

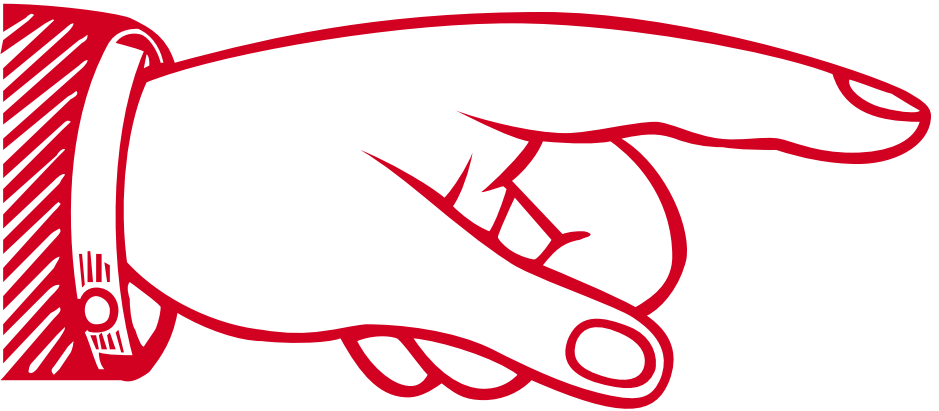
Whose Responsibility is it Anyway?

*Perspectives on public health,
the state and the individual*

Edited by Jessica Asato

The Social Market Foundation

October 2004



The Social Market Foundation

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Contents

Introduction:	6
Does the gentleman in Whitehall know best? Jessica Asato, Social Market Foundation	
Whose Responsibility Is It Anyway? Empathy and the enabling state Rt Hon John Reid MP	11
Public Health, Scare-Mongering and the Overbearing State Claire Fox, Institute of Ideas	20
Evidence and Public Health Interventions Nick Doyle, Health Development Agency	30
Building a Healthier Future: The built environment and public health Adrian Harvey, CABE	37
Investors in Health? The role and responsibility of employers in promoting good health Michael A. Hall and David Furness, Standard Life Healthcare	44

Introduction: Does the gentleman in Whitehall know best?

Jessica Asato, Social Market Foundation

After countless consultations, ‘Big conversations’, and acres of media conjecture, the Government’s White Paper on public health will finally be released shortly after the publication of this collection. Prompted by the stark challenge of the ‘fully engaged scenario’ first presented by Derek Wanless’ health funding report in 2002¹ and followed up by a second report published in February this year², the Government has launched itself into a campaign to change the NHS from being a ‘sickness service’ to one that makes the prevention of ill health a priority. Keen to downplay accusations of nanny-statism, the Government has been careful to emphasise that responsibility for public health problems must be shared equally between individuals, communities, employers, and the state – indeed it is only by working jointly that public health solutions will be found. But the questions of how much state intervention into people’s lifestyle choices is legitimate and concurrently, exactly what responsibilities are imposed on individuals to keep themselves healthy, continue to court controversy.

Public health reform is not as easy as it used to be at the time of Chadwick’s 1842 report on the sanitary conditions of the working classes which initiated major public health advances. Then the role of central government was obvious: to compel local authorities to take on the responsibility of providing clean water supplies, organising refuse collection, and appointing local health officers. The reasons why central

3 National Audit Office (NAO)
Tackling Obesity in England,
2001

4 *Tackling Obesity in England*,
House of Commons Committee
of Public Accounts Ninth
Report, 2002

5 National Audit Office (NAO)
Tackling Obesity in England,
2001

1 *Securing Our Future Health: taking a long-term View*, Derek Wanless, April 2002, see www.hmtreasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm

2 *Securing Good Health for the Whole Population*, Derek Wanless, February 2002

government felt compelled to put pressure on local administrations was also evident; first, to ensure there were enough able-bodied men to ensure the success of the industrial revolution, and second, to guarantee a steady supply of men to send to war, the Boer War in particular. Chadwick never pretended to be a ‘do-gooder’. The economic gains to be made from an improvement in public health drove his initial incentive for research, but his findings led to a step-change in the nature of government from laissez-faire to interventionist, which eventually led to agreement that government should play a strong role in directing the nation’s health.

A changing rationale for public health

That rationale has changed remarkably in the last thirty years with the near eradication of infectious diseases and massive improvement in the quality of people’s lives, but many in the political class, particularly those who are left-leaning, have argued that the state’s interventionist role in public health matters should be as strong as ever. By arguing for bans on smoking in public places and on junk-food advertising to children, they tacitly agree with Douglas Jay’s oft-quoted line that “In the case of nutrition and health... the gentlemen in Whitehall really do know better what is good for the people than the people know themselves.” Amongst the headlines of ‘obesity time-bomb’ and ‘growing ladette culture’ the resounding cry of ‘something must be done’ grows in the corridors of Parliament with members eager to be the first to find a legislative solution to our irrational life choices.

That there is a problem with the public’s health, however, should not be disputed. In the last ten years the number of obese children in the UK has doubled and around 10% of all children are now pronounced ‘officially obese’. According to a National Audit Office report, more than 31,000 people a year are dying prematurely, equalling 6% of all deaths, as a result of a lifestyle of fatty diets and lack of exercise.³ The cost to the NHS of obesity has been calculated as close to £500 million and if you add to that the loss to the economy through obesity related illness and death the figure is more like £2 billion.⁴ Based on present trends, therefore, the combined annual costs are likely to increase to £3.6 billion by 2010.⁵

Smoking continues to present a public health headache with about 120,000 people in the UK killed by smoking every year, accounting for one fifth of all UK deaths.⁶ Smoking is known to cause more than 50 non-fatal illnesses and 20 fatal illnesses. It is estimated that half of all teenagers who are currently smoking will die from diseases caused by tobacco if they continue to smoke. Sexual diseases are also moving back into the nation's consciousness, with diagnoses of syphilis rising in 1998-99 by 58% in males, chlamydia by 76% and the number of new cases of gonorrhoea rising from 12,462 in 1997 to 15,572 in 1999.⁷ By far the most difficult of our public health problems, however, is alcohol misuse which results in costs not just through illness, but also an incalculable social cost through public disorder, deaths from drink-driving, and domestic abuse.

In his speech included in this publication, John Reid sounds a warning bell to those who rush to condemn other people's habits. He argues that without empathy for people *"we, the strong willed, assume the right to protect the weak willed against their own weakness"* ignoring their own capacity for change and damaging the notion of freedom that is so important to people in this country. Public health problems often stem from the condition people find themselves in – poverty, low self-esteem, unemployment, poor skills and education, lack of time and most of all, loss of control – all contribute to an atmosphere which makes it harder to take personal responsibility for health problems. John Reid makes it clear that while the individual must shoulder the responsibility of bettering their own health, society and state also have a role in changing the conditions which mould an individual's choices.

Much of the reaction from the public health lobby has been to urge the government to legislate to change people's behaviour and to restrict the activities of the food and drink industries in particular. But while major government intervention may initially seem an appropriate response to the growing problems we face, it is not clear that such intervention will have the result of engaging the public in a decision to look after its own health which is what Wanless argues is required. A ban on junk food advertising to children, for example, while likely to appease over-pressured parents, is unlikely to change the nutritional intake of children.⁸ A ban on smoking in public

6 The UK Smoking Epidemic: Deaths in 1995, Health Education Authority, 1998.

7 Public Health Laboratory Service

8 The report by Gerard Hastings found for example that *'...there is little evidence to show whether the influence of food promotion on children's food behaviour and diet is greater or lesser than any other factors'*. Hastings, G; Stead, M; McDermott, L; Forsyth, A; MacKintosh, A..M; Rayner, M; Godfrey, C; Caraher, M; Angus, K. *Review of research on the effects of food promotion to children*. September 2003. p18.

9 Derek Wanless stated in his report *Securing Good Health for the Whole Population*: *"Some studies estimate that a workplace smoking ban in England might reduce smoking prevalence by around 4 percentage points – equivalent to a reduction from the present 27 per cent prevalence rate to 23 per cent if a comprehensive workplace ban were introduced in this country."* (Box 4.2)

places may lead to a decrease in smoking, but only by around 4%.⁹ More important than headline grabbing, top-down, public health campaigns, therefore, is an evidence-based approach that predicated policy initiatives on effective public health outcomes with the requisite cost-benefit analysis.

A lack of public health evidence?

That this will be difficult is acknowledged by Nick Doyle in his article for this collection which outlines the poor evidence base we have traditionally had in the UK – though it's important to make the point that this is shifting. Through the work of organisations such as the Health Development Agency and better co-ordination between government departments, the evidence on 'what works' is slowly growing. Much of it suggests, however, that finding the right level of intervention directed to the right group in the local population is key to improving public health outcomes. The consequent policy solutions, therefore, are not likely to shock and awe the pundits waiting for 'radical action' from the Government and yet they have the potential to make more difference in the long-term.

The way forward

Two examples of possible steps forward are illustrated in this collection. Adrian Harvey from the Commission for Architecture and the Built Environment makes the case for designing buildings, streets and green spaces with a public health remit – an area which is often neglected in debates about public health. The second policy idea put forward by Standard

A ban on junk food advertising to children, for example, while likely to appease over-pressured parents, is unlikely to change the nutritional intake of children.⁸ A ban on smoking in public places may lead to a decrease in smoking, but only by around 4%

Life Healthcare is to establish an ‘Investors in Health’ standard for employers following the success of Investors in People. Instead of viewing industry as merely a negative influence on public health in this country, this is an example where the corporate sector can fulfil their responsibility in the public health equation.

A final cautionary note about the current climate surrounding the debate on public health is sounded by Claire Fox in her essay included in this collection. In it she argues that in our quest to make individuals more responsible for their own health, we risk turning people into the ‘worried well’, while at the same time government takes up even more of the responsibilities that were once provided by society and family. Claire Fox also expresses concern that in the rush to allay fears about the problems we face in public health, the evidence will be sidelined or over-emphasised in an attempt to ‘scare’ people into making better choices for their health.

As policy-makers and politicians gather over the coming months to deliberate over how best to reach Wanless’ ‘fully-engaged’ scenario, they would do well to keep a check on their impulses to force individuals to fulfil their own notion of a ‘good citizen.’ As all smoking cessation advisers would be quick to tell you, it’s only when an individual makes up their own mind to change that change will start to become a reality, and it’s very unlikely that any government could be successful in sidestepping that process.

Whose Responsibility Is It Anyway? Empathy and the enabling state

Speech given to the Social Market Foundation, London, 15 July 2004

Rt Hon John Reid MP, Secretary of State for Health

Today I want to take the opportunity to explain to you the philosophical premise that informs my own thinking on the subject of public health.

Let me start by putting this into a more general context. One of the key challenges that the progressive Left in Europe has to face, and the key question that they have to ask is – what is the role of collective ethos and provision in a society that is increasingly marked by growing individualism and consumer power? Some of us might refer to their response to this challenge as the Third Way, others Blairism, others Clintonism; I prefer to refer to it as the modern application and development of social democracy in a mature capitalism - the latter being in turn defined as the advanced stage of social development marked by the generalisation of commodity production.

In this context, of course, the role of the state is an important consideration – my own preference being for a state directed at “enabling” opportunity rather than the state “imposing” its view on individuals: simply, getting the state off people’s backs and putting it where it should be – beneath their feet. Recognising that while the mass production or provision of uniform products or services can be a clear leap forward in liberating one generation, centralist uniformity can also increasingly become a fetter, on the productive capacity in

the next generation, thwarting their increased expectations and ambitions.

But how does all this apply to public health? This isn't about identifying the best health outcomes that we want to achieve – we know what they are. What the Department of Health's public health consultation has been about is how we can achieve the outcomes. How do we balance beneficial health outcomes with our precious freedoms that we hold so dear?

So, I want to start off with some unashamedly difficult ideas. If we ask who is responsible for our health and expect the answer to be simply answered by an either/or – either the individual or the government – we will get very little sense. We must start answering the question by saying *both*, and then working out what that means for different people at different points in their lives, whether acting as an individual or as an instrument of state.

It's everyone's responsibility

So, I start with what used to be called dialectics. Not either/or, but both. And I start with the proposition that men and women make their own health, but they do not do so under conditions of their own choosing. It sounds simple but this means that any sensible government needs to both respect and assist people to make those choices themselves, and to work with people to improve the conditions under which they will make those choices. As we shall see, this is a completely different proposition and task from making choices *for* those people whose conditions are a bit more difficult and constraining when we don't like the choices they themselves are making.

This question of responsibility is made complex by the changing nature of personal and social responsibility in a modern free democracy in a whole host of areas. And the welfare state has had a role in this.

In the past many people who come from my own personal background were not encouraged to feel responsible for – for example – their housing. The council did that. Headteachers looked after their children's education. And, yes, doctors looked after their health.

One of the reasons why these questions of responsibility are different now is that there is an emerging change not only

The NHS – let alone the Government – cannot make you healthy. It can help. It can support. It can cajole. It can incentivise. It can prod. It can provide. It can enable. But it cannot make you healthy

in our priorities for health care and public health, but also a change in how people talk about those priorities and in how people have become empowered and have grown used to empowerment in so many areas of their lives in recent decades.

In the NHS over the last few years we have invested heavily in a previously underfunded service; we have increased capacity to enable us to deliver improved health care. But this is only a start.

Empowering patients

The next stage in the NHS's journey – following on from capacity building – is to ensure that a drive for a more responsive, convenient and personalised service takes root across the whole of the NHS and for all patients, whether they are acute or chronically ill. To empower them inside the public services – as they become empowered as consumers in so many other areas of their lives.

And, then, complementing that drive for a high-quality personal service for individual patients when they are ill, there will be a much stronger emphasis on prevention and an individual's personal role in that prevention. So the NHS aims to lead a coalition to stop people getting sick in the first place and to try to make some in-roads into inequalities in health, which in relative terms have widened, not narrowed, over the last 60 years.

But let's be clear about what this is saying. The NHS – let alone the Government – cannot make you healthy. It can help. It can support. It can cajole. It can incentivise. It can prod. It can provide. It can enable. But it cannot *make* you healthy.

The only way you attain good health is through you taking some responsibility. This is not an idea; it is a material fact.

In so many ways individuals have a lock on the Government's ability or the state's ability to do anything very much about your health. Of course, governments can act to change the conditions in which you live and act. This may indeed be a necessary condition for you changing your lifestyle. But it is rarely on its own a sufficient condition.

So not only is your health in your hands, but so too is government's ability to do anything about it.

Therefore, if we want to realise our long-term ambition of creating a true health service in this country – and not just a sickness service – the health service has to gain your acceptance at least, and hopefully, your active co-operation. That's why the health White Paper is called 'Choosing Health?' – it's not called 'Making you healthy' – recognising the power of the individual over their own health, or lack of health. So on a day to day basis we want more people making healthier choices for themselves.

This is not as straightforward as it sounds and will in fact involve rewriting the rules for engaging the different interested parties.

Personalising services

That's because over a life time we are all placed in very, very different situations in terms of our ability to make and sustain healthy choices. Of course we are each today the same person – with roughly the same amount of will power as we have always had. But many of us are making very different decisions than those we made 20 years ago. That's because the conditions that surround us in making these decisions are different now from then. So for some people, in some situations, some choices are easier to make, some changes are easier to effect than for others in different situations.

There are two very important philosophical points I want to make about this. They have run through all of my thinking as I have approached not only the consultation on public health but also the White Paper that will be published this autumn. And they have a direct impact on how government can help more people make healthy choices. One is about subjective motivation and the second concerns objective conditions.

Empathising with individuals

The first of these is about empathy. When we want someone to do something that is good for them and they keep on *not* doing it, then of course we can get very exasperated. And this exasperation can help undermine what I believe is essential, that is, empathy with that person. When we do that it is potentially counter-productive (at best) and dangerous (at worst).

I got into trouble last month by empathising with a young single mother who enjoyed smoking. Apparently it is wrong for a Secretary of State to understand that she might actually *enjoy* smoking.

I want to turn this argument round. And this is very important. If we don't understand that some people enjoy doing things that are medically bad for them, if we don't understand that this particular pleasure may be among the most enjoyable things in their life, then we will never be able to help them change. And since for me the point is to bring about that change in people's behaviour and not simply to tell them off for being bad, then that understanding and empathy matters a lot because I do want people to lead healthy lives.

Even worse, as a general rule, without empathy we start treating people badly. Without empathy our self-righteousness may get the better of us. And without empathy we get to thinking it is our job to tell people how to live their lives. Not just to protect others from their actions. But to take it upon ourselves to "protect" them from themselves. Under this approach we who are brighter and better informed decree that we will take it upon ourselves to protect them against their own ignorance or stupidity – we, the "strong willed" assume the right to protect the "weak willed" against their own weakness. And so we give up on their capacity to change and decide we will pass laws to tell them how to live. Historically, without empathy, people do bad things to each other. That is why we need to balance our precious freedom and the desirable health outcomes we want to achieve.

So in trying to help people change their behaviour let's firstly recognise why they are behaving as they are.

Understanding the conditions in which people make choices

The second requirement is to understand the objective factors. To consider the different conditions that surround people

making healthy choices (or not), because these conditions have a powerful impact on these decisions. All of us know that in deciding to give up something that is bad for us or take up something good, we need to gain some control over our life. For all of us this gain of control is hard. But if you are short of money, short of time, high in stress, short of all the *bits of ease* that the rest of us have in our lives, it can be a gigantic leap.

Again to make a philosophical point, it is not that those conditions determine our actions absolutely - they don't tell us what to do as if we have no free will. But it is the fact that they can shape, inform, influence or circumscribe more what some people do than what others do. So statistically it looks more difficult for people from manual working class backgrounds to give up smoking than for most of us. Not impossible, but more difficult than for others.

Thus we know from surveys that the healthiest in society find it easier to make healthy choices than those with the poorest health, and that low-income groups can feel that health is beyond their control. And whilst we have some idea about why that might be, we don't *know* clearly and precisely why that is the case. But it does lead us to try some interesting things and there is a lot of innovation around. In Hartlepool we now have smoking cessation services in pubs. People go into the pubs for a smoke and a drink and they are met there with people who will help them give up through informed choice.

Understanding 'difference'

But let me explain a bit more about this interaction between conditions and the individual. We can only understand this if we understand 'difference'. If we expect everyone to be the same, to be 'the public', then we don't begin to understand this interaction. Trevor Phillips, Chair of the Commission for Racial Equality, and I have published a Fabian pamphlet called *The Best Intentions. Race Equity and Delivering Today's NHS*. This argues for both a politics of race and a politics of the health service that celebrates difference and organises services to meet those differences. Treating people as if they are the same will not work. Indeed, for decades, treating people as if they are the same has led to a widening of health inequalities.

So our challenge then is to work with disadvantaged people to create the conditions where all members of society, especially people from disadvantaged groups and areas, are helped and encouraged to make healthier choices. This means more responsibility for individuals and, paradoxically, more responsibility for government too.

It is this balance between the state as an enabling and informing body, but with the individual as the ultimate arbiter of his or her own life, that we are aiming to achieve. That is the whole point of our public consultation on health – not to discover where we want to get to but *how* we get there.

This still means that we in government have a responsibility to help people make these choices through providing information, removing barriers to choice and providing support, assistance, persuasion and encouragement. But ultimately in a free and democratic society, we must all take final responsibility for our own health.

What is already being achieved

Of course we go to enormous collective effort to help individuals. For example, Newham Food Access Partnership is working hard to promote healthy eating and increase access to fresh fruit and vegetables in 'food deserts' – areas with limited access to shops. The partnership provides free delivery of healthy food to members of the community, breaking down the barriers to affordable and healthy food. This is an example of the way in which local organisations can make healthy choices available to the local community. But ultimately it is up to individuals to decide whether or not they want to take up this service.

And although, as I've outlined already, government does have a vital role to play in removing barriers and encouraging healthy choices, it is often not the institution best placed to influence people's behaviour. Issues around sexual health, food and mental health are incredibly personal, and the government, the state, and even to some extent the NHS, are institutions or concepts far-removed from the everyday reality of people's personal decisions. Indeed, health messages will be disregarded by some people if they are seen as unwelcome diktats from the Government. This is where other organisations, closer to people's everyday lives, can come in.

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For example, in Slough, a health activists project is targeting specific areas within minority ethnic populations to deliver accredited training to local communities and professionals. A 12-week Open College Network course has qualified 21 health activities from the local community, 87 sessions have been run in the community and nearly 1,400 people have accessed healthy hearts information.

In Camden, the Greenlight Pharmacy runs a health promotion and education campaign, including seminars in Bengali and Arabic. The pharmacy is located in an area of high deprivation and serves a largely Bengali population where information on the talks is circulated through local networks including the local Mosque. Seminars are held on a weekly basis and cover a variety of topics including diet and exercise, diabetes, and CHD. The sessions generally consist of information on the topic and additional information, referrals and follow-ups are provided. The talks were set up to provide a service for the community about three years ago and are now more in demand than ever before.

So we can, and already do, make particular efforts to project particular services and messages in ways most conducive to particular and individual conditions. We need a lot more of that.

The public health consultation has come at a time when people's health and well-being is one of the main personal and social issues of the day.

All of my life I have believed passionately in the social and economic advance of ordinary working people.

All of those social, economic and material advances and advantages mean nothing unless they are predicated upon

a state of health and freedom from pain – a condition Bevan described as a state of “serenity” – in which to enjoy them.

The capability of citizens to advance themselves

But I have also always believed in the innate character and capability within our fellow citizens which allows them, when circumstances and conditions permit, to secure their own advance. It is important that there is a collective effort to create and change those conditions in order to permit the individual to advance and flourish and liberate themselves from illness – in this case from the risk of pain and unhealthy lifestyles.

There is a growing recognition of the responsibility of the whole range of public, private and voluntary organisations for the health of the public. It is clear then that while we must rely on individuals to change their behaviour, to take responsibility and choose to better their health, we cannot do without the efforts of government to facilitate and support such choices. This will be the lesson that we carry forward into the forthcoming White Paper. One of partnership, balancing the rights and responsibilities and informed choice of people, in a free and democratic society. No easy task, but one very worthwhile and long overdue.

Public Health, Scare-Mongering and the Overbearing State

Claire Fox, Institute of Ideas

The current debate on public health is often presented as a political clash between the individual's freedom to choose personal and possibly unhealthy, irresponsible lifestyles, versus the state's responsibility to promote collective solutions to health problems. Smoking is obviously bad for individuals' health, so should society allow people to be free to make that unhealthy choice, with allegedly deleterious effects on non-smokers, or should smoking in public places be banned? Another question raised is whether individuals' failures to take responsibility for their own health over-burdens the state with unreasonable and unnecessary demands, such as the costs of smoking-related illness care. This, in turn, forces the state to intervene and promote greater individual responsibility.

However, these apparent clashes mask a more complex relationship. It is my contention that the contemporary emphasis on health promotion as prevention, plays on the anxieties of an individuated, overly health-obsessed population. In turn, this undermines any possibility for a truly societal solution to health issues. Furthermore, the present 'public health' narrative adopts a degraded version of collective society-wide solutions, which has more in common with authoritarian impositions on atomised individuals than with past campaigns such as the introduction of universal health care or sanitation.

While the individual has never been more concerned with or responsible for his or her own health than today, state

intervention in health matters has not diminished. Instead, the state has assumed even greater responsibilities for health-related issues. Never before have people in western societies lived longer or healthier lives and yet so many of us, together with the state, seem obsessed with individual health and fears of illness. My intention is to explore these contradictions through seven propositions as well as to shed light on our obsession with our health, which, I believe, is leading to a new destructive relationship between the individual and the state.

Too much individual responsibility can lead to the opposite of a 'healthy society'

My first proposition is that the acceptance of personal responsibility for our own health, which is all the rage at the moment, does not lead to a 'healthy' public health service. Everyone has become an expert on his or her own health. If you go to a dinner party the conversation boringly revolves around food allergies, cholesterol, alcohol units and fitness. If you hang around the school gates, parents are avidly discussing MMR, the nature of vaccinations, ADHD, junk food, obesity and so on. There's been an attendant massive rise in self-diagnosis. The proliferation of medical websites and the rise in self-help patient groups mean that everybody feels that they can go to the doctor and tell him or her what's wrong with them.

This version of individual responsibility often clashes with a broad social commitment to medical science and has led to some irrational and dangerous trends. With the increase in individual responsibility, we have also seen a parallel rise in mistrust for the medical profession. Harold Shipman has become a potent symbol of the malign doctor, while scandals such as that of Alder Hey have further weakened the doctor-patient balance of trust. The rise in patient litigation as well as the veiled threat to sue for misdiagnosis or negligence has resulted in a defensive, risk averse, medical profession. Because GPs are under pressure "to do something," they are more likely to refer patients to hospitals or specialists rather than to reassure or tell them to go home because they are not as ill as their Internet-derived self-diagnosis suggests.

There's also been a rise in the use of alternative medicine. However cranky, unorthodox and lacking proof of efficacy,

there is no official opposition to these treatments. Largely as a defensive response to patient and consumer demand, the BMA has even endorsed some of these anti-scientific and irrational procedures as valid complements to traditional medicine. Such consumer empowerment, however disguised as patients striving to take responsibility for their own and their families' health, has a dark side. A perfect example of this trend is the MMR crisis and its inherent cynicism about medical expertise. Parents of autistic children led the anti-MMR lobby. Courted by the media as the authentic voice of 'ordinary people', these parents were pitted against the 'closed ranks' of government medical officers. It is clear then that individual responsibility for health can mean a rejection of real public health such as mass vaccinations.

We are turning into the 'worried well'

My second proposition is that people's preoccupations with taking responsibility for their own health could rather be seen as a symptom of an *unhealthy* society in the broadest sense. The context is the well-documented decline in political and social engagement, which has resulted in the rise of a more individuated and fragmented public. The decline of politics with a big 'P' and the reduction of the public sphere have led to a retreat into the personal spheres of lifestyle, lifespan and health. This climate of atomisation leads society to be increasingly inward looking, self-preoccupied and over anxious. It is interesting that the Government boasts that NHS Direct has been a success. Why? Because there have been ever greater numbers of hits on the website and calls to the phone-line. Rather than successful, I'd say this phenomenon is instead representative of a sort of mass hypochondria - dubbed the 'worried well syndrome' - and not of a newly responsible population taking charge of their health.

It is worth considering that there is danger of losing a sense of proportion when society becomes so preoccupied about its health. When people become so over-anxious they are inclined to seek a check-up for every ailment, ache or pain in fear that there are signs of cancer, Aids or heart disease. Ironically then, individuals taking responsibility for their own health negatively impacts on NHS resources. GPs have

a difficult enough time treating the sick without the added burden of having to reassure frightened individuals who spend endless hours examining their bodies for lumps and symptoms of decline.

My third proposition is that this introspective anxiety makes the public easy prey to official scare mongering. All too often, contemporary public health campaigns exploit people's fears. In numerous instances, the phenomenon of the over-anxious worried well is the direct result of government-backed health campaigns. We all know the phenomena of the responsible individuals who have variously thought they were anorexic, obese, gave up red wine ("I'm a binge drinker") and then took it up again ("it's good for your heart"), depending on the buttons pushed by the Department of Health that month. Raising public awareness is frequently a code for scaring the living daylight out of us. Too often the warnings of public health zealots amount to emphases on human vulnerability while they bombard us with dread warnings on the dangers of fatty foods, salt or bottle-feeding babies.

This leads to my fourth proposition. This emphasis on human frailty in the face of threats to our health means people are kept in a permanent help-seeking state. Even the future is tinged with impending doom. Indeed, the 'Health Time Bomb' is always set to explode in the years to come. Here are just a few recent newspaper headlines to illustrate the point: 'Young Face Skin Cancer Time Bomb'; 'Lung Disease Time Bomb Revealed'; 'Teen Lifestyle Health Time Bomb'; 'Time Bomb Alert Over Child Obesity'. The message is clear: "things may seem okay now, but wait till you see what's waiting for you round the corner!" "Do as we say today or the time bomb will get you tomorrow!" This theme was vividly illustrated this summer when numerous local authorities issued dire warnings on the dangers of sunbathing. This advice went beyond common sense. The warnings suggested we stay on our guard, forever fearful. St Albans council was particularly doom saying, telling us "there is no such thing as a safe tan" and warning that "skin cancer can cause death" but can be prevented by "protecting your skin throughout your life". You can never relax, even when the sun goes in. Under a heading 'Tanning Myths', Surrey Heath Borough Council warned "you CAN

burn...in the shade and when it's cloudy... UV rays penetrate light clouds and mist and fog." Terrifying, no?

Scare-mongering distorts the evidence

My fifth proposition is that, despite this government's evidence-based policy, rhetoric preying on fears leads to overlooking scientific evidence. As an aside, the present broad definition of evidence needs to be ring-fenced. Too frequently, anecdotal, experiential and hearsay evidence are given equal weight to objective assessments. And then comes advocacy. While we are right to query the questionably self-serving tobacco industry evidence in the smoking debate, we tend to suspend our critical faculties when campaign groups such as ASH (Action Smoking and Health) present equally contentious evidence. We must therefore be careful that amidst the present official enthusiasm for health promotion evidence is not prostituted for political ends.

One hates to let the facts get in the way of a good public health panic, but there are too many examples of a cavalier attitude to scientific research. For example the sunburn / cancer equation just doesn't add up in the black and white way it is presented. When councils such as Surrey Heath declare that "Nearly all skin cancers are caused by over exposure to the sun", they are in fact being rather loose with the objective evidence. Relatively rare malignant melanomas do account for the majority of skin cancer deaths, but crucially, these are only tenuously linked to sunburn. They are mainly found on areas of the body not commonly exposed to the sun, such as soles of the feet, scalps and buttocks. They have a similar incidence in Japan where there's little history of sunbathing. Those 90% of skin cancers in Britain which are linked to sun exposure (basal-cell or squamous cell carcinomas) tend to grow slowly and are thankfully easy to treat.

Before discussing the supposed obesity epidemic, it is worth noting that the body mass index (the BMI) by which obesity levels are measured, is acknowledged by many to be crude and imprecise. When taken on its own, it is a fairly meaningless measure of health and well-being. It is worth casting a sceptical eye on the way statistics are compiled. For example, the BMI was only adopted as a measure for

10 House of Commons Health
Committee Third Report of
Session 2003-04, 10th May
2004

The BMI was only adopted as a measure for obesity in 1998 and in one swoop the number of Americans classified as obese doubled.

obesity in 1998 and in one swoop the number of Americans classified as obese doubled. According to the BMI equation, George Clooney is seriously overweight and Tom Cruise is obese.

On a more serious note, the House of Commons Health Select Committee's May report on obesity states in the very first paragraph that 'With quite astonishing rapidity, an epidemic of obesity has swept over England....' Then in paragraph two we are told the tragic story of '.... a child of three dying from heart failure where extreme obesity was a contributory factor'.¹⁰ There's no context and no explanation for how this child became so large or what ultimately caused her death, just a suggested link between an alleged epidemic of obesity sweeping England and a fat toddler dying of heart failure. There is then a quote about how such children are "choking on their own fat". By the time the press picked up the story, the parents of the three-year-old were accused of stuffing her to death and some commentators suggested they should be charged with neglect.

Unfortunately, the Committee didn't check their facts. The fact was that the child was suffering from a rare genetic illness. By the time this was exposed (by journalists rather than health professionals), the importance of the specifics of facts and evidence were being queried by the report's apologists. They argued that concerns about one example should not distract from the 'broader truth' of the report's message about the need for drastic action to combat child obesity. But it should concern us that such a headline-grabbing example, so prominently placed at the start of such an influential report, misled us all. Surely we all agree there can be no licence to publish dodgy facts by claiming that they serve a worthy cause.

Growing state intervention

My sixth proposition is that, despite contentious evidence, the authorities are using public health campaigns to intervene in ever more intimate areas of our lives. Under the guise of public health campaigns about the dangers of sunbathing, local councils now feel free to give detailed instructions to “irresponsible” sun-worshippers on the minutiae of their lives. They tell us what to wear. Fareham Council advises we “cover up: with loose clothing...wear a hat with a brim or flap that covers the ears and the back of your neck”. We are told where we should sit and when (in the shade, between 12 and 3pm). And it’s not enough to tell us to wear sunscreen. Oxford County Council insists we use a “high skin protection factor of at least SPF 15 and a 3 or 4 star rating”. We must apply this “at least 30 minutes before sun exposure...and reapply at least every 2 hours”.

Ever-wider areas of people’s lives are now in open season for official intervention. It’s not just the Department of Health that is lecturing us about how to live in order to avoid obesity, five other departments are geared around tackling this problem. The Department of Transport tells us how much we should walk while introducing cycling strategies and walking buses. They even make unsavoury attacks on mums for doing the school run; implicitly blaming them for their children’s obesity. Tessa Jowell from the DCMS identifies the way we live in the modern world as the problem, “Rising prosperity means that many of us eat what we like, when we like...means that we travel in comfort in our cars...means that...our homes are filled with labour-saving devices...that we can entertain ourselves in front of TV screens, computer screens, games consoles.” (Tackling Obesity in Young People conference, February 25 2004) But do not fear, Tessa will put a stop to all that comfort in the name of saving us all from our unhealthy selves.

The DFES has now got embroiled. Ever-svelte fitness guru Charles Clarke exploits parental concern about educational standards when he declares “Good health and effective learning go hand-in-hand, a healthy body leads to a healthy mind.”¹¹ It is now suggested school trips include “visits to local allotments” and teachers, who obviously have little better to do, should set up gardening clubs. While it might be churlish to object to *The Healthy Living Blueprint* which will mean

11 *Healthy Living Blueprint*,
6th September 2004

two million 4–6 year olds will be given a free piece of fruit or vegetable each school day, one might balk at the way “the full capacity of the curriculum” is to be hi-jacked to “teach about healthy lifestyles”. The obesity panic is to be reclassified as fact and taught in science lessons along with Personal, Social and Health Education classes. It is an odd fact indeed that while the contemporary discourse on obesity frets about the potential manipulation of the young by the food industry’s aggressive marketing campaigns, state agencies think nothing of manipulating what children think through the re-organisation of education around health policy ends.

Public health policy is just another form of social control

This leads to my seventh proposition. The Government’s public health policy is really a programme of social control repackaged as health promotion. In responding to, and often stirring up, public anxieties, the Government is seizing the opportunity to conduct a large-scale experiment in behaviour modification through the use of an unprecedented degree of supervision into people’s personal lives and choices.

However, to be clear, this is not an Orwellian social control scenario. Of late, the political elite has been extremely anxious about the breakdown of traditional sources of order, social control and morality. As GP and medical author Michael Fitzpatrick has argued in his book *Tyranny Of Health*, health provides an ideal vehicle for reconnecting with individuals’ preoccupations, and reasserting official authority through targeting personal behaviour. Remember the AIDS campaign, a watershed in the new approach to health promotion? The traditional morality of religion has become a discredited deterrent to youthful sexual experimentation, so the Safe Sex campaign replaced fear of eternal damnation with fear of lethal disease. The ethic of goodness was replaced by the ethic of safety. The new morality preaches precaution and restraint in the name of protecting our health rather than our souls.

Where once the state’s interest in health might have involved building hospitals, developing NHS services, or investing in medical science to find cures to disease, the focus is now on modifying individual lifestyles. One can only speculate as to what it is that drives authorities to indulge in this new

role. Are they feeling so disconnected that the only way they hope to influence people by is by playing on their fears, and then acting as a source of help? Are they so unable to command the electorate's respect in the public realm of politics that all they can do to give themselves a mission is to exert iron dominion over people's personal lives?

Maybe I'm wrong. When John Reid assured us that the government should not tell people how to live their lives, and emphasised the importance of people making positive choices about their own health, I was temporarily reassured. But Reid's alternative, that what we need is to give people lots more information doesn't seem the best solution. Being bombarded by information, can mean a constant diatribe of official nagging. And such a tut-tutting state can be even more insidious and invidious than any interfering 'Nanny State'. We all know nannies are things of the past – instead we have the model of the caring, supportive parental-state. It admonishes us; chastises us; of course it doesn't smack us, but it certainly infantilises us. Of course, the nanny state label can be avoided through the use of proxies. Margaret Hodge is keen to use 'peer-to-peer work' in Sure-start schemes. She thinks neighbours, friends and extended family will be better placed to guilt-trip bottle-feeding mothers into breast-feeding than social workers and health visitors who may be perceived as too officious in such a personal decision. John Reid is right to fear the over-sanctimonious anti-smoking lobby will cause a backlash amongst the working class. And yet, he is happy to take a supposedly more subtle approach and so advocates the infiltration of smoking cessation officers into pubs and football grounds. Open up the Health Development Agency's briefing on public health interventions: they advise a new army of recruits policing our health. They suggest that "high quality bar staff" are given "intensive... training" to help reduce "the levels of intoxication in customers". There's just nowhere to hide!

In conclusion, does contemporary health promotion work? It's fashionable for those opposed to it to argue that it's counterproductive. They cite young people reacting against drug promotion – we all remember Heroin Chic. They cite 1920s prohibition and the increased underground alcohol consumption. But my concern is that it works too well. It has

succeeded in creating a health-obsessed, fearful population. A population that is more concerned with avoiding ill health than with living life to the full. It certainly works at the level of behavioural conditioning. But the question is; at what cost? I recently visited Ireland and many people will be delighted to know that my chain-smoking, heavy-drinking cousins have all changed their behaviour. They really have cut down the cigarettes and they're really drinking less. However, in their words, it's a joyless life: "There's no craic!" Their freedom is curtailed; their behaviour is policed and spied on. As one of my cousins pointed out, you could probably reduce adultery in Ireland if stoning were introduced, as you could cut down on pickpockets through the threat of cutting off their hands. But would we want to live in such a society? Would that society be truly *healthy*? I'd say, certainly not, if we were to use *healthy* in any meaningful sense of the word.

Evidence and Public Health Interventions

Nick Doyle, Health Development Agency

Evidence-based medicine as a concept has been around for about 50 years but it is within the last ten or so that it has become an international movement with a powerful influence on health policy and medical practice. Markers of the movement's spread in this country include the establishment of the Cochrane Collaboration in 1993, the NHS Centre for Reviews and Dissemination in 1994, and the National Institute for Clinical Excellence (NICE) in 1999, which has the role of promoting clinical excellence and the effective use of resources within the NHS. Numerous other sources of evidence and guidance about healthcare have emerged in this period, including the government sponsored electronic information portal, the National electronic Library for Health (NeLH).

In this same period the notion that policies and interventions should be based on evidence has taken hold in other social policy fields. A commitment to evidence-based policy has been part of the movement to modernise government since 1997,¹² exemplified by the outputs of Cabinet Office units, such as the Performance and Innovation Unit (PIU), its successor, the Strategy Unit, and the Office of Public Service Reform (OPSR), whose job has been to improve policy-making and delivery across government.¹³ The establishment of the Campbell Collaboration in 1999 reflected the research community's desire to systematise the social policy evidence base, with the aim of doing for social and educational policy and practice what the Cochrane Collaboration does for healthcare. Similarly, the ESRC Centre for Evidence Based

14 Acheson D *Report of an independent inquiry into inequalities in health*. (1999)

15 Department of Health *Saving Lives: Our Healthier Nation*. (1999)

16 Wanless D et al *Securing better health for the whole population*. (2004)

12 Davies P (2004)

13 See for example Cabinet Office (1999) *Professional policy-making for the 21st century*; PIU (2001) *Better policy delivery and design*.

Policy and Practice, through its Evidence Network offers access to policy and practice-relevant research.

A lack of evidence

Not surprisingly, the same sort of thinking about evidence and medicine has affected the public health field. In 1999 the Acheson Report, a compendium of evidence on public health with substantial influence on subsequent policy on health inequalities, expressed concern about the shortage of public health evidence, particularly controlled studies of public health interventions.¹⁴ Later that year the public health White Paper, *Saving Lives: Our Healthier Nation*, echoed some of Acheson's concerns, noting that there was not enough robust evidence upon which standards governing public health practice could be based.¹⁵ To fill the gap, it announced the creation of the Health Development Agency (HDA), with a remit that included 'maintaining an up-to-date map of the evidence base for public health and health improvement'. The HDA came into being in April 2000, but will become part of NICE in 2005 following the Department of Health's review of its arm's length bodies.

The Treasury-sponsored Wanless Review into the future resource requirements of the NHS in its turn lamented the patchiness of public health evidence.¹⁶ It concluded that the lack of evidence about the cost-effectiveness of interventions was an important obstacle to achieving the NHS's holy grail - the 'fully engaged scenario'. This has been described as a state of affairs in which there are high levels of public engagement in health, a responsive NHS, especially on disease prevention, and a highly efficient use of NHS resources.

Gaps in the evidence base may also hinder the work of the new Healthcare Commission as its ability to assess how well NHS organisations are performing will depend on the development of criteria that reflect the best available knowledge about what constitutes effective practice.

What is evidence?

The terms 'evidence' and 'evidence based' are slippery ones. Depending on one's viewpoint they can have a variety of interpretations. For some, evidence is information produced

by a rigorous process of data analysis, research, experiment or evaluation. For others, evidence is a broader knowledge base about the causes of a problem and possible solutions drawn from a variety of viewpoints and sources, which may include scientific research. An example of this latter, more pragmatic approach at the national level is the work of the Social Exclusion Unit, which, though using syntheses of research evidence, leans heavily on case studies; good practice examples; expert opinion, particularly the opinions of organisations and individuals ‘on the ground’, and on ‘key ideas’ emerging from its investigations.¹⁷ Health overview and scrutiny committees are a local example of a wide-ranging approach where the views of communities are a particularly important form of evidence. In the intensity of its preoccupation with issues of scientific rigour and quality of evidence, the health (and public health) field stands out from other policy fields, where even the principle that interventions should be tested is less widely accepted.¹⁸

Information about problems rather than possible solutions is vital, particularly in public health

Even if one favours the science-oriented interpretation of evidence, there are further distinctions to be made. As indicated already, evidence on ‘what works’ is a relatively recent addition to the menu of information for policy making. A great deal of policy is now, and will remain, data-driven. Information about problems rather than possible solutions is vital, particularly in public health. For example, epidemiological and demographic data about the scale, distribution and impact of diseases or hazards are vital in setting priorities, allocating resources and identifying emerging threats to health; so too is information about patterns of health-related knowledge, attitudes and behaviour in the population. Yet even here the Wanless review highlighted important gaps, such as the failure of the NHS to exploit the health data it generates; the lack of comprehensive information on the health status of the population, particularly the prevalence

17 See SEU *Preventing Social Exclusion, (2001)* and *SEU National Strategy for Neighbourhood Renewal: a framework for consultation. (2000)*

18 Cabinet Office (1999) see 13 above.

19 Health Development Agency. *Public Health Intervention Research: The Evidence. (2003)* www.hda-online.org.uk/documents/pubhealth_intervention.pdf

of behavioural factors, or on actual NHS spending on public health; and the weakness of systems for gathering reliable information about a PCT’s own population.

In addition, current government priorities about tackling health inequalities mean that debates about public health policies and strategies are coloured by research findings on, for example, the ‘pathways’ between and among broader social, economic and environmental factors and individual lifestyles that lead to health inequalities, or on possibly protective aspects of people’s social environment, such as social capital.

The problem with evidence

This concern for evidence is one of the strengths of the public health culture. However, it creates problems too. For example, a hierarchy of evidence that attaches highest value to experimental methodologies implicitly devalues evidence produced by other means, not just qualitative research but also learning extracted from case studies, good practice, and the growing number of evaluations of broader programmes sponsored by various government departments, particularly programmes aimed at tackling social exclusion in deprived neighbourhoods. For a similar reason, it also creates barriers to partnership working with other agencies, such as local authorities, whose evidence base draws heavily on recommendations from comparative studies of practice or individual good practice examples. Finally, it can lead to naïvety about what really influences decision-making – often not scientific evidence but the expertise, judgement, prejudices or values of the decision-makers themselves, the impact of lobbyists and pressure groups, the climate of public opinion, or political calculation.

What then is the state of the public health evidence base on ‘what works’? What are the problems and are there promising developments? As noted earlier, a key problem is the patchiness of the evidence, particularly on cost-effectiveness. An important factor in this is the lack of investment in research into public health interventions. An HDA study into existing research in the public health areas outlined in *Saving Lives* found that only a tiny fraction of the total public health research reported in bibliographic databases in the UK – 0.4 per cent – looked at interventions for the prevention and reduction of ill-health.¹⁹

The study confirmed the view that most scientific research in public health seeks to answer research questions of interest primarily to researchers rather than of interest to policy makers and practitioners.

The absence of cost-benefit data reflects the failure of public health historically to conduct much by way of systematic appraisal of costs and benefits of interventions nationally and locally. The HDA has recommended that the Department of Health, working with other government departments and the research funding bodies, should develop a public health research and development strategy that focuses on increasing the flow of practice-oriented evidence from research on interventions, including economic evaluations.²⁰

What works in tackling health inequalities?

Another crucial gap is evidence about what works in tackling health inequalities. As Wanless acknowledged, the ways in which different segments of the population respond to similar interventions is not well developed, and there has been a long-term failure in public health to truly tailor and target interventions at the different segments of the population with their particular needs.

But tailoring and targeting requires greater clarity than is currently evident about the aims of policies on tackling health inequalities. Three possible aims can be discerned in interpretations of the task of tackling health inequalities:

- To improve matters for the most socially excluded, those carrying most risk factors, and those who are most difficult to reach;
- To improve the health of the poorest at a faster rate than that of the wider population, thereby narrowing the health gap;
- To improve health at each step up the socio-economic ladder, thereby reducing the health gradient.²¹

Interventions pursuing the first two of these aims deal with a relatively small part of the population – about 20 per cent – and do not greatly affect the overall health of the population. The third option, reducing the health gradient, which the HDA recommends, involves recognising the real health

20 HDA (2004)

21 Graham H *Tackling health inequalities: Health disadvantages, health gaps and health gradients: HDA Briefing*, London: Health Development Agency, (2004a)

22 See Kelly M (2004) *The evidence of effectiveness of public health interventions – and its implications*. www.hda.nhs.uk/downloads/pdfs/choosing_health/CHB1-public-health.pdf

23 *ibid*

24 Kelly M et al *Evidence into Practice*. (2004)

disadvantages of those below the middle of the spectrum and focusing interventions on them, as well as on the most socially disadvantaged groups. It can reach huge numbers of people in the population who could not be described as socially excluded, but who in health terms are relatively disadvantaged, and among whom preventive and other interventions could produce massive improvement, with proportionate savings for the health care system. However, the kinds of approaches to prevention activity with the group below the middle of the spectrum will be different to those with the most socially excluded. So without appropriate tailoring and targeting interventions may run the risk of making the gradient in inequalities even steeper.²²

A further problem is about the extent to which even the best quality evidence provides a definitive guide to action. Evidence of effectiveness only in very exceptional circumstances prescribes precisely which policies or practices should be implemented. The reason for this is that interventions reported in the scientific literature and reviewed in systematic reviews are usually implemented under controlled scientific and well-resourced experimental conditions. They may be considerably less effective when applied under non-experimental circumstances of routine service delivery.²³

Linking scientific evidence with practitioner knowledge

The HDA has been testing a reliable, replicable process for enhancing the value of evidence to users by integrating scientific evidence, locally-derived practitioner knowledge, and local understanding of health improvement needs. The scientific knowledge provides a framework of social scientific or biological plausibility for a given intervention – for example, promoting physical activity or preventing accidental injury to children. Practitioner knowledge is the basis for assessing the likelihood of success for the intervention in ‘real life’.²⁴ This process is in the development phase but has potential as a means of both bringing together diverse forms of evidence within a rigorous framework and overcoming the often observed resistance to change of practitioners.

Much of this paper has been about problems to do with evidence, but in concluding, it is important to recognise that

the public health evidence base is growing. For example, in its submission to the consultation on the new public health White Paper, *Choosing Health?*, the HDA was able to recommend 70 interventions with a high likelihood of success in areas such as alcohol, accidental injury, obesity and nutrition, drug misuse, children and young people, tobacco, mental health, physical activity, housing, and working with communities.²⁵ Whether it will grow fast enough to meet the demands upon it, however, is uncertain.

25 HDA *Choosing Health?*
*A consultation to improve
 action to improve people's
 health. The HDA's response.*
 (2004)
[www.hda.nhs.uk/downloads/
 policy%20response%20to/
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 response_28-06-04.doc](http://www.hda.nhs.uk/downloads/policy%20response%20to/Choosing_Health_The_HDA_response_28-06-04.doc)

Building a Healthier Future: The built environment and public health

Adrian Harvey, CABI

When it comes to health and illness, doctors and hospitals are a crucial, but ultimately, small part of the story. The capacity to treat the sick is a necessary one, but in this case, as the old adage says, prevention is better than cure. From the Romans to the Victorians, public health has been recognised as the foundation of healthy cities – often literally, in the case of the subterranean architecture of effective sewerage and clean water beneath our streets. The importance of public health is also recognised today, of course. But a comparison of the resources and attention applied to public health initiatives with those devoted to primary and acute care shows we are very much bolting stable doors.

To its credit, the Government is shifting the focus from treating sickness to promoting health. And this ‘new public health agenda’ represents something of a shift in emphasis. Traditionally, public health was concerned with environmental factors – reducing exposure to infection and pollution, for example – to be dealt with through technical interventions, such as vaccination and sewerage. These measures, in the UK at least, have been largely successful and over the past two generations, the attention of public health professionals has shifted to behavioural and lifestyle issues. Smoking has been the primary focus of this approach, but increasingly obesity and heart disease are the targets of the new public health debate.

None of this is to deny the continued threat of infection. From HIV to vCJD to MRSA, the threat of infectious disease is never far away. But these are not the big killers. As the second Wanless report²⁶ noted, protection against disease has been a very effective part of public health; obesity and smoking are now the most important determinants of future health and the main challenges are about changing behaviours, something both practically and theoretically difficult in a free society.

In responding to these challenges, Wanless argues that the main levers available to a democratic government are taxes, subsidies, service provision, regulation and information. Shaping the built environment is barely mentioned. Yet even the late Victorian municipal leaders recognised the importance of public parks and public spaces in encouraging healthy behaviour amongst their citizens. In this paper, I want to argue that, in our increasingly urbanised society, the built environment has a vital part to play in the new public health debate, particularly in relation to obesity.

Calories in, calories out

While the war on tobacco continues its long attrition, smoking has been surpassed as the biggest killer by the diseases associated with over-eating and under-exercising. Among these diseases of plenty and leisure are coronary heart disease, diabetes, and cancer, as well as osteoporosis, back pain and osteoarthritis, and mental health problems. Underpinning many of these conditions is obesity.

At the centre of the growth in obesity is a simple equation: calories in, calories out. If the former is greater than the latter for sustained periods, weight gain and ultimately obesity are inevitable. Over the past 50 years, a major transition has occurred on both sides of this equation, with the result that for most people in the industrialised world, the tendency towards obesity is the default condition.

On the input side, there has undoubtedly been a dramatic shift in the diet of Europeans since the 1950s. From the end of food shortages to today's ready availability of richer and more processed foods, there is now effectively no external limit on the calories that can be consumed. But this alone does not account for the current obesity epidemic; it is the corresponding

26 Securing Good Health for the Whole Population, Feb 2004

27 Green Exercise: Complementary Roles of Nature, Exercise and Diet in Physical and Emotional Well-Being and Implications for Public Health, Jules Pretty, Murray Griffin, Martin Sellers, & Chris Pretty, CES Occasional Paper 2003-1, University of Essex, citing Eurodiet 2001 and NAO 2001 figures.

28 Pretty et al, 2003

On average, European adults now expend about 500 calories less energy a day than they did 50 years ago

activity shift that has taken place, with people burning up fewer calories, that has really imbalanced the equation.

Much is made of the importance of sport and exercise in an active lifestyle, and this has led for example to high levels of gym membership. But the decrease in overall activity has not been caused by a decrease in participation in organised sports. Most calories in the past were burned in the work place and through 'getting around'. The increasingly sedentary nature of work, transport and leisure – with the decline in manual work, widespread car ownership and usage and the prevalence of inactive leisure pursuits – has had a much more profound impact on levels of physical activity. On average, European adults now expend about 500 calories less energy a day than they did 50 years ago; in the UK, changes in lifestyle over this period have led to reduced physical activity equivalent to running a marathon each week.²⁷ For children, the ability to burn off calories by informal exercise, either in outdoors play or in getting around have diminished more starkly through a combination of perceived traffic and other dangers, and the availability of parental 'taxi'. The result is that whereas in the 1970s 90% of children walked to school, only 10% do now.²⁸

So promoting sport alone is unlikely to rebalance the equation. Too little time is available in busy lives - for most people, the loss of a marathon a week through lifestyle activity is a great deal to replace through jogging. Certainly, sport has a part to play, as does encouraging healthier diets. But we need to find ways to encourage 'lifestyle activity' if we are to find a sustainable response to concerns about obesity.

Building in lifestyle activity

The built environment has a huge potential to support this. The way we design and construct our buildings and public

spaces – and the way we maintain and manage them – can have a huge impact on promoting greater physical activity. There are three areas where specific approaches to design in the built environment can have a direct impact on physical activity; building design, streets and neighbourhoods, and parks and green space.

Building design

At the most basic level, the provision of showers and other facilities in offices can encourage people to cycle to work, or to take exercise before or during the working day. But there are more intrinsic aspects of building design that can modify and shape our behaviour. The increasing invisibility of stairs in many commercial, public or even residential buildings is a case in point. If you think about the lobby of recently built offices, hotels and other public and quasi-public buildings, one of the consistent elements is the mysterious absence of stairways. They exist (fire regulations demand them) but they are more often than not invisible, hidden away, while banks of lifts signal that the way to move around the building is by standing still. Compare this with buildings of previous generations, where not only were stairs visible, they were celebrated as a central and grand aesthetic element of the building.

Of course, the technological changes – including lift technology itself – that have allowed for much taller buildings, coupled with the entirely legitimate demands of equal access, mean that stairs cannot be the only or even primary means of moving between floors. But it is hardly surprising that some people without mobility difficulties will still use lifts to move just a couple of floors if stairs are hidden, unattractive and made inconvenient to use.

Streets and neighbourhoods

If we want to encourage people to walk and cycle around their neighbourhoods, rather than use their cars, we have to make our streets safe, attractive and fit for purpose. At the most fundamental level, we need to rebalance the design of street layout so that it meets the needs of all users, not just drivers. Too many recent housing developments are

built effectively as compounds, with one (road)way in and out, usually marked by a roundabout and limited, if any, footpaths. Retail parks are even more forbidding. Even the most determined pedestrian has to battle with a hostile environment, clearly designed precisely to discourage their presence, often in the interests of road safety. And usually the street layout forces pedestrians to take lengthy diversions from the logical, direct route, creating further discouragement.

These features seriously undermine the potential connectivity between areas which is essential if we are to encourage people to use alternatives to the car for local journeys. A great deal has been done, in fact, to clam traffic and improve the usability of some neighbourhoods, not least the excellent Home Zones initiative. But such ‘safe areas’ have to be linked if we are to create safe routes to school, work or the shops. This does not mean more soulless walk ways and underpasses to separate pedestrians and others from cars; rather we need to find ways to produce the kind of shared streetscape that exists in some of our more established urban areas.

There are good examples in the Netherlands and Denmark of radical redesigning of road layout and changes in priority which appear successful. In blurring the boundaries between ‘traffic’ and ‘people’, by removing road signs and markings, levelling pavements with road surfaces and making other physical changes to the street scene, driver behaviour has been modified. Because drivers have to rely on eye contact to negotiate rights of way they feel more vulnerable and so take more care resulting in lower speeds and reduced accidents. While probably a step too far for the UK, interesting experiments, such as the new layout of High Street Kensington, could show a way forward.

Of course, traffic is only one factor that discourages people from using their streets and public places. Vandalism, crime and the fear of crime combine to produce insecure and unattractive places. There is a good understanding now of how urban design can reduce crime and limit vandalism, which goes well beyond simply ‘bullet-proofing’. But as well as safety and security, we need attractive and clean public

spaces that people can feel happy to spend time in. This is in part a design question, but – as with crime – it is as much a question of maintenance and management, repairing damage and putting eyes on the street.

Parks and green spaces

Parks and green spaces can be seen as the ‘gyms’ of lifestyle activity. They provide open space where people can be active, from walking the dog to throwing a Frisbee, from flying a kite to kicking a ball. As with other public space, the importance of good design and maintenance is critical. A park can quickly become a no-go zone if neglected, but even a well maintained park that does not provide spaces for different uses and users will not play its full part.

The built environment has health impacts beyond obesity, of course, and this is particularly true of parks and green space. For example, there is a great deal of evidence that well designed and accessible green space can contribute to better mental health outcomes; proximity to nature and greenery can relieve some of the stress of city living, and good public space can foster beneficial social interaction, which adds to well-being. However, this requires the creation of spaces for civic engagement, rather than spaces per se. Unfriendly, insecure public space can actually undermine levels of social interaction and trust. We need to design defensible, manageable public spaces, as the “quality

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29 *Mental Health and the Built Environment: More than bricks and mortar?*, David Halpern, Taylor and Francis, 1995

of people’s relationships... is critically mediated by the extent to which they are able to regulate their interactions with them”.²⁹

Building healthy neighbourhoods

The Government’s medium term priority for health is to move from treating disease to supporting people in leading healthy lives. Yet, in the shift from an environmental to a behavioural public health framework, the importance of the built environment risks being overlooked. We need a greater recognition that the ‘physical capital’ stored in our towns and neighbourhoods can be used to promote healthier lifestyles. The quality of the places and spaces where we live, work, learn and play is a major determinant of how active we are, providing the landscape within which we make choices. Changing diets and promoting more active lives through other means are essential, but unless we also design and build better places, the task becomes that much harder.

This essay represents the author’s views and not necessarily those of CABE

Investors in Health?

The role and responsibility of employers in promoting good health

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This essay examines the role and responsibility of employers in promoting good health, and proposes a non-legislative solution to the problem of lack of employer engagement in this area. Good health is good for business, good for employees and good for wider society. There is an urgent need to engage business in a shared goal of improved health.

The “obesity time-bomb” ticking in “Fat Britain” cannot have escaped the attention of anyone who has picked up a newspaper in recent months. The horror stories of young children already morbidly obese and a Britain with “One foot in the gravy”³⁰ have led to a vigorous national debate about what should be done to lessen the impact of preventable health problems.

Of course, obesity is only one aspect of the current battle against ill health. Smoking, a poor diet and lack of exercise contribute to a frightening range of dreadful diseases, from heart disease to cancer, and condemn many people to a shortened life of reduced quality.

However, preventing ill health is not just a question of alleviating individual suffering but has significant implications for government, industry and society at large.

For the government, rising levels of preventable ill health pose a threat to the provision of health services. Treasury adviser Derek Wanless, in his report *Securing our future health*:

31 Wanless D, *Securing our future health: Taking a long term view* (2002) p.75

32 CBI *Annual absence and labour turnover survey* (2004)

33 CIPD; *Employee absence 2003: A survey of management policy and practice* (2003)

30 The Sun, 30th April 2004

Taking a long term view, wrote that unless we become “fully engaged” with our health, the NHS will require an extra £30bn a year by 2022–23.³¹ Put simply, Wanless’ “fully engaged” population would be educated health consumers accustomed to making healthy choices. Clearly, this is some way from our current situation. The fact that the UK population is far from fully engaged with its health makes Wanless’ stark prognosis of the need for an extra £30bn each year to resource the NHS a big challenge for any government. Preventable ill health will most certainly affect the ability of future governments to fund health services.

The link between ill health and consumption of health resources is a clear one, with obvious consequences for government and society. What is perhaps less clear is the link between ill health and business performance with real significance for the economy. This crucial area of concern to us all is often neglected in the furore over the future of the NHS and the government response to our public health problems.

Sickness absence

Ill health causes sickness absence. Sickness absence reduces business productivity, harms UK competitiveness and consequently restricts the general good that is a consequence of a thriving economy. 176 million working days were lost to absence in 2003, costing businesses £11.6bn to cover the salary of the absentee and any resulting overtime and temporary cover.³² Employers recognise that staff ill health impacts upon the profitability of their business; a Chartered Institute of Personnel and Development survey found that for 90% of companies sickness absence is a significant or very significant cost to the organisation.³³

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However, ill health does not just impact on business through sickness absence but also through impaired employee performance. Common sense tells us that when we are feeling ill we perform badly, and conversely we are better at work when we are in better health. As George Cox, Director General of the Institute of Directors (IoD), writes “...evidence is now emerging that healthier staff contribute more to corporate success”.³⁴ For example, Canada Life Assurance achieved a 2.7% gain in efficiency across their workforce after the implementation of a worksite health and fitness programme.³⁵

Not only does ill health cause extra costs for business, it also hampers productivity. By promoting good health, businesses can reduce the costs incurred by sickness absence but also benefit from the increased productivity of healthier, more motivated staff. The issue of stress is also an important one, causing reduced effectiveness, increased absence and opening employers to the risk of litigation for failing to contain levels of stress in the workplace.

Encouraging behaviour change in the workplace

There is great potential for businesses to invest in the health of their workers. The workplace can become an environment in which individuals are encouraged to alter their behaviour and become more healthy. Employers can communicate directly with their staff and have the power to alter the working environment, making healthy choices more accessible. We spend many of our waking hours at work, so the workplace should be central to any attempt to promote good health.

However, British businesses have not, as a rule, invested a great deal in health promotion. This is a result of the nature of health services in Britain, where the state has, since 1948, been the major provider of healthcare. A parallel might be drawn with other European countries where businesses have invested more in health promotion as a result of their responsibilities of provision.

In Germany, for example, employers make a contribution to statutory health insurance premiums for their employees. This has the result of forging a direct link between the finances of the company and the health of the employee. The same cannot be said for British employers’ National Insurance

34 Cox G, in Health and Well-being in the Workplace: a Director’s Guide” (2002) p.5

35 Information from Vielifie health management

36 European Network for Workplace Health Promotion

37 Ibid.

38 Ibid.

39 BBC News online 5th February, 2004.

contributions; since they do not represent a hypothecated NHS tax, they do not form the same link between the employer and the health of the employee.

German health insurance companies now fund workplace health promotion projects to the level of 2.36 per insured person each year.³⁶ This gives a clear incentive for companies to invest in the health of their workers, and also benefits employees and insurance companies. The employees gain from a healthier working environment and the health insurance firms will hope in time to experience reduced claims from a healthier customer base.

According to the European Network for Workplace Health Promotion 31.6% of German small businesses now implement workplace health promotion. In Britain, no comparable data is collected. This serves to show how far Britain lags behind its European business partners in engaging with the health agenda.

The German example is a salutary one for the UK. Germany’s Prevention Act introduced into law a government programme to form a network of initiatives on prevention and health promotion which also aims to increase awareness of the necessity of prevention among German citizens. The government also instituted the bonus programme which guarantees a contribution from health insurers towards workplace health promotion in an effort to maintain the financial integrity of its health insurance system.³⁷ This demonstrates the successful application of appropriate government intervention to encourage businesses to do more to promote good health.

Other European countries have ‘caught on’ to the need for workplace health promotion as an effort which can bring benefits to business, employees and relieve pressure on health services. Indeed, in Finland roughly 80% of companies have implemented workplace health promotion.³⁸ This is an interesting point to consider for the UK, where Finland has often been held up as an example of how to achieve better public health. In the 1970s Finland had the highest rate of deaths from heart problems in the world, and in the 1980s levels of obesity were twice that of the UK.³⁹ These public health problems were successfully tackled and the emphasis on health at work played an important part. We in the UK should learn from this and aim to adopt an approach to public health that encourages full participation from industry.

An IoD survey found that 50% of businesses do not provide any kind of occupational health service for their staff

Making the business case for investing in health

The message that good health benefits business must be heard more widely in our commercial communities. We have already seen some strong leadership from the government in this area, with the Secretary of State for Trade and Industry writing, “Promoting and maintaining health, safety and well-being at work is not a fad – it makes sound business sense.”⁴⁰ Scotland has taken a lead, with the establishment in August 2004 of Healthy Working Lives, an organisation to improve health in the workplace. Announcing the decision, Deputy Health Minister Tom McCabe said “Improving the health of Scotland’s working age population is vital to the country’s economic prosperity”.

However, more action needs to be taken, especially south of the border, to convince business that they have much to gain, and much to give to wider society, by taking a lead in promoting good health.

A poor record on workplace health provision for staff

Quite clearly not enough is being done. An IoD survey found that 50% of businesses do not provide any kind of occupational health service for their staff. This, even in an environment where the IoD argues that “...the ability to actively participate in occupational health activity is an essential part of good health”⁴¹ and 58% of people believe that their employer should be responsible for their healthcare.⁴²

So, it is clear that ill health impacts on business, and the European example demonstrates the public health and commercial benefits to be gained from having a healthier workforce.⁴³ There are examples to be found in the UK too – since introducing a workplace health promotion programme in 1984, sickness absence due to illness at the DVLA has

40 Patricia Hewitt MP in *Health and Well-being in the Workplace: a Director’s Guide* (2002) p.7

41 Day, G; *IoD Health and Rehabilitation at Work*, August 2003.

42 Standard Life Healthcare *Attitudes to Healthcare survey 2003*

43 See Kreis and Bödeker, *Health related and economic benefits of workplace health promotion and prevention: Summary of the scientific evidence* (2004) for a full discussion of the benefits of promoting good health at work.

44 Ibid.

45 Information available at www.iipuk.co.uk

fallen from 7.9% to 3.5%⁴⁴. But how can we achieve greater participation in workplace health promotion in the UK?

One solution would be government legislation designed to mandate business to provide health promotion activities for staff. However, this approach would create an environment in which it was difficult for such activities to be successful.

At Standard Life Healthcare, the health promotion programme introduced in 2002 formed part of a wider initiative called ‘Great Place to Work’, which aimed to improve working conditions throughout the company. A key part of this was increasing trust between management and staff. Without this trusting working environment health promotion would have been less effective at Standard Life Healthcare – staff would have responded less positively to an innovation from management. That’s why government legislation to compel businesses to offer health promotion at work would be ineffective; companies need to choose to invest in health to stand any chance of success. If neither management nor staff are enthusiastic, then health promotion will sink without a trace; the danger of a legislative approach.

Additionally, the Government would open itself up to accusations of ‘nanny state-ism’ by legislating to insist on certain activities taking place in the workplace. It would be far preferable to rely on voluntarism for an increased business uptake of health promotion. We need to find a non-legislative solution to encourage business to adopt health promotion as an important commercial aim.

The best way to achieve this would be to establish a standard, offering a competitive advantage to companies who invest in the health of their staff. We have seen the success of the Investors in People standard, which over 32,000 companies, representing 27% of the UK workforce, have obtained since its launch in 1990. The standard established a “national framework for improving business performance and competitiveness, through a planned approach to setting and communicating business objectives and developing people to meet these objectives”.⁴⁵ Businesses must comply with four key principles (Commitment, Planning, Action, Evaluating) to move towards the standard. It has made a tremendous difference to training and development, resulting in tangible business benefits; 80% of accredited companies have increased

customer satisfaction, and 70% say that their competitive edge and productivity has improved.⁴⁶ Clearly, the standard has been a resounding success in benefiting both employers and employees.

An Investors in Health standard

The success of Investors in People could be replicated through an ‘Investors in Health’ award to encourage greater business participation in health promotion. That way, as Patricia Hewitt MP wrote, “...employers that instigate change now will be able to reap long-term benefits for productivity, their people and their community”.⁴⁷

The ‘Investors in Health’ (IIH) award would be a standard for companies that demonstrate a commitment to providing health promotion and preventative health measures for staff. The ‘healthy’ organisation would ensure that its employees work in a healthy environment that provides information about good habits in diet, exercise, sleep and stress as well as support, advice and opportunities to change behaviour. Workplace health promotion can take many forms, from a set of individual initiatives which combine to demonstrate a commitment to good health, to the integrated programme used by Standard Life Healthcare with health management firm Vielife. The individual activities in which companies might choose to participate include the provision of after work fitness classes, on-site massage sessions, healthy menus in staff restaurants, provision of water machines, or company memberships to gyms.

The integrated approach, in Standard Life Healthcare’s case, includes personal online health assessments for each member of staff leading to individual health advice on identified problem areas. The company is aware of general trends in the health of its staff and can target interventions accordingly. These might include free fruit or a new staff restaurant menu if nutrition is a problem, or the provision of counselling lines if stress is identified as causing difficulties.

Improvement can be tracked through regular surveying of staff, and the benefits to the company can also be identified. This integrated system of health promotion can benefit companies of every type and can incorporate many of the individual actions described above. Both approaches would demonstrate

46 Ibid.

47 Patricia Hewitt MP in *Health and Well-being in the Workplace: a Director’s Guide* (2002) p.7

48 Standard Life Healthcare consumer research May 2004

the type of commitment required to achieve Investors in Health.

The standard could either be established as an independent entity or by becoming a subsidiary of Investors in People thus enjoying good market penetration from an early stage.

It is important that IIH should be cost effective. It has already been shown that health promotion carries with it a business benefit that outweighs the costs involved in introducing the necessary resources and activities to the workplace. Because of this, obtaining the award itself should incur minimal costs for business. The assessment for Investors in People costs £550 per day, and there is no reason to think that IIH would require a larger assessment fee. There would be some cost to government, as there was with Investors in People where the then Department for Employment helped to establish the standard, but this should be seen as a worthwhile investment in a venture in the public interest. Funding IIH would be a cost effective measure to tackle some of our public health problems.

As well as experiencing the business benefit of healthier workers, companies with IIH would be more attractive to potential employees. Standard Life Healthcare’s own research indicated that 85% of people in full-time employment would prefer to work for a company with a recognised standard for supporting the health and well-being of its employees.⁴⁸ Health promotion is the mark of a progressive, forward looking company that cares about its staff. This is an attractive combination for potential employees, and can have other benefits in terms of increased morale from existing workers who respond well to their employer’s investment in their health.

It is difficult to measure the potential impact of IIH on public health given the different results likely to be experienced by different companies. However, it is clear that companies

The success of Investors in People could be replicated through an “Investors in Health” award to encourage greater business participation in health promotion

have seen tangible health benefits after instituting health promotion programmes. Better health in our workplaces will contribute to tackling wider public health problems.

The benefits of managing health in the workplace

Since introducing a health management programme, Standard Life Healthcare has seen some encouraging results in terms of health improvement. 60% more staff members now eat 5 or more portions of fruit and vegetables each day; there has been a 9.1% reduction in the number of smokers, absence decreased by nearly 5% in the first year, and overall health status increased by 12%. Clearly, if these benefits were seen on a wider scale, there would be significant improvements in public health in the UK. It is also important to remember that the positive behaviour encouraged at work may also be passed on to the family and into the wider community. Health promotion in the workplace does not simply affect employees but all the people with whom they come into contact. Fostering a healthy culture in Britain's workplaces would go some way to creating the same in Britain as a whole.

There are clearly a whole range of positive consequences that could result from the establishment of an Investors in Health standard to mirror Investors in People. However, we should also be aware of potential problems which may have affected the latter.

The latest quinquennial review of Investors in People highlighted the lack of penetration of the standard among SMEs – only 2% of these businesses had obtained Investors

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49 DFES Quinquennial Review of Investors in People UK April 2002 p.1

in People.⁴⁹ This is a common problem with business standards where only larger companies have the resources to obtain them. With IHH, it would be important to recognise commitment rather than resourcing when making an award to a healthy company. It is perfectly possible for SMEs to provide a healthy workplace; it just wouldn't take the same form as a larger company. For example, every business, including SMEs should be expected to provide water fountains for staff. That is the sort of activity that might contribute towards the award of the IHH standard. It is not reasonable to expect a small company to devote the same level of resources to health promotion as a larger firm, but there are other ways of demonstrating a commitment to promoting good health. Investors in Health must retain flexibility in order to reach every kind of business.

Additionally, Investors in People has received some criticism for its perceived status as another 'hoop' for business to jump through, especially since so many businesses (c.32,000) have achieved it. There are some legitimate points to be raised about the bureaucratic requirements of standards like Investors in People, but the general criticism seems to stem from its ubiquity in modern UK business.

This seems to miss the point. Investors in People set out to disseminate good practice in training and development. That 32,000 companies now follow the principle they have established is a testament to the changed business environment in which good people development is seen as standard.

At present, we are a long way from this point in the area of health promotion. It would be a tremendous achievement if an award like Investors in Health became so widespread that people started questioning its value. It would be a positive outcome for all of the UK if we were to reach a point where workplace health promotion was the norm rather than the preserve of only a very few companies.

The Investors in Health standard can follow in the largely successful footsteps of Investors in People to make health promotion a central part of our working lives. This would benefit business as well as having a positive, and potentially wide-ranging, impact on the public health problems facing the UK. Non-legislative Investors in Health would encourage creativity in business without the heavy hand of regulation and

would be welcomed by employees who believe that employers should be doing more to look after the health of their staff.

If we have, as the Sun claims, “One foot in the gravy”, Investors in Health would go some way to extracting us from that particularly sticky situation.

One of the first acts of the 1997 Labour Government was to establish the position of public health minister; two decades after the Medical Officer of Health was abolished. The Government's White Paper on public health, *Our Healthier Nation*, signalled its intention to put public health at the heart of Government policy on health. Five years on, however, the numbers of people smoking have reached a plateau, teenage drinking and drinking amongst women is increasing, obesity, particularly among children, is rapidly increasing, and scare stories about the rise in STDs rock the news agenda daily. As a second White Paper on public health approaches, it is timely to ask who should take responsibility for changing public behaviour in relation to public health and when it is legitimate for the state to intervene.

This collection brings together different perspectives on the public health debate, seeking to find the balance between state intervention and individual responsibility. Contributors include: Rt Hon John Reid MP, Secretary of State for Health; Claire Fox, Institute of Ideas; Nick Doyle, Health Development Agency; Michael A. Hall, Standard Life Healthcare; and Adrian Harvey, CAFE.

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