The Smith Institute
The Smith Institute is an independent think tank that has been set up to look at issues which flow from the changing relationship between social values and economic imperatives.

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community leadership and public health:

the role of local authorities

Edited by Kevin Skinner

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Preface

Wilf Stevenson, Director, Smith Institute

The Smith Institute is an independent think tank, which has been set up to undertake research and education in issues that flow from the changing relationship between social values and economic imperatives. In recent years, the Institute has centred its work on the policy implications arising from the interactions of equality, enterprise and equity.

The government's commitment to reform the NHS is one of the defining themes of its second term and embraces the principles of devolution, flexibility and choice as the means to deliver modern health services. Reform based on these principles will move power away from Whitehall and put a premium on decisions being taken at a local level with local buy-in, bringing significant consequences for local authorities.

But this issue goes further than simply the need for devolution and introducing "contestability" in healthcare. Delivering high-quality care means understanding the holistic nature of care, shifting away from last-minute interventions and towards greater investment in preventative services.

In public health, core elements such as preventing disease, improving health and reducing inequalities were once the responsibility of local authorities. After 30 years of change, policy makers increasingly recognise that public health can be affected, for good or bad, by organisations not directly involved in the health sector, and that it is necessary to draw on and combine the strengths of the NHS, local government and the voluntary sector to promote public health. Although devolution of control is now recognised as a key principle of reform, there remain a number of important issues that, unless resolved, are likely to compromise the efficacy of local government as a key lever in the delivery of quality healthcare.

The Smith Institute, in partnership with Kent County Council, is pleased to be publishing this collection of essays by key experts in the fields of local government and public healthcare provision. We hope that their contributions will help to develop the debate on how to link up the health sector itself with the many organisations whose activities influence the delivery of public health.

Foreword

Kevin Skinner, Strategic Policy Manager, Kent County Council

Public health issues tend to be discussed within two overarching themes: first, the medical conditions that result in ill health; and second, the non-medical influences that cause ill health. Subjects such as infectious diseases, genetics and medical advances fall within the first theme, while subjects such as personal behaviours, education, poverty and environmental factors fall within the second. This monograph focuses on the latter theme – the non-medical causes of ill health – and also on the significant connections and overlaps between these two themes.

The World Health Organisation's 1984 definition of public health is:

"The extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is, therefore, a resource for everyday life, not the objective of living ... a positive concept emphasising social and personal resources, as well as physical capacities."

The official Department of Health definition of public health is: "the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society". That definition, coined in 1998 in the report *Public Health in England* by Sir Donald Acheson, reflects the essential elements of modern public health and is the one that we shall use in this discussion.

The public health outcomes sought by most elected representatives in central and local government range from a healthier nation, at the broader end, to reduced obesity, substance misuse, cancer, heart disease and so on, on a more specific basis. It is not so difficult to reach agreement now between public service agencies and central and local government departments on what are the "wicked issues" in public health, or about the broad outcomes that we seek. There is even a fair degree of consensus in the UK on the causes of ill health and health inequalities. Most policy makers agree that there needs to be a twin track approach to public health measures; the first track being to improve the health of everyone, and the second being to reduce the gap between the most and the least healthy.

Public health as an NHS responsibility

In 1974, public health formally became an NHS rather than a local government responsibility, subsequently moving from the area health authorities to commissioning health authorities and, more recently, to the smaller primary care trusts, with supplementary roles for strategic health authorities and NHS regions. Yet, it does not appear that public health has ever truly found its home within the NHS, although there are now more directors of public health than ever before (too few of them appointed jointly with councils).

Primary-level prevention has never become a top NHS priority, and unlike treatment and care services – waiting lists, bed-blocking and so on – it has not been a high priority for most politicians. The Department of Health is reorganising itself with the aim of becoming slimmer, more strategic and, hopefully, more of a department for health rather than one for illness. This may rely both on the Department of Health focusing on prevention and public health, and on the successful devolution of responsibilities for NHS service delivery to strategic health authorities and primary care trusts.

However, for the bulk of the service and its highly influential NHS professionals, the service passion will naturally always be about improving care and treatment services. This passion can lead to priorities being skewed towards investment in ever more advanced and complex technologies, at the expense of public health investments, some of which can better deliver effective (and more widely distributed) health gain. Even most local authority social services, as they have increasingly specialised – in line with the NHS – and have sought to ration scarce resources, have found it very challenging to take on a strategic public health agenda, as opposed to caring better for those most disabled or disadvantaged.

Influences on public health

In 1979, Peter Townsend helped make the concept of relative poverty more widely understood. Since the 1970s, there has been growing knowledge about the relationship between public health, health and equalities, and socioeconomic status. In the 1980s, this just seemed to make public health improvements a more daunting task. The Black report proposed reductions in child poverty as one of the keys to improving public health. Its proposed public health improvements have subsequently taken place, although the secretary of state at the time said that they were "unrealistic in any foreseeable economic circumstances".

The government commissioned *The Health Divide* from Margaret Whitehead in 1987 but it was alleged to be political dynamite. More recently, in 1998, Donald Acheson undertook an independent inquiry into inequalities in health, and employed a social model of health, with child and family poverty at the forefront of his attention. He referred to the commonly accepted Whitehead and Dahlgren social model of public health, which is represented as concentric layers of influence.

The inner layer is about the more classically researched public health "wicked issues" and where individual behavioural and lifestyle changes are required. The second and third layers are where public services are usually seen as having a specific impact upon public health, and can be well (or poorly) connected in order to influence and support the health of service users, of local communities – and of the nation.

The outer layer includes the socioeconomic, cultural and environmental dimensions: structural determinants of health. Three of the contributors to this volume were invited to address each of these three groups of determinants, in the context of community leadership and the role of local (or non-national) government. The final contribution then applies this broad social model of public health to developing policies for one particular stage of the life cycle – old age.

Targets for reducing health inequalities

In 2003, the Department of Health published *Health Inequalities: A Programme for Action*. This set out a three-year plan to carry forward the recommendations in the national 2002 cross-cutting spending review on health inequalities, with the aim of ensuring that departments deliver on their commitments and support local actions that reflect this agenda. It aspires to meet the 2010 health inequalities target on life expectancy (by geographical area) and infant mortality (by social class), by building on current work and addressing the wider causes of inequalities in the years beyond.

Programme themes include supporting families, parents and children, to ensure the best possible start in life and to break intergenerational health cycles; and engaging communities and individuals to ensure relevance, responsiveness and sustainability. They also include the themes of preventing illness and providing effective treatment and care – highlighting the NHS's own contribution, as well as addressing some of the underlying determinants of health inequalities.

Success in public health is now generally defined both in terms of improving the health of the population as a whole, and in terms of reducing the health gap between sections of the population – whether that is expressed in terms of reducing poverty or supporting independence, and so on. Ideally, new public health aspirations and success measures (targets and performance indicators) need to address dimensions simultaneously, in order to gain broad political and organisational support. There is huge potential for local and central government to work together to make better connections between and rationalise the many success measures that are designed to support positive public health outcomes.

Derek Wanless has now reported again for the Treasury, this time on how the "fully engaged scenario" for public health can be achieved in England.[1] Achieving this scenario is seen as the way to make the continued funding of a national health service viable in the long run. The report looks at the leadership role of public agencies in relation to public health, and assumes that primary care trusts will provide it, in the main.

It makes 21 varied recommendations, one of which is the joint determination of shared local objectives by primary care trusts and local authorities. Wanless review team consultees, including some leading local authorities, have advocated due emphasis on the whole public health picture. No doubt, today's nay-sayers will say that the extent of the

1 *Securing Good Health for the Whole Population: Final Report,* Derek Wanless (HM Treasury, February 2004).

improvements sought by the Wanless team is unrealistic, or that public health and its determinants are too complex for public agencies to have a significant and demonstrable impact on the bigger picture.

In spite of (or, perhaps, partly because of) the emphasis in the British NHS on top-down performance management and centralisation of political accountability, the UK does not feature among the top five in the EU league tables on any of the commonly accepted objective public health measures: mortality; life expectancy; infant and maternal deaths; cancer incidence; tuberculosis; heart and circulatory disease; and cerebrovascular disease.

In Sweden a new public health policy was agreed in 2003, which has 11 high-level, longer-term public health objectives, against which local agencies can formulate interim targets and develop indicators where appropriate. These objectives seem to be a pretty balanced set, addressing all the layers of influence on public health. So, when responding to the British nay-sayers, it may be helpful to point out that the comprehensive step changes needed in public health here are achievable – they are happening right now in a country near you!

A stronger role for councils

In the Local Government Act 2000, local authorities were given a "power of well-being"as part of an increasing (re-)acknowledgement of their community leadership rather than just their service delivery roles. This gave them the authority to do anything that other laws do not explicitly forbid, in order to improve the social, economic and environmental well-being of their residents.

It is unfortunate that this provision was not explicitly defined as a "power of health and well-being". However, it is sufficiently broad and relevant to public health and its causes to have supported several local authorities, including Kent County Council, Kirklees Council and the Greater London Authority, in their work as community leaders, as if it were a comprehensive definition.

Successive governments have justified not devolving more powers and responsibilities to local authorities – and, indeed, have mostly taken them away – on the basis of well-publicised failures by "basket-case" councils. Comprehensive performance assessment has given central and local government the opportunity to negotiate freedoms, flexibility and endorsement so that high-performing local authorities can play a fuller role in community leadership. The relative underperformance of many local NHS organisations serves to

underline the potential for councils to play a stronger part through every layer of the Whitehead and Dahlgren model, particularly where this NHS underperformance is within the area of a high-performing council.

Acting in partnership with primary care trusts at the first (lifestyle) layer, and with many other partners at other layers, local authorities are the agencies with the most levers for public health improvement. The potential positive impact that all local authorities – apart from the worst performing – could make seems to have been widely underestimated in recent years, both within local authorities and externally.

Perhaps one of the reasons for this is that public health research has sought to be evidence based, on a par with its health intervention and cure cousins – although, clearly, double-blind randomised control trials can never become the pinnacle of respectability in this particular field. Evidence needs to be of a different nature if it is to be more than just supportive of narrower, disease-control-focused policies. The Wanless report states that where there is a serious risk to the nation's health, the lack of conclusive evidence should not block action proportionate to that risk.

Investing in broader, more fundamental public health outcomes has, so far, appeared to be in conflict with the emphasis on medium-term, measurable government targets. Achieving significant gains in public health, with reductions in health inequalities, and supporting citizens' independence and quality of life probably requires 10-year aspirational plans addressing cross-cutting themes, with agreements on actions, responsibilities, indicators and outcomes – much more so than a focus on a list of performance targets. Health impact assessments have been one recent means by which public services – sometimes excluding the NHS itself – have been encouraged to consider the effects of their service policies, developments and reconfiguration proposals on the public health of their communities.

Although they make connections that are welcome as far as they go, health impact assessments are merely a specific example – too easily constrained by silo thinking – of what economists call "externalities". Externalities are not just about minimising the costs to the NHS of other agencies' actions, and the theory well reiterated in the Wanless report needs to be more broadly applied for public health. Externalities are the best means of assessing how to distribute resources and incentives equitably, such that those agencies that invest in preventative measures receive benefits or recompense, and those that benefit most contribute to the costs of the preventive effort.

Devolved service management

Local authorities, certainly better-performing ones, succeed in today's world by proactively participating in – and, often, leading – partnerships between local, private and voluntary agencies, to deliver policy and service outcomes across the board. This is true, to some extent, nationally and regionally, as well as locally. There has been a move towards increasing managerial devolution within the NHS, the education sector and other public services, but this has yet to be matched with an equivalent degree of political devolution. The new localism should be able to embrace proposals for the better-performing councils to play a stronger community leadership role in public health, – at both managerial and political levels.

Of course, a new emphasis on devolution will immediately raise another old chestnut used to defend centralisation of accountability – the "postcode lottery". There is, actually, little evidence that having locally accountable, devolved services produces either any more or any fewer disparities than does nationally accountable, devolved service management. Furthermore, for all devolved public services, there is an apparent contradiction between equity on the one hand (allegedly achieved through standardisation, although that means equitable inputs and outputs, rather than outcomes), and diversity on the other hand (allegedly achieved through individual consumer choice).

There is a paradox at work here – it is possible to fuse equity and diversity. One way is to agree national service frameworks within which there are national floor targets and standards, along with local political, cultural and consumer choices; the former two expressed through selecting more adventurous targets, authority by authority, with agreements between nationally and locally accountable representatives.

There are other new solutions being developed right now, under the auspices of the innovation forum between "excellent" rated councils and the government. One solution makes governance arrangements more devolved and robust, and makes partnership working deliver outcomes – this is ideally placed to support public health improvements. Another solution allows some strategic commissioning for reduction of avoidable hospital admissions and community reinvestment to be local authority led and government supported, without the need for structural change or competition between service commissioners.

Reference can be made to a number of other current public policy principles that further support the case for moving away from an overconcentration of public health

responsibilities on NHS bodies. These include "contestability" – choosing the best agency for the job in a particular community; and public value – the search for equity combined with efficiency and effectiveness. These could support more devolved, local political accountability for public health strategies, whether on a local authority, subregional or regional basis. This should not imply or require that the Department of Health should lose its role as the lead government department for public health; indeed, it could strengthen it.

Through the second generation of public service agreements and, where appropriate, through even more innovative means of getting robust partnership agreements to deliver, councils could also be the best agents for strategic local leadership, and for local agencies, together, to achieve national medium-term targets. They are also more likely to act in a way that is sensitive to the needs and circumstances of their particular communities, and hence to do so in a way that reduces health inequalities.

Local government is no longer fixated on taking back responsibilities en masse from the NHS, or on taking over other agencies, and most of its leaders do not like what they sometimes perceive to be continuous agency restructuring elsewhere. Elected councils might be, in many cases, the local leaders of choice for any government that seeks a radical transformation of the health of individuals, families and communities in England. Of course, they have no monopoly on innovative ideas or energy for action, and it is vital to continue to source a good supply from the NHS itself. My conclusion, and an implication to be drawn from each of the contributions in this volume, is that public health improvement on the Wanless scale will just not occur without elected councils' full engagement.

Chapter 1

Changing behaviour means working across boundaries

Professor Sue Atkinson, Director for Public Health,
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Changing behaviour means working across boundaries

Individuals and the NHS alone cannot improve people's health – it has to be a combined effort. There are clear layers of influence that have an impact on individuals' health, such as the environment and housing, employment, education and skills, availability and quality of utilities, food and agriculture, as well as health services and the broader socioeconomic, cultural and environmental conditions. These are reflected in the Whitehead and Dahlgren diagram. Many of these factors are the province of statutory and governmental agencies, particularly local government. While any individual's behaviour and lifestyle are important for their health, there are many other factors at work.

In order to improve health, behaviour needs to change – and not only that of individuals but also that of professionals. Within the NHS, this means working with other partners; in other sectors, it means ensuring that improving health and addressing inequalities are part of their policies and practices.

Lifestyle is not just an individual choice

Innermost in the circle of influence on people's health are individual lifestyle factors (Whitehead and Dahlgren). However, these are surrounded by other layers of influence – those of social and community networks, the influence that public and other sectors can bring to bear on improving people's health, and those of the overall socioeconomic and cultural environment. None of these layers functions independently and none can be considered in isolation. The overall strategic direction, the environment, and the incentives that come into play as a result of a variety of policies all influence individuals and enable them to make real choices about their lifestyle.

An apposite example would be obesity, which has been much in the news recently, with media coverage of the increasing levels of obesity in the UK, particularly among children. What are the factors that have influenced such an increase and, therefore, what are the factors that may be able to influence a reduction? At its most simplistic, this issue is about the balance of food (calorie) intake and physical activity. However, this disguises what has caused the imbalance – factors such as the availability of fast food, the economic pressures that cause families to have reduced time for cooking, or children's inability to play outside and use up energy in physical activity because of fear of crime. It is these wider causal factors that need to be addressed if a difference is to be made in individual behaviours. Derek Wanless has acknowledged this recently in his team's report, *Securing Good Health for the Whole Population*.

In terms of improving health, we need to provide simple messages about healthy eating and increased physical activity. We need, however, to make sure that we provide the right environment and incentives for people to be able to make those healthier choices about what they eat. Moreover, we need to ensure that they have the skills and knowledge to eat and cook properly and we must make it easy for them to take the right amount of exercise or physical activity.

What must be done at local level covers a whole gamut of issues, such as early learning and behaviour for healthy diets, teaching home economics skills (shopping and cooking), and making available good, cheap food – possibly through markets and food co-ops – to prevent "food deserts" on poor estates, where only relatively expensive and processed foods can be purchased. But also important, at a national level, are providing adequate incomes to families and adopting farming and food policies that encourage available local produce, put limitations on fast food and additives, and require proper food labelling.

These are all policies that can be effected only by organisations working in consort with the Department of Health and the NHS, at national, regional and local levels, to address the broad aspects of public health and to ensure that environment, incentives and strategies are pulling and pushing in the right directions.

Some good initiatives have recently demonstrated their worth and achieved win–win scenarios in several ways. For example, the national school fruit scheme, which gives every four-, five- and six-year-old child a piece of fruit a day in school, has been a real success, both in terms of take-up by schools and children and in influencing families and friends to eat more fruit. Moreover, teachers have reported the benefits of this in schools in terms of both educational focus and children's greater ability to learn, behave well and concentrate better.

We must not make the mistake of expecting that giving out information and imploring individuals to behave differently will have the desired outcome. I doubt that a campaign to tell children and parents to eat more fruit would have had the desired effect. Children experiencing and tasting fruit for themselves, some for the first time, and learning around fruit, is what has made the difference. Fruit now seems accessible to them. We need to create the environments, incentives, policies and strategies that will encourage and enable the whole population, and particularly those at greatest risk, to make change.

Partnership is crucial

Failure to act in this coherent and partnership-based way will make health inequalities worse. This has been seen in smoking, over the past 20 years. Information about the effects of tobacco on health, and preventive programmes, have been available for some time, but while those in the higher socioeconomic groups have been able to act on this message, so that smoking prevalence in managerial and professional occupations now stands at 17% (Office for National Statistics, 2002), 34% of those in routine and manual occupations still smoke. We have made the health inequalities worse by the health promotion activities, by merely focusing on individual lifestyles and individuals' behaviour.

This is where the associated layers of influence – the community networks, the actions of many agencies other than health agencies, and cultural and economic factors – must come into play. Community leadership and the role of local and regional authorities and other agencies are crucial. Many of these influential factors are the province of local and regional government: education, housing, roads, planning, utilities, environment, and so on.

There has recently been a major focus in the NHS on stopping smoking; it accounts for one of the primary care trusts' targets, and much effort and energy is being invested in tackling this and supporting people to stop smoking. We know that there are critical times in people's lives, such as when they are ill, when there is a better response to advice on stopping smoking. Both the NHS and other agencies in touch with people who are ill, such as social services, need to be able to encourage stopping smoking at these critical times. Those on the front line need to be given the tools to do this.

Over and above this, what environment and incentives could help people to stop smoking? In London recently, through the London Health Commission, the public have been asked their opinions about smoking in public places through "thebigsmokedebate". The results, from nearly 40,000 hits to the web-based survey, are that 78% would like many public places, including train stations, taxis and restaurants, to be smoke-free. Many of these locations are workplaces, so not only would making public places smoke-free protect employees from second-hand smoke, but smoke-free environments would also encourage many smokers to quit.

The NHS or individuals alone cannot achieve smoke-free public places; they can be achieved only by working in partnership with other agencies. Community leaders could give a strong lead, particularly building on the evidence of the public's views. Smoke-free

public places legislation has often been a local or regional government initiative, for example in New York City, and various Australian states and Canadian provinces.

Partnership with others, including businesses, to achieve smoke-free workplaces – building on health and safety considerations and the positive business case for a healthier workforce – or with the hospitality industry to enable greater public choice, have all been areas in which local government has, elsewhere, taken a lead. These areas could be viewed as part of local authorities' community leadership in using their power of improving well-being. Work is going on in numerous local authorities (such as Liverpool, Manchester and Brighton) to see if existing powers over licensing, planning, and so on, can be used to require smoke-free environments.

Taking another example, where inequalities among children are greatest: there are five times as many accidents to children of social class five as there are to those of social class one. Again, it is a matter of what causes these accidents and, therefore, what must be addressed. Safe play areas and traffic calming are both of major importance. Neither of these is under the control of the NHS, but local authorities have the ability to make changes and could do so through both their community leadership and their power of improving residents' environmental well-being.

The NHS in London has teamed up with Transport for London to instigate a programme of Children's Traffic Clubs to ensure that all preschool children and their families have access to information and tools to help children learn about safety on the roads. All primary care trusts in London are participating in this initiative. So much more could be done about the inequalities across London by a more concerted effort between all the primary care trusts, local authorities and Transport for London.

These are just some examples of where, while individual behaviour may be important, the influence on that behaviour and the enabling of positive behaviour is equally or more important. It is here that change is needed in the behaviour of those working within the NHS and those working in partner organisations, such as local government and business, who have the power as community leaders and policy makers to make change. Without such change, problems such as health inequalities will not be addressed, as they will not be integral to these organisations' policies.

These influences are relevant not just at the local level but also at regional and national level. In terms of influence at regional level, my own role as health adviser to the mayor

and the Greater London Authority has afforded opportunities to work across agencies. Much of this has been undertaken more recently by the London Health Commission – a strategic partnership across London, set up initially to implement the London health strategy by addressing health inequalities, regeneration, black and minority health issues, and transport.

Health impact assessment as a tool

The work of the London Health Commission has encompassed responsibility for a programme of work on health impact assessment. This involves taking the lead in assessments of major strategies and programmes, developing health impact assessment as a tool, and supporting the use of the technique by others through training and development activities. Our work has demonstrated that health impact assessment can make a difference.

A principle success of this programme, and of the London Health Commission itself, has been the completion of health impact assessments on all of the mayor's statutory strategies. Given the GLA's responsibility to take into account the impact that it has on the health of the population of London in all that it does, the mayor – an obvious community leader – committed to subjecting his strategies to health impact assessment at the early draft stage. Health impact assessment was used as a tool to gauge and forecast the effect that each strategy would have on population health. A three-stage process was followed, involving:

- a review of research evidence showing the relationship between health and the particular draft strategy (such as transport and health, and urban development and health);
- a policy appraisal workshop, with participants from a wide range of sectors;
- a report to the mayor and the London Assembly on the findings of the workshop, with recommendations.

Such a structured approach provided the opportunity for a range of stakeholders to raise concerns about the health impact of the developing strategies from their perspectives. This provided the opportunity to modify each strategy in order to increase its positive impact on health.

The mayor has now produced eight strategies, each of which was subject to a health impact assessment. In retrospect, the process provided an extraordinarily positive method of multisectoral and integrated planning for health development. An independent

evaluation of the process of conducting such assessments demonstrated that the health impact assessment process materially changed strategies as they were being developed. That is – it made a difference.

The experience of successfully conducting health impact assessments at the city and regional level, with such high-level political commitment and community leadership, is something that others may wish to draw on. It is a clear demonstration of how community and political leadership at the highest level can ensure the public health benefit of policies.

The scope of this paper does not permit lengthy elaboration of the health impact assessment process, which is still evolving. Currently, an approach to integrated impact assessment is being explored and developed. A short guide to health impact assessment and a more comprehensive resource for health impact assessment is available on the London Health Commission website at *www.londonshealth.gov.uk/hia.htm*

Bringing health and urban planning closer together

Changing behaviour is hard. It is hard for us in our personal lives and it is hard in professional life. Encouragement and support as well as knowledge are needed. At a regional level, we are trying to put some of this into action – changing the behaviour of both those in the NHS and planners – in order to influence the health and environment of new developments across London.

The mayor's spatial development strategy, the London Plan, sets out the major strategic issues facing London over the next 15 years and the proposed response. It provides the framework for all the GLA's strategies and activities. The principle challenge for public health is to develop a city environment where everyone enjoys a good quality of life, health and well-being, while accommodating the 700,000 extra people expected to be living in London in 15 years' time. The health impact assessment on the London Plan confirmed the plan's key health components.

Population growth of this magnitude (approximately 10%), matched by an increase in the number of jobs, points to the need for a significant number of new urban developments to meet the current housing shortage and the other demands of the extra people living in the city.

The GLA and national government are committed to developing sustainable communities, so that new housing is not built without reference to the components that contribute to a place becoming somewhere that people enjoy a high quality of life. It is recognised that communities need to have good-quality housing and environment, good transport links, local jobs and access to high-quality public services (including health services) and must be well governed at a local level.

A key concern for London is the practical delivery of this vision. Earlier in 2003, the Regional Public Health Group for London commissioned a study to examine how new urban developments can be influenced so that they promote health and well-being and, at the same time, support the NHS in planning the additional health services that will be needed. The aim is to bring health and urban planning closer together.

The outcome of the study was to establish a robust case for setting up a Healthy Urban Development Unit. The main function of this unit is to support the health sector practically, working with urban developers and planners on both a health improvement and health service agenda.

The unit has subsequently received backing and funding from the Regional Public Health Group, the five strategic health authorities in London, and the London Development Agency (one of the functional bodies of the GLA, charged with economic development and the regeneration of London). The Healthy Urban Development Unit is now in the process of establishing itself and taking forward a work programme across London.

The unit presents a model of supporting integrated multisectoral delivery at a local level. It provides a focal point for the health sector to link with development, and a focus to enable NHS personnel to change their behaviour in respect of planning and development and, likewise, for those in other sectors to change their behaviour in respect of health issues.

The concept of the Healthy Urban Development Unit is founded on a consortium of partners from different sectors of urban planning and health. Through it, the health sector is constantly kept attentive to new urban developments and the development sector made aware of any health concerns in implementing new schemes. What makes this unit remarkable is that its integrated and multisectoral approach to individual developments ensures that health remains a key focus, as this often gets lost or left out during implementation and delivery. The unit ensures that a multisectoral and integrated approach is maintained throughout the life of a project.

Not only is public health wide-ranging, but, without partnership working, it will not achieve the outcome of improving health. Individuals cannot on their own affect such issues as urban development and its health impact. Moreover, the responsibility for planning lies with local and regional government, so clear leadership on ensuring that health improvement and well-being are built into the process should lie there.

All these examples aim to demonstrate some of the range of public health issues and their impact on individuals' lives. They also indicate the importance of individual behaviour to lifestyle and hence health and well-being of the individual. However, and more importantly, they strive to demonstrate that this is not achievable by imploring individuals to change. Partnership working, to ensure that policies encourage, enable and ensure an environment and other factors that are right for individuals to improve their health, must be the responsibility of those who have control of the policies. In these cases, it can be seen that many agencies in the public, private and voluntary sectors are involved, both as partners and community leaders, at local, regional and national levels, and that they need to work together to achieve such change.

It can also be seen that the behaviour of those who are instrumental in developing and implementing policies and strategies to ensure that individuals can improve their health also needs to change. Working together in a more coherent way, developing their skills and knowledge, both in terms of what affects health and in terms of new tools – such as health, and integrated impact assessment – will be a crucial step if we are to achieve the health improvement and reduction in health inequalities that is needed in the UK to bring it into line with its counterparts.

Chapter 2

Local government and public health

Peter Gilroy, Strategic Director (Social Services),
Kent County Council

Local government and public health

Public health matters. In 2001, the average life expectancy at birth in Britain was 76 years for men, and 80.6 years for women.[2] But:

In the late 19th century, life expectancy in the industrial city of Liverpool was about 35 – lower than in any developing country today. A key reason for the abbreviation of those lives was the lack of safe water and sanitation, and providing these services was a decisive turning point in reducing infant death rates.[3]

The great advances in combating infectious diseases in the 19th and 20th centuries meant that people born in 2000 could expect an extra 30 years of life compared with those born 100 years earlier.[4]

Yet today we are told by the Food Standards Agency Chairman, Sir John Krebs, "What we are faced with is a situation where, if nothing is done to stop the trend, for the first time in 100 years life expectancy will actually go down."[5] Child obesity, due to poor nutrition and lack of exercise, means young people today will not live as long as their parents – the first reduction in over a century. The great majority of children in Britain do not now suffer from the ailments and diseases that shortened the lives of previous generations, such as cholera, tuberculosis and starvation, but their lives may well be affected by others:

- One in 20 children is obese.
- School-age children spend an average of 11.5 hours a week watching television, videos and DVDs, but just eight hours playing sport.
- The Royal College of Physicians estimates that up to 17,000 hospital admissions of children under five each year are as a result of their parents smoking.
- In 2003, 11-year-olds were drinking twice as much as they were drinking 10 years ago. About a quarter of 11-year-olds admitted to drinking 10.5 units of alcohol in the week before they were questioned, compared with 5.3 units in the equivalent survey in 1983.
- If health warnings such as those on cigarettes were put on alcohol, about 20% of young adults would have difficulty reading them, based on present literacy levels.[6]

2 *Securing Good Health for the Whole Population: Final Report,* Derek Wanless (HM Treasury, February 2004).
3 Akhtar Hameed Khan, quoted in *The Progress of Nations* (UNICEF, 1997).
4 *Securing Good Health for the Whole Population: Final Report,* Derek Wanless (HM Treasury, February 2004).
5 BBC News Online, 9 November 2003.
6 Dr Ann Limb, Chief Executive of Ufi/learndirect, November 2003.

In 2004, 9% of children aged between two and four years old are classed as obese, prompting a Department of Health voucher scheme to provide free fruit and vegetables for children, to encourage lifelong healthy eating habits and tackle obesity.[7] It is a particular irony that this measure is being implemented under the welfare food scheme, which was established in 1940 as a wartime measure to protect the health of young children during times of rationing.

Demographic change

The early experiences of children are crucial in shaping their future health and development, but there are also challenges created by the changing demographic pattern of the population over the next 25 years:

- From 2006 onwards, the number of older people, especially the very old, is due to increase rapidly. The 2001 census showed that over-60s outnumbered the under-16s for the first time. By 2025, more than a third of the population will be over 50.
- The fastest-growing group is the over-80s, who will treble in number over the next 25 years. In 1951, there were 270 centenarians in Britain; the predicted number for 2030 is 45,000.
- The ratio of working-age people to those of pensionable age will fall from 3.35 to 3.1 by 2011, and to 2.5 by 2031. Many more people will become carers for elderly relatives and therefore be economically inactive.[8]

While increased life expectancy is to be generally welcomed, there are concerns about how healthy these older people will be. In the last two decades of the 20th century, life expectancy for men aged 65 increased by 2.5 years to 80.4 years, while for women aged 65 it rose by 1.7 years to 83.6 years. For women, the number of years of good health that someone could expect to enjoy broadly kept pace with this, but increased much less for men.[9] Coupled with the far greater numbers of older and very old people, this could prove to be a very challenging issue for Britain as a whole.

Over time, mortality from infectious diseases has fallen, but disability caused by chronic diseases has increased. Most diseases are caused by the interaction of biological, lifestyle and environmental factors. The number and proportion of elderly people has risen, and the ageing process results in biological degeneration, which in turn increases vulnerability

7 Department of Health website press release, 16 February 2004.
8 Times Online *Sunday Times Magazine*, 15 February 2004.
9 *Securing Good Health for the Whole Population: Final Report,* Derek Wanless (HM Treasury, February 2004).

to disease. As a person ages, their cumulative exposure to environmental and lifestyle risks increases, resulting in a higher probability of succumbing to chronic disease. So, the age structure of the population is one of the most important factors in determining the pattern of morbidity. [10]

Health inequalities

But public health is not just about trying to ensure that children and older people are healthy. Sir Donald Acheson[11] identified a range of inequalities that affect individuals from different groups in society, and used a socioeconomic model to analyse the causes. Social class, gender, ethnicity, social disadvantage and deprivation, and access to services, housing, education and employment are some of the important factors in determining a person's health. Inequalities are compounded by the inverse-care law – those living in the most deprived circumstances are offered the worst services.

The Joseph Rowntree Foundation estimates that 7,500 deaths a year of people under 65 years old could be prevented if inequalities in wealth narrowed to their 1983 levels; that 2,500 of these deaths could be avoided if full employment were to be achieved; and 1,400 lives of children under 15 could be saved each year if child poverty was eradicated.[12]

This health gap has, in many ways, been widening over the past 25 years and is the focus of the government's initiative, Tackling Health Inequalities. It led to this recent declaration by the Secretary of State for Health, John Reid:

Now is the time ... to move on to a focused debate about what will help make the most improvements to the health of the public, both individuals and communities, over the next five years, and what are the most important actions for the longer term. This debate must generate some real momentum for social action in response to the huge individual and public appetite for progress.[13]

John Reid's vision corresponds to the "fully engaged scenario" recommended by Derek Wanless as the most effective way of addressing the health issues of the 21st century.[14]

10 Ibid.
11 *Independent Inquiry into Inequalities in Health* report (1998).
12 *Reducing Health Inequalities in Britain* (Joseph Rowntree Foundation, September 2000).
13 Speech by John Reid MP on 3 February 2004 (Department of Health website).
14 *Securing Good Health for the Whole Population: Final Report*, Derek Wanless (HM Treasury, February 2004).

The new agenda

The public health agenda is therefore as clear now as it was 150 years ago. The great reforms of the Victorian era and of the last century, including the establishment of the NHS, proved highly successful at combating the main killers of the time, primarily infectious diseases. The welfare state and a general increase in standards of living ensured that absolute poverty was not a major determinant of health for the vast majority of the population. Access to health services was also vastly increased.

Today we face different, but no less important, challenges – affluence, inactivity, and inequality may have as far-reaching consequences as the problems that previous generations faced. How will we address the stark inequalities that still exist? How will we enable our children to live as long as their parents? How will we ensure that people are healthy enough to enjoy the extra years that better healthcare has delivered?

Many of the early successes in tackling health problems were the result of great municipal initiatives to improve the physical environment. Clean water, adequate sanitation, environmental and pollution controls, open spaces in the cities, adequate housing and clean air were often initiated by, or through, local government. As the focus shifted to the treatment of medical conditions, investment and influence shifted to the NHS.

As a consequence, there has been a concentration in the past 50 years on managing and treating ill health, rather than on promoting and maintaining well-being. The municipal advances of the previous age have been replaced by sometimes spectacular advances in medical science and treatments – for example, organ transplants and replacement, bypass operations, chemotherapy, and cancer treatments. All of these have played a huge part in saving and extending lives, but they inevitably concentrate mainly on the treatment of conditions, rather than the prevention of ill health.

Public health information campaigns have been a staple feature of the approach to public health, but short bursts of advertising have only a short-term impact – the AIDS campaign of the 1980s was very effective at the time, but this was not sustained and young people are now less conscious of the implications of not using condoms.

The new approach

To address the wider issue of how to keep people healthy requires a much broader approach, as recognised by Derek Wanless, Sir Donald Acheson and John Reid.

There is overwhelming evidence that early intervention in the lives of children can reap enormous benefits later in life. Sir Donald Acheson highlights the need for this throughout his report.[15] The earlier, the more intensive, and the greater the quality of intervention, the greater the likelihood of sustainable long-term benefits. Examples of this range from specific interventions, such as that to provide free fruit and vegetables for toddlers, cited above, to much broader programmes such as Surestart. Another key policy thrust is the provision of high-quality childcare, and opportunities to develop parenting and education of parents – family centres, Playlink, Homestart, prenatal and postnatal care are all important in providing children with the best possible start to life and helping them develop into healthier adults.

The standard of education that children receive and the levels of educational achievement that they attain remain a crucial area of inequality and an important factor in their eventual health outcomes. Diet and exercise have clear links to school curricula.

The circumstances in which children grow up are obviously paramount – deprivation and disadvantage lead to health inequalities. There are still environmental factors that need to be addressed – poor housing and fuel poverty still exist within vulnerable populations; transport is poorest in the most deprived areas, and access to services and social opportunities is worst for the most vulnerable members of the population; poorer communities experience more crime and violence; more children die and are injured in road accidents in disadvantaged areas.

But a community is not just a collection of people living in the same place, and assisting communities is not just about improving the physical environment – it means involving local people in decision making and planning; it has to foster a spirit of co-operation and belonging, developing people's ability to be independent, if given the right support. Access to training and employment for adults, and meaningful social interactions for older people, are also priorities.

The technology gap between those with access to the internet and other high-tech communications, and those without, needs to be closed.

While a focus on areas of multiple deprivation is essential, it must also be recognised that most disadvantaged people do not live in these areas. Policies that properly address

15 *Independent Inquiry into Inequalities in Health* report (1998).

inequalities and the causes of poor health outcomes must also target smaller groups and individuals in the wider population. A good example of such a policy is the Supporting Independence programme in Kent, which is designed specifically to do this.

Prevention, not cure

To effect prevention rather than cure, the focus needs to shift away from last minute, reactive interventions, which tend to be less successful and more expensive, towards greater investment in preventative services and the creation of an environment that encourages healthy choices. Policies that give people the skills, information, and support to make and sustain healthy lifestyle choices are therefore important, for example in such areas as smoking, diet and physical activity, which have an impact on the major killers and debilitating conditions later in life.

There is a consensus that these issues need to be tackled on a broad front. The Department of Health's approach is that:

While action will be taken nationally, the main contributions will be made locally. This programme encompasses local solutions for local health inequality problems, given that local planners, front-line staff and communities know best what their problems are, and how to deal with them. Leadership and social enterprise will be important to the success of the programme and help unlock the potential within communities to regenerate areas. The local strategic partnerships have a key role in tackling health inequalities locally.[16]

While there is plenty of work for everyone and all organisations at all levels, the key question is who is best placed to deliver what is required? The co-ordination of such a broad and wide-ranging approach is complicated. There is clearly a need for the ability to translate national policy into local action, and to provide leadership while fully involving the local community and population. There will need to be a range of mechanisms available that enable consistent and effectively evaluated delivery.

Local government works with health and education, and with businesses and other social care agencies, but it also brings other facilities into play to:

- bring local leadership, for example the prioritisation and design of programmes to tackle local needs and achieve consensus on outcomes;

16 *Tackling Health Inequalities: A Programme for Action* (Department of Health, 2003).

- establish a broad vision of public health that brings together all the interconnected contributions of different partners;
- involve local people and communities, understand their needs and cope with differences, as well as bring coherence;
- guide investment in preventative services to reduce the burden, cost and personal trauma of acute care later in life;
- provide strategic intelligence on risk groups at a local level; and
- empower frontline staff across agencies.

Local government can use its experience in working within a mixed economy, and has increasingly become much more customer focused and devolved. Furthermore, it is big enough to strike deals with government that address both national and local priorities through public service agreements, and is democratically accountable to local communities and judged on outcomes.

Local government strengths

Local government is ideally placed to lead and co-ordinate a public health approach. Local government has an established track record in delivering public health initiatives. It has the statutory powers to improve the well-being of the local population, and the ability to scrutinise health services and processes. In addition, providing community leadership is one of its core activities. Above all, local government has the democratic mandate that legitimises its involvement and sensitises it to the wishes and aspirations of the local population.

Local government also has a number of robust and mature mechanisms at its disposal to facilitate the co-ordination and leadership that are required. Focusing energies into mainstreaming public health at a local level is a challenge, but a successful way forward is the use of public service agreements, which have matured partnerships and provided a focused approach across agencies, with one central objective. This does not involve organisational change; it does involve a shift of priorities in the way public expenditure is deployed, and underpinning all of this should be the principle of devolved public expenditure and empowering local people and individuals to shape their own lives and choices.

Public service agreements should be seen not as a bolt-on but as a mainstream part of business. What is important now is a focus on public-sector ownership and agreements, moving away from micro-management and leaving local government to be central government's agent in taking forward the overriding key strategic objectives.

This enhanced role for local government will result in individual solutions to tackle local circumstances, guided by newly empowered customers and staff. This contrasts with the present trend of top-down, bureaucratic and expensive structural changes that throw the public sector into turmoil and often result in additional costs and yet-to-be-proven improvements. Modernising is not simply about structural change – it is about the behavioural and cultural change of the public sector in dealing with both service users and the public in general.

Politicians should not be surprised if the modernising ingredients are more regulation and constant structural change – the service may end up costing more and be poorer in quality. The balance has to be carefully struck, and is best managed by local government. Reducing costs and improving services is important and a good example of a public service agreement partnership with central government is in Kent, where the number of "looked after children" continues to fall, against the national trend, as families are empowered.

Decentralisation

Decentralisation based on the transition between local and central government through public service agreements is an opportunity that should not be lost. There is a tension between the principles of policies and coherence of performance, and allowing local services to determine their own priorities. This demands that a careful balance be struck, and public service agreements are the best way. Local government should not be based on what is worst, but what is best.

The key challenge is to put the customer at the centre of the public health agenda and promote measures that will enable customers to realise their independence.

All too frequently public health has been seen from the perspective of individual agencies and professions, each with their own specific priorities, targets, planning and funding regimes, and monitoring and inspection burdens. The actions of individual agencies have not always come together in ways that add value to each other. Both the discipline of public health and individual customers have suffered and this must change. Authorities must cease to be inward-looking and paternalistic; instead, customers must be empowered so they can live as independently as possible and have control of their own destinies, including their own health.

Present problems

The government has attempted to build a whole set of themes into its policies – from the

economy, to learning, to modern public services – all set within a better environment, with a healthier lifestyle and a transport system fit for the 21st century, and with quality of life being a big issue for politicians over future years.

The government talks about joining up existing systems and initiatives on housing, employment, environment, health, social care, education and transport – all of which fall within the remit of local government, either by statute or by means of scrutiny.

The government is trying to focus attention across the board, but this is confusing. It has tried to suggest everything is joined up, but the problem in applying these policies is that the word "partnership" has been overused, local government has been overburdened with targets, and processes have become ends in themselves. This has had a massive impact on transaction costs, and the return on investment, so far, is looking rather fragile. The whole thrust has had elements of good and bad news. There have been successes with certain policies but it has often been disempowering, both to local government and, ultimately, to individuals, when the very aim has been to increase choice and empowerment for local service users.

In attempting to deal with these issues, the consequence may be too many specialist services, albeit multiagency, working in new silos and not joined up with other central government departments. It is not until you get to the front line, with individual customers, that everything is supposed to come back together. The reality is that a number of people from different specialisms will visit a family or individual, which is expensive and confusing. Outcomes are confusing and responsibility and energy are dissipated. This is also very confusing for the public.

One of the difficulties is funding, as it comes from multiple streams, with different sources and life spans. In the US, many excellent programmes have collapsed because of the complex funding issues. In the UK, we should have a better opportunity to create more coherence if we think more creatively about how these streams are brought together. A sharper focus by local government on the real local priorities, with fewer strategies and funding regimes, would allow for a more concerted effort and deliver better outcomes.

New thinking: the education economy

The education economy has had, and will continue to have, a central role in bringing together a range of services that can make dramatic improvements to public health. The potential of schools, as already stated, goes far beyond traditional teaching. They are part

of a wider "whole education economy" that embraces schools that are healthy and safe, both for their pupils and also for the wider community.

Schools could have an outreach role in the community and, where appropriate, could act as the centre of the hub of services to enable a more customer-focused approach to children and families. The school that never sleeps, providing seven-days-a-week service, for example, could provide restaurant meals with a high nutritional value for local people. This could also encourage the local economy by using local produce. Raising the popularity of good school meals not only provides added nutrition to a child's diet, but also offers a disciplined environment for a child to sit down and eat in a social group. If some parents were encouraged to join them, this would provide a social structure (for some of them) as well.

All these things should not distract from the principle objective – positive education outcomes. This is where the social care industry and health economy could work more creatively as a campus so that teachers do not have to be all things to all people. Again, the holistic nature of local government provides a real opportunity here.

There is a proportion of children in schools who are not inspired by traditional academic learning, and there is a shortage of health and social care staff. Agencies, including the government, should work together to devise NVQ courses and qualifications for young people in their teens. This would prepare them for gainful employment in the expanding health and social care industries, rather than focusing on an academic syllabus that is not meeting the needs or potential strengths of individuals.

Customer focus

Given how present policies are developing specialists in everything, the challenge is how the skill base can be used to benefit customers. At present, an individual customer may have to endure a number of assessments, each to assess various health and social care conditions, the need for income support or their general financial position. This is inefficient, bureaucratic and, ultimately, degrading to the customer. Single points of access and significant investment in e-commerce, with the underlying principle of perceiving the world from the customer's point of view, not the public sector's, would be better.

There also needs to be a creative approach to training and sharing of universal principles or values that will underpin organisations and be reinforced by multidisciplinary training experiences.

There is already a lot of good practice with co-location and single access points through call-centre technology and physical buildings, offering customers easier access to different services and more efficient administration of front office and back office functions. But the vision must become wider than that, so that the services of different agencies are integrated from the customer's point of view, not just from a structural point of view. Services should be judged on outcomes, not transactions.

The health and social care industries are among the few areas that provide 24/7 availability of services, but in the main these are emergency services only. It is important to ensure that the general public have sensitive advice and access outside office hours. Local government at its best is dynamic, outcome focused and understands the nature of facilitating single-access points on a 24-hour basis. The implications of joining up all public services outside office hours are more coherence for the public and more efficiency in financial terms, which will promote the noble goal of being there, while promoting the independence of individuals.

Increasing access to, and participation in, leisure activities is also a prerequisite for improved public health. Once again, this is an area in which a variety of public-sector agencies, private-sector providers, and voluntary and community groups all have a contribution to make. Some more joined-up thinking on provision, access and marketing would encourage more people to follow more active lifestyles and, as part of the structure plan, local government has the gift to take this forward.

Another area where a variety of agencies can come together and improve public health is in the broader provision of health and well-being checks. A number of employers are recognising the benefits of undertaking these and are funding their own programmes, which complement the NHS's existing health-screening programmes. Local government can build on this through checks targeted towards either particular vulnerable groups or particular localities.

The e-commerce revolution and the media

Developments in e-commerce are revolutionising the way the world operates. The increased availability and accessibility of interactive web technology to customers in their homes and local communities will affect every part of the public sector. The e-commerce revolution can support the devolution of decisions to the customer and permit customers to take responsibility for their own needs and services. The public sector must move rapidly or be left a long way behind.

The applications are numerous, but essentially come under the banner of promoting independence and giving customers much more power over their own packages of care services. Charge cards, which give consumers the freedom and choice to purchase a range of services from a range of different providers to suit their needs, are already being introduced for social care. Charge cards could be extended into broader areas of public health to promote good health, initially targeted at those at risk of ill health.

All these changes create the possibility of some visionary interactive assessment services with which people can be assessed online, their needs identified and a suitable package of services across the agencies provided. Customers can then self-manage their packages online.

In developing e-commerce enabled assessments and solutions we must be mindful that we do not exacerbate health inequalities between those who have and do not have access to information technology. Therefore, the broader availability of this technology in public areas, such as shopping centres, community centres, schools and public houses, is a prerequisite.

The way in which government in all its forms, including local government, communicates and attempts to shape public attitudes needs to be based on positive imaging and a sustainable approach, in encouraging both a sense of self-determination and responsibility for the community. It perhaps needs a smarter view of the entertainment industry as a whole and the media in particular.

Encouraging writers to think about positive imaging in soaps may feel like social engineering. But the power of advertising and the way in which the arts influence behaviour is self-evident. Public services need to use this expertise in a much more dynamic way, for example, encouraging positive messages in popular TV programmes.

Public policy should not see enforcement as the only way to change public behaviour. A new dynamic and partnership with the film, television, publishing and advertising industries should be seen as a central tenet of policy for both central and local government. Of course, overriding all these issues is the central theme of public education and long-term sustainability.

The physical environment

The government's sustainable communities plan identifies many of the improvements

needed and gives the opportunity to design in public health from the outset. But it needs to go further, and these improvements need to go beyond new communities into existing communities.

Housing is a particular case in point – we really should be planning for the demographic and other challenges that we will face in the future. With an ageing population and more people with additional needs living in the community, why are our homes not designed so that they are suitable for our whole life? They should be designed with safety and security features built in, for example, telecare and hotlines, which would make it much easier for people to remain independent in their own homes. Energy-efficient homes are also critical to combating the problems of fuel poverty and cold-related mortality, which is crucial to the improvement of public health.

With such clear and proven connections between employment and well-being, the promotion of good local employment opportunities is critical. As we know, local government and regional agencies are key to encouraging regeneration and inward investment. As for the quality of employment, all public-sector employers should be leading the way in the provision of flexible and family-friendly employment policies to reduce stress levels and improve health, including mental health. This would, of course, have a positive impact on the wider economy, by reducing sickness levels and improving productivity.

For too long, developments have been built around the presumption that people have access to private transport. New developments should encourage people to walk or cycle to essential services or, where this is not possible, reliable and convenient public or community transport should be provided. There should also be easy access to sporting and leisure facilities, and to the countryside.

Crime and fear of crime paralyses certain communities; much can be and is being done to make people feel more secure in public areas. Some of these are design issues, such as infrastructure layout and building design using e-commerce as a safety tool, while others have moved towards more public visibility of professionals called community wardens.

There are a range of other safety issues and initiatives that can affect public health, such as road safety, public disorder and domestic violence, all of which have an impact on many of the other issues mentioned in this paper in many ways. Local government is leading this initiative with other stakeholders, critically police colleagues, and is making significant changes that will have long-term positive implications.

However, it is clear that the public is affected as much by the small issues as by the large. Litter, graffiti, dirty streets, unsafe street lighting and antisocial behaviour are all well documented and, given government initiatives over the last couple of years, now have the potential to be dealt with creatively and firmly by local government, in partnership with the police authorities and central government. But it will, again, require a sense of sustainable policies, and not fashionable one-off initiatives.

Capitalising on the potential

The Department of Health is at present the lead government department responsible for making progress towards national public service agreement targets in public health. What has been demonstrated in this paper is that the Department of Health can influence only part of the public health agenda and that more of the levers are held by local government. If the case for enhancing the role of local government is accepted, then consideration needs to be given to how to achieve this.

As has been set out, local government is already doing a terrific amount to improve public health, and the potential to do more is huge. Much of what is being achieved is through partnerships – through joint planning groups with primary care trusts, or through interagency groups such as local strategic partnerships, drug action teams and crime reduction partnerships. Although partnership working is a strength, it has associated problems. Different partners come to the table with different targets and priorities, different funding regimes, different monitoring and inspection requirements and, above all else, different lines of accountability. We should also quietly reflect on whether or not we have too many partnership groups. This can paralyse and disempower action.

A way through this needs to be found, so that the contributions and resources of individual agencies can be pooled at the local level to achieve sustainable advances in public health.

The last four years have seen a different relationship emerging between central and local government. Starting with local public service agreements in 2001, and then the agreement of shared priorities between central and local government in 2002, the latest manifestation of this new relationship is the innovation forum made up of government ministers and the local authorities classified as excellent in their comprehensive performance assessment. These developments show that central government is prepared to view local government as an equal and valid partner.

This sets the backdrop for a new negotiated agreement between central government and the best local authorities, to advance public health. The agreement would need to identify the principle desired outcomes, which would need to address both national and local priorities. The local authority would then act as central government's agent to deliver the desired outcome in their area. The leadership of the local authority would assume the risk for the delivery and would be held to account for progress, both by government and by the electorate.

The other side of the deal would be a significant freeing up of controls by central government, and also the recognition by government that the local authority be expected to exercise local governance in partnership with other agencies. In practice, this means the local authority setting the public health priorities for the locality, agreeing other agencies' strategies with them, and calling to account other agencies in the area for their progress.

Local government, where it works well, is ideally placed to bring together the vision, strategy, democratic legitimacy and service response across the complex web of individual national and local agencies, thus ensuring a joined-up and improved service. Local authorities are already comprehensively involved in strategies and services that can be developed to close the health gaps and promote the well-being of their populations.

Chapter 3

Why public health must become a core part of council agendas

Tony Elson, Chief Executive, Kirklees Metropolitan Borough Council

Why public health must become a core part of council agendas

Read any historical text on public health and you will find an open acknowledgement of the importance of the wider determinants of health. It will list those factors that, a century or more ago, made such a major contribution to improvements in the health of the nation, such as a pure water supply, adequate sewage disposal, decent housing standards, regulated food hygiene and a safe working environment.

The root cause of many of these problems lay in the poverty experienced by so many people because of the lack of regular, secure employment offering an adequate living wage. Most of the actions that were taken to address the problems of poor health within local communities focused on the provision of services, rather than on improved access to income. At a local level, through the organised institutions of local government or charitable activity, people sought to compensate for the problems created by poverty. They provided basic subsidised services – for example, council housing to replace slum dwellings, free education supported by clothing grants and free school meals, and low-cost access to sport and leisure facilities.

The loss of local involvement

Providing income support rather than subsidised services has been seen as a national government responsibility since the middle of the last century. Locally based services supported through local taxation had no direct and overt role in providing income to poor families.

There have been few direct exceptions to this rule. The employment practices of local authorities and other local government agencies often used to include providing paid employment for people who would struggle to retain employment in the private sector. From the 1970s, the push for greater efficiency, coupled with competitive tendering, forced many people who were less than fully efficient out of the public-sector employment market. Many low-skill jobs in gardening and kitchen work disappeared altogether. The push for greater output from fewer people destroyed many entry-level jobs in the public sector and training levels for unskilled people fell significantly.

Traditional jobs in blue-collar work no longer guaranteed the relatively well-paid and secure future that people had come to expect. Competitive terms and conditions eased the tax burden, but also led to a shift in the profile of the workforce retained within the public sector. Budget reductions hit blue-collar posts far harder than white-collar employment.

While this role as paternalistic direct employers diminished, local authorities strengthened their activity in economic regeneration. Without very clearly defined responsibilities in this area, they still managed to develop new ways of supporting business growth. They helped people in dying industries to make the move to emerging industries, and stretched their educational responsibilities as far as possible to support skill training to help people back into work. They used their limited capital investment to encourage private firms to invest in training. They developed new partnerships to redevelop their areas and stimulate their local economies.

However, these kinds of development were not driven by the goal of health improvement for the most deprived areas of each council area. They built on a more general motivation, to encourage the physical regeneration of run-down areas through wealth creation. The very real health benefits that accrue from alleviating poverty were rarely identified in the early stages of intensive regeneration-based projects.

Shifting the emphasis

Why were councils so narrow in their understanding of the kind of truths that previous generations had taken for granted? It was, perhaps, an unintended consequence of the creation of the NHS that the emphasis moved from these wider determinants to a focus on medical models of intervention. The success of immunisation and screening programmes, the development of new and dramatically effective forms of drug therapy and surgical interventions, and a better understanding of lifestyle factors as causes of ill health have moved the agenda firmly into territory occupied by the medical profession.

Perhaps the 1980s and 1990s marked the watershed for this tendency. Government policy played dangerously with an implicit (and sometimes fairly explicit) belief that, in a world of effective medical intervention, poor public health could be blamed on the reckless irresponsibility of the individual. Eating chips, smoking and failing to take exercise were examples of moral weakness and the failure of people to live up to their responsibilities to the more responsible taxpayer, who ended up footing the bill for their recklessness. The language used was not about health inequalities but about health variations, and government seemed to distance itself from any sense of responsibility for what was happening.

The failure of one of the main public health publications in this period, *The Health of the Nation*, even to contemplate poor housing and poverty as causal factors for poor health will, no doubt, become an interesting if somewhat puzzling case study for social historians in years to come. How could this happen? Let me leave some clues to help them unravel the mystery.

I suggest that the cause was, and to a large degree remains, a breakdown in the effective governance of health. However, to build my case I need first to widen the debate a little.

Let us remind ourselves of the events of the last 50 years. The creation of the NHS in 1948 marked a major change in public provision. These changes have received widespread support in the years that have followed. Political parties that have been portrayed as threatening the future of a service committed to the treatment of sick people, free at the point of delivery, have paid a high political price.

Without questioning the value of this service, it is, however, possible to point to some of the unplanned consequences of the creation of the NHS.

Side-effects of the NHS

First, the dominance of a model of provision that focuses on sickness and ill health, rather than on the promotion of good public health. It has for many years been a source of some frustration to me that while we have mountains of data measuring the prevalence of sickness, we have few well-established measures of good health.

Whenever the challenge has been taken up by the health service, the debate has had a surprising habit of returning to measures of the incidence of cancers and heart disease. Important and necessary measures as these are, can they really be a sufficient test of the health status of the population, most of whom are not suffering from the symptoms of cancer or heart disease at any point in time?

Second, the health service has been and remains an essentially responsive service, reacting to demand generated by the expectations of the public. The disproportionate influence that frequent users (sometimes disparagingly referred to as the "worried well") have had on its development has worked against approaches that seek to improve the health of those who do not regularly present themselves at the doctor's surgery.

Third, the health service was founded on a premise that the state could meet all demand for healthcare, but there never seems to have been any credible attempt to establish how much the full cost would be and how it would be met. The consequence has been the development of many different forms of rationing, almost always undeclared and often unrecognised, but nevertheless effective in suppressing demand. The differential impact of these rationing mechanisms on different parts of the community has also frequently gone unnoticed.

Finally, the value placed on a service that provides a uniform, even-handed response to people seeking treatment, from Land's End to John O'Groats, reflects an assumption that people with differing backgrounds, cultures and expectations will all place similar demands upon the health service; perhaps not too surprising an assumption, when resources have always seemed to lag behind demand, and where widening access to services can be seen as a quick route to longer waiting lists, overspent budgets and, in the modern world, lower performance in areas that affect your organisation's star ratings!

In a world where we no longer question the evidence that the health status of the population is unequally distributed, planning still seems to cling to an unconscious belief that need is distributed uniformly across the nation and across local communities.

The paradox is that when you actually examine the way the health service has allocated resources, you find evidence that allocation reflects demand, not need, and more money has often gone into helping parts of our community that have significantly better health than more disadvantaged areas. Parts of our community that do not have established traditions of using services will continue to receive lower levels of service. New populations that have particular health needs and cultural expectations of the health service have struggled to receive recognition.

Prioritising the public health agenda

For all the talk of a national programme to tackle health inequalities led by primary care services, I would suggest that there is unconvincing evidence of any major attempt to redistribute resources to reflect health need.

This analysis is not intended as an attack on the existence or competence of the National Health Service. As I have indicated, there is strong public support for services that address the concerns of people who are unwell, and it is not surprising that this agenda has dominated the thinking within the NHS.

I know that when I am unwell I want to have local access to a doctor, and that I do not want to wait for tests or treatment. Nor do I expect to be told that I cannot receive some essential but expensive treatment because the money needs to be spent on a number of other people who will benefit from services to promote their general health and well-being. I do not need to be pushed very far before I can hear myself saying that I pay my taxes and my national insurance, and I expect a service in return.

What this text does point to is the very real difficulty that will be experienced by anyone concerned with the management or governance of an ill-health-dominated service, in giving equal weight to the public health agenda.

We need to strengthen the sense of responsibility and ownership, for this area of work, of those people who traditionally did play a major part in promoting public health. We need once more to engage those who work in local government, whose day-to-day agendas are inextricably linked with initiatives that impact on public health, and who have the detailed understanding of the inequality that exists within and across communities.

It is only by reawakening a sense of responsibility at this level that we can hope to create sufficient leverage to make the promotion of the public's health a mainstream part of public policy once more.

Why a reawakening? The reasons are simple. With the birth of the health service in 1948, local government gave up its traditional responsibilities for this area of public service. The effect was compounded with the transfer of formal public health responsibilities from local government to the NHS in 1974.

Local government accepted the implications of these changes. I recall many discussions with councillors in the 1980s who could see no reason for their council to give any attention to health matters, as that was "an NHS responsibility".

Once again, this is understandable given the circumstances at that time. We were seeing very substantial increases in expectations of local government, which led to the feeling that we had enough to do to meet our own agendas, particularly given the relentless pressure to keep costs down at the same time.

There was also a great deal of suspicion about cost-shifting, with the closure of long-stay hospitals and the introduction of community care. Whether it was intended or not, there was a lot of empirical evidence that local government was being asked to pick up the bill for changes in eligibility criteria and services that had traditionally been provided by the health service.

Our obligation to the individual

The contrast between the responsibility of local government for the health of their communities in this country and that in other countries was well illustrated at the

international local government conference held in Manchester in the early 1990s as a follow-up to the United Nations Rio conference on sustainable development. Local government here had great difficulty in contributing positively to the discussions on the health themes that, elsewhere, were seen as part of the core responsibilities of local authorities.

Against this background, those of us who have sought to argue the case for local government to have a strong role in public health have had an uphill struggle. The problem is less a difference of views about the aims than a failure to understand the part that we must play in finding solutions. No one argues any longer that health inequalities do not really exist, or that if they do then it is simply the result of individuals who fail to make the correct life choices.

Certainly, people do have a responsibility for maintaining their own health, but society, through publicly funded services, needs to ensure that they have access to the basic social requirements and have the opportunity to acquire the personal attributes that enable them to exercise genuine choices in their lives.

In other areas of public policy, local government accepts its role with confidence and commitment. The duty to promote the social, economic and environmental well-being of its area is welcomed as a general statement of the purpose of local government.

The acceptance of the promotion of public health, and the tackling of health inequalities as one of the shared priorities agreed between local government and central government, was an important step forward. It signals the renewed interest of local government in the health agenda.

Where local authorities get it right ...

Through local government's community planning role, exercised increasingly with local strategic partnerships, it sets an agenda for local action that contributes to the health of the community, even when that is not seen as the primary objective.

Councils argue strongly for the need to preserve their responsibilities for local education, and strive hard to address educational disadvantage and underperformance, building on their knowledge of the local area.

They accept a responsibility for supporting children in their early years, not only to protect them from neglect or abuse, but also to give each child a secure start in life that

can counter the effects of poor parenting.

Local authorities accept responsibility for the homeless, and strive to ensure that there is an adequate supply of affordable housing that meets basic standards of decency. They work to counter the problems of neighbourhoods in decline, and seek to create employment opportunities and positive support to communities where this is necessary. They have programmes of work designed to alleviate poverty.

They accept a growing responsibility for tackling the kinds of social disorder that can lead to the collapse of community life, and can cause individuals to live in fear and depression.

Councils provide resources to promote healthy leisure and recreation opportunities for those members of the population who have insufficient income to buy gym memberships or join private sports clubs. They actively promote the involvement of sections of the community that do not traditionally participate in organised leisure activities, and see this wider engagement as part of the mainstream duties of a successful local authority.

They seek to reduce the risk of accidental or unintended injuries to people on the roads, as well as through food hygiene and health and safety regulation, by licensing public events and by planning for civil emergencies.

Through their traditional roles in social care they provide support to those who – through the frailty of advancing years, through chronic sickness, or because of disability – are not well-placed to care for themselves.

These examples, and many more, illustrate the kinds of activities that local government accepts as its core agenda. All of these examples describe activities that have a significant impact on the health of part or all of the community. Some of the impact can be seen in the short term, some over longer time-scales.

In each area, if you ask those involved to describe the work they are doing, they will be unlikely to categorise it as a health initiative. The language and the customs of local government, for the reasons outlined earlier, do not lead to mind-sets that use health gain as a primary justification for action.

... and where they get it wrong

Of course, if everything that needed doing got done without people paying conscious

attention to it, there would be no major problem. Unfortunately, this is not the case. Opportunities to maximise the health gains that can be achieved with little change in focus by mainstream services are missed, because those charged with responsibility for service delivery are not tuned into their responsibilities under the health agenda.

This is particularly true when it comes to addressing health inequalities, not least because many local government resources are already committed to working with the same groups of people who face the greatest health disadvantage, and the problem of poor health makes the achievement of so many local government objectives – like educational improvement, secure employment and socially responsible behaviour – more difficult to accomplish.

Which brings me back to where I began. Major improvements in public health and a narrowing of health inequalities must be built, in large part, on a wider acceptance within local government that this is a core part of council agendas. This is important so that opportunities are taken to plan and deliver services in ways that maximise a positive health outcome, and address the underlying problems of poverty that restrict choice and limit people's ambitions and expectations.

All those charged with the responsibility for local governance – councillors and senior managers – need to accept responsibility for ensuring that this happens.

Within the NHS, the focus has, to date, been so strongly on the problems of treating the sick that the longer-term public health agenda has been too often passed over in favour of today's priorities. It is not easy to see how in the short term those responsible for the governance of primary care and hospital services will be helped to turn their attention from waiting-lists and budgetary pressures to develop what for many will be a new agenda.

It is certainly possible to identify the positive role that health managers and non-executive members could play in the work of local strategic partnerships. Through their public health professionals they can help local government and other partners identify the health impact of the things they do and make positive changes. But this assumes there is capacity at senior levels within the health system to take on new partnership roles, which will be time-consuming, certainly in the early days, and will be challenging to people whose experience to date has been dominated by the need to respond to the problems posed by sickness.

Both central and local government have pledged themselves to tackle health inequalities

during the first decade of this century. There is no shortage of commitment to the principle. Traditionally, there have been concerns that we did not understand the causes of health inequalities sufficiently to achieve improvement, but that argument is no longer as strong as it was.

The challenge of change

The main obstacle lies where so many problems of translating public policy into practice have fallen over the years: a failure to understand and address the process of how we implement change. It is the need to recognise that unless there are sufficient people available with a clear understanding of the things that need to change, and the time available to lead the change process, progress will be limited.

We see in the Programme for Action on Health Inequalities a government statement of the problem; a very thorough analysis of the changes that need to take place, but no real detail about how the change will be implemented.

Exactly how will the key leaders of this change be identified? How will they be helped to understand the scale and nature of the changes that are necessary? How will their priorities be reordered so that they are given the time to commit themselves to this new work? What will motivate them to take this task on in the first place – the incentives and performance management framework that will shape the changes?

Having posed the difficult questions, let me finish on a positive note. None of this falls into the "too hard to tackle" category. It is all achievable, given time and clear leadership from the top. But that assumes that there is a will to give a very high priority to a future where people have the best health possible, rather than existing just above the sickness line, and where individuals are not destined to lead shorter, less healthy lives because of social factors that fall outside their personal control.

Local government, like most local delivery organisations, is populated by people who are intrinsically well-motivated and have a great deal of experience of delivering change. They need stronger leadership if health improvement and narrowing health inequalities are to become part of the everyday thinking that underpins the way services develop and are delivered.

Chapter 4

Living well in later life: from prevention to promotion

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Living well in later life: from prevention to promotion

One of the most fundamental objectives of public policy is to promote and secure health and well-being for all citizens to the fullest extent possible. In the case of older people, these objectives may be expressed in terms of policies to ensure that, individually and collectively, citizens experience the later years of life as ones in which they live well and age successfully. These concepts of "successful ageing" and "living well in later years" are essential elements of genuinely comprehensive and person-centred policies for the later years. In particular, they:

- imply a proactive and promotional approach to ageing, rather than one that seeks merely to slow down an apparently inevitable process of physical and intellectual decline;
- promote a positive image of age, ageing and older people, not only to reduce discrimination by society, but also to empower older people themselves;
- focus on effectiveness criteria rooted in aspirations for the quality of later life as well as in the lived experiences of individuals and communities in their later years.

In short, these concepts and approaches are central to any public policy that seeks to be person-centred and responsive to standards set by its actual and potential beneficiaries. Consequently, the goals of successful ageing and living well in later life are centred in the demands and needs of individuals and communities for maximising their well-being, rather than in those of provider groups and organisations for managing demands on their resources.

Redefining prevention

In this context, the twofold definition of prevention advanced by Wistow and Lewis (1997) remains relevant, if only in highlighting the limited nature of conventional policy thinking. Their suggestion was that prevention should be conceptualised as:

- preventing or delaying the need for care in higher-cost, more intensive settings; and
- promoting the quality of life of older people and their engagement with the community.

The first of these definitions has underpinned community care policies since at least the Guillebaud report almost half a century ago (see Wistow, 1995). It has also provided the underpinning for much of the revival of interest and investment in prevention and rehabilitation over the last decade. In practice, it may be described as person-centred as well as resource-focused, given the extensive (and comforting) evidence that older

people generally prefer to live in their own houses and familiar environments. However, while such settings may, from some perspectives, provide the highest value, they may not always be provided at the lowest cost – as the imposition of cost limits on community care packages clearly demonstrated.

This definition provided a valuable focus for the "rediscovery" of prevention and rehabilitation in the 1990s. It is increasingly clear, however, that a more comprehensive approach, embracing the second dimension more fully, is required to promote health and well-being more effectively. In the last decade, a number of policy drivers supported increased priority for prevention, especially under the first definition (see first box).

As a result, central government provided the first ever earmarked resources for prevention, and requested local agencies to develop comprehensive policies and strategies at the local level. In practice, much of the resulting planning and expenditure emphasised secondary and tertiary prevention from the perspective of health and social care agencies. Priorities in primary prevention were developed much less extensively, particularly those encompassing the wider local-authority community leadership role and the NHS health development function.

Prevention becomes a priority
- Rediscovery of rehabilitation
- Cost of continuing care
- Perverse consequence of post-1993 targeting
- Managing demand on hospitals
- Value of low-intensity support recognised
- Engagement, citizenship and successful or active ageing
- Initiatives for a healthier nation and healthier ageing

Invaluable as this experience was, it is now necessary to adopt both the elements of the original prevention definition in order to advance more comprehensive strategies for primary prevention as part of the wider promotion of health and well-being. Fortunately there are, again, a number of policy drivers that are supportive of such an approach (see second box).

Taken together, these forces are generating a sharper focus on the promotion of health and well-being through the reduction of inequalities, the promotion of community capacity

building, the reduction of social exclusion and the strengthening of local democracy. Each of these elements is reflected in a recent World Health Organisation conceptualisation of "active ageing" as the "process of optimising opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organisation, 2002).

Developing recognition of importance of health and well-being

- Promoting healthy and active life in old age (Better Government for Older People)
- Wanless report on compressing morbidity
- Recognition of inequalities in health and life expectancy
- Local strategic partnerships and community plans
- New localisation and sustainable communities
- World Health Organisation "active ageing"

The term "active ageing" could too easily convey a meaning limited to physical activity. However, the concept advanced by the WHO – continuing participation in social, economic, cultural and civil affairs – together with its understanding of health as embracing mental and social, as well as physical, well-being, approximates to our own understanding of "successful ageing" and "living well in later life". In practice, we prefer the latter terms because they are less open to meanings or understandings restricted to the physical dimension of ageing.

Inequalities in health and well-being

The recently published national action plan for addressing health inequalities (Department of Health, 2003) has a number of important implications for living well in later years:

- It reasserts the centrality of health status and health outcomes (broadly defined) as a driving force for health policy more generally.
- The action plan's emphasis on the evidence of gross inequalities in life expectancy (some 10 years' difference for males born in Dorset and Manchester) and associated patterns of illness, highlights the need to see successful ageing as a lifelong process, rather than a policy that kicks in at some arbitrary later point in the life course.
- In addition, with life expectancy for males aged 65 being two-and-a-half years greater for social classes one and two (and two years for females) than for social classes four and five (Acheson, 1998), the action plan highlights the existence of inequalities in health experience within the older age groups.

Alongside inequalities in access and outcomes within the older population, inequalities also exist between age groups in terms of the impact of ageist and discriminatory policies (Grattan et al, 2002). Finally, the equalisation of outcomes and access as part of strategies for living well in later life should not obscure the equally critical importance of "dying well" and of equalising opportunities for a "good" death, as well as for a "good" life in later years.

Inequalities in health and well-being are not independent variables. Rather, they reflect the interplay of factors as diverse as genetic make-up and individual behaviour with social, economic and environmental factors in the community. Therefore strategies for reducing inequalities and improving health outcomes and strategies for successful ageing share a recognition that public policy must address the full range of such influences on health status. Successful ageing requires a cross-government focus, whether centrally or locally, that engages with communities and individuals as well as the full range of public and private resources.

Engagement and capacity-building

A commitment to promoting successful ageing invites questions about how success is to be defined and whose standards are to be applied. These issues, in turn, suggest further questions about how growing older is experienced by individuals and their networks of family, friends and neighbours (where these exist). In addition, it is necessary to understand, reinforce and modify those factors and influences that are experienced as either contributing to, or undermining, positive experiences of ageing by all relevant parties. The adoption of such a perspective leads to a number of understandings:

- In practice, older people are active agents in managing their own ageing by minimising losses and maximising gains (Baltes and Baltes, 1990).
- Such individual processes of decision making need to be located within the social and material contexts of people's lives (Godfrey and Randall, 2003).
- Successful independent living appears to be related to the quantity and quality of family and social networks as providers of emotional and social support (ibid).
- People are more likely to be healthy when they live in neighbourhoods where there is a sense of pride and belonging – social cohesion and strong networks benefit health (Department of Health, 1999)
- Social and productive activities that involve little or no enhancement of fitness lower the risk of all causes of mortality as much as fitness activities do (Newton, 2000).

This evidence suggests that the two most important elements of a strategy for successful ageing should be control and interdependence, in contrast with the more conventional description of choice and independence as the core public policy goals for people in later life. There is evidence that mortality and morbidity are more strongly related to the experience of control over one's life than the exposure to health risks as such. In addition, there is some evidence that community-based social capital is associated with better health status (for example, Wolf and Bruhn, 1993).

From a number of perspectives, therefore, it appears that the ability to live successfully in local communities is based more on interdependence than independence. Older people need to be able to give as well as receive if they are to maintain their self-esteem and sense of purpose in life. In practice, therefore, it is the interdependence and social integration of individuals in local communities that make possible the independent lifestyles on which public policy has more traditionally focused (Wistow, 2002).

Policy and practice implications

This paper has argued the need to achieve a better balance between a prevention agenda understood primarily as avoiding high(er) cost, intensive care settings, and one that addresses the root causes of "unsuccessful" ageing and a poor quality of life in later years, including inequalities in health between individuals and groups over their life course as well as between different age groups. In addition, it has identified evidence suggesting that control and interdependence are fundamental to successful ageing.

Consequently, these concepts should supplement, if not replace, the more conventional emphasis on choice and independence. Without autonomy and control, choice is an unrealistic, if not specious concept. Similarly, independent lifestyles that are judged to be successful and fulfilling are generally determined by the extent and quality of relationships with others, together with the extent to which social cohesion provides economic, social and psychological security in later life.

More specifically, the above discussion implies that promoting health and well-being in later life requires holistic policy and practice developments at three levels: individual, community and government. The interdependence between the first two levels has already been identified. In addition, a holistic approach at all levels of government is essential to secure cohesive policy and practice interventions at, and between, each of the first two levels.

From the perspective of social care and social services, distinct contributions are possible and necessary at each level. At the individual level, holistic assessments should take account of existing, emerging and future needs in the context of family, friends and community networks. More fundamentally, a basic social-work approach should identify needs and resources, so that individuals can be empowered to make appropriate decisions and transitions at different points in their life-course. Such an approach is fundamental to successful ageing, defined as achieving a personally acceptable balance between gains and losses.

Further, the interdependence between individuals and community networks is an essential element in the provision of social care. Community as well as individual capacity-building is, therefore, a necessary social care contribution to the promotion of health and well-being among all age groups, including older people (Wistow, 2002).

However, community development processes that succeed in interweaving formal and informal contributions to successful ageing remain underdeveloped in social care practice. Similarly, the aggregation of data about needs and demands, from individual to local community and wider population levels, could be a powerful planning tool when allied to understandings of the dynamics of successful ageing. Again, it is the holistic perspective of social care that could make a critical contribution to living well in later life.

Finally, in central and local government, the capacity to understand policy interdependencies and to promote partnership working at all levels in the policy and practice systems could be a valuable impact for social care. This might include promoting and supporting the community leadership role of local government and advocating an effective cross-government approach to ageing. One of the implications of moving from prevention to promotion is that the range of partners and partnerships needs to extend well beyond traditional health and social care services. At the same time, there remains an essential need to ensure that such a shift in emphasis takes place.

Social care agencies are well equipped in terms of values and understandings to fulfil such a role. We have suggested that this broadening-out of preventive strategies will enhance successful ageing; we need to embrace the proactive promotion of successful ageing. In this context, the role of social care is to lead, lobby for, and secure the co-ordination of public policy interventions that enable local populations to live well in later life, and in accordance with their own criteria for successful ageing.