among customers, as well as unhealthy competition between licensees. It is also likely to widen health inequalities, as pubs that don’t serve food are concentrated in poor neighbourhoods, where more people smoke and find it harder to give up. There is evidence that a total ban would be popular with the public and has worked well in other countries. This was a golden opportunity – missed more for ideological reasons (the ‘choice’ agenda again) – than for any points of health-related evidence.

Too much dependence on voluntarism. In a similar vein, it is a pity that the carrot-and-stick approach to restricting food and drink promotion to children has not been extended to efforts to improve food content and labelling. It is doubtful whether ‘discussions with the food industry’ will lead to prompt and effective action, unless there is a promise of enforcement if voluntarism fails to show results within a specified time frame.
Shortage of detail on critical points. In spite of its prodigious length and breadth, and its multitude of announcements, the White Paper has too little detail on a number of critical points. Some proposals sound intriguing but lack substance. For example, how will the Child Health Promotion Programme, the Communities for Health scheme and ‘health champions’ operate, and how will the latter relate to the proposed ‘health trainers’? How, if at all, will ‘health trainers’ relate to the large numbers of health advocates already operating at community level? Part of the problem may lie with an apparent reluctance to connect the White Paper with its antecedents, or to develop ideas that have originated in local government rather than in the NHS. Other themes, such as mental health and alcohol, are dealt with at some length but there is little said about upstream prevention.

Too little attention to black and minority ethnic health. There are few substantive references to black and minority ethnic communities. Evidence of inequalities suffered by these groups, in physical as well as mental health, has been highlighted by the London Health Observatory. It is regrettable that the White Paper did not pay closer attention to their specific needs.

Questions and challenges

Can choice and equal opportunity be reconciled? The White Paper attempts to accommodate two objectives that do not fit together easily. The first is to transform the culture and practice of the NHS to provide a stronger focus on preventing illness and reducing health inequalities. The second is to promote a health agenda that seeks to change personal behaviour by supporting individual choice. The Government needs to articulate more clearly how these two objectives can both be pursued successfully.

Is there enough money? The Department of Health plans to invest at least £1 billion in public health over the next three years, but it is not clear whether this is all new money, where it comes from and what it is expected to cover. The White Paper makes explicit reference to investment in health education campaigns, school nurses, health trainers and obesity and sexual health services. Is there enough to meet the demands of all these objectives and how will all the other initiatives mentioned in the White Paper be financed?

How much of it will be implemented and by when? If all the initiatives set out in the White Paper were implemented within the next Parliament, there would be every reason to expect a ‘step change’ leading to better health for all and reduced health inequalities. However, everything depends on the quality of implementation, and on how well the many component parts of the White Paper fit together and work in practice.

Will there be strong and sustained leadership for change? A critical factor will be how strongly implementation of the White Paper is led from the centre. Will public health policy continue to have a high profile and be given priority at senior level across the Department of Health and the NHS? Or will it have to wait to be realised until health care problems are solved? If there is a new ministerial team after the next election, which is highly likely, will they champion the cause of implementing the White Paper, or want to start something new of their own? Strong and sustained national and local leadership, enduring well beyond the next election, will be essential.

Is there a clear story that everyone can understand and support? As the dust settles, will all stakeholders be able to share a view about what the objectives are and what can be achieved? This may be difficult, given the length of the White Paper, its many and varied announcements, and the fact that it harbours ill-fitting ideologies. Much will depend on how it is interpreted by those responsible for disseminating its messages and drawing up the implementation plan.

What are the incentives for the NHS to push the improvement of public health up the agenda? At present the NHS is receiving unprecedented financial investment. Even so, many NHS organisations – in particular Primary Care Trusts – are financially hard pressed. Given the lack of strong evidence of the cost-saving effect of measures to improve public health, it is not clear what are the incentives for Primary Care Trusts in particular to turn their attention more seriously to some of the measures proposed in the White Paper. Unless this issue is addressed, there is a risk that the excellent measures proposed will not be implemented in a sustained way, especially in the future when resources for the NHS may be tighter.
What can be done to evaluate the cost effectiveness of a range of health promoting interventions?

There is an urgent need for a programme of research to assess the impact of both the more specific (yet complex) interventions to improve the health of people with long-term conditions and those designed to improve health more widely. Evaluation of such complex, and often multifaceted, interventions is difficult, but in the short term it will be critical to examine their impact specifically on the use of health care to test the assumption that better health means less use of health care, as asserted in Derek Wanless’ first Inquiry, Securing Good Health for the Whole Population: Population Health Trends (December 2003). There may be a role for the National Institute for Health and Clinical Excellence in this respect.

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5 Please see the following website: www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm