HEALTH NEWS BRIEFING

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES

CHCs Making our Nation Healthier:

ACHCEW's response to the public health Green paper for England

May 1998

SUMMARY

The Labour Government has published a Green Paper setting out a proposed health strategy for England, *Our Healthier Nation*. This Health News Briefing sets out the response from the Association of Community Health Councils for England and Wales (ACHCEW) as adopted at a Special General Meeting on 27 April 1998.

Our Healthier Nation is summarised, drawing attention to its emphasis on health inequalities and the four priority areas where national targets are proposed.

The Green Paper sets out a number of questions for respondents to consider. These issues are addressed in this response from the perspective of CHCs.

Six areas are highlighted as requiring Government attention if health inequalities are to be reduced significantly:

- tackling problems around poverty and work;
- providing support to informal carers;
- investing in healthy housing;
- discouraging smoking;
- ensuring that NHS services are distributed appropriately; and
- strengthening the ability of CHCs to represent the interests of the public.

ACHCEW mostly supports the proposals in the Green Paper. Without determination and radicalism, progress will be made only over a long timescale, implying a continuing heavy toll from avoidable ill-health.

CONTENTS

1. Introduction

ACHCEW welcomes *Our Healthier Nation* with its emphasis on health inequalities. It strikes a good balance between insisting that we all have to take some responsibility for our own health and recognising that many people have limited scope for making healthy choices. The Green Paper is also wise to focus on a limited number of priority areas as this creates a clearer sense of direction for all concerned, although we do suggest a few areas where additional targets would be appropriate.

This response from ACHCEW begins with a summary of the Green Paper and its priority areas. The Green Paper also includes a set of questions which respondents are asked to address and these are considered. ACHCEW's response goes on to pay particular attention to the impact on public health of: poverty and work; carers; housing; smoking; health care; and the role played by Community Health Councils in promoting health. ACHCEW concludes that radical steps will be required to make significant progress in tackling avoidable ill-health in the foreseeable future. Key recommendations from the response are listed at the end of the document.

2. Summary of *Our Healthier Nation*

The new Green Paper sets out the Government's proposed strategy to improve the public's health and reduce health inequalities in England. Four areas are prioritised - heart conditions, cancer, accidents and mental health - and for each area a "contract" is set out, describing the steps which need to be taken by central Government, by health authorities and local authorities and by individuals.

2.1 The problem

Our Healthier Nation draws attention to shocking statistics on the extent of avoidable ill-health and health inequalities, including:

- Deaths from suicide amongst women have fallen through the 1980s and early 1990s whereas such deaths amongst young men rose substantially across the same period

- Women born in West Africa or the Caribbean are over 50 per cent more likely to die of a stroke than other women

- Children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off families - and that gap is widening.

- Amongst men of working age the most recent figures show that the death rate for all cancers combined was twice as great in unskilled workers as in professionals.

2.2 The proposals

By contrast with the previous Government's *Health of the Nation* strategy, *Our Healthier Nation* places a heavy emphasis on the need to tackle inequalities in the health of different social classes and ethnic groups and on the social and environmental causes of ill-health and early deaths. The Government says the Green Paper is driven by two key aims:

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness
- to improve the health of the worst off in society and to narrow the health gap.

The Green Paper focuses on four priority areas where national targets are set:

- **Heart disease and stroke. Target:** to reduce the death rate from heart disease and stroke and related illnesses amongst people aged under 65 years by at least a third.

- **Accidents. Target:** to reduce by at least a fifth the number of accidents with lead to a hospital visit or a consultation with a GP.

- **Cancer. Target:** to reduce the death rate from cancer amongst people aged under 65 years by at least a fifth.

- **Mental health. Target:** to reduce the death rate from suicide by at least a sixth.

For each priority area, *Our Healthier Nation* sets out a "contract". This consists of a table listing steps that can be taken at three levels: by central Government, by "local players and communities" (health authorities, local authorities and voluntary or community organisations) and by individual people. In general terms, it is suggested that central Government should "provide national coordination and leadership" and "tackle the root causes of ill health". The local players should, among other tasks, "provide leadership for local health strategies by developing and implementing Health Improvement Programmes". Individual people should "take responsibility for their own health and make healthier choices about their lifestyle".

Following consultation on the Green Paper, a White Paper will be issued later in the year with fixed targets to focus the Government's public health policies for England. A public health strategy for Wales will also emerge.

3. Questions raised in *Our Healthier Nation*

The Green Paper lays down a number of specific questions which respondents are asked to consider. These questions are addressed in this section of ACHCEW's response.

What are the obstacles to partnerships at local level and how can national Government and local players help to overcome them? Are there good practice examples from which we can learn?

Conflicts can arise from the pressure on statutory authorities to provide services with tight resources and from the temptation to offload responsibilities onto other agencies. The various distinct professions have different perspectives. There are also significant cultural differences between local authorities working to elected party politicians, the NHS where power lies largely with managers and doctors in a centralised structure and the voluntary and private sectors. In order to focus on people's needs, it is essential that communities are regarded as partners in the fight against health inequalities. With their statutory duty to represent the interests in the health service of the public in their district, Community Health Councils can play an important liaison role, especially as their membership is chosen by local authorities, the voluntary sector and the NHS. Good practice examples of CHCs work with other agencies follow later in this response. *Poverty and Health*, available from the Public Health Alliance, is an excellent resource for "ideas...analysis...information... action".

Is the overall contract for health comprehensive, or are there other elements which should be added to the national, local and individual roles?

The central Government can use taxation to discourage unhealthy activities and reduce social inequalities. National and local political parties and organisations involved in promoting health can make the case for increasing the resources of relevant public services, and standing up to powerful corporate interests, in order to reduce avoidable morbidity and mortality. We welcome the reference to the need for "greater public involvement, in identifying health problems, developing local strategies and to improve health and local community action". We are concerned that the implementation of the White Paper proposals will enhance the power of GPs and other NHS professionals without significantly increasing the influence of CHCs or the public they represent.

How can public health research be strengthened?

The public's perspective can be incorporated by ensuring representation of CHCs and other non-professional interests on funding bodies and reference panels. The public's perception of the impact on their own wellbeing of

health hazards should be a leading concern in research. Research by independent and campaigning organisations should be funded to ensure a wide range of perspectives in the development of public health, not rigidly tied to an official agenda and set of priorities. The Association of Public Health and the Public Health Alliance would be able to assist at the national level. Community Health Councils are well placed to carry out or support research in their own areas and should be resourced to do so.

What task forces might be required to aid implementation of the strategy? What sort of people should be involved in them?

Alongside professionals, and representatives of local authorities, the NHS, the voluntary sector and private business, local people should be well represented to ensure that public health is not seen as something "done to" communities. CHCs should certainly be involved alongside community leaders, eg from tenants' and residents' associations and minority ethnic organisations.

We concur with the interim report on the *Chief Medical Officer's Project to Strengthen the Public Health Function in England* in its emphasis on the "need to strengthen and encourage the public as advocates and activists in changing factors affecting their health" (paragraph 8). The interim report also acknowledges the need to "actively promote the participation of those least likely to be involved and in greatest need because of social exclusion, vulnerability or existing poor health" (paragraph 12).

We endorse the interim report's recommendations to:

- commission a review of the evidence for the effectiveness of public involvement and identify the research gaps that need to be filled to increase our knowledge of good practice
- develop a national strategy for increasing public awareness and involvement in public health matters
- review the role CHCs in involving the public in public health matters.

Have we omitted organisations with a role from this chapter [chapter 3]? Are there good practice examples of their contribution?

CHCs have been omitted. Their contribution is discussed later in this response.

How should opinion on fluoridation be tested in local areas?

ACHCEW shares the Green Paper's assessment that "fluoridation offers an important and effective method of protecting the population from tooth decay" (3.34). Subject to resource constraints and competing priorities, CHCs may well be interested in researching local opinion on fluoridation through health panels, focus groups, surveys, community development work and so on. This may be a more cost-effective option than the use of citizens' juries or commissioning research from commercial consultancies. We would

suggest that all health authorities in areas without fluoridation should be required to test local opinion and engage in formal consultation procedures with CHCs, local authorities and voluntary and community organisations. Where most of the health authorities in a water company's area favour fluoridation following such a consultation procedure, the company should be required to act accordingly.

What further action should Health Improvement Programmes require?

Health Improvement Programmes should pay special attention to the needs of 'hard-to-reach' groups such as minority ethnic communities and people with learning disabilities. HIPs should be subject to formal consultation with CHCs and other representatives of the public, in addition to CHCs being informally involved in their early development and continual review.

How can the Local Authority role in health be strengthened and supported?

Following a resolution passed at ACHCEW's AGM in 1995, a Working Party was set up to consider accountability in the NHS and relations with local authorities. It has been suggested that accountability in the NHS could be improved if a single agency were to be responsible for commissioning health services rather than health and local authorities sharing responsibilities. The members of the Working Party agreed that unified commissioning would probably improve service delivery and accountability to the public but felt that all of the suggested models for unified commissioning have shortcomings. The issues are discussed in ACHCEW's 1996 document *CHCs, Health Authorities and Social Services Departments: Accountability and Joint Working*. It is important that local authorities involve and consult CHCs in the development of proposals for community care, social services and public health.

How can we encourage and foster local community action to improve health? Are there examples of good practice?

Many sources of ill-health lie in the local environment in which people live and work. To a large extent these environmental threats to health require the input of significant public resources, well beyond the means of local residents on low incomes.

However, community development initiatives offer great hope for mobilising the untapped skills, time and commitment of local people. Community development projects can be supported by external agencies but members of the community must take the lead and they must be seen as independent of officialdom (including health authorities and local authorities). Pointers to effective community development can be found in *Poverty and Health - Tools for Change*, available from the Public Health Alliance (of which ACHCEW is a member). The interim report of the *Chief Medical Officer's Project to Strengthen the Public Health Funcation in England* rightly stresses the need

for "reliable medium term funding" for community development (paragraph 13).

What structures are needed to ensure effective joint planning at local level?

CHCs and voluntary community organisations should be represented at planning meetings and proposals should be subject to proper consultation.

What action is needed to make healthy schools, healthy workplaces and healthy neighbourhoods a reality? Are there are examples of good practice? What are the obstacles to success and how can these be overcome?

We note that schools are expected to "set nutritional standards for school meals" (page 50) and suggest that these standards should be set nationally. Employers should aim to ensure that employees do not work excessive hours, are not subject to harassment or discrimination, have reasonable security of employment and are properly remunerated. Effective monitoring of health and safety standards is essential and recalcitrant employers should be severely penalised. Work to promote healthy neighbourhoods should consider the interests of all local people including safe and healthy play areas for children. In schools, workplaces and neighbourhoods, empowerment of the affected populations can play an important role.

Are the priority areas the right ones on which to focus the strategy?

The four areas identified are sound priorities. It is not clear in practice how much weight will be placed on the pursuit of the general targets for these areas. The Government aims to "ensure the maximum room for Health Improvement Programmes to set local targets reflecting local priorities" (4.10). In any case, the health strategy "will be very broadly based", drawing on a wide range of data sources for the "development of the strategy and the monitoring of progress and interpretation of change" (4.54).

Have the targets been set at the right level?

We have no concerns about the levels as such.

We are concerned about the emphasis on people aged under 65 and that the targets may underline existing institutional age discrimination.

We are not persuaded that the official suicide rates are accurate since it cannot always be firmly established whether someone has deliberately taken their own life. We do not see suicide rates as an adequate measure of mental health. Targets should be based on tracking poor mental health rather than mortality. We recommend that the targets for mental health must include objectives which ensure that mental health care within primary care is improved dramatically from its low level and is provided to all patients who

require such a service, not just those who are chronically mentally ill.

ACHCEW is concerned that the Government has not included in the Green Paper the previous targets around sexual health. ACHCEW is concerned that the dropping of targets on HIV/AIDS could have negative implications for the funding of HIV and AIDS services. We recommend that the Government reconsiders this issue and restores targets for sexual health in the White Paper.

ACHCEW is concerned that the Green Paper fails to incorporate maternal health targets. ACHCEW notes with alarm recent evidence which highlights Britain's very poor record for producing seriously underweight babies. We recommend that the Government includes targets around maternal nutrition in the White Paper.

Is the approach that is suggested for intermediate targets (ie for 2005) appropriate?

We look forward to being consulted on intermediate targets. 2005 seems a sound point for the setting of intermediate targets although year-on-year progress should be sought especially in areas where recent trends have been disappointing, eg obesity and teenage smoking.

What would you add to the draft national contracts on heart disease and stroke, accidents, cancers and mental health?

Some issues are discussed in the next section of this response.

How should local inequality targets best be centrally monitored?

We hope that, following the deliberations of the Acheson Committee, a national target will be set for reducing health inequalities. We hope that annual reports will be issued by the Department specifying the targets set in each Health Improvement Programme and the progress achieved, identifying good practice models.

How should local priorities be determined? On what evidence and by what process?

It is essential that these priorities reflect the felt needs of local communities, especially the most deprived and unhealthy sections of these communities. CHCs can play a very effective role in community development and research, empowering local people to express their perceptions.

4. Steps for making a healthier nation

ACHCEW would like to take this opportunity to discuss briefly a number of areas where action is urgently required if inequalities in health, and avoidable mortality, morbidity and disability, are to be reduced significantly.

4.1 Poverty and work

The Green Paper can be praised for its straight talking about the scale of the task facing the country if significant progress is to be made on tackling health inequalities. We endorse the analysis that: "Tackling inequalities generally is the best means of tackling health inequalities in particular".

At the core of the Government's strategy for tackling poverty is the Welfare to Work programme. A significant reduction in unemployment would undoubtedly involve significant gains in income, self-esteem and health. We therefore hope that the Welfare to Work programme is successful while also hoping that the Government will consider other possible approaches to reducing unemployment.

The health effects of employment depend however on the nature of the work. In particular, some people work in unhealthy or dangerous conditions. Some employees are poorly remunerated so we look forward to learning details of the Government's proposed national minimum wage. We feel that employers have a major role to play in improving health, and would welcome improved health and safety standards at work, and improved working conditions.

We hope that the White Paper will pay more attention to the nature and distribution of work, both paid and unpaid. Compared with other European countries, Britain's employees work long hours which in some cases may adversely affect their health. In addition, a great deal of work is, of course, not remunerated, including child-rearing, caring for dependents and involvement in voluntary community activities. Our society needs to develop practical ways to support people with these commitments as well as demonstrating that this work is valued and not forgotten.

Parents and carers therefore have obligations which restrict their availability for paid employment. There are many other groups who are not in paid employment (or only part-time) due to no fault of their own, including pensioners, people living in areas with declining industries and few employment vacancies and people who experience discrimination in finding work due to their race, age or disability. Some people do not claim the benefits to which they are entitled. If the poverty and ill-health of people without paid employment is to be tackled, the uptake of benefits could be improved, benefit levels could be increased and additional services in kind (eg child care, respite care, luncheon clubs) could be developed.

4.2 Carers

The position of informal carers is of particular concern to CHCs. Undoubtedly, they contribute massively to the health and well-being of their dependents and save health and social services huge amounts of money as a result (estimates value their contribution at over £30 billion a year). Informal carers are also, in many cases, severely overworked and at risk of ill-health. The development of respite care services should be a priority, carefully monitored centrally by the NHS Executive and locally by CHCs.

Cleveland FHSA commissioned a research project by South Tees CHC which was published in 1994. This showed a high degree of commonality in the needs of carers, 80 per cent of whom had received no information about caring for their dependent. The range of training needs was extensive, requiring immediate attention. "The results show that carers are in desperate need of care and support themselves..."

Leeds CHC conducted research financed through Joint Funding arrangements. The 1995 report found that knowledge of services was sparse "and many older people who were in need of support had limited experience of formal services". The assessment process provided an opportunity for people to learn about benefits to which they were entitled. Support to carers varied considerably and "opportunities for a break from the caring role were rare".

In 1996, Wirral CHC published a survey of clients' and carers' needs for respite care for the elderly. Many carers appeared to receive "minimal support from the statutory services". Information on respite care "appeared to be lacking but this may be reflective of the extent of provision". However: "There is evidence of ongoing Carer development work with various statutory and voluntary agencies".

In June 1997, Worthing CHC published two reports on respite care. The families of children with special needs felt that respite care was "significantly lacking" and "often insufficient in terms of quantity and flexibility". The research relating to people with palliative care needs found "varying comments about the availability and quality of respite care".

4.3 Housing

Many people in poverty also suffer from poor housing or even homelessness. This increases the likelihood of their suffering ill-health.

The Association of CHCs was a member of the Standing Conference on Public Health (SCOPH) which published a report *Housing, Homelessness and Health* in November 1994. This report referred to the 1991 English House Conditions Survey which found 1,498,000 dwellings "unfit for human habitation".

The number of households accepted as homeless in England rose from 57,000 in 1979 to 148,250 in 1992. In 1992, 62,470 households in England were in temporary accommodation and the average length of stay in temporary accommodation was 47 weeks in 1991. "Women, children and ethnic minorities are vastly over-represented in the statutory homeless population...Ethnic minority households themselves make up 40-50 per cent of the official homeless population." In addition, the report points out that many people are homeless but not counted in the official statistics. The number of public sector housing starts fell from an average of 111,000 a year during the 1970s to under 40,000 a year during the 1980s, including housing association starts.

The SCOPH report points out: "dampness/mould, cold and overcrowding are important risk factors in a number of health disorders". The effects of inadequate housing on mental health are also highlighted.

ACHCEW calls for:

- Local Authorities to be given the power to provide accommodation to meet housing needs in their area
- a licensing system for Houses in Multiple Occupation
- a system of low interest loans for housing improvement, subsidised by central government
- rental deposit bond and guarantee schemes to help single homeless people who are often denied access to housing because they are unable to afford the deposit demanded by the landlord
- the planning of new housing to take into account the need to build communities rather than housing estates.

4.4 Smoking

Smoking is undoubtedly one of the main causes of avoidable ill-health and mortality and of the unacceptable inequalities in health. The Green Paper points out that in 1996 28 per cent of boys aged 15 and 33 per cent of girls aged 15 smoked regularly and these figures are rising. It has been estimated that for every 1,000 young smokers, one will be murdered, six will be killed in a road accident and 250 will die before their time because they smoke. It is essential that the trend is reversed so that a significantly smaller proportion of teenagers take up smoking.

As a member of the Tobacco Control Alliance, ACHCEW is pleased that the Government is no longer calling for Formula One to have a permanent exemption from the European Commission directive on advertising and sponsorship. We note that the ban should be complete by 1 October 2006. We also note the World Bank's conclusion: "In industrial countries a 10 percent price increase reduces consumption by about 4 percent in the general population and about 13 percent among adolescents". We are

concerned by the growing evidence of the harm caused by passive smoking (eg in the *Report of the Scientific Committee on Tobacco and Health*) but note that the NHS Centre for Reviews and Dissemination has concluded: "Research evidence shows that there are highly cost-effective ways to help people stop smoking".

ACHCEW calls for the forthcoming White Paper on tobacco to adopt the following ten-point programme:

- the achievement of a UK ban on tobacco advertising and sponsorship well before the European deadline of 1 October 2006
- using taxation to increase the real price of tobacco products at a rate far above the increases in disposable income of young people
- bringing the age restriction on tobacco sales in line with alcohol so that it becomes illegal to sell cigarettes to anyone under 18
- stronger enforcement of the age restriction on tobacco sales
- policies to extend smoke-free environments in public places including a ban on smoking in public service buildings and on public transport, other than in designated and isolated areas
- a legal right to clean air at work, barring specified exceptional circumstances
- a high budget mass media campaign to complement work in schools to educate children about the dangers of smoking
- health professionals systematically to identify patients who smoke and to encourage and support them to stop smoking, including intensive cessation advice to pregnant women
- Nicotine Replacement Therapy products to be available on NHS prescription and health professionals to encourage the use of NRT by those smokers who are motivated to quit
- health authorities and other commissioners of health care to develop co-ordinated smoking cessation strategies and fund their implementation.

4.5 Health care

Health care can make a major contribution to tackle inequalities in health. While it is proper to stress the extent to which avoidable ill-health is due to social conditions and individual behaviour, we should not ignore the potential role of effective and equitable health care.

The Weighted Capitation Formula should be implemented and kept continually under review to ensure that allocations to health authorities give proper weight to the health care needs of areas with high levels of deprivation, morbidity and mortality.

Improvements in primary care should take place first in the areas of greatest need of effective health care. The development of Personal Medical Services, GP commissioning and Primary Care Groups should draw health care towards pockets of ill-health (contrary to GP fundholding which

disproportionately facilitated improvements in comparatively healthy and wealthy areas).

Resource allocation is also the job of individual clinicians who decide which medicines and services should be made available to which patients (and how soon). Little is known about clinical decision-making in terms of the criteria which doctors and nurses use when prioritising between patients: how much weight is attached to the occupational status of the patient? to the patient's caring responsibilities? to the patient's behaviour (eg smoking)? There is a risk that the effect is to disadvantage groups whose health care needs are greatest. Research, evaluation and accountability in this area are long overdue.

The health care needs of people from minority ethnic groups must also be considered. Issues of communication, advocacy, sensitivity and responsiveness should be built into the quality assurance mechanisms of the NHS. As the NHS becomes increasingly "primary care-led", with resource allocation decisions reached within Primary Care Groups, the case for effective ethnic monitoring within primary care is enhanced.

There is a growing body of research evidence on the deterrent effect of NHS charges. The existing exemptions mean that many people on low incomes do not face charges. Nevertheless, NHS charges contribute to the present inequalities in health. ACHCEW is disappointed by the recent increase in prescription charges but hopes that the fundamental spending review will lead to changes including:

- the exemption of all patients on long-term medication
- charges levied per prescription rather than per item prescribed
- free eye tests and dental check-ups.

Inequalities in NHS care need to be tackled by levelling the worst services up, not by levelling the best services down. If equity in health is to be pursued, policies should not be adopted which encourage affluent patients to opt out of NHS restrictions by going private. We are also concerned that pharmaceutical and other commercial pressures may lead individuals to place too much emphasis on medication, bought privately and without professional advice, as the route to good health.

4.6 Community Health Councils

Community Health Councils, with their statutory duty to represent the interests in the health service of the public in their district, are not mentioned once in the 90 pages of the Green Paper. In fact, CHCs have helped by identifying unmet needs for health care and other services, by providing health promotion and information and by supporting practical initiatives to improve public health.

CHCs regularly undertake research - including surveys, focus groups or informal discussions - into health problems in their patch.

- Brent CHC has been working on public health partnerships on urban estates. They have been networking with local residents in Stonebridge through rapid appraisal groups, then acting as their voice to the authorities. They have facilitated local residents in putting together a community-led Health From Leisure project on the Chalkhill Estate. They are active partners in Brent's Health Action Zone bid.

- Members of Bristol CHC met many people in a variety of community based groups active on an estate with high health need in Weston-super-Mare. The CHC recommends that a Healthy Living Centre and a dedicated GP practice should be set up on the estate.

- South Durham & Weardale CHC in conjunction with Sedgefield Health Alliance conducted a survey of health and social needs. The Health Alliance is a partnership between Sedgefield Borough Council, County Durham Health Authority and Durham County Social Services. A questionnaire was circulated to a random selection of 5000 residents. 48 per cent of respondents stated that they or a member of their family had a long term or recurring health problem.

- A report by Liverpool Eastern CHC led to the recruitment of peripatetic female GPs and funding for a youth worker.

CHCs advise members of the public on steps to improve their health, through advice sessions, leaflets and handbooks.

- Wandsworth CHC has produced a series of handbooks directed at the health needs of women, men and older people.

- Southport & Formby CHC has published a Community Support Directory which has been sent to voluntary organisations, church groups and post offices as well as being widely circulated within the local NHS.

- In partnership with a local voluntary organisation and North Tees NHS Trust, North Tees CHC is involved in a Lottery funds project to improve education, health promotion and health service awareness for local minority ethnic groups.

Occasionally, CHCs have picked up local concerns about potential environmental risks to health.

- Hillingdon CHC surveyed 800 residents about breathing difficulties and problems caused by noise from Heathrow Airport and the M4 motorway. The CHC then took evidence to the Terminal 5 Enquiry, opposing this development.

- With a high local incidence of asthma, Pembrokeshire CHC became concerned by a proposal to burn Orimulsion, a very dirty fuel, at a local power station. The CHC lobbied for a public inquiry, supported by local GPs and environmental groups. The plans were abandoned.

To achieve practical changes for the better, CHCs have often worked with other local groups and individuals.

- Liverpool Central & Southern CHC helped set up the Toxteth Health and Community Care Forum which has an emphasis on racial minority health and was successful in campaigning with the CHC for a children's minor injury unit. Funding was obtained from the Lottery to set up a health shop.

- The Bentley Health Forum was established in 1995 following a locality survey by Doncaster CHC. Tangible outcomes have included a "taxi scheme" which entitles registered members to reduced fares to GPs and the hospital and the installation of dropped kerbs at GP premises and "elderly persons" road traffic signs.

- Airedale CHC and Bradford CHC are partners in Bradford's bid for a Health Action Zone and, if successful, will be represented on the board. The bid places particular emphasis on the need to develop support for diabetics, to improve the co-ordination of recuperation and rehabilitation services and to tackle health inequalities in the inner city by linking economic and social regeneration to improvements in health care and access to health services.

The pursuit of public health should not be dominated by local authorities, health authorities and the medical profession. The most important "partners" are the public. With their legal status, nationwide coverage, cost-effectiveness and independence of the NHS and local government, CHCs have an important role to play. With adjustments to CHCs' statutory powers and rights and adequate resourcing, this role could be enhanced, to better meet current and future challenges.

5. Conclusion

Our Healthier Nation is an encouraging step which places due weight on the need to tackle health inequalities and the causes of ill-health, while also recognising the need for individuals to take responsibility for their own health. In response to the question raised at the end of the Green Paper, ACHCEW does "mostly support" the proposals.

It is however clear that if significant progress is to be achieved in the foreseeable future, a radical set of policies will be required from the Government. These are likely to involve programmes which will arouse the opposition of powerful vested interests (in particular, the tobacco and allied industries) and imply significant public expenditure which cannot be met from present NHS resources. Without determination and radicalism, progress will be made only over a long timescale, implying a continuing heavy toll from avoidable ill-health.

6. Summary of recommendations

6.1 The national targets

We recommend that the White Paper should ensure that any targets on cancer and on health disease and stroke for people under 65 do not encourage age discrimination in NHS services.

ACHCEW is concerned that the Government has not included the previous targets around sexual health. ACHCEW is concerned that the dropping of targets on HIV/AIDS could have negative implications for the funding of HIV and AIDS services. We recommend that the Government reconsiders this issue and restores targets for sexual health in the White Paper.

ACHCEW is concerned that the Green Paper fails to incorporate maternal health targets. ACHCEW notes with alarm recent evidence which highlights Britain's very poor record for producing seriously underweight babies. We recommend that the Government includes targets around maternal nutrition in the White Paper.

We recommend that there should not be a national target based on official suicide statistics since these may be inaccurate and are not an adequate measure of mental health. Targets should be based on tracking poor mental health rather than mortality. We recommend that the targets for mental health must include objectives which ensure that mental health care within primary care is improved dramatically from its low level and is provided to all patients who require such a service not just those who are chronically mentally ill.

We recommend that, subject to the conclusions of the Acheson Committee, a national target should be set for reducing health inequalities. Annual reports should be also issued by the Department of Health specifying the targets set in each Health Improvement Programme and the progress achieved, identifying good practice models.

6.2 Poverty, work and nutrition

We endorse the analysis in the Green Paper that: "Tackling inequalities generally is the best means of tackling health inequalities in particular". To reduce the poverty and ill-health of people without paid employment, the uptake of benefits could be improved, benefit levels could be increased and additional services in kind (eg child care, respite care, luncheon clubs) could be developed. We also feel that employers have a major role to play in improving health, and would welcome improved health and safety standards at work, and improved working conditions.

Informal carers contribute massively to the health and well-being of their dependents and save health and social services huge amounts of money as a result. Informal carers are also, in many cases, severely overworked and at risk of ill-health. We recommend that the development of respite care services should be a priority, carefully monitored centrally by the NHS Executive and locally by CHCs.

We note that the Green Paper suggests that schools be expected to "set nutritional standards for school meals" (page 50). We recommend that these standards should be set nationally.

6.3 Housing

ACHCEW calls for:

- Local Authorities to be given the power to provide accommodation to meet housing needs in their area
- incentives to owners to bring empty housing into use
- a licensing system for Houses in Multiple Occupation
- a system of low interest loans for housing improvement, subsidised by central government
- rental deposit bond and guarantee schemes to help single homeless people who are often denied access to housing because they are unable to afford the deposit demanded by the landlord
- the planning of new housing to take into account the need to build communities rather than housing estates.

6.4 Smoking

ACHCEW calls for the forthcoming White Paper on tobacco to adopt the following ten-point programme:

- the achievement of a UK ban on tobacco advertising and sponsorship well before the European deadline of 1 October 2006
- using taxation to increase the real price of tobacco products at a rate far above the increases in disposable income of young people
- bringing the age restriction on tobacco sales in line with alcohol so that it becomes illegal to sell cigarettes to anyone under 18
- stronger enforcement of the age restriction on tobacco sales
- policies to extend smoke-free environments in public places including a ban on smoking in public service buildings and on public transport, other than in designated and isolated areas
- a legal right to clean air at work, barring specified exceptional circumstances
- a high budget mass media campaign to complement work in schools to educate children about the dangers of smoking

- health professionals systematically to identify patients who smoke and to encourage and support them to stop smoking, including intensive cessation advice to pregnant women
- Nicotine Replacement Therapy products to be available on NHS prescription and health professionals to encourage the use of NRT by those smokers who are motivated to quit
- health authorities and other commissioners of health care to develop co-ordinated smoking cessation strategies and fund their implementation.

6.5 Fluoridation

ACHCEW endorses the Government's view that "fluoridation offers an important and effective method of protecting the population from tooth decay" (3.34). We recommend that all health authorities in areas without fluoridation should be required to test local opinion and engage in formal consultation procedures with CHCs, local authorities and voluntary and community organisations. Where most of the health authorities in a water company's area favour fluoridation following such a consultation procedure, the company should be required to act accordingly.

6.6 Health care

The Weighted Capitation Formula should be implemented and kept continually under review to ensure that allocations to health authorities give proper weight to the health care needs of areas with high levels of deprivation, morbidity and mortality.

Improvements in primary care should take place first in the areas of greatest need of effective health care.

Little is known about the criteria which doctors and nurses use when prioritising between patients. There is a risk that the effect might be to disadvantage groups whose health care needs are greatest. We call for research and evaluation in this area.

The health care needs of people from minority ethnic groups must also be considered. Issues of communication, advocacy, sensitivity and responsiveness should be built into the quality assurance mechanisms of the NHS. With the NHS becoming increasingly "primary care-led", with resource allocation decisions to be reached within Primary Care Groups, ACHCEW recommends the development of effective ethnic monitoring within primary care.

ACHCEW is disappointed by the recent increase in prescription charges and recommends:
- the exemption of all patients on long-term medication
- charges levied per prescription rather than per item prescribed

- free eye tests and dental check-ups.

6.7 Empowerment and CHCs

The pursuit of public health should not be dominated by local authorities, health authorities and the medical profession. The most important "partners" are the public. It is essential that local public health priorities reflect the felt needs of local communities, especially the most deprived and unhealthy sections of these communities. CHCs can play a very effective role in community development and research, empowering local people to express their perceptions.

We recommend that the public's perspective be incorporated in public health research by ensuring representation of CHCs and other non-professional interests on funding bodies and reference panels. The public's perception of the impact on their own wellbeing of health hazards should be a leading concern in research. Research by independent and campaigning organisations should be funded to ensure a wide range of perspectives in the development of public health, not rigidly tied to an official agenda and set of priorities. CHCs are well placed to carry out or support research in their own areas and should be resourced to do so.

We endorse the following recommendations of the interim report from the *Chief Medical Officer's Project to Strengthen the Public Health Function in England*:

- commission a review of the evidence for the effectiveness of public involvement and identify the research gaps that need to be filled to increase our knowledge of good practice
- develop a national strategy for increasing public awareness and involvement in public health matters
- review the role of CHCs in involving the public in public health matters.

Community Health Councils have a record of identifying unmet needs for health care and other services, providing health promotion and information and supporting practical initiatives to improve public health. Given their legal status, nationwide coverage, cost-effectiveness and independence of the NHS and local government, CHCs have an important role to play. With adjustments to CHCs' statutory powers and rights and adequate resourcing, this role could be enhanced, to better meet current and future challenges.

Ben Griffith
Mayl 1998

infoleft: ben/workarea/green28a

Published by:

ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES
30 DRAYTON PARK LONDON N5 1PB

TEL: 0171 609 8405 FAX: 0171 700 1152

Price: £6.50 (inc. p&p)