Consultation response from the National Heart Forum

Consultation:	Securing good health for the whole population by Derek Wanless
Consulting body:	HM Treasury
Date:	December 2003

THE NATIONAL HEART FORUM AND THE UKPHA SUBMISSION TO:

HM Treasury Review:
Securing Good Health for the Whole Population by Derek Wanless.
December 2003

INTRODUCTION

1. The National Heart Forum[1] (NHF) and the UKPHA[2] warmly welcome the opportunity to contribute to Derek Wanless's Review for HM Treasury: *Securing Good Health for the Whole Population* which seeks to make recommendations to achieve the fully engaged scenario mapped out in the Wanless Review 2002 *Securing our Future Health.* This fully engaged scenario was the least expensive and delivered better health outcomes. In this submission **the NHF and UKPHA strongly advocate that to secure the good health of the whole of the population along the lines of the fully engaged scenario[3] a sustainable comprehensive, cross government, public health strategy which focuses on a life course approach to avoidable chronic disease must be implemented. This should be supported by sufficient investment in public health research and infrastructure. The NHF and the UKPHA believe that investing in public health is the key to reducing unnecessary demand on the NHS and can have a substantial impact on reshaping and modernising services.**

PUBLIC HEALTH IN CONTEXT

2. Public health is the *'politics'* not just the "*art and science*" of improving health. It is about advocating & supporting social change which can only be brought about via the political arena. **In order to achieve the fully engaged scenario we need social change; in order to achieve social change we need sustained political commitment to better population health.**

Political priorities

3. Public health has been a Government priority in rhetoric only – welcomed policy statements have not been matched by actions or effective implementation. Waiting lists and healthcare services have always taken precedence over improving health and avoiding chronic disease. **There has been no long term planning for public health and insufficient investment in public health action, research and infrastructure - especially in comparison to the medical sciences. This Review however signals a significant shift in this**

[1] See Annex A: *About NHF*

[2] See Annex B: *About UKPHA*

[3] Fully engaged scenario: the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive with high rates of technology uptake.

balance and is warmly welcomed and encouraged by the NHF and the UKPHA.

4. Much criticism has been directed at the public health service, but it must be acknowledged that over the years it has suffered neglect, fragmentation, lack of capacity and has been starved of financial resources and relegated to an 'also ran' status within political priorities.

5. Public health (usually a long term endeavour) is a victim of the political cycle: investment in public health is often short term and not sustained. **What is needed is political will, sustained over time to comprehensively tackle ill health and heath inequalities, rather than topical short lived vote winners. Clear, informed and committed leadership is needed.**

Recent developments

6. There have been promising developments in public health policy over the past eight years; the appointment of a minister for public health and the public health white paper *Saving Lives* were warmly welcomed and commended by the public health community; but we were disappointed that *Saving Lives* was largely superseded by the *NHS Plan* which focuses on investment in health services and contains only a short and insufficient chapter on public health and health inequalities. Investment and modernisation of treatment services is applauded, but not at the cost of health improvement measures. It is important to note that the rising percentage of GDP spent on health care is an opportunity cost: the larger the proportion of GDP spent on health care services, the smaller the proportion that is available for other goods and services, including major public goods which have an important preventive health impact.

7. We understand that the Department of Health is reviewing the *Saving Lives* White Paper. **The NHF and the UKPHA recommend that this should be published and open to expert consultation, with a view to re-launching it as a national public health strategy. This should coincide with the elevation of the role of public health to cabinet level to ensure cross government political commitment**.

Public health functions

8. One of the obstacles to the development of public health policy is seen as the broad reaching functions of its practitioners. The Faculty of Public Health separates these into three roles: health protection, quality of health and social care, and health improvement. These three roles are all crucial to public health, but each is quite distinct – even though there may be some overlap, each requires different skill sets from their individual specialists; no one specific discipline can cover the whole range. Although, often the three roles are undertaken by one practitioner – largely clinicians. This has resulted in an imbalance between the three functions, with health improvement losing out, and issues of health protection and quality taking precedence. This in turn has led to the focus by public health professionals on communicable disease and care standards, rather than on the prevention of non-communicable disease which causes greater morbidity and mortality.

9. **We strongly recommend that the three functions of public health practice be viewed as distinct disciplines, with a greater emphasis on health improvement.**

10. **More resources should be channelled into the development of health improvement training for public health professionals.**

Social justice and inequalities

11. Public health is fundamentally political by its very nature as an advocate for social chance, therefore we suggest that there should be a move from the language of 'health' towards the 'politics of health'. Public health needs to be properly contextualised and viewed in the context of social justice rather than the narrow, and usually bio-medical, often victim blaming, conception of 'health'. The issues which face public health improvement are often about inequality and should be addressed in the context of social justice: poor housing and education often accompany health inequality. **By couching public health within the context of social justice it will enable this issues to be adopted across all sectors and at all levels. As a consequence more importance would be attributed to health improvement/disease prevention.**

PRIORITIES FOR PUBLIC HEALTH

Avoidable chronic disease (ACD)

12. **Priorities for public health must be the avoidable leading killer diseases: heart disease, some cancers and stroke. Public health policy must address the linked determinants of these diseases which include physical inactivity, diet, obesity, poverty and alcohol.**

13. Avoidable chronic disease (ACD) prevention must be the priority for public health given the 20 year timescale the Review is considering. ACDs and their determinants are the only logical focus for bringing together many public health priorities and perspectives. This claim does not detract from the importance we confer to communicable disease control which the new Health Protection Agency deals with directly.

14. Public health priorities should be set on the basis of a combination of
    a) the impact of the attributable and avoidable disease burden on the NHS and the social economy of England
    b) the scope for reducing the level of modifiable population level risk factors
    c) the need to invest in sustaining low population levels of the main risk factors.
    d) The priorities should be described and apportioned using a lifecourse approach.

Primary prevention of ACDs

15. The main disease burden on the National Health Service (NHS), and social and economic burden on society, is disability, morbidity and premature mortality caused by the linked and avoidable chronic diseases. Coronary Heart Disease (CHD) and Stroke, obesity, hypertensive and respiratory diseases and type two Diabetes share common linked lifestyle risk factors including diet, physical inactivity, tobacco, alcohol and elevated blood pressure. **The Government should be investing in primary prevention to reduce the prevalence of these risk factors at a population level, therefore reducing the incidence of these diseases and consequentially the demands on the NHS.**

16. Despite the potentially huge impact of primary prevention on ACDs, this has been a marginal activity for the NHS. Currently a very small proportion of health expenditure is spent on population health programmes at national and local levels. Rather, actions through the NHS are in the most part unsystematic and focus on high-risk individuals late in life and primary prevention efforts have been under resourced, piecemeal, and, in the main, short term.

17. This is a crucial opportunity missed given the potential returns on investment in shaping NHS demand. **We strongly recommend that primary prevention is positioned at the centre of NHS, and cross government, resource planning, in order to reduce the future demand on its services and achieve the fully engaged scenario.**

National Strategies

18. At national level we believe that there should be comprehensive national strategies for the promotion of healthy nutrition and physical activity - equivalent to that set for tobacco in the White Paper *Smoking Kills*. The DH is developing a food and nutrition action plan as part of the Government's sustainable food and farming strategy under the auspices of DEFRA, and is also developing plans for the promotion of physical activity with the DCMS as part of the implementation of the Government Strategy Unit's *Game Plan*. However plans for both are still at an early stage of development, despite their announcements some time ago. They are also of questionable status in terms of Government commitments, not least because in neither case was the DH the initiating agency, and they lack the comprehensive action signalled very clearly in *Smoking Kills*.

19. To date no comprehensive long term national inter-sectoral plan of action has been developed. There have been excellent national initiatives such as the free fruit scheme but these should be part of a much bigger strategic programme of sustained long-term action. **It is fundamental to the achievement of the fully engaged scenario that there are substantial, comprehensive and competent nation-wide, harmonised, strategies for physical activity and nutrition – which have strong leadership and direction from Government.**

20. **The Government should also set out the next wave of concerted action over the next five years on tobacco control, smoking prevention and smoking cessation following the successes of *Smoking Kills*.**

A national plan for children and young people's health and well-being

21. In addition there needs to be comprehensive national plan for protecting and promoting the health and well-being of children and young people. The origins of the ACDs begin early in life at critical periods of development and have a cumulative effect throughout childhood and into adulthood. The NHF has set out the scientific and policy basis of such a national plan in the *young@heart* initiative (2002). Primary prevention must begin in early life and continue throughout adolescence if the policy is to reduce disease incidence and prevent the epidemic of ACDs our children and young people face in 20 and 30 years time. The health indicators for children and young people are of great concern, they exhibit worrying trends in diet, physical inactivity and smoking, and will be an increasing burden to the NHS. Given the ageing demographic trends in England this is a major public policy issue for the sustainability of the economy. The National Service Framework for Children has been delayed, although focusing on 'services' it is anticipated that it will make some contribution to child health. However, it must be underpinned and supported by a **comprehensive co-ordinated national plan of action across all government departments on children's health and well-being like that set out in the NHF's *young@heart* initiative**. The DFES must play a critical role as health promotion activities and approaches in schools and other educational settings are not the priority they should be.

National Health Service

22. Within the NHS previous investment and new resources have overwhelmingly been focused on reducing waiting lists and servicing the NHS's demand led culture, rather than forward planning. The consequences of this are thus two fold: minimal NHS investment in public health interventions and minimal forward planning.

23. The NHS has evolved into a demand led service delivery mechanism which has focused on medical treatment, emergencies and diseases of old age. Leaving little scope to channel resources into public health interventions which might prevent these very pressures on the NHS. The increasing demands on the NHS perpetuate this dilemma which sees politicians focusing on reducing waiting lists, emergency treatment and chronic disease – leaving little space to invest in interventions which may alleviate this demand (see annex C).

24. The largest causes of morbidity and mortality in the UK are *avoidable* chronic diseases. In eliminating these there would be significant reductions in demand on the NHS. Even though determinants of ACD must also be tackled outside the NHS**, it is imperative that the NHS must address the prevention of ACD not simply to reduce morbidity and early mortality but as a matter of long-term forward planning to reduce the demands on its services** – by reducing avoidable chronic disease.

25. It is not only long term planning that the NHS must address, but also planning for the shorter term. NHS culture is not only demand led but also risk adverse[4]. One example is emergency winter admissions, which are excessive in the UK by European standards, these could be significantly reduced by sensible primary

[4] Kings Fund. *Five-Year Health Check: A review of Government health policy 1997-2002*. London: Kings Fund, 2002.

care identification and referral of those in need of energy efficiency benefits. Fifty per cent of excess winter deaths are due to cardiovascular events brought on by cold weather spells and the NHF's *Fuel poverty and health toolkit* (2002) sets out excellent primary care interventions. It has been extremely difficult to get this issue on the NHS agenda, and to foster forward planning based on a wealth of evidence for the need for action as in the case of fuel poverty. **We urge this Review to recommend forward looking planning systems to ensure appropriate national and local actions are in place to deal with expected demands on the NHS.**

Appropriate targets

26. Another focus for investment in the NHS over recent years has been meeting government priorities and targets such as smoking cessation services.

27. There are few public health targets in the *Planning and Priorities Guidance* 2003-2006. There may be scope to include further targets from 2007 onwards. As targets are seen by many as the engine of change for investing in public health we believe that this [lack of public health targets] could seriously affect the achievement of the fully engaged scenario if the bulk of public health action and investment will continue to be directed downstream.

28. That being said, we do have concerns regarding the usefulness of targets and their potential to detract attention away from the primary objectives of public health to improve health towards inputs and processes.

29. Therefore, if the target culture continues to prevail we recommend that there are fewer, more intelligent targets, focused on public health outcomes and increasing life expectancy for everyone.

30. The Department of Health's *Planning and Performance Guidance* needs to include more public health mandates and be more joined up in relation to performance and incentive management, the Primary Care Trust Star Rating System, PCT commission plans and the GMS contract developments.

31. On national and local levels health and Local Government targets must be focused on public health imperatives for the prevention of ACDs.

32. The DH/NHS must move away from a preoccupation with waiting lists and targets which are not measures of productivity.

33. Public Service Agreements should have a specific focus on preventing ACDs.

National service frameworks (NSFs)

34. The NSFs implemented and being drawn up over recent years set highly laudable standards and objectives for the treatment and management of disease. **However, their health improvement and disease prevention standards/components are not assigned appropriate significance or importance – this needs to be rectified. Although NSFs have been, and are under review, there do not seem to be any mechanisms to ensure compliance. This should be introduced together with improved quality standards. NSFs should not be seen as substitutes for comprehensive national public health strategies.**

35. We recommend that the National Service Frameworks should

- **be regularly and systematically reviewed and upgraded.**
- **be developed as a basis for setting joint standards and milestones for health and local authorities; and**
- **offer incentives for achieving higher public standards.**

36. The NHF and the UKPHA also recommend that consideration be given to developing a NSF for public health, which would bring together and coordinate the common prevention interventions for adults from the already existing and planned NSFs.

37. Public health development funds should be increased to help the delivery of the prevention standards in the NSFs.

Social marketing

38. There is not major [investment in] core health promotion or social marketing programmes to engage the public – which could have huge influences on health behaviour. There seems to be a reluctance by the Government to invest/regulate to protect and promote the public's health in relation to ACDs even when there is overwhelming public support for such measures for example on the control of smoking in public places, and the marketing of foods high in fat, salt and sugars to children. Such investments would have great impact on reducing demand from ACDs on the NHS and complement primary prevention interventions. Market research studies have found that 70% of the public want controls on food marketing. The advertising spend by industry on confectionery and snacks is over ten times the amount spent by government over the last three years on the free fruit scheme in England[5].

39. Evidence for the effectiveness of social marketing initiatives are available from the National Audit Office in its case study on HIV/AIDs (1994) and from the reports of the HEA's programmes to the DH (1997) (already supplied to the Treasury Wanless team by the NHF).

40. Competent, sophisticated and sustained social marketing is a key mechanism/ technology for ensuring public engagement in health. There needs to be a resurrection of this key cost effective function and competence at national level. **Well researched and organised social marketing is a vital means of shifting the cultural and social health norms of the public and securing popular and**

[5] National Heart Forum (2003) *Policy analysis on the marketing of food to Children*. Unpublished

thus political support for introducing population health protection measures such as controls on tobacco and food marketing to children. Social marketing should be seen as an integral component of a wider programme of public health development and implementation measures. However the effectiveness of social marketing investment with the Government as the messenger needs to be reviewed as often this is counterproductive with some target populations. **Social marketing know-how is not an expertise currently located within government departments and agencies and needs to be developed urgently.** The Health Education Board for Scotland, the Welsh Health Promotion Agency and the International Union for Health Promotion Education all have evidence of experience in this area.

Hypertension

41. We recommend a more systematic approach to preventing, identifying and managing high blood pressure in people at risk. It is estimated that the cost of poor blood pressure control in the UK results in 62, 000 deaths per year[6]. If systolic blood pressure was reduced to 140 mm Hg for adults there would be a reduction of 28-44% in Stroke, 20-35% in CHD. **The ideal public health approach would include primary prevention through primary health care and reducing salt in processed foods** in the diet which account for 80% of the salt in the diet over which individuals exercise little control. This area of health improvement offers huge potential health gains.

FULLY ENGAGED SCENARIO

42. The fully engaged scenario is dependent on a high level of public engagement in relation to health. The need to involve populations in looking after their own health was first given official endorsement in *Prevention and Health: Everybody's Business* [7] in 1976. More recently in 1999 the UK Public Health Association extended the Acheson definition in the light of the Ottawa Charter to include environmental and ecological models of public health (see below), the central role of social justice and health inequalities, and contextualising this in political processes necessary to engage legislators and communities.

43. Public Health is an approach which focuses on the health and well-being of a society and the most effective means of protecting and improving it. Public Health encompasses the science, art and politics of preventing illness and disease and promoting health and well-being. It addresses the root causes of illness and disease, including the interacting social, environmental, biological and psychological dimensions, as well as the provision of effective health services. Public health addresses inequalities, injustices and denials of human rights, which frequently explain large variations in health locally, nationally and globally. Effective public health works through partnerships that cut across professional and organisational boundaries and seeks and promotes the participation of the populations who are themselves the subject of policy and action." (UKPHA 1999)

[6] Journal of Human Hypertension 2003, Jul;17:455-7
[7] Department of Health and Social Security (DHSS) (1976) *Prevention and Health: Everybody's Business*. London: HMSO

Whole society approach

44. The Ottawa Charter (1987), and all modern public health thinking, acknowledge that disease determinants interact with each other in a complex way and that what counts in terms of health status outcomes, for individuals as well as populations, is the combined impact of all determinants. **Given this reality, public health policy requires a 'whole society' approach, giving precedence to social, environmental and ecological perspectives. The NHF and the UKPHA believe that to achieve a truly fully engaged scenario it must be rooted in this 'whole society' approach.**

45. The 'whole society' approach encompasses an environmental model of public health which recognises that economic, cultural and social factors play central roles in the health and well-being of the population.

- Economic factors include differential rates of subsidy to industries (such as the Common Agricultural Policy and), rates of taxation of harmful and potentially harmful products (such as tobacco and alcohol), the general regulatory impacts on health-affecting industries and patterns of income and inequality.

- Cultural factors include: patterns of health belief (behaviour) and influences on it including the media (print and broadcast) and other commercial activities.

- Social factors range from the demographic make-up of society, the changing balance between young and old, and the interrelationship within and between social groups.

46. Similarly an ecological model within the whole society approach acknowledges the multi-stranded and complex nature of health problems and the necessity for cross-cutting interventions. This implies:

- The need for a shift from an individual to a population-based approach in practice, research, policy, and community engagement.

- Clearer understanding of the nature of the public health infrastructure, its generalist and specialist components, including its interface with the health care delivery system, local authorities, NGOs and others.

- Clarification of the roles of non-governmental actors, such as the research community, business, local communities and the media.

RESEARCH

Evidence base

47. Lack of action on the policy agenda has been blamed on the lack of evidence of effective intervention. We warn that this preoccupation with evidence distracts from the real change agenda and is an excuse for further inaction. Lack of

evidence has not stopped the NHS from investing in other areas. In the long run the needs of the healthy are quite as important as the needs of the sick. It should not be forgotten that there is already convincing and substantial evidence of the need for action.

48. Nevertheless **the development of the evidence base is a research priority. In developing national programmes the public health evidence base and policy analysis should systematically consider the full range of upstream as well as downstream interventions.** These should include macro-economic evaluations, assessments, projections and modelling.

49. Due to the long-term nature of many public health actions they should also be evaluated against the achievement of intermediate indicators such as organisational, social, cultural and individual behaviour changes as well as health/disease outcomes.

Research council

50. A new cross government public health research council should be developed and/or a substantial new strategic programme of research should be funded. This should be multidisciplinary and focused on public health policy and intervention. This work should include investment in the economic evaluation of public health policy and implementation and the development of the broad public health sciences.

51. The science of public health modelling and forecasting needs to be developed as a priority by the DH, HM Treasury and Research Funders and Institutes.

52. The Data Protection Act and European Directives need urgent clarification with respect to confidentiality and public health research. Reliable population health data are part of the necessary infrastructure of proper public health.

Health Impact Assessment

53. The Treasury "Green Book "on public policy evaluations should also include the health impact assessment.

54. The development of a quantified monetary value for human life should be considered - similar to those used by Australia and the United States – which includes a thorough assessment of the discounting issues as applied to human health. This should be discussed and agreed with the public health community, health economists and the public.

ORGANISATION OF PUBLIC HEALTH

Government

55. The fully engaged scenario needs a fully engaged government in which all departments are engaged in health improvement. Cross government commitment is needed for public health with clear leadership. This should be achieved through the appointment of a Secretary of Public Health to the Cabinet (see para. 7).

National Health Service and the Department of Health

56. In the fully engaged scenario the NHS and the DH must ensure that public health and prevention of ACDs are attributed sufficient importance within their structures and frameworks which include: National Service Frameworks, Public Service Agreements, Primary Care Trust Star Ratings, the GMS contract, etc. (See paras 34-37)

Public health agencies

57. The work of the Food Standards Agency has developed and progressed since its establishment and this should be commended. **We recommend that its powers in relation to public health nutrition should be enhanced and public health activity should be prioritised as its main function.**

58. On the back of this success **a Tobacco and Alcohol Regulatory Agency should also be established** (see annex D) to regulate the unethical and largely the unregulated product and social marketing techniques used by these industries and to evaluate the extrinsic costs to society.

59. We welcome the establishment of the Health Protection Agency, and now look forward to a focus on avoidable chronic disease (see paras. 12-14). **We recommend that the establishment of an Agency for Chronic Disease Prevention be considered.**

60. In the light of these recommendations and **the current roles and responsibilities of the national public health agencies these should be reviewed in relation to the gaps in functions and investment, in particular the HDA, NICE, the FSA and the HPA.** There are many national organisational possibilities ranging from strengthening existing agencies to establishing new organisations such as a public health institute (see paras. 74-75) or a specialist chronic disease prevention agency.

61. **NICE needs to construct guidance on pharmaceuticals in the NHS which include reference to associated public health measures, alternatives and consequences.** For example the current debate about the move to pharmacy only medicated statins for those at moderate risk needs to be analysed for effectiveness in terms of health gain against, or in conjunction with, lifestyle interventions and the potential to lead to unhealthier behavior and the impact on widening health inequalities. Also new drugs like the Polypil should be compared in terms of efficacy and cost effectiveness with compliance/concordance with lifestyle alternatives. **The same NICE cost effectiveness threshold standard of**

£30,000 per QALY should be applied to public health interventions. This is not routinely undertaken. A comparison of such QALYS for CHD prevention is attached as Annex C.

Public health staff development

62. **There is huge scope for the development of the public health roles within NHS staffing structures, this opportunity should be utilised and carried out in conjunction with any reform of the public heath function and remit** (see paras. 8-11).

63. Specialist public health workforce planning needs to be systematically undertaken and clear accountabilities for action described at national and local levels.

64. Public health roles outside the NHS also need to be developed, particularly those within Local Government.

65. Following the Chief Medical Officer's report to strengthen the public health function, the Department of Heath were working on, and due to publish, a workforce development plan. We recommend that the in the light of this Treasury review that the DH review and publish this plan.

Local Government

66. **There should be joint responsibility between Local Government and the NHS to ensure public health objectives are met and interventions implemented**. Local Government is empowered to enact through the Local Government Act 2000 with responsibilities for economic, environmental and social health of the population.

Voluntary Sector Advocacy

67. As part of the social marketing and policy development (see paras. 38-40) **there needs to be strategic investment in public health advocacy and campaigning by voluntary sector organisations.** This is in line with the recommendations of the recent Treasury and Cabinet Office Strategy Unit reviews (2002/2003) of Community Voluntary Service organisations. This is a further mechanism for engaging the public's participation in public health issues and is also a countervailing force to the anti health excesses of some industries. This arrangement should be in addition and complimentary to building such capacity in the Statutory Sector. Taking forward public health action to shape new social norms will need to involve a close strategic collaboration between the Government and voluntary sectors. Arrangements for securing that partnership could be established via the NGO Public Health Forum. Strategic core funding from Government should be made available for health watchdogs. Core funding should also support independent policy development initiatives like the proposed institute for public health (see paras. 74-75).

Corporate social responsibility (CSR)

68. **New models/forum for engaging with the corporate sector to produce incentives for healthy products and services should be developed. New independently monitored public (health) interest standards for CSR are needed**. This could be carried out by a public health institute (see paras.74-75) or a specialist chronic disease prevention agency (see para. 59). The extension of an ethical funding basis for public health should be explored such as the model of the "energy efficiency commitment " which is in effect a hypothecated tax for public health.

Europe

69. The Inter Governmental Conference is currently negotiating EU Treaty Reform. Although public health has been ascribed a 'supporting competency' in the draft Treaty, we urge the UK government to press for health to be an objective of the Union under article three of the Treaty and argue for a 'shared competency' for health protection measures for the prevention of avoidable chronic diseases. If public health remains a supporting competency progress on health protection measures will depend on other EU legislative instruments and the leadership of one or more member sates on particular issues. This will probably result in a lack of a strategic approach to securing human health**. The UK needs to take a strategic approach to championing European legislation which has impacts on public health** – past examples of legislation include: TV Without Frontiers, the Tobacco Directive, Labelling and Health Claims on Food Directive and the Common Agricultural Policy.

International

70. **The UK's International public health functions need to be strengthened as increasingly health and disease determinants transcend national boundaries – through trade, travel and communications. Health is a central element to the UK's foreign policy, and should be supported**.

71. The UK should work with and through international organisations and United Nation's bodies including the World Health Organisation, the Food and Agriculture Organisation and the World Trade Organisation to ensure the highest standard of public health in Britain and abroad. The current WHO consultation on a Global Strategy on diet, physical activity and health, is an excellent opportunity for the UK to show global leadership and commitment to prevention of ACDs.

72. The UK should take the lead in initiating bilateral and multi-lateral partnerships on health protection measures that require international agreement within the framework and legislative competency of the EU and other international health treaties, to ensure that these reflect the UK priorities and protect the public health.

73. **An international public health observatory should be established to support national, regional and local public health activity in relation to this function and locate and spread effective and good practice**. This could be located in the recommended public health institute (see below).

Public health agency/institute

74. **We believe the effectiveness of public health policy would be greatly enhanced by the establishment of an independent expert public health institute which is transparent and accountable, to focus on policy research, analysis and development** (see full detail in model set out in the box below). Such a body could follow the example set by Wales and Scotland and act as a co-ordinating hub for UK-wide and international work. Such an arrangement minimises inappropriate political interference and the lack of public transparency, which has undermined public health investment for decades. Funding could come from a collection of public interest funders, which would help ensure a robust independence from single bodies/organisations. Independence could also be established by appointing an independent broad based scientific advisory group. The work of this organisation should be multi-disciplinary and multi-sectoral and across government departments. Such an organisation would be timely given the downsizing and cultural changes with Whitehall based government departments. (this could incorporate or be closely aligned with the research council see paras 50-52)

75. In order to establish the exact nature and use of such a structure, analysis of the influence it would have on government and community action on public health should be sought. Developments within the Welsh and Scottish public health bodies, and the Public Health Observatories should also be monitored.

A MODEL FOR A
UK INSTITUTE FOR PUBLIC HEALTH:

The Institute for Health Improvement
To inform policy making to improve and promote the public's health

Underpinning principles	Functions
Independent	Policy development
Transparent	Policy analysis
Accountable	European and International surveillance
Eminent	Research and development
Centre of excellence	Health economic analysis
	Epidemiological modelling
Central subject areas	Health information
Social justice	Social marketing
Health inequalities	Professional development
Life course	Monitoring and evaluation
Health forecasting	

Structure
Key links: Leading academic institutions, government agencies, research charities, health and social groups and think tanks
eg: LSHTM, Durham, Liverpool and Glasgow University, HDA, FSA, NHF, BHF, Nuffield, Kings Fund, UKPHA
Funding: Multi-funded: health/medical charities, social philanthropic donors, government grants, appropriate private funding.

PRINCIPLES FOR PUBLIC HEALTH

Fully engaged model

76. The fully engaged scenario implies promoting the health of the entire population while also addressing the particular needs of groups and individuals within it. Such a model would need to:

- Adopt a population health approach that considers all health determinants
- Strengthen the public health infrastructure across all sectors
- Build inter-sectoral partnerships
- Require accountability and leadership among all sectors of the public health system
- Create the notion of a 'public health service' which crosses the boundaries of professions and organisations
- Develop a public health evidence base that is both upstream and downstream
- Provide leadership in promoting the health of the population which is not compromised by the short term demands of the political system
- Facilitate communication within, and between actors in, the public health system, and the general public

Principles and standards for investing in public health

77. Planning for public health improvements should always be open and transparent and begin with a systematic and comprehensive analysis of the policy and strategy options that should include the upstream as well as downstream mechanisms.

78. The formulation and planning of public health action should be a combination of evidence and/or necessary precaution as well as expert and public opinion to protect public health.

79. The public health policy response should be proportionate to the threat to public health and the risk to the public purse.

80. Decisions on public health interventions should be made utilising a precautionary approach to health protection where there is a probability of continuing substantial harm to the public, especially for the young and vulnerable. This situation arises where there is an absence of absolute definitive evidence of an effective intervention but where it would be unethical not to exercise a reasonable judgement that the intervention could be successful.

81. Public health interventions should not in principle result in a widening of health inequalities, and should narrow them.

82. Population health measures should only be implemented after consultation with the public.

83. The health consequences of public policy should routinely and rigorously be assessed and reviewed before full-scale implementation.

84. Changes to the NHS and increases in public expenditure on the NHS should always be subject to public scrutiny via comparative economic evaluations of the short and long term social benefits.

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